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Pennsylvania Court Sets Out New Work Product Privilege Considerations for Medical Providers' PSQIA Information

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In the period following an adverse patient event, a hospital is likely to find itself facing two competing tensions—on the one hand, the desire to conduct a comprehensive analysis to determine the event's cause and how best to avoid a similar outcome going forward, while on the other the need to gird itself against any possible litigation that may be forthcoming. As a recent decision by the Pennsylvania Superior Court demonstrates, hospitals seeking to balance these tensions with respect to information submitted to Patient Safety Organizations (PSOs) pursuant to the federal Patient Safety and Quality Improvement Act (PSQIA) must ensure not only that the content of their analyses and reporting is covered by the PSQIA's statutory privilege, but also that they conduct themselves in such a way to maintain the privilege.

I. Statutory Background

The PSQIA provides a mechanism for medical providers, including hospitals, to report patient safety information to PSOs, who in turn aggregate and facilitate the analysis of such information in order to improve patient outcomes. No doubt anticipating that providers may be reluctant to submit such information to a PSO if it could then be subject to discovery in litigation, Congress included language within the PSQIA establishing a work product privilege for so-called "patient safety work product," with such privilege codified at 42 U.S.C. § 299b-23. As relates to information generated by medical providers, the PSQIA defines patient safety work product as:

> [A]ny data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements— (i) which— (I) are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety

> organization . . . and which could result in improved patient safety, health care quality, or health care outcomes; or (ii) which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

42 U.S.C. § 299b-21 (7) (A). This same section of the PSQIA specifically excludes a patient's medical records, billing, and discharge information, and other original patient or provider records from being considered patient safety work product. *See* 42 U.S.C. § 299b-21 (7) (B).

II. Recent Decision – *Ungurian v. Beyzman*

Against that statutory backdrop, the Pennsylvania Superior Court's recent decision in *Ungurian v. Beyzman* adds another layer of consideration for medical providers seeking to qualify information or analyses as patient safety work product. In *Ungurian*, a patient's mother sued various entities, including the patient's hospital, alleging that the defendants' negligence in the course of a medical procedure had rendered her son totally and permanently incapacitated. As would be expected, the plaintiff submitted requests for production of documents as well as interrogatories to the defendants. The hospital, in turn, asserted that certain documents, including an event report and a root cause analysis, were privileged under the PSQIA as well as a related privilege pertaining to the peer review process. As such, the hospital duly submitted a privilege log for these and other documents.

The plaintiff's attempts to discover the event report and the root cause analysis did not end there. Rather, the parties proceeded to engage in motion practice over the discoverability of these and the other privileged documents. The plaintiff asserted in her motion to compel that the hospital had failed to establish properly that either privilege applied and that these documents were thus subject to discovery. In response, the hospital submitted an affidavit from its director of patient safety services stating, among other things, that the event report had been completed in accordance with the hospital's "Event Reporting Policy," was prepared "for the express purpose of improving patient safety," and was maintained within a system designated for reporting information to the hospital's PSO. With respect to the root cause analysis, the director stated that it was 1) maintained within a system specifically meant for reporting information to the hospital's PSO, and 2) that the hospital had, in fact, provided the root cause analysis to the PSO.

The Superior Court rejected the hospital's privilege claims as to both the event report and the root cause analysis. In finding that neither document qualified as patient safety work product under the PSQIA, the Superior Court conducted a statutory analysis of the relevant portions of the PSQIA and credited the trial court's interpretation of these statutes in finding that the hospital had failed to meet its burden of demonstrating privilege. With respect to the event report, the Superior Court agreed that it was insufficient for the hospital merely to state that it had prepared the event report for patient safety purposes and stored it in a PSO-related system. Rather, for the privilege to apply,

the hospital would have had to *actually* transmit the event report to its PSO. For the root cause analysis, meanwhile, the Superior Court agreed with the trial court's conclusion that the failure of the director to assert in her affidavit that the root cause analysis was "developed for the purpose of reporting to the PSO," as well as the hospital's admission that the information found in the root cause analysis was not maintained exclusively in the hospital's PSO reporting system, negated the privilege.

III. Key Takeaways

Ungurian provides an important lesson for hospitals and other medical providers preparing information for PSOs: even if the *subject matter* of the information would qualify as privileged under the PSQIA, a provider's *conduct* in collecting and managing the information is equally important to invoking the privilege. As such, three best practice lessons emerge for providers:

1. Ensure that any information collected or prepared for purposes of PSO submission is actually submitted to the PSO, preferably in a timely manner, following an adverse patient event.
2. Ensure that such information or analyses are developed for the purpose of reporting to the PSO, and that hospital employees tasked with administering such reporting can and do truthfully state the same in any affidavits or testimony.
3. Ensure that such information or analyses are maintained only within a designated system intended for PSO reporting.

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