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Corporate Negligence Actions Against Hospitals—Can the Plaintiff Prove the Case?

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CORPORATE NEGLIGENCE ACTIONS AGAINST HOSPITALS—CAN THE PLAINTIFF PROVE A CASE?

In *Pedroza v. Bryant*[1] the Washington Supreme Court expressly adopted the theory of hospital corporate negligence.[2] Under this theory, a hospital has an independent duty to use reasonable care in selecting and evaluating its medical staff members.[3] A week after the *Pedroza* decision, the Washington Supreme Court, in *Coburn v. Seda*,[4] held that the

1. 101 Wn. 2d 226, 677 P.2d 166 (1984).

2. *Id.* at 233, 677 P.2d at 170. Maria Pedroza was near the end of her pregnancy when she became ill and began to exhibit the classical signs and symptoms of pre-eclampsia. She visited the office of her private physician, Dr. Bryant, and was advised to take aspirin and remain at home in bed. Two days later she was brought to the hospital in a coma, having suffered an intracerebral hemorrhage resulting from eclampsia. She was admitted and treated by another physician, but within a week she died. *Id.* at 227–28, 677 P.2d at 167–68.

Mrs. Pedroza's husband sued Dr. Bryant and the hospital where he was a medical staff member. Mr. Pedroza alleged that Dr. Bryant negligently treated his wife, and that the hospital was negligent in granting staff privileges to Dr. Bryant. He also alleged that this breach of duty proximately caused Mrs. Pedroza's death. The hospital moved for summary judgment dismissing the claims against it, and the trial court granted the motion. The Supreme Court affirmed the judgment because Mrs. Pedroza was not a patient of the defendant hospital when the allegedly negligent acts occurred. *Id.* at 237, 677 P.2d at 172. The court, however, expressly recognized that such an action could be brought in a case where the physician's negligent acts occurred within the hospital. *Id.*

3. *Id.* at 230, 677 P.2d at 168–69. Discussion of the theory can be found in Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I my Brother's Keeper?"* 5 N. KY. L. REV. 27 (1978); Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care: A Legal Perspective*, 14 PAC. L.J. 55 (1982); Lisko, *Hospital Liability Under Theories of Respondeat Superior and Corporate Negligence*, 47 U.M.K.C. L. REV. 171 (1978); Loveridge & Kimball, *Hospital Corporate Negligence Comes to California: Questions in the Wake of* Elam v. College Park Hospital, 14 PAC. L.J. 803 (1983); Ludlam, *The Impact of the* Darling *Decision upon the Practice of Medicine and Hospitals*, 11 FORUM 756 (1976); Payne, *Recent Developments Affecting a Hospital's Liability for Negligence of Physicians*, 18 S. TEX. L.J. 389 (1977); Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452 (1978); Strodel, *The Impaired Physician-Hospital Corporate Liability*, 24 TRIAL LAW. GUIDE 488 (1980); Zaremski & Spitz, *Liability of a Hospital As an Institution: Are the Walls of Jericho Tumbling?*, 16 FORUM 225 (1980); Zaslow, *Vicarious Liability of a Hospital for Tortious Acts of its Independent Contractors Delivering Medical Care*, 49 PA. B.A.Q. 466 (1978); Note, *Wisconsin Hospital Held to Owe a Duty to its Patients to Select Qualified Physicians*, 65 MARQ. L. REV. 139 (1981); Comment, *Hospital May Be Held Liable for Permitting Incompetent Independent Physician to Operate*, 8 RUT.-CAM. L.J. 177 (1976); Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incomptence?*, 32 RUTGERS L. REV. 342 (1979) [hereinafter Note, *Hospital Corporate Liability*]; Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383 (1980); Note, *Corporate Negligence of Hospitals and the Duty to Monitor and Oversee Medical Treatment*, 17 WAKE FOREST L. REV. 309 (1981); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975) [hereinafter Comment, *The Hospital-Physician Relationship*].

4. 101 Wn. 2d 270, 677 P.2d 173 (1984). Denny Coburn died while undergoing a cardiac catheterization procedure at Kadlec Hospital. His family brought a medical malpractice action against the hospital and the physician who performed the procedure. During discovery the plaintiffs sought infor-

proceedings, reports and written records of hospital quality review committees[5] are shielded from discovery in a medical malpractice action by section 4.24.250 of the Washington Revised Code.[6] If the *Coburn* decision is extended to apply to corporate negligence actions, a plaintiff in such an action may find it impossible to meet his or her burden of proof.[7] Unless this proof problem can be overcome, the theory of corporate negligence could become a practical nullity in Washington.

This Comment first explains the theory of corporate negligence as adopted in Washington and describes the role of a hospital's quality review committees in fulfilling the hospital's corporate duty. It then reviews present law on the use of committee records in litigation. Next, this Comment considers the conflict between the goals of protecting medical staff committee records and permitting recovery in corporate negligence actions. It concludes that medical staff committee records should be protected from discovery in hospital corporate negligence actions and that the evidentiary use of hospital quality review committee records should be prohibited as well. Because this extended protection will create proof problems for hospital corporate negligence plaintiffs, this Comment proposes that the court adopt an in camera review proceeding to permit such plaintiffs access to hospital records of former patients of the physician whose alleged negligence caused the plaintiff's injury.

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mation concerning a review committee at the defendant hospital, which had investigated the incident. When the defendant hospital refused to divulge the requested information, the plaintiffs moved to compel the hospital to answer their interrogatory and produce the committee's written report. The trial court granted the motion. On appeal, the Washington Supreme Court reversed, finding that § 4.24.250 of the Washington Revised Code shielded such information from discovery in medical malpractice actions. *Id.* at 279, 677 P.2d at 179.

5. A hospital can best meet its corporate duty through the efforts of quality review committees composed of hospital medical staff members.

6. 101 Wn. 2d at 271, 677 P.2d at 174. WASH REV. CODE. § 4.24.250 (1983) reads as follows:

> Any health care provider as defined in RCW 7.70.020 (1) and (2) as now existing or hereafter amended who, in good faith, files charges or presents evidence against another member of their profession based on the claimed incompetency or gross misconduct of such person before a regularly constituted review committee or board of a professional society or hospital whose duty it is to evaluate the competency and qualifications of members of the profession, including limiting the extent of practice of such person in a hospital or similar institution, or before a regularly constituted committee or board of a hospital whose duty it is to review and evaluate the quality of patient care, shall be immune from civil action for damages arising out of such activities. The proceedings, reports, and written records of such committees or boards, or of a member, employee, staff person, or investigator of such a committee or board, shall not be subject to subpoena or discovery proceedings in any civil action, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a health care provider as defined above.

7. *See infra* notes 51–56 and accompanying text.

I. BACKGROUND

A. *Corporate Negligence Theory*

Prior to the adoption of the corporate negligence theory in Washington, a patient injured by a physician's negligent act had limited remedies. She could bring an action against the physician, or, in rare cases, against the hospital for breach of its independent duty of care.[8] The hospital, however, was not liable for negligent selection or evaluation of the physicians allowed to practice within the institution. Under the corporate negligence theory a hospital that fails to exercise reasonable care in the selection and evaluation of a non-employee medical staff member may be liable if that staff member negligently injures a hospitalized patient.[9] This expansion of hospital liability is justified for several reasons.

First, the expanded role of hospitals as health care providers warrants an increase in the scope of their liability. Historically, the hospital was seen as a physical plant in which the physician, as an independent contractor, found the proper facilities for the practice of medicine.[10] The legal obligations of the institution were thus appropriately limited to the exercise of reasonable care in the maintainence of the facilities and the

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8. In two prior cases the Washington Supreme Court impliedly recognized that the hospital owed an independent duty of care to its patients. In Pederson v. Dumouchel, 72 Wn. 2d 73, 431 P.2d 973 (1967), the hospital was held liable for permitting a dental operation to proceed without the presence of a medical doctor in the operating room as required by the hospital's rules. *Id.* at 80, 431 P.2d at 978. In Osborn v. Public Hosp. Dist., 80 Wn. 2d 201, 205–06, 492 P.2d 1025, 1028 (1972), it was recognized that the defendant hospital had an independent statutory duty of care for the safety of its patients. Until *Pedroza*, however, no Washington case had recognized the hospital's duty to regularly evaluate the competence of its medical staff members.

9. *Pedroza*, 101 Wn. 2d at 229, 677 P.2d at 168. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253, 258 (1965), *cert. denied*, 383 U.S. 946 (1966), was the landmark decision that established that a hospital may be held liable for failure to require hospital staff review of the treatment given by one of its physicians.

Following *Darling*, jurisdiction after jurisdiction moved toward a recognition of the hospital's corporate duty to exercise reasonable care in evaluating the quality of care given by its medical staff members. *See, e.g.*, Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); Kitto v. Gilbert, 570 P.2d 544 (Colo. App. 1977); Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); Ferguson v. Gonyaw, 64 Mich. App. 685, 236 N.W.2d 543 (1975); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972); Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 173 N.W.2d 881 (1970); Moore v. Carson-Tahoe Hosp., 495 P.2d 605 (Nev.), *cert. denied*, 409 U.S. 879 (1972); Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975); Felice v. St. Agnes Hosp., 65 A.D.2d 388, 411 N.Y.S.2d 901 (1978); Bost v. Riley, 262 S.E.2d 391 (N.C. App.), *disc. rev. denied*, 300 N.C. 194, 269 N.E.2d 621 (1980); Utter v. United Hosp. Center, Inc., 236 S.E.2d 213 (W. Va. 1977); Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

10. Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 434 (1973); *see also* Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92, 94 (1914).

selection of employees.[11] In recent years, however, the role of the community hospital has expanded to meet the demand for sophisticated health care services. The hospital now provides not only the specialized consultants and costly diagnostic equipment necessary for the care of many hospitalized patients, but also often holds itself out as a community resource for outpatient and emergency care.[12] Increased public reliance on the hospital for health care services should result in a corresponding increase in the scope of the hospital's legal obligations.[13]

Second, the expansion of hospital liability provides hospitals with a financial incentive to monitor the quality of medical care given by their staff members.[14] The hospital is in a particularly good position to survey physician performance because professional practices can be observed regularly at the site where the care is being rendered.[15] Furthermore, the hospital can make use of its organized medical staff to accurately assess the quality of care delivered by other physicians.[16]

Third, the doctrine of respondeat superior has been unsatisfactory as a basis for holding a hospital liable for the negligence of its staff members.[17] Physicians have traditionally been categorized as independent contractors,[18] whose practice of medicine is not subject to the control of

11. Southwick, *supra* note 10, at 434.

12. *Id.* at 435; *see also Pedroza*, 101 Wn. 2d at 231, 677 P.2d at 169.

13. *Pedroza*, 101 Wn. 2d at 231, 677 P.2d at 169.

14. *Id.* at 232, 677 P.2d at 170. *But see* Note, *Hospital Corporate Liability*, *supra* note 3, at 379 (arguing that non-profit hospitals may not respond to increased liability by undertaking a more active role in ensuring physician competence because they lack a profit motive).

15. *Pedroza*, 101 Wn. 2d at 231–32, 677 P.2d at 169.

16. *See infra* Part I*B*; *see generally* Southwick, *supra* note 10, at 437.

17. This theory assigns vicarious liability to an employer for the torts of employees acting within the scope of their employment and is based on the employer's right to control the employee's manner of performance. W. PROSSER, THE LAW OF TORTS §§ 69–70 (4th ed. 1971). In two classes of factual situations, courts used respondeat superior to find the hospital vicariously liable for the negligence of a medical staff member. The first class of cases held that a salaried arrangement between the hospital and physician was sufficient to impute the latter's negligence to the former. *See, e.g.*, Gilstrap v. Osteopathic Sanatorium Co., 24 S.W.2d 249 (Mo. App. 1929) (hospital liable for the salaried physician's negligent performance of a tonsillectomy); Bryant v. Sweet Clinic, 167 Wash. 166, 8 P.2d 972 (1932) (medical clinic liable for negligence of salaried surgeon); Vaughan v. Memorial Hosp., 130 S.E. 481 (W. Va. 1925) (hospital liable for negligence of physicians it supplied pursuant to contract).

The second line of cases held that the hospital had created the appearance of an employer-employee relationship. Under this reasoning the hospital was estopped from asserting the independent contractor status of the physician as a defense because it supplied the physician's services as though it were an employer. *See, e.g.*, Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972) (hospital liable for negligence of radiologist where patient had no choice of physician due to exclusive service contract); Seneris v. Haas, 291 P.2d 915 (Cal. 1955) (hospital vicariously liable for negligent acts of unsalaried anesthesiologist); Adamski v. Tacoma Gen. Hosp., 20 Wn. App. 98, 579 P.2d 970 (1978) (summary judgment for hospital inappropriate where jury could have found that hospital "held itself out" as providing medical care to public).

18. For a discussion of independent contractor status, see RESTATEMENT (SECOND) OF AGENCY § 250 (1958).

the hospital's board of directors. Thus, the doctrine does not closely fit the physician-hospital relationship.[19] Judicial attempts to base hospital liability on respondeat superior have resulted in a distortion of the doctrine.[20] Moreover, in jurisdictions unwilling to stretch the doctrine, plaintiffs have been denied any recovery against the hospital.[21]

B. The Role of Hospital Committee Review in Preventing Corporate Negligence

In *Pedroza,* the Washington Supreme Court suggested that the standards of care to which hospitals will be held are those of the Joint Commission on Accreditation of Hospitals (JCAH).[22] These standards require the hospital medical staff to organize into committees for the purpose of regularly evaluating the quality of medical care given within the institution.[23] Mandatory state regulations also require that hospitals have organizational patterns capable of conducting quality assurance review.[24]

19. Comment, *The Hospital-Physician Relationship, supra* note 3, at 388; *see also* Southwick, *Vicarious Liability of Hospitals,* 44 MARQ. L. REV. 153, 154 (1960).

20. The cases reflect a willingness on the part of the judiciary to adapt the doctrine of respondeat superior to cover the hospital-physician relationship in spite of the absence of any real control by the hospital over the medical practice of the physician. Southwick, *supra* note 19, at 182.

21. *See, e.g.,* Mayers v. Litlow, 316 P.2d 351, 354 (Cal. 1957) (no master-servant relationship where physician was independent practitioner even though a member of the hospital's medical staff); Overstreet v. Doctor's Hosp., 142 Ga. App. 895, 237 S.E.2d 213 (1977) (respondeat superior not appropriate where hospital had no right to control medical practice); Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 299, 280 N.Y.S.2d 373, 378 (1967) (hospital cannot direct the medical practice of the private physicians on its staff).

22. Pedroza v. Bryant, 101 Wn. 2d 233–34, 677 P.2d 170–71. The JCAH is a private, non-profit organization that establishes minimum standards for hospital patient care. It was organized in 1952 to standardize hospital practices throughout the nation. Commission accreditation can be gained only by following its recommendations. *See* Langhenry, *Immunity of In-Hospital Staff Committee Members and Confidentiality of Staff Committee Records,* 24 FED'N OF INS. COUNS. Q. 3, 4 (1974).

The recommendations of the JCAH are provided to each participating institution in its annual Accreditation Manual for Hospitals. JCAH standards mandate that the governing body of the hospital is ultimately responsible for the overall quality of patient care provided in the institution. Joint Commission of Accreditation of Hospitals, *Accreditation Manual for Hospitals 1983 Edition* 151. Thus, in order to comply with JCAH standards, the hospital's medical staff must be organized in such a way that it can conduct regular reviews for the governing board.

23. Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals 1983 Edition* 106.

24. WASH. REV. CODE 70.41.010 (1983), for example, declares that in order to promote safe and adequate care of individuals in hospitals the state board of health shall establish standards, rules, and regulations for the construction, maintainence, and operation of hospitals. Pursuant to this statutory grant of authority, the board promulgated WASH. ADMIN. CODE R. 248-18-030 (1980), which recommends that the medical staff be organized and perform its functions in accordance with the standards of the JCAH or those of the Bureau of Hospitals of the American Osteopathic Association.

These internal evaluations are essential if the hospital is to avoid liability for the negligent acts of its medical staff members.[25]

Medical staff committees perform two basic quality assurance functions for the hospital's governing board. First, they evaluate the qualifications and competence of hospital staff members.[26] Because the governing board of the hospital is usually composed of lay members who are not prepared to assess the professional credentials of medical staff members, the responsibility to perform such evaluations must be delegated to the medical staff itself.[27] This function is usually performed by a credentials committee[28] which reviews all applications for renewal of staff privileges. This committee also conducts investigations into possible reduction or removal of such privileges.

Second, as agents of the hospital's governing board, the medical staff committees evaluate the quality of patient care given within the institution.[29] The committees or departments responsible for this assessment may review particular classes of cases such as deaths, unexpected complications, or prolonged hospitalizations, or they may make use of internal audit procedures to find cases that do not comport with established criteria.[30] The committee members then review the care rendered in such cases, identify deficiencies, and communicate their findings to the medical staff members responsible. These committees may also refer their conclusions to the credentials committee for action if they decide the staff member's performance warrants a review of his or her staff privileges.[31]

Medical staff committees are essential if the hospital is to meet its independent duty to maintain a competent medical staff. Only through this ongoing review process can the hospital be made aware of physician incompetence.

25. Southwick, *supra* note 10, at 437.

26. *See* Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 AM J.L. & MED 245, 248–49 (1975).

27. *See* Southwick, *supra* note 10, at 437.

28. A thorough discussion of committee structure can be found in Langhenry, *supra* note 22, at 3; *see also* Copeland, *supra* note 3, at 47; Hall, *supra* note 26, at 248–50; Holbrook & Dunn, *Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records*, 16 WASHBURN L.J. 54, 57–63 (1976).

29. Langhenry, *supra* note 28, at 5.

30. *Id.*

31. *Id.* A third medical staff responsibility delegated by the hospital governing body is that of utilization review. The Federal Medical Act of 1965 requires hospitals to create committees to review the utilization of hospital services. 42 U.S.C. § 1395b-1(a)(1)(B) (1972). These committees are charged with evaluating the medical necessity of hospitalization in order to prevent unjustified use of hospital services paid for with medicare benefits. They review cases that exceed length-of-stay norms, or that are brought to their attention by hospital staff members, and forward their conclusions to the attending physician. Habitual length-of-stay problems on the part of a particular medical staff member could prompt the committee to request further evaluation by another medical staff review committee.

C. *Protection of Hospital Committee Records*

Hospital review committee records contain several kinds of documents. Information gathered by the committee for review may include statistical data from in-hospital audits, patient records, written complaints and memoranda from individuals or other committees, and references or evaluations of personnel from other institutions. Information produced by the committee may include inquiries or criticisms in the form of letters to individual physicians, memoranda that communicate its findings to other committees and the hospital's governing board, and minutes of the committee meetings.

Section 4.24.250 of the Washington Revised Code provides that the proceedings, reports, and written records of hospital medical staff committees shall not be subject to subpoena or discovery proceedings in any civil action except one arising out of committee recommendations involving the restriction or revocation of the staff privileges of a health care provider.[32] In *Coburn*, the Washington Supreme Court construed this

32. WASH. REV. CODE 4.24.250 (1983). Modern rules of discovery permit parties to "obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action." WASH. C.R. 26(b)(1). The broad scope of this provision is intended to aid parties in preparation for litigation, to narrow the issues during the pretrial process and thus conserve judicial resources, and to facilitate the search for the truth by bringing out all the available facts. C. WRIGHT & A. MILLER, FEDERAL PRACTICE AND PROCEDURE § 2001 (1970). To effectuate these goals, courts have generally construed the rules of discovery liberally. *See, e.g.*, Bushman v. New Holland Div. of Sperry Rand Corp., 83 Wn. 2d 429, 434, 518 P.2d 1078, 1081 (1974). However, medical staff committee review procedures demand both frank discussion by the committee members and candid participation by the physician being reviewed. This deliberative process would be stifled by permitting its discovery.

In jurisdictions where there is no controlling non-discovery statute, courts have reached different results, based on these conflicting policies. *Compare* Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C. 1970) (importance of candid and conscientious evaluation in ensuring quality health care outweighs the plaintiff's interest in discovery), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973), *with* Wesley Medical Center v. Clark, 243 Kan. 13, 669 P.2d 209 (1983) (public interest in allowing parties access to relevant material outweighs the interest in furthering peer review processes).

These polar results, produced by courts balancing the same public policy arguments, illustrate that the strength of such policies is, as one court put it, "nearly in equipoise." Davidson v. Light, 79 F.R.D. 137, 139 (D. Colo. 1978). As the pretrial value of medical staff committee reports became more apparent and early decisions on their discoverability proved unpredictable, state legislatures began to enact statutes aimed at their protection. *See, e.g.*, CAL. EVID. CODE § 1157 (West Supp. 1984); COLO. REV. STAT. § 12-43.5-103 (Supp. 1978); FLA. STAT. § 768.40 (West Supp. 1984); GA. CODE ANN. § 88-3204 (Supp. 1983); MINN. STAT. ANN. § 145.61 *et. seq.*; N.Y. EDUC. LAW § 6527.3 (McKinney Supp. 1983–84). Cases construing these statutes have, for the most part, honored the legislative public policy choice in favor of confidentiality. *See, e.g.*, Matchett v. Superior Court, 40 Cal. App. 3d 623, 115 Cal. Rptr. 317, 320 (1974) (protective statute represents legislative choice in favor of medical staff candor at cost of impairing plaintiff's access to evidence); Texarkana Memorial Hosp. Inc. v. Jones, 551 S.W.2d 33, 35 (Tex. 1977) (statute precludes disclosure of hospital committee minutes in a medical malpractice action). *But see* Young v. King, 136 N.J. Super. 127, 344 A.2d 792, 794 (1975) (statute does not preclude discovery of records of audit committee, tissue committee, infection control committee, and medical council).

statute to protect committee records from discovery in medical malpractice actions.[33] The court noted that such protection is necessary to encourage the frank committee discussions necessary for thorough quality review.[34] The court warned, however, that if information is otherwise available from its original sources, it cannot be immunized by introducing it at a review committee meeting.[35]

While medical staff committee records are not discoverable in civil actions, their admission into evidence is not expressly prohibited by section 4.24.250.[36] Although recognizing that policy considerations might warrant a full evidentiary privilege, the *Coburn* court reserved that question and held only that the statute created an immunity from discovery.[37] Thus, the general rules of evidence would probably govern the admissibility of such records.[38]

The public policy considerations that prompted these protective statutes are the same ones discussed in earlier cases. However, because the statutes reflect a legislative preference for confidentiality, their existence has been enough to tip the scales in favor of non-discoverability of medical staff committee records in most jurisdictions. *See* Morse v. Gerity, 520 F. Supp. 470 (D. Conn. 1981); Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Posey v. District Court, 586 P.2d 36 (Colo. 1978); Danklef v. Wilmington Medical Center, 429 A.2d 509 (Del. Super. Ct. 1981); Hollowell v. Jove, 247 Ga. 678, 279 S.E.2d 430 (1981); Murphy v. Wood, 105 Idaho App. 180, 667 P.2d 859 (1983); Mennes v. South Chicago Community Hosp., 100 Ill. App. 3d 1029, 427 N.E.2d 952 (1981); Oviatt v. Archbishop Bergan Mercy Hosp., 191 Neb. 224, 214 N.W.2d 490 (1974); City of Edmond v. Parr, 587 P.2d 56 (Okla. 1978). *But see* Good Samaritan Hosp. Ass'n v. Simon, 370 So. 2d 1174 (Fla. Dist. Ct. App. 1979); Walker v. Alton Memorial Hosp., 91 Ill. App. 3d 310, 414 N.E.2d 850 (1980); Marchand v. Henry Ford Hosp., 398 Mich. 163, 247 N.W.2d 280 (1976); Kalish v. Mt. Sinai Hosp., 270 N.W.2d 783 (Minn. 1978).

33. Coburn v. Seda, 101 Wn. 2d 270, 271, 677 P.2d 173, 174 (1984).

34. *Id.* at 273–74, 677 P.2d at 176.

35. *Id.* at 277, 677 P.2d at 177. The court remanded the case for the trial court's determination of whether the Kadlec Hospital committee was a regularly constituted hospital committee whose duty it was to review and evaluate the quality of patient care. In making this determination the court said that the trial judge should consider the guidelines and standards of the JCAH, the hospital's own regulations and bylaws, and whether the committee's function is one of current patient care or retrospective review. *Id.* at 277–78, 677 P.2d at 178.

The court held that if the committee was a regularly constituted hospital committee whose duty it was to review and evaluate the quality of patient care, then the defendant hospital would be obligated to disclose only the existence and name of the committee, and the location and time of the review. *Id.* at 278, 677 P.2d at 178. Any other disclosure would interfere with the statute's purpose of encouraging effective quality review.

36. The issue of admissibility of committee proceedings and records is distinct from that of their discoverability. Information that is relevant and not privileged may nevertheless be inadmissible because it violates one of the formal requirements of the rules of evidence or because its prejudicial impact outweighs its probative value. Conversely, a party in possession of non-discoverable material may desire to offer it as evidence.

37. *Coburn*, 101 Wn. 2d at 274–75, 677 P.2d at 177.

38. Whether medical staff committee records are admissible depends first on whether they are relevant to the issues in the case. FED R. EVID 402; WASH R. EVID 402. When the litigation is limited to the issue of a particular physician's negligence, committee records are least likely to be admissible. For example, the probative value of a committee finding that the defendant physician had rendered substandard care in previous cases would be outweighed by its prejudicial impact. FED R.

II. THE CONFLICT BETWEEN PROTECTING HOSPITAL COMMITTEE RECORDS AND PERMITTING HOSPITAL CORPORATE NEGLIGENCE ACTIONS

The legal system can encourage quality health care in different ways. In *Pedroza,* the Washington Supreme Court chose a direct method when it imposed on hospitals the legal obligation to assure the competence of their medical staff members.[39] The threat of potential litigation may well motivate hospitals to use reasonable care in the selection and periodic evaluation of the physicians who use their facilities. In *Coburn,* on the other hand, the court recognized that quality health care could be indirectly promoted by protecting the internal quality assurance process from discovery by malpractice plaintiffs.[40] This protection is intended to facilitate the candid and conscientious review necessary for continual improvement in hospital medical care.

Although these two decisions have the same goal, the methods adopted by each may conflict in application and interfere with the achievement of that goal. If the protection offered by the *Coburn* decision is extended to preclude discovery of medical staff committee records in hospital corporate negligence actions, plaintiffs may be unable to produce the evidence necessary to substantiate a claim. The deterrent effect of *Pedroza* will thus be lost. Conversely, if an allegation of hospital corporate negligence can unlock the doors of the internal review process in every medical malpractice action, the protection offered by *Coburn* will be destroyed. These two cases will promote quality health care only if the proof

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EVID. 403; WASH. R. EVID. 403; *see also* Hall, *supra* note 26, at 279–80. Furthermore, such a finding might well be excluded on the ground that it contains conclusions that would invade the province of the jury. FED. R. EVID. 701; WASH. R. EVID. 701; *see also* Hall, *supra* note 26, at 280. However, when the plaintiff alleges that the hospital was negligent in failing to monitor the defendant physician's performance, the review committee's work is put directly in issue. *See* Hall, *supra* note 26, at 281; *see also* Loveridge & Kimball, *supra* note 3, at 826.

The second possible barrier to the admissibility of review committee records is the hearsay rule. Evidence is classified as hearsay if it is an out-of-court statement, offered in court, to establish the truth of the matter asserted. FED. R. EVID. 801; WASH. R. EVID. 801; *see also* C. MCCORMICK, THE LAW OF EVIDENCE 460 (1954). Such evidence is deemed unreliable because the person making the out-of-court statement cannot be examined for faulty perception, erroneous memory, insincerity, or ambiguity. C. MCCORMICK, *supra* at 460. Hospital committee records are usually classified as hearsay evidence. Judd v. Park Ave. Hosp., 235 N.Y.S.2d 843, 845–46 (Sup. Ct.), *aff'd,* 235 N.Y.S.2d 1023 (App. Div. 1962). Although such records could fall within the "business records" exception to the hearsay rule, WASH. REV. CODE § 5.45.020 (1983), they would usually contain second levels of hearsay for which there would be no exception. However, if such records are introduced to demonstrate that the defendant hospital had notice of prior physician incompetence, they would not be hearsay at all because they would not be offered to prove the truth of the matter asserted.

39. Pedroza v. Bryant, 101 Wn. 2d 226, 233, 677 P.2d 166, 170 (1984).

40. Coburn v. Seda, 101 Wn. 2d 270, 271, 677 P.2d 173, 174 (1984).

problems of a hospital corporate negligence action can be overcome without a corresponding disruption of the medical staff review committee process.

A. *Protection of Committee Records Should be Extended to Corporate Negligence Actions*

1. *Discovery*

Section 4.24.250 allows discovery of medical staff review committee records in civil actions arising out of committee recommendations that involve restriction or revocation of physician privileges.[41] Hospital corporate negligence is based on the theory that the hospital breached a duty to the plaintiff when it failed to restrict or revoke the privileges of an incompetent physician;[42] therefore, such an action could fall within this statutory exception. This exception, however, should not be construed to allow discovery in hospital corporate negligence actions.

First, this exception was apparently drafted to allow discovery in suits by physicians claiming arbitrary or wrongful exclusion from the hospital medical staff.[43] Many protective statutes in other jurisdictions contain exceptions that permit discovery by physicians who are bringing suit for wrongful restriction or revocation of their hospital privileges.[44] These exceptions are based on the particular relevancy of the records in such actions,[45] and the need for plaintiff access to prevent peer review groups from being used for anti-competitive purposes.[46] The exception in section 4.24.250 was drafted to permit discovery in such cases.

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41. WASH REV CODE § 4.24.250 (1983).

42. *See supra* Part IA.

43. When the statute was discussed in the Washington legislature before its enactment, one representative noted the purpose of the exception: "[t]his particular language makes an exception that the written records will be available in the instance where the doctor appeals from the hospital review board's decision to the court." HOUSE JOURNAL OF THE FORTY-SECOND LEGISLATURE OF THE STATE OF WASHINGTON 876–77 (1971).

44. *See, e.g.*, COLO REV STAT § 12-43.5-102 (Supp. 1978) (records not protected in actions by physicians seeking review of committee action); ILL. ANN STAT ch. 110, § 8-2101 (Smith-Hurd 1984) (claim of confidentiality shall not be invoked to deny physician access to data upon which staff privileges decision was based); MD HEALTH OCC. CODE ANN § 14-601(e)(1) (1981) (discovery allowed in action by person aggrieved by committee decision); R.I. GEN LAWS §§ 23-17-24, 23-17-25 (1979) (records available in actions arising out of sanctions imposed); *see also* Schulz v. Superior Court, 66 Cal. App. 3d 440, 136 Cal. Rptr. 67 (1977) (statutory exception permits discovery in suits by physicians claiming wrongful exclusion from hospital staff).

45. Robinson v. Magovern, 83 F.R.D. 79, 89 (W.D. Pa. 1979) (discovery request went to heart of issue of plaintiff's denial of staff privileges).

46. *Id; see also* Memorial Hosp. v. Shadur, 664 F.2d 1058 (7th Cir. 1981) (action for unlawful restraint of trade); Ott v. St. Luke Hosp., 522 F. Supp. 706 (E.D. Ky. 1981) (civil rights action based on denial of staff privileges).

Second, the policy reasons for protecting the records from discovery in medical malpractice actions apply with equal force in hospital corporate negligence actions. As the *Coburn* court stated, the prohibition against discovery in medical malpractice actions encourages the candor and constructive criticism necessary for effective quality review.[47] However, it is not only the apprehension that a committee member's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit[48] that stifles frank and open discussion. Rather, the risk that the committee records will be opened for public perusal is sufficient to discourage both complaints and free discussion about the competence of medical staff members.[49] Therefore, even though the defendant in a hospital corporate negligence action is not a colleague of the committee members, the discovery of committee records in such a suit would be enough to discourage effective quality assurance.

Finally, in most hospital corporate negligence actions the plaintiff is probably also suing the medical staff member whose malpractice caused the injury. Allowing discovery in such cases based on the corporate negligence claim would dilute the protection offered by section 4.24.250 and the *Coburn* decision: the plaintiff could not be prevented from using the discovered information in preparation for the malpractice suit. Furthermore, such a decision would result in allegations of hospital corporate negligence in every medical malpractice action solely for the purpose of circumventing the discovery prohibition.

2. *Evidentiary Use*

The issue of the admissibility of hospital medical staff committee records could arise in two ways. First, if such records were inadvertently disclosed by a hospital during the discovery process, the plaintiff in a hospital corporate negligence case might offer them into evidence. Second, the hospital might offer them into evidence in its defense.

Although the admission of medical staff committee records in civil actions is not expressly prohibited by section 4.24.250, the policy reasons that preclude discovery of such records should also prevent their evidentiary use. The disclosure of medical staff committee proceedings during trial would damage the quality review process no less than the pretrial discovery of such information. The possibility of exposure to an entire courtroom stifles a committee member's candid criticism just as surely as

47. *Coburn*, 101 Wn. 2d at 275, 677 P.2d at 176; *see also* Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973).

48. Dade County Med. Ass'n v. Hlis, 372 So. 2d 117, 119 (Fla. Dist. Ct. App. 1979).

49. Schulz v. Superior Court, 66 Cal. App. 3d 440, 136 Cal. Rptr. 67, 70 (1977).

the chance of perusal by a malpractice plaintiff. The evidentiary use of these records, like their discovery, should be prohibited in hospital corporate negligence actions in order to preserve the effectiveness of the committee review process.

Considerations of fairness also demand that these records be excluded from evidence. The defendant hospital should not be permitted to deny the plaintiff pretrial access to material that it intends to use in its own defense.[50] However, at the present time there are no safeguards against such surprise tactics.

The Washington courts should extend the protection of section 4.24.250 to immunize medical staff committee records from discovery in hospital corporate negligence actions. This would preserve the confidential nature of such proceedings and ultimately result in improved hospital care for the Washington health consumer.

B. Inadequacy of Alternative Means of Proof Available to Plaintiffs in Corporate Negligence Actions Under Present Law

If the protection of section 4.24.250 is extended to prevent the discovery or evidentiary use of medical staff review committee records in hospital corporate negligence actions, the plaintiff may be unable to produce the evidence necessary to prove her case. Such evidence would have to establish that, prior to the plaintiff's injury, the hospital had sufficient notice of the physician's incompetence to cause a reasonable institution to limit or revoke that physician's privileges.[51]

In some cases the plaintiff will be able to find outside evidence of physician incompetence, which a reasonable investigation by the hospital would have revealed. Previous dismissals from other hospital staffs,[52] inadequate training,[53] other malpractice actions,[54] suspension or revocation of a license to practice, and testimony of other persons who were injured by the negligent physician while patients in the defendant hospital[55] could all be used to show that the hospital knew, or should have known, that the physician was incompetent. In many cases, however, such outside

50. *See generally* Hall, *supra* note 26, at 277–78.

51. This proof problem was recognized by the California court in Matchett v. Superior Court, 40 Cal. App. 3d 623, 115 Cal. Rptr. 317, 320–21 (1974), where it commented that the protective statute might seriously jeopardize or even preclude the plaintiff's recovery.

52. *See, e.g.*, Johnson v. Misericordia Comm. Hosp., 99 Wis. 2d 708, 301 N.W.2d 156, 174 (1981) (surgical privileges at other hospitals had been limited or revoked).

53. *See, e.g., id.* (physician had not acquired board certification in orthopedics).

54. *See, e.g.*, Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335, 343–45 (1972) (malpractice suits against physician and hospital admissible to show notice of incompetence).

55. *See, e.g., id.*, 500 P.2d at 344 (several previous patients called as witnesses).

evidence will be unavailable. Furthermore, hospital staff members will rarely agree to testify to incidents of prior negligence.[56]

The most persuasive evidence of the quality of prior physician performance is contained in the medical records of other patients. Under present Washington law, such records could not be given to the plaintiff without the consent of the patients whose medical care they document.[57] They are, therefore, as a practical matter, unavailable to the hospital corporate negligence plaintiff. As a result, the plaintiff may be unable to produce evidence on the issue of the hospital's breach of duty and so the hospital corporate negligence action may fail.

III. PROPOSAL FOR CHANGE IN WASHINGTON LAW

The proof problems involved in a hospital corporate negligence action can be solved without disrupting hospital quality assurance mechanisms if the plaintiff is given access to the hospital records of former patients of the negligent physician.[58] These records can be expunged of any identifying marks by in camera review proceedings and then given to the plaintiff for evaluation by her own experts.[59] This compromise preserves the

56. For a case where the plaintiff was successful in finding physicians to testify to prior acts of negligence see Community Hosp. Ass'n v. District Court, 570 P.2d 243, 244 (Colo. 1977).

57. WASH. REV. CODE § 5.60.060(4), which creates the physician-patient privilege, provides in pertinent part: "A regular physician or surgeon shall not, without the consent of his patient, be examined in a civil action as to any information acquired in attending such patient, which was necessary to enable him to prescribe or act for the patient . . . ."

The statute has been construed to apply to hospital records. Randa v. Bear, 50 Wn. 2d 415, 421, 312 P.2d 640, 644 (1957); Toole v. Franklin Inv. Co., 158 Wash. 696, 291 P. 1101 (1930); *see also* Parkson v. Central DuPage Hosp., 105 Ill. App. 3d 850, 61 Ill. Dec. 651, 435 N.E.2d 140 (1982) (hospital records protected by physician-patient privilege); Boddy v. Parker, 45 A.D.2d 1000, 358 N.Y.S.2d 218 (1974) (patient records privileged).

58. This approach has been adopted by several jurisdictions faced with the problem. *See, e.g.*, Ziegler v. Superior Court, 656 P.2d 1251 (Ariz. App. 1982) (plaintiff entitled to discover records of other pacemaker patients with all clues to identity deleted); Community Hosp. Ass'n v. District Court, 570 P.2d 243 (Colo. 1977) (medical records of patients of neurosurgeon ordered produced after identifying marks deleted); Louisville Gen. Hosp. v. Hellmann, 500 S.W.2d 790 (Ky. App. 1973) (one hundred random emergency room records ordered produced with patients' names, addresses, and other identifying information expunged).

One commentator has proposed that the plaintiff's proof problem be solved by placing the burden of explanation on the hospital. Loveridge & Kimball, *supra* note 3, at 828–30. If the medical staff committee records cannot be used in the hospital's defense, however, the hospital is in no better position than the plaintiff to produce evidence on the negligence issue.

59. *See* Rudnick v. Superior Court, 11 Cal. 3d 924, 114 Cal. Rptr. 603, 610–11, 523 P.2d 643, 650 n.13 (1974) (disclosure that reveals ailments but not identity would not violate physician-patient privilege). *But see* Parkson v. Central DuPage Hosp., 105 Ill. App. 3d 850, 61 Ill. Dec. 651, 435 N.E. 2d 140 (1982) (identities of patients might not remain confidential even though names deleted from records); Boddy v. Parker, 45 App. Div. 2d 1000, 358 N.Y.S.2d 218 (1974) (discovery of other patient records not allowed due to privileged nature of such documents).

integrity of the quality assurance process, yet allows the plaintiff enough data to prove a corporate negligence action.

The hospital records of former patients of the negligent physician are peculiarly appropriate tools for a determination of hospital negligence. Such records make up the major portion of the raw data reviewed by the hospital's quality assurance committees. Giving the plaintiff's experts access to this data will place them in a position similar to that of the hospital's review committee. Their subsequent criticism of the hospital's failure to limit or revoke the negligent physician's hospital privileges should be sufficient to create a question of fact as to the hospital's breach of duty.

In addition, the hospital can be charged with notice of the medical care reflected in such records. The records detail the physician's past performance in caring for patients at the defendant hospital. Thus, they indicate facts of which the hospital, through its medical staff committees, should have been aware.

The privacy of former patients can be adequately safeguarded by concealing their identities before the records are given to the plaintiff. The resulting anonymity would preserve the physician-patient privilege as well, since the free flow of information between physician and patient that the privilege seeks to foster[60] will not be hindered if the patient's identity is protected.

IV. CONCLUSION

The policy considerations that led the Washington legislature and the court to exempt medical staff committee proceedings from discovery in medical malpractice actions should lead to their protection in hospital corporate negligence actions as well. If the protection is extended to preclude discovery and evidentiary use of committee proceedings in such actions, the plaintiff will have difficulty producing evidence establishing a breach of duty on the part of the hospital. This proof problem can be overcome by allowing the plaintiff access to the hospital records of prior patients of the plaintiff's physician. Such a compromise will preserve the integrity of the internal review process and still provide enough information to the plaintiff to allow her to meet the burden of production in a hospital corporate negligence action.

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60. *See* Dept. of Social and Health Serv. v. Latta, 92 Wn. 2d 812, 819, 601 P.2d 520, 525 (1979) (primary purpose of privilege is to create aura of confidentiality and thus promote proper medical treatment by facilitating full disclosure of information, secondary purpose is to protect patient from embarrassing disclosures of intimate medical details).