STATE OF MICHIGAN

IN THE SUPREME COURT

THE ESTATE OF DOROTHY KRUSAC, Deceased, by her Personal Representative John Krusac,

Plaintiff-Appellee,

v.

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

Defendant-Appellant,

Supreme Court Case No. 149270

Court of Appeals Case No. 321719

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

AMICI CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE MICHIGAN STATE MEDICAL SOCIETY

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STATEMENT OF QUESTIONS PRESENTED

(1) Whether *Harrison v Munson Healthcare, Inc*, 304 Mich App 1; 851 NW2d 549 (2014, erred in its analysis of the scope of the peer review privilege, MCL 333.21515.

Plaintiff-Appellee says "no."

Defendant-Appellant says "yes."

Amici AMA and MSMS say "yes."

(2) Whether the Saginaw Circuit Court erred when it ordered the defendant to produce the first page of its 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 says "no."

Defendant-Appellant says "yes."

Amici AMA and MSMS say "yes."

STATEMENT OF INTEREST

Amicus Curiae Michigan State Medical Society ("MSMS") is a professional association which represents the interests of over 14,000 physicians in the State of Michigan. Organized to promote and protect the public health and to preserve the interests of its members, MSMS is frequently called upon to express its views with respect to legal issues of significance to the medical profession.

Amicus Curiae American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents and medical students in the United States are represented in the AMA's policy-making process. AMA members practice and reside in all states, including Michigan. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. The AMA joins this brief on its own behalf and as a representative 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.

In the pending appeal, this Court will decide whether the Court of Appeals erred when it held that Michigan's statutory peer review privilege did not protect the factual portion of an incident report from disclosure in *Harrison v Munson Healthcare, Inc*, 203 Mich App 1; 85 NW2d 549 (2014), and whether the Saginaw County Circuit Court erred when, in reliance upon *Harrison*, it ordered Defendant-Appellant Covenant Health Center to produce the first page of an "improvement report" on the basis that "objective facts gathered contemporaneously with an event do not fall within the definition of peer review privilege."

The hospital peer review process, mandated by Article 17 of the Michigan Public Health Code, MCL 333.20101 et seq., is an important component of the delivery of health care in this state. As credentialed members of hospital medical staffs, members of MSMS and the AMA are actively involved in efforts to improve the quality of care provided in Michigan hospitals. Many MSMS and AMA members serve on peer review committees, which seek to ensure the quality of medical care provided in the hospital, and to review the qualifications and practices of physicians providing that care, for the purpose of reducing morbidity and mortality. MSMS and AMA members are also the subject of peer review activities.

Thus, MSMS and AMA have an active interest in the issues before this Court and, in accordance with MCR 7.306(D), greatly appreciate this opportunity to share their views.

STATEMENT OF FACTS

In this wrongful death action, Plaintiff John Krusac, Personal Representative of the Estate of Dorothy Krusac, alleges that Ms. Krusac fell off the procedure table in the cath lab when the nurses at Defendant Covenant Healthcare left her unattended and/or without close monitoring following a cardiac catheterization. The nurses' testimony contradicted this allegation. They maintained that Ms. Krusac's instability was noticed and two of the nurses reached her in time to cradle her and gently lower her to the floor without substantial trauma or impact. Nurse Deb Colvin testified that following the event she prepared an incident report, referred to as an "Improvement Report," describing what occurred. The discoverability of the Improvement Report is the central issue in this appeal.

Covenant asserts that the Improvement Report was given to Ms. Colvin's nursing supervisor and routed through the appropriate channels to the hospital's peer review committee, and is therefore statutorily protected from disclosure by Michigan's peer review privilege, particularly MCL 333.21515 and MCL 333.20175(8). Nonetheless, in light of the Michigan

Court of Appeals opinion in *Harrison v Munson Healthcare, Inc*, 304 Mich App 1; 851 NW2d 549 (2014), Saginaw County Circuit Court Judge Fred Borchard held that the first page of the Improvement Report is not privileged and must be disclosed while "[t]he second page and balance of the report reflect a review process and ... is confidential." The Circuit Court explained:

> This Court agrees with the [*Harrison v] 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.

Opinion and Order Re: Discovery at 2 (Exhibit A). The Court added that even assuming that the Report is "a peer review" document, "it is not the facts themselves that fall under the peer review privilege but rather what is done with those facts." *Id.*

In *Harrison*, the parties were in the midst of a medical malpractice trial when, in response to questioning by the trial judge, an employee of Munson disclosed that a member of the surgical staff had prepared a peer review privileged incident report concerning a burn injury the plaintiff sustained during surgery. The trial judge ordered that it be produced for an in camera inspection. After completing his review of the report, Grand Traverse County Circuit Court Judge Philip E. Rodgers sua sponte declared a mistrial on the ostensible basis that the facts stated in the incident report were inconsistent with the defense being presented by the hospital. Judge Rodgers subsequently conducted an evidentiary hearing to determine whether the documents were protected by the peer review privilege and whether Munson and its counsel committed a breach of ethics by presenting a "habit and practice" defense while failing to disclose the contents of the incident report.

Judge Rodgers ultimately concluded that the report was protected by the peer review privilege provided in MCL 333.20175(8) and MCL 333.21515, but went on to hold that the hospital and its counsel nonetheless had a duty to review those privileged documents and disclose the facts and conclusions to plaintiff's counsel in response to plaintiff's discovery requests. Judge Rodgers further concluded that presenting a "habit and practice" defense without disclosing this information to plaintiff's counsel was cause for sanctions.

On appeal in *Harrison*, the Court of Appeals concluded that the initial page of the incident report did not fall within the peer review privilege but the balance of the report, which reflected a review process, was protected. The Court remanded for a redetermination of sanctions. Munson sought leave to appeal to this Court in *Harrison*, while Covenant filed an application in the Michigan Court of Appeals for leave to appeal from the *Krusac* ruling. Leave was denied in *Krusac*. *See Krusac v Covenant Medical Center Inc*, Order dated May 12, 2014 (Docket No. 321719). Covenant then sought leave to appeal to this Court. On June 20, 2014, this Court granted leave in *Krusac* and directed the parties to include among the issues to be briefed:

> (1) whether *Harrison v Munson Healthcare, Inc*, 203 Mich App 1 (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."

See Order dated June 20, 2014 (Case No. 149270) (Exhibit B). The *Harrison* application was simultaneously held in abeyance pending resolution of this appeal in *Krusac*. On November 4, 2014, this Court granted the motion of MSMS and the AMA to file an amici brief. *See* Order dated November 4, 2014, Exhibit C. This brief is now being submitted pursuant to that order.

STANDARD OF REVIEW

A de novo standard of review governs the issues on appeal. While an order regarding discovery is reviewed for an abuse of discretion, whether the production of documents is barred by statute is a question of law subject to de novo review. *Ligouri v Wyandotte Hosp*, 253 Mich App 372, 375; 655 NW2d 592 (2002). Questions of statutory construction are also reviewed de novo. *Feyz v Mercy Mem Hosp*, 475 Mich at 663, 672; 719 NW2d (2006) . The Court's role "is to give effect to the intent of the Legislature, as expressed by the language of the statute" and to "apply clear and unambiguous statutes as written, under the assumption that the Legislature intended the meaning of the words it has used ..." *Id.* (footnotes omitted).

ARGUMENT

I. *Harrison* Should Be Reversed Because It Erroneously Limits the Scope of Michigan's Peer Review Privilege to the Deliberative Process and Wrongfully Excludes From the Privilege Contemporaneous Facts and Information Collected By or For a Peer Review Committee.

The orders and opinions in *Harrison* and *Krusac* evidence a dangerous departure from the peer review protocol that is elevating the quality of health care provided to Michigan citizens. The patient safety/quality care mandate now emanates from nearly every sector of hospital-based health care governance, including federal, state, regulatory, accrediting and voluntarily-imposed authorities. Michigan has heeded that call and is poised to become a leader in a health care revolution that is escalating efforts to improve the quality, safety, accessibility and cost-effectiveness of patient care throughout the country. As the Michigan Health & Hospital Association ("MHA") explained in its *2011 Patient Safety and Quality Annual Report*, "Michigan hospitals and health systems are committed to leading our state toward becoming the national benchmark for health care quality and patient safety in this decade." Michigan Health & Hospital Association, *Patient Safety and Quality Annual Report 2011*, at 2

<http://www.mhakeystonecenter.org/documents/2011psqreport.pdf> (accessed November 5, 2014) ("2011 MHA Report").

Michigan's statutorily-mandated peer review process, with the protections it provides for frank discussion, has been an important part of that effort. "Speaking out about errors is the single most important action a health care worker can take as an individual to impact culture," the MHA'S 2011 Report emphasizes, but "unfortunately, fear can often lead to silence." *Id.* at 16. Countermanding the "fear" disincentive is a *sine qua non* of Michigan's peer review privilege.

The importance of confidentiality in the peer review process is well-recognized. It is an important component of federal safety initiatives as well. For example, the federal imperative to improve patient care, safety and quality is articulated in the federal Patient Safety and Quality Improvement Act ("PSQIA"), which was enacted in 2005 "to provide for the improvement of patient safety and to reduce the incidence of events that adversely affect patient safety." 42 USC § 299b-21 et seq. According to the Agency for Healthcare Research and Quality, the PSQIA focuses on "creating a voluntary program through which health care providers can share information relating to patient safety events with PSOs [Patient Safety Organizations], with the aim of improving patient safety and the quality of care nationwide." 73 FR 70732, 70796 (2008). Privilege and confidentiality protections are provided to encourage the sharing of information without fear of liability. *Id.*[1]

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[1] The Agency explains:

> While the Patient Safety Act does establish new Federal confidentiality and privilege protections for certain information, these protections only apply when health care providers work with PSOs and new processes, such as patient safety evaluation systems [] that do not currently exist. *These Federal data protections provide a mechanism for protection of sensitive information that could improve the quality, safety, and outcomes of health care by fostering a non-threatening*

(footnote continued . . .)

MHA created a PSO in 2007 ("MHA Patient Safety Organization"). In its 2011 Report, the MHA notes that nearly every Michigan hospital is an active member. One of the MHA PSO's functions is to permit providers to "seek expert help in understanding patient safety events and preventing their recurrence in a protected legal environment." 2011 MHA Report at 13. "By coming together in the MHA PSO's protected forum to discuss a culture of safety, adverse event management and patient engagement, Michigan hospitals have taken another step in leading the nation in seeking to make health care free from harm." *Id.* at 16.[2]

> *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.*

Id. at 70795-70796 (emphasis added).

[2] The Patient Protection and Affordable Care Act also seeks to improve patient access to high-quality, affordable health care for all Americans and to that end, directed the Secretary of the Department of Health and Human Services ("HHS") to establish a National Strategy for Quality Improvement in Health Care ("National Quality Strategy"). *See* National Strategy for Quality Improvement in Health Care, *2014 Annual Progress Report to Congress* <http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2014annlrpt.pdf> (accessed November 5, 2014). The aims of the National Quality Strategy are to (1) "[i]mprove the overall quality, by making health care more patient-centered, reliable, accessible, and safe;" (2) "[i]mprove the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care;" and (3) "[r]educe the cost of quality health care for individuals, families, employers, and government." *Id.* at 3. The principles for the National Quality Strategy state in part that "[t]he best way to improve health care quality is to help professionals evaluate their own performance and their colleagues' performance, quickly learn how interventions fare in the 'real world,' and see the benefits of innovation firsthand-and then widely share the lessons they learn." National Strategy for Quality Improvement in Health Care <http://www.ahrq.gov/workingforquality/nqs/principles/htm> (accessed November 5, 2014). The March 2011 Report to Congress: National Strategy for Quality Improvement in Health Care highlights patient safety organizations as a means by which clinicians and other providers can obtain timely and actionable feedback to improve patient safety and quality of care. National Strategy for Quality Improvement in Health Care, *2011 Annual Progress Report to Congress* <http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2011annlrpt.pdf> (accessed November 5, 2014).

On all of these fronts, confidentiality has become an essential component of the health care community's efforts to improve the quality of hospital-based medical care. Michigan's peer review privilege, as envisioned by the Legislature, is essential to that effort. But its effectiveness has been undermined by *Harrison*. With a focus on litigation rather than improved patient care, *Harrison* has parsed the privilege into untenable segments that are at odds with the statutory language and far removed from its intended moorings.

The privilege began with, and is tethered to, a mandate. To reduce morbidity and mortality and to improve patient care, the Michigan Legislature commanded hospitals to establish peer review committees to review "professional practices in the hospital for the purpose of reducing morbidity and mortality," including "the quality and necessity of the care provided and the preventability of complications and deaths occurring in the hospital." MCL 333.21513.[3] To enable Michigan hospitals to perform this function, and to encourage a "[c]andid and conscientious evaluation of clinical practices," the Legislature enacted "two primary measures" which "protect peer review activities from intrusive public involvement ***and from litigation***." *Feyz v Mercy Mem Hosp*, 475 Mich 663, 680-681; 719 NW2d 1 (2006) (footnotes omitted) (emphasis added). The first grants immunity to persons, organizations and entities that provide information to peer review groups or that perform a protected peer review function. *See* MCL

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[3] MCL 333.21513 provides in pertinent 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.

331.531.[4] The second measure, which underlies the issue presently before this Court, renders ***records, data, and knowledge collected for or by peer review entities*** confidential and protects them from discovery.

For decades, persons called upon to participate in the peer review and credentialing process have relied upon these protections as an incentive to disclose the untoward events that impede the attainment of quality health care goals. Our appellate courts have encouraged this reliance by consistently upholding the peer review privilege against encroachment, in keeping with its plain meaning and intended scope. That has now changed. With the orders in *Harrison* and *Krusac*, the privilege has been spliced into segments that derive not from the actual language of the statute, but from a judicially-imposed policy preference. *Harrison* and *Krusac* will do a great disservice to the Legislature's health care improvement agenda – and to the quality of care in Michigan - if not reversed.

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[4] MCL 331.531 provides in pertinent part:

> (1) A person, organization, or entity may provide to a review entity information or data relating to the physical or psychological condition of a person, the necessity, appropriateness, or quality of health care rendered to a person, or the qualifications, competence, or performance of a health care provider.
>
> (2) As used in this section, "review entity" means 1 of the following:
>
> (A) A duly appointed peer review committee . . .
>
> (3) A person, organization, or entity is not civilly or criminally liable:
>
> (a) For providing information or data pursuant to subsection (1).
>
> (b) For an act or communication within its scope as a review entity.
>
> (c) For releasing or publishing a record of the proceedings, or of the reports, findings, or conclusions of a review entity, subject to sections 2 and 3.
>
> (4) The immunity from liability provided under subsection (3) does not apply to a person, organization, or entity that acts with malice.

A. *Harrison* Was Wrongly Decided.

The limited scope of the peer review privilege under *Harrison* is seriously flawed. The plain meaning of the statute does not bifurcate the privilege between "contemporaneous facts" and "deliberative processes." The protection afforded by the privilege is expressly broad in keeping with its plain meaning and intended effect. 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.

In nearly identical language, MCL 333.20175(8) 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

Similar language exists in MCL 331.533 (relating to the release of information for medical research and education):

> The identity of a person whose condition or treatment has been studied under this act is confidential and a review entity shall remove the person's name and address from the record before the review entity releases or publishes a record of its proceedings, or its reports, findings, and conclusions. Except as otherwise provided in section 2, the record of a proceeding and the reports, findings, and conclusions of a review entity and data collected by or for a review entity under this act are confidential, are not public records, and are not discoverable and shall not be used as evidence in a civil action or administrative proceeding.[5]

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[5] The exceptions in Section 2, MCL 331.532, are:

> (a) To advance health care research or health care education.
>
> (b) To maintain the standards of the health care professions.
>
> (c) To protect the financial integrity of any governmentally funded program.
>
> (d) To provide evidence relating to the ethics or discipline of a health care provider, entity, or practitioner.

(footnote continued . . .)

Exceedingly out of sync with the rules of statutory construction, *Harrison* disregarded the plain language of these clear and unambiguous statutes, imposing upon them a meaning they do not express.[6] *Harrison* determined that "contemporaneous, handwritten operating-room observations were not subject to a peer-review privilege" but that "[th]e balance of the report ... reflected a review process and was confidential." This interpretation reflects a policy choice made by the judiciary, not the Legislature; most particularly, the *Harrison* panel's desire to limit the power of risk managers to insulate information from discovery. *Harrison* explains:

> 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. ***To hold otherwise would grant risk managers the power to unilaterally insulate from discovery firsthand observations that the risk managers would prefer remain concealed. The peer-review statutes do not sweep so broadly.***

Harrison at 34 (emphasis added).

That *Harrison* has overstepped its bounds could not be clearer. Its multiple errors turn traditional legal analysis on its head. Those errors include: (1) disregard of binding Michigan precedent regarding the scope of ***Michigan***'s peer review privilege and its application to incident reports and contemporaneous facts; (2) selective reliance upon out-of-state decisions that either do not address a statutory peer review privilege or that have a statute bearing no resemblance to the statute here; (3) failure to apply the statutory language as written, opting to instead read

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> (e) To review the qualifications, competence, and performance of a health care professional with respect to the selection and appointment of the health care professional to the medical staff of a health facility.
>
> (f) To comply with section 20175 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.20175 of the Michigan Compiled Laws.

[6] The *Harrison* court did not find that the peer review statute was ambiguous but nonetheless construed the statute as if its plain meaning was unclear. *Harrison v Munson Healthcare*, 304 Mich App at 24-35.

unexpressed limitations into the statute; and (4) interpreting the statute to effectuate the Court's policy preferences, rather than to accomplish the Legislature's intent.

1. The Rule Announced in *Harrison* Conflicts With the Binding Precedent of This Court and Other Court of Appeals' Decisions.

Michigan jurisprudence does not support *Harrison*'s dichotomous view of the peer review privilege. In several decades of law on the subject, the appellate courts of this state have never limited the privilege to retrospective deliberative processes in the manner suggested by *Harrison*. To the contrary, Michigan's peer review privilege has historically spanned the bounds of the peer review process. As this Court remarked in *Feyz*, "[p]eer review is a communicative process, designed to foster an environment where participating physicians can freely exchange and evaluate information without fear of liability ..." 475 Mich at 685.

The unmistakable breadth of the peer review process was explicitly described in *Feyz*. This Court explained that "[i]t is obvious that peer review immunity is designed to promote free communications about patient care practices, ***as both the furnishing of information to the peer review entity*** and the proper publication of peer review materials are acts which are granted immunity." *Id.* "***All the protected activities relate to the exchange and evaluation of such information***," this Court emphasized, and "***[a]ll the peer review communications are protected from discovery and use in any form of legal proceeding***." 475 Mich at 685 (emphasis added).

This important privilege is clearly an incentive to open and frank disclosnre. Nearly 30 years ago, this Court observed that "[t]o encourage and implement productive peer review procedures, the Legislature has provided that the information and records developed and compiled by peer review committees be confidential and not subject to court subpoena." *Attorney General v Bruce,* 422 Mich 157, 161; 369 NW2d 826 (1985). Emphasizing the need to preserve the integrity of the peer review process in *Bruce,* this Court rejected the Attorney General's attempt to subpoena, on behalf of the Department of Licensing and Regulation and the

Michigan Board of Medicine, a hospital's peer review committee proceedings. Likewise, in *Dorris v Detroit Osteopathic Hosp*, 460 Mich 26, 42-43; 594 NW2d 455 (1999), this Court remarked that without "the assurance of confidentiality as provided by §§ 21515 and 20175(8), the willingness of hospital staff to provide their candid assessment will be greatly diminished" which "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."

In contrast to *Harrison*'s compelled disclosure of contemporaneous factual information within an incident report, this Court made no such distinction when it held in *Gregory v Heritage Hosp* that the trial court erred in compelling the disclosure of ***incident and investigative reports*** of an assault and battery occurring while the plaintiff was a patient at the hospital. This Court relied upon the affidavit of the hospital's manager of quality and utilization management, which established that the materials were used "for the purpose of maintaining health care standards at the hospital, improving the quality of care provided to patients, and reducing morbidity and mortality within the hospital." 460 Mich at 42.[7] The sought-after materials included investigative reports, statements, notes, memoranda, records and reports. The Court remanded to permit plaintiff to challenge "the veracity of defendant hospital's procedures." *Id.* at 48-49.

The Court of Appeals has similarly applied the privilege to incident/investigation reports without parsing between contemporaneous facts and deliberative processes. In *Gallagher v Detroit-Macomb Hosp Ass'n*, 171 Mich App 761, 769; 431 NW2d 90 (1988), the Court of Appeals afforded complete protection to an incident report, the purpose of which was to assist the hospital in monitoring its own activities to reduce accidents, injuries, morbidity and mortality

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[7] *Gregory* was decided in conjunction with *Dorris*.

at the hospital. The Court's description of that report – and its similarity to the reports in *Harrison* and *Krusac* – is instructive:

> Thompson explained that an incident report is completed for all unusual occurrences at the hospital and that its purpose was to assist the hospital in monitoring its own activities to reduce accidents, injuries, morbidity and mortality at the hospital. The report is routed to the unit supervisor and the department head for further review and investigation and then to the hospital's legal affairs department. It is tabulated with other reports to identify trends, patterns or problems at South Macomb Hospital. The information is then routed to either the hospital's Safety Committee or Quality Assurance Committee. Both committees are assigned the responsibility of identifying trends or problems at the hospital. Based on Thompson's testimony, the quality and safety committees appear to fulfill the protected review functions.

Id. at 769.

Noting that MCL 333.20175 and MCL 333.21515 "evidence the Legislature's intent to *fully* protect quality assurance/peer review records from discovery" and, without distinguishing between facts and deliberations, the Court of Appeals in *Ligouri v Wyandotte Hosp*, 253 Mich App at 377, concluded that reports regarding a patient's fall at the hospital were protected. *See also, Raslan v Providence Hosp*, unpublished opinion per curiam of the Court of Appeals dated September 11, 2001 (Docket No. 220159), 2001 Mich App LEXIS 2576, at *7 (applying the privilege to investigation reports, peer review reports, and employee records relating to review of professional practices and the quality of care provided in the hospital); *Maviglia v West Bloomfield Nursing & Convalescent Center, Inc*, unpublished opinion per curiam of the Court of Appeals, issued November 9, 2004 (Docket No. 248796), 2004 Mich App LEXIS 3048, at *2 (holding that because incident reports are data collected for the purpose of professional review, they must not be snbject to discovery in a malpractice case)(emphasis added); *Beaumont Hosp v Medtronic, Inc*, 2010 US Dist LEXIS 39093 (ED Mich, Apr 21, 2010) (variance and sentinel event reports protected by privilege); *Loyd v Oakland/Trinity Health*, 2013 US Dist LEXIS 37039 at *6 (ED Mich, Mar 18, 2013) ("Michigan courts have repeatedly held that the peer

review privilege encompasses hospital incident reports where such reports are 'compiled in furtherance of improving health care and reducing morbidity and mortality'"); *Lindsey v St John Health Sys*, unpublished opinion per curiam of the Court of Appeals, issued February 6, 2007 (Docket Nos. 268296, 270042), 2007 Mich App LEXIS 268, at *18 (occurrence report is not discoverable as it "necessarily related to a document that concerned the review of professional practices and the quality of care provided by the hospital").[8]

Rejecting disclosure pursuant to a search warrant in *In Re Lieberman*, 250 Mich App 381, 387; 646 NW2d 199 (2002), the Court of Appeals observed that § 21515 demonstrates that the Legislature has imposed a ***comprehensive ban*** on the disclosure of any information collected by, or records of the proceedings of, committees assigned a professional review function in hospitals and health facilities" (emphasis added). The comprehensive nature of the privilege was also acknowledged in *Johnson v Detroit Medical Ctr*, 291 Mich App 165, 169 n1; 804 NW2d 754 (2010), which reversed a trial court order requiring defendants to disclose the contents of a physician's credentials and privileges file, explaining "[b]ecause ***everything*** within the file is protected, there is no merit to plaintiff's argument that defendants should be required to prepare a list of the file's contents so that items can be evaluated individually." *Id.* (emphasis added).[9]

This long history of enforcing the privilege against encroachment is not undone by the Court of Appeals' decision in *Centennial Healthcare Mgmt Corp v Dep't of Consumer & Indus*

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[8] Unpublished cases are attached as Exhibit D.

[9] *See also, Dye v St John Hosp*, 230 Mich App 661; 584 NW2d 747 (1998) (vacating trial court order compelling the production of information from defendant physician's credentials file); *Jeung v Allen*, unpublished opinion per curiam of the Court of Appeals, issued April 20, 2004 (Docket No. 245997), 2004 Mich App LEXIS 989, at *3 ("[P]laintiffs seek information obtained by a peer review committee pursuant to its peer review function. The privilege therefore applies").

Servs, 254 Mich App 275; 657 NW2d 746 (2002). *Harrison* relied upon *Centennial* to "buttress" its distinction between *facts* and *deliberation*, quoting *Centennial* as follows:

> Certainly, in the abstract, a peer review committee cannot properly review performance in a facility without hard facts at its disposal. However, it is not the facts themselves that are at the heart of the peer review process. Rather, it is what is done with those facts that is essential to the internal review process, i.e., a candid assessment of what those facts indicate, and the best way to improve the situation represented by those facts. *Simply put, the logic of the principle of confidentiality in the peer review context does not require construing the limits of the privilege to cover any and all factual material that is assembled at the direction of a peer review committee.*

Harrison, 304 Mich App at 32 (emphasis in original).

Harrison's reliance upon *Centennial* is misplaced. Like *Harrison*, *Centennial* did not apply the plain language of the statute as written but instead considered the "logic" of confidentiality in the peer review context, and found that protection should only be afforded when necessary to "effectuate other purposes outlined in the Public Health Code." 254 Mich App at 290-291. While that may have been the *Centennial* court's view, it is not the Legislature's view. In fact, it is dramatically opposed to the meaning expressed in the words of the statute, which limit the "use" of the information, not the "protection" of the information, to purposes "provided in this article." The reports in *Centennial* were prepared to comply with certain administrative rules governing nursing homes. Wisely, in *Maviglia*, *supra*, the Court of Appeals concluded that *Centennial*'s reasoning should be limited to the state agency context, explaining:

> The *Centennial* Court's decision and reasoning is not applicable where, as here, the party seeking disclosure of the information is a private litigant. MCL 333.20175(8) clearly bars release of the "records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility." The accompanying regulations, 1979 AACS, R 325.21101, also relied on by plaintiff, provides that accident records and incident reports shall be kept in the home and shall be available to the director or his or her authorized representative for review and copying if necessary. But the rule only authorizes copying of the reports by the director or an authorized representative. It does not indicate that the reports should be available for copying by anyone else.

2004 Mich App LEXIS 3048, at *5-6. *Centennial* does not excuse *Harrison's* disregard of binding Michigan precedent. [10]

2. *Harrison*'s Purported Reliance Upon *Monty* to Elevate the Sway of Inapposite Out-of-State Cases Is Misplaced.

In its analysis, *Harrison* did not examine the cases decided by this Court and prior Court of Appeals' panels regarding the scope of the privilege and its applicability to incident reports. *Harrison* ignored those cases, purporting to instead use as guideposts three out-of-state decisions cited by this Court in *Monty v Warren Hosp Corp*, 422 Mich 138; 366 NW2d 198 (1985). The cases are: *Bredice v Doctors Hosp, Inc*, 50 FRD 249 (DC 1970); *Davidson v Light*, 79 FRD 137 (D Colo 1978); and *Coburn v Seda*, 101 Wn2d 270; 677 P2d 173 (1984).

The weight *Harrison* affords to *Bredice*, *Davidson* and *Coburn* and the rule it derives from those cases is not warranted by the mere mention they receive in *Monty*. Quite the contrary, *Harrison* misconstrued *Monty*'s reference to those cases and reached a decision that is sharply at odds with *Monty* and the other precedential pronouncements of this Court and the Court of Appeals.

The issue in *Monty* was the propriety of a trial court order which directed defendant hospital to appear *in open court* with the personnel records of defendant doctors and to provide the information necessary for the court to determine if the documents were subject to the peer review privilege. This Court reversed that order insofar as it mandated that the hearing be conducted in *open court*, stating that this could conceivably result in the disclosure of

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[10] Further, contrary to *Harrison*'s insistence that under the general rule, statutory privileges are to be narrowly construed, 304 Mich App at 25, prior courts have held that the peer review privilege is broad, *In re Lieberman*, 250 Mich App 381, 389-390; 646 NW2d 199 (2002), evidencing "the Legislature's intent to fully protect quality assurance and peer review records from discovery." *Ligouri*, 253 Mich App at 376.

confidential *information, thereby defeating the privilege.* 422 Mich at 146. This Court mentioned *Davidson, Bredice* and *Coburn* but only in passing, stating:

> In determining whether any of the information requested is protected by the statutory privilege, the trial court should bear in mind that 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. *Marchand, supra*, 168. Also, in deciding whether a particular committee was assigned a review function so that information it collected is protected, the court may wish to consider the hospital's bylaws and internal regulations, and whether the committee's function is one of current patient care or retrospective review. Compare *Davidson v Light*, 79 FRD 137 (D Colo, 1978), with *Bredice v Doctors Hospital, Inc*, 50 FRD 249 (D DC, 1970), *aff'd without opinion* 156 U.S. App DC 199; 479 F2d 920 (1973). *See Coburn v Seda*, 101 Wash2d 270, 277; 677 P2d 173 (1984).

Id. at 146-147.

This mere mention of *Bredice, Davidson* and *Coburn*, without reference to their contexts, analyses or holdings hardly constitutes a ringing endorsement of, let alone encouragement for, the dichotomous *Harrison* rule. *Monty* does not use these cases to distinguish between facts and deliberation. The distinction *Monty* makes in ***upholding*** the privilege is between "current patient care" and "retrospective review." In *Harrison* and *Krusac*, the incident reports were not created for the purpose of rendering current patient care, but were instead designed to enable the hospital's peer review entities to conduct a retrospective review of hospital practices for the purpose of reducing morbidity and mortality. *Monty* does not support the aberrant *Harrison* rule.

3. The Out-of-State Cases Are Not Instructive Because They Do Not Address a Peer Review Statute Similar to the Statute Here.

To the extent reference to case law is required or even desired to determine the scope of Michigan's statutory peer review privilege, traditional legal analysis would first consider Michigan's own jurisprudence. Absent that, instructive authority construing similarly worded statutes from other jurisdictions might be considered. However, one would never expect reliance

to be placed upon out-of-state cases that address dissimilar peer review statutes or no statute at all. Inexplicably, that was the framework of the *Harrison* analysis.

Harrison first considered *Bredice v Doctors Hosp, Inc*, 50 FRD 249 (DC 1970), which ***rejected*** a request for the minutes and reports of any board or committee of defendant hospital relating to the death of plaintiff's decedent. *Harrison*, 304 Mich App at 28. *Harrison* also relied upon *Davidson v Light*, 79 FRD 137 (D Colo 1978), finding it to have distinguished *Bredice* on the basis that the infection-control records sought in *Davidson* contained factual data relating to the plaintiff's infection as well as the review committee's opinions/evaluations of the care provided to plaintiff, which indicated that the review committee functioned "'as a part of current patient care, investigating the source of infections and attempting to control their proliferation.'" *Harrison* viewed the third case, *Coburn v Seda*, 101 Wash2d 270; 677 P2d 173 (1984), as "particularly instructive." 304 Mich App at 29. The demand in *Coburn* was for the hospital review committee's report regarding the death of plaintiff during a heart catheterization procedure. *Coburn* remanded the case for a determination as to whether Washington's peer view privilege statute applied. *Harrison* quoted *Coburn* as instructing that the statute "may not be used as a shield to obstruct proper discovery of information generated outside review committee meetings" and "does not grant an immunity to information otherwise available from original sources." 304 Mich App at 29-30.

From these decisions, *Harrison* derived "a distinction between factual information objectively reporting contemporaneous observations or findings and 'records, data, and knowledge' gathered to permit an effective review of professional practices." *Id.* at 30. But *Harrison*'s reliance upon *Bredice*, *Davidson*, and *Coburn* is misplaced. Peer review statutes were not at issue in *Bredice*. In denying disclosure of committee minutes and reports in *Bredice*, the Court relied upon the public interest in having "staff meetings held on a confidential basis so

that the flow of ideas and advice can continue unimpeded." 50 FRD at 250-251. While this rationale is consistent with the purpose underlying Michigan's peer review statute, *Bredice* is otherwise inapposite to this statutory interpretation question.

Davidson is also dissimilar. The Colorado statute addressed (in part) in *Davidson* did not embrace the sought-after report of the hospital's infection control committee. "Admittedly, this statute does afford certain immunities to members of the committees with which it is concerned, but infection control committees and their members are obviously not included." 79 FRD at 140. Further, "the committee report ... preceded the effective date of the statute." *Id.* Thus, the purported distinction between facts and deliberations which *Harrison* gleans from *Davidson* did not derive from a peer review statute analogous to the statute here.[11]

A peer review statute was at issue in *Coburn* but it bears no similarity to the statute here. It did not protect records, data or knowledge collected by or for individuals and committees assigned a review function. It applied only to "proceedings, reports, and written records" of certain committees and boards. That is why the *Coburn* court concluded that documents "generated outside review committee meetings" must be disclosed. Rev. Code Wash 4.24.250 provides in pertinent part:

> (1) . . . ***The proceedings, reports, and written records of such committees or boards, or of a member, employee, staff person, or investigator of such a committee or board, are not subject to review or disclosure, or subpoena or discovery proceedings in any civil action***, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a health care provider as defined in RCW 7.70.020 (1) and (2).

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[11] *Harrison* also relied in part on *Bernardi v Community Hosp Ass'n*, 166 Colo 280; 443 P2d 708 (1968), a case briefly addressed in *Davidson*. *Bernardi* is inapposite. In *Bernardi,* an incident report completed by the nurse following the event was included in the patient's hospital chart. *Id.* at 709. The asserted privilege related to the attorney-client privilege, not the peer review privilege. The *Bernardi* court ordered production on the basis that the incident report was not prepared for counsel. *Id.*

Id. (emphasis added). This language is not expansive. It is expressly limited to "proceedings, reports and written records" of boards and their members and agents. *Coburn*'s analysis of this statute has no bearing on the proper scope of Michigan's peer review statute.

Equally misplaced is *Harrison*'s reliance upon other out-of-state cases for the proposition that "facts concerning a patient's care, and in particular facts incorporated within an incident report, are not entitled to confidentiality." 304 Mich App at 32-33. As with the above cases, *Harrison* makes no attempt to correlate the language of the peer review statutes in those cases to the language of MCL 333.20175(8) or MCL 333.21515, rendering the entire discussion meaningless. A comparison of the statutes reinforces this conclusion; they are too dissimilar to be instructive.

For example, *Harrison* quotes *Columbia/HCA Healthcare Corp v District Court*, 113 Nev 521, 531; 936 P2d 844 (1997), for the proposition that "'[o]ccurence reports ... are nothing more than factual narratives' which contain information usually unearthed in discovery." 304 Mich App at 32-33 (brackets and ellipses in original). However, the Nevada statute at issue in *Columbia* is far more narrowly drawn than the Michigan statute. Only proceedings and records of organized committees are protected. NRS 49.265 states in relevant part that "1. Except as otherwise provided in subsection 2: (a) *The proceedings and records of:* (1) Organized committees of hospitals... having the responsibility of evaluation and improvement of the quality of care rendered by those hospitals or organizations; and (2) Review committees of medical or dental societies, are not subject to discovery proceedings..." (emphasis added).

Further, the *Columbia* court noted that "the narrow issue" before it was "one of statutory interpretation: whether occurrence reports were intended to be included in the phrase of NRS 49.265 'proceedings and records of' and, therefore, exempted from discovery." 936 P.2d at 849. *Columbia* relied upon *Trinity Medical Ctr v Holum*, 544 NW2d 148, 157 (ND 1996), which had

construed the phrase "proceedings and records of" the committee as limited to the formal proceedings before the committee and internal records of the committee. *Id.* *Trinity* explained that the phrase includes testimony given to the committee, committee deliberations, discussions among committee members, and minutes of committee meetings but ***"[i]t does not include other information or data provided to the committee or collected for the committee's*** review by hospital departments or employees." *Id.* (emphasis added). In other words, *Trinity* expressly *excluded* from "proceedings and records of" the committee that which is expressly *included* in the Michigan statute, i.e., records, data, and knowledge collected for or by the committee. This case certainly has no relevance to Michigan's peer review statute.

Harrison also relies upon *State ex rel AMISUB, Inc v Buckley*, 260 Neb 596, 614; 618 NW2d 684 (2000). But that reliance is tied to the statutory language which merely protects documents "requested by a hospital medical staff committee or a utilization review committee" and the reports, records and communications of a medical staff committee or a utilization review committee. Expressly excluded are facts or information contained in hospital medical records, and nothing in the statute is to preclude or affect discovery relating to the treatment of a patient in the ordinary course. The statute provides:

> The ***proceedings, minutes, records, and reports of any medical staff committee or utilization review committee*** as defined in section 71–2046, ***together with all communications originating in such committees are privileged communications*** which may not be disclosed or obtained by legal discovery proceedings unless (1) the privilege is waived by the patient and (2) a court of record, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports, or communications. ***Nothing in sections 71–2046 to71–2048 shall be construed as providing any privilege to hospital medical records kept with respect to any patient in the ordinary course of business of operating a hospital nor to any facts or information contained in such records nor shall sections 71–2046 to 71–2048 preclude or affect discovery of or production of evidence relating to hospitalization or treatment of any patient in the ordinary course of hospitalization of such patient.***

Neb. Rev. Stat. § 71-2048 (1996) (emphasis added). It was this express statutory language – that does not appear in the Michigan statute – that caused *Buckley* to differentiate between facts and deliberations. The Court explained:

> [E]ven if the incident report and fall lists had been specifically requested by a hospital-wide committee, such documents would not have been privileged under §71-2047, because reading §§ 71-2047 and 71-2048 together, these documents consist of merely "facts and information" which is not privileged from discovery under §71-2048 ...

618 NW2d at 696. Thus, the statement quoted by *Harrison* about "percipient witnesses" and "bare facts" was expressly tied to the statutory language. The Court made no universal pronouncement beyond what the statute required.

Harrison also relies upon *John C Lincoln Hosp & Health Ctr v Superior Court*, 159 Ariz 456, 459; 768 P2d 188 (1989). However the Arizona statute, which protects proceedings, records and materials prepared in connection with peer review, is not as broad and inclusive as the Michigan statute. A.R.S. 36-445.01 provides:

> A. All ***proceedings, records and materials prepared in connection with the reviews*** provided for in section 36-445, including all peer reviews of individual health care providers practicing in and applying to practice in hospitals or outpatient surgical centers ***and the records of such reviews, are confidential and are not subject to discovery*** except ...

Id. (emphasis added).

Harrison's reliance upon *Babcock v Bridgeport Hosp*, 251 Conn 790, 838; 742 A2d 322 (1999), is also misplaced. The Connecticut statute bears no resemblance to Michigan's peer review statute. Conn. Gen. Stat. § 19a-17b(d) protects the "proceedings of a medical review committee conducting a peer review" and has a much narrower scope than the Michigan statute:

> The ***proceedings of a medical review committee conducting a peer review*** shall not be subject to discovery or introduction into evidence in any civil action for or against a health care provider . . .; ***provided the provisions of this subsection shall not preclude (1) in any civil action, the use of any writing which was recorded independently of such proceedings;*** (2) in any civil action, the testimony of any person concerning the facts which formed the basis for the

> institution of such proceedings of which he had personal knowledge acquired independently of such proceedings; (3) in any health care provider proceedings concerning the termination or restriction of staff privileges, other than peer review, ***the use of data discussed or developed during peer review proceedings***; or (4) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restriction imposed, if any.

Id. (emphasis added). The *Babcock* court held that "by using the word 'proceedings,' the legislature intended to restrict the privilege to the substantive discourse that takes place at the actual meetings during which 'matters which are subject to evaluation and review by such committee,' are discussed and deliberated." 742 A2d at 343. This includes the "dialogues, debates and discussions that transpire at a peer review meeting" and the "opinions and conclusions reached by committee members." *Id.* [12] The same restriction does not appear in the Michigan statute.

These elemental differences in the out-of-state cases – ignored in *Harrison* – render them analytically valueless. But their preeminence in *Harrison* is even more surprising when one considers that Michigan does not lack specific authority on this issue. It was completely unnecessary for the *Harrison* court to reach for instructional analysis beyond Michigan's jurisdictional boundaries because binding Michigan precedent exists. *Harrison* simply ignores and fails to follow it.

4. *Harrison* Changes the Meaning of the Statute to Effectuate the Court's Policy Preference Rather Than the Legislature's Intent.

The plain language of the statute does not support *Harrison*'s conclusion that "factual information," even if collected by or for a committee performing a review function, is not protected by the peer review privilege, only the deliberative process is protected. Rather, this

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[12] Conn. Gen. Stat. § 19a-25 was also addressed. That too was construed to protect only the committee's work, based upon a concluding sentence which states "This section shall not be deemed to affect disclosure of regular hospital and medical records made in the course of the regular notation of the care and treatment of any patient, ***but only records or notations by such staff committees pursuant to their work***" (emphasis added).

distinction between factual information and the deliberative process reflects a policy preference that emanates from the *Harrison* court's concern that risk managers might otherwise have the power to "insulate from discovery firsthand observations that the risk managers would prefer remain concealed." 304 Mich App at 34. This concern is misplaced. Risk managers do not dictate what is or is not placed in the medical record, and facts and observations reported in the medical record are discoverable. But including that same information – or even a different version of the information, in an incident report does not make the incident report or any part of it, discoverable.

If the report was created pursuant to peer review protocol the privilege applies, irrespective of whether the report might have benefited a claimant or a defendant in subsequent litigation. The Legislature has determined that the importance of fostering a candid evaluation of the practices within the hospital outweighs all other competing considerations. The peer review statute is the balance struck by the Legislature and it expressly embraces "records, data, and knowledge," each of which, by definition, includes "facts."

For example, the *Merriam-Webster Online Dictionary* defines "data" as a "collection of factual knowledge about something." See http://www.merriam-webster.com/thesaurus/data (accessed November 10, 2014). Similarly, a "record" is "a body of known or recorded facts about something or someone especially with reference to a particular sphere of activity ..." http://www.merriam-webster.com/dictionary/records (accessed November 10, 2014). The definition of "knowledge" includes "the fact or condition of being aware of something" or "the range of one's information or understanding." http://www.merriam-webster.com/dictionary/knowledge?show=0&t=1415602228 (accessed November 10, 2014). *Harrison* could not have excluded contemporaneous facts from the peer review privilege if it had applied the plain meanings of these words.

Harrison was not authorized to disturb the balance reached by the Legislature. As this Court has often expressed, a court is not empowered to contort the meaning of a statute to satisfy its own policy preferences. In *Ligouri*, the Court noted that "[w]hile production of the records may appear under these circumstances to be the equitable result, equity may not be invoked to avoid application of a statute." 253 Mich App at 377 n 4. Even *Feyz* recognized that the broad sweep of peer review might "insulate from review and sanction the participants' liability for some adverse outcomes ..." 475 Mich at 687. But reaching the proper balance is for the Legislature, not the Court. The Court of Appeals explained in *Johnson*:

> §333.21515 clearly and unambiguously prohibits discovery of Dr. Nunn's credentials and privileges file. *Attorney General*, 422 Mich at 173. "To hold otherwise ***would require us to create an exception*** to the [evidentiary] privilege granted such information by the Legislature; ***that is not for us to do***.

291 Mich App at 169 (emphasis added)(brackets in original).

Rejecting the assertion that "compelling policy considerations" militate in favor of holding the privilege inapplicable to criminal investigations, the *Lieberman* court said that "[a] proper, objective reading of the statute ... must be considered the Legislature's statement of public policy. Because the Legislature protected peer review documents in broad terms, the public policy argument must be resolved in favor of confidentiality." *In Re Lieberman*, 250 Mich App at 389. Similarly, affirming a motion to quash a subpoena for information subject to the psychologist-patient privilege amidst allegations that the decision would lead to "unfair treatment" and "absurd or illogical results," the Court of Appeals explained in part:

> As Michigan courts have long recognized and often stated, a party having complaints about the wisdom of plain statutory language should direct his arguments to the Legislature. *Robertson v DaimlerChrysler Corp*, 465 Mich 732, 752; 641 NW2d 567 (2002) ("'[O]ur judicial role precludes imposing different policy choices than those selected by the Legislature ....'")(citations omitted); *Gilliam v Hi-Temp Products, Inc*, 260 Mich App 98, 109; 677 NW2d 856 (2003)("The fact that a statute appears to be impolitic, unwise, or unfair is not sufficient to permit judicial construction. The wisdom of a statute is for the

> determination of the Legislature and the law must be enforced as written.") (footnote omitted).

In Re Petition of Attorney General for Investigative Subpoenas, 282 Mich App 585; 766 NW2d 675 (2009) (the panel of which included two of the *Harrison* jurists).

This same judicial restraint should have been exercised here. Instead, *Harrison* has fashioned a rule that violates the Legislature's intent and is unworkable. Both the Trial Court and the Court of Appeals concluded that the incident report was a peer review document. *See* 304 Mich App at 34. At that point, under the plain meaning of the statute, the peer review privilege should have attached. But now it will be necessary for a Court, despite a peer review finding, to splice peer review documents to determine whether certain aspects should be disclosed. This gives little comfort to participants in the peer review process who can no longer be assured that confidentiality will attach to their peer review activities. The uncertainty further undermines the ability of a statutorily protected peer review committee to undertake a review of the professional practices in the hospital for the purpose of reducing morbidity and mortality. *Harrison* should be reversed.

II. The Trial Court Erred in Ordering Covenant to Produce the First Page of the Improvement Report On the Basis That "Objective Facts Gathered Contemporaneously With An Event Do Not Fall Within the Definition of Peer Review Privilege."

In *Krusac*, the privilege was not applied to the Improvement Report prepared by Nurse Colvin on the ostensible basis that the information contained within the report was merely an account of the factual occurrence. Relying upon *Harrison*, the Trial Court concluded that "objective facts gathered contemporaneously with an event do not fall within the definition of peer review privilege" and "to hold otherwise would unilaterally insulate from discovery first-hand observations." *Krusac* Opinion and Order Re: Discovery, Exhibit A. For the reasons expressed above, *Harrison* was erroneously decided and does not accurately state the law

governing Michigan's peer review statute. But even beyond the Trial Court's misplaced reliance on *Harrison*, enforcing the peer review privilege does not insulate "first-hand observations" from discovery. Discoverable medical records are filled with first-hand observations, which are also subject to re-telling during depositions and other modes of discovery. Placing a fact in an incident report does not immunize the fact from discovery through other means.

Mr. Krusac argues that the information in the Improvement Report was collected by Nurse Colvin, not the peer review entity and that under this Court's decision in *Marchand v Henry Ford Hosp*, 398 Mich 163; 247 NW2d 280 (1976), protected material must be collected at the direction of a peer review committee; the privilege cannot attach to material which is merely in the possession of a peer review committee. Respectfully, Mr. Krusac is mistaken. In preparing the Improvement Report, Ms. Colvin was doing what was required by the hospital's peer review protocol pursuant to the hospital's mandate to reduce morbidity and mortality. Unlike the Improvement Report, the information requested in *Marchand* was collected by a physician on his own initiative to see how hyperalimentation feeding worked and whether it was effective. *Id.* at 167-168. This Court therefore concluded that it was not "collected pursuant to a directive from a '[committee] assigned this review function'" and while this information "was subsequently presented at a general staff meeting, the ex post facto submission does not satisfy the 'collection' criteria bringing the data within the ambit of the evidentiary privilege." *Id.* at 168. Here, the Improvement Report was created pursuant to established hospital procedures, as in *Dye v St. John Hosp, supra*, where the Court of Appeals explained that materials the credential committee wanted to review before granting staff privileges, even if "submitted" by others as part of the application process, were "collected for or by" the committee and are thus subject to the privilege. 230 Mich App at 667.

Also erroneous are Mr. Krusac's twin assertions that because Nurse Colvin did not make an entry in the medical record (1) the Improvement Report is subject to discovery pursuant to MCL 333.20175(1) which, Mr. Krusac argues, requires hospitals to maintain medical records which would include Ms. Colvin's observations, and (2) requiring disclosure of the facts contained in the Improvement Report fulfills a purpose "provided in this article."

With respect to the first assertion, this Court cannot credit the premise that Ms. Colvin was required to record her observations regarding Ms. Krusac's fall in the medical records. As Covenant explains, Ms. Colvin was the circulating nurse during the catheterization procedure and her notation in the record was limited to the medications she administered to Ms. Krusac. Colvin Dep at 48. Another nurse, Heather Gengler, was charged with documenting events during the catheterization procedure. *Id.* at 36-37; Gengler Dep at 10. But beyond that, the Improvement Report was not created to further Ms. Krusac's care and treatment; it was created and maintained as a confidential document in accordance with the hospital's peer review protocol to reduce morbidity and mortality.[13] Irrespective of whether Ms. Colvin was or was not obligated to record her observations in the medical record, peer review materials are not a back-up. The statutory procedure does not require or even allow a court overseeing a medical malpractice case to determine whether the hospital's obligation to record observations has been satisfied and, if not, to order that the medical record be supplemented with peer review materials. The confidentiality incentive fostered by the privilege would be eviscerated in the face of such uncertainty.

[13] The Administrative Manual provides in part under the section titled INCIDENT AND IMPROVEMENT REPORTING, Policy 6.06, that "[t]hese reports will be tracked and trended for the purposes of developing safety prevention, loss control and peer review programs which will benefit all patients and users of Covenant Health Care System's facilities and services." Plaintiff's Appendix at 50b.

As to the second assertion, enhancing the discovery posture of claimants in litigation is clearly not the purpose of any provision of Article 17 of the Public Health Code. Quite the contrary, MCL 333.21515 and MCL 333.20715 expressly protect against court compelled disclosure. The very suggestion that disclosing the facts contained in the Improvement Report would be for a "purpose[] provided in ... article [17]" turns the purpose of the statute on its head.

Finally, this Court would have to reverse decades of law governing the peer review statute if it were to hold that the statute does not create a privilege. To make this argument, Mr. Krusac focuses on language that describes "records, data, and knowledge collected for or by individuals or committees assigned a review function" as "confidential." But in addition to deeming this material "confidential," the statute goes on to say that the materials "shall be used only for the purposes provided in this article, shall not be public records, and shall not be available for court subpoena." Those commands can only be given effect if peer review materials are protected from disclosure. That is certainly the effect this Court has consistently given to the statute over the past several decades. For example, in *Marchand, supra,* this Court explained that MCL 331.422(2) [the predecessor to MCL 333.21515], "creates an evidentiary privilege regarding certain information gathered pursuant to the review function mandated in subsection 1 of the statute." 398 Mich at 167. In *Monty*, this Court explained that "[t]o require production of the documents in open court in order to establish applicability of the ***privilege*** could conceivably result in disclosure of confidential information, thereby defeating the ***privilege***." 422 Mich at 146 (emphasis added). There is no basis to depart from this well-established precedent.

RELIEF REQUESTED

For these reasons, Amici Curiae Michigan State Medical Society and the American Medical Association respectfully urge this Court to hold (1) that *Harrison* was wrongly decided

and (2) that the Trial Court in *Krusac* erred when it ordered the defendant to produce the first page of its Improvement Report on the basis that "objective facts gathered contemporaneously with an event do not fall with the definition of peer review privilege."

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