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OF THE STATE OF WASHINGTON

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STATE OF WASHINGTON

LEASA LOWY,  
Respondent,  
vs.

PEACEHEALTH, a Washington corporation; ST. JOSEPH HOSPITAL;  
and UNKNOWN JOHN DOES, Defendant.

Petitioners,

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ANSWER TO PETITION FOR REVIEW

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## **I. RESTATEMENT OF ISSUE PRESENTED FOR REVIEW**

Whether the Court of Appeals erred in holding that RCW 70.41.200(3) does not prohibit a hospital from conducting an internal review of its Quality Assurance (QA) files to facilitate the identification and production in discovery of documents and information maintained elsewhere in the hospital, where no one outside the hospital will review the QA files, and where the documents to be identified and produced are not created specifically for the hospital's QA committee, are not privileged from discovery by the QA statutes and are indisputably relevant, and where no other means exists for identifying the discoverable documents and information in the hospital's possession?

## **II. SUMMARY OF THE ARGUMENT**

This Court has long recognized that the Quality Assurance statutes conflict with a plaintiff's right to discovery, and for this reason, the Court has determined that these are to be strictly construed. *Coburn v. Seda*, 101 Wn.2d 270, 276, 677 P.2d 173 (1984); *Anderson v. Breda*, 103 Wn.2d 901, 905, 700 P.2d 737 (1985); *Adcox v. Children's Orthopedic Hosp. and Medical Center*, 123 Wn.2d 15, 31, 864 P.2d 921(1993). Subsequent cases affirming the right of discovery as part of the constitutional right of access to courts only underscores the reasoning of these cases. See *Putman v.*

*Wenatchee Valley Medical Center*, 166 Wn.2d 974, 216 P.3d 374 (2009);  
*John Doe v. Puget Sound Blood Ctr.*, 117 Wn.2d 772, 819 P.2d 370 (1991).

The Court of Appeals in this case approves a limited and reasonable discovery order which protects Dr. Lowy's right to discover facts relevant to her claim, while preserving the protections of the QA statutes for the hospital. The opinion does *not* require the disclosure of *any* privileged information or documents in the hospital's QA file or permit anyone outside the hospital to review the file. Rather, the Court of Appeals only required the hospital to examine its QA file in order to identify and produce in discovery *non-privileged* materials in its possession, items which are indisputably relevant and discoverable. This procedure is the only means available for identifying this discoverable material, other than a laborious page by page search of thousands of patient records.

The hospital repeatedly misstates this limited holding of the Court of Appeals. The issue according to the hospital is whether "the plaintiff can force the hospital to review such [QA] records or database ***and disclose to the plaintiff information contained therein?***" Pet. at 3 (emphasis added). The hospital complains that the Court of Appeals' opinion requires it to review its QA file "and tell her what it contains to aid her in her medical malpractice litigation." Pet. at 10. The QA database becomes "a mother lode of data for

plaintiffs' lawyers to mine." Pet. at 13. It contends that this result "vitiates the privilege conferred upon hospital quality improvement databases." Pet. at 10. The Court's opinion will "transform hospital quality improvement program databases into clearinghouses for records production in medical negligence lawsuits—precisely what the legislature meant to protect hospitals from." Pet. at 12.

This argument is an exercise in hyperbole. The Court of Appeals' opinion does not allow disclosure of any protected information generated by the hospital's QA process. As the opinion states (p. 8):

The medical charts Lowy seeks were not created specifically for the quality assurance committee, are maintained external to committee files, and are indisputedly relevant and discoverable. In disclosing them, the hospital will not be required to disclose who participated in the review process concerning IV injuries, which incidents the hospital found relevant or important, or how it sorted, grouped, or otherwise organized those incidents. The hospital will not disclose any analysis, discussions, or communications that occurred during the proceedings of the quality assurance committee. The response to the discovery request will reveal no more than if the hospital had produced the medical records through a burdensome page-by page search.

The Court of Appeals in a well-reasoned opinion correctly decided the single question of statutory construction before it, i.e., whether a 2005 amendment to the QA statutes prohibit the hospital from conducting an internal review of its QA files. The Court properly ruled that while the

statute bars external review of QA material, a prohibition on internal review would frustrate the very purpose of the QA statutes. Further, the hospital's claim that the statute prohibits internal review is undermined by the fact "the hospital has already conducted an internal review of the database." Op. at 6.

The Court properly found that the legislative history supported this interpretation of the meaning of "review" in the statute. The 2005 amendment was intended to prevent extrajudicial access to QA materials, access not hitherto prohibited. This uncontroversial bill was supported by the Washington State Trial Lawyers Association and the Washington State Hospitals Association, and approved unanimously. Op. at 8-9.

The Court of Appeals has issued a solid, well-reasoned opinion which has a limited, but important, effect on the conduct of discovery in this case. That opinion does not present the "parade of horrors" suggested by the hospital. Review is not warranted.

### **III. RESTATEMENT OF THE CASE**

The facts relevant to the legal issues presented by this case are clearly and accurately laid out in the Court of Appeals opinion. Op. at 2-4. On June 21, 2007, Dr. Leasa Lowy, a staff physician at the time for the hospital, was admitted as a patient. While hospitalized, the hospital staff improperly administered an IV to her left arm, seriously and permanently injuring it.

Dr. Lowy brought medical malpractice and corporate negligence claims against the hospital. She subsequently learned that the hospital had a serious and systemic problem with IV infusion injuries. She did not, as Petitioner implies, seek out this information, or make any improper use of her position to obtain it. She described how she learned of the problem:

Stephanie Jackson, who works in the system office, came to me and asked me if I would go have a cup of coffee with her. And she brought her computer over. And we were not in a meeting. We were not doing anything. And she said, there is something I really want to show you. And I said, okay. And we were talking about her personal life, and her significant other, and their stuff in Eugene. And I thought maybe she was going to show me some pictures of her family. And she opened up a program called Pro Clarity or Clarity. And she showed me the screen. And the screen had what looked like a list. And she said, these are all the IV injuries that we've had. And I've been trying to get the PeaceHealth people to put an IV team in place. There is about 170 IV injuries. And she said, I wanted to know how you're doing, because we're not—nothing is getting done about this. And she said I don't understand why nothing is getting done about it.

CP 29-30; 40-41.

The information which Dr. Lowy saw on the screen did not disclose patient names. It did disclose dates, what appeared to be an identification number for each incident, and some details of patient injury. Dr. Lowy saw the screen for about five minutes. She was not offered and does not have a printout of the information on the screen. CP 41.

Dr. Lowy requested discovery of incidences of IV infusion

complications and/or injuries at the hospital. CP 20-23. The hospital did not contest the relevancy of the information to her claims. It conceded that review of the QA file was a “potential reasonable source” of identifying the requested information, (CP 19), but it argued that the QA statutes precluded this use of the QA file. Further, it contended that the alternative method of identifying the records, a page by page review of every patient record at the hospital over a period of years in search of responsive incidents was unduly burdensome. CP 25 (Whealdon Dec. ¶3).

Dr. Lowy did not contest the claim that the page by page search was unduly burdensome. She also made clear that she was not seeking discovery of QA privileged documents or information. CP 32.<sup>1</sup> Dr. Lowy argued, however, that responsive and discoverable information could be produced without violating the QA statutes by using the following procedure:

(1) A person or persons on behalf of the hospital will review the QA material.

(2) The hospital will use the information gathered in this process to identify non-privileged medical records and other documents. The hospital has never denied that non-privileged medical records and information could

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<sup>1</sup> Plaintiff also made clear that she did not intend to violate patient privacy rights, and that redaction of personal identifiers would be proper. CP 28.

be identified from the QA material; nor has it contended that this procedure is unduly burdensome.

(3) The hospital will disclose the non-privileged information it identifies, consisting of “underlying facts and explanatory circumstances charted in hospital records relating to alleged injuries, complications, malfunctions or adverse events associated with any IV infusions,” information not protected by the QA privilege. CP 54.

The trial court initially granted the Dr. Lowy’s proposed order (A4-5), but on reconsideration, it denied the requested discovery. Although regarding Dr. Lowy’s proposal as “reasonable” and “practical,” the court ruled that RCW 70.41.200 compelled denial of the requested discovery. A1-3.

The Court of Appeals granted discretionary review, and on January 31, 2011, issued its opinion reinstating the original trial court order.

#### **IV. ARGUMENT WHY REVIEW SHOULD BE DENIED**

A. **The Court of Appeals Correctly Followed this Court’s Precedent Strictly Construing the QA Statutes, and Correctly Considered the Purposes of the QA Statutes, the Legislative History, and Plaintiff’s Right to Discovery in Ruling that RCW 70.41.200(3) Permits Internal Review of a Hospital’s QA Files in order to Facilitate the Identification and Production of Relevant Non-Privileged Information.**

Washington has two Quality Assurance (QA) statutes: (1) RCW 4.24.250, originally enacted in 1971, and (2) RCW 70.41.200, originally

enacted in 1986. RCW 4.24.250 applies to health care providers, including hospitals. RCW 70.41.200 applies only to hospitals. *See Adcox v. Children's Orthopedic Hosp. and Medical Center*, 123 Wn.2d at 31. However, the language relevant to this case is identical in both statutes.<sup>2</sup>

RCW 70.41.200(3) provides in relevant part:

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 Court's case law on RCW 4.24.250 provided the legal framework for the Court of Appeals' interpretation of RCW 70.41.200(3). The QA statutes are strictly construed because they are in derogation of common law and the general policy in favor of discovery. *Coburn v. Seda*, 101 Wn.2d at 276; *Anderson v. Breda*, 103 Wn.2d at 905. Op. at 6-7. As this Court observed in *Coburn*, 101 Wn.2d at 276 (emphasis added):

What is the scope of the statute's grant of immunity from

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<sup>2</sup> The hospital asserted both statutes in the courts below, and its argument did not distinguish between them.

discovery? The protection afforded by the statute was nonexistent at common law. [citation omitted]. Further, the prohibition of discovery is in sharp contrast to the general policy favoring broad discovery. [citations omitted]. **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.**

In *Adcox v. Children's Orthopedic Hosp. and Medical Center*, 123 Wn.2d 15, 31, 864 P.2d 921(1993), this Court reaffirmed its earlier decisions.

We have already recognized that this statute, being contrary to the general policy favoring discovery, is to be strictly construed and limited to its purposes. *Coburn v. Seda*, 101 Wn.2d 270, 276, 677 P.2d 173 (1984). Moreover, the burden of proving the statute's applicability rests with the party seeking its application. *Anderson*, 103 Wn.2d at 905, 700 P.2d 737.<sup>4</sup>

Under RCW 70.41.200(3), QA documents are “*not subject to review or disclosure, except as provided in this section, or discovery or introduction into evidence in any civil action.*”<sup>5</sup> The four discrete protections are to be strictly construed. None apply here.

The Court of Appeals does not allow the *disclosure* of any QA

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<sup>4</sup> *Adcox* rejected the hospital's contention that an “informal investigation” was entitled to the QA privilege. The hospital failed to show that the review was conducted by a “regularly constituted review committee.” Because it failed to meet the requirements of the statute construed strictly, the hospital was not entitled to assert the QA privilege. 123 Wn.2d at 31.

<sup>5</sup> RCW 4.24.250 contains language identical to the language emphasized and quoted here.

document or information to Respondent. It does not allow the production in *discovery* of any QA document or information. It does not allow the *introduction into evidence* of any QA document or information. Finally, it does not allow Respondent to *review* any QA document or information.

The hospital argues, however, that the “review” language bars internal review of the QA information by the hospital itself. This argument fails and the Court of Appeals rightly rejected it.

First, the hospital never explains why its broad interpretation of the meaning of “review” is consistent with the strict construction required of the QA statutes when they are used to prevent discovery. “To strictly construe a statute simply means that given a choice between a narrow, restrictive construction and a broad, more liberal interpretation, we must choose the first option.” *In re Detention of Martin*, 163 Wn.2d 501, 510, 182 P.3d 951 (2008). The hospital’s broad interpretation of “review” ignores this canon.

Second, the QA statute is “to be strictly construed *and limited to its purposes.*” *Coburn*, 101 Wn.2d at 276 (emphasis added). Internal review is essential to the purposes of the QA statutes. As the Court of Appeals pointed out, “preventing all hospital personnel from reviewing the contents of the database would frustrate the very purpose for which the quality assurance committee gathered the records in the first place.” Op. at 6. The

court rightly concluded that “it is not reasonable to interpret the statute as containing an outright prohibition on internal review.” *Id.*

Third, the Court of Appeals’ interpretation of “review” is consistent with the limited purpose of the statute, to protect a hospital’s self-assessment, while at the same time, allowing a plaintiff to obtain relevant non-privileged evidence. In *Coburn*, 101 Wn.2d at 274, this Court described how both interests are given effect:

The discovery protection granted hospital quality review committee records, like work product immunity, prevents the opposing party from taking advantage of a hospital’s careful self-assessment. The opposing party must utilize his or her own experts to evaluate the facts underlying the incident which is the subject of suit and also use them to determine whether the hospital’s care comported with proper quality standards.

The Court of Appeals’ opinion does not allow Dr. Lowy to access the hospital’s own self-assessment of its IV problem. It does not give her access to incident reports, or statements or testimony specifically created for the committee. But she is entitled to have access to non-privileged facts so that her experts can make their own assessment. The requested discovery provides her with access to those non-privileged facts.

Fourth, internal review of the QA file is a proper part of discovery. Mere placement of a document in a QA file does not immunize it from discovery. By its express terms, RCW 70.41.200 protects only information

and documents “created specifically for, **and** collected **and** maintained by, a quality improvement committee.” (Emphasis added). As *Coburn* states:

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.

*Coburn*, 101 Wn.2d at 277.

Since a QA file may contain non-privileged information, a hospital must internally review the file in response to a discovery request. And as the Court of Appeals pointed out, the hospital has already conducted an internal review of its QA database in response to Dr. Lowy’s discovery request. Op. at 6; CP 24-25. If the statute prohibits “internal review,” then the hospital violated the statute in this case.<sup>6</sup> The hospital, however, did not violate the statute. Rather, it properly carried out an “internal review” in response to the discovery request.

Fifth, the Court of Appeals rightly noted that the legislative history supports its interpretation of the “review” language. Op. at 8-9. That

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<sup>6</sup> In the Court of Appeals, the hospital argued that the “plain and unequivocal” meaning of “review” prohibits the hospital’s internal review of the QA file. Respondent’s Court of Appeals’ brief at 16. The hospital does not make the “plain meaning” argument in this Court, presumably because it cannot explain why it ignored this “plain meaning” when it internally reviewed the QA file.

language was added by chapter 291 of the Laws of 2005, as follows:<sup>7</sup>

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 . . . .<sup>8</sup> (Emphasized language added by Laws of 2005, ch. 291).

Before passage of this bill, the protections of RCW 70.41.200(3) applied in the judicial setting. It prohibited “discovery or introduction into evidence” of QA protected materials, but it did not prohibit dissemination of QA protected material extrajudicially, i.e., to the public. The legislature intended Chapter 291 to fill this gap by prohibiting extrajudicial access of the public to QA materials. The testimony supporting the bill states:

It adds protection for quality improvement and peer review committees that do not exist statutorily. This allows open discussion without the fear of the information being released to the **public**, and provides the opportunity to candidly discuss bad outcomes and near misses. The **public** still retains access to the information that goes into the committee and that comes out of the committee, but does not have access to the inner workings of the committee. (Emphasis added).

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<sup>7</sup> Appendix A9-A15 contains ch. 291 in its entirety. The addition of the “review or disclosure” language to RCW 70.41.200, RCW 4.24.250 and RCW 43.70.510 were the only changes made by this chapter.

<sup>8</sup> Prior to the passage of Laws of 2005, ch. 291, the relevant portion of 70.41.200(3) stated: “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 . . .”

App. at 17 (Senate Bill Report EHB 2254).

The bill enjoyed bipartisan support for this limited purpose. Both the Washington State Trial Lawyers Association and the Washington State Hospitals Association agreed to the bill, and the bill passed unanimously. Appendix at 17, 20. Nothing in the history of this uncontroversial bill indicates that the legislature intended the unprecedented expansion of the scope of the QA statutes described by the hospital. Although the hospital argues that the Court of Appeals erred in imputing a non-existent intention to the legislature, the hospital itself ignores the actual legislative history reflecting the limited intention of the legislature.

In sum, considerations of statutory construction, the purposes of the statute, the countervailing purposes of discovery, and legislative history all support the Court of Appeals' opinion. In addition, the hospital's criticisms of the decision miss the mark by a wide margin.

The hospital contends that the Court of Appeals improperly limited "review" to "external review" even though the statute does not contain the word "external." Pet. at 10-12. Both *Coburn* and *Anderson* expressly stated that RCW 4.24.250 was intended to prohibit "external access" to committee

proceedings, even though the word “external” does not appear in that statute.<sup>9</sup> This Court recognized that the prohibition on “external access” expressed the legislative intention.

Petitioner argues that the Court of Appeals’ reasoning “vitiates the privilege conferred upon hospital quality improvement databases” and that this reasoning “could be applied to *any* type of privilege.” Pet. at 10 (emphasis added). The reasoning of the Court of Appeals already applies to other privileges. For instance, an attorney or client may not be required to answer questions about a privileged attorney-client communication. But an attorney unquestionably may review privileged communications if necessary in order to identify and disclose non-privileged information and/or documents responsive to discovery. Indeed, when an attorney prepares ordinary discovery responses, the attorney typically engages in privileged communications with the client in order to determine what response should be made, and what information needs to be disclosed. The privileged communications themselves are not disclosed, but they are reviewed in order

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<sup>9</sup> “Statutes bearing similarities to RCW 4.24.250 prohibit discovery of records on the theory that *external* access to committee investigations stifles candor and inhibits constructive criticism thought necessary to effective quality review.” *Coburn*, 101 Wn.2d at 275 (emphasis added). “The Legislature recognized that *external* access to committee investigations stifles candor and inhibits constructive criticism thought necessary to effective quality review.” *Anderson*, 103 Wn.2d at 905 (emphasis added).

to make non-privileged disclosures.

As another example, if the client responds to a question in a deposition or at trial with an answer that differs from that given in a previous privileged communication, the attorney may review the privileged communication with the client for the purpose of making sure the record or evidence is truthful. The attorney may do so without waiving the privilege which attaches to the communication, or without disclosing any information about the privileged communication itself.

The hospital in effect is contending that the QA statutes give it a “superprivilege” with protections over and above the traditional privileges recognized at common law. This argument stands the law of privileges on its head. One of the reasons QA privilege is given a narrow construction is because it derogates from the common law. The attorney-client privilege should in fact be given a broader construction than the QA privilege because the former is not in derogation of common law. *See e.g., In re Schafer*, 149 Wn.2d 148, 160, 66 P.3d 1036 (2003) (the attorney client privilege is the oldest of the common law privileges).

In its Petition to this Court, the hospital now points out that certain language in RCW 70.41.200(3) “is even more broadly worded than RCW 4.24.250” with the implication that the analysis in *Coburn* and *Anderson*

does not apply to RCW 70.41.200(3). See Pet. at 13-15. Petitioner did not make this argument to the Court of Appeals, for the obvious reason that the key language in both statutes is identical, as the hospital admitted in its Court of Appeals' brief.<sup>10</sup> The minor differences in wording found elsewhere in the statute constitute distinctions without a difference.<sup>11</sup>

Instead of addressing the legislative history of the 2005 legislation, the hospital supports its interpretation of Washington law with cases from South Carolina, Michigan, Massachusetts, and the federal courts. Pet. at 13-20. None of the statutes in these cases contain the "review" language found in Washington's QA statute. None has Washington's unique legislative history. Further, in each case a party was attempting to obtain the protected material itself. Dr. Lowy is not. Finally, no case applied strict construction, the fundamental canon for interpreting QA statutes in Washington.<sup>12</sup>

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<sup>10</sup> The hospital's brief observed that RCW 4.24.250(1) "contains identical language to that of RCW 70.41.200(3) relevant to the issue in this case." Respondent's Brief in the Court of Appeals, p. 13 n. 6.

<sup>11</sup> Respondent is at a loss to understand the practical difference between protection accorded "proceedings, reports, and written records" in RCW 4.24.250 versus protection accorded "Information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee . . ." under RCW 70.41.200(3). The hospital certainly does not explain how these minor variations make a difference in the issue here.

<sup>12</sup> *In re Lieberman*, 646 N.E.2d 199 (Mich. App. 2002), the Michigan court rejected the prosecutor's contention that the privilege should be narrowly construed, in favor of a broad construction of the statute. 646 N.W.2d at 203. This type of

Petitioner faults the Court of Appeals for its failure to apply *Dayton Newspapers, Inc. v. Dept. of the Air Force*, 107 F.Supp.2d 912 (S.D. Ohio 1990), a case involving a Freedom of Information Act (FOIA) request for a quality assurance database operated by the Defense Department. *Dayton Newspapers* is readily distinguishable, and the Court rightly ignored it.

First, the federal QA statute in *Dayton Newspapers* is much broader than RCW 70.41.200(3). It protects QA records from disclosure “regardless of whether the contents of such records originated within or outside of a medical quality assurance program.” 107 F.Supp.2d at 917. If a record is created as a QA record, *or* maintained as a QA record, the federal statute prohibits its disclosure. Thus, an ordinary patient record placed in the federal QA file is immune from disclosure.<sup>13</sup> As noted above, the same record in Washington is discoverable, even if it is maintained in the QA file.

Second, as noted above, strict construction applies to Washington’s QA statute because it conflicts with a plaintiff’s right to discovery. *Dayton Newspapers*, a FOIA case, did not involve civil discovery. The court did not

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difference is indicative of why these out of state cases are not helpful in interpreting Washington law.

<sup>13</sup> The federal statute, 10 U.S.C. §1102(h), does not authorize “disclosure of a patient’s medical files from a medical quality assurance record.” 107 F.Supp.2d at 917. Such disclosure can only be made from an outside source. *Id.*

consider the implications of the decision on the right to obtain discovery. It had no occasion to apply to apply strict construction, and it did not do so.

Third, *Dayton Newspapers* does not address the relief sought by Respondent. Plaintiffs in *Dayton Newspapers* did not ask the Defense Department to review its database in order to identify materials outside the database. The newspapers sought production of the database itself. Dr. Lowy is not asking for production of the database here. *Dayton Newspapers* has no relevance in interpreting Washington's statute on the facts here.

Finally, the hospital's interpretation of the statute would completely deprive Dr. Lowy of the discovery of evidence in support of her claims, evidence which is indisputably not privileged, and which exists in the hospital's non-QA files. In *Putman v. Wenatchee Valley Medical Center*, 166 Wn.2d 974, 216 P.3d 374 (2009), this Court reaffirmed the constitutional foundations of civil discovery. The Court stated:

The very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury. . . . The people have a right of access to courts; indeed, it is "the bedrock foundation upon which rests all the people's rights and obligations." . . . This right of access to courts "includes the right of discovery authorized by the civil rules." ... As we have said before, "[i]t is common legal knowledge that extensive discovery is necessary to effectively pursue either a plaintiff's claim or a defendant's defense."

*Id.*, 166 Wn.2d at 979 (citations omitted).

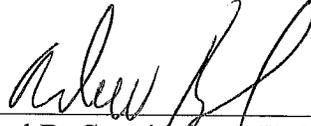
The interpretation of the QA statute must take account of the fundamental nature of a plaintiffs' right to discovery. Discovery is not simply a "mere value" to be discarded when lawyers are able to conjure an interpretation of a statute which allows a party to avoid discovery obligations. Where, as here, the statute can be interpreted so as to give effect both to the language of the statute and a plaintiff's right to discover highly relevant information, that interpretation should be adopted. The Court of Appeals' opinion did just that. It avoids the constitutional objections posed by the hospital's interpretation while preserving the legitimate purposes of the QA statutes.

**V. CONCLUSION**

Dr. Lowy respectfully asks this Court to deny the Petition for Review.

Dated this 1<sup>st</sup> day of April, 2011.

LUVERA, BARNETT, BRINDLEY,  
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PEACEHEALTH, a Washington corporation; ST. JOSEPH HOSPITAL;  
and UNKNOWN JOHN DOES, Defendant.

Petitioners,

---

APPENDIX

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JUN 17 2009

Office of Luvera Barnett Brindley  
Beninger & Cunningham

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SUPERIOR COURT OF THE STATE OF WASHINGTON FOR KING COUNTY

|  |   |                      |
|--|---|----------------------|
| LEASA LOWY,                            | ) |                      |
|  | ) | No. 08-2-37646-0 SEA |
| PLAINTIFF,                             | ) | ORDER                |
| v.                                     | ) |                      |
| PEACEHEALTH, a Washington corporation; | ) |                      |
| ST. JOSEPH HOSPITAL; and UNKNOWN       | ) |                      |
| JOHN DOES,                             | ) |                      |
| DEFENDANTS.                            | ) |                      |

Defendants have moved the Court to reconsider its order of April 30, 2009 requiring the disclosure of the underlying factual basis contained in hospital records relating to any injuries, complications, malfunctions or adverse events associated with any IV infusions during the period January 1, 2003 through March 31, 2009. The Court has considered Defendant's Motion for Reconsideration, Plaintiff's Response in Opposition and Defendant's Reply, as well as the previous submissions of the parties.

The Court's order of April 30, 2009 was an effort to balance plaintiff's broad discovery rights under CR26 with the statutory mandate of R.C.W. 70.41.200 (3), specifically prohibiting the disclosure of "[i]nformation and documents, including complaints and incident reports created specifically for, and corrected and maintained by a quality improvement committee" *Id.* The statutory language chosen by the legislature had made clear its intent to bar disclosure while

ORDER

1.

Judge Harry J. McCarthy  
King County Superior Court  
516 Third Avenue  
Seattle, WA 98104  
206-296-9205

1 simultaneously created a privilege for all information collected by the hospital committee, The  
2 question again presented to the Court is whether or not the liberal discovery rules of CR26  
3 trump the prohibitions set forth at R.C.W. 70.42.200 (3).  
4

5 As a general matter, Washington's liberal discovery rules would ordinarily prevail over a  
6 statute in derogation of common law, such as R.C.W. 70.41.200. Helpful case authority on this  
7 issue is scarce. In its analysis of a similar statute, R.C.W. 4.24.250, Division Three of the Court  
8 of Appeals in Ragland v. Lawless, 61 Wn. App 830, 838-39 812 P.2d 872 (1991), held that "all  
9 civil actions not falling within the specific exemption are subject to the statutory provision  
10 shielding certain information from discovery." Id at 838. The Court's analysis in Ragland is  
11 instructive as applied to the circumstances of this case.  
12

13  
14 The statutory scheme examined in Ragland precluding discovery except in certain  
15 specific instances, is very similar to R.C.W. 70.41.210 (3). Both statutes reflect a legislative  
16 decision to bar discovery of any hospital peer evaluation committee records unless a particular  
17 exemption can be shown. Here, as in Ragland, plaintiff does not claim that any of the  
18 exceptions apply but instead argues that a practical accommodation should be reached so that  
19 plaintiff's right to discovery of important, relevant underlying factual information present in the  
20 hospital records can be achieved.  
21

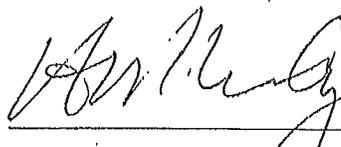
22  
23 The court's order of April 30, 2009 authorized access to the relevant, factual complaints  
24 and related information in order to balance the competing interests at stake. However  
25 reasonable or practical such an accommodation may be, it appears to be contrary to the language  
26 of R.C.W. 70.41.210 (3).  
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ORDER

1 It is unfortunate that a more practical solution allowing plaintiff relevant discovery is  
2 unavailable, but the plain language of R.C.W. 70.41.200 (3) compels the conclusion that any  
3 kind of disclosure, whether of committee opinion or underlying factual complaints, shall not be  
4 disclosed. Therefore, on further review and reconsideration, the court is persuaded that the  
5 Order of April 30, 2009 must be reversed.  
6

7 Defendants' Motion for Reconsideration is GRANTED.  
8

9  
10 DATED this 15 day of June, 2009

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14 \_\_\_\_\_  
15 Harry J. McCarthy, Judge  
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ORDER



1 and quality assurance committee at St. Joseph's Hospital pursuant to R.C.W. 4.24.250 and  
2 70.41.200,

3 It is ORDERED as follows:

4 The designated agent of St. Joseph's Hospital shall review all relevant records of the  
5 quality assurance and peer review committee for the period January 1, 2003 through March 31,  
6 2009 and disclose the following information:  
7

8 The underlying facts and explanatory circumstances charted in hospital records relating  
9 to alleged injuries, complications, malfunctions or adverse events associated with any IV  
10 infusions.  
11

12 Any peer review or quality assurance committee commentary, evaluations, opinions,  
13 discussion or conclusions related to alleged IV injuries, complications, malfunctions or adverse  
14 events associated with IV administrations, shall not be disclosed. Any information and  
15 documentation, other than records of the underlying facts and explanatory circumstances,  
16 "created specifically for, and collected and maintained by a quality improvement committee,"  
17 R.C.W. 70.41.200 (3), shall not be disclosed.  
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22 DATED this 30 day of April, 2009.

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26 Harry J. McCarthy, Judge  
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ORDER

Westlaw

West's RCWA 70. 41. 200

Page 1

West's Revised Code of Washington Annotated Currentness

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

Chapter 70.41. Hospital Licensing and Regulation (Refs &amp; 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, im-

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A6

proved 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.]

Current with 2010 Legislation effective through February 15, 2010

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WA LEGIS 291 (2005)

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2005 Wash. Legis. Serv. Ch. 291 (H.B. 2254) (WEST)

(Publication page references are not available for this document.)

WASHINGTON 2005 LEGISLATIVE SERVICE  
59th Legislature, 2005 Regular Session

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Additions are indicated by **Text**; deletions by  
~~Text~~. Changes in tables are made but not highlighted.  
Vetoed provisions within tabular material are not displayed.

## CHAPTER 291

H.B. No. 2254

EXECUTIVE DEPARTMENT--COMMITTEES--COORDINATED QUALITY IMPROVEMENT PROGRAMS  
AN ACT Relating to peer review committees and coordinated quality improvement  
programs; and amending RCW 4.24.250, 43.70.510, and 70.41.200.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 4.24.250 and 2004 c 145 s 1 are each amended to read as follows:

&lt;&lt; WA ST 4.24.250 &gt;&gt;

(1) Any health care provider as defined in RCW 7.70.020 (1) and (2) ~~as now exist-~~  
~~ing 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 com-  
petency 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 re-  
view 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 pre-  
sumption 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,  
~~shall not be~~ ~~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 clin-  
ical or staff privileges of a health care provider as defined ~~above~~ in RCW

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7.70.020 (1) and (2).

(2) A coordinated quality improvement program maintained in accordance with RCW 43.70.510 or 70.41.200 and any committees or boards 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) and 70.41.200(3).

Sec. 2. RCW 43.70.510 and 2004 c 145 s 2 are each amended to read as follows:

<< WA ST 43.70.510 >>

(1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof may 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 as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1) (a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the institution, facility, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, or any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether com-

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plying with the requirement set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply. In reviewing plans submitted by licensed entities that are associated with physicians' offices, the department shall ensure that the exemption under RCW 42.17.310(1)(hh) and the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of five or more providers may 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 as set forth in RCW 70.41.200. All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. All such programs must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply.

(3) 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 (6) of this section is not subject to an action for civil damages or other relief as a result of the activity or its consequences. 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.

(4) 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 that form the basis for the institution of such proceedings of which

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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 challenging the termination of a contract by a state agency with any entity maintaining a coordinated quality improvement program under this section if the termination was on the basis of quality of care concerns, introduction into evidence of information created, collected, or maintained by the quality improvement committees of the subject entity, which may be under terms of a protective order as specified by the court; (e) 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 (f) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) Information and documents created specifically for, and collected and maintained by a quality improvement committee are exempt from disclosure under chapter 42.17 RCW.

(6) 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 with RCW 70.41.200 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 (4) of this section and RCW 4.24.250.

(7) The department of health shall adopt rules as are necessary to implement this section.

Sec. 3. RCW 70.41.200 and 2004 c 145 s 3 are each amended to read as follows:

<< WA ST 70.41.200 >>

WA LEGIS 291 (2005)  
2005 Wash. Legis. Serv. Ch. 291 (H.B. 2254) (WEST)  
(Publication page references are not available for this document.)

(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, 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, 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 commit-

WA LEGIS 291 (2005)

2005 Wash. Legis. Serv. Ch. 291 (H.B. 2254) (WEST)

(Publication page references are not available for this document.)

tee 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

WA LEGIS 291 (2005)  
2005 Wash. Legis. Serv. Ch. 291 (H.B. 2254) (WEST)  
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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 with RCW 43.70.510 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 and RCW 4.24.250.

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

Approved May 4, 2005.

Effective July 24, 2005.

WA LEGIS 291 (2005)

END OF DOCUMENT

# SENATE BILL REPORT

## EHB 2254

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As Reported By Senate Committee On:  
Health & Long-Term Care, March 31, 2005

**Title:** An act relating to peer review committees and coordinated quality improvement programs.

**Brief Description:** Clarifying protections provided to quality improvement activities.

**Sponsors:** Representative Cody.

**Brief History:** Passed House: 3/15/05, 96-0.

**Committee Activity:** Health & Long-Term Care: 3/30/05, 3/31/05 [DP].

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### SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

**Majority Report:** Do pass.

Signed by Senators Keiser, Chair; Deccio, Ranking Minority Member; Benson, Brandland, Franklin, Johnson, Kastama, Kline, Parlette and Poulsen.

**Staff:** Stephanie Yurcisin (786-7438)

**Background:** Hospitals must maintain quality improvement committees to improve the quality of health care services and prevent medical malpractice. Quality improvement proceedings review medical staff privileges and employee competency, collect information relating to negative health care outcomes, and conduct safety improvement activities. Provider groups and medical facilities other than hospitals are encouraged to conduct similar activities.

With some limited exceptions, information and documents created for or collected and maintained by a quality improvement committee are not subject to discovery, not admissible into evidence in any civil action, and are confidential and not subject to public disclosure. A person participating in a meeting of the committee or in the creation or collection of information for the committee may not testify in any civil action regarding the content of the committee proceedings or information created or collected by the committee.

A provision of law immunizes a health care provider who, in good faith, files charges or presents evidence against another provider before a regularly constituted review committee or board of a professional society or hospital on grounds of incompetency or misconduct. The proceedings and records of a review committee or board are not discoverable except in actions relating to the recommendation of the review committee or board involving restriction or revocation of the provider's privilege.

**Summary of Bill:** The review or disclosure of information and documents specifically created for, and collected and maintained by, quality improvement and peer review committees is prohibited unless there is a specific exception.

**Appropriation:** None.

**Fiscal Note:** Not requested.

**Committee/Commission/Task Force Created:** No.

**Effective Date:** Ninety days after adjournment of session in which bill is passed.

**Testimony For:** This bill is an effort to ensure that quality improvement committee protections are still in place even with the potential passage of an initiative that will be on the ballot this fall. It adds protection for quality improvement and peer review committees that do not exist statutorily. This allows open discussion without the fear of the information being released to the public, and provides the opportunity to candidly discuss bad outcomes and near misses. The public still retains access to the information that goes into the committee and that comes out of the committee, but does not have access to the inner workings of the committee. This bill is agreed to by the Washington State Hospitals Association and the Washington State Trial Lawyers.

**Testimony Against:** None.

**Who Testified:** PRO: Representative Cody, prime sponsor; Lisa Thatcher, Washington State Hospitals Association.

# HOUSE BILL REPORT

## EHB 2254

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### As Passed Legislature

**Title:** An act relating to peer review committees and coordinated quality improvement programs.

**Brief Description:** Clarifying protections provided to quality improvement activities.

**Sponsors:** By Representative Cody.

#### Brief History:

##### Committee Activity:

Health Care: 2/28/05, 3/1/05 [DP].

##### Floor Activity:

Passed House: 3/15/05, 96-0.

Passed Senate: 4/12/05, 44-0.

Passed Legislature.

#### Brief Summary of Engrossed Bill

- Prohibits the review or disclosure of information and documents created for quality improvement and peer review committees.

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### HOUSE COMMITTEE ON HEALTH CARE

**Majority Report:** Do pass. Signed by 9 members: Representatives Cody, Chair; Campbell, Vice Chair; Morrell, Vice Chair; Appleton, Clibborn, Green, Lantz, Moeller and Schual-Berke.

**Minority Report:** Do not pass. Signed by 6 members: Representatives Bailey, Ranking Minority Member; Curtis, Assistant Ranking Minority Member; Alexander, Condotta, Hinkle and Skinner.

**Staff:** Chris Blake (786-7392).

#### Background:

Hospitals must maintain quality improvement committees to improve the quality of health care services and prevent medical malpractice. Quality improvement proceedings review medical staff privileges and employee competency, collect information related to negative health care outcomes, and conduct safety improvement activities. Provider groups and medical facilities other than hospitals are encouraged to conduct similar activities.

With some limited exceptions, information and documents created for or collected and maintained by a quality improvement committee are not subject to discovery, not admissible into evidence in any civil action, and are confidential and not subject to public disclosure. A person participating in a meeting of the committee or in the creation or collection of information for the committee may not testify in any civil action regarding the content of the committee proceedings or information created or collected by the committee.

A provision of law immunizes a health care provider who, in good faith, files charges or presents evidence against another provider before a regularly constituted review committee or board of a professional society or hospital on grounds of incompetency or misconduct. The proceedings and records of a review committee or board are not discoverable except in actions relating to the recommendation of the review committee or board involving restriction or revocation of the provider's privileges.

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**Summary of Engrossed Bill:**

The review or disclosure of information and documents specifically created for, and collected and maintained by, quality improvement and peer review committees is prohibited unless there is a specific exception.

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**Appropriation:** None.

**Fiscal Note:** Not requested.

**Effective Date:** The bill takes effect 90 days after adjournment of session in which bill is passed.

**Testimony For:** This is a placeholder for discussions related to the application of protections for quality improvement and peer review programs.

**Testimony Against:** None.

**Persons Testifying:** Larry Shannon, Washington State Trial Lawyers Association; and Lisa Thatcher, Washington State Hospital Association.

**Persons Signed In To Testify But Not Testifying:** None.

# FINAL BILL REPORT

## EHB 2254

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C 291 L 05

Synopsis as Enacted

**Brief Description:** Clarifying protections provided to quality improvement activities.

**Sponsors:** By Representative Cody.

**House Committee on Health Care**

**Senate Committee on Health & Long-Term Care**

### **Background:**

Hospitals must maintain quality improvement committees to improve the quality of health care services and prevent medical malpractice. Quality improvement proceedings review medical staff privileges and employee competency, collect information related to negative health care outcomes, and conduct safety improvement activities. Provider groups and medical facilities other than hospitals are encouraged to conduct similar activities.

With some limited exceptions, information and documents created for or collected and maintained by a quality improvement committee are not subject to discovery, are not admissible into evidence in any civil action, and are confidential and not subject to public disclosure. A person participating in a meeting of the committee or in the creation or collection of information for the committee may not testify in any civil action regarding the content of the committee proceedings or information created or collected by the committee.

A health care provider who, in good faith, files charges or presents evidence against another provider before a regularly constituted peer review committee or board of a professional society or hospital on grounds of incompetency or misconduct is immune from liability for these activities. The proceedings and records of a review committee or board are not discoverable except in actions relating to the recommendation of the review committee or board involving restriction or revocation of the provider's privileges.

### **Summary:**

The review or disclosure of information and documents specifically created for, and collected and maintained by, quality improvement and peer review committees or boards is prohibited unless there is a specific exception.

### **Votes on Final Passage:**

|        |    |   |
|--------|----|---|
| House  | 96 | 0 |
| Senate | 44 | 0 |

**Effective:** July 24, 2005

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

LEASA LOWY, )  
 )  
 Appellant, )  
 )  
 v. )  
 )  
 PEACEHEALTH, a Washington )  
 corporation; ST. JOSEPH HOSPITAL; )  
 )  
 Respondents, )  
 )  
 and )  
 )  
 UNKNOWN JOHN DOES, )  
 )  
 Defendants. )

No. 63866-1-I  
DIVISION ONE

PUBLISHED OPINION  
FILED: January 31, 2011

**FILED**  
COURT OF APPEALS  
DIVISION ONE  
JAN 31 2011

BECKER, J. — An issue concerning discovery of patient records comes to us on discretionary review. The plaintiff sustained a neurological injury to her left arm after an intravenous infusion in the hospital. As relevant to her cause of action against the hospital for corporate negligence, she requests production of medical charts of other patients who have experienced complications or injuries at the hospital in connection with intravenous infusions. To meet this request would be unduly burdensome unless the hospital is permitted to use its quality improvement database to identify the relevant records. The hospital contends the use of the database to identify relevant patient records is prohibited by RCW

70.41.200(3), a statute designed to protect the confidentiality of information created for and maintained by a quality improvement committee. We disagree and hold the hospital may internally review the database for this purpose. The order denying discovery is reversed.

Appellant Leasa Lowy, formerly a staff physician at St. Joseph's Hospital in Bellingham, stayed at the hospital as a patient for six days in January 2007. Lowy alleges that during her stay, she sustained permanent neurological injury to her left arm as a result of negligence when she had an intravenous, or IV, infusion. According to her physician, Lowy will no longer be able to practice her specialties of obstetrics and gynecology due to the injury.

The hospital is owned and operated by PeaceHealth. Lowy commenced this action against PeaceHealth and certain hospital employees. One of her theories against PeaceHealth is that the hospital is liable for corporate negligence. The doctrine of corporate negligence applies to hospitals in Washington. Pedroza v. Bryant, 101 Wn.2d 226, 229-33, 677 P.2d 166 (1984).

In connection with her theory of corporate negligence, Lowy sought to obtain, through a deposition under CR 30(b)(6), information relating to instances of "IV infusion complications and/or injuries at St. Joseph's Hospital for the years 2000-2008." It is undisputed that the requested information is relevant.

One way for the hospital to gather the requested information would be to go through its entire database of patient records. But the hospital lacks the capability of conducting such a search electronically. The parties agree that

requiring the hospital to conduct the search manually, page-by-page, would be unduly burdensome.

Another way for the hospital to obtain the requested information would be to consult a computerized database maintained by the hospital quality assurance committee. As a member of a quality and safety leadership team at the hospital, Lowy knew the database was capable of producing a list of patient IV injuries indexed by date and identification number. It is undisputed that the hospital, through use of such a list, could readily identify the records of patients who experienced complications with IV infusions. After redactions to protect patient confidentiality, those records could then be produced to Lowy.

PeaceHealth believes the use of the quality assurance database to identify the records sought by Lowy is prohibited by RCW 70.41.200(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.

RCW 70.41.200(3). PeaceHealth moved for a protective order based on the statute, contending that the information in the database is protected because it is "derived from incident reports, which are themselves quality assurance and peer review documents."

The trial court at first denied the motion. On April 30, 2009, the court ordered the hospital to designate an agent to review the quality assurance records and then to disclose "underlying facts and explanatory circumstances

charted in hospital records relating to alleged injuries, complications, malfunctions or adverse events associated with any IV infusions.” The only condition was that no records be disclosed that were “created specifically for, and collected and maintained by a quality improvement committee.” After considering PeaceHealth’s motion for reconsideration, however, the trial court reversed itself and concluded that the statute prohibits any disclosure arising from the use of the quality assurance database:

The court’s order of April 30, 2009 authorized access to the relevant, factual complaints and related information in order to balance the competing interests at stake. However reasonable or practical such an accommodation may be, it appears to be contrary to the language of RCW 70.41.200(3).

It is unfortunate that a more practical solution allowing plaintiff relevant discovery is unavailable, but the plain language of RCW 70.41.200(3) compels the conclusion that any kind of disclosure, whether of committee opinion or underlying factual complaints, shall not be disclosed. Therefore, on further review and reconsideration, the court is persuaded that the Order of April 30, 2009 must be reversed.

Lowy asks this court to vacate the order granting reconsideration and to reinstate the order of April 30, 2009. Because a question of statutory interpretation is involved, our review is de novo. Cedell v. Farmers Ins. Co. of Wash., 157 Wn. App. 267, 272, 237 P.3d 309 (2010).

The court’s purpose in interpreting a statute is to discern and implement the intent of the legislature. The first inquiry is whether, looking to the entire statute in which the provision is found and to related statutes, the meaning of the provision in question is plain. If so, the court’s inquiry ends. But if the statute is susceptible to more than one reasonable interpretation, it is ambiguous. In that

case, the court may resort to statutory construction, legislative history, and relevant case law. Columbia Physical Therapy, Inc. v. Benton Franklin Orthopedic Assocs., 168 Wn.2d 421, 432-33, 228 P.3d 1260 (2010).

Title 70 RCW concerns public health and safety. Chapter 70.41 RCW addresses hospital licensing and regulation. The primary purpose of the chapter is to “promote safe and adequate care of individuals in hospitals through the development, establishment and enforcement of minimum hospital standards for maintenance and operation.” RCW 70.41.010. The quality improvement statute, RCW 70.41.200, requires every hospital to “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.” RCW 70.41.200(1). The statute requires hospitals to create quality improvement committees to monitor and review the performance of their staff, including the “maintenance and continuous collection of information concerning the hospital’s experience with negative health care outcomes and incidents injurious to patients.” RCW 70.41.200(1)(e). According to the provision under review, such records “are not subject to review or disclosure.” RCW 70.41.200(3).

Plainly, the statute prevents the hospital from disclosing the quality assurance records themselves or allowing persons outside the hospital to review them. The question, however, is whether the statute likewise prevents the hospital itself from conducting an internal review to facilitate the location of hospital records that were not created specifically for the quality improvement

committee and that are maintained elsewhere in the hospital. The statute does not expressly draw a distinction between internal and external review. But to interpret it as preventing all hospital personnel from reviewing the contents of the database would frustrate the very purpose for which the quality assurance committee gathered the records in the first place. Indeed, the hospital has already conducted an internal review of the database, as shown by a declaration stating that hospital personnel examined it and determined that it contained no responsive, nonprivileged documents.

Because it is not reasonable to interpret the statute as containing an outright prohibition on internal review, we conclude the statute is most reasonably interpreted simply as prohibiting review of committee records by persons outside the hospital. This interpretation is supported by the Supreme Court's opinion interpreting a similar statute in Coburn v. Seda, 101 Wn.2d 270, 276, 677 P.2d 173 (1984), and it is also supported by the legislative history of RCW 70.41.200.

The statute addressed in Coburn was RCW 4.24.250, which protects records created by regularly constituted committees that evaluate the quality of patient care in hospitals or similar institutions. Because it is 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." Coburn, 101 Wn.2d at 276. The court explained that the purpose of the protection from discovery afforded by RCW 4.24.250 is to encourage the quality review process,

based on the theory that external access to the committee's work stifles the candor that is necessary to engage in constructive criticism:

Policies favoring both discovery immunities and evidentiary privileges underlie RCW 4.24.250. The discovery protection granted hospital quality review committee records; like work product immunity, prevents the opposing party from taking advantage of a hospital's careful self-assessment. The opposing party must utilize his or her own experts to evaluate the facts underlying the incident which is the subject of suit and also use them to determine whether the hospital's care comported with proper quality standards.

The discovery prohibition, like an evidentiary privilege, also seeks to protect certain communications and encourage the quality review process. Statutes bearing similarities to RCW 4.24.250 prohibit discovery of records on the theory that external access to committee investigations stifles candor and inhibits constructive criticism thought necessary to effective quality review.

Coburn, 101 Wn.2d at 274-75; see also Anderson v. Breda, 103 Wn.2d 901, 905, 700 P.2d 737 (1985) ("The Legislature recognized that external access to committee investigations stifles candor and inhibits constructive criticism thought necessary to effective quality review.").

At the same time, the statute "may not be used as a shield to obstruct proper discovery of information generated outside review committee meetings."

Coburn, 101 Wn.2d at 277. To illustrate the point, the court commented that information from original sources "would not be shielded merely by its introduction at a review committee meeting." Coburn, 101 Wn.2d at 277. The statute was meant to protect "substantive information about specific cases and individuals generated in the course of committee meetings." Coburn, 101 Wn.2d at 278.

PeaceHealth has not demonstrated that the legislative purpose of encouraging internal candor, open discussion, and constructive criticism will be served by an interpretation of the statute as banning internal review of the database to identify the records Lowy requests. The medical charts Lowy seeks were not created specifically for the quality assurance committee, are maintained external to committee files, and are undisputedly relevant and discoverable. In disclosing them, the hospital will not be required to disclose who participated in the review process concerning IV injuries, which incidents the hospital found relevant or important, or how it sorted, grouped, or otherwise organized those incidents. The hospital will not disclose any analysis, discussions, or communications that occurred during the proceedings of the quality assurance committee. The response to the discovery request will reveal no more than if the hospital had produced the medical records through a burdensome page-by-page search.

Legislative history also weighs in favor of a narrow interpretation of what is meant by the prohibition on "review or disclosure." The version of RCW 4.24.250 addressed in Coburn provided that the records of quality assurance committees "shall not be subject to subpoena or discovery proceedings in any civil action," with certain exceptions not relevant here. Former RCW 4.24.250(1)(2) (2004). In 2005, the legislature enacted an amending statute adding the prohibition on "review or disclosure" to RCW 4.24.250 (health care providers) and RCW 43.70.510 (health care institutions and medical facilities other than hospitals), as well as to the statute at issue in the present case, RCW 70.41.200 (hospitals).

Laws of 2005, ch. 291, §§ 1-3. The vote was unanimous. SENATE JOURNAL, 59th Leg., Reg. Sess., at 1089 (Wash. 2005); HOUSE JOURNAL, 59th Leg., Reg. Sess., at 566 (Wash. 2005). According to a bill report, the 2005 amendment was supported by representatives of trial lawyers and hospitals. S.B. REP. on E.H.B. 2254, 59th Leg., Reg. Sess. (Wash. 2005). It is unlikely that the bill would have enjoyed such broad support if it had been intended to prohibit internal review as well as external review of quality assurance records. According to the summary of testimony in the bill report, the bill was designed to fill a gap in the earlier versions of these statutes. Before the 2005 amendment, the statute provided that quality assurance records were not subject to discovery or introduction into evidence "in any civil action." The purpose of the 2005 amendment was simply to ensure that the records could not be released to the public in some extrajudicial context, that is, outside of a civil action. S.B. REP. on E.H.B. 2254 (Wash. 2005).

In summary, the first order entered by the trial court satisfied Coburn's mandate that the statute be strictly construed and limited to its purposes, and it reflects an interpretation that is supported by legislative history. The hospital must deny review of its quality assurance records by outside persons, thereby preserving confidentiality of those records. But the statute may not serve as an artificial shield for information contained in ordinary medical records. We conclude that the hospital may review its quality assurance records for the limited purpose of identifying and producing these medical charts.

The order granting reconsideration is reversed. The original order is to be reinstated.

Becker, J.

WE CONCUR:

Spreen, J.

Appelwick, J.

NO. 856974

SUPREME COURT OF THE STATE OF WASHINGTON  
[Court of Appeals Division I No. 63866-1-I]

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LEASA LOWY, Petitioner

vs.

PEACEHEALTH, a Washington corporation; ST. JOSEPH HOSPITAL;  
Respondents

and

UNKNOWN JOHN DOES, Defendant.

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CERTIFICATE OF SERVICE

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