STATE OF MICHIGAN

IN THE SUPREME COURT

ON APPEAL FROM THE MICHIGAN COURT OF APPEALS

THE ESTATE OF DOROTHY KRUSAC,
deceased, by her Personal Representative,
JOHN KRUSAC,

Plaintiff-Appellee,

-vs-

COVENANT HEALTHCARE, assumed name for COVENANT MEDICAL CENTER, INC.; COVENANT MEDICAL CENTER-HARRISON, assumed name for COVENANT MEDICAL CENTER, INC.; COVENANT MEDICAL CENTER, INC.; Michigan Corporations, jointly and severally,

Defendants-Appellants.

/

Supreme Court No. 149270

Court of Appeals No. 321719

Saginaw County Circuit Court
No. 12-15433-NH-4

PLAINTIFF-APPELLEE'S BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

CERTIFICATE OF SERVICE

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II. DID THE CIRCUIT COURT PROPERLY ORDER DEFENDANT TO PRODUCE THE FIRST PAGE OF THE INCIDENT REPORT DETAILING WHAT DEBORAH COLVIN OBSERVED AT THE CONCLUSION OF DOROTHY KRUSAC'S HEART CATHETERIZATION PROCEDURE?

Plaintiff-Appellee says "Yes".

Defendant-Appellant says "No".

COUNTERSTATEMENT OF FACTS

At approximately 12:45 a.m. in the morning of September 13, 2008, a Covenant Medical Center (Covenant) CRNA discovered a patient, Dorothy Krusac, in respiratory arrest. (App. 12b). The hospital staff was able to resuscitate Ms. Krusac, but she had suffered brain damage as a result of lack of oxygen. MS. Krusac did not leave the hospital alive. She died on October 6, 2008 while still a Covenant patient.

Only hours before Ms. Krusac was found in respiratory arrest, she had been involved in an incident that occurred in a Covenant heart catheterization lab. That incident is the central focus of this medical malpractice action.

At approximately 3:00 p.m. on September 12, 2008, Ms. Krusac was taken to Covenant's cardiac catheterization lab. (App. 1b). The catheterization was performed by Dr. Pramod Sanghi. Three other Covenant staff members were present in the catheterization lab during all or a portion of Ms. Krusac's procedure: Deborah Colvin, the circulating nurse, Heather Gengler, the nurse at the catheterization monitor, and Rogers Gomez, a technician.

During the catheterization procedure, Dr. Sanghi placed a stent in Ms. Krusac's posterior descending artery. This procedure is normally performed after a patient is given two drugs, Fentanyl and Versed. However, Ms. Krusac suffered an adverse reaction to the first of these two drugs and another drug had to be given to reverse the effect of the Fentanyl. (App. 3b). This meant that for the remainder of the procedure, Ms. Krusac was sedated only with Valium. Without the usual sedation, Ms. Krusac had difficulty remaining still and she had to be reminded numerous times by the catheterization lab staff to stop moving around. (App. 4b).

The catheterization procedure ended at 5:16 p.m. and Dr. Sanghi left the lab to report to Ms.

Krusac's family that the procedure had gone well and the stenting was successful. Less than 15 minutes after Dr. Sanghi gave this positive report, Ms. Krusac's family learned that she had fallen off the table that she had been placed on during the catheterization procedure.

For purposes of the issues that are being presented to this Court in this case, what is perhaps most significant about Ms. Krusac's fall is how that fall is recorded in the medical records that were produced to plaintiff. Those records include a five page Procedure Log of the catheterization procedure itself. (App. 1b - 5b). The entry on that Procedure Log at 5:49:45 pm contains the only six words in that log describing Ms. Krusac's fall: "pt [patient] rolled off table to floor." (App. 5b). The Procedure Log further recorded that Ms. Krusac remained on the floor until a cervical collar and back board could be applied. A stat head and neck CT scan was also ordered. (App. 8b).

In a progress note that he prepared of Ms. Krusac's catheteriztion, Dr. Sanghi made the following mention of Ms. Krusac's fall:

> Complications: after procedure pt fell off the cath lab table
>
> * * *
>
> s/p fall from cath lab table.

(App. 7b).

At 6:33 p.m., Ms. Krusac was returned to her room where she reported soreness. (App. 11b - 12b). Ms. Krusac's family was allowed to be with her at this time, but they were advised that Ms. Krusac had to lay flat and keep her spine and neck immobilized. (App. 12b).

At 7:30 p.m. a trauma surgery team evaluated Ms. Krusac. The team recorded in a progress note that Ms. Krusac was experiencing neck and back pain resulting from her fall in the catheterization lab. (App. 9b). The progress note prepared at 7:30 p.m. contained this additional

information about Ms. Krusac's fall:

> Neck & back pain after falling approximately 3-4 ft post cath procedure. Fell on left side. Pt & nurses did not see fall, unsure if head hit floor. Unknown angle of impact.

(*Id.*)

Thus, the trauma team note recorded the fact that the nurses did not see Ms. Krusac's fall.

One of the trauma surgeons consulted on September 12, 2008 after Ms. Krusac's fall was Dr. Sugal G. Patel. Dr. Patel's own consult notes also confirmed that none of the three staff members who were in the catheterization lab with Ms. Krusac witnessed her fall. Dr. Patel's consult note indicated:

> According to the nursing staff, patient fell off the bed in the cath lab during heart catheterization with angioplasty, it was an unwitnessed fall, possibly on the left side.

(App. 10b).

Following his appointment as personal representative of the Estate of Dorothy Krusac, John Krusac filed this action in the Saginaw County Circuit Court on February 28, 2012, alleging that Covenant's agents were negligent in failing to prevent Ms. Krusac from falling from the catheterization lab table. In his Complaint, Mr. Krusac alleged that as a result of her fall, Ms. Krusac developed neurogenic pulmonary edema which only hours later caused her respiratory arrest.

During the course of discovery, plaintiff deposed all three Covenant employees who were in the catheterization lab at the time Ms. Krusac fell. All three of these employees gave testimony as to the circumstances of Ms. Krusac's fall that could not be harmonized with the contemporaneous medical records that plaintiff had been provided.

Thus, far from acknowledging that Ms. Krusac's fall had been "unwitnessed," Deborah Colvin testified in her October 24, 2012 deposition that she heard movement coming from the table

on which Ms. Krusac was laying (App. 56a). According to Colvin, she quickly turned and ran towards Ms. Krusac and managed to get her hands and arms under Ms. Krusac (App. 57a). Colvin testified that she was able in this manner to soften Ms. Krusac's descent to the floor. (App. 58a).

Colvin further testified that she made no documentation in Ms. Krusac's medical records as to her fall. (App. 59a). She did, however, fill out an incident report which she gave to her nursing supervisor. (*Id.*)[1]

In the deposition he provided in this case, Rogers Gomez also testified that he was able to save Ms. Krusac from falling directly to the floor. Gomez testified that he heard Colvin shout a warning that Ms. Krusac might be falling and he turned and saw Ms. Krusac rolling toward the side of the table. (App. 74a). He testified that Colvin had her arms under Ms. Krusac who was coming down slowly from the table. He was also able to get his arms under Ms. Krusac before she even made contact with the floor. (App. 75a). According to Gomez, as he and Colvin cradled Ms. Krusac in their arms, Ms. Krusac's head never made contact with the floor until he laid her down gently. (*Id.*)

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[1]On page 8 of its brief to this Court, Covenant cites to pages 47 and 48 of Colvin's deposition (App 59a) in support of the following representation: "Nurse Colvin testified that she filled out an Improvement Report after this event. Moreover, she testified that the report was given to her nursing supervisor *and routed through the appropriate channels to defendant's peer review committee.*" Def's Brief, at 8 (emphasis added). This is a flat-out misrepresentation of Colvin's testimony. While Colvin did testify that she filled out the form and gave it to her supervisor (App 59a), she had absolutely nothing to say in her deposition of where her incident report got "routed to" after she provided it to her supervisor. Colvin never testified that it got routed to Covenant's peer review committee.

The same page of Covenant's brief also states that "Gomez testified that he was questioned for purposes of providing information to a peer review committee . . ." Def's Brief, at 8. Again, Covenant has misrepresented the substance of its employee's testimony. Gomez testified on page 28 of his deposition that he was interviewed by his supervisor Pam Elmers. (App 76a). He never testified that this interview was part of a peer review process.

The third occupant of the catheterization lab, Heather Gengler, also testified that this incident unfolded right in front of her. (App. 65a). Gengler indicated in her deposition that she too saw Ms. Krusac begin to fall and she too was able to quickly rush to Ms. Krusac's side and get to her before she made contact with the floor. (App. 66a).

The trial in this case was scheduled to begin in March 2014. In anticipation of that trial, Mr. Krusac filed a motion in limine in which he sought production of the facts provided in Colvin's incident report. (App. 119a-161a).

Covenant responded to Mr. Krusac's motion in limine by asserting that the incident report was protected from disclosure under two Michigan statutes, MCL 333.20175(8) and MCL 333.21515. (App. 16b - 34b). Covenant offered no evidence as to how the peer review process functioned within its facility nor did it provide any evidence as to how the incident report that Colvin prepared had been processed. Instead, in its response to Mr. Krusac's motion in limine, Covenant simply announced in conclusory terms "[t]he report was created as part of Defendant's peer review process, in an effort to reduce patient mortality and morbidity. The Incident Report was not made part of Ms. Krusac's medical record." (App. 25b).

A hearing on plaintiff's motion in limine was held on March 5, 2014. At that hearing, the circuit court ruled that it would not order production of the incident report nor would it require an in camera inspection of its contents. (App. 177a-178a). A written order denying Mr. Krusac's motion was signed on March 21, 2014. (App. 181a-182a).

Thirteen days later, Mr. Krusac filed a motion for reconsideration. Covenant filed a response to that motion (App. 35b - 49b) that once again provided no information as to how its peer review process operates in general. Nor did that response delve into the specifics of how Colvin's incident

report had been handled.

On May 2, 2014, the circuit court issued an order granting Mr. Krusac's motion for reconsideration. (App. 183a-184a). The circuit court indicated in that order that it would "conduct an In Camera inspection of the facts contained in the Covenant Healthcare incident report regarding Ms. Krusac's fall to determine if said portion qualifies as privileged under Defendant hospital's assertion of peer review . . ." (App. 184a). Three days later, the circuit court examined the incident report in camera and asked to be provided with the depositions taken of Colvin, Gengler and Gomez.

After conducting its in camera review, the circuit court issued an order dated May 8, 2014, requiring production of the first page of what the court now referred to as an "Improvement Report." (App. 195a-196a). The May 8, 2014 order indicated that this Improvement Report had been completed by Colvin the same day that Ms. Krusac fell from the catheterization lab table and that, in the portion of that report that Colvin filled in, she "described the facts of the incident." (App. 195a).

Relying on the Court of Appeals decision in *Harrison v Munson Healthcare, Inc.*, 304 Mich App 1; 851 NW2d 549 (2014), the circuit court ruled in its May 8, 2014 order that a portion of Colvin's incident report was not protected from disclosure:

> This Court agrees with the *Munson* case that objective facts gathered contemporaneously with an event do not fall within the definition of peer review privilege. Having reviewed the report in question, this Court concludes that the first page of the report, that is the front page, is not immune from disclosure as material collected pursuant to MCL 333.21515. As noted in the *Munson* case to hold otherwise would unilaterally insulate from discovery first-hand observations. In the case before this Court, Nurse Colvin was present and reported the "facts" under that section of the report on the same date and within 10 minutes of the occurrence.
>
> Even assuming, for argument purposes, that the "Improvement Report" is a peer review report, it is not the facts themselves that fall under the peer review privilege

> but rather what is done with those facts. The back side of the report covers what was done with the facts and this Court concludes that the second page (back page) is, in fact, covered by peer review.
>
> (App. 196a).

Covenant filed an emergency appeal in the Court of Appeals, which denied leave to appeal in an order dated May 12, 2014. (App. 203a). On request for emergency review, this Court initially ordered a stay of all proceedings in the circuit court (App. 206a) and on June 20, 2014, it issued an order granting Covenant's application for leave to appeal. *Krusac v Covenant Medical Center, Inc.*, 496 Mich 855; 847 NW2d 499 (2014). In its order granting leave, the Court instructed the parties to include in their briefs the following two issues:

> (1) whether *Harrison v Munson Healthcare, Inc.*, 304 Mich App 1; ___ NW2d ___ (2014), erred in its analysis of the scope of the peer review privilege, MCL 333.21515; and (2) whether the Saginaw Circuit Court erred when it ordered the defendant to produce the first page of the improvement report based on its conclusion that "objective facts gathered contemporaneously with an event do not fall within the definition of peer review privilege.

Covenant has now filed its brief on the merits. That brief contains references to another Saginaw Circuit Court action in which Covenant is involved, *Doyle v Covenant Medical Center, Inc.*, Saginaw County Circuit Court 12-016476-NH. The Appendix accompanying Covenant's brief also contains both a copy of an order entered in the *Doyle* case (App. 78a-83a) as well as the transcript of an evidentiary hearing conducted in the *Doyle* case on December 20, 2013. (App. 84a-118).

Plaintiff would note that the *Doyle* material that Covenant includes in its Appendix and discusses in its brief is not part of the lower court record in this case. But, inasmuch as defendant views this Court's grant of leave to appeal as an invitation to supplement the record, plaintiff will

respond in kind.

Plaintiff is, therefore, including in his Appendix additional documents from the *Doyle* case. These documents include a copy of the two exhibits that were introduced at the December 20, 2013 evidentiary hearing conducted in the *Doyle* case. (App 50b - 58b). These two exhibits consist of a section of Covenant's Administrative Manual, containing Covenant's policies regarding incident reports. (App. 50b - 56b) and a blank copy of a Covenant Improvement Report form. (App. 57b - 58b).

ARGUMENT

According to Dorothy Krusac's medical records, on September 13, 2008, at the conclusion of a heart catheterization procedure, she fell off the procedure table onto the floor. The fall was sufficiently severe that Ms. Krusac was immediately placed in a cervical collar and on a back board. It was sufficiently severe that a stat CT scan was ordered and performed of both her head and neck. According to her medical records, Ms. Krusac's fall from the catheterization lab table was not witnessed by any of the three Covenant staff members who were in the lab during her procedure. (App 9b - 10b).

Four years after Ms. Krusac's unwitnessed fall to the catheterization lab floor, depositions were taken of the three individuals who were in the lab when this incident took place. All three testified under oath that Ms. Krusac's medical records were wrong in two important respects. According to all three of these witnesses, Ms. Krusac did *not* fall to the floor from the catheterization lab table. Instead, according to these three witnesses, Ms. Krusac gently descended to the floor with the alert and adroit assistance of all three of the Covenant employees who were in the room. Moreover, according to all three of these witnesses, Ms. Krusac's gentle descent (not fall) was most definitely not unwitnessed. In fact, as they portrayed it, all three of Covenant's employees saw Ms. Krusac begin to roll from the table, and together they managed to cradle Ms. Krusac before she fell to the floor.

Thus, in this case in which Ms. Krusac's fall from the table represents the centerpiece of the plaintiff's case, there is a sizable distance between what Ms. Krusac's medical records say and what Covenant's three most important witnesses are willing to say.

One of these three witnesses, Deborah Colvin, made no entry at all in Ms. Krusac's medical

records concerning this incident. However, Colvin prepared a report of the incident which she gave to her supervisor. That report is the subject of this appeal.

The contents of that report are obviously of considerable importance to the legal issues to be discussed in this brief. Plaintiff is, however, working under the disadvantage of not having seen that document. In the discussions that follow, plaintiff will be operating under the following assumptions as to this document. Based on Colvin's deposition testimony, plaintiff assumes that this document was actually filled out and signed by Colvin. (App. 59a). In its May 8, 2014 order requiring production of Colvin's portion of the incident report, the circuit court indicated that this report was written by Colvin, it "described the facts of the incident" and it was prepared "within ten minutes of the occurrence." (App. 195a - 196a). Plaintiff will be assuming these facts are true.

Plaintiff will be making one additional assumption regarding the incident report that Colvin filled out. Plaintiff will assume that the "Improvement Report" form that Colvin filled out is either similar or identical to the Covenant "Improvement Report" form that Covenant produced as an exhibit in *Doyle* and which is provided in plaintiff's Appendix. (App. 57b - 58bb).

This brief is divided into two parts. First, it addresses Covenant's claim of statutory privilege under the existing case law construing that privilege. The final issue in this brief will address the text of the statutes involved and analyze why this Court should reexamine the contours of the privilege being claimed here.

I. THE CIRCUIT COURT DID NOT ERR IN ORDERING PRODUCTION OF THE INCIDENT REPORT COLVIN PREPARED.

A. The Statutory Framework

Since this case involves construction of a statutory privilege, the appropriate place to start

is the relevant statutes. Article 17 of Michigan's Public Health Code (MCL 333.20101 - MCL 333.22260) governs "health facilities or agencies." That term is expansively defined and includes hospitals. MCL 333.20106(1)(g).

MCL 333.21513 sets out some of the general duties of the operation of a hospital licensed under a Michigan law. That statute provides in relevant part:

> The owner, operator, and governing body of a hospital licensed under this article:
>
> * * *
>
> (d) Shall assure that physicians and dentists admitted to practice in the hospital are organized into a medical staff to enable an effective review of the professional practices in the hospital for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients. The review shall include the quality and necessity of the care provided and the preventability of complications and deaths occurring in the hospital.
>
> MCL 333.21513(d).

In *Attorney General v Bruce*, 422 Mich 157; 369 NW2d 826 (1985), this Court relied on MCL 333.21513 for the conclusion that "[h]ospitals are required to establish peer review committees whose purposes are to reduce morbidity and mortality and to ensure quality of care." *Id.*, at 169.

Article 17 of the Public Health Code has two similarly worded statutes addressed to the confidentiality of materials collected by or for any such peer review committee. One of these statutes is found in Part 215 of Article 17, the portion of that Article addressed to hospitals. That statute, MCL 333.21515, provides:

> The records, data, and knowledge collected for or by individuals or committees assigned a review function described in this article are confidential and shall be used only for the purposes provided in this article, shall not be public records, and shall not be available for court subpoena.

A second provision providing for confidentiality of peer review material is contained in MCL

333.20175(8), which provides:

> The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency, or an institution of higher education in this state that has colleges of osteopathic and human medicine, are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena.
>
> MCL 333.20175(8).

Another subsection of that same statute, MCL 333.20175(1), addresses the medical records that every Michigan health facility is required to maintain and make available and accessible to its patients. That subsection provides in pertinent part:

> (1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. Unless a longer retention period is otherwise required under federal or state laws or regulations or by generally accepted standards of medical practice, a health facility or agency shall keep and retain each record for a minimum of 7 years from the date of service to which the record pertains. A health facility or agency shall maintain the records in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure their accessibility and availability to each patient or his or her authorized representative as required by law.
>
> MCL 333.20175(1).

B. Why Covenant's Claim Of Privilege Must Fail, Part I

Covenant argues on appeal that this Court should apply MCL 333.20175(8) and MCL 333.21515 and conclude as a matter of law that Colvin's incident report is protected by the peer review privilege. There is clearly no basis for this result in light of the complete absence of record evidence necessary to support Covenant's privilege claim.[2]

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[2]As Covenant notes in its brief, the circuit court did not conduct an evidentiary hearing into its claim of privilege, thus explaining the lack of record evidence supporting that claim. Covenant attempts to assign responsibility for the lack of an evidentiary hearing on the circuit court. It represents in its brief that Rebecca Schultz, Covenant's Director of Risk Management,

A party asserting a privilege has the burden of establishing the predicate for that privilege. *Lawrence v Fox*, 357 Mich 124, 141; 97 NW2d 719 (1959). In the circuit court, Covenant did no more than announce its right to a privilege; it offered nothing to back up any claim of privilege. It came forward with no evidence explaining how the peer review process operates within its facility. Nor did it offer any insight into how Colvin's incident report was handled once she wrote it and gave it to her supervisor.[3]

It is obvious that, to sustain Covenant's privilege claim, this Court would have to know much

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appeared at the May 12, 2014 hearing and defense counsel offered her to the court to "provide testimony relative to the hospital's peer review process, as well as the purposes and policies behind the existence of the Improvement Reports." Def's Brief. at 10. The suggestion is that it was the circuit court which refused to take Schultz's testimony. Once again, this statement in Covenant's brief does not square with the actual trial court record. At the May 12, 2014 hearing, Covenant's attorney, Thomas R. Hall, introduced Schultz as a nurse and an attorney and he indicated that she was present in court because she "can address the Court if need be about Covenant's position on this issue and why we hold it so near and dear." (App. 198a). Hall did *not* tell the circuit court that Schultz was present to give testimony about the mechanism of Covenant's peer review process. More importantly, Hall never insisted that an evidentiary hearing had to take place before the circuit court could decide the privilege issue presented to it.

[3]As noted previously, Covenant has attempted to make up for this gap in the factual record by presenting the Court with an evidentiary hearing transcript in *Doyle*, another malpractice action instituted against it. (App. 84a - 118a). This material is not part of the record in this case and, therefore, should not even be considered as a factual predicate for Covenant's claim of privilege. Moreover, the evidentiary hearing conducted in *Doyle* is itself inadequate in addressing Covenant's privilege claim. As will be discussed, this Court has indicated that a court addressing a peer review privilege claim must have a sense of the persons or committees within a hospital who have been assigned a peer review function. That inquiry requires consideration of hospital bylaws and internal regulations. *Monty v Warren Hospital Corp*, 422 Mich 138, 147; 366 NW2d 198 (1985); *Dorris v Detroit Osteopathic Hospital Corp*, 460 Mich 26, 42; 594 NW2d 455 (1999). There was no examination of Covenant's bylaws or internal regulations in *Doyle* and, as such, there is no method of ascertaining from the material in Covenant's Appendix whether the peer review privilege applies. But, even if the *Doyle* material that Covenant has supplied could provide the Court with the information it might need to understand how the peer review function works in general within Covenant, the one thing that the *Doyle* material cannot help the Court with is the equally important question that is specific to this case - what happened to the incident report once it left Colvin's hands?

more than it does at present regarding both the operation of the peer review process at Covenant in general and the handling of Colvin's incident report in particular.

MCL 333.20175(8) and MCL 333.21515 both require that the material subject to its confidentiality provisions must be (1) collected for or by (2) a committee assigned a review function. The language of these statutes demands factual development before a party can successfully claim peer review privilege.

For example, Covenant would have to establish that Colvin's incident report was *collected* in a manner consistent with §20175(8) and 21515. This would require consideration of the Court's decision in *Marchand v Henry Ford Hospital*, 398 Mich 163; 247 NW2d 280 (1975). *Marchand* was a medical malpractice action involving intravenous hyperalimentation, a process by which nutrition is supplied intravenously. On his own initiative, a physician on the defendant hospital's staff kept records pertaining to the use of hyperalimentation feeding at the hospital. The physician later shared the results of his study with other physicians at a general staff meeting.

The plaintiff in *Marchand* sought production of the doctor's investigation into this feeding technique. The hospital asserted that the study was protected by the peer review privilege. This Court, after first remanding the case for further factual development, *Marchand v Henry Ford Hosp,* 394 Mich 906; 249 NW2d 866 (1975), rejected the hospital's claim of privilege. Noting that the hyperalimentation study was not collected pursuant to a directive from a peer review committee, the *Marchand* Court concluded that it was not "collected for or by" such a committee as §20175(8) and §21515 require. 398 Mich at 168. The Court noted that this conclusion was not altered by the fact that the study's contents were later shared with a body that might qualify as a peer review committee under the statute. *Id.*

Marchand teaches that the statutory privilege extends to material collected at the direction of a peer review committee and that a privilege does *not* attach merely because material is in the possession of a peer review committee. *See also Monty v Warren Hospital Corp*, 422 Mich 138, 146-147; 366 NW2d 198 (1985) ("mere submission of information to a peer review committee does not satisfy the collection requirement so as to bring the information within the protection of the statute."). Thus, being "collected for or by" a peer review committee under §20175(8) and §21515 does not equate with being "handed to" or "in possession of" such a committee. Obviously, there has been no factual development in this case sufficient to address the question of whether Colvin's incident report was "collected by or for" a properly constituted peer review committee.

This Court's decision in *Monty* also demonstrates that factual development is necessary with respect to the character of the committee that collected purportedly privileged material. In *Monty*, this Court noted that a court might have to determine whether a particular body constituted a review committee covered by the statutes and that this task could involve consideration of "the hospital's bylaws and internal regulations . . ." 422 Mich at 147. The Court in *Monty* further noted that the privilege claim might also hinge on whether the material was being collected "for or by" such a committee since the "mere submission of information to a peer review committee does not satisfy the collection requirement so as to bring the information within the protection of the statute." *Id.*, at 146-147; *cf Harrison*, 304 Mich at 26 ("Whether a particular document qualifies as privileged under the peer-review statute depends on the circumstances surrounding its creation.")[4]

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[4]A further factual inquiry that might be necessary concerns any uses of the claimed privileged material outside of those authorized in §20175(8) and §21515. Notably, both of these statutes specify that peer review materials "shall be used only for the purposes provided in this article." What is to happen to a claim of privilege where this statutory provision is violated? The Court of Appeals was presented with this factual scenario in *Harrison* when it came to light

The easy question presented in this appeal is whether Covenant can win this appeal outright, securing a decision reversing the circuit court's ruling on the ground that Colvin's incident report is as a matter of law confidential under §20175(8) and §21515. It cannot. The slightly more difficult question is whether Covenant's claim of privilege must fail even if it were to establish the requisite factual basis for that privilege. That question is addressed in the next section of this brief.

C. Why Covenant's Claim Of Privilege Must Fail, Part II

Let us assume for the moment that Colvin's incident report passed from the hands of her supervisor directly to a person or committee assigned a review function for the purposes of "reduc[ing] morbidity and mortality and to ensure quality control." *Dorris v Detroit Osteopathic Hosp Corp*, 460 Mich 26, 41; 594 NW2d 455 (1999). Let us also assume that, consistent with §20175(8) and §21515, the material in question was "used only for the purposes provided in [Article 17 of the Public Health Code.]" The question then becomes whether the front page of Colvin's incident report can be protected from disclosure in this case by these two statutes.

Colvin's incident report was written within minutes of Ms. Krusac's fall and it "described the facts of the incident." (App. 195a). While plaintiff does not know the precise contents of Colvin's report, there is one other thing that can be said with certainty - whatever Colvin wrote in

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that the incident report was shared with trial counsel in the malpractice action arising out of that incident. The Court in *Harrison*, however, did not decide whether this violation of §20175(8) and §21515 constituted a waiver of any privilege claim the defendant may have had. While plaintiff herein has no comparable evidence of purportedly privileged material being used for some purpose other than that stated in §20175(8) and §21515, it should be noted that Covenant's own policies state that incident reports will be used to enhance several different types of programs, including peer review, loss control and the somewhat frighteningly titled safety prevention program. (App. 50b). Thus, only one of the programs identified in Covenant's own incident report policy is peer review. The question remains as to the legal status of this material if it is used for some purpose other than risk management.

that incident report, she did *not* write that same thing in Ms. Krusac's medical records. We know this for a fact because Colvin made *no* entry into Ms. Krusac's records pertaining to the incident that occurred at the conclusion of the September 13, 2008 catheterization. Colvin only recorded her observations in the incident report.

What Colvin wrote on the front page of the incident report cannot be withheld from plaintiff on the basis of a peer review privilege. This information cannot be withheld because to do so would violate the same provision of the Public Health Code that contains the privilege that Covenant now claims.

MCL 333.20175 not only includes a subsection providing for the privilege Covenant claims in this case, it also contains a subsection pertaining to hospital record-keeping. Subsection 1 of that provision specifies that a hospital *shall* keep and maintain a record for each patient. That subsection also specifies what *must* be included in those records: "a full and complete record of tests and examinations, *observations made*, treatments provided, and in the case of a hospital, the purpose of hospitalization." MCL 333.20175(1) (emphasis added). Ms. Krusac's medical records were, therefore, supposed to contain a full and complete record of "observations made" by Covenant's staff. *Cf Dorris*, 460 Mich at 40 (characterizing §20175(1) as outlining "a hospital's duty to keep and maintain records regarding all treatment given to patients at that facility."). Moreover, §20175(1) also specifies that a hospital's medical records are to be maintained in such a way as to "ensure their accessibility and availability to each patient . . ."

The observations made by Colvin that found their way into her incident report were required

by Michigan law to be in her medical records.[5] Covenant's own Risk Management Department Director, Rebecca Schultz, agreed with this proposition and she confirmed that Covenant's own policies were consistent with Michigan law on this point. Testifying in the *Doyle* case, Schultz confirmed that all *facts* pertaining to a patient's case are supposed to be included in that patient's medical record *including those facts that find their way into an incident report*:

> Q. And as I heard you testify, one of the things that are included in the incident report are, in fact, the facts of what happened?
>
> A. That's correct.
>
> Q. And that's one of the requirements of filling out the form?
>
> A. It is. *But anything that factually happened should be – and it's in our policy as well – located in that patient's medical record. Anything that happened to the patient should be there, in the record, as well.*
>
> Q. So the policies of the hospital require, as I understand what you are saying, that all the facts and circumstances regarding the events of the patient be recorded in the medical chart or medical record?
>
> A. That happened to the patient, correct.
>
> (App. 104a) (emphasis added).

MCL 333.20175(8) and §21515 must be read in harmony with §20175(1). There is no legal or logical justification for allowing a hospital to sift through the facts related to a patient's care, enshrining some of these facts into the patient's medical records which by law must be accessible

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[5]Covenant's policy with respect to the generation of incident reports actually uses a comparable term to that which is contained in §20175(1). That subsection demands that medical records contain "observations made" of a patient by a hospital's staff. Covenant's incident report policy indicates that "[t]he employee . . . involved in, *observing*, or discovering the incident is responsible for initiating and completing the appropriate sections of the Improvement Report Form." (App. 51b) (emphasis added).

to the plaintiff,[6] while diverting other facts or "observations made" by its staff to an incident report which will then be withheld from the plaintiff as privileged.

There is textual support in the peer review statutes for construing them in a manner consistent with the rest of Article 17 of the Public Health Code, which includes §20175(1). Both §20175(8) and §21515, using identical language, specify that the "records, data and knowledge" subject to those provisions "shall be used only for the purposes provided in this article."

In §20175(1), the Legislature has unequivocally expressed the view that hospitals are to maintain medical records "to ensure their accessibility and availability to each patient." And, the Legislature has gone further by identifying what must be in those records, including "observations made" during the course of a patient's care. Thus, requiring disclosure of the *facts* contained in Colvin's incident report represents a use of the material "for the purposes provided in this article," as both §20175(8) and §21515 provide.

In light of the dictates of §20175(1) and its command that the *facts* of a patient's treatment be contained in the records to which a patient must have access, it is worth considering the stance that Covenant takes on the basis of what it perceives to be the lofty public policy goal served by the peer review privilege. As Covenant portrays it, the health care sky will fall in if this Court does not reverse this case and *Harrison* because of the importance that the peer review privilege plays in promoting patient care. As Covenant puts it in its brief, the peer review privilege:

> [p]romotes the willingness of hospital staff to provide candid information to a peer review committee for assessment in peer review proceedings. *See Dorris* at 42. *To*

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[6]In addition to §20175(1)'s assurance of the "accessibility and availability" of a patient's medical records, the Michigan Legislature also incorporated a separate act into the Public Health Code, the Medical Records Access Act, MCL 333.26263, *et seq.*, which likewise guarantees patients access to their medical records.

hold otherwise would have a substantial chilling effect on healthcare professionals' willingness to provide candid information for fear that these "objective facts" could later be used against them in a legal setting - much as Plaintiff and his counsel now seek to do.

Def's Brf. at 22 (emphasis added).

The Court should pause for a second to consider the rather profound cynicism reflected in this particular statement. This is a case in which Covenant is claiming a privilege to avoid disclosure of *facts*. What Covenant is saying in the italicized sentence from its brief cited above is that in order for Covenant's staff to ever be fully candid (at least internally) about these facts, this Court must guarantee that this candid view of the facts is never disclosed to anyone else, including (and especially) the patient.

What Covenant is arguing is that, in the purported interest of patient well-being, *this Court must reach a decision that extends to Covenant the right to choose when its agents will be fully candid about the facts of a patient's care and when they will be less than candid about those facts.* But, §20175(1) does not give Covenant or any other Michigan hospital a choice as to when it will be fully candid about the facts associated with the medical care being provided to a patient.[7] These facts *must* be included in the patient's medical records and those records must be available to the patient, even to a patient who might be prompted by those facts to sue a hospital for negligence.

Covenant's view that this Court must recognize its right to unilaterally select when it will or

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[7]This expression of public policy should be contrasted with that which might be invoked in the protection of a peer review committee's *deliberative* process. The purpose of the privilege extended to a peer review committee's deliberations was expressed quite well by the Connecticut Supreme Court in *Babcock v Bridgeport Hospital*, 251 Conn 790; 742 A2d 322, 344 (1999): the privilege in this setting is designed "to encourage committee members to 'take positions that they might not otherwise take if they thought they were going to be subpoenaed in the middle of a malpractice case.'" But, committee members do not (or at least should not) "take positions" with respect to the underlying *facts* of a patient's care.

will not be fully candid about the facts of a patient's hospitalization goes a long way toward explaining the type of fraud that was perpetuated on the Grand Traverse County Circuit Court in *Harrison*. What Munson Hospital and its agents argued for in that case was the right to be completely candid in an internal and purportedly privileged incident report written shortly after the malpractice giving rise to that case, even where that completely candid description of the facts was not reflected in the patient's medical records and even where that candid description of the facts happened to be at odds with the defense that Munson was mounting at trial. Thus, Munson (much like Covenant here) claimed the right to be totally candid as to the facts of the plaintiff's medical care in only one setting, at the expense of total candor to its patient or, ultimately, to the court.

Covenant argues that this Court should, in the purported interest of advancing patient care, put its imprimatur on this selective "candor" with respect to the facts of a patient's medical care. The Michigan Legislature in §20175(1) has declared otherwise, thus avoiding the scenario that was described by the Illinois Supreme Court in *Roach v Springfield Clinic*, 157 NW2d 29, 41-42; 623 NE2d 246, 251 (1993):

> If the simple act of furnishing a committee with earlier-acquired information were sufficient to cloak that information with the statutory privilege, a hospital could effectively insulate from disclosure virtually all adverse facts known to its medical staff, with the exception of those matters actually contained in a patient's records. As a result, it would be substantially more difficult for patients to hold hospitals responsible for their wrongdoing through medical malpractice litigation. So protected, those institutions would have scant incentive for advancing the goal of improved patient care. The purpose of the act would be completely subverted.
>
> *Id.*

A hospital cannot bury relevant facts in a document that qualifies as peer review and keep those facts outside the reach of the patient. Because §20175(1) decrees that these facts must be in

the patient's medical records and that these medical records must be accessible to the patient, there can be no claim of privilege to these facts.

D. The Court Of Appeals Decision In *Harrison*

One of the two issues on which this Court requested briefing is whether the Court of Appeals properly resolved the peer review question presented to it in *Harrison.* In that case, the plaintiff received a burn on her arm during a surgical procedure that took place at Munson Medical Center. When the plaintiff brought suit against Munson and the doctor who performed the surgery, the defendants embarked on a defense that was patently at odds with the contents of an incident report written by an operating room nurse only 90 minutes after plaintiff's surgery was completed.

The defendants' artifice was not uncovered until the parties were mid-trial and, after declaring a mistrial, the circuit court conducted an evidentiary hearing which delved into the applicability of Michigan's peer review privilege. At that hearing, Munson's vice-president of legal affairs, Paul Shirilla, testified. His testimony at that evidentiary hearing was summarized in the Court of Appeals January 30, 2014 decision in *Harrison* as follows:

> [Shirilla] described at length the peer-review process utilized at Munson and the relationship of the incident report to that process. According to Shirilla, oversight for the peer-review process emanates from the board of trustees, which appointed the quality committee to review information submitted by other review committees. The quality committee does not review individual incident reports, but rather receives "a collection of trends ... that ... emanate from these other committees" and reviews "data and knowledge related to the quality of care delivered at the hospital." Incident reports, Shirilla claimed, are part of the peer-review process even though they are retained only in the risk-management office. Shirilla admitted, "[t]his is probably the first occurrence report that I've reviewed," and further acknowledged, "I don't believe a [peer review] committee reviewed this occurrence report."
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> 304 Mich App at 17.

Another witness who testified at the *Harrison* evidentiary hearing was the head of Munson's

risk management department, Bonnie Schereiber. She confirmed that incident reports are stored at the risk management department and are not provided to peer review committees.

The Court of Appeals went on to rule in *Harrison* that the incident report written shortly after the plaintiff sustained her injury was not protected by §20175 or §21515, Based on the testimony of Shirilla and Schreiber, the Court held in *Harrison*:

> Here, Shirilla confirmed that Munson's quality committee does not "collect" or even review incident reports. He and Schreiber agreed that at Munson, incident reports are stored within the risk-management department and are not provided to peer-review committees for study. And Schreiber acknowledged that no "peer review file" was ever created concerning Harrison's burn. Given this evidence, we conclude that the factual information recorded on the first page of the incident report was not immune from disclosure as material collected pursuant to MCL 333.21515.
>
> *Id.*, at 34.

The *Harrison* Court's resolution of the peer review issue was correct. Both §20175 and §21515 specify that a party claiming this privilege must, at a minimum, demonstrate that the material in question was "collected for or by" a peer review committee. Since the testimony provided at the evidentiary hearing demonstrated that the incident report never even made its way to a review committee, the claim of privilege in *Harrison* was properly rejected.

The facts of the *Harrison* case also serve to underscore how §20175(1) must be given effect. The plaintiff in *Harrison* was burned by a cauterizing device, a bovie. When not in use, that device must be holstered and everyone involved in the *Harrison* case appeared to acknowledge that failing to holster the device when it was not being used would constitute negligence.

The defendants in *Harrison* mounted a defense based on the hypothesis that the bovie had been properly reholstered after it was used, but during surgery it was inadvertently (and nonnegligently) dislodged from its holster. However, that version of the operative events was at

odds with an incident report prepared by one of the operating room nurses shortly after plaintiff's surgery. That note recorded what the nurse had seen in the operating room: "During procedure bovie was laid on drape, in a fold."[8]

Under the unequivocal dictates of §20175(1), this observation made during the course of the plaintiff's surgery could not be protected from disclosure in the plaintiff's malpractice claim simply by including it in an incident report. That "observation made" by the nurse *had to be* included in the plaintiff's medical records and made accessible to the plaintiff.

The *Harrison* Court did not expressly rely on §20175(1) in rendering its ruling that the nurse's observations did not fall within the statutory privilege, but the panel in *Harrison* certainly grasped why these observations could not be deemed privileged:

> *By protecting peer review from external scrutiny, Michigan's Public Health Code does not concomitantly erect a barrier to a patient's quest for objective facts concerning the patient's own surgical procedure.*
>
> 304 Mich App at 43 (emphasis added).

The *Harrison* Court was correct. The Public Health Code did not create a barrier to a patient's "quest for objective facts." Indeed, the Public Health Code in §20175(1) did quite the opposite - it precluded any health facility from ever erecting a barrier to the "objective facts" of a patient's care, by mandating that certain facts be in a patient's medical records and by further mandating that these records be accessible and available to the patient.

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[8]The significance of this observation was not lost on Munson's operating room manager, the person who investigated the circumstances of the plaintiff's injury. She concluded that plaintiff was burned because of the failure to follow hospital procedure in that the holster "was in field for this case, however bovie was not placed in it." 304 Mich App at 14.

II. UNDER AN APPROPRIATE TEXTUAL APPROACH TO MCL 333.20175 AND MCL 333.21515, COVENANT'S CLAIM OF PEER REVIEW PRIVILEGE SHOULD BE REJECTED.

This Court has in recent years repeatedly expressed its commitment to the interpretation of statutes according to their literal text. Additionally, this Court in recent years has not been particularly timid about revisiting and revising prior court decisions that have not been fully consistent with statutory text. In that same spirit, this Court should reexamine §21075(8) and §21515 and apply them the way that the Michigan Legislature wrote them.

These two statutes specify that "[t]he records, data, and knowledge collected for by individuals assigned a review function . . . are confidential . . ." Both statutes further provide that this confidential material "shall be used only for the purposes provided in the article," it is not to be construed as a public record and it is not subject to court subpoena.

Michigan courts have obviously construed these two statutes as establishing a peer review *privilege*. In doing so, prior courts have taken the word that is used in these statutes, "confidential," and substituted another word, "privileged," in its place. But that is not what the Legislature wrote when it adopted these two statutes. The Legislature did *not* indicate that the "records, data and knowledge" of a review committee were *privileged*; rather it only indicated that these "records, data and knowledge" were *confidential.*

There is a difference between these two concepts. That difference was explained in a law review article which canvassed the law in various states on this subject, Scheutzow & Gillis, *Confidentiality And Privilege Of Peer Review Information: More Imagined Than Real*, 7 J.L. Health 169 (1992-1993). This article noted that some peer review statutes refer to material as "confidential," some refer to it as "privileged," and some refer to both. The differences in this

wording is significant:

> Confidentiality and privilege are two compatible, yet distinct, concepts. Privilege addresses a person's right not to have another testify as to certain matters as part of a judicial process, while confidentiality addresses the obligation to refrain from disclosing information to third parties other than as part of legal process. Confidentiality may be imposed by law or by agreement. In many cases, if there is a privilege against testifying, there is also a requirement to keep information confidential; for instance, many states which recognize the attorney-client privilege or physician-patient privilege also provide that the attorney or physician can be subject to state license disciplinary action for willful betrayal of a professional confidence.

Id., at 192.

State statutes protecting peer review material vary greatly. *Id.*, at 186-187. These variances counsel against any involved discussion of statutes in existence in other statues and their potential impact on Michigan law. Nevertheless, there is at least one state statute with some resemblance to Michigan's peer review statute and that statute and its judicial construction are worth considering in this context. The state in question is North Dakota, which has a peer review statute providing:

> "Any information, data, reports, or records made available to a ... committee ... are confidential and may be used by such committees and the members thereof only in the exercise of the proper functions of the committees. The proceedings and records of such a committee are not subject to subpoena or discovery or introduction into evidence in any civil action arising out of any matter which is the subject of consideration by the committee."

Section 23-01-02.1, NDCC

The North Dakota peer review statute contains two sentences. The first sentence, in language that is very close to that contained in §20175(8) and §21515, indicates that the "information, data, reports or records" made available to a peer review committee are *confidential*. The second sentence protects the "proceedings and records" of such a committee and provides that these proceedings and records are not subject to discovery or subpoena and may not be introduced at trial in a civil action.

The North Dakota Supreme Court considered this statutory language in *Trinity Medical Center, Inc. v Holum*, 544 NW2d 148 (ND 1996). In *Trinity Medical*, a hospital being sued for malpractice argued that it could not be compelled to produce any of the "information, data, reports or records" that had been made available to a peer review committee because that material was privileged under the peer review statute. Thus, the hospital in *Trinity Medical* claimed peer review privilege based on the first sentence of the North Dakota statute.

The North Dakota Supreme Court rejected the hospital's argument as a misreading of the peer review statute:

> Trinity's argument is flawed by its misreading of Section 23–01–02.1. The first sentence of the statute provides that "[a]ny information, data, reports, or records made available to" a covered committee "are confidential." The second sentence specifies that "proceedings and records of such a committee are not subject to subpoena or discovery or introduction into evidence."
>
> *Trinity has confused confidentiality with privilege. It is the second sentence which creates the privilege. The first sentence merely provides that information made available to the committee is confidential, and "may be used by such committees and the members thereof only in the exercise of the proper functions of the committees." That provision is directed to those who acquire information in the course of serving on the committee, and directs that they are not free to disseminate such information to third persons or the public. Confidentiality, however, is not synonymous with privilege.*
>
> 544 NW2d at 156 (emphasis added).

The North Dakota Supreme Court in *Trinity Medical* construed the text of its peer review statute correctly. The first sentence of the North Dakota statute did *not* create a privilege; it only decreed that the information provided to a peer review committee was *confidential.* Declaring certain material as *confidential* does not render that material privileged nor does it exempt this material from discovery in a civil suit. Some other language was necessary to create such a privilege.

What the Court held in *Trinity Medical* was that one would have to look elsewhere for a statutory *privilege*. In *Trinity Medical*, the peer review privilege was set out in the second sentence of the North Dakota statute, which specified that the proceedings and records of a peer review committee "are not subject to subpoena or discovery or introduction into evidence in any civil action . . ."

Similar to the North Dakota statute being construed in *Trinity Medical*, what §20175(8) and §21515 specify is that the "records, data and knowledge" collected for or by a peer review committee are *confidential* and the committee maintaining this confidential material must ensure that it is "used only for the purposes provided in this article." But, unlike the North Dakota statute, Michigan's peer review statutes do not have a second sentence indicating that peer review material cannot be the subject of discovery or introduced as evidence in a civil action. The two Michigan statutes do, however, explicitly exempt the "records, data and knowledge" collected by or for a peer review committee from a court subpoena. Thus, a hospital cannot be compelled to provide this material in response to a court subpoena. To the extent there is a privilege component in §20175(8) and §21515, it is to be found in their shared language specifying that a hospital cannot be compelled to produce peer review material *in response to a subpoena.*

But, under the Michigan court rules, Mr. Krusac did not require a court subpoena to obtain Colvin's incident report. As such, the last clauses of both §20175(8) and §21515 were inapplicable in this case. The Michigan Legislature certainly could have written a statute similar to that adopted in North Dakota. It would have written a statute that would render the "records, data and knowledge" collected by a peer review committee (1) exempt from a court order compelling their production; or (2) exempt from discovery in a civil action or (3) prohibited from being introduced into evidence in a civil action. But that is not what the Michigan Legislature did. The Legislature

only declared in §20175(8) and §21515 that the records, data and knowledge were to be confidential and it limited the Court's subpoena power over this material.

The conclusion that the confidentiality mentioned in these two statutes does not equate with privilege is fully confirmed by the fact that the Michigan Legislature has had no difficulty in numerous other statutes in declaring certain information *both* privileged *and* confidential. *See e.g.* MCL 3.692; MCL 3.1012; MCL 3.1041; MCL 333.16648(1); MCL 339.732(1); MCL 393.506(2); MCL 462.71; MCL 500.814a(6); MCL 500.943(3); MCL 500.1246(3); MCL 691.1697(5); MCL 767.5a(2); MCL 791.229; *see also* MCR 9.126(A); MCR 9.221(A). Each one of these statutes demonstrates the distinction that exists between confidential and privileged information. Each of these statutes further demonstrates that the Legislature is fully capable of drafting a statute that renders certain material *both* privileged and confidential. That is not what the Legislature did when it enacted §20175(8) and §21515.

The literal text of §20175(8) and §21515 does not support the peer review privilege that has been adopted in prior Michigan appellate decisions. This Court should correct this misinterpretation of these two statutes.

RELIEF REQUESTED

Based on the foregoing, plaintiff-appellee, The Estate of Dorothy Krusac, deceased, by her Personal Representative, John Krusac, respectfully requests that this Court affirm the circuit court's May 8, 2014 order and remand this case to the Saginaw County Circuit Court for further proceedings.

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