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VIA EMAIL

To the Rules Committee of the Superior Court:

Thank you for providing the Connecticut Defense Lawyers Association ("CDLA") with this opportunity to comment on a proposal for standardized written discovery in medical malpractice cases. We circulated the drafts to all CDLA members, and also received comments directly from in-house counsel and risk managers at several hospital systems. This letter attempts to summarize the voluminous feedback we received from both counsel and the health care providers that will ultimately be subject to these requests.

At the outset, the CDLA would like to thank the members of the subcommittee that worked diligently on these drafts for many months. We understand that the subcommittee invested significant time discussing and considering these drafts, and the CDLA greatly appreciates those efforts.

Overall, the CDLA agrees with the approach of having certain standard interrogatories and requests for production, and the ability to supplement with an additional 20 interrogatories and 20 requests for production in specific cases. Medical malpractice cases can vary greatly in the medical and legal issues presented, so the ability to supplement with additional discovery requests is critical to ensuring full and fair disclosure.

With regard to the draft standard discovery directed to hospitals and individual health care providers, the CDLA received comments that focused on three general areas.

First, Interrogatory #17 in the draft discovery directed to hospitals, which provides:

> (17) With respect to the negligence alleged in the Complaint, state whether you had any written or unwritten protocols, manuals, directives, instructions and/or guidelines related to the specific allegations of negligence in the Complaint that were in effect at the office, hospital, or other medical facility where the defendant physician or health care provider practiced at the time of the negligence alleged in the Complaint concerning:

(a) Care, treatment, monitoring, evaluation, diagnosis, consultation or referral to others, or the type(s) thereof, at the time of the event(s) that is(are) the subject of this litigation;

(b) Training requirements and/or protocols for any physician or health care provider, including but not limited to medical staff, caring for, evaluating, diagnosing, consulting or referring patients either in the facility, department or unit where the care, treatment, evaluation, diagnosis, consultation or referral to others at issue took place; and

(c) Reporting and/or investigation of adverse events at the facility, department or unit where the care, treatment, evaluation, diagnosis, consultation or referral to others at issue took place.

The feedback on this proposed interrogatory included concern that the request is very broadly worded and somewhat vague, which will make it very difficult to ensure compliance. The allegations of negligence in a medical malpractice complaint are often very broad and non-specific, and usually include a catch-all allegation of the "failure to appropriately and properly care for or treat" the patient. The exact allegations of negligence may not be apparent until well into the discovery process, perhaps even after the disclosure and deposition of expert witnesses. At the early written discovery stage of a case, it will be difficult if not impossible for defense counsel to answer this question completely and accurately, without further guidance and discussion with plaintiff's counsel to identify what exactly is being requested. In most hospital systems, there is not a single repository of written and unwritten policies and protocols; responding to this single interrogatory may require interviewing multiple people in multiple different departments. This is especially true in the most complicated medical malpractice cases, which implicate several different medical specialties. For example, in a case alleging negligence during the delivery of an infant who then spends time in a neonatal intensive care unit (NICU), does this question seek policies and procedures related to labor and delivery, neonatal care, or both? Within the NICU, the infant may receive consultations from cardiology, infectious disease, neurology, and many other specialties. The list of responsive policies and protocols could be very lengthy. The inability to object to this request makes the Interrogatory particularly concerning. Defense counsel expressed concern that a failure to identify all of the potentially relevant policies and protocols on a whole host of different subjects in the very early stages of a case might later be used to preclude the admission of relevant policies and procedures at trial.

For that reason, the CDLA proposes that a request for relevant policies and procedures is not amenable to a standard interrogatory. Instead, this request should be deleted from the standard draft, and left for a supplemental request that can be more targeted and specific to the issues in each individual case. The proposed amendment to Practice Book § 13-14 permits 20 supplemental interrogatories and 20 supplemental requests for production; a request for policies and protocols is best suited to be within those supplemental requests, so that the request can more clearly identify the relevant subject matter requested. Counsel can then discuss and negotiate the request for policies, consistent with the current practice.

In the alternative, if a request for policies or protocols remains in the standard discovery set, the CDLA recommends the following alternative language:

> (17) State whether, at the time of the negligence alleged in the Complaint, you had any protocols, manuals, directives, instructions, guidelines, training requirements and/or guidelines directly related to the specific allegations of negligence in the Complaint (as articulated in the healthcare provider's report which forms the basis of the good faith certificate attached to the complaint) that were in effect at the office, hospital, or other medical facility where the defendant physician or health care provider practiced.

This proposed language identifies more clearly what is being requested, using the good faith certificate required by General Statutes § 52-190a as a guide. Additional requests for documents can be left to supplemental requests, so that defense counsel may object to an overly broad request and/or communicate with plaintiff's counsel to ascertain what exactly is being requested and why (i.e., how is it likely to lead to the discovery of admissible evidence).

Second, Request for Production #1 in the discovery directed to hospitals and Request for Production #2 in the discovery directed to health care providers are identical,[1] and provide in relevant part:

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[1] As a housekeeping matter, it would be helpful if the numbering of identical requests were identical (i.e., if this request were #1 for both hospitals and health care providers). A simple reshuffling of the order of requests would make this possible.

All nonprivileged documents that you know of, possess, or have power to obtain, not subject to attorney-client or statutory privilege, concerning the Plaintiff's care, scheduling, appointments, treatment, evaluations, diagnosis, consultation or referral to others, including but not limited to:

(a) All documents typically maintained as part of a patient's designated health record;
(b) Office management records including jackets, file covers, face sheets, transmittal documents for any requests for studies or consultations, and/or transportation records;
(c) Nursing notes;
(d) Hospital records;
(e) Laboratory records;
(f) Testing records;
(g) Radiology requisitions, reports, images/studies (lossless images), and audio recordings of radiology reviews;
(h) Notes, sticky notes or written markings;
(i) Pharmacy medication records;
(j) Automated medication dispensing system records;
(k) Any images/photographs taken during treatment or pathological examination;
(l) Pathology reports;
(m) Drafts and/or audio recordings of pathology reports;
(n) Quality improvement documents related to root cause analysis that are not part of the peer review process
(o) Documents provided in connection with a peer review, other than those prepared as part of the peer review process;
(p) Intra-department transportation records;
(q) Laboratory test results;
(r) Documents and communications concerning the subject matter of the Complaint; and
(s) Investigations or reports concerning the Plaintiff and the allegations in the Complaint.

The CDLA received comments from its members as well as several hospital systems, expressing concern that this request is very broad, ambiguous and unduly burdensome. The listed documents may be housed in different departments or databases within a hospital. Several of the requests are unclear and subject to interpretation – for example, subparts (b), (h) and (r) are vague and unclear.

As drafted, the request for production does not contain any limitation in time or with respect to subject matter (i.e., related to the claim in this case). Read literally, a hospital may have to produce many years' worth of irrelevant records to a patient who had multiple hospital admissions over several years, the last of which is subject to suit. At a minimum, the request for production should contain some link to the allegations in the lawsuit. Records related to prior admissions may contain highly sensitive material, including mental health treatment records, which the patient/plaintiff might not expect to be disclosed without his permission, even to his own attorney. The broad and limitless nature of this standard production request is deeply concerning.

In addition, the full list of requested documents is unlikely to be relevant in the majority of medical malpractice cases. For example, if a patient happens to have an MRI, but the challenged care has nothing to do with the MRI itself, counsel and hospital administrators should not need to search for and produce drafts and audio recordings and requisition forms for the MRI as part of standard discovery. Imagine a lengthy hospitalization in which there are several MRIs and radiology reports, none of which are part of the alleged negligence. In that circumstance, hospital administrators would need to go on a wild goose chase for each of these different categories of documents, when the documents themselves would add little to the merits of the dispute. While it is easy to imagine the audio recordings of a radiology interpretation being relevant in a case that ***does*** involve the interpretation of an MRI, it is just as easy to imagine a multitude of cases where the additional documents will be wholly irrelevant. For that reason, many of these requests could easily be subject to a supplemental request in a case where the requested documents are likely to lead to the discovery of admissible evidence.

Most troubling is the request for "quality improvement documents related to root cause analysis that are not part of the peer review process" and "documents provided in connection with a peer review other than those prepared as part of the peer review process," found in subparts (n) and (o). Requiring the production of quality improvement documents as part of standard discovery threatens to discourage hospitals and health care providers from engaging in quality improvement activities, to the detriment of patient safety overall. As a practical matter, it is not always easy to split hairs between what documents were created for, or used as part of, a peer review process. There are also so many potentially applicable privileges – work product, attorney client privilege, the state peer review statute, the state morbidity and mortality statute and the state and federal patient safety organization statutes (just to name a few) – that it is

difficult to imagine a standard production of these documents without the ability to object. Defense counsel will struggle to advise their clients on which documents need to be gathered and produced in response to these requests. In addition, hospital counsel, physicians and risk managers at several hospital systems shared a very serious concern that including quality assurance documents as part of a standard production request will have a chilling effect on the internal reporting and investigation of adverse events. Quality assurance and patient safety literature shows that health care providers may not be as forthcoming and candid when reporting an adverse event if they know that the results will be disclosed during litigation. Requiring the blanket production of quality assurance materials will likely have a detrimental impact on overall patient safety, losing the forest for the trees.

The CDLA submits that the better approach would be for the standard discovery requests to include a request for the "designated record set," as defined in federal regulations under HIPAA, which already defines what records a hospital needs to produce to a patient. The "designated record set" is defined as:

> A group of records maintained by or for a covered entity that is:
>
> (i) The medical records and billing records about individuals maintained by or for a covered health care provider;
>
> (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
>
> (iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

45 CFR § 164.501. This is a more appropriate definition of the scope of medical records to be produced. Indeed, by way of contrast, Requests for Production Nos. 1 and 2 directed to plaintiffs cite directly to HIPAA and require a plaintiff to produce subsequent treatment records and/or a HIPAA-compliant authorization. Presumably, those productions will include only the designated record set, as defined by HIPAA, and not the voluminous list of subparts (a) through (s) requested from the defendants in the current draft. The CDLA respectfully submits that the production requests directed to defendant hospitals and health care providers should track the language in the production requests directed to plaintiffs.

Accordingly, the CDLA recommends the following language for Request for Production #1:

> All non-privileged documents that you possess, not subject to attorney-client, work product, statutory or Practice Book privilege(s), concerning the specific clinical treatment that is the subject of this litigation (as articulated in the healthcare provider's report which forms the basis of the good faith certificate attached to the complaint), including but not limited to:
>
> (a) All documents typically maintained as part of a patient's designated health record as defined by 45 C.F.R. § 164.501;
> (b) All correspondence to, from and/or concerning the plaintiff's care and treatment that is the subject of this litigation;
> (c) Any images or photographs taken during the treatment or pathological examination that is the subject of this litigation; and
> (d) Any other documents directly related to the specific allegations of negligence in the Complaint (as articulated in the healthcare provider's report which forms the basis of the good faith certificate attached to the complaint).

Additional requests for documents beyond the above categories (a) through (d) should be left to supplemental requests, so that defense counsel may object to an overly broad request and/or communicate with plaintiff's counsel to ascertain what exactly is being requested and why (i.e., how is it likely to lead to the discovery of admissible evidence).

Third, CDLA members commented on the draft discovery regarding electronic medical records (EMR). Interrogatories #13-15 in the draft discovery set directed to hospitals and Interrogatories #29-31 in the draft discovery directed to a health care provider are identical[2] and provide as follows:

> (13) Did you create, use, or maintain any "electronic protected health information" (hereinafter "health information"), as defined in C.F.R. § 160.103 during the treatment of the Plaintiff?
>
> (14) If the answer to the previous interrogatory is in the affirmative, list the names and versions of any and all electronic "information

[2] See footnote 1 above regarding the numbering of these identical requests.

system(s)" (hereinafter "EMR system(s)"), as defined in 45 C.F.R. § 164.304, that contain or previously contained the health information of the Plaintiff.

(15) Identify the medical provider(s), database manager(s), or other administrator(s)whose job responsibilities include performing queries of your audit database of EMR system(s) at the time this interrogatory is answered.

Comments focused specifically on Interrogatory No. 15, which asks for the name of any persons responsible for performing an audit query on an EMR system. This request may be overbroad and unduly burdensome in many circumstances. In some health systems, there may be several different EMR systems, and many people assigned to run reports on those systems for a variety of different reasons.

Presumably, Interrogatory No. 15 is intended to identify a person to be deposed about the reporting capability of the EMR system. To that end, it is not necessary: plaintiff's counsel can easily use Practice Book § 13-27(h), which allows for the designation of specific deposition topics and asks a defendant to designate and produce a witness with the most knowledge about those topics. There is simply no need for Interrogatory No. 15, and no benefit to plaintiff's counsel from having the name of a person disclosed in response to standard written discovery; by the time of a deposition many months later, that person's position and/or responsibilities may have changed.

The Interrogatory, as currently drafted, is also vague and unclear. There is no definition of what it means to perform "queries of your audit database"; this may mean different things to different people. There is no "audit database" in most EMR systems. In fact, there is no defined and recognized meaning of the term "audit trail."

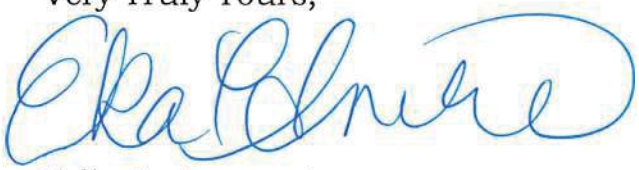
EMR is simply not "one size-fits all." Far from it, there are many different programs and software systems that health care providers use and have used over time. Each of these EMR systems has different capabilities and properties. The software underlying these EMR systems is proprietary and protected. In order to access and use the EMR, in most instances, health care providers must contract with the manufacturers of these EMR systems, pay license fees and sign confidentiality and non-disclosure agreements. Health care providers then attend extensive and continuous training to learn how to optimize the use of the EMR system. As with any software, the systems are regularly updated, and may

be phased out over time in favor of new technology. The technology changes quickly, and what is available today is very different from what was in place just a few years ago, or what will be in the future.

Although there may be situations where specific discovery relating to an "audit trail" may be relevant, those cases are by far the exception, not the rule. Discovery related to an "audit trail" is best addressed on a case-by-case basis, in order to consider the propriety of (and need for) such information, the burden and costs to the parties, the scope of disclosure and the manner in which the disclosure occurs. In non-form, case-specific discovery requests, the parties can narrowly tailor the requests to the specific type of EMR system at issue, the "audit trail" or access log requested, and the data's relevance to the particular case to ensure that the request is not overly broad or unduly burdensome. Absent some showing that an "audit trail" will be relevant and/or likely to lead to the discovery of admissible evidence in a particular case, there is no reason to disclose the names of the various employees who may be able to run an audit query on the EMR system.

Thank you for your consideration of the CDLA's perspective on these important issues. Please do not hesitate to reach out to me with any questions or comments.

Very Truly Yours,



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