IN THE COURT OF APPEALS OF IOWA

No. 0-793 / 10-0264
Filed December 22, 2010

JANEL ORGAVANYI, Individually and As Next Best Friend of Dorotea Orgavanyi and Gabor Orgavanyi,
Plaintiffs-Appellees,

vs.

HENRY COUNTY HEALTH CENTER,
Defendant-Appellant.

Appeal from the Iowa District Court for Henry County, Cynthia H. Danielson, Judge.

The defendant hospital appeals a discovery order granting the plaintiffs' motion to compel production of a "patient safety report." **AFFIRMED.**

James E. Shipman, Christine L. Conover, and Kerry A. Finley of Simmons, Perrine, Moyer, Bergman, P.L.C., Cedar Rapids, and Constance Alt of Shuttleworth & Ingersoll, P.L.C., Cedar Rapids, for appellant.

J. Russell Hixson and Terrence D. Brown of Hixson & Brown, P.C., Clive, for appellees.

Heard by Mansfield, P.J., and Danilson and Tabor, JJ.

MANSFIELD, P.J.

This appeal presents the question whether a nurse's incident report to a hospital risk manager is covered by Iowa's statutory peer review privilege. *See* Iowa Code § 147.135 (2007). Because we conclude that it is not, at least where the evidence does not establish the report is in the hands of a peer review committee or an employee thereof, we affirm the decision below.

I. Factual and Procedural Background.

On the evening of December 10, 2007, while Iowa was experiencing severe winter weather, Janel Orgavanyi appeared at the emergency room of Henry County Health Center (the Hospital). She was twenty-six weeks pregnant. She had complaints of pain and bleeding. During the night Janel was attended by Nurse Darla Fisher, who communicated by phone with Dr. Kent Metcalf. A fetal heart monitor was attached. Dr. Metcalf ordered an ultrasound for the morning, and told Nurse Fisher not to do a vaginal exam until then. At approximately 11:30 p.m., Janel voided blood and two quarter-sized pieces of tissue. Dr. Metcalf contends he was not informed of these findings. During the early morning hours of December 11, Janel continued to have pain and cramping, but according to the Hospital, no contractions. Contact was again made with Dr. Metcalf. Dr. Metcalf ordered that Janel be given pain medications. Around 6:00 a.m., Nurse Fisher responded to a call from Janel and noticed she had discharged a large amount of blood and amniotic fluid. Dr. Metcalf was called to the Hospital. Before he arrived, Janel spontaneously delivered her baby, Dorotea. Efforts were made to resuscitate the baby. Because of the

weather, neonatologists from the University of Iowa Hospitals did not arrive until after 9:00 a.m. Dorotea now suffers from serious and permanent brain injuries.

Sometime after the events of December 10-11, Nurse Fisher completed a "patient safety form." This is a form for staff to report an incident. Three boxes allow the employee to indicate whether he or she is reporting "a medical accident," "a good catch/close call/near miss," or "a hazardous situation or an 'accident waiting to happen.'" There are places on the form for the staff member to identify the patient involved, describe the incident, explain why it happened, and state how it could be avoided in the future.

On September 8, 2008, this medical malpractice action was commenced against the Hospital and Dr. Metcalf. Plaintiffs allege the defendants were negligent in, among other things, failing to perform a vaginal exam or an ultrasound on Janel immediately upon her arrival, failing to diagnose her contractions, failing to administer medication to stop her preterm labor, and failing to transfer her to an obstetrical unit with available neonatal resuscitation before delivery.

In the course of discovery, the Hospital revealed that Nurse Fisher had prepared a "patient safety report." It claimed the report itself was privileged under Iowa Code section 147.135, but provided a sample of the form. On June 19, 2009, plaintiffs filed a motion to compel production of the report. In resistance to the motion, the Hospital submitted an affidavit of Carol A. Adamson, its risk management coordinator. The affidavit states:

> Henry County Health Center is in possession of a 'Patient Safety Report' authored by Darla Fisher, R.N. Henry County

> Health Center has a formalized risk management plan and peer review system.
>
> At the time Ms. Fisher authored her report, patient safety reports were submitted directly to the Quality/Risk Management Department, who, in turn, submitted analysis of the report to the Performance Improvement Committee of the Board of Trustees and the Medical Staff Quality Improvement Committee.
>
> Paragraph 11.4 of the Medical Staff Bylaws explains the purpose of the Medical Staff Quality Improvement Committee and provides that all functions of the committee are confidential, peer-review functions as described in Article 13 of the Bylaws. Copies of Paragraph 11.4 and Article 13 from the Medical Staff Bylaws in effect at the time of Ms. Orgavanyi's admission to Henry County Health Center are attached to this affidavit.
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> Consequently, Ms. Fisher's 'Patient Safety Report' is deemed part of Henry County Health Center's formal peer review process.

Plaintiffs withdrew their motion and took Adamson's deposition. In her deposition, Adamson testified that she is the risk management coordinator for the Hospital. She is the "point person, so to speak, to receive patient safety reports, otherwise known as incident reports, as well as patient complaints." She maintains a file in risk management where all patient safety forms are kept. Fisher's completed form was in that file. Adamson clarified, however, that she was not the risk manager at the time Fisher submitted her "patient safety report."

When plaintiffs' counsel asked if Fisher's actual report was actually forwarded to either of the committees referenced in her affidavit (the Hospital's performance improvement committee or medical staff quality improvement committee), the Hospital's counsel objected and instructed her not to answer. The Hospital's counsel also directed Adamson not to reveal whether an analysis of the report had been provided to either committee. Adamson denied that she was an actual member of those committees.

Plaintiffs then refiled their motion to compel. A hearing on the renewed motion was held December 7, 2009. The district court granted the motion, ruling as follows:

> Based upon the evidence and argument presented, it is difficult to classify this incident report form as "relating to license discipline or professional competence." It does not necessarily relate to professional competence; rather, it can merely give a heads-up about an accident or close call, such as the example given by Adamson. Even if it does qualify, there is a question of possession. In this case there is no evidence that the Fisher report was actually provided to the peer review committee.
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> The burden is on HCHC to show the privilege. Defense counsel prevented Adamson from answering questions about the Fisher document. Her affidavit indicated that in general such reports would go to the peer review committees, but she stated in her deposition she generally forwards them to Ann Corrigan and the department heads. It is impossible to determine who looked at the Fisher report, only that it is now stored in the risk management office. The question becomes whether risk management is considered an "employee" or "serves" the peer review committees. If so, the document could be privileged as "in the possession of . . . an employee of a peer review committee." The evidence provided in support of HCHC's position simply does not explain what relation the committees have to the risk management office or what capacity the risk management office serves such committees in regard to incident reports. Absent such a showing Defendant HCHC has failed to meet its burden of proof on its assertion of privilege.

The Hospital applied for interlocutory appeal. The supreme court granted the application and transferred the appeal to our court.

II. Standard of Review.

We review a district court's ruling on a motion to compel discovery for an abuse of discretion. *Keefe v. Bernard*, 774 N.W.2d 663, 667 (Iowa 2009). We afford the district court wide latitude, and will reverse only when the court's discretion is exercised on grounds or for such reasons clearly untenable or to an extent clearly unreasonable. *Hutchinson v. Smith Labs., Inc.*, 392 N.W.2d 139,

141 (Iowa 1986). A ruling based on an erroneous interpretation of a discovery rule can constitute an abuse of discretion. *Keefe*, 774 N.W.2d at 667.

III. Analysis.

Iowa Code section 147.135(2) provides:

> As used in this subsection, "peer review records" means all complaint files, investigation files, reports, and other investigative information relating to licensee discipline or professional competence in the possession of a peer review committee or an employee of a peer review committee. As used in this subsection, "peer review committee" does not include licensing boards. Peer review records are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release to a person other than an affected licensee or a peer review committee, and are not admissible in evidence in a judicial or administrative proceeding other than a proceeding involving licensee discipline or a proceeding brought by a licensee who is the subject of a peer review record and whose competence is at issue.

In short, for Nurse Fisher's "patient safety report" not to be discoverable, it must be (1) a "complaint file[], investigation file[], report[], and other investigative information," (2) "relating to licensee discipline or professional competence," (3) "in the possession of a peer review committee or an employee of a peer review committee." The district court found the second requirement may not have been met, in that the report "does not necessarily relate to professional competence . . . ." It also found the third requirement clearly had not been met, because there was "no evidence that the Fisher report was actually provided to the peer review committee."

The supreme court has stated that the privilege conferred by section 147.135 is "broad," *Carolan v. Hill*, 553 N.W.2d 882, 886 (Iowa 1996), but in the same case reaffirmed that "[w]hen an asserted privilege is based on a statute, the terms of the statute define the reach of the privilege." *Id*. Thus, we need to

decide whether the "patient safety report" in question meets the three criteria of subsection 147.135(2).

On our review of the matter, we agree with the district court that the Hospital failed to establish the third element of the statutory privilege. The record does not demonstrate that the Fisher report was "in the possession of a peer review committee or an employee of a peer review committee." Adamson's affidavit says only that an "analysis" of the report would have been provided by the risk management department to the performance improvement committee and the medical staff quality improvement committee. Moreover, when plaintiffs asked Adamson in deposition whether the report itself or an analysis thereof had been provided to the committee, she was instructed not to answer. We believe these instructions were improper. *Zander v. Craig Hosp*., __ F.Supp.2d __, 2010 WL 4025341 (D. Colo. 2010) (characterizing as improper instructions not to answer foundational questions that might bear upon the existence or nonexistence of a peer review privilege). Regardless, having told its own witness not to answer, the Hospital is not well situated to argue we should infer the answer would have been favorable to its position.[1]

From reading the form itself, the affidavits, and the deposition testimony, we think it logical to conclude that Nurse Fisher's report was not part of a peer review process, but part of the Hospital's regular risk management system. In an appropriate case, a peer review might have been initiated following such a report,

[1] At the hearing on the motion to compel, the Hospital's counsel did make a representation "that the analysis was provided and the report was provided in this peer review process, and it was reviewed." The district court's ruling, quoted above, does not mention this representation. We believe the district court properly resolved the motion based on the written record that was before it.

but that does not make the report itself subject to the peer review privilege. Thus, a number of other jurisdictions have found these kinds of incident reports not to be subject to their own states' peer review privileges. *See Powell v. Cmty. Health Sys., Inc*. 312 S.W.3d 496, 509 (Tenn. 2010) ("regularly prepared complaints and incident reports are not privileged even though they might precipitate a peer review proceeding"); *Chicago Trust Co. v. Cook County Hosp.,* 698 N.E.2d 641, 647-49 (Ill. App. Ct. 1998) ("If, however, a document was created in the ordinary course of the hospital's medical business, or for the purpose of rendering legal opinions, or to weigh potential liability risk, or for later corrective action by the hospital staff, it should not be privileged, even though it later was used by a committee in the peer-review process."); *John C. Lincoln Hosp. & Health Ctr. v. Superior Court for Ariz.,* 768 P.2d 188, 191 (Ariz. Ct. App. 1989) ("The record indicates that Incident Reports are issued by hospital personnel in the regular course of providing medical care. These reports are intended for use whenever there is an unusual occurrence of any kind in the day-to-day administration of the hospital. Thus they are very broad in nature and cover situations as diverse as an electrical failure, a patient's loss of personal articles, and an incorrect type of anesthesia. Though Incident Reports sometimes precipitate peer review, they do not always do so, and they are not made solely for that purpose."). *Cf. Ussery v. Children's Healthcare of Atlanta, Inc.,* 656 S.E.2d 882, 894 (Ga. Ct. App. 2008) (finding that incident reports were privileged where "the forms on their face indicate that their purpose was for 'Quality Improvement Review' as well as 'Peer Review'"). We believe the same result

follows under Iowa law, as to any copy of the report not in the possession of a peer review committee or an employee thereof. *See* Iowa Code § 147.135(2).

The Hospital argues that it is a "Level I, county hospital" and does not "need or have layers and layers of bureaucracy." We agree. Employees can wear more than one hat. But in this case, the record shows only that a risk manager has custody of an incident report. That is not peer review activity in and of itself. Adamson is not a peer of Nurse Fisher or Dr. Metcalf. Loss prevention, while certainly laudable, is not the same as peer review and a loss prevention report, under Iowa law, cannot be deemed privileged unless at a minimum it is in the hands of a peer review committee. *See Day v. Finley Hosp.*, 769 N.W.2d 898, 901 (Iowa Ct. App. 2009) (holding that section 147.135 protects certain information in the possession of a peer review committee whether generated by the peer review committee or not).

Finally, the Hospital argues that "[t]he genie cannot be put back in the bottle" and if there is a question whether the "patient safety report" met the parameters of the statutory peer review privilege, we should remand for an *in camera* review of the report by the district court. But it was the Hospital's burden below to establish the elements of the privilege. *Hutchinson*, 392 N.W.2d at 141 ("One resisting discovery through assertion of a privilege has the burden of showing that a privilege exists and applies."). If it believed an *in camera* review would have been helpful, it should have offered that to the district court. Our normal practice on appeal is not to give a litigant a second opportunity to meet its burden of proof, after we find it failed to do so the first time. We also do not agree with the closing statement in the Hospital's reply brief that "[t]he chilling

effect of an order making such critical analyses public simply cannot be overstated." In the first place, we are not making the report "public." We are simply affirming the district court's order that it be made available to the Janel, her attorneys, and her experts. Second, as we read the form, the individual making the report has the option of remaining anonymous. Thus, the form itself accounts for the possibility that some individuals may be deterred from making a report, and provides the remedy of anonymity. Lastly, we are only finding the report discoverable; we are not ruling on trial admissibility.

AFFIRMED.