

THE MAINE SUPREME JUDICIAL COURT

SITTING AS THE LAW COURT

Cum-18-445

CAROL A. KENNELLY,
Appellee

v.

MID COAST HOSPITAL
Appellant.

ON APPEAL FROM

SUPERIOR COURT (CUMBERLAND)

APPENDIX

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¹ Although the plaintiff captioned this pleading as a motion with an incorporated memorandum of law, the filing that initiated the judicial action appealed is the plaintiff’s letter requesting judicial resolution pursuant to M.R. Civ. P. 26(g). (A. 22.) The court then ordered the parties to submit written argument, due by the same date. (A. 53.) The plaintiff captioned her written argument as a motion. (A. 27.) Because of the choice of caption, and because of the court’s chosen caption for its order, the plaintiff’s written argument is placed with the mandatory contents, though arguably it may belong in the discretionary contents.

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² The plaintiff’s exhibits 1 and 2 are included at A. 22 and A. 47, respectively, and are not duplicated here.

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SUPERIOR COURT
CUMBERLAND, ss.
Docket No PORSC-CV-2016-00471

DOCKET RECORD

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Docket Events:

- 02/02/2018 Party(s): CAROL A KENNELLY
SUPPLEMENTAL FILING - COMPLAINT FILED ON 01/31/2018
PLAINTIFF'S COMPLAINT. (MC)
- 02/02/2018 ASSIGNMENT - SINGLE JUDGE/JUSTICE ASSIGNED TO JUSTICE ON 02/02/2018
THOMAS D WARREN , JUSTICE
- 02/16/2018 Party(s): MID COAST HOSPITAL
RESPONSIVE PLEADING - ANSWER FILED ON 02/12/2018
OF DEF MID COAST HOSPITAL (AT)
- 02/16/2018 Party(s): CAROL A KENNELLY
MOTION - MOTION TO PREPARE TRANSCRIPT FILED ON 02/15/2018
PLTF'S UNOPPOSED MOTION TO TRANSCRIBE THE PANEL HEARING, WITH PROPOSED ORDER (AT)
- 02/16/2018 CASE STATUS - CASE FILE LOCATION ON 02/16/2018
SENT TO J WARREN FOR REVIEW (AT)
- 02/21/2018 CASE STATUS - CASE FILE RETURNED ON 02/20/2018
- 02/21/2018 Party(s): CAROL A KENNELLY

MOTION - MOTION TO PREPARE TRANSCRIPT GRANTED ON 02/16/2018
THOMAS D WARREN , JUSTICE
COPIES TO PARTIES/COUNSEL ON 02/21/18. (MC)

02/21/2018 ORDER - SCHEDULING ORDER ENTERED ON 02/20/2018
THOMAS D WARREN , JUSTICE
ORDERED INCORPORATED BY REFERENCE AT THE SPECIFIC DIRECTION OF THE COURT. COPIES TO
PARTIES/COUNSEL ON 02/21/18. (MC)

02/21/2018 DISCOVERY FILING - DISCOVERY DEADLINE ENTERED ON 10/16/2018

03/01/2018 Party(s): CAROL A KENNELLY
JURY FILING - DEMAND FOR JURY TRIAL FILED ON 02/28/2018
OF PLTF \$300 JURY FEE PD

03/07/2018 Party(s): MID COAST HOSPITAL
SUMMONS/SERVICE - ACCEPTANCE OF SERVICE SERVED ON 02/05/2018
UPON DEF MID COAST HOSPITAL TO ATTY PHILIP COFFIN

03/07/2018 Party(s): MID COAST HOSPITAL
SUMMONS/SERVICE - ACCEPTANCE OF SERVICE FILED ON 03/07/2018

03/22/2018 Party(s): MID COAST HOSPITAL
ATTORNEY - RETAINED ENTERED ON 03/22/2018
Defendant's Attorney: ABIGAIL VARGA

05/25/2018 CASE STATUS - CASE FILE LOCATION ON 05/25/2018
SENT TO JUSTICE WARREN FOR REVIEW

06/14/2018 Party(s): CAROL A KENNELLY
DISCOVERY FILING - RULE 26(G) LETTER FILED ON 06/14/2018
OF PLTF REQUEST FOR HEARING W/ THE COURT

06/18/2018 Party(s): MID COAST HOSPITAL
LETTER - FROM PARTY FILED ON 06/18/2018
OF DEF LETTER FROM DEF IN RESPONSE TO PLTF'S 26(G) REQUEST

06/25/2018 Party(s): CAROL A KENNELLY
LETTER - FROM PARTY FILED ON 06/25/2018
OF PLTF LETTER IN RESPONSE TO DEF 26(G) REQUEST

07/05/2018 CASE STATUS - CASE FILE RETURNED ON 07/05/2018

07/06/2018 ASSIGNMENT - SINGLE JUDGE/JUSTICE RECUSED ON 07/06/2018
THOMAS D WARREN , JUSTICE

07/06/2018 ASSIGNMENT - SINGLE JUDGE/JUSTICE ASSIGNED TO JUSTICE ON 07/06/2018
LANCE WALKER , JUSTICE

07/06/2018 CASE STATUS - CASE FILE LOCATION ON 07/06/2018
TO JUSTICE WALKER FOR REVIEW OF PLAINTIFF'S RULE 26(G) LETTER. (MC)

07/16/2018 CASE STATUS - CASE FILE RETURNED ON 07/16/2018

07/16/2018 ORDER - COURT ORDER ENTERED ON 07/16/2018
LANCE WALKER , JUSTICE
ORDERED INCORPORATED BY REFERENCE AT THE SPECIFIC DIRECTION OF THE COURT. COPIES TO
PARTIES/COUNSEL

07/16/2018 ORDER - 26(G) ORDER ENTERED ON 07/16/2018
LANCE WALKER , JUSTICE
PROCEDURAL ORDER REGARDING PENDING RULE 26(G) DISPUTE. THE PARTIES ARE TO FILE WRITTEN
ARGUMENTS RELATIVE TO THE DISCOVERY DISPUTES BY 7/30/18, AFTER WHICH THE CLERK SHALL
SCHEDULE A TELEPHONIC CONFERENCE BETWEEN COUNSEL AND THE COURT. COPIES SENT TO
PARTIES/COUNSEL ON 07/16/18. (MC)

07/31/2018 Party(s): MID COAST HOSPITAL
OTHER FILING - OTHER DOCUMENT FILED ON 07/30/2018
DEFENDANT MID COAST HOSPITAL'S DISCOVERY DISPUTE WRITTEN ARGUMENT WITH ATTACHED EXHIBITS
A-C. (MC)

07/31/2018 Party(s): CAROL A KENNELLY
MOTION - MOTION TO COMPEL FILED ON 07/30/2018
PLAINTIFF'S MOTION TO COMPEL PRODUCTION OF DISCOVERY WITH INCORPORATED MEMORANDUM OF LAW
AND ATTACHED EXHIBITS 1-6. (MC)

08/15/2018 Party(s): CAROL A KENNELLY
LETTER - FROM PARTY FILED ON 08/15/2018
PLAINTIFF'S LETTER INFORMING THE COURT THAT THE PARTIES HAVE REACHED RESOLUTION REGARDING
THE ISSUE OF PLAINTIFF'S SUPPLEMENTAL REQUEST FOR PRODUCTION OF DOCUMENTS #1 (AUDIT TRAIL
DOCUMENTS). (MC)

08/22/2018 Party(s): CAROL A KENNELLY
OTHER FILING - OTHER DOCUMENT FILED ON 08/22/2018
PLAINTIFF'S LETTER TO COURT ALONG WITH ATTACHED COPY OF RECENT DECISION FROM THE LAW COURT
RELATING TO THEIR PENDING MOTION TO COMPEL. (MC)

08/27/2018 HEARING - 26(G) CONFERENCE SCHEDULED FOR 08/30/2018 at 12:00 p.m.
TELEPHONIC RULE 26(G) CONFERENCE. PARTIES NOTIFIED BY PHONE BY CLERK.

09/28/2018 Party(s): CAROL A KENNELLY
MOTION - OTHER MOTION FILED ON 09/28/2018
PLAINTIFF'S CONSENTED TO MOTION FOR DATE CERTAIN FOR TRIAL ALONG WITH PROPOSED ORDER. (MC)

09/28/2018 CASE STATUS - CASE FILE LOCATION ON 09/28/2018
TO JUSTICE WALKER FOR REVIEW OF CONSENT MOTION FOR DATE CERTAIN FOR TRIAL. (MC)

10/02/2018 CASE STATUS - CASE FILE RETURNED ON 10/01/2018

10/02/2018 Party(s): CAROL A KENNELLY
MOTION - OTHER MOTION GRANTED ON 10/01/2018
LANCE WALKER , JUSTICE
PLAINTIFF'S CONSENTED TO MOTION FOR DATE CERTAIN FOR TRIAL ALONG WITH PROPOSED ORDER.
COPIES SENT TO PARTIES/COUNSEL ON 10/02/18. (MC)

10/15/2018 HEARING - 26(G) CONFERENCE HELD ON 08/30/2018

LANCE WALKER , JUSTICE
 Defendant's Attorney: ABIGAIL VARGA
 Plaintiff's Attorney: TRAVIS MARTAY BRENNAN
 TELEPHONIC CONFERENCE HELD. NO RECORDING. (MC)

10/15/2018 Party(s): CAROL A KENNELLY
 MOTION - MOTION TO COMPEL GRANTED ON 10/11/2018
 LANCE WALKER , JUSTICE
 COPIES TO PARTIES/COUNSEL ON 10/15/18. (MC)

11/05/2018 Party(s): MID COAST HOSPITAL
 APPEAL - NOTICE OF APPEAL FILED ON 11/02/2018
 DEFENDANT MID COAST HOSPITAL'S NOTICE OF APPEAL OF ORDER ON PLAINTIFF'S MOTION TO COMPEL
 PRODUCTION OF DISCOVERY DATED 10/11/18 (DOCKETED 10/15/18) ALONG WITH \$175.00 APPEAL FEE
 PAID. DATE STAMPED COPIES OF THE NOTICE OF APPEAL SENT TO PARTIES/COUNSEL ON 11/05/18.
 (MC)

11/05/2018 Party(s): MID COAST HOSPITAL
 APPEAL - NOTICE OF APPEAL SENT TO LAW COURT ON 11/05/2018
 COPIES OF DEFENDANT'S NOTICE OF APPEAL, APPEAL CHECKLIST AND DOCKET RECORD SENT TO CLERK
 OF THE LAW COURT ON 11/05/18. (MC)

11/05/2018 Party(s): CAROL A KENNELLY
 OTHER FILING - WITNESS & EXHIBIT LIST FILED ON 11/05/2018
 PLAINTIFF'S WITNESS AND EXHIBIT LIST ALONG WITH INCORPORATED ESTIMATE OF TIME FOR TRIAL.
 (MC)

11/05/2018 OTHER FILING - STATEMENT OF TIME FOR TRIAL FILED ON 11/05/2018
 ESTIMATE WAS FILED AS AN INCORPORATED ESTIMATE OF TIME FOR TRIAL (4 DAYS EXCLUDING JURY
 SELECTION). (MC)

11/28/2018 OTHER FILING - OTHER DOCUMENT FILED ON 11/16/2018
 CARBON COPY OF LETTER FROM CLERK OF THE LAW COURT TO PARTIES/COUNSEL STATING THE RECORD ON
 APPEAL IS DUE IN THE LAW COURT BETWEEN 11/30/18 AND 12/07/18. (MC)

11/30/2018 APPEAL - RECORD ON APPEAL SENT TO LAW COURT ON 11/30/2018
 ATTESTED COPIES OF THE DOCKET RECORD WERE SENT TO PARTIES/COUNSEL ON 11/30/18. (MC)

LAW

Receipts

11/28/2016	Misc Fee Payments	\$200.00	paid.
12/19/2016	Misc Fee Payments	\$200.00	paid.
02/01/2018	Misc Fee Payments	\$150.00	paid.
02/28/2018	Misc Fee Payments	\$300.00	paid.
11/02/2018	Misc Fee Payments	\$150.00	paid.
11/02/2018	Misc Fee Payments	\$25.00	paid.

A TRUE COPY

ATTEST:



Clerk

MCV

STATE OF MAINE
CUMBERLAND, ss.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-16-471

CAROL A. KENNELLY,)
)
Plaintiff)
)
v.)
)
MID COAST HOSPITAL,)
)
Defendant.)

ORDER ON PLAINTIFF'S MOTION
TO COMPEL PRODUCTION OF
DISCOVERY

STATE OF MAINE
Cumberland County Clerk's Office

OCT 18 2018

RECEIVED

8:02AM

Before the Court is Plaintiff's motion to compel production of operative notes from third-party patients' medical records, a physician's personnel file, and materials reflecting the physician's training and continuing medical education.¹ For the following reasons, Plaintiff's motion is granted.

I. Background

On January 31, 2018, Plaintiff filed in this Court a Complaint for medical negligence. The Complaint alleges that on September 2, 2015, Dr. Mia Marietta, an agent or employee of Defendant Mid Coast Hospital, performed on Plaintiff a laparoscopic cholecystectomy ("lap chole") during which Dr. Marietta erroneously transected Plaintiff's common hepatic duct and common bile duct, necessitating biliary reconstruction surgery to repair.

According to Plaintiff's motion to compel, Defendant's expert, Dr. David Schwaizberg, testified at his deposition that the "critical view of safety" ("CVS") approach is the safest way to perform a lap chole and is the standard of care in major cities, but that "a surgeon in Maine is within the standard of care as long as they use an approach that they feel comfortable with." (Pl.'s Mot. Compel 2.)² At her deposition, Dr. Marietta testified that she adhered to her safety precautions

¹ Plaintiff also requested audit trail materials, but as noted by Defendant, these materials have already been produced. (See Def.'s Opp'n to Mot. Compel Ex. C.)

² Plaintiff did not attach Dr. Schwaizberg's deposition to her motion.

in performing a lap chole, but that she does not label her process “CVS” because that term is nonspecific and non-descriptive. (Marietta Depo. 130:5-19, 150:14-15.) Plaintiff argues the requested operative notes, training documents, and continuing medical education materials are relevant to establish whether Dr. Marietta indeed used her usual process in performing Plaintiff’s surgery and whether that process satisfies the applicable standard of care. Plaintiff further argues that because Dr. Marietta no longer works for Mid Coast Hospital, her personnel file may contain information relevant to Plaintiff’s negligence claim.

II. Standard of Review

In accordance with M.R. Civ. P. 26(b), “Unless otherwise limited by order of the court ... parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action....” Liberal discovery is a procedural mechanism utilized “to eliminate the sporting theory of justice and to enforce full disclosure between the parties.” *Pinkham v. DOT*, 2016 ME 74, ¶ 12, 139 A.3d 904 (quotation marks omitted).

III. Discussion

Defendant generally resists production on the grounds that the information sought by Plaintiff is irrelevant and is shielded from discovery by privilege and a number of privacy laws.

A. Operative Notes

The first request to which Defendant objects is a request to produce, with names and identifying information redacted, the operative notes for the 25 lap choles performed by Dr. Marietta prior to Plaintiff’s lap chole and the 25 lap choles performed by Dr. Marietta after Plaintiff’s lap chole. (Pl.’s Mot. Compel Ex. 1.)

1. *Privacy*

Defendant argues the operative notes are not discoverable due to a number of privacy considerations. It contends that (1) state and federal statutes protect the confidentiality of these records, and (2) these records are privileged and not subject to disclosure by any exception or waiver. This issue recently came before the Superior Court and the Law Court. The Superior Court (Penobscot County, *Murray, A., J.*) granted the motion to compel in conjunction with a protective order requiring extensive redaction of the requested records. *McCain v. Vanadia*, PENS-CV-2016-117 (Me. Super. Ct., Penobscot Cty., Aug. 7, 2017). On appeal, the Law Court did not reach the merits, but Justice Alexander issued a dissenting opinion, contending the Court should reach the merits and should vacate the Superior Court's order for many of the reasons now argued in Defendant's opposition. *See McCain v. Vanadia*, 2018 ME 118, ¶ 19, __ A.3d __ (Alexander, J., dissenting).

a. Confidentiality. The Maine Health Security Act (MHSA) provides: "An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility" other than as provided by certain exceptions not relevant here. 22 M.R.S. § 1711-C(2). Plaintiff contends that under the MHSA, the definition of "health care information" applies only to "information that directly identifies the individual," and thus the statute does not apply to records in which identifying information is redacted. *Id.* § 1711-C(1)(E).

Pursuant to the statute, the Maine Health Data Organization (MHDO) has adopted rules to define "health care information that directly identifies an individual," which includes 25 categories of identifying information. *See id.*; 90-590 C.M.R. ch. 125, § 3 (2009). At minimum, all of this information would have to be redacted from each patient's medical record prior to disclosure in order to avoid violation of the MHSA. The MHDO's list is not exclusive, and as noted by Justice Alexander in his dissenting opinion in *McCain*, redaction of all identifying information may be

difficult to ensure because “[a]s the treatment at issue necessarily would be identified in any records reviewed and provided, the likelihood of actual confidentiality of identification of patients, at least in smaller Maine communities where only a few treatments may be provided a year, would be uncertain.” *McCain*, 2018 ME 118, ¶ 27, __ A.3d __ (Alexander, J., dissenting).

Nonetheless, in theory, if all “information that directly identifies an individual” were redacted, these records would be removed from the purview of the MHSA. Furthermore, the MHSA permits disclosure of health care information “[a]s directed by order of a court....” 22 M.R.S. § 1711-C(6)(F-1).

Defendants also seek protection in the federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA generally protects from disclosure “individually identifiable health information,” the definition of which includes information “[t]hat identifies the individual; or [w]ith respect to which there is a reasonable basis to believe the information can be used to identify the individual.” 45 C.F.R. § 160.103. As with the MHSA, redaction of information that identifies or reasonably could be used to identify an individual would remove the information from HIPAA protection. HIPAA also permits disclosure of even protected health information “[i]n response to an order of a court ... provided that the covered entity discloses only the protected health information expressly authorized by such order.” 45 C.F.R. § 164.512(e)(1).

While state and federal law treat medical records as sensitive information worthy of protection from disclosure in many circumstances, neither the MHSA nor HIPAA absolutely bars the disclosure of medical records. With substantial redaction of information, the records requested in this case would be removed from statutory protection altogether. Even without redaction, both the MHSA and HIPAA permit disclosure of health care information as directed by a court order.

The Court concludes records redacted pursuant to the same provisions outlined in the Superior Court's order in *McCain* would not be protected from disclosure by the MHSA or HIPAA.

b. Privilege. The issue of privilege presents a closer question. Defendants argue the requested records are privileged pursuant to M.R. Evid. 503, the physician-patient privilege, which provides:

A patient has a privilege to refuse to disclose, and to prevent any other person from disclosing, confidential communications made for the purpose of diagnosing or treating the patient's physical ... condition, ... between the patient and [t]he patient's health care professional.... There is a presumption that the person who was the health care ... professional at the time of the communication in question has authority to claim the privilege on behalf of the patient.

M.R. Evid. 503(b), (d)(2). Rule 503(e) contains exceptions which are not applicable here, but unlike the MHSA and HIPAA, the privilege contains no exception for court-ordered disclosure of privileged information.³

In *McCain*, the Superior Court determined that properly redacted records are not protected by the privilege. *McCain*, PENS-CV-2016-117 (Me. Super. Ct., Pensobscot Cty, Aug. 7, 2017). However, Justice Alexander disagreed with the Superior Court and opined that even redacted records would be privileged. *McCain*, 2018 ME at ¶¶ 32-33, __ A.3d __ (Alexander, J., dissenting).

Courts around the country have split on whether or not medical records are protected from disclosure due to privilege. Compare *Wipf v. Altstiel*, 2016 SD 97, ¶ 10, 888 N.W.2d 790 (“anonymous, nonidentifying information is not protected by the physician-patient privilege because there is *no patient* once the information is redacted;” recognizing other courts are almost unanimous in this position), *Snibbe v. Superior Court*, 224 Cal. App. 4th 184, 194 (2014) (refusing to recognize a “blanket prohibition against disclosure of redacted patient medical records” and

³ See Advisers' Note to former M.R. Evid. 503 (1976) (recognizing Rule 503 represents a departure from the former statutory privilege, 32 M.R.S. § 3295, which required disclosure of patient-physician communications pursuant to a court order).

determining privilege does not apply to deidentified postoperative orders) and *Staley v. Jolles*, 2010 UT 19, ¶ 25, 230 P.3d 1007 (“Where redaction of personal information will prevent identification of the patient connected to the medical information, the redacted information is not subject to” the physician-patient privilege), with *Roe v. Planned Parenthood Southwest Ohio Region*, 2009-Ohio-2973, ¶ 49, 912 N.E.2d 61 (rejecting argument that redaction eliminates privilege because “[r]edaction of personal information ... does not divest the privileged status of confidential records. Redaction is merely a tool that a court may use to safeguard the personal, identifying information within confidential records that have become subject to disclosure either by waiver or by an exception”) and *Parker v. Central Du Page Hosp.*, 105 Ill. App. 3d 850, 855, 435 N.E.2d 140 (1982) (“As the patients disclosed this information with an expectation of privacy, their rights to confidentiality should be protected.”).

Although the Utah Supreme Court permitted disclosure, it acknowledged that “an underlying premise to upholding redaction and limited review is that patient identification will be impossible. Whether and under what circumstances redaction can make good on its promise of anonymity depends on the circumstances of each case.” *Staley*, 2010 UT at ¶ 23. This echoes Justice Alexander’s concern that, particularly in rural Maine, even minimal information such as the type of procedure and the date of surgery could provide sufficient information to identify a particular patient.⁴

While not unanimous, the majority of courts that have considered this issue have concluded that records redacted of identifying information are not privileged. The Court recognizes that privilege, unlike the privacy statutes, has no bright line exception that would apply to the

⁴ Indeed, Dr. Marietta testified that she performs between 100 and 150 lap choles per year (Marietta Depo. 24:22-25), which is, on average, fewer than one per day.

information sought in this case, and Justice Alexander's concerns about the ability to identify patients in rural communities based on minimal information are not unwarranted. Yet even South Dakota, a state with many rural localities, applies the majority rule that redacted records are not privileged. *See Wipf*, 2016 SD 97, ¶ 10, 888 N.W.2d 790. Following the Penobscot County Superior Court and the majority of courts around the country that have considered this issue, and in the absence of mandatory authority to the contrary from the Law Court, this Court will apply the majority rule and that medical records fully redacted of identifying information are not protected by the physician-patient privilege.

2. Relevance

Defendant further argues production of the operative reports should not be compelled because medical records of patients who are not parties to the lawsuit are irrelevant to this case. Plaintiff contends that because Defendant's expert, Dr. David Schwaitzberg, testified that "a surgeon in Maine is within the standard of care as long as they use an approach that they feel comfortable with," (Pl.'s Mot. Compel 2), other patients' records are relevant to determine whether the procedure Dr. Marietta used in Plaintiff's surgery is consistent with her standard practice for performing gallbladder surgeries. Plaintiff alternatively contends these records could verify Dr. Marietta's testimony that her standard practice is not to use the CVS approach, which Dr. Schwaitzberg opined is the safest way to perform a lap chole and is the standard of care in major cities.

Plaintiff summarizes her relevance argument as such: "Dr. Marietta's operative reports may in fact confirm that her standard practice is to always use the 'Mia Marietta' approach to removing gallbladders. Conversely, her operative reports may demonstrate that she used the CVS approach in her other gallbladder removal surgeries, but failed to use that approach during Carol's

surgery.” (Pl.’s Mot. Compel 8.) If she always uses the “Mia Marietta” approach, arguably she did not breach the standard of care as defined by Dr. Schwaitzberg for a surgeon in Maine because that is apparently “an approach that [she] feel[s] comfortable with.” However, if she uses the CVS approach in her other surgeries, but failed to do so in Plaintiff’s surgery, then the CVS is presumably the approach she feels comfortable with, and she breached the standard of care by deviating from that practice.⁵

Defendant’s counterarguments to relevance are not compelling. It first argues that non-party patient records have no bearing on the care provided to Plaintiff. Plaintiff’s position, however, is that, in particular because Dr. Marietta testified that she did not use the CVS procedure, other patients’ records would demonstrate whether she indeed has a method of her own that she regularly uses, or whether she usually uses CVS but did not do so in Plaintiff’s surgery. Defendant’s second argument is that Dr. Marietta’s testimony makes it clear that Plaintiff’s records fully describe the steps she took during the surgery. Again, though, Plaintiff’s question is not what Dr. Marietta did during this surgery, but whether it was consistent with her usual practice in lap chole surgeries. That information cannot be gleaned from Plaintiff’s records. More than a mere fishing expedition for irrelevant surgical errors in other surgeries, Plaintiff seeks this information to better establish what procedures would be consistent with the applicable standard of care and whether the procedure Dr. Marietta used in Plaintiff’s surgery breached that standard.

The Court cautions that third-party patients’ medical records will not always be relevant in a medical negligence case. Here, because the standard relied upon by the parties requires some assessment of the physician’s usual practice, the procedure the physician has used in other

⁵ Unfortunately, the standard suggested by Dr. Schwaitzberg for surgeons in Maine is inexact and difficult to apply for purposes of determining whether Dr. Marietta breached the standard of care, as well as the extent to which other patients’ records would be relevant to determining whether she breached the standard of care.

surgeries has some tendency to make it more or less probable that she breached the standard of care in this case. *See* M.R. Evid. 401(a). The Court concludes the requested operative reports are relevant to Plaintiff's claim.

3. Burden

Finally, Defendant argues that production of the requested materials will be unduly burdensome, due both to administrative burdens and to the possibility that production of these records will "undermine the trust and confidence of patients who will surely question whether their sensitive medical information is truly protected by Mid Coast." (Def.'s Opp'n to Mot. Compel 7.) To reduce the burden on Defendant, Plaintiff reduced its request from 100 operative reports to 50 operative reports. The Court is satisfied that redaction and production of the requested records will not be unduly burdensome in this case.

B. Personnel File

Plaintiff's second contested request is for "[t]he complete personnel file for Mia Marietta, M.D. including but not limited to all documents relating to application, hiring, employee benefits, job description, employee reviews." (Pl.'s Mot. Compel Ex. 1.) Defendant argues that Dr. Marietta's personnel file is protected pursuant to 26 M.R.S. § 631, which grants an employee the right to review her personnel file and states: "Records in a personnel file may be maintained in any form including paper, microfiche or electronic form. The employer shall take adequate steps to ensure the integrity and confidentiality of these records." However, confidentiality of records is not a bar to discovery; rather, discovery is constrained by principles of privilege and relevance. *See* M.R. Civ. P. 26(b)(1); *Pinkham*, 2016 ME 74, ¶¶ 12-13, 139 A.3d 904.

Defendant cites *Burnett v. Ocean Props.*, No. 2:16-cv-00359-JAW, 2017 U.S. Dist. LEXIS 119 (D. Me. July 31, 2017), for the proposition that Plaintiff should request these materials from

Dr. Marietta, not from her former employer. However, in *Burnett*, the defendant requested records from the plaintiff's current employer. *Id.* at *5. The Court, citing potential difficulties that could result from subpoenaing records from a litigant's current employer, quashed the subpoena, noting the defendants had not attempted to use other means to discover the plaintiff's personnel file.⁶ *Id.* Because Plaintiff requests records from Dr. Marietta's former employer, which is a party to the litigation, the concerns raised in *Burnett* are not present here.

Defendant next argues that certain information in the personnel file is privileged. Pursuant to 24 M.R.S. § 2510-A, "professional competence review records are privileged and confidential and are not subject to discovery ... and are not admissible as evidence in any civil, judicial or administrative proceeding." Similarly, records pertaining to sentinel events are "confidential and privileged information" and are not "[s]ubject to discovery ... or [a]dmissible as evidence in any civil, criminal, judicial or administrative proceeding." 22 M.R.S. §8754(3). To the extent Dr. Marietta's personnel file contains professional competence review records or records pertaining to sentinel events, those records are privileged and are not discoverable. Nonetheless, rather than withholding Dr. Marietta's entire personnel file, Defendant may claim the privilege in accordance with M.R. Civ. P. 26(b)(5)(A), while producing all non-privileged information in the file.

As to relevance, Defendant argues "[t]he fact that Dr. Marietta is no longer employed by the hospital is irrelevant to the care provided to the Plaintiff during the time period in question when she was a hospital employee." (Def.'s Opp'n to Mot. Compel 8.) To the contrary, it seems the fact that Dr. Marietta is no longer employed by the hospital is particularly relevant to Plaintiff's claim; as Plaintiff argues, if Dr. Marietta was negligent in her treatment of Plaintiff, that negligence may have led to the termination of her employment. (Pl.'s Mot. Compel 8-9.) Given the broad

⁶ Ultimately, the Court ordered the plaintiff himself to produce his personnel file, subject to a confidentiality order. *Id.* at *13.

scope of discovery, this request is “reasonably calculated to lead to the discovery of admissible evidence,” and these documents are relevant. M.R. Civ. P. 26(b)(1).

C. Training and Continuing Medical Education Materials

The final requests under consideration are for “[a]ll documents in your possession, custody, or control relating to the training and/or continuing medical education of Mia Marietta, M.D.” and “[a]ny and all documents submitted by Mia Marietta, M.D. to Mid Coast Hospital showing continuing education credits earned between 2011 and 2015.” (Pl.’s Mot. Compel Ex. 1.) Defendant objects to the disclosure of this information, arguing that because Defendant obtains these documents from its physicians as part of the confidential privileges and credentialing process, the documents are privileged and confidential professional competence review records. *See* 24 M.R.S. §§ 2502(9), 2510-A.

A document’s use during the credentialing process is not determinative of its privileged status. To the extent these materials were “created for purposes other than professional competence review activity” and are “available from a source other than a professional competence committee,” they are not professional competence review records and are therefore not privileged as such. 24 M.R.S. § 2502(8). In the unlikely event that any of Dr. Marietta’s training records and continuing medical education materials do fall within the definition of professional competence review records, Defendant may claim privilege pursuant to M.R. Civ. P. 26(b)(5)(A).

Defendant also argues these records are irrelevant because there is no allegation that Dr. Marietta was not a properly trained physician. Plaintiff counters that Dr. Marietta’s training goes to the standard of care because Dr. Schwaitzberg’s testimony regarding the applicable standard of care in this case is based on the assumption that Dr. Marietta lacked knowledge of and training in the CVS approach. If Dr. Marietta was in fact trained in the CVS approach, she may have breached

the standard of care by choosing not to use this approach. As with the personnel file, given the broad scope of discovery, these documents are relevant.

IV. Conclusion

Based on the foregoing, Plaintiff's motion to compel is GRANTED. Defendant is hereby ORDERED to produce redacted operative notes of the 25 laparoscopic cholecystectomies performed by Dr. Marietta before she performed the surgery on Plaintiff and the 25 laparoscopic cholecystectomies performed by Dr. Marietta after she performed the surgery on Plaintiff. Each redacted record shall include only the year of the surgery, the name of the surgeon (Dr. Marietta), the name of the procedure, and a portion of the section labeled "operative procedure" (*i.e.*, all information other than the year, the name of the surgeon, the name of the procedure, and a portion of the "operative procedure" section will be redacted). The "operative procedure" section shall be provided only to the point in the surgery where the gallbladder was removed. To the extent there is any identifying information (*e.g.*, name, date of birth, age, sex, race) in the "operative procedure" section, such information shall also be redacted. The Court is satisfied that these significantly redacted records will not identify any non-parties and that their identification will not be able to be discerned from the records or otherwise.

Defendant is further ORDERED to produce Dr. Marietta's personnel file, training materials, and continuing medical education materials.

It is ORDERED that all records produced pursuant to this Order shall be used by Plaintiff solely for the purpose of prosecuting her claim before the court. Plaintiff's counsel shall not attempt to identify persons whose identities have been redacted and shall not provide copies of the records to anyone, other than expert witnesses in the case. Any expert witness shall be required to

not share the copies with anyone, to use such copies only for the purpose of this case, and to return the copies to Plaintiff's counsel at the end of the case.

The Clerk is directed to incorporate this Order into the docket by reference pursuant to M.R. Civ. P. 79(a).

Dated: 10/11/18



Lance E. Walker, Justice
Maine Superior Court

Entered on the Docket: 10/15/18 McJ

COPY

STATE OF MAINE
CUMBERLAND, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO.: CV-16-471

CAROL A. KENNELLY

Plaintiff

v.

MID COAST HOSPITAL

Defendant

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COMPLAINT

Carol A. Kennelly, by and through counsel, complains against Defendant Mid Coast Hospital as follows:

PARTIES

1. Carol Kennelly ("Carol") is a resident of Brunswick, County of Cumberland, State of Maine.
2. Defendant Mid Coast Hospital ("Mid Coast Hospital") is a Maine corporation which operates a general hospital in Brunswick, County of Cumberland, State of Maine.
3. Mia Marietta, M.D. is a physician licensed to practice in the State of Maine, with a specialty in general surgery.
4. At all times material to this Complaint, Dr. Marietta was an agent and/or employee of Mid Coast Hospital.
5. At all times material to this Complaint, Dr. Marietta was acting within the course and scope of her employment at Mid Coast Hospital.

FACTS

6. On August 31, 2015, Ms. Kennelly saw her primary care provider for a complaint of stomach pain and nausea. Carol's primary care provider ordered an abdominal ultrasound.

7. The abdominal ultrasound showed a large stone lodged in the neck of the gallbladder.

8. Ira Bird, M.D. at Mid Coast Medical Group-Surgical Care saw Carol on September 1, 2015 for a surgical consultation. Dr. Bird recommended laparoscopic cholecystectomy. Dr. Bird scheduled the surgery with Dr. Marietta, because Dr. Marietta had operating room time available the following day.

9. On September 2, 2015, Dr. Marietta attempted Carol's laparoscopic cholecystectomy.

10. During the surgery, Dr. Marietta misidentified Carol's biliary anatomy and incorrectly cut through Carol's common hepatic duct and common bile duct.

11. On September 6, 2015, Dr. Marietta discharged Carol home with a bile leak. Dr. Marietta referred Carol to Douglas Howell, M.D. at Maine Medical Partners for an endoscopic retrograde cholangiopancreatography ("ERCP").

12. On September 8, 2015, Carol saw Dr. Howell and underwent an ERCP. The ERCP demonstrated a severe bile duct injury.

13. On September 12, 2015, Lisa Rutstein, M.D. performed an exploratory laparotomy in which she found that Dr. Marietta had transected the common hepatic duct and common bile duct. She repaired Carol's biliary system by performing a Roux-en-Y retrocolic hepaticojejunostomy.

14. Carol remained an inpatient at Maine Medical Center until September 19, 2015.

15. Carol has had a complicated course following biliary reconstruction surgery. She required both in-house nursing services and hospital-based wound care services. She suffered from cellulitis of the abdominal wall, which required several rounds of antibiotics. On

November 23, 2016, she required surgery for an incarcerated ventral hernia. In the spring of 2017, she developed a seroma in her abdominal cavity, which had to be drained by Dr. Rutstein on May 21, 2017.

COUNT I: MEDICAL NEGLIGENCE

16. Plaintiff repeats and realleges the allegations of Paragraphs 1 through 15 as if fully set forth herein.

17. Mid Coast Hospital, acting by and through its agents, owed a duty of care to Carol.

18. Mid Coast Hospital, acting by and through its agents, breached the duty of care for reasons including, but not limited to the following:

- a. Failing to take the time to reasonably review the pre-operative imaging reports and to develop a reasonable surgical plan based upon all available information;
- b. Using sub-standard operative techniques;
- c. Failing to attempt to obtain the critical view of safety;
- d. Proceeding with an operation without the ability to appropriately visualize the critical structures;
- e. Failing to adequately identify the critical anatomy; and
- f. Failing to perform an intraoperative cholangiogram, convert to an open procedure, or take other measures to identify the critical anatomy.

19. As a direct and proximate result of Mid Coast Hospital's negligence as set forth above, Carol suffered severe and permanent personal injuries, including but not limited to injuries to her biliary system.

20. As a direct and proximate result of Mid Coast Hospital's negligence, Carol was damaged. The elements of her damage include extraordinary medical expenses, pain and suffering, loss of enjoyment of life, and permanent impairment.

21. Mid Coast Hospital is vicariously liable for the acts and omissions of its employees and agents, including, without limitation, the acts and omissions of Dr. Marietta.

WHEREFORE, Plaintiff Carol Kennelly demands judgment against Defendant Mid Coast Hospital in an amount reasonably sufficient to compensate her for her damages, together with interest and costs.

January 29, 2018



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Julian L. Sweet, Esq.
Maine Bar No. 2395
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JUN 14 2018

Travis M. Brennan RECEIVED
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June 12, 2018

Julie Howard
Clerk of Court
Cumberland County Superior Court
P.O. Box 412
Portland, ME 04112

Re: Carol (Arsenault) Kennelly v. Mid Coast Hospital
Docket No.: CV-16-471
Our File No.: 26762-01

Dear Julie:

Pursuant to M.R. Civ. P. 26(g), I am writing to request a hearing with the Court to resolve a discovery dispute involving the Defendant's Responses to Request for Production. The Defendant has refused to produce any responsive documents related to the requests below.

I. Dr. Marietta's Operative Notes

In Request for Production numbers 1 and 2, Plaintiff requested that Defendant produce operative notes for fifty laparoscopic cholecystectomies that Dr. Marietta performed prior to Plaintiff's surgery on September 2, 2015 and operative notes for fifty laparoscopic cholecystectomies that Dr. Marietta performed after Plaintiff's surgery:

1. The operative notes for the fifty (50) laparoscopic cholecystectomies that Dr. Marietta performed prior to Carol Kenneally's laparoscopic cholecystectomy on September 2, 2015 with the names and identifying information for the individual patients redacted to preserve patient confidentiality.

OBJECTION: In addition to the general objections set forth above, Defendant objects to this request to the extent it seeks information or documents which are confidential including, but not limited to, information or material protected by the Maine Health Security Act, 32 M.R.S.A. § 3296, HIPAA, or any other applicable privilege or doctrine. Defendant further objects to this request because it is over broad, unduly burdensome, and seeks information not reasonably calculated to lead to the discovery of admissible evidence.

2. The operative notes for the fifty (50) laparoscopic cholecystectomies that Dr. Marietta performed after Carol Kenneally's laparoscopic cholecystectomy on September 2, 2015 with the names and identifying information for the individual patients redacted to preserve patient confidentiality.

OBJECTION: In addition to the general objections set forth above, Defendant objects to this request to the extent it seeks information or documents which are confidential including, but not limited to, information or material protected by the Maine Health Security Act, 32 M.R.S.A. § 3296, HIPAA, or any other applicable privilege or doctrine. Defendant further objects to this request because it is over broad, unduly burdensome, and seeks information not reasonably calculated to lead to the discovery of admissible evidence.

Plaintiff is willing to narrow this request to twenty-five operative notes before her surgery on September 2, 2015 and twenty-five operative notes after her surgery.

II. Dr. Marietta's Personnel File

Plaintiff requested Dr. Marietta's personnel file.

5. The complete personnel file for Mia Marietta, M.D. including but not limited to all documents relating to application, hiring, employee benefits, job description, employee reviews.

OBJECTION: In addition to the general objections set forth above, Defendant objects to the extent that this request seeks documents which are confidential and protected by statute or third party privacy rights, including, but not limited to the Maine Health Security Act, the Health Care Quality Improvement Act of 1986 and 26 M.R.S.A. § 631. Defendant further objects to this request because it is vague, over broad both temporally and in scope, and seeks personal and commercially sensitive, confidential and proprietary information not reasonably calculated to lead to the discovery of admissible evidence.

III. Training & Continuing Education

Plaintiff requested documents related to Dr. Marietta's training and continuing education.

7. All documents in your possession, custody, or control relating to the training and/or continuing medical education of Mia Marietta, M.D.

OBJECTION: In addition to the general objections set forth above, Defendant objects to this request on the grounds that it is overly broad, unduly burdensome, and not reasonably calculated to lead to the discovery of admissible evidence. Further, Defendant objects to the extent that this request seeks documents which are confidential and protected by statute or third party privacy rights, including, but not limited to the Maine Health Security Act, the Health Care Quality Improvement Act of 1986 and 26 M.R.S.A. § 631

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8. Any and all documents submitted by Mia Marietta, M.D. to Mid Coast Hospital showing continuing education credits earned between 2011 and 2015.

OBJECTION: In addition to the general objections set forth above, Defendant objects to this request on the grounds that it is overly broad, unduly burdensome, and not reasonably calculated to lead to the discovery of admissible evidence. Further, Defendant objects to the extent that this request seeks documents which are confidential and protected by statute or third party privacy rights, including, but not limited to the Maine Health Security Act, the Health Care Quality Improvement Act of 1986 and 26 M.R.S.A. § 631.

IV. Audit Trail Materials

In Plaintiff's Supplemental Request for Production of Documents, Plaintiff requested audit trail materials from the Defendant.

1. Any and all documents through the present that show an audit trail for the electronic medical records, including, but not limited to, electronic medical records used in the LOGICARE and/or PACS systems, created for Carol (Arsenault) Kennelly's care at Mid Coast Hospital in September 2015. These records should include the date and time that every entry was made, as well as the date and time of any edits. These records should include the identity of the person making the entry, as well as the substance of each entry.

OBJECTION: Defendant objects to this request as audit trails are not part of the medical records as they do not reflect any treatment rendered, and no health care practitioner relied on them to render care. Defendant further objects because audit trails are not designed nor created for any clinical purpose, but solely to facilitate the discharge of obligations under the federal Privacy Rule. Audit trails are configured to support compliance with federal privacy mandates and are not intended for, nor used as a record of, patient care processes. The use of privacy related logs which serve to identify the potential viewing of a patient's health information are rarely designed at the detail level, nor would they identify the underlying processes of patient care in an organization. Some EHR privacy logs may go further to indicate whether a record was updated or a report printed, but those high level activities would not provide details as to what was updated nor which screen or field was read by a provider or other clinical or business user. As the audit trail does not readily distinguish between specific medical record access by personnel and events that register on the audit trail as a result of aggregate or report level information, their probative value is de minimis, at best. Defendant further objects because the audit trails themselves are unlikely to be admissible as evidence at any hearing or trial. Further, insofar as audit trails reflect access to the record by persons whose responsibilities include professional competence review activities, including reviewing the quality and/or safety of medical care, they are protected from discovery by 24 M.R.S.A. § 3510, 24 M.R.S.A. § 2510-A, 32 M.R.S.A. § 2599, and 32 M.R.S.A. § 3296. Likewise, insofar as audit trails reflect access to the EHR by risk management personnel, they reflect the Defendant's mental impressions and activities in anticipation of litigation, and are therefore protected by the work product privilege.

Defendant further objects because creating audit trails is generally a burdensome and expensive process. The time burden, which includes human resource and attorney time, combined with the associated expense that is required to create and then to review them to avoid the disclosure of privileged information, substantially outweighs whatever limited value those materials may contribute to the discovery process.

Plaintiff is willing to further limit this request to include just the audit materials that relate solely to Dr. Marietta's entries in Plaintiff's medical record.

Pursuant to Rule 26(g), undersigned counsel and Defense counsel conferred in good faith to try and resolve this discovery dispute. The Defendant stands by its objections and will not produce any responsive documents.

Julie Howard
June 12, 2018
Page 5

Undersigned counsel requests relief from this Court in the form of an Order requiring the Defendant to produce responsive documents to these requests.

I request that this matter be considered at this Court's earliest convenience.

Sincerely,

A handwritten signature in black ink, appearing to read 'Travis M. Brennan', with a long horizontal flourish extending to the right.

Travis M. Brennan

TMB/msh

cc: Carol A. Kennelly
Philip M. Coffin, III, Esq. ✓

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STATE OF MAINE
CUMBERLAND, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO.: CV-16-471

CAROL A. KENNELLY

Plaintiff

v.

MID COAST HOSPITAL

Defendant

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**PLAINTIFF’S MOTION TO COMPEL
PRODUCTION OF DISCOVERY WITH
INCORPORATED MEMORANDUM OF LAW**

INTRODUCTION

This is a case, in which Mia Marietta, M.D., a surgeon and employee at Mid Coast Hospital (“Mid Coast”), misidentified critical biliary anatomy during a gallbladder removal surgery (laparoscopic cholecystectomy). Dr. Marietta’s error caused her to cut Carol Kennelly’s (“Carol”) common bile duct, which caused Carol to leak bile into her abdomen and required that Carol undergo a complex surgery to repair her biliary system.

The main issue in this case is whether Dr. Marietta violated the standard of care during Carol’s surgery. For well over a decade, there has been a consensus among general surgeons about the safest way to remove a patient’s gallbladder. This approach, referred to as the “critical view of safety” (“CVS”), requires a surgeon to clearly identify biliary anatomy before clipping and cutting biliary anatomy. The CVS technique has been recommended by leading medical societies; adopted by major medical textbooks, including the American College of Surgeons and Sabiston; and promoted in peer reviewed publications as the safest technique to perform this surgery.

There is no dispute in this case that Dr. Marietta failed to obtain the CVS before she clipped and cut Carol's biliary anatomy—both Dr. Marietta and Mid Coast concede this point. Dr. Marietta testified that she has her own, “Mia Marietta,” approach to performing gallbladder removal surgery, which satisfies the standard of care.

Mid Coast's expert in this action, David Schwartzberg, M.D, who teaches at the Jacobs School of Medicine in Buffalo, New York, testified that he personally uses the CVS and that he teaches all his residents and fellows to use CVS. He further testified that the CVS is the standard of care for surgeons practicing in any major city, such as New York, Boston, or Chicago. Dr. Schwartzberg concedes that Dr. Marietta failed to obtain the CVS. He maintains, however, that a surgeon in Maine is within the standard of care as long as they use an approach that they feel comfortable with.

Plaintiff has propounded discovery requests regarding four separate topics that are relevant to whether Dr. Marietta breached the standard of care and which are non-privileged: (1) Dr. Marietta's operative notes for non-party gallbladder removal surgeries, (2) Dr. Marietta's personnel file, (3) documents regarding Dr. Marietta's training and continuing education, and (4) an audit trail for Dr. Marietta's entries in Carol's electronic medical records. Mid Coast objected to the production of **any** documents that are responsive to these requests.¹ Mid Coast, however, has failed to raise any valid argument for withholding documents that are responsive to Carol's requests. In fact, controlling precedent in the Superior Court, Law Court decisions, and Maine's Rules of Civil Procedure governing discovery demonstrate that this Court should compel Mid Coast to produce the requested documents.

¹ Carol's document requests and Mid Coast's objections are contained in Carol's request for a hearing, dated June 12, 2018, which is attached as **Exhibit 1**. After Carol's request for a hearing, Mid Coast submitted a letter to the Court that was originally sent to undersigned counsel related to Mid Coast's objections. **Exhibit 2**.

ARGUMENT

I. Dr. Marietta's Operative Notes are Discoverable

Dr. Marietta testified that she does not use the critical view of safety approach. Deposition Testimony (“Marietta Depo”) 130, 150-51. Instead, she has her standard practice—the “Mia Marietta” way—for performing gallbladder removal surgery. Testimony from Pre-Litigation Screening Panel (“Panel”) 57, attached excerpts at **Exhibit 3**; Marietta Depo 150-51, attached excerpts at **Exhibit 4**. She testified that she followed this standard practice during Carol's surgery.

Carol requested redacted operative notes for the fifty gallbladder removal surgeries that Dr. Marietta performed before and after Carol's surgery on September 2, 2015. Carol agreed to narrow this request to the twenty-five operative notes before her surgery and twenty-five after her surgery.² These operative notes are necessary to assess whether the surgery that Dr. Marietta describes in Carol's operative note is consistent with her standard practice for performing gallbladder removal surgery. Moreover, these operative notes are relevant to determining whether Dr. Marietta has used the CVS in other gallbladder removal surgeries, something she denies.

A. The Superior Court Recently Ordered Production of Operative Notes in a Similar Case

The Superior Court recently ordered production of redacted operative reports in a similar medical malpractice case involving gallbladder removal surgery. *McCain v. Vanadia*, PENS-CV-2016-117 (Me. Super. Ct., Pen, Cty, Aug. 7, 2017) (Murray, J.) (attached as **Exhibit 5**.)³ In

² Dr. Marietta testified that she performed upwards of 150 gallbladder removal surgeries in 2015. Marietta Depo. 24-25.

³ This decision has been appealed to the Maine Supreme Court. Until they rule, this decision is still precedential. See *Bourgeois v. Great Northern Nekoosa Corp.*, 1999 ME 10, ¶ 5, 722 A.2d 369, 371

that case, the surgeon failed to describe identifying the critical anatomy in his operative note. The surgeon testified that he must have visualized the critical anatomy during the surgery at issue in the case, because he had a standard practice of visualizing the critical anatomy. Justice Murray concluded that without non-party operative reports, the plaintiff had little opportunity to challenge the surgeon's claim regarding his general habits during surgery and in drafting operative reports. *Id.* at 4.

The Court ordered the hospital to produce operative notes for the fifteen gallbladder removal surgeries the surgeon performed before the Plaintiff's surgery and the fifteen after. The Court ordered the Defendant to redact any identifying information so that only the year of the surgery, the name of the surgeon, and the description of the procedure were produced. The Court further ordered as follows:

The Court is fully satisfied that these very significantly redacted records will not identify any non-parties and that their identification will not be able to be discerned from the records or otherwise. It is further ordered that the redacted copies be used by the plaintiff solely for the purpose of presenting her claim before the Medical Malpractice Screening Panel or in connection with prosecuting a claim before the court. Plaintiff's counsel shall not attempt to identify the persons whose identities have been redacted and shall not provide copies of the redacted records to anyone, other than expert witnesses in the case. Any expert witness shall be required to not share the redacted copies with anyone, to use such copies only for the purpose of this case, and to return the copies to plaintiff's counsel at the end of the case.

Id. at 11. Plaintiff does not object to similar protective orders regarding the production of Dr. Marietta's operative notes.

("[D]eliberate or solemn decision of a court, after argument on a question of law fairly arising in the case, the disposition of which is necessary to the determination of the case, is an authority or binding precedent in the same court and in other courts of equal or lower rank, in subsequent cases where the very point is again in controversy.") If the Law Court reaches a decision while this Motion is pending, Plaintiff will notify the Court.

B. The Non-Party Operative Reports Are Discoverable Because They Are Relevant to Determining the Surgical Approach That Dr. Marietta Uses During Gallbladder Removal Surgery

Parties in a civil action are entitled to discovery of information that is “reasonably calculated to lead to the discovery of admissible evidence.” M.R. Civ. P. 26(b)(1). Plaintiff’s central argument in this case is that Dr. Marietta failed to obtain the CVS before cutting Carol’s biliary anatomy. Dr. Marietta testified that she did not generally follow the CVS technique; instead opting for her own method she called “Mia Marietta’s critical view.” Panel 57. Carol is entitled to discovery reasonably calculated to explore whether Dr. Marietta actually followed her standard practice during Carol’s surgery. Carol’s request for redacted operative reports is narrowly tailored to accomplish this purpose.

C. There Is No Legal Basis for Withholding the Operative Reports

Mid Coast claims that Carol’s request seeks material that is privileged and confidential. As a threshold matter, all claims for confidentiality and/or privilege are designed to protect *patients* from disclosure of their medical information, not to protect *doctors* from liability for medical malpractice. Moreover, even if the medical records were not redacted, production of otherwise confidential material, where relevant to a pending civil matter, is commonplace. *See Pinkham v. DOT*, 2016 ME 74, ¶ 12, 139 A.3d 904, 909. Courts have mechanisms for dealing with this: redaction or a protective order.

Plaintiff’s document request eliminates any concern about disclosure of confidential medical information, as the request is limited to portions of other operative reports redacted to eliminate any patient-specific information. An appropriate protective order (to which Plaintiff does not object) would further preserve such confidentiality. In short, there are multiple

protections easily put in place to prevent the dissemination of any other person's confidential medical information.

1. Neither State Nor Federal Statutes Pose Any Bar to the Production of Redacted Medical Records

Maine statutory law poses no bar to the production of redacted operative notes, because such records do not contain personal "health care information," as that term is defined in 22 M.R.S.A. § 1711-C. Pursuant to 22 M.R.S.A. § 1711-C(1)(E), "health care information" is defined as "information that **directly identifies the individual** and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual." (emphasis added). If medical records do not contain identifying information, they are not protected pursuant to 22 M.R.S.A. § 1711-C.

Even if, for the sake of argument, the Court concludes that redacted operative reports do fall under the definition of "health care information," the Legislature provides an exception that allows the production of protected health care information in legal proceedings. A healthcare practitioner may disclose healthcare information without authorization from the patient "[a]s directed by order of a court or as authorized or required by statute." 22 M.R.S.A. § 1711-C(6)(F-1). Information may also be disclosed without authorization "[t]o attorneys for the health care practitioner or facility that is disclosing the health care information or to a person as required in the context of legal proceedings or in disclosure to a court or governmental entity, as determined by the practitioner or facility to be required for the practitioner's or facility's own legal representation." 22 M.R.S.A. § 1711-C(6)(K).

Federal statutory law also poses no barriers. Pursuant to HIPAA regulations, protected health information is defined as "individually identifiable health information" that is transmitted

by electronic media, maintained in electronic media or transmitted to maintained in any other form or medium. “Individually identifiable health information” is defined as information that:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

45 C.F.R. § 160.103 (emphasis added). HIPAA has a built-in mechanism by which medical providers can de-identify individually identifiable health information and thereby disclose information. 45 C.F.R. § 164.514(a)-(b). Moreover, even if redacted medical records were considered “individually identifiable health information,” HIPAA contains an exception for the disclosure of health information in the course of legal proceedings. *See* 45 C.F.R. § 164.512 (e).

2. The Requested Records Are Not Privileged

There is likewise no privilege that shields otherwise relevant medical records from production in a civil case alleging medical malpractice. While Rule 503(d) provides a doctor-patient privilege, standing to assert this privilege belongs to the *patient*, not the doctor. The Superior Court has dealt with this precise issue by ordering that the records be produced with the name of the patient redacted. *Balian v. Kamm*, 1987 Me. Super. LEXIS 376 (granting Defendant’s motion to compel production of records that contained patients’ names so long as names were redacted from records).

In its May 17, 2018 letter to the Court, Mid Coast cited *Bennett By and Through Bennett v. Fieser*, 152 F.R.D 641 (D. Kan. 1994). In that case, the U.S. District Court in Kansas ordered

production of non-party medical records. In its analysis, the court observed that the “**vast majority of states that have addressed this issue have held that non-party patient medical records are discoverable and do not violate the physician-patient privilege where there are adequate safeguards to protect the identity of the non-party patient.**” *Id.* at 642 (emphasis added).

This Court should order the production of Dr. Marietta’s operative reports, because these reports are reasonably calculated to lead to the discovery of admissible evidence, and these reports are not privileged. Dr. Marietta’s operative reports may in fact confirm that her standard practice is to always use the “Mia Marietta” approach to removing gallbladders. Conversely, her operative reports may demonstrate that she used the CVS approach in her other gallbladder removal surgeries, but failed to use that approach during Carol’s surgery.

II. Dr. Marietta’s Personnel File is Discoverable

When Dr. Marietta was deposed in this matter on April 25, 2017, she was employed at Mid Coast. In June 2017, Dr. Marietta left her employment at Mid Coast Hospital. Panel 6. She has worked as contractor for Advantage Wound Care, a company that provides personnel to skilled nursing facilities, since September 2017. Panel 6-8. She no longer performs general surgery under anesthesia. Panel 8.

A. The Documents in Dr. Marietta’s Personnel File Are Relevant

At the panel hearing, undersigned counsel asked Dr. Marietta, “Did your leaving [Mid Coast] have anything to do with this case?” Dr. Marietta replied, “No it did not.” Panel 7. Without the documents from Dr. Marietta’s personnel file, Plaintiff has no way to challenge Dr. Marietta’s assertion. Moreover, to the extent records in her personnel file state that she was

terminated for substandard or negligent care those documents are relevant to Carol's claim and may require additional discovery.

In a recent medical malpractice case in the United States District Court for the District of Maine, the defendant nurse practitioner testified at deposition that she was no longer working at the practice where the alleged malpractice occurred. She testified that her departure had nothing to do with the actions described in the malpractice claim. Over the United States' objection, the U.S. District Court ordered the entire personnel file be produced for in camera review. *Cummins v. United States of America*, Docket No. 17-CV-0119-DBH (Nivison, J.) (D. Me. Dec. 5, 2017). Attached as **Exhibit 6**. After reviewing the documents, Judge Nivison identified three documents that contained "information potentially relevant" in the matter and ordered those documents be produced. *Id.* One of the documents stated specifically that the nurse practitioner was terminated due to her "**negligent**" treatment of the decedent.

As in the *Cummins* case, there may be documents in Dr. Marietta's personnel file that are admissible or "reasonably calculated to lead to the discovery of admissible evidence." *See* M.R. Civ. P. 26(b)(1).

B. None of the Maine Statutes Cited by Mid Coast Authorize Mid Coast to Withhold Dr. Marietta's Personnel File

Mid Coast's argument that Maine law precludes the production of Dr. Marietta's **entire** personnel file is without merit. A close examination of each statute cited by Mid Coast demonstrates that these statutes do not provide any justification for Mid Coast's decision to withhold every document in Dr. Marietta's personnel file.

Mid Coast first cites 26 M.R.S.A § 631, the labor department's statute that gives employees the right to review their own personnel file. This statute does shield the production of documents in a personnel file in a professional negligence civil suit. Section 631 merely states

that an employer may maintain its employee's personnel files on paper, microfiche, or electronic form, but it must take adequate steps to ensure the integrity and confidentiality of the files. 26 M.R.S.A § 631.

Mid Coast next argues that any medical records or references to medical information in Dr. Marietta's personnel file are non-discoverable because they are confidential. Claims of confidentiality do not limit a party's right to conduct discovery. Discovery is "constrained by principles of relevance and privilege," not confidentiality. *Pinkham v. DOT*, 2016 ME 74, ¶ 12, 139 A.3d 904, 909 ("Whereas FOAA governs the disclosure of non-confidential public information, discovery regards the disclosure of information—which may be confidential—within the closed universe of litigation."). Thus, the documents are discoverable if they are non-privileged and relevant. If this Court is concerned that the requested documents are confidential, there are well-established mechanisms to maintain confidentiality, including protective orders, in camera review, and redaction of identifying information. *Id.*, fn. 10.

Defendant argues that portions of Dr. Marietta's personnel file may be privileged pursuant to 24 M.R.S.A. § 2510-1A of the Maine Health Security Act if her personnel file contains professional competence review records. This privilege, however, is limited to professional competence review records, which are specifically defined as "the minutes, files, notes, records, reports, statements, memoranda, data bases, proceedings, findings and work product prepared at the request of or generated by a professional competence review committee relating to professional competence review activity." 24 M.R.S.A § 2502(8). The records are not professional competence review records if they were created for a purpose other than professional competence review activity and are available from a source other than a professional competence committee. *Id.* The only way to determine whether any of the

documents in the personnel file may fall into this narrow category of privileged material is through the production of a detailed privilege log or through in camera review. Mid Coast cannot simply rely on this blanket objection as a basis to withhold the entire personnel file.

Mid Coast also maintains that any written sentinel event reports in the personnel file are privileged pursuant to 22 M.R.S.A § 8754. The privilege does not apply to: (1) [a]ny final administrative action; (2) [i]nformation independently received pursuant to a 3rd-party complaint investigation conducted pursuant to department rules; or (3) [i]nformation designated as confidential under rules and laws of this State. 22 M.R.S.A § 8754(3)(E). The only way to determine if any individual documents are privileged is through the production of a very detailed privilege log or through in camera review.

III. Documents Related to Dr. Marietta's Training and Continuing Education Are Discoverable

Plaintiff requested all documents currently in Mid Coast's possession, custody, or control relating to the training and/or continuing education of Dr. Marietta, including all documents she submitted to Mid Coast showing the continuing education credits she earned between 2011 and 2015.

Dr. Marietta's training on the CVS is relevant to the issue of whether she should have used the CVS in this case. Mid Coast's expert, Dr. Schwaitzberg testified that Dr. Marietta did not breach the standard of care even though she did not use the CVS approach, because many doctors like Dr. Marietta do not know about the CVS and are not trained in this approach. Therefore, Dr. Schwaitzberg's opinion is reliant on Dr. Marietta's lack of knowledge and training.

If Mid Coast has documents related to Dr. Marietta's training and education, those documents are relevant to this claim. Without these documents, Plaintiff has no ability to

challenge Dr. Marietta's assertion that she was never trained on the CVS. If Dr. Marietta was trained in this technique, but simply chose not to employ it during Carol's surgery, that fact is highly relevant.

A. No Maine Statute Justifies Withholding Documents Regarding Dr. Marietta's Training And Continuing Education

Mid Coast argues that any responsive documents they have related to Dr. Marietta's training and continuing education are privileged as professional competence review records. The requested documents, however, are extremely unlikely to fall within the definition of professional competence review records (see above discussion on page 10-11). 24 M.R.S.A. § 2502(8). If the records were created for purposes other than professional competence review activity and are available from a source other than the committee, they are not privileged records. *Id.* If Mid Coast claims that any documents regarding Dr. Marietta's education or training are privileged, they are required to submit a detailed privilege log or produce the records for in camera review.

Defendant Mid Coast also repeatedly claims that, because Dr. Marietta is not a named party in the post-panel proceedings, they have no obligation to produce material that Dr. Marietta could possibly produce. This argument is non-sensical. These requests were made to Mid Coast regarding documents that may be in their possession. Whether or not Dr. Marietta may maintain her own copies of particular documents is irrelevant to the analysis about whether the documents are relevant and non-privileged.

IV. Audit Trail Materials are Discoverable

Carol requested documents that show an audit trail for the electronic medical records created for her care at Mid Coast in 2015. The requested records should show the date and time that each entry was made, as well as the date and time of any edits. The requested records

should include the identity of the person making the entry, as well as the substance of each entry. Plaintiff has narrowed her request to the audit materials that relate only to Dr. Marietta's entries in Plaintiff's medical record.

Any medical facility that uses electronic medical records must implement protocols for creating audit trails to comply with HIPAA regulations. To ensure that patients' personal health records are secure and private, Mid Coast must have a system in place to perform an audit of who has accessed which records. *See* 45 C.F.R. § 164.308(a)(1)(ii)(C); 45 C.F.R. § 164.308(a)(1)(ii)(D); 45 C.F.R. § 164.312(b).

Audit trail production has become a standard part of medical malpractice litigation. An audit trail is created by automated software that contemporaneously records the manipulation of a patient's electronic medical record as it occurs. Every time a user views a medical record, edits, prints, deletes, downloads, exports, or otherwise manipulates any part of a patient's electronic medical record, the computer system makes a record of that activity. The record is known as an audit log or audit trail.⁴ The audit trail provides direct evidence of exactly what was done, when, and by whom to a patient's medical record. In fact, the audit trail is part of the patient's medical record; it cannot be separated from the medical record because every access, entry, and edit to the electronic medical record generates a corresponding entry in the audit trail. This information provides direct evidence regarding the care Carol received at Mid Coast.

A. The Audit Trail Is Discoverable Because It Is Relevant to Carol's Claim

When Dr. Marietta accessed the medical record and what edits she made are highly relevant to this case. For example, whether Dr. Marietta made any edits to her operative note after she became aware that Carol had a bile duct injury is information that is highly relevant.

⁴ If the log or audit only shows who accessed that record (and when they did so), the document is an access log or access trail.

That type of information is not only relevant, but it is not obtainable from any other part of the medical record.

B. Mid Coast Cannot Withhold the Audit Trail Simply Because They Believe the Audit Trail Will Not Be Admissible at Trial

Mid Coast objected to the production of the audit trail on the basis that an audit trail itself may not be admissible. Admissibility is not the standard for whether data is discoverable; it is whether it is “reasonably calculated to lead of the discovery of admissible evidence.” M.R. Civ. P. 26(b)(1). The request for the audit trail in this case is certainly calculated to lead to the discovery of admissible evidence.

C. The Audit Trail is Not Privileged

Mid Coast objected to the production of the audit trail to the extent that it is privileged as part of professional competence review activities. Dr. Marietta did not create an operative report for professional competence review reasons. She accessed Carol’s medical records and created an operative report as part of her medical care and general recordkeeping—this is not privileged. If Mid Coast is concerned that specific entries may be privileged, they can produce a detailed privilege log.

D. It Is Not Unduly Burdensome to Produce an Audit Trail.

Mid Coast employs IT staff who are required to be trained regarding the creation of audit trails to comply with Medicare or Medicaid requirements, for internal purposes, or in response to concerns about HIPAA violations. An audit trail is created when an IT employee performs a simple database query. The production of an audit trail will not take clinicians away from their patients.

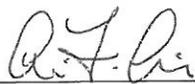
Because Carol was treated at Mid Coast for a limited period of time, and she is only requesting the audit trail that reflects Dr. Marietta’s entries, the audit trail in this case is likely

very concise. It is hardly burdensome for an IT department to produce a document that is most likely less than ten pages of data.

CONCLUSION

For the reasons set forth above, Plaintiff respectfully requests that this Court order Defendant Mid Coast Hospital to produce all documents responsive to Plaintiff's Requests #1, 2, 5, 7, 8, and Supplemental Request #1.

Dated: July 30, 2018

 Travis M. Brennan, Esq. *Maine Bar No 10033*
for
Maine Bar No. 4525
Berman & Simmons, P.A.
P.O. Box 961
Lewiston, ME 04243-0961
(207) 784-3576
Attorney for Plaintiff

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STATE OF MAINE
CUMBERLAND, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO.: CV-16-471

CAROL A. KENNELLY

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*

Plaintiff

v.

ORDER

MID COAST HOSPITAL

Defendant

After careful review and consideration, the Court hereby **GRANTS** Plaintiff Carol A. Kennelly's Motion to Compel Production of Discovery with Incorporated Memorandum of Law. Defendant Mid Coast Hospital shall produce documents that are responsive to Plaintiff's Requests #1, 2, 5, 7, 8, and Supplemental Request #1.

Dated: _____

JUSTICE, SUPERIOR COURT

STATE OF MAINE
CUMBERLAND, ss.

SUPERIOR COURT
CIVIL ACTION
Docket No.: CV-16-471

CAROL A. KENNELLY,)	
)	
Plaintiff)	
)	
v.)	ANSWER TO PLAINTIFF'S COMPLAINT
)	
MID COAST HOSPITAL)	
)	
Defendant)	

NOW COMES the Defendant, Mid Coast Hospital, by and through its undersigned counsel, and answer Plaintiff's Complaint as follows:

PARTIES

1. Defendant is without information or knowledge sufficient to form a belief as to the truth of the allegations contained in Paragraph 1 of Plaintiff's Complaint and, therefore, denies the same.

2. Defendant admits the allegations contained in Paragraph 2 of the Plaintiff's Complaint.

3. Defendant admits the allegations contained in Paragraph 3 of the Plaintiff's Complaint.

4. Defendant admits the allegations contained in Paragraph 4 of the Plaintiff's Complaint.

5. Defendant admits the allegations contained in Paragraph 5 of the Plaintiff's Complaint.

FACTS

6. Defendant admits the allegations contained in Paragraph 6 of the Plaintiff's Complaint.

7. Defendant admits the allegations contained in Paragraph 7 of the Plaintiff's Complaint.

8. Defendant admits the allegations contained in Paragraph 8 of the Plaintiff's Complaint.

9. In response to Paragraph 9 of Plaintiff's Complaint, Defendant admits that Dr. Marietta performed a laparoscopic cholecystectomy on September 2, 2015, but denies the remaining allegations in Paragraph 9 of Plaintiff's Complaint.

10. Defendant denies the allegations contained in Paragraph 10 of the Plaintiff's Complaint.

11. Defendant admits the allegations contained in Paragraph 11 of the Plaintiff's Complaint.

12. Defendant admits the allegations contained in Paragraph 12 of the Plaintiff's Complaint.

13. In response to Paragraph 13 of Plaintiff's Complaint, Defendant admits that Dr. Rutstein performed an exploratory laparotomy in which she found that Dr. Marietta had transected the common bile duct and performed a Roux-En-Y retrocolic hepaticojejunostomy, but denies the remaining allegations contained in Paragraph 13 of Plaintiff's Complaint.

14. Defendant admits the allegations contained in Paragraph 14 of the Plaintiff's Complaint.

15. Defendant is without information or knowledge sufficient to form a belief as to the truth of the allegations in Paragraph 15 of Plaintiff's Complaint, and therefore denies the same.

COUNT I: MEDICAL NEGLIGENCE

16. Defendant repeats and reasserts its answers to the allegations contained in Paragraphs 1 through 15 of the Plaintiff's Complaint as though set forth in full herein.

17. Paragraph 17 of Plaintiff's Complaint purports to state a legal conclusion to which no response is required; to the extent a response is deemed required, Defendant denies the allegations contained in Paragraph 17 of Plaintiff's Complaint.

18. Defendant denies the allegations contained in Paragraph 18 of the Plaintiff's Complaint.

19. Defendant denies the allegations contained in Paragraph 19 of the Plaintiff's Complaint.

20. Defendant denies the allegations contained in Paragraph 20 of the Plaintiff's Complaint.

21. Defendant denies the allegations contained in Paragraph 21 of the Plaintiff's Complaint.

WHEREFORE Defendant Mid Coast Hospital demands judgment on Plaintiff's Complaint and such other and further relief as the Court deems just and reasonable.

AFFIRMATIVE DEFENSES

1. Plaintiff's Complaint fails to state a claim upon that relief can be granted.

2. At the prelitigation screening panel hearing in this case, the panel found unanimously in favor of Defendant and its physician-employee, Dr. Marietta, demonstrating there are no good grounds to proceed on this complaint.

3. Plaintiff's complications were the result of conditions over which Defendant had no control.

WHEREFORE Defendant Mid Coast Hospital demands judgment on Plaintiff's Complaint and such other and further relief as the Court deems just and reasonable.

Dated at Portland, Maine this 9th day of February, 2018.



Philip M. Coffin III, Esq., Bar No. 2462
Attorney for Defendant
Mid Coast Hospital

LAMBERT COFFIN
One Canal Plaza, Suite 400
P.O. Box 15215
Portland, ME 04112-5215
(207) 874-4000

L A M B E R T / C O F F I N

ATTORNEYS

June 15, 2018

Abigail C. Varga
avarga@lambertcoffin.com

Julie Howard, Esq., Clerk
Maine Superior Court
County of Cumberland
205 Newbury Street, Ground Floor
Portland, ME 04112

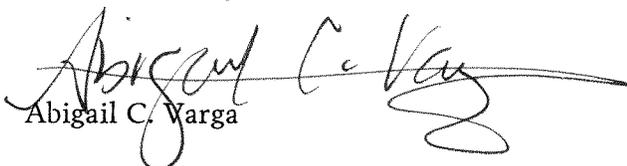
Re: ***Carol A. Kennelly v. Mid Coast Hospital***
Docket No: CV-16-471
LC File No: 4784-181

Dear Ms. Howard:

I just received Attorney Brennan's request for a 26(g) conference with the Court. I have attached the response letter from the Defendant to Plaintiff that preceded the pending request, as it describes in greater detail the Defendant's position on the Plaintiff's overly broad and unduly burdensome requests, and "describe[s] the nature of the dispute and the relief requested" as require by Rule 26(g). Could you please provide this letter to the Court?

Thank you for your assistance.

Very truly yours,


Abigail C. Varga

Enclosure

cc: Travis M. Brennan, Esq. (w/ enc)
Robert P. Hayes, Esq. (w/enc)

L A M B E R T / C O F F I N

ATTORNEYS

May 17, 2018

Abigail C. Varga, Esq.
avarga@lambertcoffin.com

Travis M. Brennan, Esq.
Berman & Simmons, PA
PO Box 961
Lewiston ME 04243-0961

Re: ***Carol A. Kennelly v. MidCoast Hospital***
Docket No: CV-16-471
LC File No: 4784-181

Dear Travis:

I am writing to you in response to your letter dated April 30, 2018, in the attempt to resolve this discovery dispute. I respond to each of your lettered requests below.

A. Requests 1 & 2: Operative notes

I requested Dr. Marietta's redacted operative notes for laparoscopic cholecystectomies she performed before and after her surgery with Ms. Kennelly. Please confirm whether you intend to produce these operative notes.

MidCoast's Response:

This request is not reasonably calculated to lead to the discovery of admissible evidence. Pursuant to M.R. Evid. 401, “[e]vidence is relevant if: (a) It has any tendency to make a fact more or less probable than it would be without the evidence; and (b) The fact is of consequence in determining the action.” Generally, prior statements or actions are not relevant if “they do not deal with or relate to the conduct in” the case at issue. *See Jacob v. Kippax*, 2011 ME 1, ¶ 18, 10 A.3d 1159; *see also State v. Jordan*, 1997 ME 101, ¶ 7, 694 A.2d 929. Indeed, the Law Court has held that statements and admissions made in a disciplinary proceeding before a licensing board “are not relevant because they do not deal with or relate to the conduct in this case,” and are not “probative evidence of negligent treatment” of a plaintiff in a subsequent malpractice action. *Jacob v. Kippax*, 2011 ME 1, ¶ 18 10 A.3d 1159; *see also Jordan*, 1997 ME 101, ¶ 7, 694 A.2d 929 (holding that evidence of prior acts against a third party “had no probative value in proving [the defendant’s] guilt of the later crime committed against someone else”).

The care questioned in this matter involves the care provided to Ms. Kennelly during the laparoscopic cholecystectomy performed by Dr. Marietta. The documentation related to surgeries performed on non-party patients has no tendency to make it more or less likely that Dr. Marietta met the standard of care in her treatment of Ms. Kennelly. In addition, absent identifying information regarding these other non-party patients that describes private medical histories, anatomies, comorbidities, etc., there is no way to determine whether these patients are similarly situation to Ms. Kennelly. Producing medical records – even with redactions- would result in an

analysis of the entire medical histories of non-party patients; a clear violation of their rights to privacy, confidentiality, and privilege.

Further, the operative note describes the steps Dr. Marietta took during the procedure; there is no testimony by Dr. Marietta disputing what the operative note says. This is not a case in which a physician is arguing that the operative note fails to mention steps normally taken as part of a routine or custom practice that warrants violating the rights of the non-party patients to their protected healthcare information that the plaintiff wishes to explore.¹

Needless to say, this request also seeks materials and/or information that is private, privileged and confidential. Not only are there state and federal statutes protecting a patient's health care information, *see e.g.* 22 M.R.S. § 1711-C and HIPAA, codified in 45 C.F.R. 164, but the doctor/patient privilege is also intended to protect non-party patients from disclosures such as these. Under M.R. Evid. 503(b), "[a] patient has a privilege to refuse to disclose, and to prevent any other person from disclosing, confidential communications made for the purpose of diagnosing or treating the patient's physical, mental, or emotional condition . . ." Generally, "M.R. Evid. 503 defines as a confidential 'communication' those 'communications not intended to be disclosed to third persons.'" *Halacy v. Steen*, 670 A.2d 1371, 1376 (Me. 1996); *see also* M.R. Civ. P. 26(b)(1) ("parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action . . ."). In this day and age of modern technology, it is questionable at best whether a non-party's confidential medical information would be adequately protected by redaction. *See e.g. Bennett v. Fiesler*, 152 F.R.D. 641, 643 (D. Kan. 1994) ("[P]roviding medical records with names and identifying information removed could nonetheless provide vital clues which would assist a party in identifying the nonparty patient."). Privileges "serve to facilitate candor in important relationships that rely on the sharing of sensitive, confidential information." *State v. Tracy*, 2010 ME 27, ¶ 17, 991 A.2d 821 (discussing privileges generally). As such, the doctor/patient privilege shields disclosure of the operative notes of non-party patients.

Finally, the burden that plaintiff attempts to place on MidCoast cannot be understated – not only are the administrative burdens great, but the request would undermine the trust and confidence of patients who will surely question whether their sensitive medical information is truly protected by MidCoast. Indeed, if this were a legal malpractice claim, a request for production seeking non-party attorney/client communications would undoubtedly be denied, and no amount of redacting would render such a production appropriate.

In summary, because 1) Dr. Marietta's testimony makes it clear that she is not relying on habit or routine practice evidence, 2) non-party patient records have no bearing on the care provided to the claimant, 3) privacy statutes preclude such a production, 4) physician/patient privilege and the Maine Rules of Civil Procedure preclude such a production, and 5) the burden on the Defendant would be great on not only an administrative and monetary basis but also upon its goodwill in the community, MidCoast maintains its objections to your request for production and will not produce a non-party's private, privileged, and confidential medical records.

¹ Notably, even if Dr. Marietta was relying on custom and routine practice, which she is not, such information would still not be relevant.

B. Request 3: Complication Rates for other surgeons at Mid Cost Hospital performing laparoscopic cholecystectomy

I requested documents reflecting complication rates for all surgeons at MidCoast Hospital who performed laparoscopic cholecystectomy between January 1, 2012 and December 31, 2015. Please confirm whether you intend to produce these documents.

MidCoast's Response:

Please see the response to your Request lettered A. Of further note, adding to the irrelevant nature of your request, not only does this request ask for information regarding other non-party patients, but it also asks for information regarding other non-party *surgeons*. The way in which another surgeon operates on another patient has no bearing on whether Dr. Marietta breached the standard of care in her treatment of Ms. Kennelly.

C. Request 4: Dr. Marietta's complication rate

I requested documents reflecting Dr. Marietta's complication rate for laparoscopic cholecystectomy between January 1, 2012 and December 31, 2015. Please confirm whether you intend to produce these documents.

MidCoast's Response:

Please see the response to your Request lettered A.

D. Request 5: Dr. Marietta's personnel file

I requested Dr. Marietta's personnel file. It is my understanding from Dr. Marietta's testimony at the panel hearing, that she is no longer employed at MidCoast. My request encompasses documents related to the circumstances under which she left MidCoast Hospital, any disciplinary actions that were taken against her by the hospital, and any reviews of her in her personnel file. Please confirm whether you intend to produce these documents.

MidCoast's Response:

This discovery request for Dr. Marietta's personnel file is overly broad, vague, unduly burdensome, and not reasonably calculated to lead to the discovery of admissible evidence. The fact that Dr. Marietta is no longer employed by the hospital is not relevant to the care provided to your client during the time period in question when she was a hospital employee.

Furthermore, the contents of Dr. Marietta's personnel file are protected pursuant to 26 M.R.S.A. § 631, which directs employers to "take adequate steps to ensure the integrity and confidentiality" of the records in an employee's "personnel file." Personnel files are created with the employee's right to confidentiality in mind: the contents of personnel files are disclosed only to the individual employee and are never made available to the public. I also note that you chose not to name Dr. Marietta in this lawsuit. While that decision is yours to make, MidCoast does not become the conduit by which you obtain information that could come from Dr. Marietta.

I further note that to the extent that Dr. Marietta's personnel file contains written professional competence review records, these too would be protected under the Maine Health Security Act:

all professional competence review records are privileged and confidential and are not subject to discovery, subpoena, or other means of legal compulsion for their release to any person or entity and are not admissible as evidence in any civil, judicial or administrative proceeding. Information contained in professional competence review records is not admissible at trial or deposition in the form of testimony by an individual who participated in the written professional competence review process.

24 M.R.S.A. § 2510-A.

Similarly, to the extent that Dr. Marietta's personnel file contains written sentinel events reports, these records are protected by the Health Care Quality Improvement Act of 1986, and 22 M.R.S.A. § 8754, which states that "[n]otifications and reports filed pursuant to this chapter[, Sentinel Events Reporting,] and all information collected or developed as a result of the filing and proceedings pertaining to the filing, regardless of format, are confidential and privileged information." 22 M.R.S.A. § 8754.

Of further note, to the extent that Dr. Marietta's personnel file includes medical information generated from a pre-employment physical or other medical examinations, not only would these records be irrelevant and not reasonably calculated to lead to the discovery of admissible evidence, these records are treated as confidential medical records. 5 M.R.S.A. § 4572(2)(C)(2). Likewise, to the extent that Dr. Marietta's personnel file contains any medical information, including information received during the processing of sick leave, family medical leave request, workers' compensation, or disability claims, the Americans with Disabilities Act provides that these records must be treated as a confidential medical record. 42 U.S.C.A. § 12112.

Given that the contents of Dr. Marietta's personnel file are not reasonably calculated to lead to the discovery of admissible evidence that there was any alleged breach in the standard of care as it pertains to Ms. Kennelly, and that it contains information that is provided the protection by the aforementioned statutes, MidCoast maintains its objections to this request.

E. Request 6: Privileging and credentialing

I requested documents relating to privileging and/or credentialing of Dr. Marietta to provide surgical services at MidCoast Hospital. Please confirm whether you intend to produce these documents.

MidCoast's Response:

MidCoast maintains its objection as not only are such records irrelevant, but they are protected under the Maine Health Security Act, 24 M.R.S.A. § 2510-A, and, to the extent that the privileging and/or credentialing records contain information regarding any written sentinel events reports, these records are protected by the Health Care Quality Improvement Act of 1986, and 22 M.R.S.A. § 8754.

Travis Brennan, Esq.
May 17, 2018
Page 5

F. Request 7: Training and continuing medical education

I requested documents reflecting Dr. Marietta's training and/or continuing medical education. Please confirm whether you intend to produce these documents.

MidCoast's Response:

MidCoast maintains its objection as not only are such records irrelevant, but they are protected under the Maine Health Security Act, 24 M.R.S.A. § 2510-A, and, to the extent that the privileging and/or credentialing records contain information regarding any written sentinel events reports, these records are protected by the Health Care Quality Improvement Act of 1986, and 22 M.R.S.A. § 8754. Again, while it was your decision to not name Dr. Marietta in this lawsuit, MidCoast does not become the conduit by which you obtain information that is confidentially maintained in its files, but could possibly come from Dr. Marietta.

G. Request 8: Continuing education credits

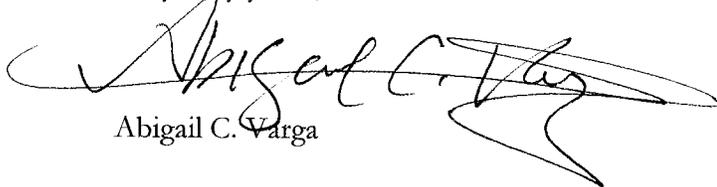
I requested documents showing Dr. Marietta's continuing education credits between 2011 and 2015. Please confirm whether you intend to produce these documents.

MidCoast's Response:

MidCoast maintains its objection as not only are such records irrelevant, but they are protected under the Maine Health Security Act, 24 M.R.S.A. § 2510-A, and, to the extent that the privileging and/or credentialing records contain information regarding any written sentinel events reports, these records are protected by the Health Care Quality Improvement Act of 1986, and 22 M.R.S.A. § 8754. Again, while it was your decision to not name Dr. Marietta in this lawsuit, MidCoast does not become the conduit by which you obtain information that is confidentially maintained in its files, but could possibly come from Dr. Marietta.

Finally, to the extent that you plan to request a conference with the Court regarding the abovementioned requests, I ask that you include this response, detailing defendant's position, when you do so.

Very truly yours,


Abigail C. Varga

Cc: Rob Hayes, Esq. (via email only)

JUL 18 2018

RECEIVED

Travis M. Brennan
(207) 784-3576
tbrennan@bermansimmons.com

June 22, 2018

Julie Howard
Clerk of Court
Cumberland County Superior Court
P.O. Box 412
Portland, ME 04112

Re: Carol (Arsenault) Kennelly v. Mid Coast Hospital
Docket No.: CV-16-471
Our File No.: 26762-01

Dear Julie:

I am in receipt of Attorney Varga's letter to this Court dated June 15, 2018, in which Attorney Varga enclosed a letter between the parties that preceded the request for a discovery hearing. The Defendant claims that it sent this letter to the Court because "it describes in greater detail the Defendant's position on the Plaintiff's overly broad and unduly burdensome requests."

I object to Attorney Varga's enclosure of this letter because it expressly violates M.R. Civ. P. 26(g). Pursuant to Rule 26(g)(1), the moving party is limited to providing a letter to the Court that "shall succinctly and without argument or citation describe the nature of the dispute and the relief requested." Rule 26(g)(2) states that "**no written argument shall be submitted, and no motion papers shall be filed with the Clerk without prior leave of the Court.**" (emphasis added).

The Defendant's "letter" is tantamount to a memorandum of law and represents a backdoor attempt to argue these issues before the Court. If the Defendant wishes to request supplemental briefing to argue its points, the Defendant should request leave from this Court to do so. The Defendant cannot, however, include a memorandum of law under the guise of a "letter" and suggest that they have complied with either the letter or the spirit of Rule 26(g).

Thank you for your attention to this matter.

REC'D CLERK CLERKS OF
JUN 25 '18 AM 11:19

Warren

Julie Howard
June 22, 2018
Page 2

Sincerely,



Travis M. Brennan

TMB/msh

cc: Carol A. Kennelly
Philip M. Coffin, III, Esq.

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mcv

7/16/18.

The parties are to file written arguments relative to the discovery disputes by 7/30/18, after which the Clerk shall schedule a telephone conference between counsel and the court.



Lance Walker

STATE OF MAINE
CUMBERLAND, ss.

SUPERIOR COURT
CIVIL ACTION
Docket No.: CV-16-471

CAROL A. KENNELLY)	
)	
Plaintiff)	MID COAST HOSPITAL'S DISCOVERY
)	DISPUTE WRITTEN ARGUMENT
v.)	
)	
MID COAST HOSPITAL,)	
)	
Defendant)	

NOW COMES the defendant, Mid Coast Hospital (“Mid Coast”), by and through its undersigned attorneys, Lambert Coffin, and, pursuant to the Court’s July 16, 2018 Order, submits this written argument relative to the pending discovery dispute between the parties.

PROCEDURAL HISTORY

A brief summary of the procedural history of this matter is helpful in providing some context leading up to the pending discovery dispute.

The plaintiff, Carol Kennelly, filed a Notice of Claim dated November 18, 2016, in which she alleged that Mia Marietta, M.D. failed to meet the standard of care of a reasonable competent general surgeon in the care she provided to Plaintiff. Plaintiff claims that Dr. Marietta negligently transected the common hepatic duct while performing a laparoscopic cholecystectomy¹ (“lap chole”) on September 2, 2015. Plaintiff’s sole claim against Mid

¹ A laparoscopic cholecystectomy is a surgery during which a doctor removes the gallbladder. This procedure uses several small cuts instead of one large one. A laparoscope, a narrow tube with a camera, is inserted through one incision, allowing the doctor to see the gallbladder on a screen.

Coast was that it was vicariously liable for Dr. Marietta's actions. The matter proceeded through the prelitigation screening process as required by Maine law. *See* 24 M.R.S. § 2853.

On January 24, 2018, the prelitigation screening phase culminated with a panel hearing before three panelists – panel chair Marilyn Ashcroft, Esq.; Mary Collins, M.D.; and Michael Povich, Esq. Mid Coast and Dr. Marietta were each represented by separate counsel at the panel. The panel unanimously found in favor of Dr. Marietta and Mid Coast; concluding that neither were negligent, and they did not proximately caused the injury complained of by Plaintiff. *See Exhibit A, a true and accurate copy of the panel findings.*

In a Complaint dated January 29, 2018, the Plaintiff alleged a sole count of medical negligence against only Mid Coast, alleging that it was vicariously liable for any and all actions of its employees. The sole basis for the assertion of negligence echoed those stated in the Notice of Claim. Plaintiff did not name Dr. Marietta as a defendant in the civil suit.

The parties proceeded to engage in standard discovery per the Court's scheduling order. The parties are at an impasse, however, regarding a number of the Plaintiff's requests for production, which has resulted in the need for the Court's assistance under Rule 26(g).²

² Mid Coast is prepared to respond fully to the discovery issues presented to the Court, however, given the allegations contained in Plaintiff's June 22, 2018 letter, a few facts bear mentioning. In Plaintiff's June 12, 2018 letter to the Court requesting a discovery hearing, the Plaintiff (1) changed the scope of the initial request for documents, indicating that Plaintiff is now willing to change certain requests, and (2) added additional discovery issues never raised with Mid Coast relating to a supplemental request for production such that Mid Coast never had the opportunity to engage in good faith discussions regarding this supplemental request. It is also questionable whether writing a letter to opposing counsel simply reiterating a discovery request and never engaging in any discussion regarding the opposing party's position constitutes a good faith effort to resolve a discovery dispute. Of further note, counsel for Plaintiff never engaged in any communications with counsel for Mid Coast regarding their differing interpretations of what should or should not be provided to the Court with a request for a discovery hearing, and instead ignored the explicit request by counsel to provide the Court with information that "describe[s] the nature of the dispute." Although Mid Coast could reasonably object to Plaintiff's representation to the Court that

PENDING DISCOVERY DISPUTES

I. Requests 1 & 2: Operative notes

Plaintiff requested copies of Dr. Marietta's operative notes for the fifty (50) laparoscopic cholecystectomies she performed before and after her surgery with Ms. Kennelly. In her June 12, 2018 letter, Plaintiff indicates that she is now willing to narrow this request to the notes for the twenty-five (25) laparoscopic cholecystectomies she performed before and after her surgery with Ms. Kennelly.

Mid Coast's argument in support of its objections:

This request is not reasonably calculated to lead to the discovery of admissible evidence because it asks for information that is irrelevant to the care provided to the Plaintiff. Pursuant to M.R. Evid. 401, “[e]vidence is relevant if: (a) It has any tendency to make a fact more or less probable than it would be without the evidence; and (b) the fact is of consequence in determining the action.” Generally, prior statements or actions are not relevant if “they do not deal with or relate to the conduct in” the case at issue. *See Jacob v. Kippax*, 2011 ME 1, ¶ 18, 10 A.3d 1159; *see also State v. Jordan*, 1997 ME 101, ¶ 7, 694 A.2d 929. Indeed, the Law Court has held that prior statements and admissions made in a prior case “are not relevant because they do not deal with or relate to the conduct in th[e] pending] case,” and are not “probative evidence of negligent treatment” of a plaintiff in a subsequent malpractice action. *Jacob*, 2011 ME 1, ¶ 18 10 A.3d 1159; *see also Jordan*, 1997 ME 101, ¶ 7, 694 A.2d 929 (holding that evidence of prior acts against a third party “had no probative value in proving [the defendant’s] guilt of the later crime committed against someone else”).

the parties engaged in good faith communications regarding the pending discovery issues, counsel is mindful of the futility of form over substance positions, and is prepared to engage in a substantive discussion about the discovery requests at a time to be determined by the Court.

The care questioned in this matter involves the care provided to Ms. Kennelly during the laparoscopic cholecystectomy performed by Dr. Marietta. The documentation related to surgeries performed on non-party patients has no tendency to make it more or less likely that Dr. Marietta met the standard of care in her treatment of Ms. Kennelly.

Further, the medical records that have already been exchanged and discussed at the depositions and the panel hearing by the parties and their experts describe the care provided to the Plaintiff, including the steps Dr. Marietta took during the procedure.³ There is no testimony by Dr. Marietta disputing what the operative note says. In fact, in response to Plaintiff's counsel's question at her deposition: "Do you believe that your operative note is accurate . . . [a]nd consistent with what you actually did during surgery," Dr. Marietta responded: "I do." *See Exhibit B, Excerpts from Dr. Marietta's deposition at pgs 122-123.* This is not a case in which a physician is arguing that the operative note fails to mention steps normally taken as part of a routine or custom practice that could possibly warrant violating the rights of non-party patients to their protected healthcare information that the plaintiff wishes to explore.⁴

Needless to say, this request also seeks materials and information that is private, privileged and confidential. There are stringent state and federal statutes protecting a patient's health care information. *See e.g.* 22 M.R.S. § 1711-C and HIPAA, codified in 45 C.F.R. 164; *see also* M.R. Evid. 503(b) ("[a] patient has a privilege to refuse to disclose, and

³ Indeed, counsel for Plaintiff spent a significant amount of time discussing Dr. Marietta's detailed operative note with Dr. Marietta at her deposition. *See Exhibit B, pgs 48-66 of Dr. Marietta's deposition.*

⁴ Notably, even if Dr. Marietta was relying on her custom and routine practice to describe the care she provided to Ms. Kennelly, which she is not according to her testimony, such information would still not be discoverable.

to prevent any other person from disclosing, confidential communications made for the purpose of diagnosing or treating the patient’s physical, mental, or emotional condition. . . .”); M.R. Civ. P. 26(b)(1) (“[p]arties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action”); *cf.* *In re Motion to Quash Bar Counsel Subpoena*, 2009 ME 104, ¶ 13, 982 A.2d 330 (the purpose of the attorney-client privilege is “to encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and administration of justice.” (citations omitted) (quotation marks omitted)).

The Maine Legislature made it clear: “An individual’s health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility,” with certain exceptions not applicable here. 22 M.R.S. § 1711-C(2). The plain language of the statute provides that patients who seek care in Maine can rely on the fact that their records will be kept confidential, such that they will not be disclosed without their authorization. There is no assertion by the Plaintiff that any exception to the confidentiality statute applies here; simply because a record may be relevant (which, here, it is not), does not mean that it is excepted from the confidentiality protections. *See e.g.* *Voorhees Cattle Co. v. Dakota Feeding Co.*, 2015 S.D. 68, ¶ 13, 868 N.W.2d 399, 406 (rejecting argument that communication subject to attorney-client privilege was waived because attorney’s advice was relevant to show knowledge of attorney’s clients).

Plaintiff’s position appears to be that asking for redacted medical records provides adequate protections for non-party patients. This ignores not only the Legislature’s mandate that this “information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility,” 22 M.R.S. § 1711-C(2), but also that in

this day and age of modern technology, it is questionable at best whether a non-party's confidential medical information could ever be adequately protected by redaction. *See e.g. Parkson v. Central Du Page Hospital*, 105 Ill. App. 3d 850, 855, 61 Ill. Dec. 651 (1982) ("Whether the patients' identities would remain confidential by the exclusion of their names and identifying numbers is questionable at best. . . . As the patients disclosed this information with an expectation of privacy, their rights to confidentiality should be protected.) (citations omitted); *Bennett v. Fieser*, 152 F.R.D. 641, 643 (D. Kan. 1994) ("[P]roviding medical records with names and identifying information removed could nonetheless provide vital clues which would assist a party in identifying the nonparty patient."). This is especially true in states with rural areas like Maine. In community-based hospitals like Mid Coast, and the many other rural hospitals in the State, patients seek medical treatment with the expectation that their medical records and the information contained therein will be kept confidential. It is not only feasible, but likely, that there are certain areas of this State where requesting the notes for fifty other patients who were seen by a general surgeon would result in a Plaintiff finding out personal information about a member of his or her community. All it would take would be for a Plaintiff to know that a neighbor also had a lap chole (one of the most commonly performed surgical procedures) around the same time as the operation at issue to then figure out which record goes with which patient to vitiate any potential "confidentiality safeguards" for that information.

Further, even with redaction, there is no way to determine whether these non-party patients are or are not similarly situated to Ms. Kennelly without providing identifying information that describes private medical histories, anatomies, comorbidities, etc. Producing medical records – even with redactions- would result in an analysis of the entire

medical histories of non-party patients; a clear violation of their rights to privacy, confidentiality, and privilege. There are no sufficient safeguards to put in place to protect the confidentiality of the non-party patients whose records the Plaintiff has requested.

Finally, the burden that plaintiff attempts to place on Mid Coast cannot be understated – not only are the administrative burdens great, but the request would undermine the trust and confidence of patients who will surely question whether their sensitive medical information is truly protected by Mid Coast. Indeed, if this were a legal malpractice claim, a request for production seeking non-party attorney/client communications would undoubtedly be denied, and no amount of redacting would render such a production appropriate.

In summary, the medical records of a non-party patient are both privileged and confidential. Indeed, public policy supports candid communications between patients and providers to ensure quality care. If a patient fears identification through the production of medical records these communications, and subsequent care, could be impacted even in the face of alleged “safeguards” to protect patient identity, especially in a state such as Maine where there are few, if any, safeguards that could truly protect a non-party patient’s identity. Because 1) non-party patient records are irrelevant and have no bearing on the care provided to the Plaintiff, the only care at issue in this case, 2) Dr. Marietta’s testimony makes it clear that the Plaintiff’s medical records fully describe the steps she took during the surgery at issue, 3) privacy statutes preclude the production of non-party patient records, 4) physician/patient privilege and the Maine Rules of Civil Procedure preclude such a production, and 5) the burden on the Defendant would be great on not only an administrative and monetary basis but also upon its goodwill in the community, Mid Coast

maintains its objections to Plaintiff's request for production and respectfully requests that the Court conclude that such confidential medical records are irrelevant, privileged, and should not be produced.

II. Request 5: Dr. Marietta's personnel file

Plaintiff requested Dr. Marietta's personnel file, including documents related to the circumstances under which Dr. Marietta left Mid Coast Hospital, any disciplinary actions that were taken against her by the hospital, and any physician reviews.

Mid Coast's argument in support of its objections:

This discovery request is also not reasonably calculated to lead to the discovery of admissible evidence. The fact that Dr. Marietta is no longer employed by the hospital is irrelevant to the care provided to the Plaintiff during the time period in question when she was a hospital employee.

Furthermore, the contents of Dr. Marietta's personnel file are protected pursuant to 26 M.R.S.A. § 631, which directs employers to "take adequate steps to ensure the integrity and confidentiality" of the records in an employee's "personnel file." Personnel files are created with the employee's right to confidentiality in mind: the contents of personnel files are disclosed only to the individual employee and not to the public.⁵ Of further note, Plaintiff chose not to name Dr. Marietta in this lawsuit. Although that decision was Plaintiff's to make, Mid Coast does not become the conduit by which Plaintiff obtains information that could have come from Dr. Marietta. *See* 26 M.R.S. § 631 (stating that

⁵ This makes sense as, to the extent that Dr. Marietta's personnel file includes personal medical information, not only would this information be irrelevant and not reasonably calculated to lead to the discovery of admissible evidence, but it would also be confidential. 5 M.R.S.A § 4572(2)(C)(2), 42 U.S.C.A. § 12112(3), (4).

employees are entitled to a copy of their personnel files); see e.g. *Burnett v. Ocean Properties, Ltd.*, No. 2:16-CV-00359-JAW, 2017 WL 3262163, at *2 (D. Me. July 31, 2017) (quashing a subpoena because a party “did not use other means to obtain the personnel file documents at issue before resorting to a subpoena of the plaintiff’s personnel file from his current employer”).

Additionally, to the extent that Dr. Marietta’s personnel file contains written professional competence review records, which Plaintiff appears to explicitly request, regardless if included in the personnel file or not, these are protected under the Maine Health Security Act:

all professional competence review records are privileged and confidential and are not subject to discovery, subpoena, or other means of legal compulsion for their release to any person or entity and are not admissible as evidence in any civil, judicial or administrative proceeding. Information contained in professional competence review records is not admissible at trial or deposition in the form of testimony by an individual who participated in the written professional competence review process.

24 M.R.S.A. § 2510-A. Similarly, to the extent that Dr. Marietta’s personnel file contains documents relating to sentinel events reports, these records would be “confidential and privileged” pursuant to the Health Care Quality Improvement Act of 1986, and 22 M.R.S.A. § 8754(3).

Given that the contents of Dr. Marietta’s personnel file are not reasonably calculated to lead to the discovery of admissible evidence that there was any alleged breach in the standard of care as it pertains to Ms. Kennelly; that personnel files are statutorily confidential; and that the personnel file could contain statutorily protected information, Mid Coast maintains its objections to this request.

III. Request 7: Training and continuing medical education

Plaintiff requested documents reflecting Dr. Marietta's training and/or continuing medical education.

Mid Coast's argument in support of its objections:

These records are irrelevant as there is no allegation that Dr. Marietta was not a properly trained physician. They are also protected under the Maine Health Security Act because Mid Coast obtains these documents from its physicians as part of the confidential privileges and credentialing process.⁶ See 24 M.R.S.A. § 2510-A; 24 M.R.S.A. § 2502(9) (designating the privileging process as a protected written professional competence review process).

IV. Supplemental Request: Audit Trail Materials

The Plaintiff requested any and all documents through the present that show an audit trail for the electronic medical records created for Ms. Kennelly's care at Mid Coast Hospital in September 2015.

Mid Coast's argument in support of its objections:

Although Mid Coast maintains its objections and will continue to dispute the admissibility of any such documents at trial, Plaintiff's indication to the Court that this is a discovery issue is confusing because, notwithstanding Mid Coast's objections, these documents were already produced on June 9, 2017. See Exhibit C, Defendant's 060917 response to Plaintiff's Supplemental Request for Production.

Given that these documents have already been produced, and while maintaining its objections regarding the admissibility of any such documents, Mid Coast is not aware of

⁶ Information regarding Dr. Marietta's training or participation in CMEs can presumably be requested from Dr. Marietta, avoiding the statutory protections associated with Mid Coast's professional competence review process.

any discovery dispute regarding the production of the audit trail. To the extent that Plaintiff has a further issue regarding her request that Mid Coast has not been aware of, Mid Coast reserves the right to so respond.

Wherefore, Mid Coast maintains its objections to Plaintiff's discovery requests for those reasons described above, and respectfully requests that the Court deny Plaintiff's request for such information.

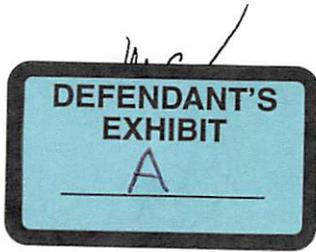
DATED at Portland, Maine, this 30th day of July, 2018.



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STATE OF MAINE
Cumberland, ss.

FEB 01 2018

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-16-471

RECEIVED

Carol Arsenault Kennelly
Claimant

v

PRELITIGATION SCREENING PANEL
FINDINGS

Mid Coast Hospital
Mia Marietta MD
Respondents

After consideration of the evidence, the panel makes the following findings:

A. Whether the acts or omissions complained of constitute a deviation from the applicable standard of care by the health care practitioner or health care provider charged with that care:

Yes _____	No <u>✓</u> _____
Yes _____	No <u>✓</u> _____
Yes _____	No <u>✓</u> _____

B. Whether the acts or omissions complained of proximately caused the injury complained of:

Yes _____	No <u>✓</u> _____
Yes _____	No <u>✓</u> _____
Yes _____	No <u>✓</u> _____

C. If negligence on the part of the health care practitioner or health care provider is found, whether any negligence of the part of the patient was equal to or greater than the negligence on the part of the practitioner or provider:

Yes _____	No <u>✓</u> _____
Yes _____	No <u>✓</u> _____
Yes _____	No <u>✓</u> _____

Marybeth
Michael E. Povey

Maney C Ashcraft

Dated: 24 Jan 18

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DEFENDANT'S EXHIBIT
B

STATE OF MAINE
Cumberland, ss.

SUPERIOR COURT
Civil Action

CAROL A. KENNELLY,
Claimant,

vs.

MID COAST HOSPITAL

and

MIA MARIETTA, M.D.,

Respondents.

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Civil Docket No.
CV-16-471

VIDEOTAPED DEPOSITION OF: MIA H. MARIETTA, M.D.

Taken before Peggy J. Stockford, Notary Public
in and for the State of Maine, on **April 25, 2017**, at
the offices of Germani, Martemucci & Hill, 43
Deering Street, Portland, Maine, commencing at 9:30
a.m. pursuant to notice given.

APPEARANCES:

FOR THE CLAIMANT: TRAVIS M. BRENNAN, ESQ.
FOR THE RESPONDENTS: JAMES F. MARTEMUCCI, ESQ.
ALSO PRESENT: JAMES BILODEAU

1 immediately after the surgery?
 2 **A. Whenever feasible, yes.**
 3 **Q. And especially in cases let's say on a Wednesday,**
 4 **which this surgery occurred on, where you might have**
 5 **at least one or maybe four other surgeries that**
 6 **you've done, to avoid getting things mixed up from**
 7 **other surgeries, your preference is to do it right**
 8 **after?**
 9 **A. It is, yes.**
 10 **Q. And if we look at your operative note in Miss**
 11 **Kennelly's case, your operative note is consistent**
 12 **with what your practice was, which is to dictate**
 13 **things in a sequential order, correct?**
 14 **A. Yes.**
 15 **Q. Okay. In your operative note you describe taking**
 16 **down omental adhesions in the interior abdominal**
 17 **wall?**
 18 (The witness reviews document(s))
 19 **A. Yes.**
 20 **Q. And that was using the scissors that you had passed**
 21 **through the trocar?**
 22 **A. I would imagine it was a combination of tools.**
 23 **Q. Okay. And once you took the adhesions down, you**
 24 **were able to see part of the gallbladder, correct?**
 25 **A. Correct.**

1 **Q. And in this surgery, Dr. Marietta, the goal**
 2 **initially is to uncover the -- the infundibulum of**
 3 **the gallbladder, correct?**
 4 **A. I think it depends on, number one, your surgical**
 5 **approach; it depends on the anatomy that presents**
 6 **itself to you when you are initially inspecting the**
 7 **area.**
 8 **Q. So let's talk about what you -- what you found from**
 9 **your operative note here. You document that you**
 10 **were able to visualize part of the gallbladder and**
 11 **that it was swollen, enlarge -- enlarged, and**
 12 **abnormal appearing, correct?**
 13 **A. Yes.**
 14 **Q. And -- and, Doctor, that would be consistent with**
 15 **the preoperative information that you had, correct?**
 16 **A. In fact, it was even more pronounced than**
 17 **anticipated from the preoperative evaluation, yes.**
 18 **Q. But not entirely unexpected, correct?**
 19 **A. Nothing is entirely unexpected ever.**
 20 **Q. Okay. And so I guess my point, though, is that the**
 21 **swelling or the inflammation of the gallbladder,**
 22 **that's consistent with cholecystitis --**
 23 **A. Sure.**
 24 **Q. -- correct?**
 25 **A. Yes.**

1 **Q. And it's also consistent with an obstruction and a**
 2 **-- and a stone in the cystic duct, correct?**
 3 **A. Not necessarily.**
 4 **Q. Okay.**
 5 **A. You can have acute cholecystitis with a swollen,**
 6 **abnormal-appearing gallbladder without a definitive**
 7 **obstruction.**
 8 **Q. When you say "abnormal appearing," what do you mean?**
 9 **A. So in general if you -- a gallbladder that is**
 10 **operating and appearing normally will be a general**
 11 **robin's egg blue, it will be very pliant, the wall**
 12 **will be, again, pliant and fairly thin, and so**
 13 **anything that deviates from that description can be**
 14 **characterized as abnormal. But a gallbladder can**
 15 **have a whole host of pathological appearances.**
 16 **Q. Mm-hmm. And so I guess I'm asking from your**
 17 **operative note. When you say "abnormal appearing,"**
 18 **is that -- that's because you had seen the -- the**
 19 **fact that it was swollen and enlarged?**
 20 **A. Yeah. It was discolored, it was obviously swollen**
 21 **and turgid, hemorrhagic, and by that I mean it was**
 22 **bloody appearing.**
 23 **Q. And the gallbladder, from your operative note, had**
 24 **additional omental adhesions throughout the body of**
 25 **the gallbladder, correct?**

1 **A. Yes.**
 2 **Q. And then you described taking down these adhesions,**
 3 **correct?**
 4 **A. Yes.**
 5 **Q. And then once you took down the adhesions, you could**
 6 **see most of the gallbladder?**
 7 **A. Yes.**
 8 **Q. You next describe difficulty in grasping the**
 9 **gallbladder, correct?**
 10 **A. Yes.**
 11 **Q. And you described there was a -- a stone emanating**
 12 **from the neck and the infundibulum, correct?**
 13 **A. Yes.**
 14 **Q. And, again, part of the difficulty in grasping,**
 15 **that's not uncommon when you have a -- an inflamed**
 16 **gallbladder, as you were dealing with in this case,**
 17 **correct?**
 18 **A. Yes. It's very common, in the event of a very small**
 19 **gallbladder, for it to be very difficult to grasp.**
 20 **Q. In other words, Dr. Marietta, as someone who**
 21 **performs laparoscopic cholecystectomy, you've**
 22 **encountered this situation before in terms of**
 23 **difficulty with grasping a gallbladder that's**
 24 **acutely inflamed?**
 25 **A. Correct.**

1 Q. As a result -- it sounds like as a result of the
 2 difficulty in kind of grasping the gallbladder, you
 3 describe a hole that was inadvertently created in
 4 the gallbladder?
 5 A. (The witness nods).
 6 Q. Correct?
 7 A. Yes.
 8 Q. Okay. And, again, that's something that can happen
 9 in situations where you're dealing with an inflamed
 10 gallbladder with -- an inflamed gallbladder?
 11 A. Yes. In fact, at times we purposely create a hole
 12 in an effort to decompress the gallbladder, make it
 13 easier to grasp.
 14 Q. Okay. So, Doctor, then you describe using a suction
 15 irrigator and then dissecting further omental
 16 adhesions, correct?
 17 A. I see it here, yes.
 18 Q. Okay. And then at that point, Doctor, you placed
 19 three additional trocars?
 20 A. So if you -- if you look at that section, please
 21 also note that the trocars had been placed. So this
 22 is one instance --
 23 Q. Right.
 24 A. -- where I had probably forgotten to include the
 25 placing of the trocars in exact, you know -- you

1 know, temporal order, but I wanted to make sure that
 2 that was included in the note.
 3 Q. So the three trocars you placed, that's pretty
 4 standard?
 5 A. It's very standard, yes.
 6 Q. Right. And then you describe the -- the additional
 7 steps you took. So you say that you -- basically,
 8 Doctor, you worked to take down the omental
 9 adhesions, and then you say that you identified what
 10 you believed was the cystic duct?
 11 A. Yes.
 12 Q. You state that the duct was emanating directly into
 13 the gallbladder with no intervening tissues between
 14 this and the liver?
 15 A. That's correct.
 16 Q. Okay. And, Doctor, before you saw this duct, is it
 17 fair to say you used the Maryland dissector and a
 18 hook/suction irrigator to create a window to
 19 identify anatomy?
 20 A. That's fair.
 21 Q. Okay. And you had created that window, though,
 22 before you had begun dissecting the lower part of
 23 the gallbladder from the liver bed, correct?
 24 A. You mean before I had begun trying to remove the
 25 gallbladder from the liver bed --

1 Q. Right.
 2 A. -- proper?
 3 Q. Yes.
 4 A. According to my operative note, yes, that's the
 5 case.
 6 Q. And, Doctor, what -- when you say in the portion of
 7 your operative note that you used this window to
 8 clarify the anatomy, what do you mean by that?
 9 A. So my goal, as is a practice of many, is once I have
 10 identified what I believe to be the duct, I want to
 11 ensure that it is, in fact, the duct. So the steps
 12 I take are when you're looking at a gallbladder
 13 prior to the start of any dissection, there's a lot
 14 of connective tissue both in the front and the back
 15 and on the sides and what have you, and so this is
 16 typically avascular, meaning there's no blood supply
 17 or there's very little blood supply, and so it is
 18 amenable to gentle dissection through a combination
 19 of blunt dissection with instruments and
 20 electrocautery; and so in my mind it's essential to
 21 clear the area of that tissue in order to ascertain
 22 beyond any uncertainty that the structure is what I
 23 believe the structure to be. Does that make sense?
 24 Q. Right. And so what you're saying clarifying the
 25 anatomy, clarifying that you're looking at the

1 cystic duct?
 2 A. Correct.
 3 Q. Okay. And once -- once you had done that, you then
 4 describe the next sequence after you believe you
 5 identified the -- the cystic duct. The next step
 6 you took was to place clips proximally and distally
 7 on what you believed was the cystic duct?
 8 A. Correct.
 9 Q. And then after you placed those clips, you proceeded
 10 to cut what you believed was the cystic duct?
 11 A. Yes.
 12 Q. And, Doctor, I want to ask you for a moment, you
 13 then describe in your operative note that there was
 14 hemidivision?
 15 A. Yeah. That just means I placed a clip partially
 16 across the duct, yes.
 17 Q. Okay. And -- and you note that the area --
 18 A. Or sorry. I'm sorry. I cut partially across the
 19 duct. That's what hemidivision refers to. I'm
 20 sorry.
 21 Q. Right. So it's -- it's like a half division --
 22 A. Correct.
 23 Q. -- if you will?
 24 A. Yes.
 25 Q. Okay. And -- and you note that that area in which

1 you -- you describe the area in which you kind of
 2 cut halfway through as a patulous area?
 3 **A. Patulous, yes.**
 4 **Q.** Am I correct in understanding that you mean that to
 5 be it was kind of widened or floppy?
 6 **A. Yes.**
 7 **Q.** So am I correct to understand that once you identify
 8 what you believed was the cystic duct --
 9 **A. Yes.**
 10 **Q.** -- you cut halfway through the cystic duct?
 11 **A. Yes.**
 12 **Q.** What you believed was the cystic duct.
 13 **A. Correct.**
 14 **Q.** And at that time that you were cutting through what
 15 you believed was the cystic duct, it was kind of
 16 floppy or widened?
 17 **A. It was widened, right.**
 18 **Q.** And -- and so you -- then did you place additional
 19 clips?
 20 **A. I believe I did, and confirming here, yes, clips**
 21 **were then placed fully across the duct; and the**
 22 **reason is you want to ensure or you want to minimize**
 23 **chance of backleak.**
 24 **Q.** And so am I -- am I correct in understanding,
 25 **Dr. Marietta, that the sequence is that when you**

1 identify what you believed was the cystic duct, you
 2 placed was it one or two clips proximally and one or
 3 two clips distally?
 4 **A. While I have not -- let me -- give me two seconds to**
 5 **review what I dictated here.**
 6 (The witness reviews document(s))
 7 I didn't specify. My practice would be to
 8 usually place two above and two below. In this
 9 instance, I'm speculating, but I would have probably
 10 placed one, one, and then placed additional clips
 11 after I divided partially.
 12 **Q.** Right. So if we read the full context of your note
 13 where you describe the -- you would have placed the
 14 clips -- a clip proximal and a clip distal before
 15 you did any cutting, correct?
 16 **A. Yes. That is correct.**
 17 **Q.** And -- and -- and you believe, if you look at the
 18 context of your note, that that's likely what you
 19 did in this case?
 20 **A. I agree, yes.**
 21 **Q.** And then you did the hemidivision, correct?
 22 **A. Yes.**
 23 **Q.** Noted the past -- patulousness of the area, correct?
 24 **A. Yes.**
 25 **Q.** And then you believe you placed one additional clip

1 -- or two additional clips in total, one proximal
 2 and one distal?
 3 **A. Correct.**
 4 **Q.** Then I guess the next step that you described in
 5 order here in your operative note is then conducting
 6 -- or spending a significant amount of time
 7 dissecting the gallbladder free from the -- is it
 8 the gallbladder bed or the liver bed?
 9 **A. The gallbladder bed designates that area where the**
 10 **gallbladder sits in the liver.**
 11 **Q.** Okay. And so that's the area you were dissecting
 12 away?
 13 **A. Yes.**
 14 **Q.** Okay. So after you had cut and flipped the cystic
 15 -- what you believed was the cystic duct, you then
 16 spent what you say, a significant amount of time
 17 dissecting the gallbladder free from the gallbladder
 18 bed?
 19 **A. Yes.**
 20 **Q.** And that's the order in which you did things?
 21 **A. Yes.**
 22 **Q.** And really what you are then describing at that
 23 point is -- is freeing up the lower third of the
 24 gallbladder?
 25 **A. In this instance I would have taken an approach just**

1 the gallbladder in general. You have to understand
 2 that in a case of severe cholecystitis with a lot of
 3 swelling, this blurs any sort of definitive boundary
 4 line, so I would have just been approaching the
 5 gallbladder as a whole --
 6 **Q.** Okay.
 7 **A.** -- trying to gain entry where entry was feasible, if
 8 that makes sense.
 9 **Q.** To dissect --
 10 **A. Correct.**
 11 **Q.** -- to dissect the gallbladder --
 12 **A. To creating a plane.**
 13 **Q.** -- away?
 14 **A. Yes.**
 15 **Q.** Okay. So that's basically the next step that you
 16 were focusing on and that you describe in your
 17 operative note?
 18 **A. Correct.**
 19 **Q.** From your operative note the next thing that you
 20 identify as you were conducting that dissection is a
 21 vessel that was tented up emanating from the liver
 22 with close approximation to the gallbladder,
 23 correct?
 24 **A. Correct.**
 25 **Q.** And that's the order in which you remember

1 identifying that vessel, correct?
 2 **A.** That's what I dictated, yes.
 3 **Q.** And when you saw the vessel, you then -- you state
 4 that you separated this vessel from the gallbladder.
 5 **A.** Yes.
 6 **Q.** So I just want to be clear in terms of terminology.
 7 **A.** Mm-hmm.
 8 **Q.** Is -- when you say "separate," is that something
 9 different from clipping and cutting?
 10 **A.** Correct. It's -- so this vessel did not seem to be
 11 related or part of gallbladder anatomy, so my goal
 12 in this instance, I figured it was closely adherent
 13 to the gallbladder due to the inflamed picture and
 14 her state of cholecystitis, so my goal was to
 15 separate it so that I could minimize any injury. So
 16 to rephrase, my goal was to preserve this vessel.
 17 **Q.** And so after you noted that vessel and you separated
 18 it, you then continued with your dissection,
 19 correct?
 20 **A.** Correct.
 21 **Q.** And you state from your operative note that at the
 22 end of your dissection of the gallbladder you --
 23 sorry. Let me -- let me rephrase.
 24 The next thing that you describe as you dissect
 25 the gallbladder free from the liver bed is a vessel

1 **A.** Yes.
 2 **Q.** Then carrying on dissection of -- to dissect the
 3 gallbladder free from the liver bed, correct?
 4 **A.** Yes.
 5 **Q.** During that dissection of the gallbladder from the
 6 liver bed you first encounter a tented-up vessel --
 7 **A.** Correct.
 8 **Q.** -- correct?
 9 You separate that vessel, correct?
 10 **A.** Yes.
 11 **Q.** And then you proceed with further dissection,
 12 correct?
 13 **A.** Correct.
 14 **Q.** Identify another vessel on the lateral aspect of the
 15 gallbladder, correct?
 16 **A.** Yes.
 17 **Q.** You then clip and cut that lateral vessel?
 18 **A.** Yes.
 19 **Q.** That's the order in which you did things?
 20 **A.** That's correct.
 21 **Q.** You observed the mild to moderate blood in the
 22 gallbladder. Is that -- sorry. In the gallbladder
 23 bed.
 24 **A.** Mm-hmm.
 25 **Q.** Is that normal?

1 on the lateral aspect of the gallbladder running
 2 freely into the gallbladder --
 3 **A.** Yes.
 4 **Q.** -- correct?
 5 **A.** Yes.
 6 **Q.** And with this vessel you placed clips proximally and
 7 distally on the vessel and divided it, correct?
 8 **A.** Yes.
 9 **Q.** And that's, again, the order in which you did
 10 things?
 11 **A.** That is correct.
 12 **Q.** The -- am I correct to understand with this vessel
 13 that you would have placed two clips proximally and
 14 two clips distally?
 15 **A.** Generally on occasion I place only one clip on the
 16 gallbladder side of the vessel as that's being
 17 removed, but...
 18 **Q.** Doctor, after the gallbladder was removed, you
 19 observed mild to moderate blood in the gallbladder
 20 bed, correct?
 21 **A.** Correct.
 22 **Q.** Okay. Sorry. And let me just back up for a second.
 23 So from -- from the order of your operative note you
 24 describe clipping and cutting what you believed to
 25 be the cystic duct, correct?

1 **A.** That can be very normal, very common after this
 2 degree of pathology, yes.
 3 **Q.** And at that point what did you believe the blood was
 4 coming from?
 5 **A.** The dissection field. So as I indicate in my note,
 6 often times if you're operating on a gallbladder
 7 that's relatively normal, there is a fairly clear,
 8 readily-accessible plane between the gallbladder and
 9 the liver, and that's usually what we call
 10 avascular, not a lot of bleeding. But in a case
 11 with a lot of disease or sometimes coupled with
 12 someone's inherent anatomy, the gallbladder can be
 13 more fused to the liver bed, and when you disrupt
 14 around the liver -- it's called a capsule, and if
 15 you disrupt that, it tends to bleed.
 16 **Q.** So the fact that there was some bleeding or blood
 17 that was in this area wasn't -- didn't raise your
 18 index of concern for anything?
 19 **A.** No. I felt it was commensurate with the type of
 20 operation.
 21 **Q.** And am I correct from your operative note it wasn't
 22 active bleeding at that point? There was just some
 23 remaining blood there?
 24 **A.** More residual from the operative intervention. No
 25 active bleeding.

1 Q. Right. Because if -- if -- if, in fact, there is
 2 active bleeding, then that raises the next concern
 3 for potential vascular injury?
 4 A. Not necessarily. There's all sorts of different
 5 types of bleeding, and far, far more common to
 6 vascular injury the backup would be very obvious,
 7 for example, it would -- it would not be subtle.
 8 But there is very commonly some -- just some
 9 bleeding from the dissection field that, given some
 10 time, typically would abate.
 11 Q. When you say "given some time," is that something
 12 that you would monitor, though, intraoperatively
 13 just to make sure that there's not continued
 14 bleeding?
 15 A. Sure. If there's concern for bleeding, we would
 16 wait and ensure that this had dissipated prior to
 17 closing.
 18 Q. What is Surgiflo?
 19 A. Surgiflo is a -- a cellulose-based matrix, but it
 20 comes in a liquid form. There is a whole cadre of
 21 elements out there to stem the flow of bleeding.
 22 Just -- it just ramps up the clotting cascade.
 23 Q. Is that typical -- so in this case you deployed the
 24 Surgiflo?
 25 A. I did.

1 Q. Is that typical for you to do that?
 2 A. I would do it on occasion. Certainly not every
 3 time, but now and again.
 4 Q. So you would do it in cases where there was some
 5 residual bleeding?
 6 A. Sure, in the event of a -- like a -- a -- it's
 7 called a hemorrhagic cholecystitis where they tend
 8 to be more bloody.
 9 Q. After you deployed the Surgiflo, you then placed a
 10 number 19 French blade drain in the gallbladder bed.
 11 A. Correct.
 12 Q. Why did you do that?
 13 A. The degree of the inflammation and active, acute
 14 state of the gallbladder was concerning enough that
 15 should she, for example, continue to bleed, she
 16 would fair much better -- number one, she would fair
 17 better with the -- if the blood were drained out,
 18 and plus this would allow me a window just to ensure
 19 that there was not any ongoing bleeding or leak.
 20 For example also, when the gallbladder -- typically
 21 when the gallbladder is fused to the gallbladder
 22 bed, at times there can be valves, small, little
 23 bile ducts, if you will, that connect the
 24 gallbladder to the liver bed, and sometimes those
 25 can also leak; so it would not be uncommon to have

1 either blood or bile or both potentially after such
 2 an advanced gallbladder.
 3 Q. Is it common for you to place drains?
 4 A. No, it's not.
 5 Q. So in this case you placed a drain because you had
 6 some concern about bleeding, correct?
 7 A. Some, yes.
 8 Q. And -- but at the time intraoperatively you didn't
 9 believe there was a major problem associated with
 10 that bleeding --
 11 A. I did not.
 12 Q. -- correct?
 13 A. That's correct.
 14 Q. If -- if you had that concern, you would have taken
 15 additional steps intraoperatively to investigate
 16 that or call in a vascular surgeon, correct?
 17 A. I would have taken additional steps, correct.
 18 Q. And what would those additional steps have been?
 19 A. So we -- to back up, when you are observing bleeding
 20 in a laparoscopic field, everything gets magnified
 21 enormously. Often times bleeding can stop on its
 22 own, can stop with pressure. Pressure is your first
 23 recourse every time. But additional maneuvers such
 24 as deploying some sort of cellulose-based product,
 25 suture if need be, calling for help if need be. We

1 don't have vascular surgeons. It would be
 2 exceedingly rare that we would require any sort of
 3 intervention with a vascular surgeon, but we would
 4 never leave any obvious extensive bleeding. But
 5 sometimes someone can have generalized oozing, and
 6 for that sometimes an intervention, something
 7 aggressive can incite more bleeding than can
 8 actually dissipate -- dissipate the bleeding, if
 9 that makes sense; so it really depends on the
 10 situation.
 11 Q. But in this situation you didn't have -- you were
 12 not overly concerned about the blood that you saw in
 13 this area --
 14 A. Any ongoing --
 15 Q. -- correct?
 16 A. -- significant physiological --
 17 Q. Right.
 18 A. -- blood loss, no.
 19 Q. Right. Let me -- let me ask real quickly, did -- on
 20 the day you performed the surgery, were any of your
 21 other colleagues working that day?
 22 MR. MARTEMUCCI: You mean the surgeons?
 23 4MR. BRENNAN: Yeah.
 24 THE WITNESS: Likely. I'm speculating, but
 25 it's likely they were if this was a typical

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1 Q. I'm asking you do you see any other clips that are
 2 depicted in --
 3 A. I don't see any clips.
 4 Q. Okay. Could you label that, please?
 5 A. Okay.
 6 Q. Thank you. Did you speak with Dr. Howell?
 7 A. I did not.
 8 Q. You told me earlier that you reviewed Dr. Rutstein's
 9 operative note?
 10 A. I did.
 11 Q. And so, first, you're aware that Dr. Rutstein
 12 identified a transection --
 13 A. Yes.
 14 Q. -- of the -- of the common hepatic duct?
 15 A. I believe that's correct.
 16 Q. And when that is transected, the issue is that bile
 17 can't drain continuously from the liver to the
 18 intestines --
 19 A. That is generally true, yes.
 20 Q. -- right?
 21 And so one of the dangers with that is that
 22 liver [sic] can then back up into the liver,
 23 correct?
 24 A. Or just drain into the abdominal cavity.
 25 Q. So it can drain into the abdominal cavity exposing a

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1 patient to the risk of peritonitis, correct?
 2 A. Correct.
 3 Q. And an acute abdomen?
 4 A. Possibly.
 5 Q. And it can back up into the liver causing liver
 6 damage, correct?
 7 A. I suppose it's possible.
 8 Q. So the fix is -- the way to fix that where there's a
 9 transection, as occurred here, is to perform a
 10 Roux-en-Y hepatojejunostomy to create a bridge
 11 basically between the area that was transected into
 12 the small intestine, correct?
 13 A. It depends on the situation. That is one approach,
 14 yes.
 15 Q. And that's the approach that Dr. Rutstein used here,
 16 correct?
 17 A. It is.
 18 Q. And so the goal was, once Dr. Rutstein performed
 19 this repair creating a Roux limb from another part
 20 of the small intestine, bile could then continuously
 21 flow from the liver into the small intestine,
 22 correct?
 23 A. Correct.
 24 Q. Dr. Rutstein documented that she found two clips
 25 that were located proximal and two clips that were

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1 distal. Is that consistent with -- so she basically
 2 describes four clips in total that were placed. Is
 3 that consistent with your memory of the surgery, how
 4 many clips you placed?
 5 A. Yeah, that corresponds to my note and my
 6 recollection.
 7 Q. Did you ever speak with Dr. Rutstein?
 8 A. I did not.
 9 Q. After Miss Kennelly was discharged from Mid Coast
 10 Hospital, did you speak with any of her subsequent
 11 treating providers?
 12 A. I did not.
 13 Q. Based on your review of Dr. Howell's ERCP note,
 14 Dr. Rutstein's operative note, can you describe how
 15 Miss Kennelly suffered this bile duct injury?
 16 A. In retrospect, I had transected something that I
 17 believed to be the cystic duct.
 18 Q. And that that was, in fact, the common hepatic or
 19 part of the common bile duct?
 20 A. Yeah, as documented by Dr. Rutstein, the common
 21 hepatic duct.
 22 Q. And so, in retrospect, based upon Dr. Rutstein's
 23 findings, you agree to a reasonable degree of
 24 medical certainty that the clips that Dr. Rutstein
 25 found on the common bile duct were clips that you

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1 had placed during your surgery?
 2 A. The common hepatic duct.
 3 Q. Sorry. The common hepatic duct.
 4 A. Yes.
 5 Q. Dr. Marietta, in this case I just want to be clear.
 6 You don't intend to offer any opinions about Miss
 7 Kennelly's future likelihood of complications or
 8 anything, do you?
 9 A. No.
 10 Q. Dr. Marietta, looking at your operative note, you
 11 don't -- you don't describe in your operative note
 12 the cystic artery, correct?
 13 A. I don't. That's correct.
 14 Q. Do you know which of the two vessels that you
 15 observed during your dissection of the gallbladder
 16 from the liver bed was the cystic artery?
 17 A. So the vessel going directly into the gallbladder
 18 that I clipped towards the end of the case would
 19 have been the cystic artery.
 20 Q. And so you believe -- you believe the cystic artery
 21 was the vessel at the end of your dissection on the
 22 lateral aspect of the gallbladder?
 23 A. I do.
 24 Q. Do you believe that your operative note is accurate?
 25 A. I do.

1 Q. And consistent with what you actually did during
 2 your surgery?
 3 A. I do.
 4 Q. During your training and -- surgical training and
 5 residency were you trained to perform laparoscopic
 6 cholecystectomy?
 7 A. I was.
 8 Q. And during your training and residency and even
 9 beyond, did you use surgical texts as part of your
 10 training?
 11 A. Yeah. It's very standard, yes.
 12 Q. Which texts did you use?
 13 A. We used a host of texts. Sabiston would be one;
 14 Cameron; Greenfield.
 15 Q. Did you use the ACX -- ACS textbook on surgery?
 16 A. We used their modules online that our program had
 17 purchased for us, so we did that at the time.
 18 Q. When you say "modules," were those something based
 19 from ACS?
 20 A. I believe so based -- best I can recall.
 21 Q. Are you familiar with the Society of American
 22 Gastrointestinal Endoscopic Surgeons?
 23 A. I am.
 24 Q. SAGES?
 25 A. I am familiar, yes.

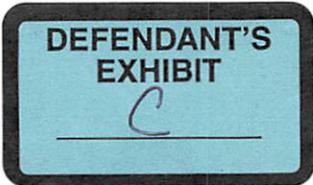
1 consent to a surgeon not following those general
 2 principles during laparoscopic cholecystectomy?
 3 A. I'm not --
 4 MR. MARTEMUCCI: Could you ask that again,
 5 please?
 6 MR. BRENNAN: Yeah.
 7 BY MR. BRENNAN:
 8 Q. Can -- can -- do you agree that a patient cannot
 9 consent to a surgeon not following the
 10 generally-accepted principles of laparoscopic
 11 cholecystectomy?
 12 A. I don't understand.
 13 MR. MARTEMUCCI: Yeah. Objection to form.
 14 There are too many negatives in there. You've got
 15 me confused.
 16 BY MR. BRENNAN:
 17 Q. You said that there are some general principles that
 18 apply to laparoscopic cholecystectomy, correct?
 19 A. I would say that most surgeons who perform
 20 laparoscopic cholecystectomy follow some general
 21 principles, yes.
 22 Q. Right. And so do you believe that a patient can
 23 consent to a surgeon doing the surgery in a way that
 24 does not use those generally recognized principles?
 25 A. Well, I think we're talking about two different

1 Q. Have you read any of SAGES literature on
 2 laparoscopic cholecystectomy?
 3 A. Over the years, absolutely.
 4 Q. Have you attended any conferences by -- that have
 5 been put on by SAGES?
 6 A. I have not.
 7 Q. Are there any other definitive texts that you've
 8 read or that inform how you perform laparoscopic
 9 cholecystectomy?
 10 A. No definitive texts, no.
 11 Q. Do you agree that any surgeon who performs
 12 laparoscopic cholecystectomy must follow
 13 generally-accepted principles for a safe operation?
 14 A. How do you define those to be?
 15 Q. I'm -- I'm -- I'm ask -- I'm just asking you do you
 16 think there are -- a surgeon must follow
 17 generally-accepted principles in performing
 18 laparoscopic cholecystectomy?
 19 A. So best of my understanding there are guidelines,
 20 but there's no absolute standard for laparoscopic
 21 cholecystectomy.
 22 Q. Do you think there are generally-accepted principles
 23 in performing laparoscopic cholecystectomy?
 24 A. I think there are some general principles.
 25 Q. Doctor, do you agree that a patient can never

1 issues, because a patient can consent to anything a
 2 patient decides to consent to.
 3 Q. That's what you believe?
 4 A. Well, I think a patient is an autonomous being. I
 5 think we're getting philosophical, though. I'm not
 6 sure what you're asking me.
 7 Q. Do you agree that one of the key principles of
 8 performing laparoscopic cholecystectomy is
 9 determining the anatomy of the cystic duct, the
 10 common bile duct, and the cystic artery?
 11 A. I think that essential to performing a laparoscopic
 12 cholecystectomy is determining the anatomy to the
 13 best of your ability.
 14 Q. And, Doctor, my question to you is do you agree that
 15 the safety of performing -- that to perform a
 16 laparoscopic cholecystectomy safely one has to
 17 determine the anatomy of the cystic duct, the cystic
 18 artery, and the common bile duct?
 19 A. So I think that sometimes the anatomy presented is
 20 not the anatomy demonstrated in the textbooks. I
 21 think that someone doing their due diligence during
 22 a laparoscopic cholecystectomy should identify the
 23 anatomy to their utmost certainty and to the best of
 24 their ability as it presents itself.
 25 Q. Right. And so, Dr. Marietta, my question is do you

STATE OF MAINE
CUMBERLAND, ss.

SUPERIOR COURT
CIVIL ACTION
Docket No. CV-16-471



CAROL ARSENAULT
KENNELLY,

Claimant

v.

MID COAST HOSPITAL, and
MIA MARIETTA, M.D.,

Respondents

RESPONDENT MID COAST HOSPITAL'S
SUPPLEMENTAL RESPONSE TO
CLAIMANT'S FIRST REQUEST FOR
PRODUCTION OF DOCUMENTS

NOW COMES Respondent, Mid Coast Hospital, by and through undersigned counsel, and provides a supplemental response to Claimant's first request for production of documents as follows:

RESPONSE

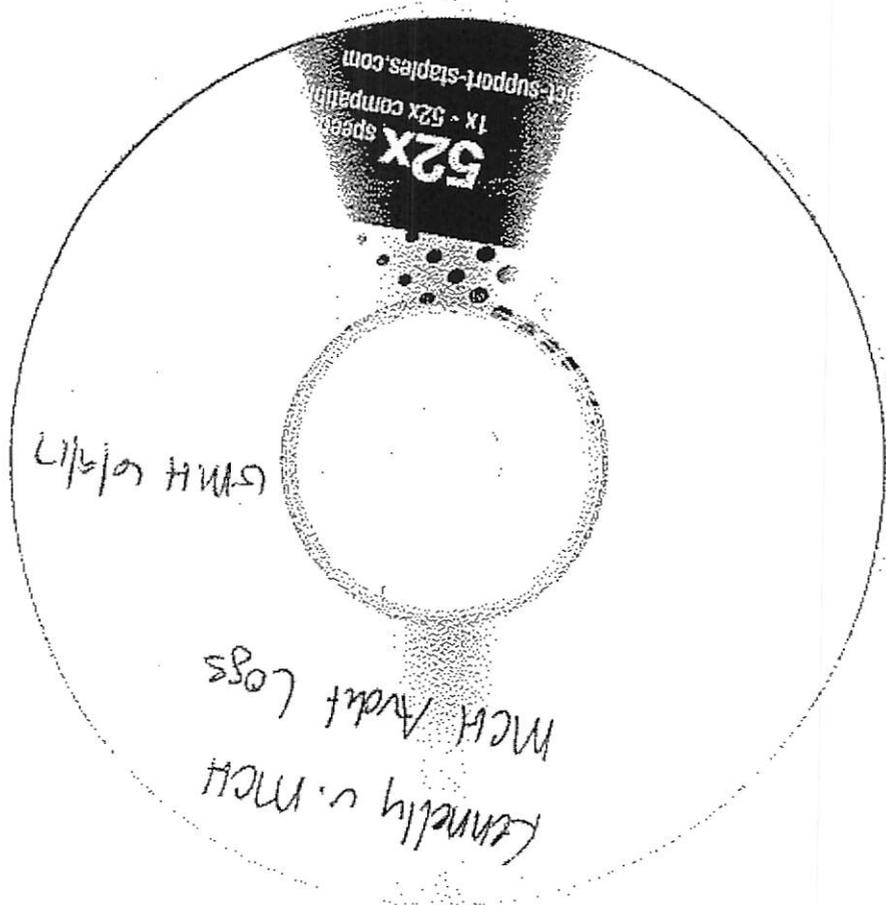
17. Any and all documents through the present that show an audit trail for the electronic medical records, including, but not limited to, electronic medical records used in the LOGICARE and/or PACS systems, created for Carol (Arsenault) Kennelly's care at Mid Coast Hospital in September 2015. These records should include the date and time that every entry was made, as well as the date and time of any edits. These records should include the identity of the person making the entry, as well as the substance of each entry.

RESPONSE: Please see previously filed objection. Without waiving and subject to that objection, please see attached CD containing audit logs.

DATED at Portland, Maine, June 9, 2017.

Respectfully submitted,


James F. Marjenucci #6878
James P. Spizuoco #5844
Attorneys for Mid Coast Hospital



STATE OF MAINE
Cumberland, ss.

SUPERIOR COURT
Civil Action

CAROL A. KENNELLY, *
*
Claimant, *
*
vs. *
*
MID COAST HOSPITAL and *
MIA MARIETTA, M.D., *
*
Respondents. *

Civil Docket No.
CV-16-471

PRE-LITIGATION MEDICAL MALPRACTICE PANEL HEARING

Taken before Peggy J. Stockford, Notary Public
in and for the State of Maine, on January 24, 2018,
at Ellsworth City Hall, 1 City Hall Plaza,
Ellsworth, Maine, commencing at 9:00 a.m. pursuant
to notice given.

APPEARANCES:

PANEL MEMBERS: MARILYN C. ASHCROFT, CHAIR
 MARY COLLINS, M.D.
 MICHAEL E. POVICH, ESQ.

FOR THE CLAIMANT: TRAVIS M. BRENNAN, ESQ.
 JULIAN L. SWEET, ESQ.

FOR MID COAST HOPT: PHILIP M. COFFIN, III, ESQ.

FOR DR. MARIETTA: ROBERT P. HAYES, ESQ.
 PIESKE REPORTING SERVICE 207-622-1616

1 A. No.

2 Q. And that's because you still -- although you've
3 taken the initial step, you haven't been able to sit
4 for that oral portion of your exam?

5 A. I'm waiting for dates to be given to me.

6 Q. And when do you anticipate that will be?

7 A. Sometime this spring.

8 Q. Doctor, the first place you began working when you
9 completed your residency in 2011 was Mid Coast
10 Hospital, correct?

11 A. Correct.

12 Q. You worked continuously at Mid Coast Hospital from
13 2011 up through sometime in 2017, correct?

14 A. That is correct.

15 Q. At the time I deposed you in April of 2017, you were
16 still working for Mid Coast Hospital, correct?

17 A. That's correct.

18 Q. Subsequent to your deposition you left Mid Coast
19 Hospital, correct?

20 A. Correct.

21 Q. When did you leave Mid Coast Hospital?

22 A. Roughly in June, mid June, of 2017.

23 Q. And why did you leave?

24 A. During that time frame I had been attempting to
25 re-stratify and restructure my career. I have two
PIESKE REPORTING SERVICE 207-622-1616

1 small children and was intermittently by myself as a
2 single parent, and part of my impetus for doing so
3 was to give myself more time and I wanted to try to
4 streamline some of the focus, so...

5 Q. Did your leaving have anything to do with this case?

6 A. No, it did not.

7 Q. What are you current -- where are you currently
8 employed?

9 A. I'm currently employed with a company called
10 Advantage Wound Care.

11 Q. What is Advantage Wound Care?

12 A. It is a company that provides direct care largely to
13 skilled nursing facilities.

14 Q. When did you start working for them?

15 A. I believe late fall. I'm unsure of the exact date.

16 Q. Late fall of 2017?

17 A. Correct.

18 Q. And do you have an office?

19 A. I am a -- I am an outside contractor, so I'm
20 self-employed, and I utilize part of my home as my
21 office presently.

22 Q. And what are the -- what jobs do you have? What's
23 your role that you play working for this company?

24 A. I'm a physician administering direct care to
25 clients.

PIESKE REPORTING SERVICE 207-622-1616

1 Q. And where do you administer direct care?

2 A. To various nursing and skilled facilities throughout
3 Maine and the greater Portland area specifically.

4 Q. Does any of the care you provide currently in your
5 job deal with surgery?

6 A. Not invasive general surgery at this time.

7 Q. Since you've started this job, have you performed
8 any surgical procedures?

9 A. I have performed bedside excisions, but no general
10 surgery under anesthesia.

11 Q. So the last time you would have performed surgery
12 under anesthesia would have been back when you were
13 working at Mid Coast Hospital, correct?

14 A. That is correct.

15 Q. Are there any other jobs that you currently hold at
16 the moment?

17 A. I am pending a likely position with a vein center as
18 well. I'm waiting for the completion of a building.

19 Q. When you say "a vein center", what does that mean?

20 A. So this is a stand-alone outpatient center that
21 largely concentrates on varicose veins.

22 Q. And what would your anticipated role be with that
23 company?

24 A. Also with a primary physician administering, for
25 example, laser therapy.

PIESKE REPORTING SERVICE 207-622-1616

1 Q. So you're searching for an explanation to answer why
2 there was this bad outcome in this case --

3 A. Of course.

4 Q. -- correct?

5 But in your note itself there's nothing that's
6 described as aberrant anatomy, correct?

7 A. Correct.

8 Q. Doctor, you stated in response to your attorney's
9 questions that you obtain what you consider to be a
10 critical view, correct?

11 A. This is apart from any sort of paper or textbook
12 interpretation of the critical view, that is, I
13 guess, Mia Marietta's critical view.

14 Q. Precisely. That's precisely my point.

15 A. Yes.

16 Q. What you considered to be the critical view for you
17 is not how the critical view is defined in any
18 medical literature, any textbook, or any guideline
19 that you've seen, correct?

20 A. Yeah. I don't use the term --

21 MR. BRENNAN: What's that?

22 CHAIR ASHCROFT: We've gone over this.

23 MR. BRENNAN: Okay.

24 BY MR. BRENNAN:

25 Q. Doctor, were you exposed to SAGES' definition of the
PIESKE REPORTING SERVICE 207-622-1616

STATE OF MAINE
Cumberland, ss.

SUPERIOR COURT
Civil Action

CAROL A. KENNELLY, *
 *
 Claimant, *
 *
 vs. *
 *
 MID COAST HOSPITAL *
 *
 and *
 *
 MIA MARIETTA, M.D., *
 *
 Respondents. *

Civil Docket No.
CV-16-471

VIDEOTAPED DEPOSITION OF: MIA H. MARIETTA, M.D.

Taken before Peggy J. Stockford, Notary Public
in and for the State of Maine, on April 25, 2017, at
the offices of Germani, Martemucci & Hill, 43
Deering Street, Portland, Maine, commencing at 9:30
a.m. pursuant to notice given.

APPEARANCES:

FOR THE CLAIMANT: TRAVIS M. BRENNAN, ESQ.
FOR THE RESPONDENTS: JAMES F. MARTEMUCCI, ESQ.
ALSO PRESENT: JAMES BILODEAU

PIESKE REPORTING SERVICE 207-622-1616

1 operation I do.

2 Q. So, Doctor, is it fair to say approximately 75 or 80
3 percent of your practice is laparoscopic
4 cholecystectomy?

5 A. Perhaps a little bit less, but it certainly does
6 form a large percentage.

7 Q. Okay. A -- certainly a majority of your surgeries
8 are lap -- laparoscopic cholecystectomy?

9 A. Greater than 50 percent I think is fair.

10 Q. Okay. And I just want to be clear when we're
11 talking about the majority of your cases being
12 laparoscopic cholecystectomy. Are you including
13 just cholecystectomy in general, or is it
14 laparoscopic cholecystectomy only?

15 A. I have done one open gallbladder procedure since
16 I've been at Mid Coast, so this would by default,
17 then, be laparoscopic cholecystectomy.

18 Q. Okay. I just wanted to make sure --

19 A. Sure.

20 Q. -- we were talking the same thing.

21 How many other general -- you mentioned Dr. Bird
22 and Dr. Hyde. How many other general surgeons are
23 on staff at Mid Coast?

24 A. Yeah. We presently have two additional surgeons
25 working with us that I have not mentioned.

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1 structures, the gallbladder, and the liver.

2 BY MR. BRENNAN:

3 Q. Is -- is -- is -- does that technique have a name?

4 A. I don't name it.

5 Q. Okay. So you talked -- I'm just following up on
6 what you said, which is there are different -- there
7 are different approaches or techniques for
8 performing this surgery, and I'm wondering do any of
9 these approaches or techniques have a name?

10 A. Yeah. So, for example, some literature says -- that
11 I recall seeing in the past, people have labeled a
12 critical view of safety. But another thing I think
13 that it's important to keep in mind is that people's
14 application of that phrase, "the critical view of
15 safety," is different in different hands and there's
16 no one standard; so that's why I -- purposefully I
17 avoid using that phrase. I'd rather describe my
18 steps than apply a term, because I think it's a
19 little bit nonspecific and non-descriptive.

20 Q. You believe that in terms of publications that
21 you've reviewed, SAGES or other textbooks, that the
22 critical view of safety is unclear in terms of what
23 that -- what that process entails?

24 A. If you look across the spectrum of literature,
25 people use different -- for example, people use
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STATE OF MAINE
PENOBSCOT, ss.

SUPERIOR COURT
CIVIL ACTION
Docket No. CV-16-117

DOROTHEA B. McCAIN,

Claimant,

v.

ORDER

JOHN F. VANADIA, D.O.,
BANGOR SURGICAL ASSOCIATES
P.A. and ST., JOSEPH HOSPITAL,

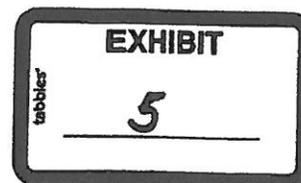
Respondents.

Presently before the Court is Claimant Dorothea B. McCain's Motion to Compel Defendants to produce medical records relating to Dr. Vanadia's treatment of non-party patients. Respondent, St. Joseph Hospital, filed an Opposition to Claimant's Motion on June 5, 2017. Respondents, John F. Vanadia, D.O., and Bangor Surgical Associates P.A., filed their Opposition to Plaintiff's Motion on June 12, 2017. Claimant filed her response to Respondent, St. Joseph Hospital, on June 12, 2017, and on June 16, 2017, Claimant filed her response to Respondents, John F. Vanadia, D.O., and Bangor Surgical Associates P.A. On June 15, 2017, the Panel Chair referred the Motion to the Chief Justice of the Superior Court pursuant to M.R. Civ. P. 80M(e). A hearing was held on June 29, 2017.

After careful consideration of the parties' respective filings, the Court grants the Motion for the reasons stated below.

I. BACKGROUND

The relevant background underlying the present dispute can be succinctly stated as follows: On November 23, 2015, Dr. Vanadia performed a laparoscopic cholecystectomy on



Ms. McCain. During the procedure, Dr. Vanadia mistakenly dissected Ms. McCain's common bile duct, which he thought at the time was her cystic duct. Ms. McCain allegedly suffered serious consequences as a result of the procedure, and filed her Notice of Claim on June 30, 2016, and proceeded in accordance with M.R. Civ. P. 80M.

During the discovery process, Dr. Vanadia agreed that the standard of care requires that a surgeon performing a laparoscopic cholecystectomy visualize certain anatomical features before dividing the cystic duct. The cystic artery, cystic duct, and gallbladder form a triangle, sometimes called Calot's Triangle, and the cystic artery node sits within the triangle. Dr. Vanadia agreed that his operative notes do not recite visualizing the necessary anatomical features before dividing what he thought was Ms. McCain's cystic duct. Dr. Vanadia testified that he was trained to and as a matter of repetition (habit) visualizes the necessary anatomical features (called the "critical view of safety" by the Plaintiff) before dividing the cystic duct. Because it was his routine "practice" to visualize the necessary anatomical features, Dr. Vanadia testified that he did so in Ms. McCain's case.

Ms. McCain requested discovery of Dr. Vanadia's operative notes for all of the laparoscopic cholecystectomies that Dr. Vanadia performed in 2015, redacted to remove any personally identifying information. Dr. Vanadia objects and claims, *inter alia*, that the Doctor-Patient Privilege, 22 M.R.S. § 1711-C, and the Health Insurance Portability and Accountability Act ("HIPAA") apply to bar Ms. McCain from accessing Dr. Vanadia's operative notes. St. Joseph Hospital also objects and raises similar issues. The Court will address each ground for objection in turn.

II. Standard of Review

M.R. Civ. P. 26(b) provides in pertinent part “Unless otherwise limited by order of the court in accordance with these rules. . . parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action. . . .” Liberal discovery is a procedural mechanism utilized to “eliminate the sporting theory of justice and to enforce full disclosure between the parties.” *Pinkham v. DOT*, 2016 ME 74, ¶ 12, 139 A.3d 904 (citations omitted).

III. DISCUSSION

A. Relevance to Subject matter of Litigation

In this medical malpractice case, the standard of care requires that the surgeon perform a particular task during the course of surgery. The surgeon’s contemporaneous notes do not reflect that he performed this particular task in Ms. McCain’s case. The evidence that the surgeon met the standard of care is his claim that it is his habit or routine practice to perform this particular task and therefore he performed the particular required task in this particular case.

If the non-party records reflect that Dr. Vanadia always makes a notation that he visualized the necessary features in question before cutting, this will corroborate the doctor’s testimony that it is his habit or routine practice to do so. Alternatively, if the non-party records reflect that Dr. Vanadia never makes a note that he visualizes the area in question before cutting or sometimes visualizes the area and other times does not, this will provide the factfinder with some evidence to evaluate whether it is in fact Dr. Vanadia’s habit or routine practice to visualize the area in question.

Without the records in question, the plaintiff has little ability to challenge the surgeon's claim of habit or routine practice. Disclosure of the records reflect on the liability question, resolution of which might otherwise rest on the surgeon's unverifiable testimony about his habit or routine practice. Therefore, given the facts of this case, including the habit or routine practice testimony on which the defense intends to rely, the court finds that the non-party records are directly relevant to the malpractice claim at issue, that there exists a need for the disclosure of the non-party records, and discovery of the same is reasonably calculated to lead to the discovery of admissible evidence. See *Snibbe v. Superior Court*, 224 Cal. App. 4th 184 (2014)(non-party medical records relevant to habit testimony).

B. 22 M.R.S. § 1711-C

22 M.R.S. § 1711-C(2) provides in relevant part "An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility except as provided in subsection 3, 3-A, 3-B, 6 or 11." "Health care information" means "information that directly identifies the individual and that relates to an individual's physical, mental, or behavioral condition. . ." 22 M.R.S. § 1711-C(1)(E). "Health care information" does not include "information that protects the anonymity of the individual by means of encryption or encoding. . ." *Id.*

Here, the information that Ms. McCain seeks is the redacted information of Dr. Vanadia's patients. With the patients personally identifying information redacted, the records would not constitute "health care information" prohibited from disclosure under the statute, because the records would not directly identify the individual. The Court need not address Respondents, Dr. Vanadia and Bangor Surgical Associates, arguments that encryption or encoding is the only means of protecting "health care information," because

the Court finds that such records, in their redacted form, do not constitute “health care information” under the statute warranting further protection through encoding or encryption.

C. HIPAA

45 C.F.R. § 160.103 provides in part:

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

...

Protected health information means individually identifiable health information:

(1) Except as provided in paragraph (2) of this definition, that is:

(i) Transmitted by electronic media;

(ii) Maintained in electronic media; or

(iii) Transmitted or maintained in any other form or medium.

45 C.F.R. § 164.514 further provides:

Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

(b) Implementation specifications: requirements for de-identification of protected health information. A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

- (i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and
 - (ii) Documents the methods and results of the analysis that justify such determination; or
- (2)
 - (i) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:
 - (A) Names;
 - (B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
 - (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
 - (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
 - (C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
 - (D) Telephone numbers;
 - (E) Fax numbers;
 - (F) Electronic mail addresses;
 - (G) Social security numbers;
 - (H) Medical record numbers;
 - (I) Health plan beneficiary numbers;
 - (J) Account numbers;
 - (K) Certificate/license numbers;
 - (L) Vehicle identifiers and serial numbers, including license plate numbers;
 - (M) Device identifiers and serial numbers;
 - (N) Web Universal Resource Locators (URLs);
 - (O) Internet Protocol (IP) address numbers;
 - (P) Biometric identifiers, including finger and voice prints;
 - (Q) Full face photographic images and any comparable images; and
 - (R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section; and

(ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

HIPAA imposes a burden upon Dr. Vanadia, or upon St. Joseph's Hospital as the Hospital appears to be in possession of the records in issue, to appropriately redact the medical records of Dr. Vanadia's patients. However, HIPAA does not prohibit the dissemination of individual medical records, but only proscribes a process by which the records must be "de-identified" before they are disseminated. To the extent that the medical records sought in this case are redacted in accordance with 45 C.F.R. § 164.514, they would no longer be individually identifiable health information or protected health information.

D. Doctor-Patient Privilege

In Maine, the doctor-patient privilege is embodied within M.R. Evid. 503(b), and states in part:

A patient has a privilege to refuse to disclose, and to prevent any other person from disclosing, confidential communications made for the purpose of diagnosing or treating the patient's physical, mental, or emotional condition, including alcohol or drug addiction, between or among the patient and:

- (1) The patient's health care professional, mental health professional, or licensed counseling professional; and
- (2) Those who were participating in the diagnosis or treatment at the direction of the health care, mental health, or licensed counseling professional. This includes members of the patient's family.

Furthermore, there exists a presumption that "the person who was the health care, mental health, or licensed counseling professional at the time of the communication in question has authority to claim the privilege on behalf of the patient." M.R. Evid. 503(d)(2). In this case, Dr. Vanadia has claimed the privilege on behalf of his patients. Dr. Vanadia has refused to disclose his operative notes for non-party patients. Plaintiff has requested only

redacted copies of the non-party operative reports, such that all identifying information is removed.

It appears that the Law Court has not yet addressed whether a physician-patient privilege protects redacted non-party medical records. However, long ago, in the face of a privilege argument, the Superior Court ordered redacted non-party patient records to be produced. *Balian v. Kamm*, No. CV-83-9, 1987 Me. Super LEXIS 376 (Dec. 22, 1987) (patient records ordered produced with the patient names redacted).

Ms. McCain argues that many states and federal courts have allowed the disclosure of redacted medical records of non-party patients under circumstances similar to those in the current litigation. See, e.g., *In re Rezulin Prods. Liab. Litig.*, 178 F. Supp. 2d 412 (S.D.N.Y. 2001) (production of redacted records does not violate the physician-patient privilege) (“The question whether the discovery of records redacted to eliminate identifying information may be compelled consistent with the privilege has been decided by a number of courts ... Almost all have ruled in favor of discovery in such circumstances.”); *Terre Haute Regional Hosp., Inc. v. Trueblood*, 600 N.E.2d 1358, 1359 (Ind. 1992) (After reviewing the decisions of other states, the Court held “that when all the information regarding the identities of these non-party patients has been redacted from the records, production of the medical records will not violate the physician-patient privilege.”); *Cnty. Hosp. Ass’n v. Dist. Court of County of Boulder*, 194 Colo. 98, 570 P.2d 243 (1977); *Snibbe v. Superior Court*, 224 Cal. App. 4th 184 (2014) (production of redacted non-party patient records does not invade the doctor-patient privilege and production ordered where doctor was claiming his habit or practice was to perform his duties in a particular way); *Ziegler v. Superior Court*, 134 Ariz. 390 (Ct. App. 1982). More recently, in 2010, the Supreme Court of Utah held that

“where redaction of personal information will prevent identification of the patient connected to the medical information, the redacted information is not subject to the [evidentiary rule of privilege]”. *Staley v. Jolles*, 2010 UT 19, p 25, 230 P. 3d 1007. The *Staley* court continued: “Because [the evidentiary rule of privilege] is not applicable where the names of the patients have been redacted in a way that adequately prevents them from being identified, and because the information sought is relevant to [the plaintiff’s] claim, we ... order [defendant] to disclose properly redacted copies of the medical records ...”. Still more recently, in 2016, in *Wipf v. Altstiel*, 2016 SD 97, the South Dakota court, after reviewing the law from other jurisdictions, held that redacted records containing anonymous, nonidentifying information are not protected by the physician-patient privilege because there is no “patient” after the identifying information is redacted. The Court held that “[I]n accordance with the rationale of the Utah Supreme Court and the almost unanimous view of other courts, we too hold that anonymous, nonidentifying medical information is not privileged per se.” *Id.*

A minority of courts that have addressed the issue of production of non-party medical records have refused to allow the disclosure of redacted, non-party medical records. See *Parkson v. Central Du Page Hospital*, 105 Ill. App. 3d 850, 855, 61 Ill. Dec. 651 (1982) (“Whether the patients’ identities would remain confidential by the exclusion of their names and identifying numbers is questionable at best. . . As the patients disclosed this information with an expectation of privacy, their rights to confidentiality should be protected.”) (citations omitted); *Roe v. Planned Parenthood Southwest Ohio Region*, 2009-Ohio-2973, ¶ 49, 122 Ohio St. 3d 399 (“Redaction of personal information, however, does not divest the privileged status of confidential records. Redaction is merely a tool that a

court may use to safeguard the personal, identifying information within confidential records that have become subject to disclosure either by waiver or by an exception.”).

This Court finds that properly redacted patient records are not privileged. To the extent the operative reports in this case constitute “confidential communications”, once sufficiently redacted so that a particular patient is not identified and reasonably cannot be identified, the physician-patient privilege does not apply.

The purpose of the physician-patient privilege is to promote candid communication between patient and physician to promote quality medical care and to prevent disclosure of highly personal information. The purposes of the privilege are achieved by sufficient redaction. Neither of these purposes is undermined by ordering that records that are not connected to any particular patient be disclosed.

E. Burdensome

The Court is fully satisfied that production and redaction of the requested records would not be unduly burdensome in this case.

F. Scope of Production and Redaction

Under the facts of this case, the court orders that Defendants produce redacted operative notes of the 15 laparoscopic cholecystectomies performed by Dr. Vanadia before he performed the surgery on Ms. McCain and the 15 laparoscopic cholecystectomies performed by Dr. Vanadia after he performed the surgery on Ms. McCain¹. Each redacted record shall include only the year of the surgery, the name of the surgeon (Dr. Vanadia), the name of the procedure, and a portion of the section labeled “operative procedure” (i.e. all information other than the year, the name of the surgeon, the name of the procedure, and a

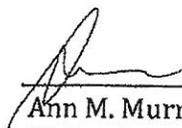
¹ During oral argument, plaintiff reduced her request to 30 reports.

portion of the "operative procedure" section will be redacted). The "operative procedure" section shall be provided only to the point in the surgery where the gallbladder was removed. To the extent there is any identifying information (name, dob, age sex, race) in the "operative procedure" section, such information shall also be redacted. The Court is fully satisfied that these very significantly redacted records will not identify any non-parties and that their identification will not be able to be discerned from the records or otherwise. It is further ordered that the redacted copies be used by the plaintiff solely for the purpose of presenting her claim before the Medical Malpractice Screening Panel or in connection with prosecuting a claim before the court. Plaintiff's counsel shall not attempt to identify the persons whose identities have been redacted and shall not provide copies of the redacted records to anyone, other than expert witnesses in the case. Any expert witness shall be required to not share the redacted copies with anyone, to use such copies only for the purpose of this case, and to return the copies to plaintiff's counsel at the end of the case.

The Entry is:

1. Claimant Dorothea B. McCain's Motion to Compel is **granted**.
2. Pursuant to M.R. Civ. P. 79, the Clerk shall incorporate this order into the docket by reference.

Dated: August 7, 2017



Ann M. Murray, Justice
Maine Superior Court

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

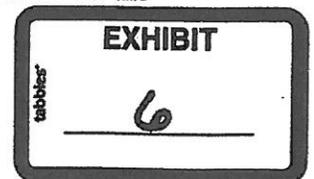
CARRIE S. CUMMINS, as)
Personal Representative of the Estate)
of Amelie E. Calabrese,)
)
Plaintiff,)
) 1:17-cv-00119-DBH
v.)
)
UNITED STATES OF AMERICA,)
et al.,)
)
Defendants)

**ORDER FOLLOWING
IN CAMERA REVIEW OF PERSONNEL RECORDS**

In this action, Plaintiff alleges in part that Katahdin Valley Medical Center, through its employee, Joan Haines, FNP, was negligent in the treatment of Amelie Calabrese in January 2015. Because Katahdin Valley Medical Center is a federally qualified health center, Defendant United States of America is a named party in accordance with the Federal Tort Claims Act.

During discovery, Plaintiff requested the production of Ms. Haines's personnel file. Defendant United States of America objects to the production of the file. On October 27, 2017, I conducted a telephonic conference to address Defendant's objection.

As I explained during the conference, I am not persuaded that the entire personnel file is relevant to the claims and defenses presented in this case. Plaintiff has not asserted a claim based on Katahdin Valley Medical Center's independent negligence. The liability issue in the case, therefore, is whether Ms. Haines's care in January 2015 satisfied the



applicable standard of care. The quality of Ms. Haines's job performance on other occasions is not necessarily pertinent to issues in this case. Nevertheless, because Ms. Haines's personnel file could possibly reference her treatment of Amelie Calabrese or otherwise contain information related to Ms. Haines's knowledge of and ability to treat the medical condition with which Amelie Calabrese presented, I ordered Defendant United States of America to produce the personnel file for an in camera inspection.

I have completed my review of the file and have determined that the file contains three documents with information potentially relevant to this matter. Specifically, Defendant United States of America shall produce the highlighted portion of document number KVHC1-000072,¹ the highlighted portion of document number KVHC1-000089, and document number KVHC1-000069. Defendant United States of America is not required to produce any other documents in the personnel file.

NOTICE

Any objections to this Order shall be filed in accordance with Fed.R.Civ.P. 72.

/s/ John C. Nivison
U.S. Magistrate Judge

Dated this 5th day of December, 2017.

¹ To preserve Defendant's right to object to this Order before the disclosure of the information, and to permit redaction of the documents in accordance with this Order, the Court will forward via U.S. Mail to Defendant a copy of the Order and copies of the pertinent documents with the portions to be produced highlighted.