IN THE SUPREME COURT

APPEAL FROM THE SAGINAW COUNTY CIRCUIT COURT

PRESIDING JUDGE FRED L. BORCHARD

THE ESTATE OF DOROTHY KRUSAC, deceased
by her representative John Krusac,

Plaintiff-Appellee,

Supreme Court No. 149270

COA No. 321719

Saginaw Cir Ct No. 12-015433-NH-4

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,

Defendant-Appellant.

Carlene J. Reynolds (P55561)
Law Office of Cy Weiner, PLC
Attorneys for Plaintiff-Appellee
4000 Town Center, Ste. 550
Southfield, MI 48075
(248) 351-2200

Mark Granzotto
Attorney for Plaintiff-Appellee
2684 Eleven Mile Rd., Ste. 100
Berkley, MI 48072
(248) 546-4649

Thomas R. Hall (P42350)
Samuel B. Oberman (P73497)
Hall Matson, PLC
Attorneys for Defendant-Appellant Covenant HealthCare
1400 Abbot Road, Suite 380
East Lansing, MI 48823
(517) 853-2929

DEFENDANT-APPELLANT COVENANT HEALTHCARE'S REPLY BRIEF ON APPEAL

TABLE OF CONTENTS

INDEX OF AUTHORITY

Cases

Statutes

LEGAL ARGUMENT

This Court's June 20, 2014 Order granting Defendant-Appellant's application for leave to appeal asked the parties to address two issues: 1) whether *Harrison v Munson Healthcare, Inc*, 304 Mich App; 851 NW2d 549 (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 Defendant-Appellant 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."

Plaintiff-Appellee (hereinafter Plaintiff) appears to have misunderstood and/or taken a more expansive interpretation of this Court's Order. Indeed, rather than addressing whether *Harrison* erred in its analysis of the scope of the peer review privilege *under MCL 333.21515*, Plaintiff argues that production of the Improvement Report was required under MCL 333.20175(1). Plaintiff also incorrectly relies upon a peer review privilege statute from the State of North Dakota in arguing that this Court and the Court of Appeals have been "misinterpreting" the intentions of the Michigan Legislature for decades. Defendant-Appellant (hereinafter Covenant) submits this Brief in order to address the inherent flaws in Plaintiff's arguments.

I. PLAINTIFF-APPELLEE'S RELIANCE ON MCL 333.20175(1) IS MISPLACED.

Plaintiff goes to great lengths in his Brief to claim that Covenant "failed to document" the events surrounding Ms. Krusac's fall from the catheterization table on September 13, 2008. Specifically, Plaintiff argues that Nurse Deborah Colvin, in particular, failed to author a medical record describing the events of Ms. Krusac's "fall." Plaintiff further maintains that the absence of Nurse Colvin's rendition of the events in Ms. Krusac's medical records requires production of Covenant's peer review records pursuant to MCL 333.20175(1).

As a prefatory matter, Plaintiff is well aware that this incident occurred in a catheterization lab. Plaintiff is also aware that per Covenant policy, the person responsible for documenting events in the catheterization lab during Ms. Krusac's procedure was Nurse Heather Gengler. (Heather Gengler Deposition Transcript at p 10, AA 64a; Deborah Colvin Deposition Transcript at p 10, AA 50a). It was **not** Nurse Colvin. (Deborah Colvin Deposition Transcript at pp 36-37 and 47, AA 56-57a and 59a). Indeed, Nurse Colvin was not responsible for authoring **any** portion of the record of Ms. Krusac's catheterization procedure other than medications given. (Deborah Colvin Deposition Transcript at pp 10, 47-48, AA 50a, 59a).

Contrary to Plaintiff's assertions, Nurse Colvin and/or Covenant personnel did not "sift through the facts" in order to "shrine" or "divert" them away. (Pl's Brief at 18). It was never Nurse Colvin's responsibility to record her observations in Ms. Krusac's medical chart. This is particularly true where "observations" were already being recorded by another staff member. Plaintiff's argument necessarily ignores the truth of this case – *Nurse Colvin's authoring of the Improvement Report was for reasons entirely separate and distinct from Ms. Krusac's ongoing medical care and treatment.*

Taken to its (illogical) conclusion, Plaintiff's argument is that *each and every staff member* of a hospital is required to document *each and every observation* made. This is the only possible interpretation of Plaintiff's argument as Ms. Krusac's medical records did in fact contain "observations made" by Covenant staff members – just not those of Nurse Colvin.

Plaintiff's argument is impractical and unattainable on its face. It would create a logistical nightmare if hospitals were required to include each and every observation made by each and every staff member in a patient's medical record. Stating the obvious, healthcare practitioners would no longer be able to quickly and efficiently review a patient's medical records for

information that is relevant and critical to the patient's ongoing care and treatment. Rather, they would be forced to read through countless pages of irrelevant and excessive information.[1], [2]

Plaintiff's argument in support of the production of Nurse Colvin's Improvement Report is flawed for an additional reason. Reading MCL 333.20175 as a whole reveals that subsection (8) contains substantially similar peer review privilege language to MCL 333.21515. Indeed, it notes that "records, data, and knowledge" collected "for or by" a peer review committee are confidential, not public records, and are not subject to court subpoena. As such, even *if* the Legislature intended to dictate the content of a patient's *medical records*, it crafted an exception for materials collected "for or by" a peer review committee – such as the Improvement Report currently at issue.

Covenant maintains that MCL 333.20175(1) does not require that each and every observation made by each and every hospital staff member be recorded in a patient's medical chart. Indeed, MCL 333.20175(1) reads as follows:

> 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

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[1]Ironically, Plaintiff's former counsel, Attorney Joel Sanfield acknowledged as much during the deposition of Nurse Gengler, wherein he indicated that "**there are things that occur . . . that don't always get documented . . . . not every single thing and every single occurrence are documented.**" (Heather Gengler Deposition Transcript at p 6, AA 63a).

[2] The painfully obvious reason Plaintiff seeks production of the Improvement Report, is for purposes of **impeaching** the testimony of Nurse Colvin, Nurse Gengler, and/or Mr. Gomez. Plaintiff has gone to great efforts to disparage and otherwise challenge the veracity and credibility of these individuals. While claiming that their collective testimony cannot be "harmonized" with Ms. Krusac's medical records, Plaintiff curiously fails to mention that the remaining sighted historical accounts of her "fall" came several hours later after she had been transferred up to the medical-surgical unit. Moreover, these "conflicting" records, were authored by medical personnel who had yet to come in contact with the patient, nor to obtain any history from those present in the catheterization lab. In this regard, it is interesting that Plaintiff elected not to depose either 1) the first year resident/medical student who obtained a subsequent history and physical from the patient sometime after 7:00pm on September 12, 2008; or 2) Dr. Sujal Patel, the trauma surgeon who later obtained his own history authored an obviously mistaken note to the effect that the fall was "unwitnessed." If Plaintiff truly seeks production of the Improvement Report for clarification of any purported "discrepancies," common sense would dictate that the depositions of the resident/medical student and Dr. Patel would be a logical first step. Again, Plaintiff has never requested, let alone conducted, these depositions.

> 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.

Contrary to Plaintiff's assertions, the clear purpose behind MCL 333.20175(1) is to create an implied *duty to provide medical records* upon a reasonable demand by a patient.[3] See *Wilson v Sinai Grace Hosp*, unpublished opinion per curiam of the Court of Appeals, decided April 29, 2004 (Docket No. 243425). The purpose of MCL 333.20175(1) is to require a health facility to maintain a patient's medical records for a period of not less than 7 years, while ensuring the confidentiality of the records.

Plaintiff tangentially mentions the Medical Records Access Act (MRAA), MCL 333.26261, et seq. (Pl's Brief at p 19 n 6). While Plaintiff fails to articulate how the MRAA is "incorporated" into MCL 333.20175, it is by and through MCL 333.20170 which indicates "[a] health facility or agency shall comply with the medical records access act." To this end, the MRAA defines "maintain" as related to a patient's medical records as "to hold, possess, preserve, retain, store, or control medical records." MCL 333.26263(g).

Accordingly, when read together, nothing about the statutory language of MCL 333.20175(1) and the MRAA dictate or otherwise require each and every staff member of a hospital to record each and every observation in a patient's medical record. Quite clearly, MCL

[3] It is again worth noting that the Improvement Report created following Ms. Krusac's fall was never made part of her medical record. The mere fact that Nurse Colvin was not responsible for recording any activities in the catheterization lab is further proof that the Improvement Report was created for purposes separate and distinct from ongoing medical care and treatment. She clearly testified that the Improvement Report was provided to her nursing supervisor, with the understanding that it would be routed through appropriate channels to a peer review committee.

333.20175(1) merely requires a hospital to maintain a patient's *medical records* for a period of not less than 7 years and to make the *medical records* available upon reasonable request.

In this matter, Plaintiff was provided with Ms. Krusac medical records. The issue before the Court is whether Covenant should now be required to turn over its Improvement Report – separately created and separately maintained for purposes of peer review. The Improvement Report was not, nor was it ever intended to be, made part of Ms. Krusac's medical record. As such, Covenant was not required to make the Improvement Report available to Plaintiff pursuant to MCL 333.20175(1). Indeed, MCL 333.20175(8) explicitly exempts "records, data, and knowledge" collected "for or by" a peer review committee from such production. As with MCL 333.21515, MCL 333.20175(8) notes that such information is confidential, not public record, and not subject to court subpoena.

In *Paul v Glendale Neurological Assocs, PC*, 304 Mich App 357; 848 NW2d 400 (2014), the Court of Appeals held that a report generated as a result of an independent medical examination did not constitute "medical records" as defined by the MRAA and was thus, not subject to the plaintiff's requests for production. Rather, the court found that MRAA refers to records maintained in the course of providing some sort of diagnostic or treatment service for the treatment and betterment of the patient. *Id.* at 366. In reaching its holding, the Court of Appeals reasoned that an independent medical examination "differs significantly from the typical interaction between a physician and patient." *Id.* at 364. The court relied heavily upon this Court's sound reasoning and judgment in *Dyer v Trachtman*, 470 Mich 45; 679 NW2d 311 (2004), in reaching its decision.

In *Dyer*, this Court noted that"[i]n the particularized setting of an IME, the physician's goal is to gather information for the examinee or a third party to use in employment or related

financial decisions. It is not to provide a diagnosis or treatment of medical conditions." *Dyer* at 51. Rather, an independent medical examination involves a "limited" relationship that "does not involve the full panoply of the physician's typical responsibilities to diagnose and treat the examinee for medical condition." *Id.* at 50.

The situation in which a peer review document is created is not so different from the situation in which an independent medical examination is conducted. Peer review documents, such as the Improvement Report at issue, are not meant for purposes of diagnosis and treatment. Rather, they are meant to provide one or more of a hospital's peer review committee(s) with pertinent information and data that will enable it to review practices within a hospital for purposes of reducing patient morbidity and mortality. Peer review documents are generated for an entirely separate purpose than that of a patient's ongoing medical care and treatment. Accordingly, peer review records should not be deemed discoverable for purposes of a civil litigation pursuant to MCL 333.20175(1) or MCL 333.21515.

Plaintiff's current argument seeks to abolish and/or erode the peer review privilege to the point it becomes meaningless. It is axiomatic that different witnesses to the same event will characteristically describe it in varying detail. Some individuals will inevitably give higher importance or more focus to certain observations than others. Accordingly, there will always be "conflicting" records. This, however does not justify a universal cry of "foul" from those representing plaintiffs in civil litigation.

II. PLAINTIFF-APPELLEE MISCHARACTERIZES SEVERAL UNDERPINNINGS OF THE *HARRISON* DECISION.

In light of Plaintiff's characterization of *Harrison*, Covenant feels compelled to provide the briefest of clarification to the factual record. A thorough reading of the *Harrison* opinion reveals that the Court of Appeals never once mentioned or gave discussion to MCL 333.20175(1) as a

basis for its erroneous decision.[4] Any attempt by Plaintiff to argue that the Court of Appeals somehow relied upon MCL 333.20175(1) is completely unfounded and improper.

Moreover, it is equally important to note that in rendering its decision, the Court of Appeals (as well as the trial court) **largely ignored** the sworn testimony of Nurse Cindy Gilliand, the individual responsible for authoring the incident report. During an *in camera* hearing, Nurse Gilliand was questioned (in fact, bullied) by the trial court relative to the context and content of her incident report. Among other matters, she attempted to testify that she **could not be sure** whether the Bovie was intentionally laid on the surgical drape. Moreover, she indicated that she was **not sure she could even see** whether the Bovie was "laid on the drape." (March 1, 2011 *In Camera Review* Transcript, Appellant's Supplemental Appendix at 97a). Subsequent efforts to clarify the situation via affidavit, were ignored by Judge Rodgers.

Unfortunately, Nurse Gilliand's testimony provides but one example of the trial court's misguided application of the underlying "facts" and law, in what amounts to a poorly motivated effort to punish Munson Medical Center. This regrettable circumstance was made even worse by the subsequent Court of Appeals' Opinion, which clearly sought to expand upon the lower court's improper invasion into the legislative process. We urge this Court to recognize this in assessing Plaintiff-counsel's strained characterization of "the facts" in *Harrison*.

III. PLAINTIFF-APPELLEE'S RELIANCE ON A NORTH DAKOTA STATUTE IS IN ERROR.

Plaintiff further attempts to use case law from a foreign jurisdiction in an effort to craft a distinction between confidentiality and privilege for purposes of Michigan law. (Pl's Brief at 26-28). Covenant maintains that there is no reason for this Court to even consider the North Dakota

[4] There was reference to the peer review privilege as provided under MCL 333.20175(8), but there is no reference or discussion relative to subsection (1).

peer review statute and corresponding North Dakota Supreme Court case, *Trinity Medical Ctr, Inc v Holum*, 544 NW2d 148 (ND1996), cited by Plaintiff. However, to the extent this Court is willing do so, both the North Dakota peer review statute and *Holum* are easily distinguishable.

The North Dakota peer review statute states as follows:

> 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 [Emphasis added.] As noted by Plaintiff, the North Dakota statute is comprised of *two separate sentences*. The first sentence ostensibly discusses only the confidentiality of certain "information, data, reports, or records." Meanwhile, the second sentence indicates that "proceedings and records of such a committee" are "not subject to subpoena or discovery or introduction into evidence in a civil action . . . ." Based on the above language and structure of the statute (consisting of two separate sentences), the North Dakota Legislature deemed it necessary to create a privilege over only the proceedings and records of a peer review committee.

Conversely, MCL 333.21515 reads:

> 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.

The Court will note that unlike North Dakota's peer review statute, MCL 333.21515 is written as a single sentence. The Michigan Legislature did not use two separate sentences to create the confidentiality and the privilege. Moreover, the Legislature did not limit the privilege to "proceedings and records" of a peer review committee.

The Michigan Legislature crafted a single sentence, which unequivocally indicates that "records, data, and knowledge collected for or by [a peer review committee] . . . 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." MCL 333.21515 (emphasis added). Thus, the Legislature has clearly expressed its intent that "records, data, and knowledge" collected "for or by" a peer review committee are not only confidential, but also privileged. Furthermore, unlike the North Dakota statute, Michigan's peer review statute does not contain any language which purports to limit this privilege to the proceedings or records of a peer review committee.

Plaintiff proceeds to reference several other statutes wherein the Michigan Legislature has used specific language relative to both privilege and confidentiality. (Pl's Brief at 28-29). Plaintiff argues that the absence of such language from MCL 333.21515 and MCL 333.20175(8) indicates that the Michigan Legislature never intended for MCL 333.21515 and MCL 333.20175(8) to create a peer review privilege. Plaintiff, much like the Court of Appeals in *Harrison,* fails to ascribe to the well-established principles of statutory construction.

This Court has repeatedly stated that "[i]t is a well-established principle of statutory construction that the Legislature is presumed to act with knowledge of statutory interpretations by the Court of Appeals and this Court." *Gordon Sel-Way, Inc v Spence Bros, Inc*, 438 Mich 488, 505-506; 475 NW2d 704 (1991). To this end, Covenant relies upon its earlier filed Brief on Appeal to this Court for the long line of cases from this Court, as well as the Court of Appeals, which have construed MCL 333.21515 and MCL 333.20175(8) as evidencing the Legislature's intent to create a statutory *privilege* that provides broad protection to peer review materials in an attempt to create a comprehensive ban on materials gathered for or by a peer review entity.

While Plaintiff argues some "misinterpretation" of the two statutes, he simultaneously acknowledges that this "this case involves construction of a statutory *privilege* . . . ." (Pl's Brief at 10)(Emphasis added). Indeed, even this Court's June 20, 2014 Order intrinsically recognizes that MCL 333.21515 establishes Michigan's "peer review privilege." (attached as AA 207a). The Michigan Legislature is well aware of the statutory interpretations made by this Court, as well as the Court of Appeals. The decisions finding that a statutory *privilege* applies to "records, data, and knowledge" collected "for or by" a peer review committee go back more than 20 years. This is more than enough time for the Legislature to correct or amend any "misinterpretations" of MCL 333.21515 and/or MCL 333.20175(8). The absence of such "corrections" is further proof of the Legislature's intent for the statutes to create a peer review *privilege.*

CONCLUSION AND RELIEF REQUESTED

Based on the foregoing, Defendant-Appellant Covenant Healthcare respectfully requests that this Court apply MCL 333.20175(8) and MCL 333.21515 as they are written and intended. In doing so, Covenant respectfully requests that this Court hold that: (1) *Harrison* was wrongly decided; and (2) overrule the trial court's May 8, 2014 order requiring production of the first page of Covenant's Improvement Report.

Respectfully submitted,

Hall Matson, PLC
Attorneys for Defendant-Appellant Covenant Healthcare

HALL MATSON PLC

By: _____

Thomas R. Hall (P42350)
Samuel B. Oberman (P73497)
Attorneys for Defendant-Appellant Covenant Healthcare
1400 Abbot Road, Suite 380
East Lansing, MI 48823
Telephone: (517) 853-2929

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