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Professional Liability Update

Superior Court Clarifies Required Processes and Procedures for Healthcare Institutions to Preserve Privilege for Investigations Pursuant to MCARE Act

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INTRODUCTION

Under Pennsylvania's MCARE Act, 40 P.S. § 1303.501, *et seq*., (hereinafter "The Act"), internal investigations and peer review conducted by a hospital's patient safety committee is privileged and protected from discovery. Importantly, this encourages and allows healthcare providers to submit feedback openly and honestly after serious events in order to improve overall patient care.

Under Section 311(a) of the Act, documents "*solely* prepared or created for the purpose of compliance with" the Act "which *arise out of* matters reviewed by the patient safety committee . . . are confidential and shall not be discoverable." However, under Section 311(c), these confidentiality safeguards are only applicable to those documents "created pursuant to the responsibility of the patient safety committee or governing board."

Recently, the boundaries of Section 311(a) were examined by the Pennsylvania Superior Court in *Wakeem Ford-Bey v. Professional Anesthesia Services, et al.*, No. 162-EDA 2022 (Pa. Super. September 12, 2023) to determine whether information gathered in accordance with an internal hospital policy "arise[s] out of" the hospital's duties under the Act, such that the information is privileged pursuant to Section 311(a).

WAKEEM FORD BEY V. PROFESSIONAL ANESTHESIA SERVICES, ET AL.

Relevant Facts/Procedural History

In June 2015, Wanetta Ford Bey ("Decedent") underwent wrist surgery at Physician's Surgical Hospital ("Hospital") and shortly thereafter suffered respiratory failure resulting in her death in July 2015. Wakeem Ford-Bey, Administrator of Decedent's estate, filed an action against Hospital and other defendants in February 2017 alleging medical malpractice.

During discovery, a dispute arose regarding whether documents related to a root cause analysis ("RCA") completed by a hospital administrator were discoverable. During the course of the RCA, the administrator conducted interviews of Hospital staff. The hospital administrator's interviews consisted of standard questions about Decedent's surgery and care based upon a standard form. Under Hospital's Sentinel Event Policy, which established the procedures for reporting an "[u]nexpected adverse occurrence involving death . . . or the risk thereof," an RCA is initiated to determine the "basic, causative factor(s) that led to the event," and it assists in determining if an intensive assessment, improvement plan, or administrative teams need to review the events and implement corrective action.

Before the trial court, Hospital argued because the RCA was a part of this Sentinel Event Policy, the form "arose out of" Hospital's obligations under the Act, and thus should be privileged information. Hospital argued that the

RCA was privileged regardless of whether a patient safety committee or governing board reviewed the documents generated as part of the RCA.

Notably, the Hospital did not have a specifically designated "patient safety committee", as mandated by the Act and was unable to clarify if the hospital administrator was the Hospital's patient safety officer because she held several different titles1. Relying on Venosh v. Henzes, 31 Pa. D. & C. 5th 411, 2013 WL 9593953 (Lackawanna Cty. 2013), aff'd, 105 A.3d 788 (Pa. Super. 2014), the trial court rejected Hospital's argument that documents arising out of the RCA were privileged for two main reasons: (1) the Sentinel Event Policy was "clearly not an implementation of the investigation or reporting requirements" of the Act; and (2) Hospital did not establish its patient safety committee or governing board "in fact" reviewed the RCA.

Appeal to the Superior Court

On September 12, 2023, the Superior Court upheld the trial court's finding that documents related to the RCA were discoverable and not subject to privilege.

Initially, the Superior Court explained that the Act mandates that a medical facility, such as Hospital, develop and implement a "patient safety plan" that designates a facility's "patient safety officer," establishes a "patient safety committee," and identifies internal systems for employees to report serious events.

Stemming therefrom, the Act requires that the patient safety committee engage in a variety of practices including receiving and reviewing documents created in accordance with the patient safety plan. *See* Section 1303.310(b). In exchange for following the requirements related to patient safety as articulated by the pertinent sections of the Act, a hospital is afforded protections under the Act which insulates those documents, **"solely"** prepared for this purpose, from discovery.

Here, the Superior Court highlighted that the Sentinel Event Policy emanated from a Kansas corporation, and Hospital adduced no clear evidence that the Policy implemented any of the special requirements articulated in the MCARE Act. Moreover, evidence proffered by Hospital only indicated that the hospital administrator was "possibly" Hospital's designated MCARE patient safety officer.

In reaching its conclusion based primarily on the facts specific to this case, the Court ultimately held that absent evidence that Hospital created MCARE-required patient safety committees and followed other required procedures, Hospital could not demonstrate that hospital administrator "solely" prepared the RCA in question to comply with Hospital's duties under the Act. Accordingly, the Superior Court affirmed the trial court order and denied as moot the Hospital's petition for allowance of appeal.

Implications and Recommendations

While the impact of this decision may be constrained by the specific facts of this case, the *Ford-Bey* decision should serve as a reminder to healthcare institutions within Pennsylvania to ensure that they have MCARE-compliant policies and procedures which strictly follow the mandates of the MCARE Act. The Superior Court has demonstrated here that a failure to ensure that hospital processes firmly align with MCARE's statutory guidelines and requirements regarding patient safety mandates will jeopardize the healthcare institution's ability to benefit from the protections outlined in the statute.

[1] This array of titles included "possibl[e]" patient safety officer, director of quality and accreditation, "performance improvement department", and senior clinical nurse.

It is recommended that hospitals and medical facilities examine their policies and procedures to confirm adherence to the requirements set forth in Sections 310 and 311 of The Act. As this decision illustrates, the important protections regarding investigations into adverse outcomes and medical incidents under MCARE may not apply if the MCARE Act is not followed. Thus, the documentation related to investigation of an adverse event may be discoverable if a hospital's policies and/or processes do not align with the specific requirements set forth in The Act as to implementation of investigations or reporting requirements of the Act, investigation of an event was not initiated or conducted by the hospital's patient safety officer or committee, and any investigation was not reviewed by the patient safety committee or governing board.

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