STATE OF MICHIGAN

IN THE SUPREME COURT

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

Supreme Court No. 149270

COA No: 321719

Plaintiff-Appellee,

Vs.

Saginaw County Circuit Court
Case No: 12-15433-NH-4

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

Defendant-Appellant.

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PLAINTIFF-APPELLEE'S RESPONSE TO DEFEDANT-APPELLANT COVENANT HEALTHCARE'S APPLICATION FOR LEAVE TO APPEAL

ORAL ARGUMENT REQUESTED

FILED
JUN 2 2014
LARRY S. ROYSTER
CLERK
MICHIGAN SUPREME COURT

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COUNTER-STATEMENT OF THE BASIS OF JURISDICTION

Defendant-Appellant seeks leave to appeal the May 8, 2014 Opinion and Order Re: Discovery issued by the Saginaw County Circuit Court, Honorable Fred L. Borchard presiding, which ordered the defense to immediately turn over to Plaintiff the first page of the report entitled "Improvement Report" which contained only the "facts" of Plaintiff-Appellee's decedent, Dorothy Krusac's fall on September 12, 2008. (Attached to Defendant-Appellant's Application as **Exhibit 1**). Following an In Camera Inspection of the report, the trial court concluded that the first page of the "Improvement Report" which contained the objective facts written by Nurse Deb Colvin, RN who was present for the occurrence and written within 10 minutes of the occurrence did not fall under the peer review privilege.

On May 12, 2014, Defendant-Appellant did file an Application for Leave to Appeal with the Michigan Court of Appeals. This Application was denied.

Defendant-Appellant seeks leave to appeal alleging that the Court of Appeals decision in *Harrison v Munson Healthcare, Inc*, ____ Mich App ____; ____ NW2d ____ (2014), was error and therefore, the trial court's ruling in this matter was also error.

Whether production of documents is barred by statute is a question of law that is reviewed de novo. *Dye v St. John Hospital and Medical Center*, 230 Mich App 661; 584 NW2d 747 (1998).

COUNTER -STATEMENT OF QUESTIONS PRESENTED

I. DID THE TRIAL COURT ERR IN ITS INTERPRETATION OF MICHIGAN'S PEER REVIEW STATUTES, WHICH WAS BASED IN PART UPON *HARRISON V MUNSON HEALTHCARE INC*?

The trial court answered:	"NO"
Appellant Covenant Healthcare answers:	"YES"
Appellee answers:	"NO"

II. DID THE TRIAL COURT ERR IN FINDING THAT THE FACT PORTION OF COVENANT'S "IMPROVEMENT REPORT" WAS DISCOVERABLE AS IT WAS NOT SUBJECT TO PEER REVIEW PRIVILEGE AND REQUIRING DISCLOSURE OF THE FACT PORTION ONLY TO PLAINTIFF?

The trial court answered:	"NO"
Appellant Covenant Healthcare answers:	"YES"
Appellee answers:	"NO"

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COUNTER -STATEMENT OF FACTS

On September 12, 2008, 80-year old, Dorothy Krusac was a patient at Defendant Covenant Medical Center, assumed name of Defendant Covenant Healthcare, when she fell off the procedure table in the catheterization lab. Plaintiff alleges that Deb Colvin, RN violated the standard of care when she turned her back and walked away from her patient that was laying on a table only 21 inches wide with no side rails, who groggy on Valium and was known to be uncomfortable and documented to be moving around on the table on a least 5 occasions during the 30 minutes prior to the fall. As a result, Dorothy Krusac "rolled off table to floor." (last page of Procedure Log, **Exhibit A**).

It is Plaintiff's allegation that as a result of this fall, Ms. Krusac developed neurogenic pulmonary edema causing her acute respiratory arrest just before midnight that same evening. As a result of her arrest, Dorothy Krusac sustained significant hypoxic encephalopathy as evidence by her pH of 7.09 and required mechanical ventilation causing her clinical decline and ultimate death on October 8, 2008.

Dorothy Krusac underwent a successful heart catheterization by cardiologist, Dr. Pramod Sanghi, on September 12, 2008 at Covenant Medical Center. The procedure log documents that for this procedure, Ms. Krusac was on the table for approximately 2 hours and 50 minutes. The table is hard and only 21 inches wide, with no side rails. Ms. Krusac was only sedated with Valium as she experienced difficulty with oxygen saturation following the administration of the usual anesthesia

given, which is Fentanyl. (**Exhibit A**). She was "uncomfortable and restless" and "having trouble keeping her legs down." (Colvin Dep, P16, Dep App's **Exhibit 3**).

The procedure log contains detailed documentation of the procedure on almost a minute-by-minute basis by the monitoring nurse, Heather Gengler, RN. In the 30 minutes before her fall, the Procedure Log contains 5 notes that Ms. Krusac was fidgeting and moving around on the table[1]:

16:47 Pt reinforced to keep legs and arms down
16:54 Pt reinforced to keep legs and arms down
16:55 Pt moving arms and legs. Verbal reinforcement given
17:11 Pt having difficulty keeping legs down. Verbal reinforcement given.
17:20 Verbal reinforcement to keep legs straight
(**Exhibit A**).

After this last note of Ms. Krusac moving around at 17:20, only her vital signs are recorded at 17:25, 17:35 and 17:45. Interestingly, at 17:45, only her heart rate is recorded and it has significantly elevated. At 17:49 on September 12, 2008, the procedure log documents that Dorothy Krusac fell off the procedure table in the cath lab.

Discovery has revealed that at the time of Ms. Krusac's fall, there were three individuals present with her in the catheterization lab; Heather Gengler, RN (monitoring nurse), Deb Colvin, RN (circulating nurse), and Rogers Gomez (technician). Discovery has further revealed that it was Deb Colvin, RN that was responsible for the patient. Nurse Colvin did not write a single word in Dorothy Krusac's medical chart about the fall or the facts surrounding the fall. (Colvin Dep,

[1] Nurse Gengler testified that there were other, additional, occurrences of Ms. Krusac moving that were not documented. (Gengler Dep, P7, Def-App's Exhibit 5)

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P46-47, Def-App **Exhibit 3**). Heather Gengler, RN documented the event with six words typed into the Procedure Log:

"Pt rolled off table to floor."

Four years after the event, on October 24, 2012, these individuals testified under oath that they had independent recollections of the event and that prior to Dorothy Krusac hitting the ground, they were all three able to get to her side, catch her, and gently cradle her to the ground.[2] As such, Defendant claims she could not have suffered any injury.

Nurse Colvin admitted that she turned her back on her patient and went over to the Pyxis machine, a few steps away from the patient, to see when she last gave Lasix to Ms. Krusac.[3] She then heard movement, turned around and saw Mrs. Krusac rolling off the table. (Colvin Dep, P28, 35, Def-App's **Exhibit 3**). Nurse Colvin testified that she was able to run over and hook her hands underneath Mrs. Krusac and bring her down to the ground with both arms underneath her:

"I run over and hook my hands underneath her."

"I bring her down, because she's going down to the ground and my arms are underneath her."
"Both arms"

(Colvin Dep, P28, 35, 37, Def-App's **Exhibit 3**).

Nurse Colvin testified that she "definitely softened her fall."

(Colvin Dep, P41,Def-App's **Exhibit 3**).

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[2] All three depositions took place on October 24, 2012.

[3] Gengler testified that Colvin was standing by the computer doing her notation, which was probably 2-3 feet away from the patient. (Gengler Dep, P14-15).

The technician, Rogers Gomez, testified that Dorothy Krusac was just at the edge of the table and Debbie was "cradling her" and "gently laid her down." (Gomez Dep, P21-22, Def-App's **Exhibit 4**). In fact, Gomez testified that he also got to Ms. Krusac in time and was able to cradle her head, neck and shoulders. (Gomez Dep, P22, Def-App's **Exhibit 4**).

Heather Gengler joined by testifying that Deb "caught" her. (Gengler Dep, P16, Def-App's Exhibit 5). In fact, before Ms. Krusac even rolled off the table, Deb had her in her arms. (Gengler Dep, P18, Def-App's **Exhibit 5**). Remarkably, although Nurse Gengler was sitting at the computer behind the wall, behind the glass, she testified that she even got to Ms. Krusac in time to help. Gengler remembers getting there in time, she just didn't remember which part of Ms. Krusac she helped cradle to the floor. (Gengler, P20, Def-App's **Exhibit 5**).[4]

Ironically,none of them documened any of their heroics in Ms. Krusac's chart. Not one note written in 2008 even hinted that Ms. Krusac was "caught" or "gently cradled" to the floor. Instead, the ONLY notes written back in 2008 indicate that Ms. Krusac fell to the ground and that a c-collar and back board were ordered, as well as a stat CT of the head was ordered for "injury to neck and head." (**Exhibit B**).

Plaintiff-Appellee further states that this "recollection" is inconsistent with other notes in the medical chart. The cardiologist, Dr. Sanghi's progress note indicates:

"Complications: after procedure pt **fell off the cath lab table**" (emphasis added).

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[4] Of note, Deb Colvin, RN did not testify that either Gengler or Gomez helped cradle Ms. Krusac to the floor. Colvin testified that Heather Gengler was charting at the monitor behind the glass (P27) and she was not sure if Gengler observed the fall (38). After the fall, Colvin directed Gengler to get a backboard and c-collar. Gengler was standing bedside her as she was still on floor with the patient. (41). Colvin testified that when she was

Dr. Sanghi's Operative Note states:

> "she reportedly moved her leg and fell onto the floor. It was unclear whether she had sustained any trauma to her head....She was placed in a neck brace as well as on a backboard....She was then sent for a stat CT scan of the head and neck." **(Exhibit B)**.

Dr. Sanghi also ordered a trauma surgery consultation to rule out traumatic neck or head injury. The trauma surgery resident's note indicates:

> CC: Neck + back pain s/p fall in cath lab.
> HPI: 80 y/o ♀ c/o neck + back pain **after falling proximately 3-4 ft post cath procedure. Fell on left side. Pt + <u>nurses did not see fall</u>. Unsure if head hit floor. Unknown angle of impact. (emphasis added)**. **(Exhibit B)**.

The trauma surgeon, Dr. Patel, noted:

> "According to the nursing staff, patient fell off the bed in the cath lab...it was an **<u>unwitnessed fall</u>**.." (emphasis added). **(Exhibit B).**

When Ms. Krusac returned to the floor, the nursing notes indicate she came back from the cath lab "with backboard and c-collar...Patient is sore....discussed with patient and family the need to lay flat and keep spine and neck immobilized. **(Exhibit B).**

On 9/14, a cardiology note indicates:

> "Pt fell of the cath table on 9/12" **(Exhibit B)**.

On 9/15, a consultation by Dr. Brown indicates:

> "Following the catheterization, the patient fell off of the table onto the floor. She subsequently sustained a cardiopulmonary arrest, required CPR, intubation and is now in the coronary care unit for further management." **(Exhibit B).**

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staying with Ms. Krusac on the floor after the fall, Gomez was at Krusac's head stabilizing her neck and spine (P41), but never said anything about Gomez assisting Ms. Krusac on her way down to the floor.

During her deposition on October 24, 2012, Deb Colvin, RN testified that she did not prepare any handwritten notes about this even, but admitted to preparing an incident report:

> Q: "Is there any handwritten not by you or any documentation by you at all about – that's inputted by you either in the computer or handwritten about this event?
> A: In the computer, no.
> Q: Anywhere?
> A: No.
> Q: Did you fill out an incident report?
> A: I did." (Colvin Dep, P47, Def-App's **Exhibit 3**).

Defendant-Appellant contends that the report was given to her supervisor and routed through appropriate channels to Defendant's peer review committee. (Def-App's Application for Leave, page 11). Plaintiff-Appellee asserts there was no such testimony. Although Colvin responded affirmatively to Plaintiff counsel's question if Colvin gave the report to her supervisor, the words "peer review" or "committee" were never even mentioned during her deposition. Defendant-Appellant further contends that "Gomez testified that he was questioned for purposes of providing information to a peer review committee." (Def-App's Application for Leave, page 11). Plaintiff-Appellee asserts Gomez testified that he was questioned by manager, Pam Eimers, for incident report. (Gomez Dep, P27, Def-App's **Exhibit 4**). Gomez made absolutely no mention of any peer review committee or the purpose of Ms. Eimers' questioning. Nurse Gengler testified that she was not approached or questioned about the incident for purposes of the incident report. (Gengler Dep, P24, Def-App's **Exhibit 5**). Yet, she is the only individual that made any documentation of the event in Ms. Krusac's medical chart.

On October 24, 2012, the defense asserted the peer review privilege applied to the incident report. (Gomez Dep, P27, Def-App's **Exhibit 4**). Following the Michigan

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Court of Appeals January 30, 2014 decision of *Harrison v Munson Healthcare, Inc.*, ____ Mich App ____; ____ NW2d ____ (2014), Plaintiff-Appellee filed a Motion In Limine on February 17, 2014 seeking production of the facts contained in the incident report. (attached to Defendant-Appellant's Application as **Exhibit 6**). In response, Defendant maintains that Dorothy Krusac was caught and cradled, being gently lowered to the floor. (**Exhibit C**, ¶5 on P2, P10). In this Response, Defendant asserted that any statements contained in the Incident Report constitute inadmissible hearsay and stated that the report was not created contemporaneously by one of Ms. Krusac's medical care providers. (**Exhibit C**, P10). Defendant's Response was signed by counsel. Pursuant to MCR 2.114, defense counsel certifies to the best of his knowledge, information and belief formed after reasonable inquiry, this information is well grounded in fact. This assertion is not consistent with Judge Borchard's later Opinion and Order Re: Discovery following his In Camera Inspection of the "Improvement Report" which states the facts were written by Nurse Colvin herself (the declarant, not some third party) and were written contemporaneously, within 10 minutes of the occurrence. (Def-App's **Exhibit 1**). Defendant also asserts that the report "was created as part of Defendant's peer review process, in an effort to reduce patient mortality and morbidity." (**Exhibit C**, P10). This "empty" assertion has not been supported with a single affidavit or any type of documentation. Following the trial court's in camera inspection, Judge Borchard made no mention of anything contained in the document to support that it was generated for, or reviewed by, a peer review committee. In fact, Judge Borchard's order states "even assuming, for argument purposes, that the "Improvement Report" is a peer review

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report..." (Def-App's **Exhibit 1**). As such, the trial court made no finding the report fell under the peer review privilege.

On March 5, 2014, the trial court heard oral argument on Plaintiff's Motion In Limine Regarding Production of Facts Contained in Incident Report. (Transcript attached to Defendant-Appellant's Application as Exhibit 7). Defense counsel opened his argument with his mantra that Dorothy Krusac had been "caught":

> "'We caught her' is the mantra or the position of my people..."
> (Def-App's Exhibit 7, P3, L17).

During oral argument, Judge Borchard clearly stated that he was a former defense lawyer and wanted to protect the peer review privilege at all costs. Judge Borchard has maintained throughout this process that if the incident report confirmed that Ms. Krusac was caught, then why would the production of the report be necessary? (Def-App **Exhibit 7**, P49). However, it has always been Plaintiff's position that it doesn't. Plaintiff clearly argued that the policy reasons behind the peer review privilege are to improve patient care, not to allow medical providers to only document bad occurrences in reports, rather than patient charts, and then ignore those facts, pretend they don't exist, and present a defense completely inconsistent with them. (Def-App's **Exhibit 7**, P45-49). At this hearing, On March 21, 2014, the Saginaw County Trial Court Judge, Fred L. Borchard, entered an Order Denying Plaintiff's Motion In Limine Regarding Production of Facts Contained in Incident Report. **(Exhibit D).**

On April 1, 2014, Plaintiff filed a Motion for Reconsideration of this Order. (Def-App's **Exhibit 8**). In Defendant's Response to Plaintiff's Motion for Reconsideration, Defendant again asserted that Nurse Colvin filled out an incident report that she gave to her nursing supervisor and routed through the appropriate channels to the peer review

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committee. (**Exhibit E**, P3). Plaintiff urges this Court to read page 47-48 of Nurse Colvin's deposition. Nurse Colvin agreed that she gave the incident report to her nursing supervisor, but there is no statement that any report was submitted to any peer review committee. (Colvin Dep, Def-App's **Exhibit 3**). Contrary to Defendant's assertion, Gomez did not testify that that he was "questioned for purposes of providing information to a peer review committee." Instead, Gomez simply testified that he was questioned about the event by his manager, Pam Eimers. (Gomez Dep, P27, Def-App's **Exhibit 4**).

On May 2, 2014, the trial court entered an Order and Opinion granting Plaintiff's Motion for Reconsideration. (Def-App's **Exhibit 9**). This Order indicated that the trial court would conduct an In Camera Inspection of the facts contained in the incident report to determine if said portion qualified as privileged peer review. On Monday, May 5, 2014, the trial court conducted the In Camera Inspection and allowed further oral argument. (Transcript attached to Def-App's **Exhibit 10**). The court also requested the deposition transcripts of Deb Colvin, RN, Heather Gengler,RN, and Rogers Gomez.

Although Plaintiff cannot speak to "what plaintiffs are doing everywhere," Plaintiff-Appellee is taking the position that Covenant Health Center is pursuing a defense in this case that is inconsistent with the facts contained in the "improvement report." Defendant-Appellant contends that following it's in camera inspection, the trial court failed to indicate that there were any "inconsistencies" with Defendant's asserted defenses, and therefore, the improvement report must be consistent with the testimony of Colvin, Gengler and Gomez. (Application, P13-14). However, on May 8, 2014, Honorable Fred L. Borchard of the Saginaw County Circuit Court issued an Opinion and

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Order Re: Discovery, which ordered the defense to immediately turn over to Plaintiff the first page of the report entitled "Improvement Report" which contained only the "facts" of Plaintiff-Appellee's decedent, Dorothy Krusac's fall on September 12, 2008. (Def-App's **Exhibit 1**). Notably, in ordering the discoverability of the "facts," the trial court noted the factual discrepancy:

> "Plaintiff argues that the patient fell from the table hitting the floor. The defense contends that the patient was caught before she struck the floor. (Def-App's **Exhibit 1**).

The May 8, 2014 Opinion and Order noted that Deb Colvin, RN completed the "Improvement Report" on September 12, 2008 wherein she described the facts of the incident within 10 minutes of the occurrence. The order further stated that the second page of the "Improvement Report" that covered what was done with the facts was covered by peer review and thus, confidential.

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LEGAL ARGUMENT

I. DID THE TRIAL COURT ERR IN ITS INTERPRETATION OF MICHIGAN'S PEER REVIEW STATUTES, WHICH WAS BASED IN PART UPON *HARRISON V MUNSON HEALTHCARE INC*?

Hospitals are required by MCL 333.21513(d) to establish peer review committees whose purposes are to reduce morbidity and mortality and ensure quality care. To encourage candid peer review assessments, the Legislature has shielded peer review activities from "intrusive public involvement and from litigation." *Harrison v Munson* (2014) citing *Feyz v Mercy Mem Hosp*, 475 Mich 663, 680; 719 NW2d 1 (2006). As part of that protection, records, data, and knowledge collected for and by peer review entities are not discoverable.

MCL 333.21515 states:
"The records, data, and knowledge collected for or by individuals or committees assigned a review function described in this article [Article 17] are confidential and shall be used only for the purposes in this article, shall not be public records, and shall not be available for court subpoena."

MCL 333.20175(8) similarly states:
"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 and shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena."

Incident reports are documents typically created contemporaneously with an accident or untoward event concerning a resident or patient. Whether it is called an "incident report' or "accident report" or "improvement report," the mere title of the document is largely irrelevant and the central focus is appropriately on how and why the document was created and for what purpose. Incident reports generally contain a factual description of an accident, including the date and time of the accident, whether it was witnessed and other basic facts pertaining to the actual accident.

Covenant contends that the facts written by Nurse Colvin in the "improvement report" are protected by the peer review privilege. As a general rule, statutory privileges should be narrowly construed. *Harrison* citing *People v Warren*, 462 Mich 415, 427; 615 NW2d 691 (2000) (marital privilege); *In re Brock*, 442 Mich 101, 119; 499 NW2d 752 (1993) (physician patient privilege). "Their construction should be no greater than necessary to promote the interests sought to be protected in the first place. *Harrison, Id.*

A. COVENANT HAS FAILED TO ESTABLISH THE "IMPROVEMENT REPORT" FALLS UNDER PEER REVIEW PRIVILEGE

Whether a document qualifies as privileged under the peer review statue depends on the circumstances surrounding its creation. The mere submission of information to a peer review committee does not satisfy the collection requirement so as to bring the information within the protection of the statute. *Monty v Warren Hosp Corp,*

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422 Mich 138, 146-47; 366 NW2d 198 (1985). Whether a particular document qualifies as privileged under the peer review statute depends on the circumstances surrounding its creation. Thus, when a litigant challenges a hospital's invocation of the peer review privilege, an in camera evidentiary hearing is required. *Harrison citing Monty, Id at* 144. In this case, the defense has asserted the peer review privilege applies to the incident report, now known to be titled "Improvement Report." (Gomez Dep, P27, Def-App's **Exhibit 4**). Plaintiff-Appellee challenged Covenant Healthcare's invocation of the peer review privilege in Plaintiff's Motion In Limine Regarding Production of Facts Contained in Incident Report filed on February 17, 2014. As such, the trial court appropriately conducted an in camera inspection of Covenant's "improvement report" on May 5, 2014.

To determine whether a record is privileged, "the court should consider the hospital's bylaws, internal rules and regulations and whether the committee's function is that of retrospective review for purposes of improvement and self-analysis and thereby protected, or part of current patient care." Citing *Gallagher v Detroit-Macomb Hosp Ass'n*,171 Mich App 761; 431 NW2d 90,94 (1988). However, the records must have been collected for or by the peer review committee. *Marchand v Henry Ford Hospital*, 398 Mich 163; 247 NW2d 280,282 (1976). In order to fall within the protections of peer review privilege, it is important that the documents at issue be generated and used for healthcare evaluative process by the peer review committee, not for purposes of risk management and assessing its liability in a potential lawsuit. In this case, Defendant-Appellant has failed to provide a single shred of evidence that this "improvement report" was generated for, or used by, any peer review committee. Nor has it been established that it was created for the purpose of assisting the hospital in monitoring its own activities to reduce accidents, injuries, morbidity or mortality at the hospital" as required by *Gallagher v Detroit-Macomb Hosp Ass'n*, 171 Mich App 761, 431 NW2d 90,94 (1988). As previously stated, despite Defendant-Appellant's assertions, neither Colvin,

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nor Gomez, testified that the report was generated for or used by any peer review committee. Instead, it has been determined that Nurse Colvin authored the factual portion herself. (Judge Borchard Opinion and Order, Def-App's **Exhibit 1**). The facts were not collected by management after interviewing employees that were present and the report is not a compilation of their findings. The facts were penned by Nurse Colin herself, not Pam Eimers, the manager that allegedly spoke to Gomez about the event. The facts were also written contemporaneously with the event. Judge Borchard noted that Nurse Colvin, who was present for the event, reported the "facts" of the event within 10 minutes of the occurrence. (Def-App's **Exhibit 1**). This would have been her first opportunity to actually put pen to paper since Nurse Colvin testified that she stayed on the floor with the patient while she sent Nurse Gengler to go get a backboard and cervical collar, those were applied, and then the patient was lifted to a cart. (Colvin Dep, P41,46, Def-App's **Exhibit 3**). In the last paragraph of his order, the trial court wrote:

> "Even assuming, for argument purposes, that the 'Improvement Report' is a peer review report..."

Following the trial court's in camera inspection, the trial court was clearly not of the opinion that the report was even a "peer review" report. Covenant has not provided any document or affidavit contending that this report was actually provided to any peer review committee or that the individual that obtained or reviewed this report was assigned any "review" function.

II. DID THE TRIAL COURT ERR IN FINDING THAT THE FACT PORTION OF COVENANT'S "IMPROVEMENT REPORT" WAS DISCOVERABLE AS IT WAS NOT SUBJECT TO PEER REVIEW PRIVILEGE AND REQUIRING DISCLOSURE OF THE FACT PORTION ONLY TO PLAINTIFF?

In determining whether facts should be disclosed as opposed to deliberation, conclusions or subsequent remedial measures, the discussion in *Centennial Healthcare Mgt Corp v Michigan Dep't of Consumer & Industry Services*, 254 Mich App 275; 657

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NW2d 746 (2002) is helpful. In discussing the scope of the peer review privilege, the Centennial Court wrote as follows:

> Certainly, in the abstract, the 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 that the direction of the peer review committee....It is not the existence of the facts of an incident or accident that must be kept confidential in order for the committee to effectuate its purpose; it is how the committee discusses, deliberates, evaluates and judges those facts that the privilege is designed to protect. *Id* at pp290, 291.

Sound public policy reasons that support the nondisclosure of protected internal investigation, then, is not so broad as to allow Defendants to ignore those facts and pretend that they do not exist.

In *Harrison v Munson Healthcare,* ____ Mich App ____; ____ NW2d ____ (2014), the Michigan Court of Appeals joined other states in drawing a distinction between factual and deliberative information in peer review materials, holding that factual material in peer review committee reports is discoverable, while deliberative information, including opinions, is not subject to disclosure. *Christy v Salem*, 841 A2d 937 (NJ Super Ct App Div 2004) (holding that the factual information contained in the peer review report could be disclosed because plaintiff's interest in obtaining factual information outweighed defendant's interest in keeping the information confidential. While the portions of the peer review report that evidenced the peer review committee's deliberative process, including opinions, were confidential and not subject to disclosure*); Atkins v Pottstown Medical Center*, 634 A2d 258 (Pa Super 1993) (peer

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review only protects records of the review committee and other records generated by the committee itself – protection does not extend to reports generated by others even if submitted to the committee for consideration); *Brown v Sun Healthcare Group, Inc*, 476 F Supp 2d 848 (E.D. Tenn 2007) (reports prepared in normal course of business relating to patient care are not protected merely because they have been provided to a peer review committee). The factual information contained in an incident report was discoverable because it concerned the problem of a single patient and generated because of a specific incident, rather than a general desire for discussion or improvement. *Davidson v Light*, 79 FRD 137, 140 (D Colorado, 1978).

In *Harrison, supra*, the Michigan Court of Appeals made 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. The internal conclusions of whether or not the hospital determined the incident to be a standard of care violation or cause for discipline are protected from discovery for sound policy reasons, but the policy reasons are "not so broad as to allow the defendant hospital to ignore those facts [contained in incident report] and pretend they do not exist." *Harrison* at 12.

The facts should be recorded in the patient's medical chart. MCL 333.20175(1) required the nursing staff to document Dorothy Krusac's fall in her medical chart.

> "A health facility or agency **shall** keep and maintain a record for each patient, including a **full and complete record** of tests and examinations performed, **observations made**, treatments provided..." (emphasis added). MCL 333.20175(1)

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Although Defendant-Appellant claims the event was documented in Dorothy Krusac's medical chart, there were only six words typed into the Procedure Log by Nurse Gengler: "Pt rolled off table to floor."

Deb Colvin, RN, the nurse responsible for Dorothy Krusac, wrote absolutely nothing in the patient's medical chart. There is no mention that the patient was caught and cradled to the floor. Those facts are not mentioned until years later. Instead, Nurse Colvin penned the facts of the event only in the "improvement report" which Defendant alleges are not discoverable under the peer review privilege. In *Harrison*, the Michigan Court of Appeals stated that the factual information contained in the incident report that the nurse elected to place on a risk management form rather than within the patient's medical records did not trigger the statutory privilege, and was thus discoverable. The court reasoned that the factual information concerns "a single patient" and was "generated because of specific incident or occurrence rather than a general desire for discussion or improvement." *Harrison citing Davidson v Light*, 79 FRD 137, 140 (D Colorado, 1978).

The peer review statutes extend the privilege to all facts collected for individuals or committees with a peer review function. The rationale for strong protection of peer review material is that:

> "[c]onfidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. To subject the discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations." *William Beaumont Hospital v Medtronic Inc*, No. 09-CV-11941, 2000 WL 2849546 (E. D Mich 8-31-09) citing *Attorney General v Bruce*, 422 Mich 157; 369 NW2d 826 (1985).

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This interpretation promotes the willingness of hospital staff to provide candid information to a peer review committee for assessment in peer review proceedings. *Dye v Detroit Osteopathic Hosp Corp*, 460 Mich 26, 42; 594 NW2d 455 (1999). Defendant-Appellant's argued "the whole purpose behind gathering that information, and people interviewing folks within the hospital setting, is so that they can candidly go about saying this is what I did, this is what I remembered..." (Transcript of arguments on 5/5/14, the day of in camera inspection, P12-13, Def-App's **Exhibit 10**). In this case, there was no candid discussion to protect. In this case, the facts in the improvement report were penned by Nurse Colvin herself. The facts were not written following a candid investigation with Nurse Colvin by a nursing or risk manager. In this case, Plaintiff-Appellee asserts that Nurse Colvin's objective facts that she personally penned within 10 minutes of the occurrence are not covered under the peer review privilege and are, therefore, discoverable.

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A. THE FACTUAL DISTINCTION OF THIS CASE FROM HARRISON V. MUNSON HEALTHCARE, INC SUPPORTS THE PRODUCTION OF THE FACTS CONTAINED IN THE "IMPROVEMENT REPORT"

Plaintiff-Appellee asserts that the Court of Appeals holding in *Harrison* is proper. This proper ruling allows plaintiffs to discover the "facts" regarding patient injuries; facts that should be contained in the patient's medical chart; facts that hospitals such as Covenant Medical Center are trying to withhold and hide under the guise of "peer review." The holding of *Harrison* pertaining to the discovery of the facts that are contained in incident reports that the medical staff has chosen to exclude from the patient's chart would be controlling in this matter. However, the case at bar also contains some distinguishable features from *Harrison* which Plaintiff-Appellee contends

render the factual portion of the improvement report discoverable, whether or not this Court affirms *Harrison*.

In *Harrison*, the patient suffered a burn on her arm during thyroid surgery. Munson insisted that no one in the operating room remembered the incident. At her trial deposition, Nurse Gilliand testified that if a patient suffered a burn in the operating, she would document that in the patient chart. She further testified that she had no memory of Harrison's surgery or being involved in an investigation of Harrison's burn. Without any memory of the cause of the burn, the defense claimed it was an accident. During the trial court's in camera inspection of the incident report, it was learned that Nurse Gilliand did participate in an investigation off how the burn occurred as she had authored an incident report. In fact, she penned the first page of an incident report 90 minutes after the incident, stating how the burn occurred; the Bovie was laid on the drape, in a fold, and Dr. Potthoff was leaning against the patient where the bovie was.

After Nurse Gilliand authored the incident report, the operating room manager conducted an investigation and questioned various individuals, and then wrote a conclusion in the report 15 days later. The conclusion also noted that the matter had been reviewed by an inservice. Ms. Harrison sought further information from Munson and was sent a letter advising her that her incident was confidentially reviewed and that a new system was put into place to prevent future burns.

In *Harrison*, the trial court declared a mistrial and sanctioned Munson Hospital and its counsel for unethical behavior of pursuing a defense at odds with facts known to Munson. The trial court noted that the facts, which were contained in the incident

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report, should have been documented in the patient's chart. If the defendant elects not to include those facts in the patient's chart, they should be precluded ethically from offering an explanation that is inconsistent with those facts. The Court of Appeals agreed that this behavior was unethical, but went further to distinguish between the facts collected in preparation of the incident report and what was done with such information. Plaintiff-Appellee agrees with the Court of Appeal's decision in *Harrison*, but notes an underlying distinction in the facts of this case and Harrison. In both *Harrison* and the present matter of Krusac, both nurse Gilliand and Nurse Deb Colvin failed to document the occurrence in the patient's medical chart and both, instead, documented the facts in a separate incident report. In both cases, the defense asserted that the separately prepared incident report, which was the key documentation of the patient's occurrence, was protected under peer review privilege. However, where nurse Gilliand in *Harrison* testified that she had no memory of the event, in the case at bar, Colvin, Gengler and Gomez all testified that they had a specific recollection of "catching" Ms. Krusac and "gently cradling" her to the floor, a recollection that is inconsistent with the medical records written in 2008. Moreover, there have been no affidavits presented, or statements made, that any peer review committed interviewed the witnesses present during the fall. In fact, Nurse Gengler has testified that no one ever questioned her or spoke to her about the occurrence following the event. (Gengler Dep, P24, Dep-App's **Exhibit 5**).. Nor has any documentation provided that Nurse Colvin's facts were ever submitted or reviewed by any committee or inservice.

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In *Harrison*, the Michigan Court of Appeals upheld a sanction of almost $54,000 imposed against Munson Hospital and defense counsel for instituting a defense that was inconsistent with facts contained in the incident report. The Court of Appeals further held that such behavior violated the rules of professional conduct. MRPC 3.3(a)(3) which prohibits an attorney from offering evidence that the attorney knows to be false, MRPC 3.3(a)(1), which disallows false statements of material fact made to a tribunal, and MRPC 3.1, which prohibits an attorney from defending a proceeding or controverting an issue unless there is a basis for doing so that is not frivolous. In affirming the trial court's award of sanctions for the despicable conduct, the Michigan Court of Appeals in *Harrison* went one step further and affirmatively stated that the factual information contained in the incident report that the nurse elected to place on a risk management form rather than within the patient's medical records did not trigger the statutory privilege, and was thus discoverable. The court reasoned that the factual information concerns "a single patient" and was "generated because of specific incident or occurrence rather than a general desire for discussion or improvement." *Harrison citing Davidson v Light*, 79 FRD 137, 140 (D Colorado, 1978). *In Harrison*, the Michigan Court of Appeals stated that to "hold otherwise would grant risk managers the power to unilaterally insulate from discovery firsthand observations that the risk manager would prefer remain concealed. The peer review statutes do not sweep so broadly." Moreover, the Court of Appeals located "no law from any jurisdiction suggesting that a hospital may ethically present a medical malpractice defense directly conflicting with the hospital's knowledge of how an

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event occurred." *Id.* Plaintiff-Appellee asserts that this is exactly what Covenant Medical Center and the defense are doing here.

B. PERJURY FALLS WITH EXCEPTIONAL NECESSITY EXCEPTION TO PEER REVIEW PRIVILEGE

Upon showing of exceptional necessity, discussions and deliberation to the discovery process may be discoverable. *Attorney General v Bruce*, 422 Mich 157; 369 NW2d 826 (1985). Although Plaintiff-Appellee maintains that the facts contained in Covenant's improvement report do not fall with peer review privilege, assuming arguendo that Covenant provides support that the privilege applies, Plaintiff-Appellee asserts that exceptional necessity allows for the discoverability of the facts contained in Covenant's "improvement report" as an exception from the peer review privilege. In *Howe v Detroit Free Press*, 440 Mich 203, 487 NW2d 374 (1992), the plaintiff brought a defamation suit against the newspaper. In defending their report of truthful information, the newspaper sought to release information contained in a probation report, which was "privileged and confidential communication" under MCL 791.229. However, truth is a defense in a case for defamation. However, the court held that the family could not hide "the truth" simply by claiming it was privileged. To prevent the use of the statutory privilege as a shield to preclude evidence of truth, this Court instituted a narrow interpretation of the privilege and held that the probation report was the proper subject of discovery indicating that there was "no rational reason to believe that the Legislature intended that the statute be used as an offensive weapon to block access to information relevant and vital to the just determination of issued in an unrelated civil case. *Id.* In the case at bar, Covenant should not be allowed to hide the truth about Dorothy Krusac's fall off the procedure table in the

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catheterization lab by claiming the truth is privileged. It is unethical for Covenant to hide the truth in an allegedly "privileged" report and then institute a defense to professional negligence in contradiction with those facts.

Moreover, in *Feyz v Mercy Memorial Hospital*, 475 Mich 663; 719 NW2d 1 (2006), this court held that the purposed of the statutory peer review immunity is to foster the free exchange of information in investigations of hospital practices and practitioners, and thereby reduce patient mortality and improve patient care within hospitals. To protect the participants in this process, the Legislature prohibited the discovery of communications made within the peer review process and granted immunity from liability to all who participate in peer review without "malice." *Id* at 665. Malice can be established when a "person supplying information or data [to a peer review entity] does so with knowledge of its falsity or with reckless disregard of its truth or falsity. Similarly a review entity is not immune from liability if it acts with knowledge of the falsity, or with reckless disregard of the truth or falsity, of information or data which it communicates or upon which it acts." *Id.* In the case, Plaintiff-Appellee does not allege that the information in the "improvement report" is knowingly false. Conservely, Plaintiff-Appellee contends that the report contains the truth and that Covenant is acting with malice rendering testimony that is false and pursuing a defense in this case based upon known falsities and with a reckless disregard for the truth. As such, Covenant's malicious actions carve out an exception to the peer review protection.

Plaintiff-Appellee is not attempting to "effectively eviscerate the peer review privilege" as alleged by Defendant-Appellant. (App, P13). Plaintiff-Appellee supports

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and respects the protection of the actual peer review process and supports this system for improving patient care and pursuing efforts to reduced morbidity and mortality in our hospitals. What the defense bar is ignoring is neglecting to mention is the abuse the peer review privilege has afforded the health care industry. In the wake of broad interpretation of the peer review privilege, medical providers have conveniently omitted the facts regarding patient falls, accidents, occurrences, and the like from the patient's medical chart and only documented the facts in incidents reports, claiming they are undiscoverable because they are privileged. Victims of medical negligence are left without explanation of what happened to themselves or their loved ones, and in many cases, without recourse. The inherent abuse is clear when faced with the scenario, as in the case at bar, that the medical providers failed to document the facts in the patient's medical chart, but penned the facts only in an "improvement report."

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CONCLUSION AND RELIEF REQUESTED

For all the of the foregoing reasons, Plaintiff-Appellee Estate of Dorothy Krusac respectfully requests that this Honorable Court AFFIRM the trial court's May 8, 2014 Opinion and Order Re: Discovery compelling the discovery of only the facts contained in the "improvement report" which were written by a fact witness contemporaneously with the event that were withheld from the patient's chart and thereby affirm the Court of Appeals' holding in *Harrison v Munson Healthcare, Inc.* which places boundaries on Michigan's peer review privilege. See MCL 333.20175(8) and MCL 333.21515.

Respectfully submitted,

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By:_____

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Dated: June 2, 2014

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