IN THE SUPREME COURT OF IOWA

SUPREME COURT NO. 16-1009

POLK COUNTY NO. LACV076894

DENNIS WILLARD
Plaintiff-Appellant,

v.

STATE OF IOWA
Defendant-Appellant.

APPEAL FROM THE IOWA DISTRICT COURT
IN AND FOR JOHNSON COUNTY, IOWA
HONORABLE MITCHELL E. TURNER, DISTRICT COURT JUDGE

AMICI CURIAE BRIEF OF AMICI AMERICAN MEDICAL ASSOCIATION AND IOWA MEDICAL SOCIETY

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INTEREST OF *AMICI CURIAE*

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including Iowa.

The Iowa Medical Society (IMS) is the largest statewide professional association for Iowa physicians, residents and medical students. With more than 6,200 members, IMS exists to assure the highest quality healthcare in Iowa through its role as physician and patient advocate.

The AMA and IMS join this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

Because of the position of their members as physicians, residents, and medical students – i.e. the main persons providing reporting under the Morbidity and

Mortality statute at issue in this matter, both the AMA and IMS provide a unique perspective or information on the purpose and policy considerations underlying the Morbidity and Mortality statute, Iowa Code sections 135.40 through 135.42, as well as the need for confidentiality of the information submitted and procured in response to such statute. The interest of the Amici in this case is to protect the benefits of the Morbidity and Mortality statute, including the reporting required under such statute. Such perspective will assist the Court in assessing the ramifications of the Court's decision in this matter.

STATEMENT OF THE CASE

The instant matter arises from the District Court's ruling granting Plaintiff/Appellee's Motion to Compel certain documents prepared pursuant to Iowa's Morbidity and Mortality statute. The Defendant/Appellant has filed the instant Interlocutory Appeal of said decision and the Amici file this Amici Curiae Brief in support of the Defendant/Appellant's interlocutory appeal.

Plaintiff/Appellee Willard was injured in a motorcycle accident and ultimately treated at the University of Iowa Hospital, an agency of the State of Iowa. Plaintiff/Appellee alleges that the Hospital handled him negligently while he was under heavy sedation and brought suit for injuries suffered as a result of such negligent handling. During discovery, Plaintiff/Appellee sought production of

various documents pertaining to his care, including an incident report ("PSN" report) prepared by the Hospital.

Defendant/Appellant objected to discovery of the report as privileged under Iowa's Morbidity and Mortality statute, Iowa Code sections 135.40-42 (2016). Plaintiff/Appellee moved to compel the disclosure and, after a Hearing on the matter where the District Court took testimony and did an *in camera* review of the documents, the District Court ordered production of the PSN report. Defendant/Appellant then filed the instant Interlocutory Appeal of such ruling.

STANDARD OF REVIEW

Generally, discovery rulings are reviewed for abuse of discretion. State v. Schuler, 774 N.W.2d 294, 297 (Iowa 2009); Fagen v. Grand View Univ., 861 N.W.2d 825, 2015 Iowa Sup. LEXIS 36 (Iowa 2015). However, when, as here, the ruling is based on or involves statutory interpretation, the Supreme Court reviews the matter for corrections of errors at law. Ashenfelter v. Mulligan, 792 N.W.2d 665, 668-69 (Iowa 2010).

ARGUMENT

I. THE POLICY AND PURPOSE BEHIND IOWA'S MORBIDITY AND MORTALITY STATUTE IS TO REPORT, STUDY, AND REDUCE ERROR LEADING TO MORBIDITY AND MORTALITY AND THEREFORE IMPROVE PUBLIC HEALTH AND THE HEALTHCARE SYSTEM

The Institute of Medicine (IOM) has determined that at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of preventable medical errors. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM, p. 26 (Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Eds. 1999). This makes preventable errors one of the leading cause of death in the United States. Id. at p. 26. Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516). Id. Total national costs (lost income, lost household production, disability, health care costs) are estimated to be between $37.6 billion and $50 billion for adverse events and between $17 billion and $29 billion for preventable adverse events. Id. p. 27.

An executive summary of the report states that the majority of errors do not result from individual recklessness or the actions of a particular group; this is not a

"bad apple" problem. "More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them." Id. p. 26-27. The Report goes on to say that mistakes are best prevented by designing the health system at all levels to make it safer. The IOM Report identifies a four-tiered strategy to effectively advance patient safety: 1) enhanced knowledge of patient safety; 2) identification of medical errors through mandatory and voluntary reporting systems and learning from those mistakes; 3) performance standards and expectations for improvement; and 4) safety systems to ensure safe practices at the delivery level. Id. p. 26-27.

The key first step to this is, of course, identifying error so that it can be studied. Bryan Liang, M.D., Ph.D, J.D., Dr. Arthur Grayson Distinguished Lecture in Law & Medicine Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney, 24 S. Ill. U. L. J. 541, 555 (2000).

Iowa's Morbidity and Mortality statute, Iowa Code sections 135.40-.42, as originally adopted by the General Assembly in 1966 and further amended in 2006, advances vital public health and patient safety interests in dynamic, robust review and analysis of how medicine can do better in treating and even curing disease (morbidities) and in preventing death (mortality). See Iowa Code §§ 135.40-42

(2016). It is Iowa's means of identifying, studying, and learning from errors to prevent future occurrences. These Iowa Code sections read as follows:

> Any person, hospital, sanatorium, nursing or rest home, or other organization *may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person* to the department, the Iowa medical society or any of its allied medical societies, the Iowa osteopathic medical association, any in-hospital staff committee, or the Iowa healthcare collaborative, *to be used in the course of any study for the purpose of reducing morbidity or mortality*, and *no liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization that has acted reasonably and in good faith, by reason of having provided such information or material*, or by reason of having released or published the findings and conclusions of such groups to advance medical research and medical education, or by reason of having released or published generally a summary of such studies.
>
> For the purposes of this section, and section 135.41, the "Iowa healthcare collaborative" means an organization which is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue

> Code and which is established to provide direction to promote quality, safety, and value improvement collaborative efforts by hospitals and physicians.

Id. § 135.40 (emphasis added).

> The department, the Iowa medical society or any of its allied medical societies, the Iowa osteopathic medical association, any in-hospital staff committee, or the Iowa healthcare collaborative shall use or publish said material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such group for general publication. In all events the identity of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances. A violation of this section shall constitute a simple misdemeanor.

Id. § 135.41.

> *All information, interviews, reports, statements, memoranda, or other data furnished in accordance with this division and any findings or conclusions resulting from such studies shall not be used or offered or received in evidence in any legal proceedings of any kind or character*,

> but nothing contained herein shall be construed as affecting the admissibility as evidence of the primary medical or hospital records pertaining to the patient or of any other writing, record or reproduction thereof not contemplated by this division.

Id. § 135.42 (emphasis added).

Effective surveillance through data gathering, incident reporting, and identification of policies, procedures and other circumstances bearing upon an instance or instances of patient care delivery is essential in determining not only potential mistakes or errors in medical judgment but also vulnerabilities in protocol, professional communications, or treatment modalities. As of this briefing, Iowa has 118 licensed hospitals, 82 of which are designated as "critical access hospitals." See https://dia-hfd.iowa.gov/DIA_HFD/Process.do. Hospitals, including the University of Iowa Hospitals and Clinics (UIHC), are required by regulations of the Iowa Department of Inspections and Appeals (DIA), the hospital licensing authority in this State, to have an ongoing hospital wide quality improvement program to assess clinical patient care and nonclinical and patient-related services within the hospital and to develop remedial action as needed. Iowa Admin. Code § 481-51.3(1) (2016). The hospital's quality improvement program must involve physician members of the hospital's medical staff and other professionals as appropriate. Id. § 481-51.3(3). The hospitals are required to have a written quality improvement plan which, among

other things, may address "the accessibility and confidentiality of materials relating to, generated by or part of the quality improvement process." Id. § 481-51.3(4)(g). A hospital acts appropriately in identifying the accessibility and confidentiality protections afforded to incident and other reports received by that hospital consistent with Iowa Code sections 135.40-42.

Further, all Iowa hospitals participate in the federal Medicare program and, as such, are required to meet Medicare's conditions of participation. Hospitals that are not critical access hospitals are subject to conditions of participation set forth in 42 C.F.R. Part 482. See 42 C.F.R. pt. 482 (2016). In particular, 42 C.F.R. section 482.21 requires hospitals like UIHC to "develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program." 42 C.F.R. § 482.21. The program must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. Id. This condition of participation proscribes several features a hospital must include within its quality assessment and performance improvement program. While this federal regulation does not specifically address confidentiality of data and other information gathered by the hospital in meeting its assessment and improvement obligations; it does demand a program with features consistent with Iowa's criteria for morbidity and mortality studies set forth in Iowa Code sections 135.40-.42 and the accessibility and confidentiality protections of that statute.

The Iowa General Assembly again acknowledged the important public and patient benefits that accrue from information, data-driven studies on patient morbidity and mortality, including in the patient safety context, when it amended sections 135.40-.42 to protect persons in making reasonable, good faith reports to the Iowa Healthcare Collaborative (IHC). Reports and Information Relating to Medical Condition and Treatment, 2006 Iowa Acts Ch. 1128; H.F. 2716, 81st G.A (2005-2006). IHC is a nonprofit entity founded in partnership between the Iowa Medical Society and the Iowa Hospital Association is "dedicated to providing a culture of continuous improvement in health care." See http://www.ihconline.org/aspx/aboutus/aboutus.aspx. Best practices are developed through, among other things, analysis of shared data. Id.

The American Medical Association (AMA), with the approval of its House of Delegates following study and recommendation by the AMA Council on Ethical and Judicial Affairs (CEJA), has adopted a *Code of Medical Ethics*, recently amended after an extensive three-year review. AMA Code of Medical Ethics (2016) *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page. Ethical Opinion 8.6 of the Code of Medical Ethics recognizes, among other things, the unique position physicians have to impact quality medical care and safe patient care delivery. Id. Opinion 8.6. That opinion advises physicians to "play a central role in identifying, reducing, and preventing medical errors." Id.

Both as individuals and collectively as a profession, physicians should, among other things, study circumstances underpinning medical errors. In doing so, however, the opinion states: "[A] legally protected review process is essential for reducing health care errors and preventing patient harm." Id. Further, physicians should establish and participate fully "in effective, confidential, protected mechanisms for reporting medical errors." Id. The liability protections afforded by Iowa's Morbidity and Mortality statute are in keeping with medical ethics and, more importantly, advance patient and public interest in ongoing, information-based studies of outcomes, procedures, policies, and protocol affecting morbidity and mortality.

While not identical to the Iowa Morbidity and Mortality statute, the U.S. Congress has also promulgated, and subsequently amended in response to the IOM Report discussed above, statutes for the reporting and study of errors in the medical field. See 42 U.S.C. 299 et. seq. (2016). The Federal Government established an Agency for Healthcare Research and Quality within the Public Health Service division in 1989. 42 U.S.C. § 299 et. seq. The purpose of such Agency is to "enhance the quality, appropriateness and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions." Id. The Agency's mission includes, among other things, researching and developing

methods for measuring quality and strategies for improving quality as well as measuring the outcomes, effectives and cost-effectiveness of health care practices. Id.

The Agency, as part of its mission, implements the federal Patient Safety and Quality Improvement Act of 2005 ("PSQIA"). 42 C.F.R. Part 3 (2016). The PSQIA recognizes the need for error (or patient safety work product) reporting to further the improvement of the health care system and the quality of health care. Id. The PSQIA provides for the formation of patient safety organizations (PSOs) to receive reports of patient safety events or concerns from health care providers and to provide analyses of such events to the reporting providers. The PSQIA acts to create a voluntary program through which health care providers can share information relating to patient safety events with PSOs, with the aim of improving patient safety and the quality of care nationwide. See Department of Health and Human Services/Agency for Health Care Research and Quality Background Statement, 73 Fed. Reg. 70732 (2008). Much like the Iowa Morbidity and Mortality statutes, the PSQIA recognizes the need and provides a mechanism for reporting errors in order to improve healthcare.

Based on the above, it is clear that not only in Iowa, but also in forty-nine (49) of the fifty (50) states, the Federal Government, and among medical societies in general, error reporting and peer review are not only considered important but

imperative for the improvement of today's healthcare system. See e.g. 42 U.S.C § 1101 (setting forth the peer review privilege for the Health Care Quality Improvement Act; Iowa Code §§ 135.40-42); KD v United States, 715 F. Supp. 2d 587, 594 (D. Del. 2010) (citing Ghazal Sharifi, Is the Door Open or Closed, Evaluating the Future of the Federal Medical Peer-Review Privilege, 42 J. Marshall L. Rev. 561, 564 (2009)) (noting all 50 states have adopted evidentiary privilege for peer review materials and discussing the PSQIA privilege); American Medical Association, H-375.962 Legal Protections for Peer Review (setting forth the AMA policy on privileged peer review information and materials).

II. CONFIDENTIALITY IS REQUIRED TO CARRY OUT THE POLICY AND PURPOSE OF THE IOWA MORBIDITY AND MORTALITY STATUTE

As set forth above, the key first step in reducing error and improving the health care system is to identify error so that it can be studied. However, in order to be able to identify error, everyone (physicians, nurses, hospital staff, etc.) must be willing to report the error and the only way people will be willing to do so is if there is a system of protection in place for such reporting. Dr. Arthur Grayson Distinguished Lecture in Law & Medicine Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney, 24 S. Ill. U. L. J. 541, 555 (Liang, Bryan, M.D., Ph.D., J.D 2000). In order for people to

be frank and honest about errors and to improve quality, you must make the information provided and discussions stemming from said information confidential and protected. Id. at 556. By protecting the information reported, people will feel more confident in reporting errors both internally and industry-wide. Id. at 563. Refusal to hold such reporting confidential eliminates the incentive to self-report. Id.

The IOM Report, discussed above, also recognizes the need for protecting reported error information (which the information reported under the Iowa Morbidity and Mortality statute falls in). The Report acknowledges that fear of medical liability legal actions is an impediment to safety incident reporting. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM, P. 26 (Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Eds. 1999). In doing so, the IOM Report notes:

> [t]he peer review privilege is the most promising existing source of legal protection for data on errors. This privilege is statutory and is specific to medical peer review within specified settings and meeting specified standards. Every state, except one, statutorily protect from discovery various records and deliberations of peer review committees. *The quality improvement purpose of peer review is consistent with the purpose of reporting systems; the statutes' value in protecting*

reporting, however, depends on fitting the reporting system to the specifics of each protective statute."

Id. p. 120 (emphasis added). With regard to the confidentiality of error reporting, the IOM Report provides:

> Fear of legal discoverability or involvement in the legal process is believed to contribute to underreporting of errors. Collaborative quality improvement efforts may be inhibited by the loss of statutory peer review protection that may occur when data are shared across institutions. Some form of protection appears necessary for each of the three components of an error reporting system: (1) the original reporters; (2) the various recipients of the information (including processors, investigators, de-identifiers, and analyzers); and (3) the reported information itself. Information voluntarily shared should be done with appropriate safeguards for patient confidentiality.
>
> Legal protections are the only possible way to protect identified reporters, report recipients, and reports from discovery but legal protections are not without problems. Specific statutory protection for a particular reporting system may be the most desirable form of protection, but this may not be a realistic option for many systems.

Id. p. 129.

Much of the analysis of confidentiality and privilege with regard to medical and error reporting has been done in terms of "peer review." See e.g. United States v. Harris Methodist Fort Worth, 970 F.2d 94 (5th Cir. 1992) (finding peer review materials were sensitive and inherently confidential and protecting that confidentiality serves an important public interest); Weekoty v. United States, 30 F. Supp. 1343, 1345 (D.N.M. 1998) (noting that the self-critical analysis privilege is particularly pertinent in the medical context because it promotes frank and honest discussion which protect lives and improve patient care); Konrady v. Oesterling, 149 F.R.D. 592, 595 (D. Minn. 1993) (noting the purpose of peer review is the improvement of patient care); Feyz v. Mercy Mem. Hosp., 719 N.W.2d 1 (Mich. 2006) (to enable Michigan hospitals to perform the function of reviewing morbidity and mortality as well as the quality and necessary of care and the preventability of complications and deaths occurring, the Michigan legislature enacted two primary measures which protect peer review activities from instructive public involvement and from litigation – it granted immunity to peer review groups and makes records, data, and knowledge collected confidential and protects them from discovery—finding all peer review communications were protected from discovery and use in any form of legal proceeding); Ayash v. Dana-Farber Cancer Inst., 822 N.E.2d 667 (2005) (noting physicians would be less willing to candidly report, testify about, and

investigate concerns of patient safety if their actions would be subject to later scrutiny and litigation); Virmani v. Presbyterian Health Servs. Corp., 515 S.E.2d 675, 694, 697 (1999), *cert. denied sub nom.* Knight Pub Co. v. Presbyterian Health Servs. Corp., 120 S.Ct. 1452 (2000) (noting open and honest communication in medical peer review proceedings helps to assure high quality public medical care and protection of the privilege surrounding peer review serves a compelling public interest); Fagen v. Detroit Osteopathic Hosp., 594 N.W.2d 455 (Mich. 1999) (noting without "the assurance of confidentiality as provided by [the Michigan statute] the willingness of hospital staff to provide their candid assessment will be greatly diminished" and that will "have a direct effect on the hospital's ability to monitor, investigate, and respond to trends and incidents that affect patient care, morbidity, and mortality."); Eubanks v. Ferrier, 267 S.E.2d 230, 232 (Ga. 1980) (noting that confidentiality is required for peer review committees otherwise the candor necessary for their effective functioning would be destroyed); Ardisana v. Northwest Cmty. Hosp., Inc., 795 N.E.2d 964, 969 (Ill. App. Ct. Dist. 2003) (finding the purpose of the statute privileging peer review materials was to advance the quality of health care by ensuring physicians effectively engage in the peer review process); Sun Health Corp v. Myers, 70 P.3d 444, 447 (Ariz. Ct. App. 2003) (holding the need for confidentiality of peer review proceedings is essential to achieve complete investigation and review of medical care); State ex. rel. St. Johns Reg'l Med. Ctr. v.

Dally, 90 S.W.3d 209, 214 (Mo. Ct. App. 2002) (finding peer review is an integral part of the health care system in the United States).

However, the "Legal Protections for Peer Review," AMA Policy H-375.962 gives a broad definition or sense of "peer review": "Peer review goes beyond individual review of instances or events: it is a mechanism for assuring the quality, safety, and appropriateness of hospital services." American Medical Association, H-375.962 Legal Protections for Peer Review. The information gathered under Iowa's Morbidity and Mortality statute easily falls within the industry definition of "peer review" and the purpose for protecting such information is analogous and equally applicable to the need and purpose for protecting the information gathered via Iowa's statute. H-375.962 further notes that "good faith peer review" is conducted "with honest intentions that assess appropriateness and medical necessity to assure safe, high quality medical care." Id. Gallagher

Peer review encourages methods for seeking to avoid preventable adverse events (errors) in the first place, thereby reducing costs and quickly preventing mistakes from reoccurring. Patricia A. Sullivan and Jon M. Anderson, The Health Care debate: If Lack of Tort Reform is Part of the Problem, Federalized Protection for Peer Review Needs to be Part of the Solution, 15 Roger Williams U. L. Rev. 41, 50 (2010). Iowa Code sections 135.40-42, in protecting persons who have acted reasonably and in good faith in furthering an objective process of information

gathering, analysis, and report for morbidity and mortality purposes, is similarly directed to achieve the goals of peer review, like assessing medical practices and preventing errors, and is appropriately limited in its scope and not overbroad in the protections that it provides or should be read to provide.

The Federal PSQIA, discussed above, also provides confidentiality and privilege protections for "patient safety work products" as defined in the rule and consistent with the statutory provisions of the PSQIA. The statute provides that all patient safety work product is privileged and shall not be subject to subpoena, discovery, disclosure, admission into evidence at trial or any proceeding, or admitted in a professional disciplinary proceeding. 42 U.S.C. § 299b.22. It also provides that all patient safety work product shall be confidential. Id. Further, such protection and confidentiality requirements do not act to alter or affect State law that provides for greater privilege or confidentiality. Id. Such protections enable all health care providers, including multi-facility health care systems, to share data within a protected legal environment, both within and across states, without threat that information will be used against the subject providers. The privilege and confidentiality protections are provided to encourage the sharing of information without the fear of liability. Department of Health and Human Services/Agency for Health Care Research and Quality Background Statement, 73 Fed. Reg. 70732 at 70795-96. This is done by providing:

> a mechanism for protection of sensitive information that could improve the quality, safety and outcomes of health care by fostering a non-threatening environment in which information about adverse medical events and near misses can be discussed. It is hoped that confidential analysis of patient safety events will reduce the occurrence of adverse medical events and, thereby, reduce the costs arising from such events, including costs incurred by state and local governments attributable to such events. Such protections are the foundations to furthering the overall goal of the statute to develop a national system for analyzing and learning from patient safety events.

Id.

Iowa's Morbidity and Mortality statute recognizes that surveillance reporting and studies may address a range of matters and may be conducted in different settings; the statute's confidentiality and disclosure protections attach to "any" person providing "information, interviews, reports, statements, memorandum, or other data" relating to a person's condition and treatment to the Iowa Department of Public Health, the Iowa Medical Society or Iowa Osteopathic Medical Society, any in-hospital staff committee, or (as of 2006), the Iowa Healthcare Collaborative. Iowa Code § 135.42. Notably, section 135.42 protects such information and documentation from *use* (in addition to being offered) in any legal proceeding of any

kind or character. Id. The express language of the statute prohibits the *use* and not just the offering into evidence of the information garnered under Iowa Code sections 135.40-42. By prohibiting the "use" of such information, E the legislature evidences the purpose and intent to protect the information garnered and keep the information confidential both at trial and in discovery.

This Court has specifically found that allowing or requiring disclosure of information maintained under the Iowa Mortality and Morbidity statute would "frustrate the very purpose" for collecting such information as it "would have a chilling effect on voluntary reporting by physicians and hospital staff. Burton v. University of Iowa Hosps. & Clinics, 566 N.W.2d 182 *, 1997 Iowa Sup. LEXIS 199 (Iowa 1997). The Court, in Burton, also noted that the reasons for maintaining the confidentiality privilege in Iowa Code section 147.135 (Iowa's Peer Review statute) applies with equal force to section 135.40-42 records:

> [The privilege] allows a physician to consult with peers about his [or her] care and treatment of a particular patient. It also allows critical retrospective analysis of cases to learn better methods of treatment for the future. Similarly, it encourages peers to lodge complaints and initiate disciplinary action against those who are practicing substandard care, without fear of disclosure or retribution.

Id. (citing Carolan v. Hill, 553 N.W.2d 882, 886 (Iowa 1996) (quoting Thomas A. Finley et al., Tort Reform and Medical Malpractice: Iowa's Past, Present, and Future, 36 Drake L. Rev. 669, 676 (1986-87))).

The instant case is similar to Gallagher v. Detroit-Macomb Hosp. Ass'n, 431 N.W.2d 90 (1988) and the reasoning behind the Michigan Court's decision is equally applicable here. In Gallagher, the Plaintiff argued the court erred in failing to admit an incident report that was prepared at the time of her husband's injury in the hospital. Id. at 94. Pursuant to the Public Health Code, MCL 333.1101 et seq.; MSA 14.15(1101) et seq., Michigan hospitals were required to review their professional practices and procedures to improve the quality of patient care and reduce morbidity and mortality. Id. To achieve this end, the legislature exempted from court subpoena information and records compiled in furtherance of improving health care and reducing morbidity and mortality. Id. The report that Plaintiff/Appellee sought to admit was completed for all unusual occurrences at the hospital and its purpose was to assist the hospital in monitoring its own activities to reduce accidents, injuries, morbidity and mortality at the hospital. Id. The Court held that the report was afforded complete protection under the Michigan statute. Similarly, in the instant case, the PSN report at issue in this matter was created to assist the hospital in monitoring activities and provide information for further study in order to reduce accidents, injuries, morbidity and mortality.

Based on the foregoing, it is evident that complete privilege and confidentiality of documents and information prepared, submitted, and reviewed under the Iowa Morbidity and Mortality statute is necessary to effect the purpose and public policy underlying the statute. Iowa's statute is definitive in its designation of records and information to be protected and is firm in its grant of protection to meet this public policy. Failure to provide a privilege protection to the information and records designated by the statute (for any use – discovery, trial, administrative hearing, etc.) would elevate immediate and singular demand for information above and beyond the statute's public policy goal to protect that information for the long-term health and safety of Iowans. Accordingly, such failure would be contrary to the public policy underlying the Morbidity and Mortality statute and would negatively impact health care in Iowa.

CONCLUSION

A privilege is only effective where the individuals providing the information know, at the time they provide the information, that it will be privileged and kept private. See Jaffee v. Redmond, 518 U.S. 1, 18 (1996) (if the purpose of privilege is to be served the participants must be able to predict with a degree of certainty whether it applies). Since the inception of the Iowa Morbidity and Mortality statute, Iowa physicians and medical staff have operated under the belief and practice that information submitted under the statute would be fully protected – in discovery,

litigation, administrative hearings, internal committees, etc. The District Court's Decision compelling disclosure of the PSN documents at issue in the instant matter, defies the purpose, policy, and express language of the Iowa Morbidity and Mortality statute and if upheld, will act to chill the reporting of information under the statute, therefore harming public health care. For the reasons set forth above, it is the Amici's position that the privilege set forth in Iowa Code 135.40-42 should include all documents and information prepared, submitted, and reviewed under said sections and that the PSN report in the instant case should be protected from discovery as the General Assembly intended. Any other decision would be contrary to the public policy underlying the Morbidity and Mortality statute and would negatively impact health care in Iowa.

Respectfully submitted,

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ATTORNEYS FOR AMICI CURIAE
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IOWA MEDICAL SOCIETY

CRTIFICATE OF ELECTRONIC FILING

I hereby certify that I have filed the attached Plaintiffs/Appellants' Appeal Brief with the Clerk of the Iowa Supreme Court through the electronic document management system on October 6, 2016.

/s/ Allison M. Steuterman

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CERTIFICATE OF SERVICE

I hereby certify that on the 6th Day of October, 2016, I served the attached Amici Curiae Brief through the electronic document management system upon the following attorneys:

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CERTIFICATE OF COMPLIANCE

1. This Brief complies with the type-volume limitation of Iowa R. App. P. 6.903(1)(g)(1) and 6.906, because this Brief contains 5112 words, excluding the parts of the Brief exempted by Iowa R. App. P. 6.903(1)(g)(1) and 6.906.

2. This Brief complies with the typeface requirements of Iowa R. App. P. 6.903(1)(e) and the type-style requirements of Iowa R. App. P. 6.903(1)(f), because the Brief has been prepared in a proportionally spaced typeface using Times New Roman font and utilizing the 2008 edition of Microsoft Word in 14 point font plain style.

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CERTIFICATE OF ATTORNEY'S COSTS

I hereby certify that the cost of printing the foregoing Plaintiffs/Appellants Appeal Brief was $0.00 (exclusive of sales tax, postage and delivery).

/s/ Allison M. Steuterman

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