

Michigan Law Revision Commission

THIRTY-SIXTH ANNUAL REPORT
2001

MICHIGAN LAW REVISION COMMISSION

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**This report may be downloaded from the Commission's Internet
Web Site, <http://www.milegislativecouncil.org/mlrcf.html>**

MICHIGAN LAW REVISION COMMISSION
Thirty-Sixth Annual Report to the Legislature
for Calendar Year 2001

To the Members of the Michigan Legislature:

The Michigan Law Revision Commission hereby presents its thirty-sixth annual report pursuant to section 403 of Act No. 268 of the Public Acts of 1986, MCL § 4.1403.

The Commission, created by section 401 of Act No. 268 of the Public Acts of 1986, MCL § 4.1401, consists of two members of the Senate, with one from the majority and one from the minority party, appointed by the Majority Leader of the Senate; two members of the House of Representatives, with one from the majority and one from the minority party, appointed by the Speaker of the House; the Director of the Legislative Service Bureau or his or her designee, who serves as an ex-officio member; and four members appointed by the Legislative Council. The terms of the members appointed by the Legislative Council are staggered. The Legislative Council designates the Chairman of the Commission. The Vice Chairman is elected by the Commission.

Membership

The legislative members of the Commission during 2001 were Senator Bill Bullard, Jr. of Highland; Senator Gary Peters of Bloomfield Township; Representative James Koetje of Grandville; and Representative Stephen Adamini of Marquette. As Legislative Council Administrator, John G. Strand was the ex-officio member of the Commission. The appointed members of the Commission were Richard McLellan, Anthony Derezinski, William Whitbeck, and George Ward. Mr. McLellan served as Chairman. Mr. Derezinski served as Vice Chairman. Professor Kevin Kennedy of Michigan State University-Detroit College of Law served as Executive Secretary. Gary Gulliver served as the liaison between the Legislative Service Bureau and the Commission. Brief biographies of the 2001 Commission members and staff are located at the end of this report.

The Commission's Work in 2001

The Commission is charged by statute with the following duties:

1. To examine the common law and statutes of the state and current judicial decisions for the purpose of discovering defects and anachronisms in the law and to recommend needed reform.

2. To receive and consider proposed changes in law recommended by the American Law Institute, the National Conference of Commissioners on Uniform State Laws, any bar association, and other learned bodies.

3. To receive and consider suggestions from justices, judges, legislators and other public officials, lawyers, and the public generally as to defects and anachronisms in the law.

4. To recommend such changes in the law as it deems necessary in order to modify or eliminate antiquated and inequitable rules of law, and to bring the civil and criminal law of this state into harmony with modern conditions.

5. To encourage the faculty and students of the law schools of this state to participate in the work of the Commission.

6. To cooperate with the law revision commissions of other states and Canadian provinces.

7. To issue an annual report.

The problems to which the Commission directs its studies are largely identified through an examination by the Commission members and the Executive Secretary of the statutes and case law of Michigan, the reports of learned bodies and commissions from other jurisdictions, and legal literature. Other subjects are brought to the attention of the Commission by various organizations and individuals, including members of the Legislature.

The Commission's efforts during the past year have been devoted primarily to three areas. First, Commission members provided information to legislative committees related to various proposals previously recommended by the Commission. Second, the Commission examined suggested legislation proposed by various groups involved in law revision activity. These proposals included legislation advanced by the Council of State Governments, the National Conference of Commissioners on Uniform State Laws, and the law revision commissions of various jurisdictions within and without the United States. Finally, the Commission considered various problems relating to special aspects of current Michigan law suggested by its own review of Michigan decisions and the recommendations of others.

As in previous years, the Commission studied various proposals that did not lead to legislative recommendations. In the case of certain uniform or model acts, the Commission sometimes found that the subjects treated had been considered by the Michigan Legislature in

recent legislation and, therefore, did not recommend further action. In other instances, uniform or model acts were not pursued because similar legislation was currently pending before the Legislature upon the initiation of legislators having a special interest in the particular subject.

In 2001, the Commission held meetings on the Administrative Procedures Act of 1969. The Commission's work and recommendation to the Legislature will be issued in 2002. The Commission also studied the three topics listed below in 2001. The Commission recommends immediate legislative action on the third topic.

The three topics are:

- (1) Health Care Information, Access and Privacy.
- (2) Emergency Preparedness and Response Legislation in Michigan.
- (3) Recent Court Opinions Suggesting Legislative Action.

Proposals for Legislative Consideration in 2002

In addition to its new recommendations, the Commission recommends favorable consideration of the following recommendations of past years upon which no final action was taken in 2001:

- (1) Revisions to the Michigan "Lemon Law", 1995 Annual Report, page 7.
- (2) Consolidated Receivership Statute, 1988 Annual Report, page 72.
- (3) Condemnation Provisions Inconsistent with the Uniform Condemnation Procedures Act, 1989 Annual Report, page 15.
- (4) Amendment of Uniform Statutory Rule against Perpetuities, 1990 Annual Report, page 141.
- (5) Amendment of the Uniform Contribution among Tortfeasors Act, 1991 Annual Report, page 19.
- (6) International Commercial Arbitration, 1991 Annual Report, page 31.
- (7) Tortfeasor Contribution under Michigan Compiled Laws §600.2925a(5), 1992 Annual Report, page 21.

- (8) Amendments to Michigan's Estate Tax Apportionment Act, 1992 Annual Report, page 29.
- (9) Amendments to Michigan's Anatomical Gift Act, 1993 Annual Report, page 53.
- (10) Ownership of a Motorcycle for Purposes of Receiving No-Fault Insurance Benefits, 1993 Annual Report, page 131.
- (11) The Uniform Putative and Unknown Fathers Act and Revisions to Michigan Laws Concerning Parental Rights of Unwed Fathers, 1994 Annual Report, page 117.
- (12) Amendments to the Freedom of Information Act to Cover E-Mail, 1997 Annual Report, page 133.
- (13) The Uniform Conflict of Laws-Limitations Act, 1997 Annual Report, page 151.
- (14) Amendments to MCL § 791.255(2) to Create a Prison Mailbox Rule, 1997 Annual Report, page 137.
- (15) Uniform Unincorporated Nonprofit Association Act, 1997 Annual Report, page 144.
- (16) Clarify whether MCL § 600.1621 invalidates pre-dispute, contractual venue selection clauses, 1998 Annual Report, page 203.
- (17) Amend the Government Tort Liability Act to cover court-appointed psychologists, 2000 Annual Report, page 84.
- (18) Examine the guilty-but-mentally ill statute and the insanity statute, 2000 Annual Report, page 85.

Current Study Agenda

Topics on the current study agenda of the Commission are:

- (1) Declaratory Judgment in Libel Law/Uniform Correction or Clarification of Defamation Act.
- (2) Medical Practice Privileges in Hospitals (Procedures for Granting and Withdrawal).
- (3) Health Care Consent for Minors.
- (4) Health Care Information, Access, and Privacy.
- (5) Uniform Statutory Power of Attorney.

- (6) Uniform Custodial Trust Act.
- (7) Legislation Concerning Teleconference Participation in Public Meetings.
- (8) Michigan Legislation Concerning Native American Tribes.
- (9) Revisions to Michigan's Administrative Procedures Act and to Procedures for Judicial Review of Agency Action.
- (10) Intergovernmental Agreements under the Michigan Constitution, Art III, § 5.
- (11) Electronic Transactions.
- (12) Termination of Parental Rights of Biological Fathers.
- (13) Government Ethics Legislation
- (14) Publishing updates of Executive Branch Reorganizations.

The Commission continues to operate with its sole staff member, the part-time Executive Secretary, whose offices are at Michigan State University-Detroit College of Law, East Lansing, Michigan 48824. The Executive Secretary of the Commission is Professor Kevin Kennedy, who was responsible for the publication of this report. By using faculty members at the several Michigan law schools as consultants and law students as researchers, the Commission has been able to operate at a budget substantially lower than that of similar commissions in other jurisdictions. At the end of this report, the Commission provides a list of more than 120 Michigan statutes passed since 1967 upon the recommendation of the Commission.

The Legislative Service Bureau, through Mr. Gary Gulliver, its Director of Legal Research, has generously assisted the Commission in the development of its legislative program. The Director of the Legislative Service Bureau continues to handle the fiscal operations of the Commission under procedures established by the Legislative Council.

The Commission continues to welcome suggestions for improvement of its program and proposals.

Respectfully submitted,

Richard D. McLellan, Chairman
Anthony Derezinski, Vice Chairman
William C. Whitbeck
George Ward
Senator Bill Bullard, Jr.
Senator Gary Peters
Representative James Koetje
Representative Stephen Adamini
John G. Strand

A STUDY REPORT TO THE MICHIGAN LAW REVISION COMMISSION ON MEDICAL INFORMATION PRIVACY

The Michigan Law Revision Commission is currently studying the subject of medical information privacy in the State of Michigan. In 2001 the Commission retained the services of Professor Elizabeth Price Foley, Michigan State University-Detroit College of Law, and Associate Professor Vence L. Bonham, Department of Medicine, College of Human Medicine, Michigan State University, to examine this subject and to prepare a preliminary report for the Commission. Their report which follows focuses on five issues:

- (1) patients' access to their own medical records,
- (2) third-party access (e.g., insurers, managed care organizations, employers, pharmacies) to a patient's medical records,
- (3) third-party use of information contained in a patient's medical records (e.g., researchers, peer review organizations, licensing boards),
- (4) treatment of sensitive medical information with a high potential for stigmatization or discrimination (e.g., information related to HIV, mental health, substance abuse, sexually transmitted diseases, abortion, or genetic information), and
- (5) the retention and disposal of medical records.

The Commission takes no position on any of these issues at this time nor does it make any recommendations to the Legislature at this time. In 2002 Professors Foley and Bonham will be submitting legislative proposals to the Commission for its review and consideration. The Commission will report to the Legislature on these proposals in its 2002 annual report.

Preliminary Report to
THE MICHIGAN LAW REVISION COMMISSION
on
MEDICAL INFORMATION PRIVACY

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I. Introduction

In the summer of 2000, the Michigan Law Revision Commission (MLRC) initiated a comprehensive review of Michigan laws regarding medical information privacy and commissioned a research project on the topic. This report presents the preliminary findings and conclusions of that research. In its charge, the MLRC indicated that it is particularly interested in knowing what Michigan's medical record privacy laws are, and how they compare with laws enacted by the federal government, particularly the Health Insurance Portability and Accountability Act ("HIPAA"). This report addresses these and other related matters.

A. Background

An individual's medical information is contained in numerous forms, including paper records and charts, electronic databases, and even oral information. It is also possessed by a dizzying array of providers, health care institutions, and business entities, including physicians, hospitals, nursing facilities, pharmacies, insurers, employers, governmental agencies, third party administrators, and marketing firms. Given the broad array of personal medical information that exists and its potentially wide dissemination--particularly in the age of computers--Americans have begun to express concerns about protecting the privacy of such medical information. An August 2000 survey conducted by Gallup for the Institute for Health Freedom¹ found that 78% of those surveyed felt that it was "very important" that their medical records be kept confidential.² Not surprisingly, then, a January 1999 survey conducted by Princeton Survey Research Associates found that 1 in 7 Americans had done something out of the ordinary to keep personal medical information confidential, including providing inaccurate information to, or withholding information from, health care providers, doctor-hopping to avoid a consolidated medical record, paying out-of-pocket for care that is covered by insurance, and even avoiding care altogether.³

(1) Enactment of HIPAA

In an attempt to address the public's concern, most states, including Michigan, have enacted numerous scattered, uncoordinated laws providing varying degrees of access to, and

¹The survey was conducted by telephone with 1,000 adults between August 11 and August 26, 2000. The margin for error of the survey is plus or minus 3 percent. The full survey report may be found at <http://forhealthfreedom.org/Gallupsurvey/>.

²An additional 14% of those surveyed felt that it was "somewhat important" that medical records be kept confidential, 5% thought it was "not too important," and 3% felt that it was "not at all important."

³The results of this poll, conducted for the California HealthCare Foundation, are reported on the website of the Institute for Health Care Research and Policy, Georgetown University, at http://www.healthprivacy.org/usr_doc/Polling%20Data%2Epdf.

privacy protection for, medical information possessed by health care providers or institutions. Because these state laws regarding medical information privacy were so varied and incomplete, Congress, as part of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”),⁴ imposed upon itself a three-year deadline for developing federal health privacy protections.⁵ Recognizing that congressional agreement on such health privacy protections may not be politically feasible, HIPAA mandated that, if Congress could not reach agreement on federal health privacy protections within the three-year time period, the task would be delegated to the Secretary of the U.S. Department of Health and Human Services (“HHS”).⁶ Perhaps not surprisingly, Congress did not meet its self-imposed deadline for developing federal health privacy protections. The task thus fell to HHS, which promulgated proposed rules on November 3, 1999.⁷ Final regulations were promulgated in late December 2000.⁸

(2) HIPAA’s Scope

(a) *Who Is A “Covered Entity” Under HIPAA?*

It is important to note that the HIPAA privacy regulations are limited in scope; they do not cover all persons or entities that have access to personal health information. More specifically, the HIPAA privacy regulations only directly cover three types of entities:

(1) health plans (e.g., managed care organizations and traditional insurers);⁹

(2) health care “clearinghouses” (i.e., entities that process health claims

⁴Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in various parts of 42 U.S.C.).

⁵Pub. L. No. 104-191, Title II, Subtitle F, § 264(c)(1), 110 Stat. 2033 (1996).

⁶*Id.*

⁷64 Fed. Reg. 59,918 (Nov. 3, 1999).

⁸65 Fed. Reg. 82,801 (Dec. 28, 2000).

⁹*Id.* at 82,799 (defining “health plan”). The definition of health plan is extremely broad, including, inter alia, self-insured ERISA plans, HMOs, traditional insurers, Medicare, Medicaid, Medigap policy issuers, issuers of long-term care insurance policies, employee welfare benefit plans that offer health benefits, CHAMPUS, the Indian Health Service, and SCHIP plans. *Id.* See also Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936, at § 1171(5).

information for providers and insurers);¹⁰ and

(3) health care providers¹¹ (e.g., physicians, hospitals, pharmacists) who transmit any health information in electronic form.¹²

It is only if a provider or entity falls within these three categories that the provider or entity is considered a “covered entity” under HIPAA.¹³ Thus, while health plans and health care clearinghouses are always covered entities (and hence, subject to the privacy regulations), health care providers are covered entities only if they transmit health information in electronic form.¹⁴ This is expected to cover most health providers, however, since most providers accept payments from insurers or managed care plans, which, in turn, generally requires that the providers transmit health information in electronic form (e.g., internet, e-mail, fax transmission, phone transmission, etc.). Moreover, another provision of HIPAA, the Electronic Data Interchange

¹⁰“Health care clearinghouse” is defined as a “public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value added” networks and switches, that does either of the following functions:

(1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.”

Id. at 82,799. *See also* Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936, at § 1171(2).

¹¹“Health care provider” is defined to include “any [] person or organization who furnishes, bills, or is paid for health care in the normal course of business.” *Id.* *See also* Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936, at § 1171(3).

¹²Examples of the transmission of health information in electronic form include, inter alia: the filing of health claims or equivalent encounter information, enrollment or disenrollment in a health plan, determining eligibility for a health plan, health plan payment and remittance, and referral certification and authorization. *See* Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936, at § 1173(a)(2).

¹³*See* 65 Fed. Reg. 82,799 (defining “covered entity”).

¹⁴65 Fed. Reg. 82,802 (Section 164.104).

(“EDI”) standards, establishes and requires the use of a uniform standard for electronic data interchange by covered entities¹⁵ and requires that, by October 16, 2003, all claims for reimbursement by Medicare submitted by providers must be submitted electronically pursuant to the uniform standard.¹⁶ With a few narrow exceptions, paper claims to Medicare will no longer be accepted.¹⁷

(b) “Business Associates” Under HIPAA

Covered entities are also required under HIPAA to impose contractual restrictions on the use or disclosure of individually identifiable health information by so-called “Business Associates.”¹⁸ Thus, if a covered entity hires another company or consultant and provides them with access to protected health information, the covered entity’s contract with the Business Associate must establish the permitted and required disclosures of such information by the Business Associate,¹⁹ and provide that the Business Associate will not further use or disclose the information other than permitted or required by the contract or as required by law, will use appropriate safeguards to prevent use or disclosure not permitted by the contract, and report (to the covered entity) any use or disclosure of the information not permitted by contract, of which it becomes aware.²⁰

It is important to note, however, that Business Associates are not directly subject to the HIPAA privacy regulations. It is the covered entity, not the Business Associate, that is solely liable for violations of privacy by the Business Associate (although, of course, the covered entity may sue the Business Associate for breach of contract). A covered entity will be deemed “not in

¹⁵See generally 45 C.F.R. § 162.100 et seq. See also 65 Fed. Reg. 50,312 (Aug. 17, 2000).

¹⁶Administrative Simplification Compliance Act, Pub. L. No. 107-105, 115 Stat. 1003, at § 3. This law was signed by President Bush on December 27, 2001.

¹⁷*Id.* The Administrative Simplification Compliance Act does state that the Secretary of HHS “shall waive” the requirement for submission of claims in electronic format if: (1) there is no method available for the submission of claims in an electronic format; or (2) the entity submitting the claim is a small provider of services or supplier; and (3) may waive the requirements in such unusual circumstances as the Secretary finds appropriate. *Id.* See also *id.* at § 3(a)(2) (defining “small provider”).

¹⁸See 65 Fed. Reg. 82,798, § 160.103 (defining “business associate”).

¹⁹The contract may permit the Business Associate: (1) to “use and disclose protected health information for the proper management and administration of the business associate”; and (2) to “provide data aggregation services relating to the health care operations of the covered entity.” *Id.* at 82,808, § 164.504(e)(2)(i).

²⁰*Id.* at § 164.504(e)(2)(ii).

compliance” with the HIPAA privacy regulations due to breaches of privacy by a Business Associate if the covered entity *knew* of a pattern of activity or practice of the Business Associate that constituted a material breach or violation of the Business Associate’s obligation under the contract.²¹ However, a covered entity will escape liability for the Business Associate’s practices if the covered entity took “reasonable steps” to cure the breach or end the violation by the Business Associate and, if such steps were unsuccessful, either (1) terminated the contract, if feasible; or (2) if termination is not feasible, reported the problem to the Secretary.²² Essentially, therefore, covered entities are held responsible for privacy breaches by a Business Associate only if the covered entity actually knew about the breach and did nothing to remedy it.

(3) HIPAA Enforcement

Any person who believes that a covered entity is not complying with the HIPAA privacy regulations may file a complaint with the Secretary of HHS within 180 days of when the individual knew or should have known that the violation occurred.²³ The Secretary may, but is not required to, investigate such complaints.²⁴ If the Secretary opts to investigate and determines that non-compliance has occurred, the Secretary must notify the covered entity “and attempt to resolve the matter by informal means whenever possible.”²⁵ If the Secretary determines that the matter cannot be resolved informally, the Secretary may, but is not required to, issue written findings (to both the covered entity and the complainant) documenting the non-compliance.²⁶

Section 1176 of the HIPAA statute establishes a general penalty for failure to comply with the requirements and standards of the Act. Specifically, the Secretary “shall” impose upon any person who violates the Act a penalty of not more than \$100 for each violation, up to a maximum of \$25,000 per calendar year for all violations of an identical requirement or prohibition. Section 1177 of the Act specifically addresses “wrongful disclosure of individually identifiable health information” and provides that a person who knowingly obtains or discloses individually identifiable health information in a manner prohibited by the Act “shall” be punished by a fine of not more than \$50,000 and/or imprisonment for not more than one year. If the violation is committed under false pretenses, the punishment escalates to a fine of not more than \$100,000 and/or imprisonment for not more than 5 years. If the violation is committed

²¹*Id.* at 82,808, at § 164.504(e)(1)(ii).

²²*Id.*

²³*Id.* at 82,801. The Secretary may waive the 180-day time limit for good cause. *Id.*

²⁴*Id.* at 82,802.

²⁵*Id.*

²⁶*Id.*

“with an intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain or malicious harm,” the punishment again escalates to a fine of not more than \$250,000 and/or imprisonment of not more than 10 years.

Neither the HIPAA statute nor regulations permit a private right of action for violations of the privacy provisions.

(4) HIPAA Preemption

While the final regulations have provided significant new federal protections for the privacy of medical information, they are considered to be a minimum, or floor, of protection. State laws contrary to *and* less protective than HIPAA’s protections are preempted; state laws that are “more stringent” than the HIPAA protections are not preempted,²⁷ even if they are contrary to HIPAA.²⁸ Three categories of state laws are explicitly *not* preempted by HIPAA

²⁷See Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, Title II, Subtitle F, § 264(c)(2), 110 Stat. 2033 (1996) (“A [health privacy] regulation promulgated [by HHS] shall not supercede a contrary provision of State law, if the provision of State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed by the regulation.”).

²⁸See *id.* at 82,801. The final regulation defines a “more stringent” state law as one which meets one or more of the following criteria:

(1) With respect to a use or disclosure, the law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under this subchapter, except if the disclosure is:

(i) Required by the Secretary in connection with determining whether a covered entity is in compliance with this subchapter; or

(ii) To the individual who is the subject of the individually identifiable health information.

(2) With respect to the rights of an individual who is the subject of the individually identifiable health information of access to or amendment of individually identifiable health information, permits greater rights of access or amendment, as applicable; provided that, nothing in this subchapter may be construed to preempt any State law to the extent that it authorizes or prohibits disclosure of protected health information about a minor to a parent, guardian, or person acting *in loco parentis* of such minor.

(3) With respect to information to be provided to an individual who is the subject of the individually identifiable health information about a use, a disclosure, rights, and

(even if they are less stringent than the protections afforded under HIPAA): (1) state laws that authorize or prohibit disclosure of protected health information about minors to parents, guardians, or persons acting *in loco parentis* (i.e., parental notification laws);²⁹ (2) state laws that provide for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health investigations;³⁰ and (3) state laws that require health plans to report or grant access to information for the purpose of audits, evaluation, or licensure, or certification of facilities or individuals.³¹

A state (acting through its chief elected official or his/her designee) or others may request, in writing, that the Secretary except a state law from preemption.³² The Secretary may except a state law from preemption if the Secretary finds one of the following: (1) that the state law is necessary to prevent health care fraud and abuse; (2) that the state law is necessary to ensure appropriate State regulation of insurance and health plans; (3) that the state law is necessary for state reporting on health care delivery or costs; (4) that the state law is necessary to serve a compelling need related to public health, safety, or welfare (and, if a privacy standard is at issue, the Secretary must determine that the intrusion into privacy is warranted when balanced against the need to be served); or (5) that the state law has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled

remedies, provides the greater amount of information.

(4) With respect to the form or substance of an authorization or consent for use or disclosure of individually identifiable health information, provides requirements that narrow the scope or duration, increase the privacy protections afforded (such as by expanding the criteria for), or reduce the coercive effect of the circumstances surrounding the authorization or consent, as applicable.

(5) With respect to recordkeeping or requirements relating to accounting of disclosures, provides for the retention or reporting of more detailed information or for a longer duration.

(6) With respect to any other matter, provides greater privacy protection for the individual who is the subject of the individually identifiable health information.

Id. at 82,800-01.

²⁹*Id.* at 82,800.

³⁰*Id.* at 82,801.

³¹*Id.*

³²*Id.*

substances.³³

Given the general lack of understanding and awareness of state law regarding medical information privacy and the broad allowance under HIPAA for the continued operation of state law, the MLRC asked the authors of this report to survey both Michigan and federal law to determine the contours of the privacy of medical information. Specifically, the authors were asked to focus on 5 issues:

- (1) patients' access to their own medical records;
- (2) third parties' access to a patient's medical records (e.g., insurers, managed care organizations, employers, pharmacies);
- (3) third party use of information in a patient's medical records (e.g., researchers, peer review organizations, licensing boards);
- (4) treatment of sensitive medical information with a high potential for stigmatizing or discriminatory impact, such as information related to HIV, mental health/substance abuse, sexually transmitted diseases, abortion, or genetic information; and
- (5) the retention and disposal of medical records.

Each of these areas will be addressed separately within this preliminary report.

B. Limitations of This Report

It should be noted that, while this report provides a comprehensive overview of the major laws relating to medical information privacy, it is not intended to be an exhaustive document. The final regulations implementing the privacy components of HIPAA, for example, were issued in late December 2000 and total over 360 pages in the *Federal Register*. The final regulations took effect April 14, 2001, although covered entities have until April 14, 2003 to actually comply with the rules.⁹ Because of the volume and complexity of the final rule, its relatively recent effective date, and the fact that most health care organizations are not expected to be in compliance with the rules for many months, it will undoubtedly take years for the full meaning and effect of the regulations to be well-understood. Likewise, except for the HIPAA regulations, our survey of state and federal law generally has been limited to a review of selected statutory law (as opposed to common law or implementing regulations), due to the sheer number, variety and complexity of relevant materials. Moreover, given that our task was to provide an overview

³³*Id.*

⁹The date of compliance is extended by one year--to April 14, 2004--for small health plans.

of state and federal laws relating to medical information privacy, we have not attempted to obtain or discuss privacy standards developed or required by private accrediting organizations (e.g., JCAHO).

II. Patients' Access to Their Own Medical Records

A. Michigan Law

Michigan law currently states that all licensed health facilities and agencies that provide services directly to patients “shall adopt” a policy describing the rights and responsibilities of admitted patients.¹⁰ Included in the list of statutorily specified minimum patients’ rights is the right to inspect and copy his/her medical record upon request.¹¹ The law explicitly states that the enumerated patients’ rights and responsibilities “are guidelines” and that no individual shall be criminally or civilly liable for failure to comply therewith.¹² Although no private right of action by an aggrieved patient is permitted, the Michigan Department of Public Health may seek administrative remedies, including license suspension/revocation or fines, against a licensed facility that denies patients’ rights.¹³

Because this law only applies to licensed health facilities and agencies (i.e., licensed institutions), it does not give patients a right to access medical records maintained outside the licensed institutional setting (e.g., a physician’s office). Thus, patients in Michigan do not have a statutory right to access general medical records maintained by physicians’ offices or other non-institutional offices.

There is, however, more specific protection under Michigan law for patients receiving mental health services. The statutes provide such patients the right to access their mental health records, provided the patient has not been adjudicated legally incompetent and does not have a

¹⁰MICH. COMP. LAWS § 333.20201(1) (2001).

¹¹*Id.* at § 20201(2)(b). Covered facilities include ambulance operations, clinical laboratories, county medical care facilities, freestanding surgical outpatient facilities, health maintenance organizations, homes for the aged, hospitals, nursing homes, and hospices. *See id.* at § 333.20106(1)(a)-(k) (defining “health facility or agency”).

¹²*Id.* at § 333.20203(1). The statute goes on to say that the enumeration of patients’ rights and responsibilities “shall not be construed to expand or diminish other remedies at law available to a patient or resident under this code or the statutory and common law of this state.” *Id.* at § 333.20203(2).

¹³*Id.* at § 333.20165(1)(f).

legal guardian.¹⁴ The entity or person who maintains a mental health record is required to provide the patient with a copy of the record “as expeditiously as possible” but in no event later than the earlier of 30 days of receiving the patient’s request or, if the patient is receiving treatment from the holder of the record, before the patient is released from treatment.¹⁵ Access may be denied to the patient if, in the written judgment of the record holder, disclosure to the patient would be “detrimental to the [patient] or to others.”¹⁶ Upon receipt of their mental health services record, a patient may challenge the accuracy, completeness, timeliness or relevance of the factual information contained in the record.¹⁷ The patient may insert a statement into the record that corrects or amends the information therein.¹⁸

B. Federal Law

(1) The Privacy Act of 1974

Under the Privacy Act of 1974,¹⁹ individuals have a right to examine, copy and amend records about them maintained by federal agencies²⁰ and contractors thereof,²¹ including medical records maintained by federal agencies such as the Center for Medicare and Medicaid Services (“CMS”).²² When a federal agency collects information from an individual, the Act requires that the agency notify the individual of the fact of collection, the authority under which the information is being collected, the principal purpose for the information, routine uses that may be

¹⁴*Id.* at § 330.1748(4).

¹⁵*Id.* at § 330.1748(4).

¹⁶*Id.* at § 330.1748(6).

¹⁷*Id.* at § 330.1749.

¹⁸*Id.*

¹⁹5 U.S.C. § 552a.

²⁰*Id.* at § 552a(d). Numerous agencies are exempted from Privacy Act requirements, including the Central Intelligence Agency and agencies “which perform[] as its principal function any activity pertaining to the enforcement of criminal laws.” *See id.* at § 552a(j).

²¹*See id.* at § 552a(m).

²²CMS is the new name for the former Health Care Financing Administration (“HCFA”), the federal agency charged with administering the Medicare and Medicaid programs. CMS and its contractors collect personally identifiable information on Medicare patients, inter alia, to pay claims, determine benefits eligibility, make payment to managed care plans, monitor fraud and abuse, administer the secondary payer program, and conduct research and demonstration projects.

made of the information, whether the individual is required to supply the information, and any effects of not so providing.²³

A federal agency that refuses to comply with an individual's request to examine or copy his/her own records is subject to a civil suit by the individual.²⁴ The statute states that the remedies for this situation are limited to the issuance of an injunction and order of production against the withholding agency²⁵ and assessment of reasonable attorney fees and other litigation costs incurred.²⁶

(2) Nursing Home Residents' Right of Access

As part of OBRA '87, Congress enacted a comprehensive set of rights for the residents of nursing homes.²⁷ The statute requires that nursing facilities receiving Medicaid reimbursement (as most nursing homes do) must maintain clinical records on all patients²⁸ and states that residents have the right to both "confidentiality of personal and clinical records" but also "to access to current clinical records of the resident upon request."²⁹ Once a request for access to the patient's clinical record has been made (by either the resident or the resident's legal representative), the nursing facility must provide such access within 24 hours (excluding weekends or holidays).³⁰

(3) Medicare + Choice Enrollees' Right of Access

Medicare beneficiaries enrolled in Medicare + Choice plans (i.e., managed care or fee-for-service plans) have a statutory right to "timely access" to medical records or other information about them maintained by the plan.³¹ Unfortunately, the statute does not specify

²³5 U.S.C. § 552a(e)(3).

²⁴*Id.* at § 552a(g)(1)(B).

²⁵*Id.* at § 552a(g)(3)(A).

²⁶*Id.* at § 552a(g)(3)(B).

²⁷*See* 42 U.S.C. § 1396r. *See also id.* at § 1396r(a) (defining "nursing facility").

²⁸*Id.* at § 1396r(b)(6)(C).

²⁹*Id.* at § 1396r(c)(1)(A)(iv).

³⁰*Id.*

³¹42 U.S.C. § 1395w-22(h)(3).

precisely what is meant by “timely access,” nor does the implementing regulation.³²

(4) Mammography Records

Federal law states that upon the request of the patient, a mammography facility must transfer the patient’s mammogram to either: (1) a medical institution; (2) a physician of the patient; or (3) the patient directly.³³ However, neither this statute nor its implementing regulation³⁴ appear to give the patient a right to demand that the mammography facility transfer the mammogram directly to the patient. In other words, the statute appears to permit a mammography facility faced with a patient’s transfer request to choose options 1 (medical institution) or 2 (physician) rather than 3 (transfer to patient directly).

(5) HIPAA

(a) HIPAA’s General Right of Access

A central feature of HIPAA is that individuals are granted a right to access their own protected (i.e., individually identifiable) health information³⁵ maintained by a provider, health plan, or a health plan’s business partner(s), if the health information is used, in whole or in part, to make health care treatment or payment decisions for the individual.³⁶ So-called “de-identified” health information is not covered by the regulation.³⁷

³²42 C.F.R. § 422.118(d).

³³42 U.S.C. § 263b(f)(1)(G)(i)(II).

³⁴See 42 C.F.R. § 900.12(c)(4)(ii).

³⁵“Protected health information” is broadly defined in the final regulation as “individually identifiable” health information that is transmitted or maintained in any medium, whether electronic, oral, or written. 65 Fed. Reg. 82,805. “Individually identifiable” health information is defined as information that identifies the individual and is created by a provider, health plan, employer, or health care clearinghouse that “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.” *Id.* at 82,804.

³⁶65 Fed. Reg. 82,554, 82,823. The final regulation makes clear that health information that is not used to make treatment or payment decisions is not accessible to the patient. Examples given are “information systems that are used for quality control or peer review analyses.” *See id.* at 82,554.

³⁷*Id.* at 82,806. The regulations specify acceptable ways in which health information may be de-identified. *See id.* at 82,818.

An individual's right of access includes the right to inspect and copy such records and exists as long as a covered entity maintains the record in which the information is contained.³⁸ A covered entity has up to 60 days (from the date of receiving the patient's request) to respond to a request if the information is maintained by the covered entity on-site, or up to 90 days to respond if the information is maintained off-site.³⁹

The final regulation also specifies that there are three types of information to which the patient does *not* have a right of access: (1) psychotherapy notes; (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (3) information maintained by a clinical laboratory subject to the Clinical Laboratory Improvement Act (CLIA), 42 U.S.C. 263a et seq.⁴⁰

While the first two of these types of information are relatively self-explanatory, the third warrants brief explanation. The federal law regulating clinical laboratories, CLIA, requires clinical labs to disclose test results to "authorized persons," as defined by state law.⁴¹ If no state law defines "authorized persons," the federal law defines it as the person who orders the test—usually the health care provider.⁴² Thus, if state law does not define the patient tested to be an "authorized person," the patient has no right to access the test results from the laboratory itself.⁴³ Assuming the laboratory reports the results to the patient's health care provider, however, the provider is likely to be a "covered entity" subject to HIPAA; hence, the patient would have the right, pursuant to the HIPAA final regulation, to inspect and copy any results conveyed to the health care provider.⁴⁴ In this indirect way, then, most patients will ultimately have the right, pursuant to the HIPAA final regulations, to access their own medical records containing the results of clinical laboratory tests.

(b) Denials of Access Under HIPAA

In addition to the three situations in which a patient lacks a right of access (*see supra*

³⁸*Id.* at 82,823.

³⁹*Id.* at 82,823-24.

⁴⁰*Id.* at 82,823.

⁴¹*Id.* at 82,554.

⁴²*Id.*

⁴³*Id.*

⁴⁴*Id.* ("We note, however, that individuals have the right of access to this information if it is maintained by a covered health care provider, clearinghouse, or health plan that is not subject to CLIA.").

Section I(B)(1), HIPAA's final regulations specify eight situations in which a patient does, in general, have a right of access, but under which a covered entity may *deny*—if they so desire—a patient's request. If a covered entity opts to exercise its denial rights, it must notify the patient, in writing, of the basis for the denial and provide the patient with information regarding a right to review, if it exists.⁴⁵ Five of these eight bases for denial are absolute, in the sense that the patient does not have a right to demand a review of the denial. Three of the eight bases, however, are qualified, in the sense that a patient denied access for one of these three reasons is given a right to demand review from a licensed health care professional.

(i). Denials for which there is no right of review

As stated above, the regulations list five situations in which a covered entity may deny a patient access to his/her medical information and for which the patient will have no right to external review of this decision.

First, of course, information requested that falls within any of the three categories listed above (*see supra* Section I(B)(1)) may be denied.⁴⁶ Second, correctional institutions (or providers acting under the direction of correctional institutions) may deny an inmate's request to *copy* his/her own medical information if obtaining a copy would "jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates or the safety of any officer, employee or other person at the correctional institution or responsible for transporting of the inmate."⁴⁷ The regulation thus permits denial of the right to copy in situations involving a risk to health or safety, but it does not permit denial of the inmate's right to *inspect* his/her medical information, which must still be honored, unless one of the other permissible denial situations applies.⁴⁸

Third, the regulations allow a covered entity to deny a request for access to information by patients who are participants in a treatment research study, but only during the time in which the research is in progress, and only if the patient explicitly consents to having such access denied during the course of the research.⁴⁹ Once the research study has ended, the patient's right of access is automatically reinstated.⁵⁰ Fourth, a covered entity may deny access under HIPAA if the information requested is contained in records that are subject to the Privacy Act, and the

⁴⁵Section 164.524(d) – at 323-24.

⁴⁶*See id.* at 82,823.

⁴⁷*See id.* at 82,555.

⁴⁸*Id.*

⁴⁹*Id.*

⁵⁰*Id.*

Privacy Act would allow denial of access by the individual.⁵¹ Finally, the regulations permit a covered entity to deny access to information that is obtained from someone other than a health care provider acting under a promise of confidentiality and providing access “would be reasonably likely to reveal the source of the information.”⁵²

(ii). Denial for which there is a right to external review

The final regulations specify three permissible bases for denying a patient’s requested access to his/her medical information for which the covered entity must provide external review upon demand by the patient. If the patient demands review of the denial, the regulations specify that the covered entity will need to have the denial determination reviewed by a licensed health care professional.⁵³ This professional need not be a physician, but may be any other health care professional licensed by the state, including a nurse or a physician’s assistant.⁵⁴ The regulations specify that the health care professional who conducts the review must not have been involved in the original decision to deny access.⁵⁵

The three bases for denial for which a right to review attaches are as follows. First, access may be denied if providing access is “reasonably likely to endanger the life or physical safety of the individual or another person.”⁵⁶ The regulations make clear, however, that this basis for denial does not permit denial based upon the general “sensitivity” of the medical information or the likelihood that the information will cause emotional or psychological harm.⁵⁷ It is only if the information is likely to result in physical violence that this basis for denial may be invoked. Under the second basis for denial for which a right to review attaches, however, emotional or psychological harm may be appropriately taken into account. Specifically, the regulations state that a patient may be denied access if the information requested makes a reference to a third party (other than a health care provider) and the patient’s health care provider has determined, in the exercise of professional judgment, that giving the patient access to such information is

⁵¹*Id.*

⁵²*Id.*

⁵³*Id.*

⁵⁴*Id.*

⁵⁵*Id.* at 82,557. The reviewer must make a determination “within a reasonable period of time,” *id.*, and the covered entity must then promptly notify the patient, in writing, of the reviewer’s decision. *Id.*

⁵⁶*Id.* at 82,555. The regulations state that “[t]he most commonly cited example is when an individual exhibits suicidal or homicidal tendencies.” *Id.*

⁵⁷*Id.*

“reasonably likely to cause serious harm” to the third party.⁵⁸ The regulations specifically state that denial may be based upon the likelihood not just of physical harm to the third party, but also the likelihood of emotional or psychological harm.⁵⁹

Third, access may be denied (with no right of review) if the access is requested by the patient’s personal representative and the covered entity has a “reasonable belief that the individual has been or will be subjected to domestic violence, abuse, or neglect by the personal representative” or that allowing the representative’s access to the medical information may endanger the patient somehow and that it is therefore not in the patient’s best interests to allow the representative such access.⁶⁰

III. Third Party Access to/Disclosure of a Patient’s Medical Records

This section will discuss the various laws regarding whether, and to what extent, a third party may access a patient’s medical information. This would include, inter alia, access by entities such as insurers, employers, marketing companies, and governmental agencies.

A. Michigan Law

(1) State Licensing Boards

Michigan law provides authority to the Department of Consumer and Industry Services (DCIS) to investigate activities related to the practice of a health professional and order relevant testimony. Specifically, the statute says:

Sec. 16221. The department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate disciplinary subcommittee. . . .⁶¹

The Attorney General, on behalf of a state licensing board, may request the circuit court to issue a subpoena requiring a health professional to produce books, papers, or documents

⁵⁸*Id.*

⁵⁹*Id.* at 82,555-56.

⁶⁰*Id.* at 82,556.

⁶¹MICH. COMP. LAWS § 333.16221(e)(ii).

(including medical records) pertaining to the investigation.⁶² Failure to comply with the subpoena issued by result in discipline by the licensing board.⁶³ The department or a disciplinary subcommittee appointed may request and shall receive reports, including information from a licensed health care facility, as to disciplinary action taken by it against a health professional.⁶⁴

(2) Private Accreditation and Peer Review Boards

Michigan laws access for investigation laws do not directly apply to private peer review boards and private accreditation agencies. A health care corporation shall not disclose records containing personal data that may be associated with an identifiable member, or personal information concerning a member without the patient's consent except when the disclosure is made to a governmental entity.⁶⁵

(3) Health Provider-Patient Evidentiary Privileges

Michigan law recognizes several patient-health provider evidentiary privileges. Most notably, Michigan statutory law establishes a physician-patient evidentiary privilege, which states that a licensed physician or surgeon "shall not disclose any information that the [physician or surgeon] has acquired in attending a patient in a professional character, if the information was necessary to enable that person to prescribe for the patient as a physician, or to do any act for the patient as a surgeon."⁶⁶ In addition, Michigan statutes recognize an evidentiary privilege for mental health providers such as psychologists and psychotherapists.⁶⁷

Of course, these evidentiary privileges are just that—evidentiary privileges—and, as such, merely prevent the health provider from testifying in court as to what the patient has told him/her in his/her capacity as a health provider. Such privileges do not prevent the health provider from divulging a patient's confidences outside the courtroom setting; however, the licensing statutes may prevent such disclosure. Specifically, Michigan statutes provide that the state licensing board may take disciplinary action against a licensed health care provider for "unprofessional

⁶²*Id.* at § 333.16235(1).

⁶³*Id.* at § 333.16221(h).

⁶⁴*Id.* at § 333.16243(a).

⁶⁵*Id.* at § 550.1406(1).

⁶⁶MICH. COMP. LAWS § 600.2157. The statute also provides for situations in which the privilege may be waived. *Id.*

⁶⁷*See id.* at §§ 333.18237, 333.20175.

conduct.”⁶⁸ The statute specifies that “unprofessional conduct” includes “betrayal of a professional confidence.”⁶⁹ Thus, a provider who divulges information conveyed by a patient as confidential may face adverse action against his/her license.

(4) Licensed Health Facilities’ & Agencies’ Records

Michigan law provides that all licensed health facilities and agencies must adopt policies that include a right of each patient to have his/her medical records treated as confidential.⁷⁰ These policies adopted by licensed facilities and agencies should include a right of the patient to refuse dissemination of their records to third parties except as required for transfer to another health facility, by a third party payment contract, or by law.⁷¹ As with the situation regarding patient access to his/her own records, this law, by only applying to licensed health facilities and agencies, does not include physician’s offices, which are not licensed by the state. Thus, under current Michigan statutes, a patient does not have a legal right to stop his/her physician from disseminating medical records to a third party.⁷² And again, because the statute merely prescribes general guidelines for the policies that must be implemented by a licensed health facility or agency, there is no specific civil or criminal penalty for non-compliance.⁷³

(5) Non-Profit Health Care Corporations’ Records

Michigan has enacted a specific statute regarding the disclosure of medical information by non-profit health care corporations (e.g., Blue Cross/Blue Shield). Specifically, the statute states that a non-profit health care corporation has a duty to use reasonable care to secure its member’s records from unauthorized access and to collect only personal data that is necessary for the proper review and payment of claims.⁷⁴ The Board of Directors of the non-profit health care

⁶⁸See, e.g., *id.* at § 333.16221(e).

⁶⁹*Id.* at § 333.16221(e)(ii).

⁷⁰MICH. COMP. LAWS §333.20201.

⁷¹*Id.*

⁷²There is a possibility that a patient could sue his/her physician under common law privacy torts, such as the tort for publication of private facts or intrusion into seclusion. There is also the possibility, of course, that the state could take adverse action against the provider for “unprofessional conduct.”

⁷³See MICH. COMP. LAWS § 333.20203. Again, as with the issue of patient access to his/her own records, there is the possibility of administrative fines being levied against a facility that actually denies the patient’s rights. MICH. COMP. LAWS § 333.20165.

⁷⁴MICH. COMP LAWS § 550.1406(1).

corporation must adopt specific corporate policies regarding the protection of member's privacy and confidentiality of personal data.⁷⁵ These corporate policies must also specify that access within the corporation to a member's personal data is limited to those persons with a "need to know" only.⁷⁶ A non-profit health care corporation that violates this law is subject to criminal misdemeanor penalties of not more than \$1,000 per violation and a private civil action for recovery of actual damages or \$200, whichever is greater, in addition to reasonable attorneys' fees and costs.⁷⁷

In addition to these internal policies and responsibilities, the non-profit health corporation may not disclose identifiable personal data, including a member's medical treatment records, without the prior, *written*, specific, informed consent of the member.⁷⁸ Exceptions are allowed for disclosure (without patient authorization) to courts, the state insurance commissioner, and governmental agencies or entities.⁷⁹ The statute also protects against re-disclosure by stating that if the patient has consented to allow the health care corporation to disclosure information to a third party, the corporation shall not release the patient's information to such third party unless the third party agrees not to further disseminate the information without obtaining another prior, specific, written, informed consent by the patient.⁸⁰

(6) Pharmacy Records

Michigan law states that persons having custody or access to prescriptions shall not disclose their contents or provide copies thereof without the patient's authorization, with seven exceptions: (1) the patient him/herself; (2) another pharmacist acting on behalf of the patient; (3) the prescriber who wrote the prescription; (4) a licensed health professional who is currently treating the patient; (5) an agency/agent of the government responsible for enforcement of laws relating to drugs and devices; (6) a person authorized by court order; (7) a person engaged in research projects or studies with protocols approved by the state licensing board.⁸¹ The statute

⁷⁵*Id.* at § 550.1406(2).

⁷⁶*Id.* at § 550.1406(2)(c).

⁷⁷*Id.* at § 550.1406(3)-(4).

⁷⁸*Id.* at § 550.1406(1). *See also id.* at § 550.1105 (defining "health care corporation"); *id.* at § 550.1107 (defining "personal data"). The statute does permit a health care corporation to release, by telephone, a patient's information to the patient him/herself, provided the identity of the patient can be identified. *Id.* at § 550.1406(1).

⁷⁹*Id.* at § 550.1406(1).

⁸⁰*Id.*

⁸¹*Id.* at § 333.17752(2).

does not specify how patient authorization may be validly obtained, which suggests that any form of authorization -- oral or written--is permissible. Pharmacists who violate this confidentiality provision are subject to discipline by the state licensing board.⁸²

(7) Third Party Administrator (TPA) Records

Third party administrators (i.e., those entities hired to process insurance or benefit claims)⁸³ are under a statutory duty to treat as confidential personal data of an individual covered by a plan.⁸⁴ As such, the statute states that a TPA shall not disclose identifiable information on a patient to any third party without the patient's prior consent, except as necessary to comply with a court order, to verify or adjudicate claims, to conduct an ERISA audit, to purchase or make claims under excess loss insurance, to the Michigan Insurance Commissioner, or for other proper plan administration.⁸⁵ Because the statute does not specify precisely how the patient's consent must be obtained, presumably it may be in oral or written form. The statute goes further, however, and states that, once a patient has provided consent for the release of identifiable information to a third party, the third party is also under a duty to keep the information confidential unless the patient "executes in writing another consent authorizing the additional release."⁸⁶ It is thus clear that, at least with regard to re-disclosure, the patient's authorization must be in writing.

Although this statutory protection appears on its face rather stringent, it does not appear to provide any penalties or remedy in the event that a TPA violates a patient's confidentiality.⁸⁷

(8) Dental Records

Michigan law states that a patient's dental records are confidential and privileged, and may not be disclosed without the written consent of the patient (or the patient's attorney in fact or personal representative)⁸⁸ except in certain narrowly defined situations, including, inter alia, as

⁸²*Id.* at § 333.17768.

⁸³*See id.* at § 550.902(k) (defining "Third Party Administrator" as "a person who processes claims pursuant to a service contract and who may also provide 1 or more other administrative services pursuant to a service contract . . .").

⁸⁴*Id.* at § 550.934(1).

⁸⁵*Id.* at § 550.934(1)-(2).

⁸⁶*Id.*

⁸⁷*See id.* at § 550.940 (defining prohibited conduct under the Third Party Administrator Act). *See also id.* at § 550.950 (establishing penalties for violating statute).

⁸⁸*Id.* at § 333.16648(1).

necessary to defend a claim challenging the dentist's professional competence, to make a claim for payment, pursuant to an audit or other good faith examination of the dentist's records for correctness, pursuant to court order, or pursuant to a death examination by a medical examiner.⁸⁹

(9) Nursing Homes' Records

Licensed nursing homes are under a duty to keep patients' records confidential and "shall not divulge or disclose the contents of a record in a manner that identifies a patient, except upon a patient's death to a relative or guardian, or under judicial proceedings."⁹⁰

(10) Governmental Agency Access to Records

Michigan law provides numerous allowances for access to a patient's medical information by various governmental agencies (including the courts) under a wide variety of circumstances. Because of the variety and number of such statutes, only a few of the major exceptions will be documented here. The state insurance commissioner, courts, other "governmental entit[ies]" and other "governmental agenc[ies]" are allowed to obtain access to records of patients who are members of non-profit health care corporations (e.g., Blue Cross/Blue Shield) without the need for obtaining the patient's consent.⁹¹ The records of nursing homes are available to state regulators and inspectors who need to determine if the nursing home is in compliance with state and federal standards.⁹² The department of consumer and industry services is allowed to access the records of all health care facilities it regulates "to the extent necessary to carry out the purpose" of relevant laws it is charged with enforcing.⁹³

B. Federal Law

(1) The Privacy Act of 1974

The Privacy Act generally prohibits disclosure to any person (or to another agency) of any record maintained about an individual by a federal agency, unless the prior written request or consent of the individual is obtained.⁹⁴ Thus, for example, medical records maintained by

⁸⁹For a complete list of exceptions, see MICH. COMP. LAWS § 333.16648(2).

⁹⁰*Id.* at § 333.21743(2).

⁹¹*Id.* at § 550.1406(1).

⁹²*See id.* at § 333.21743(2).

⁹³*Id.* at § 333.20155(11).

⁹⁴5 U.S.C. § 552a(b).

agencies such as the Center for Medicare and Medicaid Services (CMS)⁹⁵ may not be disclosed without the individual's consent, except in twelve specific situations, referred to as conditions of disclosure.⁹⁶ One permissible condition of disclosure permits disclosure of information to an employee of a federal agency if the employee needs the record to perform his/her duties.⁹⁷ Another permits disclosure for so-called "routine uses,"⁹⁸ which are defined as use of the record "for a purpose which is compatible with the purpose for which it was collected."⁹⁹

The Act also imposes a duty upon federal agencies to assure that their records are "accurate, complete, timely and relevant for agency purposes" prior to disseminating any record about an individual to any third party (other than a federal agency).¹⁰⁰ Agencies are also required to "make reasonable efforts" to notify individuals when records pertaining to the individual are "made available to any person under compulsory legal process when such process becomes a matter of public record."¹⁰¹

The Act provides for both civil and criminal penalties for violation of the disclosure provisions. Specifically, intentional or willful violation by an agency of the provisions of the act subjects the agency to civil liability of actual damages sustained by the individual (but in no case shall the individual receive less than \$1,000 as compensation for such injury), plus reasonable attorney fees and costs of bringing such civil action against the agency.¹⁰² Willful disclosure of an individual's record by an officer or employee of an agency to any person or agency not entitled to receive such record is punishable as a misdemeanor and fine of not more than \$5,000.¹⁰³ Likewise, the knowing and willful request or obtainment of any individual's record under false pretenses is punishable as a misdemeanor and fine of not more than \$5,000.¹⁰⁴

⁹⁵CMS is the new name for the former Health Care Financing Administration, the federal agency charged with administering the Medicare and Medicaid programs.

⁹⁶5 U.S.C. § 552a(b)(1)-(12).

⁹⁷*Id.* at § 552a(b)(1).

⁹⁸*Id.* at § 552a(b)(3).

⁹⁹*Id.* at § 552a(a)(7).

¹⁰⁰*Id.* at § 552a(e)(6).

¹⁰¹*Id.* at § 552a(e)(8).

¹⁰²*Id.* at § 552a(g)(4).

¹⁰³*Id.* at § 552a(i)(1).

¹⁰⁴*Id.* at § 552a(i)(3).

(2) Nursing Home & Home Health Agency Records

As stated in Section II(B)(2) (relating Patient's Access to Medical Records), the residents of nursing facilities receiving Medicaid reimbursement (virtually all nursing homes) have a statutory right to the confidentiality of personal and clinical records.¹⁰⁵ In addition, federal law requires, as a condition of participation in the Medicare program, that home health agencies are required to ensure the confidentiality of the clinical records of patients.¹⁰⁶

(3) Hospital Records

Federal regulations¹⁰⁷ require that, as a condition of participation in the Medicare program, hospitals must maintain medical records for every individual treated or evaluated in the hospital.¹⁰⁸ Records must be retained in their original (or legally reproduced) form for at least five years.¹⁰⁹ The regulations also require that the hospital "have a procedure for ensuring the confidentiality of patient records."¹¹⁰ Furthermore, information from or copies of hospital records may be released only to "authorized individuals" (not specified in the regulation) and "must ensure that unauthorized individuals cannot gain access to or alter patient records."¹¹¹ The regulation goes on to say that "original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas."¹¹² It is thus not clear, given the awkward wording of this regulation, whether: (1) non-original medical records are somehow considered distinct from original medical records; and (2) the records "may" (as opposed to "must") be released in other, non-specified situations.

(4) Medicare + Choice Records

¹⁰⁵42 U.S.C. § 1396r(c)(1)(A)(iv).

¹⁰⁶42 U.S.C. § 1395bbb(a)(1)(C). A separate statute requires that home health agencies actually maintain clinical records for each patient. 42 U.S.C. § 1395x(o)(3).

¹⁰⁷The statutory provisions cited as authorizing this regulation are very general, merely providing the HHS Secretary with the authority to prescribe "such regulations as may be necessary" to carry out the Medicare program. See 42 U.S.C. § 1395hh(a).

¹⁰⁸See 42 C.F.R. § 482.24.

¹⁰⁹*Id.* at § 482.24(b)(1).

¹¹⁰*Id.* at § 482.24(b)(3).

¹¹¹*Id.*

¹¹²*Id.*

Federal law provides that health plans participating in the Medicare + Choice program must “establish procedures” to “safeguard the privacy of any individually identifiable enrollee information.”¹¹³ The implementing regulation associated with this statute, moreover, specifies, inter alia, that the Medicare + Choice plan must have procedures that specify: (1) for what purposes such information will be used within the organization and (2) to whom and for what purposes the plan will disclose the information outside the organization.¹¹⁴ Neither the statute nor regulations prohibit the plan from disclosing information to outside entities, nor does it give the enrollee a right to prohibit the plan from so disclosing.

(5) HIPAA

(a) Permitted Disclosures for Governmental Health Oversight Purposes

HIPAA provides that a permitted disclosure is for health oversight activities such as licensure, fraud and abuse investigations, and audits:

“(d) Standard: Uses and disclosures for health oversight activities. (1) Permitted disclosures. A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of: (i) The health care system; (ii) government benefit programs for which health information is relevant to beneficiary eligibility; (iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.”

This provision would provide authority to state licensing boards to access personally identifiable health information to conduct oversight activities for licensure and disciplinary actions.¹¹⁵

(b) Disclosures to Private Peer Review & Accrediting Organizations

The HIPAA privacy rule applies directly only to health plans, health care clearinghouses, and certain health care providers. Thus, for purposes of obtaining access to protected health information, a private peer review or accrediting organization (e.g., JCAHO) would be a

¹¹³42 U.S.C. § 1395w-22(h)(1).

¹¹⁴42 C.F.R. § 422.118(a)-(b).

¹¹⁵45 C.F.R. § 164.512(d).

“Business Associate” of covered entities and thus regulated only indirectly, via contractual provisions with the covered entity.

(c) Disclosures for which Patient Consent is Required

The HIPAA final rule requires that health care *providers* who have a “direct treatment relationship”¹¹⁶ with their patients must obtain the patient’s *written consent* in order to disclose¹¹⁷ or use¹¹⁸ protected health information to third parties when such disclosure or use is for the purpose of treating the patient, obtaining payment, or for health care operations.¹¹⁹ Importantly, the consent form may be combined with other types of written legal permission (e.g., informed consent for treatment) if the disclosure consent is visually and organizationally separate from such other written legal permission and is separately signed by the individual and dated.¹²⁰ The consent form must refer the individual to a notice that contains a detailed discussion of the provider’s health information practices.¹²¹ The consent form must also inform the patient that he/she has a right to ask the covered entity to request certain restrictions regarding the use or disclosure of the information, that the covered entity is not required to agree to such restrictions,

¹¹⁶A “direct treatment relationship” is defined as “a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.” *Id.* at 82,803. An “indirect treatment relationship” is defined as “a relationship between an individual and a health care provider in which: (1) The health care provider delivers health care to the individual based on the orders of another health care provider; and (2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care directly to another health care provider, who provides the services or products or reports of the individual.” *Id.* at 82, 804. Providers with indirect treatment relationships to patients are *not* required to obtain the patient’s consent prior to using or disclosing protected health information to carry out treatment, payment, or health care operations. *Id.* at 82,810.

¹¹⁷“Disclosure” is defined as “the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.” *Id.* at 82,803.

¹¹⁸“Use” is defined as “the sharing, employment, application, utilization, examination, or analysis of [individually identifiable] information within an entity that maintains such information.” *Id.* at 82,805.

¹¹⁹65 Fed. Reg. 82,510, 82,810, at § 164.506(a). “Health care operations” is broadly defined and includes, *inter alia*, such things as quality assessment, reviewing the competency of providers or health plan, accreditation, licensing, or credentialing activities, underwriting, medical review, auditing, fraud and abuse detection and compliance, and business planning, development, or management. *See id.* at 82,803-04.

¹²⁰*Id.* at 82,810.

¹²¹*Id.* *See also id.* at 82,820 (detailing the notice requirements).

and that the individual has the right to revoke the consent in writing.¹²²

Health care providers who do *not* have a direct treatment relationship with the patient (e.g., laboratories), health plans, and health care clearinghouses may use and disclose protected health information for purposes of treatment, payment or health care operations *without obtaining patient consent*. The final rule permits such entities to obtain patient consent, if they so choose.¹²³

One other significant aspect of the HIPAA consent requirement is that the final rule explicitly permits a provider or health plan to condition treatment or enrollment on obtaining the patient's consent.¹²⁴ Thus, providers and institutions may, consistent with federal law, refuse to treat or enroll a patient if the patient does not consent to the disclosure of his/her medical records for purposes of treatment, payment, or health care operations.¹²⁵ Although patients are permitted to request that providers not share their medical information with others for the purpose of treatment, payment, or health care operations, providers are not required by law to agree to such a request. The HIPAA final regulations have thus been criticized by privacy advocates as essentially coercing consent from patients. On the other hand, CMS, in issuing the final regulations, recognized that "it would be difficult, if not impossible, for health care providers to treat their patients and run their businesses without being able to use or disclose protected health information for [treatment, payment, or health care operations] purposes."¹²⁶

(d) Disclosures for which Patient "Authorization" is Required

If the use or disclosure of protected health information is for a purpose *other than* treatment, payment, or health care operations, the rules are more stringent. No longer will mere "consent" suffice; more is required. Specifically, the rules require "authorization" by the patient, which (like consent) must be in writing, but (unlike consent) may generally not be combined with other documents and may not be made a condition to the individual's treatment, eligibility for

¹²²*Id.* at 82,810. If a covered entity agrees to a requested restriction by a patient, the restriction is binding on the entity. *Id.* In addition, a written revocation of consent to disclosure by a patient is only valid to the extent that the covered entity has not taken action in reliance on the patient's consent. *Id.*

¹²³*See id.* at 82, 810, at § 164.506(a)(4).

¹²⁴*Id.* at 82,810, at § 164.506(b).

¹²⁵*See id.* at 82,511.

¹²⁶*Id.* at 82,649.

benefits, payment, or health plan enrollment.¹²⁷ Moreover, unlike the open-ended consent, an authorization must contain an expiration date.¹²⁸

(e) When Is Consent or Authorization Not Required by HIPAA?

i. General Exceptions

One of the primary shortcomings of HIPAA is that it permits the disclosure of protected health information for many broadly defined purposes *without* the need for obtaining patient consent or authorization,¹²⁹ including, inter alia: (1) disclosure to U.S. public health authorities or foreign governmental agency officials acting in collaboration with a public health authority;¹³⁰ (2) disclosure to any person subject to FDA jurisdiction in order to report adverse events, product defects, for purposes of product tracking or post-marketing surveillance, or to enable product recalls, repairs or replacement;¹³¹ (3) disclosure to health oversight agencies for oversight activities authorized by law;¹³² (4) disclosure required by other laws, including state laws;¹³³ (5) for law enforcement proceedings and activities;¹³⁴ (6) disclosure for judicial and administrative proceedings;¹³⁵ (7) disclosure to employers if the information relates to work-related illness or injury;¹³⁶ (8) disclosure to coroners, medical examiners and funeral directors regarding deceased

¹²⁷*Id.* at 82,811. There are a few limited exceptions where such a condition may be imposed. *See id.*

¹²⁸*Id.* at 82,812.

¹²⁹*See generally id.* at 82,813-18 (listing uses and disclosures for which consent is not required).

¹³⁰*Id.* at 82,525.

¹³¹*Id.*

¹³²*Id.* at 82,528.

¹³³*Id.* at 82,524-25.

¹³⁴*Id.* at 82,531-33. This includes administrative and civil proceedings. *Id.* at 82,531. The final rules also explicitly state that covered entities are permitted to disclose protected health information for law enforcement purposes as required by other law, including state law. *Id.*

¹³⁵*Id.* at 82,529.

¹³⁶*Id.* at 82,526.

individuals;¹³⁷ (9) disclosure to organ procurement organizations¹³⁸, blood banks, sperm banks, tissue banks;¹³⁹ (10) disclosure for research purposes;¹⁴⁰ and (11) disclosure about victims of abuse, neglect, or domestic violence;¹⁴¹ and (12) disclosure for workers' compensation.¹⁴² When making these types of non-consent disclosures, covered entities are required to implement policies and procedures for disclosing the "minimum necessary" amount of health information.¹⁴³

ii. Disclosure/Use for Marketing & Fundraising Purposes

HIPAA states that a covered entity may use or disclose (to a Business Associate that assists the covered entity with such communication) protected health information for purposes of marketing¹⁴⁴ health-related goods or services in three situations:

- (1) face-to-face marketing communications with the patient regarding the entity's own services or products or the services/products of a third party (e.g., providing free samples or other information to the patient upon an office visit);¹⁴⁵
- (2) providing the patient with products or services of nominal value that contain a marketing communication (e.g., distributing pens, calendars, toothbrushes, key chains,

¹³⁷*Id.* at 82,534.

¹³⁸*Id.*

¹³⁹*Id.* at 82,477. The final rule states that "the procurement or banking of organs, blood (including autologous blood), sperm, eyes or any other tissue or human product is not considered to be health care under this rule and the organizations that perform such activities would not be considered health care providers when conducting these functions." *Id.*

¹⁴⁰*Id.* at 82,535.

¹⁴¹*Id.* at 82,527.

¹⁴²*Id.* at 82,542.

¹⁴³*See id.* at 82,544, 82,819.

¹⁴⁴"Marketing" is defined in the regulation as "a communication about a product or service a purpose of which is to encourage recipients of the communication to purchase or use the product or service." 65 Fed. Reg. 82,804 at § 164.501.

¹⁴⁵*Id.* at 164.514(e)(2)(A); *see also id.* at 82,545 (discussing intent behind marketing provisions).

etc. with the name of the covered entity on it or the name of a third party);¹⁴⁶ and

(3) marketing health-related products/services (offered by the covered entity or a third party) to the patient, but only if the communication identifies who is making the communication, states that the covered entity is being compensated for making the communication (if that is so), and informs the patient how to “opt out” of future marketing communications.¹⁴⁷ This provision does not allow a covered entity to disclose information to third parties, but merely allows the covered entity to inform patients about potentially beneficial health-related products/services offered by itself or third parties.¹⁴⁸ Covered entities will thus be permitted to inform patients of potentially beneficial drugs, treatments, or other health-related products/services.

HIPAA contains similar restrictions on fundraising by covered entities. Specifically, the final regulation states that a covered entity may use or disclose (to a Business Associate or institutionally-related foundation)¹⁴⁹ certain limited protected health information for purposes of conducting fundraising (for its own benefit only), so long as: (1) the covered entity includes, in the notice of privacy practices required by the regulation,¹⁵⁰ a statement that the entity may contact the individual to raise funds for the covered entity;¹⁵¹ and (2) the fundraising materials sent to the patient inform the patient how they may “opt out” of future fundraising communications.¹⁵² The regulation explicitly limits use/disclosure for fundraising purposes to two specific types of health information: (1) demographic information relating to the individual; and (2) dates of health care provided to the individual.¹⁵³ Any other protected health information may not be used or disclosed for purposes of fundraising.

¹⁴⁶*Id.* at 82,819 at § 164.514(e)(2)(B); *see also id.* at 82,545 (discussing intent behind marketing provisions).

¹⁴⁷65 Fed. Reg. 82,819 at § 164.514(e)(2)(C); *see also id.* at 82,820 at § 164.514(e)(3)(i).

¹⁴⁸*See id.* at 82,546 (discussing intent behind this provision).

¹⁴⁹An “institutionally related foundation” is a foundation that qualifies for Internal Revenue Code Section 501(c)(3) status and that has, in its charter statement, an explicit linkage to the covered entity. 65 Fed. Reg. 82,546.

¹⁵⁰For details on the information that must be divulged in the covered entity’s notice of privacy practices, *see* 65 Fed. Reg. 82,820-21, § 164.520(b)(1).

¹⁵¹*See id.* at 82,820, § 164.514(f)(2)(i).

¹⁵²*Id.* at § 164.514(f)(2)(ii).

¹⁵³*Id.* at 164.514(f)(1)(i)-(ii).

Because the regulations require that the covered entity inform the patient of their right to “opt out” of future marketing or fundraising communications, the regulations may be viewed as providing covered entities with “one free pass” for such communications. Thus, covered entities may use or disclose protected health information to engage in marketing/fundraising communications once, but must give patients the right to “opt out” of future such communications if they so desire.

(f) Patients’ Right to Accounting of Disclosures

Another significant aspect of HIPAA is that it establishes a right of individuals to obtain an accounting of any disclosures of protected health information by a covered entity within six years prior to the date of the requested accounting.¹⁵⁴ Exceptions are made for, *inter alia*, disclosures to carry out payment, treatment, or health care operations (i.e., necessary disclosures).¹⁵⁵ The accounting provided to the patient must include the name of the entity or person who received the information, the date of disclosure, a brief description of the information disclosed and a brief statement of the purpose of the disclosure.¹⁵⁶ The accounting generally must be provided to the patient within 60 days after receipt of the request therefor.¹⁵⁷

(6) The Freedom of Information Act

The Freedom of Information Act (“FOIA”)¹⁵⁸ requires the federal government to disclose, upon request, many different types of information possessed by the federal government. Exemption 6 of FOIA, however, allows federal agencies to withhold “personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.” 5 U.S.C. § 552(b)(6). Pursuant to the final HIPAA rules, HHS has taken the position that disclosures prohibited pursuant to HIPAA would also be subject to FOIA Exemption 6, thus avoiding most (if not all) potential conflicts between the two laws.

¹⁵⁴*Id.* at 82,826, at § 164.528.

¹⁵⁵*Id.* Exceptions are also made for disclosures for national security or intelligence purposes, to correctional institutions or law enforcement officials, etc. *See id.* at § 164.528(a).

¹⁵⁶*Id.* at § 164.528(b).

¹⁵⁷*Id.* at § 164.528(c)(1). Under certain narrow circumstances, the covered entity may extend the time frame for providing the accounting by up to 30 days. *Id.*

¹⁵⁸5 U.S.C. § 552 *et seq.*

IV. Privacy in Medical Research

Biomedical, epidemiologic, and health services research based on the study of patient medical records has been instrumental in our understanding of outcomes, patterns of practice, use, and determinants of the cost of health care. Medical information used for health services research has helped to identify potential risks for under-treatment in systems of care, evaluate cost effectiveness of surgical procedures, and other important medical interventions, methods and measures to assess the quality of care provided by health plans, hospitals, physician groups and individual physicians.¹⁵⁹ The State of Michigan and society overall must decide how best to pursue simultaneously the protection of individuals' right to privacy of health information while preserving justified research access to personally identifiable health information to conduct research to benefit society.¹⁶⁰

(1) Federal Law

Most research involving human subjects operates under the current Federal Policy for the Protection of Human Subjects known as the "common rule" (codified for the Department of Health and Human Services (HHS) at Title 45 Code of Federal Regulations Part 46) and/or the Food and Drug Administration's (FDA) human subjects protection regulations.¹⁶¹ These federal regulations have provisions that address confidentiality and are similar to, but separate from the HIPAA Privacy Rule's provisions for research.¹⁶²

¹⁵⁹Gostin, *Health Services Research: Public Benefits, Personal Privacy and Propriety Interests*, 129 *Annals Med* (10)83.

¹⁶⁰"As the fundamental nature of care, and of health data and their uses, is changing dramatically, society must—now—examine and redecide how much it cares about protecting health privacy. Health researchers must be certain that they are taking all reasonable measures to safeguard the data they collect and use, and to maintain the respect for privacy that is embodied in the very compact with society under which they work. And society must reformulate and update some of the rationales and criteria under which the health experience of individuals may be studied to benefit society." Lowrance, W.W. *Privacy and Health Research*, at <http://aspe.os.dhhs.gov/adminsimp/PHRintro.htm>.

¹⁶¹21C.F.R. § 46.111(a)(7).

¹⁶²"Q: Do the Privacy Rule's requirements for authorization and the Common Rule's requirements for informed consent differ? A: Yes. Under the Privacy Rule, a patient's authorization will be used for the use and disclosure of PHI for research purposes. In contrast, an individual's informed consent as required by the Common Rule and FDA's human subjects regulations is a consent to participate in the research study as a whole, not simply a consent for the research use or disclosure of PHI." Office of Civil Rights HIPAA Privacy Technical Assistance HHS, 164.512I.001, at <http://www.hhs.gov/ocr/hipaa/research.html>.

(a) The Common Rule

The Common Rule, which was developed largely to protect the rights and safety of human subjects, contains two general provisions to protect the privacy of health information used for research. Institutional Review Boards were required to be established pursuant to 45 C.F.R. 46 for the purpose of reviewing and having the authority to approve, require modification in, or disapprove all research activities covered by the regulations¹⁶³ including: (1) provisions to protect the privacy of human research subjects and maintain the confidentiality of data, when appropriate; and (2) requiring researchers to provide research subjects information regarding confidentiality and use of their health information as a part of the subjects' decision to consent to participate in the study. A basic element of informed consent shall include, "a statement describing the extent if any, to which confidentiality of records identifying the subject will be maintained."¹⁶⁴

A 1999 report by the General Accounting Office (GAO), *Medical Records Privacy*, reported that, "According to the Director of OPR, confidentiality protections are not a major thrust of the Common Rule and IRBs tend to give it less attention than other research risks because they have the flexibility to decide when it is appropriate to review confidentiality protections."¹⁶⁵ The Common Rule provides Institutional Review Boards with discretion to determine whether the research involves no more than minimal risk to the subjects and that informed consent may not be necessary to access personally identifiable health information.

Within the last several years, several universities' research programs have been halted because of failures of their Institutional Review Boards to protect human research subjects.¹⁶⁶ What roles if any should the State have in the protection of research subject's privacy?

(b) HIPAA

¹⁶³45 C.F.R. § 46.109 (1991).

¹⁶⁴*Id.* § 46.116 (a)(5).

¹⁶⁵United States General Accounting Office Report to Congressional Requesters "Medical Privacy Records" (February 1999).

¹⁶⁶Stout, *Citing Safety, U.S. Stops Human Research Aid at Duke*, The New York Times, May 12, 1999 at Sec. A; Col. 2.; Brainard, *Watchdog Agency Blocks New Human-Research Projects at U. of Illinois at Chicago*, The Chronicle of Higher Education, September 10, 1999 at 20.

The HIPAA final privacy rule requires that research¹⁶⁷ cannot be conducted that also involves clinical treatment where protected health information (“PHI”)¹⁶⁸ is collected without obtaining the authorization for the use or disclosure of such information from the individual patient. Health information is any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and 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.¹⁶⁹

Prior to initiating a research study a researcher must assess the extent to which information about the individual will be used by the research team, as well as used by and disclosed to parties outside of the research team. “Except as otherwise permitted by §164.512(i), a covered entity that creates protected health information for the purpose, in whole or in part, of research that includes treatment must obtain an authorization for the use or disclosure of such information.”¹⁷⁰ The consent to use the information must contain:

- (A) A description of the extent to which such protected health information will be used or disclosed to carry out treatment, payment, or health care operations;¹⁷¹
- (B) A description of any protected health information that will not be used or disclosed¹⁷²

¹⁶⁷See 45 C.F.R. § 164.501, “Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.”

¹⁶⁸ Protected Health Information (PHI) is individually identifiable health 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.

¹⁶⁹45 C.F.R. § 160.103.

¹⁷⁰45 C.F.R. § 164.508(f).

¹⁷¹*Id.* at (f)(1)(ii)(A).

¹⁷²*Id.* at (f)(1)(ii)(B).

For example, if the covered entity/researcher intends to seek reimbursement from the research subject's health plan for routine costs of care associated with the protocol, the authorization must describe types of information that will be provided to the health plan."¹⁷³

The rule also creates a new review body called a "Privacy Board." A privacy board must: (1) have members with varying backgrounds and appropriate professional competency as necessary to review the effect of the research protocol on the individual's privacy rights; (2) have at least one member who is not affiliated with the covered entity, and not affiliated with any entity conducting or sponsoring the research; and (3) not have any member participating in a review of any project in which the member has a conflict of interest.

The HIPAA final privacy rule provides a mechanism for researchers to waive authorization requirements for use of protected health information (PHI) for research purposes. The final rule provides that IRBs or the HIPAA created privacy boards have authority to make exceptions to the authorization requirements. The focus of the review is whether privacy interests of the individual will not be adversely affected.¹⁷⁴ A covered entity may receive authorization to use or disclose protected health information. Specifically, the regulations state as follows:

(2) Documentation of waiver approval by the Privacy Board or IRB. For a use or disclosure to be permitted based on a Privacy Board action the documentation must include all of the following:

- Identification and date of action. A statement identifying the IRB or privacy board and the date on which the alteration or waiver of authorization was approved;
- Waiver criteria. A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:
- The use or disclosure of protected health information involves no more than minimal risk to the individuals;
- The alteration or waiver will not adversely affect the privacy rights and the welfare of the individuals;
- The research could not practicably be conducted without the alteration or waiver;

¹⁷³Office of Civil Rights HIPAA Technical Assistance, HHS, 164.512I.001, at <http://www.hhs.gov/ocr/hipaa/research.html>.

¹⁷⁴See 45 C.F.R. § 164.512(i).

- The research could not practicably be conducted without access to and use of the protected health information;
- The privacy risks to individuals whose protected health information is to be used or disclosed are reasonable in relation to the anticipated benefits if any to the individuals, and the importance of the knowledge that may reasonably be expected to result from the research;
- There is an adequate plan to protect the identifiers from improper use and disclosure;
- There is an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law; and
- There are adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted by this subpart.
- A privacy board must review the proposed research at convened meetings at which a majority of the privacy board members are present, and the alteration or waiver of authorization must be approved by the majority of the privacy board members present at the meeting, unless the privacy board elects to use an expedited review procedure;
- A privacy board may use an expedited review procedure if the research involves no more than minimal risk to the privacy of the individuals who are the subject of the protected health information for which use or disclosure is being sought. If the privacy board elects to use an expedited review procedure, the review and approval of the alteration or waiver of authorization may be carried out by the chair of the privacy board, or by one or more members of the privacy board as designated by the chair.¹⁷⁵

An IRB must follow the requirements of the Common Rule, including the normal review procedures; To use personally identifiable health information without authorization of the individual the researchers must document: (A) The use or disclosure of protected health information involves no more than minimal risk to the individuals; (B) The alteration or waiver will not adversely affect the privacy rights and the welfare of the individuals; (C) The research could not practicably be conducted without the alteration or waiver; (D) The research could not practicably be conducted without access to and use of the protected health information; (E) The privacy risks to individuals whose protected health information is to be used or disclosed are

¹⁷⁵*Id.* at C.F.R. § 164.512 (i).

reasonable in relation to the anticipated benefits if any to the individuals, and the importance of the knowledge that may reasonably be expected to result from the research; (F) There is an adequate plan to protect the identifiers from improper use and disclosure; (G) There is an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law; and (H) There are adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use disclosure of protected health information would be permitted.¹⁷⁶

The research community including leading universities, medical schools, scientific societies, and pharmaceutical research, medical device and biotechnology firms have expressed concerns regarding the impact the Privacy Rule will have on research. “The academic and industry research communities believe that the rule’s restrictions on the use and disclosure of protected health information for research purposes and limits on retention of research data will seriously impair our ability to conduct clinical trials, clinico-pathological studies of the natural history and therapeutic responsiveness of disease, epidemiologic and health outcome studies, and genetic research.”¹⁷⁷

(c) HIPAA Shortcomings

The HIPAA Privacy Rule does not directly apply to researchers who are also not directly treating patients. The Privacy Rule applies to individually identifiable health information gained in the course of medical treatment. “The odd result is that for research involving treatment, PHI is protected by this special authorization requirement, but for research that does not involve treatment, (which includes research that may yield vital and possibly harmful PHI, such as for example, personal genetic information), no such special authorization is specifically required. The best practice, nevertheless, would be for IRBs, institutions and researchers to require these authorizations for all human subjects research, regardless of whether that research includes medical treatment.”¹⁷⁸

(2) Michigan Law

Michigan Law regarding the use of medical records for purposes of research is limited. The relevant statute provides that data including written reports, statements, notes, memoranda and other records shared with the department in the conduct of a medical research project, for the

¹⁷⁶C.F.R. § 164.512(2).

¹⁷⁷Letter to HHS Secretary Thompson on HIPAA Privacy Regulations and Research, August 14, 2001, at <http://www.aamc.org/research/Thompson.htm>.

¹⁷⁸Barnes and Krauss, *The Effect of HIPAA on Human Subjects Research*, BNA Health Law Reporter Vol. 10 No. 26, pp.1026 et. seq. (June 28, 2001).

purpose of reducing the morbidity or mortality from any cause or health condition are confidential and shall be used solely for the medical research purposes. The statute reads as follows:

Sec. 2631. Confidentiality of Information

The information, records of interviews, written reports, statements, notes, memoranda, or other data or records furnished to, procured by, or voluntarily shared with the department in the conduct of a medical research project, or a person, agency, or organization which has been designated in advance by the department as a medical research project which regularly furnishes statistical or summary data with respect to that project to the department for the purpose of reducing the morbidity or mortality from any cause or condition of health are confidential and shall be used solely for statistical, scientific, and medical research purposes relating to the cause or condition of health.¹⁷⁹

This provision was enacted as a part of the Public Health Code of 1978. The provision is limited to research conducted by the Department of Community Health and does not apply to other medical research conducted in the State of Michigan. The law does not provide any express penalties for violation. MCL 333.2632 provides that furnishing data to the department in the conduct of a medical research project does not result in the loss of a privilege protecting the data.

MCL 333.2619 provides for the establishment of registry for cancer cases and other specified diseases. The law states, “(3) the department shall maintain comprehensive records of all reports submitted pursuant to this section. These reports shall be subject to the same requirements of confidentiality as provided in section 2631 for data or records concerning medical research projects.”¹⁸⁰ This provision is limited to the Department and designated persons, agencies or organizations provided the information for research purposes by the department. A cancer registry developed by a hospital, university or other organization are not covered by the provision.

(3) Other States

A state that has legislatively addressed in a comprehensive manner access to health information for purposes of research is Minnesota. In 1997, Minnesota passed a progressive law to protect the privacy of individuals’ health information. The law provides that patients’ health records cannot be used for research purposes without a reasonable effort to obtain the patient’s written consent.¹⁸¹ Specifically providers must obtain the patients consent for release of health

¹⁷⁹MICH. COMP. LAWS § 333.2619(3) (1978).

¹⁸⁰MICH. COMP. LAWS § 333.2631 (1978).

¹⁸¹The Minnesota statute provides:

(d) Notwithstanding paragraph (a), health records may be released to an external researcher solely for purposes of medical or scientific research only as follows:

(1) health records generated before January 1, 1997, may be released if the patient has not objected or does not elect to object after that date;

(2) for health records generated on or after January 1, 1997, the provider must:

(i) disclose in writing to patients currently being treated by the provider that health records, regardless of when generated, may be released and that the patient may object, in which case the records will not be released; and

(ii) use reasonable efforts to obtain the patient's written general authorization that describes the release of records in item (i), which does not expire but may be revoked or limited in writing at any time by the patient or the patient's authorized representative;

(3) authorization may be established if an authorization is mailed at least two times to the patient's last known address with a postage prepaid return envelope and a conspicuous notice that the patient's medical records may be released if the patient does not object, and at least 60 days have expired since the second notice was sent; and the provider must advise the patient of the rights specified in clause (4);

(4) the provider must, at the request of the patient, provide information on how the patient may contact an external researcher to whom the health record was released and the date it was released. In making a release for research purposes the provider shall make a reasonable effort to determine that:

(i) the use or disclosure does not violate any limitations under which the record was collected;

(ii) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(iii) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(iv) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

MINN. STAT. § 144.335-3a(d) (2001).

records in writing. Authorization may be established if an authorization is mailed at least two times to the patient's last known address with postage prepaid return envelope and conspicuous notice that the patient's medical records may be released if the patient does not object.

In commentaries on the law researchers within the state of Minnesota expressed their concern as to how the law would adversely impact the research enterprise within the State of Minnesota.¹⁸² This law has provided an opportunity for researchers to study whether a requirement to obtain consent prior to release of health information for research purposes would adversely affect the ability to conduct research. A 1999 study found that "Requiring a patient informed consent to gain access to medical records for a specific research study was associated with a low participation rate among members of one health plan in this observational study."¹⁸³ In the study only 53% of the individuals contacted to participate responded and only 19% authorized the use of medical records and 34% declined.

V. Sensitive Medical Information

Certain types of medical information pose special privacy concerns because of the high potential for discrimination or stigmatization that often results from dissemination of such information. Included in this category generically described as "sensitive medical information" includes information pertaining to HIV/AIDS, mental health or substance abuse treatment, abortion, child abuse and genetic information.

A. Mental Health Information

(1) Michigan Law

¹⁸²"In addition to documenting clinical details that patients cannot readily recall, such information is crucial for identifying the patients who qualify for case-control studies of the cause of disease or for retrospective cohort studies of long-term prognosis or the effectiveness of treatment. Such studies complement prospective investigations and clinical trials, which invariably involve highly selected subgroups of patients. Under the new Minnesota law, patients who decline to provide the broad general authorization can be contacted to determine their willingness to participate in a particular study. This is administratively cumbersome, however, and it is likely that selection bias will be introduced into certain studies, especially at institutions unable to afford the considerable expense of obtaining prior authorization." Melton, *The Threat to Medical-Records Research*, *The New Eng. J.* 337(20) 1466 (1997).

¹⁸³Douglas, et al., *Medical Records and Privacy: Empirical Effects of Legislation*, HSR. 34(:1) (April 1999, Part II) 417-25, 422.

Michigan law has numerous special requirements for medical information pertaining to mental health services. One important statutory provision states that information contained in a record or acquired in the course of providing mental health services to a patient “shall be kept confidential and shall not be open to public inspection.”¹⁷⁴ Once this general statement is made, however, the statute goes on to establish three separate categories of possible disclosure: (1) situations in which disclosure *must* be made; (2) situations in which disclosure *may* be made, provided patient consent (or a relevant proxy, such as a guardian) is obtained; and (3) situations in which disclosure *may* be made at the discretion of the record holder, without the need for patient consent.

With regard to the first category—i.e., situations in which disclosure of mental health information *must* be made—the statute lists seven (7) such situations: (1) compliance with a subpoena issued by a court or legislature; (2) to prosecuting attorneys as needed to participate in a proceeding governed by the act; (3) to the patient’s attorney (but only if the patient or, if applicable, his/her guardian or parent, consents); (4) if needed to comply with another provision of law; (5) if needed by the department of mental health; (6) if needed by the office of the auditor general; and (7) to a surviving spouse (or, if no surviving spouse, to the individual(s) most closely related to the patient within the 3d degree of consanguinity) for the purpose of applying for and receiving benefits.¹⁷⁵

With regard to the second category—i.e., situations in which disclosure *may* be made, with the patient’s consent (or, if applicable, his/her guardian, custodial parent, a court-appointed personal representative of the patient, or the executor of the estate of a deceased patient)—there are two (2) situations specified: (1) disclosure to another provider who is providing mental health services to the patient; or (2) disclosure to the patient (or his/her guardian or, if the patient is a minor, the patient’s parent) unless the holder of the information expresses its judgment, in writing, that “disclosure would be detrimental to the recipient or others.”¹⁷⁶

Finally, the statute sets forth a third category, wherein disclosure of mental health information *may* be made by the record holder, without the need for obtaining the patient’s (or anyone else’s) consent. This type of disclosure is permissible in the “discretion of the holder of the record” and is limited to three situations: (1) as needed for the patient to apply for or receive benefits; (2) as needed for the purpose of outside research, evaluation, accreditation, or statistical compilation; and (3) to a provider of mental health or other health services or a public agency if “there is compelling need for disclosure based upon a substantial probability of harm to the recipient or other individuals.”¹⁷⁷ In the situation permitting disclosure for research, evaluation,

¹⁷⁴MICH. COMP. LAWS § 330.1748(1).

¹⁷⁵*Id.* at § 330.1748(5).

¹⁷⁶*Id.* at § 330.1748(6).

¹⁷⁷*Id.* at § 330.1748(7).

accreditation, or statistical compilation, the statute specifies that the mental health information disclosed must be stripped of identifiable information “unless the identification is essential in order to achieve the purpose for which the information is sought or if preventing the identification would clearly be impractical, but not if the subject of the information is likely to be harmed by the identification.”¹⁷⁸

In addition, there is a special Michigan statute that imposes upon mental health professionals a duty to disclose a communication by a patient involving a threat of physical violence against a reasonably identifiable third party, provided the patient has the apparent intent and ability to carry out such threat in the foreseeable future.¹⁷⁹ The mental health professional may generally discharge this duty by hospitalizing the patient or communicating the threat to the third party and relevant law enforcement authorities.¹⁸⁰ Mental health professionals and licensed mental health facilities are also under a statutory duty to report suspected criminal abuse of their patients to relevant law enforcement authorities, provided there is reasonable cause to suspect such abuse.¹⁸¹

Michigan law also provides special statutory protection for the mental health records of prisoners,¹⁸² which is essentially the same as the protections afforded to mental health information of non-prisoners, with one important difference. First, and most importantly, all of the disclosures of prisoners’ mental health information permitted by the statute are *permissive*, not mandatory.¹⁸³ As mentioned above, the statute establishing confidentiality of non-prisoner mental health information lists seven (7) instances in which disclosure of such information is mandatory.¹⁸⁴ These same seven instances are listed in the prisoner confidentiality statute—with one relatively minor difference¹⁸⁵—but they are *permissive* rather than mandatory disclosures.

¹⁷⁸*Id.* at § 330.1748(7)(b).

¹⁷⁹*See id.* at § 330.1946.

¹⁸⁰*See id.* at § 330.1946(2).

¹⁸¹*Id.* at § 330.1723.

¹⁸²*Id.* at § 330.2004a(5).

¹⁸³*Id.* (“information pertaining to a prisoner receiving mental health services from the corrections mental health program may be disclosed under 1 or more of the following circumstances . . .”).

¹⁸⁴*See id.* at § 330.1748(5).

¹⁸⁵The difference is that, with non-prisoner records, one of the situations in which mandatory disclosure is required is “[t]o a prosecuting attorney as necessary for the prosecuting attorney to participate in a proceeding governed by this act.” *Id.* at § 330.1748(5)(b). This exception is obviously not applicable to prisoners and thus is not found in the prisoner confidentiality statute.

Thus, the holder of a prisoner's mental health records is not required to disclose in these seven situations, whereas the holder of a non-prisoner's mental health records is required to disclose. Ironically, in this regard, prisoners appear to enjoy a greater right to privacy with regard to mental health information than do non-prisoners.

(2) Federal Law

HIPAA provides heightened protection to "psychotherapy notes."¹⁸⁶ For most purposes, a covered entity may not disclose information contained in psychotherapy notes without specific patient authorization.¹⁸⁷ A health plan may not condition enrollment in the plan or provision of benefits under the plan upon an individual providing authorization for disclosure of psychotherapy notes.¹⁸⁸

B. Substance Abuse Information

(1) Michigan Law

Michigan law provides that records maintained in connection with a substance abuse treatment, rehabilitation, prevention, or emergency medical service are confidential.¹⁸⁹ Disclosure may be made with the patient's written consent in three situations: (1) to health professionals for the purpose of diagnosing or treating the patient; (2) to any governmental personnel for the purpose of obtaining benefits to which the patient is entitled; or (3) to any other

In its place, however, the prisoner confidentiality statute states that a record holder may disclose mental health information "[t]o the department of corrections if the information is necessary to protect the safety of the prisoner, other prisoners, or the public, or to protect the prisoner's interactions with others in the state correctional facility." *Id.* at § 330.2004a(5)(d).

¹⁸⁶"Psychotherapy notes" are defined as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." 65 Fed. Reg. 82,805.

¹⁸⁷*Id.* at 82,811. There are a few very limited exceptions wherein authorization is not required. *See id.*

¹⁸⁸*Id.*

¹⁸⁹MICH. COMP. LAWS § 333.6111.

person specifically authorized by the patient.¹⁹⁰ Disclosure may also be made without the patient's consent in four situations: (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel for the purpose of conducting scientific research, financial audits or program evaluations, provided the identity of the individual is not disclosed by such personnel; (3) as ordered by a court of competent jurisdiction in order to determine whether an individual is under treatment by an agency; and (4) as ordered by a court for purposes of conducting a hearing to determine the need of a minor for substance abuse rehabilitation or treatment.¹⁹¹

There is a separate state statute that authorizes a treating physician (or other health professional acting on the advice and direction of a treating physician) to disclose information relating to substance abuse treatment given to or needed by a minor to the minor's spouse, parent, guardian or person in loco parentis.¹⁹² This disclosure may be made for medical reasons in the judgment of the treating physician or other health professional, even if the minor expressly objects.¹⁹³

(2) Federal Law

Federal law provides that any program relating to substance abuse education, prevention, training, treatment, rehabilitation or research which conducted, regulated, or directly or indirectly assisted by any U.S. department or agency shall keep patient records confidential.¹⁹⁴ The statute provides for four general categories of exceptions to this general rule of confidentiality: (1) substance abuse records may be disclosed with the prior written consent of the patient;¹⁹⁵ (2) they may be disclosed (without patient consent) to "medical personnel to the extent necessary to meet

¹⁹⁰*Id.* at § 333.6112.

¹⁹¹*Id.* at § 333.6113.

¹⁹²*Id.* at § 333.6121(2).

¹⁹³*Id.*

¹⁹⁴42 U.S.C. § 290dd-2(a). Substance abuse programs covered by the federal law thus include not only federally conducted or funded programs, but also federally licensed or certified programs and programs that are tax exempt. *See* 65 Fed. Reg. 82,482.

¹⁹⁵*Id.* at § 290dd-2(b)(1).

a bona fide medical emergency;”¹⁹⁶ (3) they may be disclosed (without patient consent) to “qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation” except that, in conducting such research/audits/program evaluation, such personnel may not disclose the identity of any individual patient;¹⁹⁷ and (4) they may be disclosed (without patient consent) by court order upon a showing of good cause.¹⁹⁸

The federal statute explicitly states that it does not preempt state laws regarding the reporting of incidents of suspected child abuse and neglect.¹⁹⁹ Penalties for violation of the law are subject to the imposition of fines in accordance with Title 18 of the U.S. Code.²⁰⁰

The commentary section of the HIPAA privacy regulation acknowledges that there are a number of health care providers who will be subject to both the federal substance abuse confidentiality statute and the HIPAA final regulations.²⁰¹ However, HHS states that, “in most cases, a conflict will not exist between these rules.”²⁰² This is so because, while the HIPAA privacy rules do *permit* providers to make disclosures not permitted by the substance abuse statute, the Agency emphasizes that “because these disclosures are permissive and not mandatory, there is no conflict. An entity would not be in violation of the [HIPAA] privacy rules for failing to make these disclosures.”²⁰³ In other words, while a provider may be permitted to disclose under HIPAA, he/she is not required to do so. If he/she chooses *not* to disclose, there is no violation of either HIPAA or the federal substance abuse statute. If, on the other hand, the provider chooses to disclose, he/she will not violate HIPAA, but may violate the federal substance abuse statute. It is apparently left to the provider to choose whether or not to disclose under such circumstances.

¹⁹⁶*Id.* at § 290dd-2(b)(2)(A).

¹⁹⁷*Id.* at § 290dd-2(b)(2)(B).

¹⁹⁸*Id.* at § 290dd-2(b)(2)(C). The statute says that good cause includes “the need to avert a substantial risk of death or seriously bodily harm.” *Id.* It also specifies that, in determining whether good cause for disclosure exists, the court “shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.” *Id.*

¹⁹⁹*Id.* at § 290dd-2(e).

²⁰⁰*Id.* at § 290dd-2(f).

²⁰¹*See* 65 Fed. Reg. 82,482.

²⁰²*Id.*

²⁰³*Id.*

C. HIV/AIDS

(1) Michigan Law

Michigan has numerous, scattered statutes relating to the privacy of medical information relating to HIV/AIDS.

As an initial matter, the statutes provide that all records relating to HIV/AIDS testing or test results are confidential under Michigan law.²⁰⁴ HIV or AIDS infected individuals may expressly authorize release of their HIV/AIDS records, but such authorization must be in writing.²⁰⁵ Information about HIV infection or AIDS may be released upon court order within tightly circumscribed parameters.²⁰⁶ The statute also permits disclosure to the state department, local health departments and health care providers if disclosure would (1) protect the health of an individual, (2) prevent further transmission, or (3) assist with the diagnosis and care of a patient.²⁰⁷ The information may also be disclosed to individuals who have had contact with the infected patient if the physician or local health officer determines that disclosure is needed to prevent a reasonably foreseeable risk of further transmission of the disease.²⁰⁸ Persons who violate the statute and release HIV/AIDS records without legal authority are subject to misdemeanor prosecution, with penalties of up to one year imprisonment and fines of not more than \$5,000, in addition to civil liability for actual damages or \$1,000, whichever is greater, plus costs and reasonable attorney fees.²⁰⁹

²⁰⁴MICH. COMP. LAWS § 333.5131(1).

²⁰⁵*Id.* at § 333.5131(5)(d).

²⁰⁶*See id.* at § 333.5131(3). Information on HIV infection or AIDS may be released upon a court order or subpoena only if the court determines both: (1) that other ways of obtaining the information are not available or would not be effective; and (2) that the public interest and need for disclosure of the information outweighs the potential injury to the patient. *Id.* at § 333.5131(3)(a). If a court finds both of these requirements satisfied, the court must limit disclosure to those portions of the patient's record that are essential to fulfill the objectives of the court's order, to persons whose need for the information is the basis for the court's order, and include such other measures as considered necessary to limit disclosure for the protection of the patient. *Id.* at § 333.5131(3)(b).

²⁰⁷*Id.* at § 333.5131(5)(a).

²⁰⁸*Id.* at § 555.5131(5)(b) (this is the so-called "partner notification" law). There is also a special section that permits notification of HIV/AIDS status to an employee of a school district if disclosure is needed to prevent a reasonably foreseeable risk of transmission to students. *Id.* at § 555.5131(5)(c).

²⁰⁹*Id.* at § 555.5131(8).

In addition to the above-referenced statute, Michigan has adopted a special statute dealing with the provision of treatment to minors who are, or who profess to be infected with, venereal disease or HIV.²¹⁰ Specifically, the statute states that treating physicians (or other health professionals acting on the advice and direction of the treating physician) may, but are not obligated to, disclose “for medical reasons” the treatment given or needed to the minor’s spouse, parent, guardian or person in loco parentis.²¹¹ Such disclosure may occur even if the minor objects thereto.²¹²

State law also provides that individuals who apply for a marriage license must check-off a box acknowledging that they have received information regarding the availability of HIV tests.²¹³ If a marriage license applicant chooses to undergo such testing and the results are positive, the statute provides that the physician (or her designee) “immediately shall inform both applicants of the test results” and shall provide them with counseling.²¹⁴

Police officers, fire fighters, and certain emergency medical personnel who assists a patient who is subsequently transported to a health facility may, in certain instances, be notified that the patient was subsequently tested for HIV, HBV or other infectious agents.²¹⁵ If the police officer, fire fighter or other emergency medical personnel sustains a percutaneous, mucous membrane, or open wound exposure to the blood or bodily fluids of the emergency patient, they may request that the emergency patient be tested for HIV or HBV infection.²¹⁶ If the results of such test(s) are positive, the results may be disclosed to the exposed individual,²¹⁷ but the identity of the emergency patient shall not be revealed.²¹⁸ The exposed individual who receives the results of a test performed on an emergency patient may disclose such information to others “only to the extent consistent with the authorized purpose for which the information was obtained.”²¹⁹

²¹⁰*Id.* at § 333.5127(1).

²¹¹*Id.* at § 333.5127(2).

²¹²*Id.*

²¹³*Id.* at § 333.5119(2).

²¹⁴*Id.* at § 333.5119(3).

²¹⁵*Id.* at § 333.20191(1).

²¹⁶*Id.* at § 333.20191(2).

²¹⁷*Id.* at § 333.20191(4).

²¹⁸*Id.* at § 333.20191(5).

²¹⁹*Id.*

Blood banks or other health facilities that receive donated blood that is tainted with HIV are required to immediately notify the local health department of the violation.²²⁰

Women who undergo an initial examination for pregnancy or who have recently delivered an infant may be tested for venereal disease, HIV (or antibody to HIV), and hepatitis B.²²¹ The statute makes it clear, however, that such tests are not required if the woman does not consent to be tested or if the health provider determines, in his/her professional opinion, that the tests are medically inadvisable.²²² If such tests are performed on the woman, the statute provides that the health providers shall make and retain a record of the tests and the test results (or, if no such tests were provided, the record "shall contain an explanation of why the tests were not ordered.")²²³ The statute also states that the test results and records relating thereto are not public records but "shall be available to a local health department and to a physician who provides medical treatment to the woman or her offspring."²²⁴

Each incoming prisoner in a state correctional facility shall be tested for HIV (or antibody to HIV).²²⁵ If the prisoner tests positive and subsequently behaves in a manner that could transmit HIV to others, the prisoner must be housed in administrative segregation.²²⁶ In addition, each positive test result must be reported to the department of community health.²²⁷

(2) Federal Law

Federal law provides that states may obtain federal grant money for carrying out programs to provide partner counseling and referral services, but only if the states receiving federal grant money comply with various federal requirements.²²⁸ One of the prerequisites for receiving federal grant money is that states must establish and carry out a program for partner notification (which must not disclose the identity of the infected individual).²²⁹ In addition, the state must

²²⁰*Id.* at § 333.11101. The same statute states that an individual shall not sell or donate his/her blood knowing that he/she has tested positive for HIV or an antibody to HIV. *Id.* The statute does not, however, establish a penalty for violation of this provision.

²²¹*Id.* at § 333.5123(1).

²²²*Id.*

²²³*Id.* at § 333.5123(2).

²²⁴*Id.* at § 333.5123(3).

²²⁵*Id.* at § 791.267(2).

²²⁶*Id.* at § 791.267(3).

²²⁷*Id.* at § 791.267(4).

²²⁸*See generally* 42 U.S.C. § 300ff-38.

²²⁹*Id.* at § 300ff-38(b)(3)(B).

require entities which provide HIV tests to “confidentially report the positive test results to the State public health officer in a manner recommended and approved by the Director of the Centers for Disease Control and Prevention, together with such additional information as may be necessary for carrying out such program.”²³⁰

Another federal statute, enacted as part of the Violence Against Women Act, provides that the victim of a sexual assault may obtain an order from a U.S. District Court requiring that the defendant be tested for the presence of HIV.²³¹ The test results may be communicated to both the victim and the defendant.²³² If the initial test is negative, follow-up tests may be ordered by the court six and twelve months from the date of the initial test.²³³ The statute further provides that the victim may disclose the test results only to “any medical professional, counselor, family member or sexual partner(s) the victim may have had since the attack” and that “[a]ny such individual to whom the test results are disclosed by the victim shall maintain the confidentiality of such information.”²³⁴ Any person who fails to maintain confidentiality of the test results may be held in contempt of court.²³⁵

D. Other Sexually Transmitted Diseases

(1) Michigan Law

An individual who is arrested and charged with certain crimes relating to enticing a child for immoral purposes,²³⁶ gross indecency,²³⁷ prostitution²³⁸ or criminal sexual conduct²³⁹ shall be

²³⁰*Id.* at § 300ff-38(b)(2).

²³¹42 U.S.C. § 14011; *see also* United States v. Ward, 131 F.3d 335, 339-40 (3d Cir. 1997) (applying statute and discussing interpretation thereof).

²³²42 U.S.C. § 14011(b)(1).

²³³*Id.* at § 14011(b)(3).

²³⁴*Id.* at § 14011(b)(5).

²³⁵*Id.* at § 14011(b)(7).

²³⁶MICH. COMP. LAWS § 750.145a.

²³⁷*See id.* at §§ 750.338 (gross indecency between male persons), 750.338a (gross indecency between female persons), 750.338b (gross indecency between male and female persons).

²³⁸*See id.* at §§ 750.450 (aiders and abettors), 750.452 (keeping house of ill fame), 750.455 (pandering).

²³⁹*See id.* at §§ 750.520b (criminal sexual conduct in the first degree), 750.520c (criminal sexual conduct in the second degree), 750.520d (criminal sexual conduct in the third degree), 750.520e (criminal sexual conduct in the fourth degree), 750.520g (assault with intent to commit conduct involving sexual penetration).

examined or tested for venereal disease, hepatitis B, and for the presence of HIV or an antibody to HIV if the district court determines there is reason to believe the violation involved sexual penetration or exposure to a bodily fluid of the defendant.²⁴⁰ The examinations and tests administered shall be administered confidentially, except that the statute permits disclosure of test results in numerous situations: (1) to the victim or person who was exposed to the bodily fluids;²⁴¹ (2) to the court or probate court;²⁴² (3) to the state department of community health;²⁴³ (4) to the local health department;²⁴⁴ (5) to the department of corrections (if the defendant is placed in custody thereof);²⁴⁵ (6) as required by law;²⁴⁶ or (7) upon written authorization of the defendant.²⁴⁷

(2) Federal Law

There currently is no federal law that specifically addresses the confidentiality of medical information relating to sexually transmitted diseases.

E. Pregnancy/Abortion Services

(1) Michigan Law

State law states that the identity and address of a patient who is provided information relating to abortion services or who consents to an abortion is confidential and may be disclosed “only with the consent of the patient or by judicial process.”²⁴⁸ Given that the statute does not appear to require written consent, presumably oral consent is valid. In addition, a local health department that possesses a record containing the identity of such a patient may release such information only to a physician (or qualified person assisting the physician) in order to verify the receipt of information required by law (i.e., Michigan requires that certain specific material be given to individuals seeking an abortion prior to obtaining an abortion) and must destroy any

²⁴⁰*Id.* at § 333.5129(3).

²⁴¹*Id.* at § 333.5129(5). If the victim is a minor, the statute permits disclosure of the test results to the minor’s parents, guardian, or person in loco parentis. *Id.*

²⁴²*Id.* at § 333.5129(6).

²⁴³*Id.* at § 333.5129(6)(c).

²⁴⁴*Id.* at § 333.5129(6)(b).

²⁴⁵*Id.* at § 333.5129(7).

²⁴⁶*Id.* at § 333.5129(6)(f).

²⁴⁷*Id.* at § 333.5129(6)(e).

²⁴⁸*Id.* at § 333.17015(19).

records containing the identity and address of the patient within 30 days after providing the patient with such information/counseling.²⁴⁹

: Michigan law also requires disclosure of a minor's intent to obtain an abortion to at least one of the parents or the legal guardian of the minor.²⁵⁰ Consent must be obtained by both the minor and one of the parents or the legal guardian prior to performing an abortion on a minor.²⁵¹ Violation of this provision is a misdemeanor and may be the subject of a civil action, with punitive damages awardable.²⁵²

: A treating physician (or other health professional acting on the advice and direction of the treating physician) may also, for medical reasons, inform the putative father of a child, or the spouse, parent, guardian or person in loco parentis of a minor, as to health care provided or needed by that minor relating to prenatal and pregnancy related care.²⁵³ Such information may be disclosed by the treating physician or other health professional even if the minor expressly objects.²⁵⁴

(2) Federal Law

There currently is no federal law specifically addressing the confidentiality of medical information relating to pregnancy or abortion services.

F. Child Abuse Information

(1) Michigan Law

Current state law provides that, upon written request by a family independence agency caseworker or administrator, a licensed health professional must release medical records that are pertinent to an investigation of child abuse if such records are needed to determine whether child abuse or neglect has occurred or to protect a child where there is a substantial risk of harm.²⁵⁵ Upon receiving such a request for medical records, the health professional must review the

²⁴⁹*Id.* at § 333.17015(20).

²⁵⁰*Id.* at § 722.903.

²⁵¹*Id.*

²⁵²*Id.* at § 722.907.

²⁵³*Id.* at § 333.9132(4).

²⁵⁴*Id.*

²⁵⁵MICH. COMP. LAWS § 333.16281(1).

records to determine if there is information pertinent to the investigation.²⁵⁶ If pertinent information is contained in the record, the health professional shall release the record(s) within fourteen days of receiving the request therefor.²⁵⁷ The statute explicitly states that no health professional-patient privileges are applicable to medical information released pursuant to the statute.²⁵⁸

A separate state statute requires numerous persons not employed by FIA to report suspected child abuse or neglect, including health professionals such as physicians, coroners, dentists, registered dental hygienists, medical examiners, nurses, and licensed emergency medical care providers.²⁵⁹ Such reports must be made orally and immediately, by telephone or otherwise; a written report must be completed within 72 hours after making the initial oral report.²⁶⁰

State law also provides that, prior to placing a child with foster parents, the foster parents shall be provided written information regarding the child's history of abuse/neglect, all known emotional and psychological problems, and any behavior problems that might present any risk to the foster family.²⁶¹ The child placing agency shall explain to the foster parents that the information so provided about the child and the child's family is confidential.²⁶² The statute does not provide a penalty for a violation of this confidentiality provision by the foster family.

(2) Federal Law

There currently is no federal law regarding the confidentiality of medical information related to child abuse or neglect.

G. Genetic Information

(1) Michigan Law

"The advancement of human genetic technologies may prove the defining scientific achievement of the 21st century. The success of the Human Genome Project in meeting its two main scientific goals—identifying the genes and sequencing the chemical bases in human

²⁵⁶*Id.*

²⁵⁷*Id.*

²⁵⁸This would include, inter alia, privileges such as the physician-patient privilege, the licensed professional counselor-patient privilege.

²⁵⁹MICH. COMP. LAWS § 722.623(1).

²⁶⁰*Id.*

²⁶¹*Id.* at § 722.954(2).

²⁶²*Id.* at § 722.954(3).

DNA—ensures that the genetic revolution in science will continue apace as the new century progresses.”²⁶³ The implications of the genetic revolution are only beginning to be unraveled by scientists. By the year 2010, predictive genetic tests will be available for common conditions, allowing individuals who wish to know this information to learn their individual susceptibilities and to take steps to reduce those risks for which interventions are or will be available.²⁶⁴ By the year 2020 pharmacogenomics approach for predicting drug responsiveness will be standard practice for a number of diseases. Gene-based “designer drugs” will be introduced to the market for diabetes mellitus, hypertension, mental illness, and many other conditions.²⁶⁵

Today certain genetic information can provide information important in the making healthcare decisions for individual tested and for family members but the information can also be misused.²⁶⁶ The State of Michigan has been a leader in genetic-related legislation. The State legislature in 2000 enacted laws to protect individuals from employment discrimination. An employer may not fail or refuse to hire, recruit or promote an individual because of a disability or genetic information that is unrelated to the individual’s ability to perform the duties of a particular job or position.²⁶⁷ An employer may not discharge or discriminate against an individual with respect to compensation or terms, conditions or privileges of employment because of genetic information.²⁶⁸ An employer cannot require an individual to submit to a genetic test to provide genetic information as a condition of employment or promotion.²⁶⁹ The law does not prohibit an individual from voluntarily providing to an employer genetic information that is related to the employee’s health and safety in the workplace or the employer from using the information if provided.²⁷⁰ Health insurers, HMOs and nonprofit health care corporations cannot

²⁶³Lawrence O. Gostin, James G. Hodge Jr and Cheye M. Calvo, September 2001, Genetics Policy and Law A Report for Policymakers, National Conference of State Legislatures September 2001.

²⁶⁴Francis S. Collins. Implications of the Human Genome Project for Medical Science. 285(5) JAMA 540-544, 543, February 7, 2001.

²⁶⁵*Id.* at 544.

²⁶⁶“The collection, aggregation, and analysis of genetic information may be used to prevent or delay the onset of disease, alleviate the burden of illness, or assist people in planning their futures, but genetic information can be used for a variety of other, more controversial purposes not directly related to research or the delivery of appropriate medical care.” Powers M., Justice and Genetics: Privacy Protection and Moral Basis of Public Policy, Chapter 19, Ethics and Law, 355-368.

²⁶⁷MICH. COMP. LAWS § 37.1202 (1) (a).

²⁶⁸*Id.* at (1)(b).

²⁶⁹*Id.* at (1)(h).

²⁷⁰*Id.* at (2).

require that enrollees, applicants, or their dependents undergo genetic testing as a condition of issuing, renewing or continuing an expense-incurred health insurance policy, nor can they require an enrollee, applicant, or their dependents to disclose whether genetic testing has been conducted (or the results of those tests) as a requirement of application for health care benefits.²⁷¹

The legislation enacted in 2000 was proposed as the result of the work of the Governor's Commission on Genetic Privacy and Progress that released its Final Report and Recommendations in 1999. The Commission studied three issues related to genetic privacy: 1. Is there a specific need for state privacy laws concerning genetic information? 2. Should there be any exceptions allowing physicians to disclose genetic information? 3. Should there be considerations for research?²⁷²

The Commission recommended that the genetic information not have a special or exceptional status but be protected just as all medical information is protected. The Commission concluded that research uses are important and access can be controlled in a way that keeps confidentiality intact. The Commission determined that exceptions to confidentiality should exist for criminal investigations, court proceedings, paternity disputes, decedent identification, convicted criminals and newborn screening. The Commission stated: "After the federal government enacts privacy legislation the state can conduct an analysis to determine the need for any state legislation."²⁷³

This Report to the Michigan Law Revision Commission provides an opportunity to determine whether further legislation may be needed to protect the privacy of personally identifiable genetic information.

(2) Federal Law

Genetic information that is collected by a researcher and not "created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse is not covered by the Privacy Rule."²⁷⁴ A researcher could collect DNA samples and use them for research and conceivably be exempt from the Privacy Rule. Genetic information that is collected for treatment purposes or by an employer or insurer would be covered by the rules. Genetic information is not provided any special status or heightened protection under the Privacy Rule.

²⁷¹MICH. COMP. LAWS § 550.1401 and § 540.3407b.

²⁷²Michigan Commission on Genetic Privacy and Progress, Final Report and Recommendations February 1999, at 46.

²⁷³*Id.*

²⁷⁴*Id.* at 160.163. *See* Definition of Covered Entity and Health Information

Several bills have been introduced to prohibit health insurance discrimination on the basis of genetic information. The Genetic Nondiscrimination in Health Insurance and Employment Act addresses the issue of privacy of genetic information:

e) DISCLOSURE OF PROTECTED GENETIC INFORMATION- A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not disclose protected genetic information about an individual (or information about a request for or the receipt of genetic services by such individual or family member of such individual) to—

(1) any entity that is a member of the same controlled group as such issuer or plan sponsor of such group health plan;

(2) any other group health plan or health insurance issuer or any insurance agent, third party administrator, or other person subject to regulation under State insurance laws;

(3) the Medical Information Bureau or any other person that collects, compiles, publishes, or otherwise disseminates insurance information;

(4) the individual's employer or any plan sponsor; or

(5) any other person the Secretary may specify in regulations.²⁷⁵

The proposed federal law, if enacted, shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect a standard, requirement, or remedy that more completely protects the confidentiality of genetic information or the privacy of an individual (or a family member of the individual) with respect to genetic information, including information about a request for or the receipt of genetic services by an individual (or a family member of such individual) than does the proposed law.²⁷⁶

VI. The Retention and Disposal of Medical Records

A. Michigan Law:

Michigan has numerous, scattered statutes and administrative rules dealing with the retention or disposal of various types of medical records. There is clearly no uniform approach.

²⁷⁵H.R. 602 107th Congress, Genetic Nondiscrimination in Health Insurance and Employment Act § 2754 (c) (2001).

²⁷⁶*Id.* at H.R. 602 107th Congress, § 2754 (e) LIMITATIONS ON GENETIC TESTING AND ON COLLECTION AND DISCLOSURE OF PROTECTED GENETIC INFORMATION.

(1) Health Maintenance Organizations

HMOs are required to maintain accurate clinical records for each currently enrolled member.²⁷⁷ If a patient dies or disenrolls from the HMO, the HMO must safely store and preserve the record, either electronically or as an original record or microfilm.²⁷⁸ The administrative rules do not specify the minimum time period for retention of inactive enrollee files, but does state that the HMO “shall adopt a policy concerning the length of time and provisions for the retention of inactive clinical records, which shall include a contingency plan for the retention of existing records in the event of cessation of operations.”²⁷⁹

(2) Nursing Homes

Nursing homes and nursing care facilities must maintain a clinical record for each patient in the home.²⁸⁰ These records must be maintained for a minimum of six (6) years from the date of discharge or, if the patient is a minor, three (3) years after the patient becomes an adult under state law, whichever is longer.²⁸¹

(3) Dentists’ Offices

Dentists must maintain records of all dental treatments provided and must retain such records for at least ten (10) years after the performance of the last service to the patient.²⁸²

(4) Hospices

Hospices must maintain records of services rendered and must maintain them for at least five (5) years after death or discharge of the patient or, if the patient is a minor, at least three (3) years after the patient becomes an adult under state law, whichever is longer.²⁸³

(5) Mental Health Hospitals, Sanatoria, & Psychiatric Facilities

²⁷⁷MICH. ADMIN. CODE R. 325.6801(1) (2000); *see also id.* at 325.6805 (describing minimum contents of patient records).

²⁷⁸*Id.* at 325.6810(1).

²⁷⁹*Id.* at 325.6810(2).

²⁸⁰MICH. ADMIN. CODE R. 325.21102(1) (2000).

²⁸¹*Id.* at 325.21102(6). The statute specifies that if the nursing home goes out of business, the records must be transferred with the patient to another health care facility. *Id.* at 325.21102(7).

²⁸²MICH. COMP. LAWS § 333.16644(1) (2000); *see also* MICH. ADMIN. CODE R. 338.11120 (2000).

²⁸³MICH. ADMIN. CODE R. 325.13109 (2000).

Mental health hospitals, sanatoria, and psychiatric facilities must maintain current records on each patient.²⁸⁴ There is no minimum retention period specified in the statutes or administrative code.

(6) Methadone Treatment Programs

Methadone treatment programs must maintain client records for a period of at least three (3) years after termination of treatment.²⁸⁵

(7) Pharmacies

Pharmacies must preserve their prescription records for at least 5 years,²⁸⁶ including prescriptions for controlled substances.²⁸⁷

(8) Alteration of Medical Records or Charts

The Michigan Penal Code makes it a felony for any health care provider to intentionally or willfully place (or direct another to place) in a patient's medical record or chart misleading or inaccurate information regarding diagnosis, treatment or cause of a patient's condition.²⁸⁸ A health care provider who recklessly places misleading or false information in a medical record or chart is guilty of a misdemeanor.²⁸⁹ Persons other than health care providers are also prohibited from altering medical records. Non-providers who intentionally, willfully, or recklessly place or direct others to place misleading or inaccurate information in a medical record or chart are guilty of a misdemeanor.²⁹⁰

²⁸⁴MICH. COMP. LAWS § 330.1141 (2000); *see also id.* at § 330.1746; MICH. ADMIN. CODE R. 330.1276 (2000).

²⁸⁵MICH. ADMIN. CODE R. 325.14419(1) (2000).

²⁸⁶MICH. COMP. LAWS § 333.17752(1) (2001). The statute does not specify precisely when the 5 year retention clock begins ticking, but presumably it requires retention of a record of each prescription for at least 5 years from the date the prescription was filled. *See also* MICH. ADMIN. CODE R. 338.480a.

²⁸⁷MICH. COMP. LAWS § 333.7303a(3). *See also* MICH. ADMIN. CODE R. 338.3153a(3).

²⁸⁸*Id.* at § 750.492a(1).

²⁸⁹*Id.* at § 750.492a(1)(b). The misdemeanor punishment is limited to imprisonment for not more than one year, or a fine of not more than \$1,000, or both. *Id.*

²⁹⁰*Id.* at § 750.492a(1)(c)-(d). The statute specifies that non-providers who act intentionally or willfully are subject to punishment of imprisonment of not more than one year, or a fine of not more than \$1,000, or both. *Id.* at § 750.492a(1)(c). Non-providers who act recklessly, on the other hand, are guilty of a misdemeanor, although the statute does not specify any applicable penalty. *Id.* at § 750.429a(1)(d).

Michigan law also states that a health care provider who intentionally or willfully alters or destroys (or directs another to alter or destroy) a patient's medical records or charts for the purpose of concealing his or her responsibility for the patient's injury, sickness or death is guilty of a felony.²⁹¹ Non-providers who engage in the same act are subject to misdemeanor punishment of imprisonment for not more than one year or a fine of not more than \$1,000, or both.²⁹² A private right of action is explicitly prohibited for violation of these statutory provisions.²⁹³

B. Federal Law

(1) Mammography Facilities

Federal law requires that facilities performing mammography services must maintain a mammogram in the permanent records of the patient for a period of not less than 5 years, or not less than 10 years if no subsequent mammograms are performed at the facility (or longer if mandated by state law).²⁹⁴

(2) Controlled Substances Prescriptions

Pursuant to federal regulation, a DEA registrant must retain and make available inventories and records of controlled substances for at least 2 years from the date the drug is dispensed.²⁹⁵ Hospitals must maintain records showing the dates, quantity and batch or code marks of controlled substances used for inpatient substance abuse treatment or detoxification for at least 3 years.²⁹⁶

(3) Medicare Claims

The Medicare Intermediary Manual requires that providers who make claims for payment under the Medicare program must retain all original source documentation and medical records pertaining to the Medicare claim for at least 75 months after the claim is paid.²⁹⁷

²⁹¹*Id.* at § 750.492a(2).

²⁹²*Id.*

²⁹³*Id.* at § 750.492a(4) ("This section does not create or provide a basis for a civil cause of action for damages.").

²⁹⁴42 U.S.C. § 263b(f)(1)(G)(i)(I).

²⁹⁵21 C.F.R. § 1304.04.

²⁹⁶21 C.F.R. § 291.505.

²⁹⁷Medicare Intermediary Manual, Pt. 3 (HCFA Pub. 13-3), § 3601.4.

(4) Blood & Blood Products

FDA regulations require that blood processing facilities must retain records of blood and blood product testing for not less than 5 years after the processing of the records has been completed, or 6 months after the latest expiration date, whichever date is later.²⁹⁸ If the blood or blood product does not have an expiration date, the records must be retained indefinitely.²⁹⁹

HHS regulations require clinical laboratories to retain records of blood and blood product testing for not fewer than 5 years after processing records have been completed, or 6 months after the latest expiration date, whichever is later.³⁰⁰

(5) Clinical Laboratory Reports

In addition to the requirement relating to blood and blood product testing just mentioned, federal regulations specify differing retention periods for records relating to various types of tests performed by clinical laboratories, including cytology (generally 5 years)³⁰¹ histopathology and pathology (generally 10 years)³⁰² and immunohematology (5 years).³⁰³ In addition, clinical labs must maintain the written authorization for any testing they perform for at least 2 years.³⁰⁴

(6) OSHA Employee Medical Records

Federal OSHA regulations require that any record regarding an employee's exposure to a toxic substance must be retained by the employer for at least the duration of employment plus 30 years.³⁰⁵ Records relating to an employee's exposure to noise must be maintained for at least 2 years.³⁰⁶

(7) HIPAA

²⁹⁸21 C.F.R. § 606.160(d).

²⁹⁹*Id.*

³⁰⁰42 C.F.R. § 493.1107.

³⁰¹42 C.F.R. § 492.1257(g).

³⁰²*Id.* at § 493.1259(b).

³⁰³*Id.* at § 493.1107, 493.1109, 493.1777(d)(1); *see also* 21 C.F.R. § 606.160(d).

³⁰⁴42 C.F.R. § 493.1105.

³⁰⁵29 C.F.R. § 1910.1920. The medical records of employees who have worked for the employer less than one year need not be retained if the medical records are provided to the employee upon termination of employment. *Id.* at § 1910.20(d)(1)(i)(C).

³⁰⁶*Id.* at § 1910.95(m)(3).

HIPAA does not specify any time period for the retention or disposal of medical information. The HIPAA provision granting individuals the right to access their own medical information, for example, merely states that such right of access exists only “as long as the protected health information is maintained in the designated record set.”³⁰⁷

VII. Issues Relating to the Privacy of Health Information on the Internet

There are thousands of health-related web sites.³⁰⁸ Individuals can surf the web for all types of health information, health advice, Internet extensions of physician group practices or hospital systems, online patient databases, and/or prescription and drug-related sites. “eHealth is touted as the future of health care, promising to transform the way health care entities conduct business and change the way patients relate to their health care providers. More than sixty-five million American Internet users have sought health and medical information online, and a study last fall by the Pew Internet & American Life Project showed that a significant number of them use this information to make important decisions about medical care for themselves and loved ones.”³⁰⁹

(A) Michigan Law

Michigan law does not provide any special protections for personally identifiable health information that is transmitted on the Internet.

(B) Federal Law

HIPAA applies to health plans, health care clearinghouses, and health care providers who transmit any health information in an electronic form in connection with a transaction covered by the Act.³¹⁰ However, many health web sites are not owned or operated by a covered entity. “Different rules may apply to different web sites offering the same services. Because only web sites that fit within the definition of a “covered entity” are required to comply with the privacy

³⁰⁷65 Fed. Reg. 82,823 (Dec. 28, 2000).

³⁰⁸ Eng, *The eHealth Landscape: A Terrain Map of Emerging Information and Communication Technologies in Health and Health Care*, The Robert Wood Johnson Foundation (2001).

³⁰⁹Hudson, *Exposed Online: Why the new federal health privacy regulation doesn't offer much protection to Internet users*, Report of the Pew Internet & American Life Project, November 2001 at 1.

³¹⁰*Id.* §160.102(a).

regulation, specific activities like filing a prescription, receiving e-mail alerts or getting a second opinion may be covered by the new regulation at one site and unregulated at another.”³¹¹

Electronic records have a special vulnerability that does not exist in paper records. Electronic transfer of information provides easy and efficient dissemination of the information, which can also create a greater chance of invasion of privacy. “A report of the Health Privacy Project in 1999 documented that major health web sites lack adequate privacy policies, and their practices are often in conflict with their existing privacy statements.”³¹²

Health care-related web sites promote their ability to provide consumers greater control of their health care. That the web sites provide information to assist the patient in being a partner with their health care provider in their medical decisions. However, numerous web sites require the consumer to provide personal information about their health. Web sites also collect information regarding the user without their knowledge. “A user might participate in a chat room where her e-mail addresses used as well. Additionally, a site may have banner advertisers that collect information without users ever knowing. Many of these sites track users through cookies. Cookies files allow a web site to know when a user has visited a sites and each page the user visits to create online user profiles. User profiles help sites determine what information, products, and services the visitor uses. They also allow sites to deliver specific content to users based on their previous online activities. Although cookies are only numbers assigned by a site to each user, personal data can be linked to the number when an individual provides identifiable information to the site (e.g., completing health assessments). A 1999 study of health –related web sites found, however, that profiling is not generally disclosed or explained to visitors of a site.”³¹³

(C) HIPAA Shortcomings

Many web sites are not covered by HIPAA regulations because they are not a covered entity.³¹⁴ “In effect the most popular web sites such as eDirects.com and drkroop.com, will

³¹¹ *Id.* at iii.

³¹² *Id.* at 5. Health care web sites have access to significant amount of personal health information that is freely provided by consumers without any knowledge that information may be disclosed to a third party without the individuals consent. The HIPAA Privacy Rule does not apply to many of these organizations that are collecting this personal health information. *Report on the Privacy Policies and Practices of Health Web Sites*, The California HealthCare Foundation (January 2000).

³¹³ *Id.* at 18.

³¹⁴ “For example, both the local bricks and mortar CVS drug store and CVS.com will be required to obtain written permission to use an individual’s information to fill their prescription. In contrast, an online pharmacy that fills the same prescription but is not covered by the regulation, such as Abee Well Pharmacy, would not be required to obtain the patient’s written permission

remain uncovered by the privacy rule because they are not run by health plans (such as health insurers or HMOs) or covered health care providers. The result is that the same activities conducted at different web sites will be subject to different legal treatment.”³¹⁵

Much information is transmitted that is not covered by the Privacy Rule. “For users concerned about protecting their privacy, *where* they go (i.e., what sites they visit) will determine whether there are enforceable rules about how their health information is protected. More often than not, however, users will be getting health information and services from web sites that are not covered at all by the new federal health privacy regulations. Here are some examples of web sites that are not covered:

Some of the most popular health web sites are information-based. In other words, they provide people with information about general fitness and nutrition (e.g., www.foodfit.com), medical conditions (e.g., www.drkoop.com), and treatment options (e.g., www.medigenesis.com). Some offer a broad range of information, while other specializes in a certain drug or medical condition. They do not have an offline existence where they engage in covered activities like treating patients. They only furnish health information – they do not provide “health care,” as it is defined in the federal regulation.”³¹⁶

Certain web sites assess health status and ask the user to provide information regarding their health. “For example, www.HealthStatus.com offers free general health assessments as well as disease specific assessments to determine an individual’s risk for some of the leading causes of death.”³¹⁷ These sites collect personal information that can provide a third party personally identifiable health information of a sensitive nature.

A recent example of a privacy lapse involved Eli Lilly Pharmaceutical Company’s web site for the drug Prozac. On Prozac.com, the pharmaceutical company established a message service that more than 669 individuals enrolled to receive messages reminding the subscribers to take the company’s anti-depressant drug Prozac. In June 2000 the pharmaceutical company discontinued the program and while notifying the consumers that enrolled in the program that it was discontinued the company disclosed the email addresses of everyone who had signed up for the service. Upon receiving a request to investigate by the American Civil Liberties Union a complaint was filed by the Federal Trade Commission alleging that Lilly’s privacy statement on its web site was deceptive because Lilly failed to maintain or implement internal measures appropriate to protect sensitive consumer information.

since it does not accept insurance.” *Id* at 10.

³¹⁵*Id* at 7.

³¹⁶*Id* at 17.

³¹⁷*Id*.

“The FTC complaint alleges that Lilly’s claim of privacy and confidentiality was deceptive because Lilly failed to maintain or implement internal measures appropriate under the circumstances to protect sensitive consumer information, which led to the company’s unintentional June 27th disclosure of Medi-messenger subscribers’ personal information (i.e., e-mail addresses). In fact, according to the complaint, Lilly failed to: provide appropriate training for its employees regarding consumer privacy and information security; provide appropriate oversight and assistance for the employee who sent out the e-mail, who had no prior experience in creating, testing, or implementing the computer program used; and implement appropriate checks and controls on the process, such as reviewing the computer program with experienced personnel and pretesting the program internally before sending out the e-mail. Lilly’s failure to implement appropriate measures also violated a number of its own written security procedures.”³¹⁸

Eli Lilly Company agreed to settle the complaint of unauthorized disclosure of sensitive personal information collected from consumers through its Prozac.com web site. The Director of the FTC’s Bureau of Consumer Protection stated: “Even the unintentional release of sensitive medical information is a serious breach of consumers’ trust. ... Companies that obtain sensitive information exchange for a promise to keep it confidential must take appropriate steps to ensure the security of that information.”³¹⁹

Health care web sites have access to significant amount of personal health information that is freely provided by consumers without any knowledge that information may be disclosed to a third party without the individuals consent. The HIPAA Privacy Rule does not apply to many of these organizations that are collecting this personal health information.

VIII. Conclusion

The enactment of HIPAA has radically transformed the landscape for the privacy of medical information. Important new federal privacy protections now in place are only beginning to be understood and implemented. HIPAA’s full impact will take months or years to be fully understood and its intricate contours will likely continue to evolve as its impact becomes clearer. Nonetheless, several areas not addressed (or inadequately addressed) by HIPAA have already emerged, in which states (including Michigan) may wish to consider state legislative action. These gaps include:

(1) Business Associates/Definition of Covered Entity:

(a) General Limitations of Coverage for Business Associates

³¹⁸Press Release, Federal Trade Commission, “Eli Lilly Settles FTC Charges Concerning Security Breach,” File No 012 3214, Jan.18, 2002.

³¹⁹*Id.*

As detailed in this report, HIPAA does not directly regulate Business Associates of covered entities. Thus, any entity that receives private health information that is not a provider, health plan, or health clearinghouse is not covered by HIPAA. Although HIPAA attempts to indirectly regulate these Business Associates, this indirect regulation relies solely upon contractual provisions between the covered entity and the Business Associate. Specifically, the covered entity's contract with the Business Associate must limit the Business Associate's use/disclosure of protected health information to that provided for by the contract or as required by law. Furthermore, the contract must require that Business Associates notify the covered entity of any non-permitted use/disclosure of which the Business Associate becomes aware. If a Business Associate breaches these contractual provisions, the covered entity may be held responsible under HIPAA, but only if the covered entity knew of a pattern of activity by the Business Associate that constituted a material breach of their contractual obligations. Moreover, even if the covered entity has such knowledge, the covered entity will escape responsibility under HIPAA if it takes reasonable steps to cure/end the Business Associate's breach.

HIPAA's inability to directly regulate Business Associates is viewed as a significant shortcoming within the privacy regulations. State legislatures (such as Michigan) may wish to enact their own statutes that extend the HIPAA privacy protection regulations to Business Associates (as defined by HIPAA). Such statutes would, of course, need to specify state enforcement and penalties for non-compliance by Business Associates.

(b) Health-Related Web Sites

Particularly unregulated by HIPAA are numerous health-related web sites that collect personal health information. For example, web sites may collect information about medical condition/disease status of an individual and over-the-counter and prescription drug usage. Many of these web sites will not be "covered entities" subject to HIPAA. Thus, whether or not a health-related web site is covered by HIPAA will hinge upon who owns or controls the web site, a determination that the average consumer is not in a position to make. Indeed, because of HIPAA's limited scope, two virtually identical web sites can be regulated differently— one subject to the stringent HIPAA protections, the other subject only to voluntary privacy policies (if any).

(2) Sensitive Medical Information

HIPAA essentially treats all protected health information the same. The only exception to this general rule is for psychotherapy notes, which receive heightened protection, requiring a specific patient authorization (as opposed to a blanket consent form, which is used for all other protected health information). HIPAA thus does not provide any special protections for other types of sensitive health information, including information related to genetics, HIV/AIDS, substance abuse, pregnancy/abortion, child abuse, and sexually transmitted diseases.

Existing Michigan statutes that specifically address these categories of sensitive health information should, presumably, remain in effect post-HIPAA because they are more stringent than the federal privacy rules and thus not subject to preemption. One category of sensitive health information not covered by Michigan law, however, is genetic information. Although Michigan has recently enacted anti-discrimination statutes relating to genetic information, these statutes do not address or provide privacy protections for genetic information. Additional privacy protections for genetic information may be desirable due to the stigmatization associated with such information, as well as the potentially broad-ranging adverse psychological and social effects on third parties (e.g., family members). Indeed, the adverse impact on third parties caused by the dissemination of genetic information makes genetic information unique from other types of sensitive health information and thus may necessitate additional protection here where it may not be warranted or necessary elsewhere.

The Michigan legislature thus may want to consider enacting additional statutes to provide heightened privacy protection for genetic information. For example, other states, such as California, have recently enacted special privacy protections for genetic information that require the use of a separate authorization for the release of such information and penalties for breach of privacy relating to such information.

(3) Private Right of Action

As mentioned in this report, HIPAA's enforcement scheme does not permit an aggrieved citizen (whose privacy or right of access has been violated) to institute a civil suit to recover damages or seek appropriate injunctive relief. HIPAA only permits the Secretary of HHS to seek civil and criminal penalties against a covered entity that violates the privacy regulations. States (including Michigan) may wish to adopt their own statutes providing for a private right of action against covered entities (and Business Associates, if the state expands HIPAA to directly cover such Business Associates) for violation of the HIPAA privacy protections and/or denial of the patient's right of access.

(4) Marketing/Fundraising Communications

HIPAA permits covered entities to use/disclose protected health information for marketing or internal fundraising purposes, so long as the covered entity has obtained from the patient a general treatment, payment and health care operations consent form and provides the patient with the right to "opt out" of any future marketing/fundraising communications. Some have criticized this approach as essentially providing entities with "one free pass" to use or disclose health information for such purposes. States (including Michigan) thus may wish to consider enacting legislation that would prohibit covered entities from using/disclosing protected health information to engage in any marketing or fundraising communications unless the patient has provided *specific authorization* for the entity to use/disclose health information to send such communications.

STUDY REPORT ON EMERGENCY PREPAREDNESS AND RESPONSE LEGISLATION IN THE STATE OF MICHIGAN

Prompted by the tragic and shocking events of September 11, 2001, the Michigan Law Revision Commission undertook a review and survey of current emergency preparedness and response legislation in the State of Michigan, including provisions of the Michigan Constitution dealing with governmental response to emergencies. The results of that survey follow.

I. The Michigan Constitution.

The Michigan Constitution contains two sections dealing with state emergencies.

First, Article IV, Section 39 of the Michigan Constitution makes provision for continuity of government in periods of emergency resulting from disasters caused by enemy attack. Section 39 authorizes the Legislature to provide for the prompt and temporary succession of all public offices, whether elective or appointive, whenever the incumbents become unavailable to carry out the powers and duties of such offices. Section 39 also authorizes the Legislature to enact other laws necessary and proper for insuring the continuity of governmental operations. Section 39 finally provides that elections are to be called as soon as possible to fill vacancies in elective offices temporarily occupied by operation of any legislation enacted pursuant to Section 39.

Second, Article V, Section 12 makes the Governor the commander-in-chief of the armed forces. The Governor may call them out to execute the laws, suppress insurrection, and repel invasion.

II. Implementing Legislation.

The Legislature has enacted the following laws that deal directly with statewide emergencies (each of these laws are discussed more fully below):

- 1945 P.A. 302, M.C.L. §§ 10.31-10.33, authorizing the Governor to proclaim a state of emergency and prescribing the Governor's powers and duties with respect thereto.

- 1967 P.A. 150, M.C.L. § 32.551, specifying the occasions when the Governor may order out the organized militia, and authorizing the adjutant general to do so in the Governor's absence or disability.

- 1939 P.A. 270, M.C.L. §§ 32.101-32.102, prescribing the activities of the national guard in cases of national emergency and prescribing the power and duties of the adjutant general.

- 1967 P.A. 150, as amended, M.C.L. § 32.651, creating the Michigan emergency volunteers.

- 1959 P.A. 202, as amended, M.C.L. §§ 31.1-31.15, the Emergency Interim Executive Succession Act.

- 1963 P.A. 227, M.C.L. §§ 691.971-691.977, the Emergency Interim Judicial Succession Act.

- 1953 P.A. 151, as amended, M.C.L. § 30.261, ratifying the Interstate Disaster Compact.

- 2001 P.A. 248, 249, ratifying the Interstate Emergency Management Assistance Compact.

- 1976 P.A. 390, as amended, M.C.L. §§ 30.401-30.420, the Emergency Management Act.

***A. 1945 P.A. 302, M.C.L. §§ 10.31-10.33,
authorizing the Governor to proclaim a state of emergency
and prescribing the Governor's powers and duties with respect thereto.***

M.C.L. § 10.31 provides in part:

During times of great public crisis, disaster, rioting, catastrophe, or similar public emergency within the state, or reasonable apprehension of immediate danger thereof, when public safety is imperiled, either upon application of the mayor of a city, sheriff of a county, the commissioner of the Michigan state police, or upon his own volition, the governor may proclaim a state of emergency and designate the area involved.

Following such proclamation or declaration, the Governor may promulgate reasonable orders, rules, and regulations as he or she deems necessary to protect life and property, or to bring the emergency situation within the affected area under control. Such orders, rules, and regulations may cover the following subjects:

- control of traffic
- designation of specific zones within the area in which occupancy and use of buildings and ingress and egress of persons and vehicles may be prohibited or regulated
- control of places of amusement and assembly, and of persons on public streets and thoroughfare
- establishment of a curfew
- control of the sale, transportation, and use of alcoholic beverages and liquors
- control of the possession, sale, carrying, and use of firearms, of other dangerous weapons, and of ammunition
- control of the storage, use, and transportation of explosives or inflammable materials or liquids deemed to be dangerous to public safety.

Such orders, rules, and regulations are effective from the date and in the manner prescribed in them. They may be amended, modified, or rescinded from time to time by the Governor during the pendency of the emergency, but shall cease to be in effect upon declaration by the Governor that the emergency no longer exists.

Regarding the Act's construction, the Legislature has provided that it is its intent "to invest the governor with sufficiently broad power of action in the exercise of the police power of the state to provide adequate control over persons and conditions during such period of impending or actual public crisis or disaster." M.C.L. § 10.32. Violation of the Governor's order, rule, or regulation is punishable as a misdemeanor. M.C.L. § 10.33.

The Michigan Supreme Court has held that the field of permitted action in time of civil disorder and riot has been entirely preempted by state law, so that in the absence of action by the Governor, a city lacks power to enact a curfew ordinance that gives the mayor emergency power to declare a curfew and to ban the sale of flammable liquids. *Walsh v. City of River Rouge*, 385 Mich. 623, 189 N.W.2d 318 (1971).

B. 1967 P.A. 150, M.C.L. § 32.551, specifying the occasions when the Governor may order out the organized militia, and authorizing the adjutant general to do so in the Governor's absence or disability.

Expanding on the commander-in-chief power vested in the Governor under Article V, Section 12 of the Michigan Constitution, implementing legislation codified at M.C.L. § 32.551 provides that the Governor may order to active service any member of the organized militia in case of “riot, . . . breach of the peace, . . . in time of public danger, disaster, crisis, catastrophe or other public emergency within the state.” If the Governor is absent or disabled, then the adjutant general, “if he believes the danger great and imminent,” may order out troops as he or she believes necessary to meet the emergency.

C. 1939 P.A. 270, M.C.L. §§ 32.101-32.102, prescribing the activities of the national guard in cases of national emergency and prescribing the power and duties of the adjutant general.

The duties of the adjutant general in case of a national emergency are spelled out in M.C.L. § 32.101. The adjutant general is directly responsible “to the secretary of war [sic] of the United States” for mobilizing the Michigan national guard and executing a plan for volunteer recruiting. In time of peace the adjutant general is directed to submit contingency plans for the approval of the “war department [sic],” which plans are then to be submitted to the Governor whose approval shall give the plans the full force and effect of law. M.C.L. § 32.102.

D. 1967 P.A. 150, as amended, M.C.L. § 32.651, creating the Michigan emergency volunteers.

1967 P.A. 150 authorizes the establishment of a unit known as the Michigan emergency volunteers. The act provides that when the President calls the national guard into federal service in time of national emergency, the Governor may activate the Michigan emergency volunteers as he or she deems necessary for adequate emergency assistance to the state. The emergency volunteers are to aid civil authority missions formerly reserved for the national guard as determined by the Department of Military Affairs in cooperation with the Department of State Police and the state emergency preparedness plan. During times other than national emergencies, the number of

emergency volunteers shall not exceed 15% of the Michigan national guard authorized strength. The Department of Military Affairs is to submit an annual report to the Legislature on the status of the emergency volunteers.

*E. 1959 P.A. 202, as amended, M.C.L. §§ 31.1-31.15,
the Emergency Interim Executive Succession Act.*

In the event of a statewide emergency caused by enemy attack upon the United States or by civil disorder, the Emergency Interim Executive Succession Act is designed to provide for the prompt but temporary succession to the powers and duties of state executive officers when the incumbents become unavailable to exercise their powers or to discharge their duties. "State executive officers" is defined as "the elected heads of the principal departments of this state." M.C.L. § 31.2(d).

The Governor is to designate five emergency interim successors within 30 days after his inauguration. M.C.L. § 31.3. If the Governor, Lieutenant Governor, the elected Secretary of State, the elected Attorney General, the president pro tem. of the Senate, or the speaker of the House are not able to serve as Governor, then the emergency interim successor highest in order of succession is to exercise the Governor's powers and discharge his duties. No emergency interim successor to the abovementioned offices, other the office of the Governor, may serve as Governor. M.C.L. § 31.4.

All other state executive officers are to designate five emergency interim successors within 30 days after taking office. M.C.L. § 31.5. If a state executive's deputy is unable to serve, then the highest ranking emergency interim successor is to exercise the powers and duties of the office. M.C.L. § 31.6.

No person may be designated as an emergency interim successors unless he or she may hold the office to which he or she has been designated under the Michigan Constitution and state statutes. M.C.L. § 31.7. Interim successors serve without compensation, except that necessary and actual expenses incurred in discharging the duties of the office may be reimbursed. M.C.L. § 31.11.

The Governor or the Secretary of State, or their successors, make the determination of unavailability of a state executive officer. M.C.L. § 31.10. The Legislature may by law terminate the authority of an emergency interim successor. An election to fill the vacancy is to be held within one year after the disaster. M.C.L. § 31.14.

Any dispute concerning a question of fact arising under the Act, except a question of fact relative to the office of Governor, is to be determined by the Governor or his constitutional successor. Any dispute concerning a question of fact arising under the Act with respect to the office of Governor is to be determined by the Chief Justice of the Michigan Supreme Court. M.C.L. § 31.15.

***F. 1963 P.A. 227, M.C.L. §§ 691.971-691.977,
the Emergency Interim Judicial Succession Act.***

Legislation that parallels the Emergency Interim Executive Succession Act has been enacted for the state judiciary. The Emergency Interim Judicial Succession Act authorizes the Governor to designate not less than three special emergency judges for each member of each court of record and to specify their order of succession. M.C.L. § 691.973. In the event a regular judge becomes unavailable, a special emergency judge shall exercise the duties of that judge's office. Such power may only be exercised after an attack upon the United States has occurred. M.C.L. § 691.975. The Legislature by concurrent resolution may terminate the authority of a special emergency judge at any time. Any dispute concerning a question of fact is to be resolved by the Governor. M.C.L. § 691.977.

***G. 1953 P.A. 151, as amended, M.C.L. § 30.261,
ratifying the interstate disaster compact.***

In 1981 the Legislature ratified the Interstate Disaster Compact. Thirty-five states, the District of Columbia, and the Virgin Islands are parties to it.

Article 1 of the Compact provides that the purpose of the Compact is to provide mutual aid among the states in meeting an emergency or disaster, "including fire, flood, snow, ice, windstorm, wave action, water contamination requiring emergency action to avert danger or damage, utility failure, hazardous radiological incident, major transportation accident, epidemic, air, contamination, blight, drought, infestation, explosion, or hostile military or paramilitary action." The resources of the party states, including resources available from the United States government or any other source, are to be incorporated into a plan or plans of mutual aid to be developed among the emergency management agencies or similar bodies of the states that are parties to the Compact. The directors of emergency management of all party states constitute a committee to formulate plans and take all necessary steps for the implementation of this compact.

Article 2 provides that it is the duty of each party state to formulate disaster preparedness plans and programs for application within the state. In carrying out disaster preparedness plans and programs, the party states are to provide and follow uniform standards, practices, and rules and regulations, including (1) insignia, arm bands, and any other distinctive articles to designate and distinguish the different disaster relief forces; (2) blackouts and practice blackouts, drills, mobilization of disaster relief forces, and other tests and exercises; (3) warnings and signals for drills or attacks and the mechanical devices to be used in connection therewith; (4) the effective screening or extinguishing of all lights and lighting devices and appliances; (5) shutting off water mains, gas mains, electric power connections, and the suspension of all other utility services; (6) all materials or equipment used or to be used for disaster preparedness purposes in order to assure that such materials and equipment will be easily and freely interchangeable when used in or by any other party states; (7) the conduct of civilians and the movement and cessation of movement of pedestrians and vehicular traffic prior, during, and subsequent to drills or attacks; (8) the safety of public meetings or gatherings; and (9) mobile support units.

Article 3 obligates any party state requested to render mutual aid to take such action as is necessary to provide and make available the resources covered by the Compact in accordance with its terms. However, it is understood that the state rendering aid may withhold resources to the extent necessary to provide reasonable protection for that state. Each party state is to extend to the disaster relief forces of any other party state, while operating within its state limits under the terms and conditions of this compact, the same powers (except that of arrest unless specifically authorized by the receiving state), duties, rights, privileges, and immunities as if they were performing their duties in the state in which they are normally employed or render services. Disaster relief forces continue under the command and control of their regular leaders, but the organizational units come under the operational control of the emergency management authorities of the state receiving assistance.

Article 8 on reimbursement provides that any party state rendering aid to another state pursuant to the Compact will be reimbursed by the party state receiving aid for any loss or damage to, or expense incurred in, the operation of any equipment answering a request for aid, and for the cost incurred in connection with such requests.

Article 9, dealing with evacuations, requires that plans for the orderly evacuation of the civilian population as the result of an emergency or disaster be worked out from time to time between representatives of the party states and the various local disaster relief areas thereof.

***H. 2001 P.A. 248, 249, ratifying the Interstate
Emergency Management Assistance Compact.***

At the end of 2001, the Legislature enacted the Interstate Emergency Management Assistance Compact.¹ Three other states have enacted this Compact: Iowa (Iowa Code Ann. § 29C.21), Kansas (Kan. Stat. Ann. § 48-9a01), and Minnesota (Minn. Stat. Ann. § 192.89). The Interstate Emergency Management Assistance Compact parallels the Interstate Disaster Compact in some respects, but expands upon the latter Compact in others. The *raison d'être* of the Compact, as articulated in Article II, is that many emergencies transcend political jurisdictional boundaries and that intergovernmental coordination is essential in managing these and other emergencies. There will be emergencies that require immediate outside resources to make a prompt and effective response to such an emergency. Few, if any, individual states have all the resources they may need in all types of emergencies or the capability of delivering resources to areas where emergencies exist. The prompt, full, and effective utilization of resources of the participating states, including any resources on hand or available from the federal government or any other source, that are essential to the safety, care, and welfare of the people in the event of any emergency or disaster declared by a party state, is the underlying principle of the Compact.

Article I of the Compact, *Purpose and Authorities*, provides that the purpose of the Compact is to provide for mutual assistance between the states in managing any emergency or disaster that is duly declared by the governor of the affected state, whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resource shortages, community disorders, insurgency, or enemy attack.

Article 3 outlines the responsibilities of the states which are parties to the Compact. Each party state is responsible for formulating procedural plans and programs for interstate cooperation in the performance of the responsibilities listed in this article. In formulating such plans, and in carrying them out, the party states, insofar as practical, are to do the following:

- Review state hazards analyses and, to the extent reasonably possible, determine all those potential emergencies the party states might jointly suffer, whether due to

¹ The Interstate Emergency Management Assistance Compact was enacted in two Public Acts, one enrolled in the House, 2001 P.A. 247, and the other enrolled in the Senate, 2001 P.A. 248. However, both Public Acts track each other verbatim.

natural disaster, technological hazard, man-made disaster, emergency aspects of resource shortages, civil disorders, insurgency, or enemy attack.

- Review individual emergency plans and develop a plan that will determine the mechanism for the interstate management and provision of assistance concerning any potential emergency.

- Develop interstate procedures to fill any identified gaps and to resolve any identified inconsistencies or overlaps in existing or developed plans.

- Assist in warning communities adjacent to or crossing the state boundaries.

- Protect and assure uninterrupted delivery of services, medicines, water, food, energy and fuel, search and rescue, and critical lifeline equipment, services, and resources, both human and material.

- Inventory and set procedures for the interstate loan and delivery of human and material resources, together with procedures for reimbursement or forgiveness.

- Provide, to the extent authorized by law, for temporary suspension of any statutes or ordinances that restrict the implementation of the above responsibilities.

Article III further provides that the authorized representative of a party state may request assistance of another party state by contacting the authorized representative of that state. Requests are to include the following information:

- A description of the emergency service function for which assistance is needed, such as but not limited to fire services, law enforcement, emergency medical, transportation, communications, public works and engineering, building inspection, planning and information assistance, mass care, resource support, health and medical services, and search and rescue.

- The amount and type of personnel, equipment, materials, and supplies needed, and a reasonable estimate of the length of time they will be needed.

- The specific place and time for staging of the assisting party's response and a point of contact at that location.

Article IV, *Limitations*, recognizes that the state rendering aid may withhold resources to the extent necessary to provide reasonable protection for such state. Article

IV further provides that each party state is to afford to the emergency forces of any party state, while operating within its state limits under the terms and conditions of this compact, the same powers, except that of arrest unless specifically authorized by the receiving state, duties, rights, and privileges as are afforded forces of the state in which they are performing emergency services. Emergency forces continue under the command and control of their regular leaders, but the organizational units will come under the operational control of the emergency services authorities of the state receiving assistance.

Article V provides for the reciprocal recognition of licenses and permits. Thus, whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise.

Article VI, *Liability*, provides governmental tort immunity for acts of negligence. As a threshold matter, officers or employees of a party state rendering aid in another state pursuant to the Compact are to be considered agents of the requesting state for tort liability and immunity purposes. No party state or its officers or employees rendering aid in another state pursuant to the Compact is liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith does not include willful misconduct, gross negligence, or recklessness.

The final articles of the Compact address a variety of matters. Article VII makes clear that the Compact does not preclude any state from entering into supplementary agreements with another state and does not affect any other agreements already in force between states. Article VIII on compensation provides that each party state is responsible for the payment of compensation and death benefits to injured members of the emergency forces of that state and representatives of deceased members of such forces in case such members sustain injuries or are killed while rendering aid pursuant to this compact, in the same manner and on the same terms as if the injury or death were sustained within their own state. Article IX on reimbursement states any party state rendering aid in another state pursuant to the Compact is to be reimbursed by the party state receiving such aid for any loss or damage to or expense incurred in the operation of any equipment and the provision of any service in answering a request for aid and for the costs incurred in connection with such requests. Article X on evacuation directs that plans for the orderly evacuation and interstate reception of portions of the civilian

population as the result of any emergency or disaster of sufficient proportions to so warrant, are to be worked out and maintained between the party states and the emergency management or services directors of the various jurisdictions where any type of incident requiring evacuations might occur.

***I. 1976 P.A. 390, as amended, M.C.L. §§ 30.401-30.420,
the Emergency Management Act.***

The Emergency Management Act is the centerpiece of emergency preparedness and response legislation in Michigan. The Act provides for the planning of, mitigation of, response to, and recovery from natural and human-made disaster within the state.

The Governor is given the lead role under the Act. Under M.C.L. § 30.403, the Governor is responsible for coping with dangers presented by a disaster or emergency. The Governor may issue executive orders, proclamations, and directives having the force and effect of law to implement the Act. He may declare a state of disaster or emergency if he finds a disaster has occurred, an emergency exists, or the threat of a disaster or emergency exists. The state of disaster or emergency shall continue until the Governor finds that the threat or danger has passed, or that the disaster or emergency has been dealt with to the extent that disaster or emergency conditions no longer exist. A "disaster" is defined as

an occurrence or threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or human-made cause, including, but not limited to, fire, flood, snowstorm, ice storm, tornado, windstorm, wave action, oil spill, water contamination, utility failure, hazardous peacetime radiological incident, major transportation accident, hazardous materials incident, epidemic, air contamination, blight, drought, infestation, explosion, or hostile military action or paramilitary action, or similar occurrences resulting from terrorist activities, riots, or civil disorders.

M.C.L. § 30.402(e). The Act defines an "emergency" as

any occasion or instance in which the governor determines state assistance is needed to supplement local efforts and capabilities to save lives, protect property and the public health and safety, or to lessen or avert the threat of a catastrophe in any part of the state.

The Governor is authorized to enter into a reciprocal aid agreement or compact with another state, the federal government, or a state or province of a foreign country. M.C.L.

§ 30.404(3). In addition to the foregoing powers, under M.C.L. § 30.405 the Governor is authorized to perform any of the following acts:

- suspend a regulatory statute, order, or rule prescribing the procedures for conduct of state business, when strict compliance with the statute, order, or rule would prevent, hinder, or delay necessary action in coping with the disaster or emergency (this power does not extend to the suspension of criminal process and procedures).
- utilize the available resources of the state and its political subdivisions, and those of the federal government made available to the state, as are reasonably necessary to cope with the disaster or emergency.
- transfer the direction, personnel, or functions of state departments, agencies, or units thereof for the purpose of performing or facilitating emergency management.
- subject to appropriate compensation, as authorized by the legislature, commandeer or utilize private property necessary to cope with the disaster or emergency.
- direct and compel the evacuation of all or part of the population from a stricken or threatened area within the state if necessary for the preservation of life or other mitigation, response, or recovery activities.
- prescribe routes, modes, and destination of transportation in connection with an evacuation.
- control ingress to and egress from a stricken or threatened area, removal of persons within the area, and the occupancy of premises within the area.
- suspend or limit the sale, dispensing, or transportation of alcoholic beverages, firearms, explosives, and combustibles.
- provide for the availability and use of temporary emergency housing.
- direct all other actions which are necessary and appropriate under the circumstances.

All persons are obligated to conduct themselves and manage their affairs and property in ways that will reasonably assist and will not unreasonably detract from the ability of the state and the public to cope with the effects of a disaster or an emergency.

This obligation includes appropriate personal service and the use or restriction of the use of property in time of a disaster or an emergency. Compensation for property is to be paid only if the property is taken or otherwise used in coping with a disaster or emergency and its use or destruction is ordered by the Governor or the Director of the Department of State Police. A person claiming compensation for the use, damage, loss, or destruction of property under the Act must file a claim. If a claimant refuses to accept the amount of compensation offered by the state, a claim may be filed in the state court of claims which court has exclusive jurisdiction to determine the amount of compensation due the owner. M.C.L. § 30.406.

The Director of the Department of State Police is granted various powers and assigned specific duties under the Act. First, the Director is to implement the Governor's orders and directives in the event of a disaster or an emergency. He is to coordinate all federal, state, county, and municipal disaster prevention, mitigation, relief, and recovery operations within the state. At the specific direction of the Governor, the Director is to assume complete command of all disaster relief, mitigation, and recovery forces, except the national guard or state defense force, if it appears that this action is absolutely necessary for an effective effort. The Director's powers and duties include the administration of state and federal disaster relief funds and money; the mobilization and direction of state disaster relief forces; the assignment of general missions to the national guard or state defense force activated for active state duty to assist the disaster relief operations; the receipt, screening, and investigation of requests for assistance from county and municipal governmental entities; the making of recommendations to the Governor; and other appropriate actions within the general authority of the Director. M.C.L. § 30.407.

The Act directs the Department of State Police to establish an emergency management division for the purpose of coordinating the emergency management activities of county, municipal, state, and federal governments. The Department is to provide the division with professional and support employees as necessary for the performance of its functions. The emergency management division is responsible for preparing and maintaining a Michigan emergency management plan that is comprehensive and encompasses mitigation, preparedness, response, and recovery. M.C.L. § 30.407a.² Each department of state government, each county board of commissioners, each municipality with a population of 25,000 or more must employ or

² M.C.L. § 30.415 created the emergency management advisory council to advise the Governor and the Director in the development of plans. Pursuant to Executive Order 1993-15, the advisory council was abolished and its functions transferred to the Director of the Department of State Police.

appoint an emergency management coordinator who is to serve as liaison between his or her department and the emergency management division. M.C.L. §§ 30.408-30.409.

The Act also contains several important limitations. M.C.L. § 30.417 provides that the Act shall not be construed so as to

- interfere with the course or conduct of a labor dispute. However, actions otherwise authorized by the Act or other laws may be taken when necessary to forestall or mitigate imminent or existing danger to public health or safety.
- interfere with the dissemination of news or comment on public affairs. However, any communications facility or organization, including radio and television stations, wire services, and newspapers, may be requested to transmit or print public service messages furnishing information or instructions in connection with a disaster or emergency.
- affect the jurisdiction or responsibilities of law enforcement agencies, fire fighting forces, and units or personnel of the armed forces of the United States when on active duty. However, state, local, and interjurisdictional emergency operations plans shall place reliance upon the forces available for performance of functions related to disasters or emergencies.
- limit, modify, or abridge the authority of the governor to proclaim a state of emergency pursuant to M.C.L. §§ 10.31 to 10.33, or exercise any other powers vested in him or her under the state constitution, statutes, or common law independent of, or in conjunction with, the Act.
- relieve any state or local official, department head, or agency of its normal responsibilities.
- limit or abridge the power, duty, or responsibility of the chief executive official of a county or municipality to act in the event of a disaster or emergency except as expressly set forth in the Act.

The Act contains final provisions on funding and assistance to local units of government.

III. Other Emergency-Related Legislation and Executive Orders.

The Legislature has also enacted several laws that are ancillary and at times peripheral to statewide emergencies.

- 1982 P.A. 191, as amended, M.C.L. §§ 10.81-10.87, authorizing the declaration of a state of energy emergency and providing procedures to be followed after such a declaration.

- 1967 P.A. 236, as amended, M.C.L. §§ 123.811-123.814, authorizing two or more counties, cities, villages, or townships to enter into agreements to provide mutual police assistance to one another in case of emergencies.

- 1988 P.A. 279, M.C.L. §§ 10.121-10.122, authorizing the Governor to declare a state of emergency in case an adulterated consumer product presents a threat to public safety and health.

- 1994 P.A. 451, as amended, M.C.L. § 324.31523, requiring owners of certain high and potentially hazardous dams to prepare and keep current an emergency action plan.

- 1994 P.A. 451, M.C.L. § 324.63710, prohibiting the state from extracting sand and other minerals from a sand dune area except in an emergency situation resulting from a disaster as defined in section 2 of the Emergency Management Act.

- 1994 P.A. 451, M.C.L. § 324.20302, providing that a volunteer who assists in the clean up of a hazardous material spill following the declaration of a state of disaster by the Governor pursuant to Section 3 of the Emergency Management Act is not civilly liable unless the volunteer acted in a grossly negligent manner.

- 1978 P.A. 368, M.C.L. §§ 333.20908-333.20971, directing the Department of Community Health to develop and administer a statewide emergency medical services system.

- 1978 P.A. 116, M.C.L. §§ 286.181-286.194, the John C. Hertel Toxic Substance Control Commission Act (sunsetting December 31, 1989).

- Executive Order No. 1998-5, establishing the Michigan Hazard Mitigation Council Coordinating Council which is to perform the following functions: (1) assist in the development, maintenance, and implementation of a state hazard mitigation plan; (2) assist in the development, maintenance and implementation of guidance and informational materials to support hazard mitigation efforts of local and state

government, and private entities; (3) solicit, review and identify hazard mitigation projects for funding under section 404 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, as amended, and sections 553 and 554 of the National Flood Insurance Reform, Act, P.L. 103-325; and (4) foster and promote, where appropriate, hazard mitigation principles and practices within local and state government, and with the general public.

- Executive Order No.1994-17, establishing the Michigan Emergency Planning and Community Right to Know Commission which is to perform the following responsibilities: (1) perform all the duties of a state emergency response commission prescribed under the Superfund Amendments and Reauthorization Act of 1986, P.L. 99-499, which requires the state to establish a state emergency response commission, including (a) designating emergency planning districts to facilitate preparation and implementation of emergency plans, (b) appointing members to local emergency planning committees of designated emergency planning districts, (c) notifying the Administrator of the federal Environmental Protection Agency of facilities subject to the requirements of the Act and notifying the Administrator of each notification received from a facility under section 302(c) of the Act, and (d) reviewing the plans submitted by the local emergency planning committees and making recommendations to the committees on revisions that may be necessary to ensure coordination with other emergency planning districts; and (2) protect the public health, safety, welfare and the environment by facilitating the implementation of the emergency planning and community right-to-know provisions of the Act.

- Executive Order 1994-25, expanding the responsibilities of the Michigan Emergency Planning and Community Right to Know Commission to include (1) evaluation of current state agency responsibilities pertaining to hazardous materials planning, enforcement and response; and (2) development of recommendations to ensure efficient and effective coordination of hazardous materials planning, enforcement and response.

A REPORT ON RECENT COURT DECISIONS IDENTIFYING STATUTES FOR LEGISLATIVE ACTION AND RECOMMENDATIONS TO THE LEGISLATURE

I. Introduction.

As part of its statutory charge to examine current judicial decisions for the purpose of discovering defects in the law and to recommend needed reforms, the Michigan Law Revision Commission undertook a review of two Michigan Supreme Court opinions and two Michigan Court of Appeals' decisions released in 2001. These opinions identify state statutes as potential candidates for legislative reform. The four opinions are:

Levy v. Martin, 463 Mich. 478, 620 N.W.2d 292 (2001)(accrual of a cause of action under the two-year professional malpractice statute of limitations)

Michalski v. Bar-Levav, 463 Mich. 723, 625 N.W.2d 754 (2001)(scope of protection under the Persons With Disabilities Act for persons who are regarded as having a characteristic that substantially limits a major life activity)

Gilbert v. Second Injury Fund, 244 Mich. App. 326, 625 N.W.2d 116 (2001)(apportionment of worker's compensation benefits between the "injury employer" and the Second Injury Fund under the dual employment provisions of the Worker's Compensation Act)

Decker v. Flood, 248 Mich. App. 74, 638 N.W.2d 163 (2001)(requisite qualifications of a health professional signing an affidavit of merit under M.C.L. § 600.2912d in a medical malpractice claim)

II. Accrual of A Cause of Action Under the Two-Year Professional Malpractice Statute of Limitations, M.C.L. § 600.5838(1).

A. Background.

M.C.L. § 600.5838; M.S.A. § 27A.5838 provides that a professional malpractice claim "accrues at the time that person discontinues serving the plaintiff in a professional . . . capacity as to the matters out of which the claim for malpractice arose, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim." The question when the professional "discontinues serving the plaintiff" for purposes of the accrual of a

cause of action was addressed by the Supreme Court in *Morgan v. Taylor*, 434 Mich. 180, 451 N.W.2d 852 (1990). The plaintiffs in *Morgan* filed two complaints in 1985, alleging malpractice in connection with a 1981 optometric examination. An examination also had been conducted in 1983, less than two years before the complaints were filed. The issue in *Morgan* was whether "routine, periodic examinations" extend the limitation period. Resolving the question in the affirmative, the Court wrote:

In the instant case defendant argues that the rationale underlying the last treatment rule does not apply in the context of routine, periodic examinations. It is contended that there is no air of truthfulness and trust once the examination is concluded. We disagree. It is the doctor's assurance upon completion of the periodic examination that the patient is in good health which induces the patient to take no further action other than scheduling the next periodic examination.

Particularly in light of the contractual arrangement which bound defendant and entitled plaintiff to periodic eye examinations, it cannot be said that the relationship between plaintiff and defendant terminated after each visit. The obligation and responsibility of defendant to provide glaucoma testing extended beyond the 1981 examination of plaintiff's eyes. We conclude that defendant did not discontinue "treating or otherwise serving" plaintiff "as to the matters out of which the claim for malpractice arose" until August 18, 1983. Thus, we hold that the claim of plaintiff is not barred by the statute of limitations.

Morgan v. Taylor, 434 Mich. at 194. Although the common law "last treatment" rule was eventually codified in the malpractice statute of limitations, the Legislature repealed the "last treatment" rule in connection with medical malpractice cases in 1986. See 1986 P.A. 176.

B. The *Levy v. Martin* Decision.

From 1974 until 1996, accountants Martin and Hoskow prepared the annual tax returns of Levy. As the result of an audit by the Internal Revenue Service, Levy was required to pay additional taxes for 1991 and 1992, as well as penalties and interest. He also incurred legal expenses and additional accounting expenses. In August 1997, Levy filed a complaint in which he alleged that losses exceeding \$90,000 had been caused by the malpractice of Martin and Hoskow. The 1991 and 1992 tax returns of which Levy complained were prepared and submitted in 1992 and 1993, respectively. Observing that the limitation period for a malpractice action is two years, Martin and Hoskow filed a

motion to dismiss in lieu of an answer. The circuit court agreed that the malpractice claim was not timely, and dismissed the complaint on that basis.

The Court of Appeals affirmed. The Court wrote that "[t]he preparation of yearly tax returns is not analogous to the periodic eye examinations in *Morgan v. Taylor*," since "[e]ach individual tax return reflects the examination of a discrete, contained body of information." Writing in dissent, Judge Whitbeck disagreed about the applicability of *Morgan*. He countered that the *Morgan* analysis of the statute was "instructive and, in appropriate circumstances, controlling," expressing the view that the malpractice claim had been filed timely.

The Supreme Court in *Levy v. Martin* found Judge Whitbeck's analysis persuasive and adopted it as its own:

I respectfully disagree with the majority's attempt to distinguish the "continuing care of one patient's set of eyes in *Morgan, supra*," from what the majority describes as "the series of unrelated tax calculations in this case." . . . The touchstone of the analysis in *Morgan* was *the continuing professional relationship* between a professional and the person receiving the professional's services with regard to a particular subject matter, not any direct connection between the work performed by the professional at continuing periodic sessions during that relationship. The alleged negligence in *Morgan* occurred during a glaucoma test on the principal plaintiff in *Morgan* at a 1981 eye examination. . . . The principal plaintiff in *Morgan* did not return to the defendant optical company for an examination until 1983 for his next routine eye examination. . . . There is no indication in *Morgan* that the manner in which the eye examination was conducted in 1983 had any direct connection to the performance of the 1981 glaucoma test. Nevertheless, the *Morgan* Court concluded that, due to the statutory "last treatment" rule, the statute of limitations with regard to alleged negligence in the 1981 glaucoma test did not begin to run on the date it was performed because of the continuing professional relationship between the patient and the optical company.

Similarly, in this case, plaintiffs' complaint alleges, without any contrary documentary evidence in the record, the existence of a continuing relationship of tax preparer and client that did not end until 1996. Until the end of that relationship, for purposes of applying the "last treatment" rule and thereby ascertaining whether the statute of limitations bars this suit, plaintiffs had "no duty to inquire into the effectiveness of [defendants']

measures" until the end of the professional relationship.

I note that it may (or may not) be wise for M.C.L. §§ 600.5838(1); MSA 27A.5838(1) to be amended to completely abolish the "last treatment" rule. However, "[t]he wisdom of the provision in question in the form in which it was enacted is a matter of legislative responsibility with which the courts may not interfere." *Morgan, supra* at 192, 451 N.W.2d 852, quoting *Melia v. Employment Security Comm.*, 346 Mich. 544, 561, 78 N.W.2d 273 (1956). Our duty is to faithfully apply the legislatively adopted policy of the "last treatment" rule to claims of professional malpractice, other than medical malpractice, not to attempt to limit that policy by an unduly narrow application.

463 Mich. at 486-87, 620 N.W.2d at 295-96 (quoting from Judge Whitbeck's dissenting opinion) (citations and footnotes omitted, emphasis in original).

Adding to Judge Whitbeck's analysis, the Supreme Court turned its attention to the meaning of the statutory phrase, "the matters out of which the claim for malpractice arose," and offered the following view:

How broadly to read "the matters out of which the claim for malpractice arose" was addressed by this Court in *Morgan*. There, unlike the situation in *De Haan*, the plaintiff was not receiving treatment for a specific ailment, but rather was receiving periodic eye examinations from the defendants. This Court held that it was those examinations, not any injury, that constituted "the matters out of which the claim for malpractice arose." Using the same reasoning, it is clear here that plaintiffs, rather than receiving professional advice for a specific problem, were receiving generalized tax preparation services from defendants. These continuing services, just like the continuous eye examinations in *Morgan*, to be consistent with the *Morgan* approach, must be held to constitute "the matters out of which the claim for malpractice arose."

463 Mich. at 488-89, 620 N.W.2d at 297 (footnote omitted).

In dissent, Justice Markman criticized the majority's reading of the phrase, "the matters out of which the claim for malpractice arose." He disagreed with Judge Whitbeck's assertion that "[t]he touchstone' of the 'last treatment' rule is the 'continuing professional relationship between a professional and the person receiving the professional's services,'" adding the following analysis:

The plain language of subsection 5838(1) does *not* state that a claim of professional malpractice accrues on the last date of service (i.e., "last date of treatment"), period. Rather, the statutory language clearly defines the point of accrual, confining the last date of service expressly to those matters "*out of which the claim for malpractice arose*"; from this language, certainly, a professional relationship may continue on *even though* a malpractice claim arising out of that relationship has accrued and the clock has started to run with regard to the two-year limitation period. The Court of Appeals dissent and the majority's adoption of the dissent's analysis without explanation fail to acknowledge and give effect to the plain language of the *entire* sentence comprising subsection 5838(1), thereby rendering the modifying phrase "matters out of which the claim for malpractice arose" superfluous.

463 Mich. at 496, 620 N.W.2d at 300 (emphasis in original).

Question Presented

Should the professional malpractice statute of limitations be amended to repeal the "last treatment" rule or clarified to identify when a cause of action accrues?

Recommendation

The Commission makes no recommendation to the Legislature.

III. Scope of Protection under the Persons With Disabilities Act for Persons Who Are Regarded as Having a Characteristic that Substantially Limits a Major Life Activity.

A. Background.

The Persons With Disabilities Act provides that "[a]n employer shall not . . . [d]ischarge or otherwise discriminate against an individual with respect to compensation or the terms, conditions, or privileges of employment, because of a handicap that is unrelated to the individual's ability to perform the duties of a particular job or

position." M.C.L. § 37.1202(1)(b); M.S.A. § 3.550(202)(1)(b).¹ As amended in 1990, the Act defines "handicap" for employment related purposes as follows:

(i) A determinable physical or mental characteristic of an individual, which may result from disease, injury, congenital condition of birth, or functional disorder, if the characteristic:

(A) For purposes of article 2, substantially limits 1 or more of the major life activities of that individual and is unrelated to the individual's ability to perform the duties of a particular job or position or substantially limits 1 or more of the major life activities of that individual and is unrelated to the individual's qualifications for employment or promotion.

* * * *

(ii) A history of a determinable physical or mental characteristic described in subparagraph (i).

(iii) Being regarded as having a determinable physical or mental characteristic described in subparagraph (i).

M.C.L. § 37.1103(e); M.S.A. § 3.550(103)(e).

To establish a prima facie case of handicap discrimination, a plaintiff must demonstrate that (1) she is handicapped as defined by the HCRA, (2) the handicap is unrelated to her ability to perform the duties of her job, and (3) she was discriminated against in one of the ways described in the statute. *Chmielewski v. Xermac, Inc.*, 457 Mich. 593, 602, 580 N.W.2d 817 (1998).

B. The *Michalski v. Bar-Levav* Decision.

On September 1, 1995, plaintiff signed an employment contract with defendant to begin work as an executive secretary on September 11, 1995. On September 4, 1995, plaintiff experienced numbness and tingling on her left side, which persisted for four days. She was seen by her family doctor, who referred her to Dr. Green, a

¹ The 1998 amendments of the act substituted the word "disability" for the word "handicap" and changed the title of the Act to the "Persons With Disabilities Act." 1998 P.A. 20.

neurologist. Plaintiff was able to begin work as scheduled. On September 23, 1995, plaintiff saw Dr. Green, who told her he suspected multiple sclerosis, but was unable to make a positive diagnosis at that time. Plaintiff testified at her deposition that she told defendant and others at the office about this tentative diagnosis. Plaintiff maintains that, after she revealed her condition, defendant undertook a course of harassment, which she attributed to his perception of her medical condition.

Dr. Green saw plaintiff again on October 28, 1995. At this time, plaintiff had no symptoms of multiple sclerosis, and Dr. Green indicated on her medical record that she was "doing fine, feels great." Plaintiff continued to work without incident until December 28, 1995, when she left work, experiencing a loss of vision in one eye. She was seen by Dr. Green, who diagnosed multiple sclerosis. She was hospitalized for three days, and her vision improved after treatment. However, she did not return to work.

Plaintiff brought an action alleging a violation of the Act and a claim for intentional infliction of emotional distress. Relying on subsection (iii) ("being regarded as having a determinable physical or mental characteristic described in subparagraph (i)"), plaintiff argued that defendant undertook a course of harassment because he perceived her as handicapped. After discovery, defendant moved for summary disposition. The circuit court granted the motion, concluding that "there is no evidence that the condition that Plaintiff was perceived to have was a condition which substantially limits one or more for [sic] major life activities. And no evidence to suggest that the Defendant had any knowledge that one or more of the major life activities was limited." See 463 Mich. at 727, 625 N.W.2d at 757.

On appeal, the Court of Appeals issued a split decision (Whitbeck, J., dissenting), affirming the dismissal of the intentional infliction of emotional distress count, but reversing the dismissal of plaintiff's handicap discrimination claim because it believed that plaintiff had presented sufficient evidence to establish a prima facie case of handicap discrimination. Relying on *Sanchez v. Lagoudakis*, plaintiff argued that one could find that her condition was a handicap as defined by the statute because the Act prohibits discrimination, even when an individual does not exhibit symptoms of a handicap. A majority of the Court of Appeals agreed.

In his dissent Judge Whitbeck focused on the fact that the definition of "handicap" was amended in 1990 to require that the physical or mental characteristic in question substantially limit one or more major life activities of the individual. The version of the statute in effect at the time of the events in *Sanchez* did not include this requirement; thus, it was improper for the majority to rely on that case as support for

its conclusion. Judge Whitbeck reasoned that, under the applicable version of the Act, the plain language of the statute required defendant to perceive plaintiff as having a characteristic that substantially limited a major life activity. Because plaintiff did not present any evidence that defendant regarded her as having a condition that substantially impaired a major life activity, the dissent concluded that summary disposition was properly granted.

The Supreme Court reversed the Court of Appeals. The Court wrote that while a plaintiff need not actually have a determinable physical or mental characteristic, to qualify as handicapped under subsection (iii),

the plain statutory language does require that the plaintiff prove the following elements: (1) the plaintiff was regarded as having a determinable physical or mental characteristic; (2) the perceived characteristic was regarded as substantially limiting one or more of the plaintiff's major life activities; and (3) the perceived characteristic was regarded as being unrelated either to the plaintiff's ability to perform the duties of a particular job or position or to the plaintiff's qualifications for employment or promotion. Only the first two elements are at issue in this case.

463 Mich. at 732, 625 N.W.2d at 760. In interpreting the phrase in subsection (iii), "regarded as having," the Court noted that the Legislature used the present tense. The Court found this use of the present tense significant:

Depending on whether a plaintiff is proceeding under the "actual" or "regarded as" portions of the statute, because of the Legislature's choice of present tense language in defining the term handicap, we must evaluate the physical or mental characteristic at issue either (1) as it actually existed at the time of the plaintiff's employment, or (2) as it was perceived at the time of the plaintiff's employment.

Thus, to qualify for coverage under subsection (iii), plaintiff must be regarded as presently having a characteristic that currently creates a substantial limitation of a major life activity. In this case, plaintiff did not present any evidence to create a question of fact regarding whether defendant regarded her as having a characteristic that substantially limited a major life activity at the time she was his employee. She presented no evidence that Dr. Bar Levav regarded her as unable to perform basic tasks

of ordinary life. Indeed, from all indications, she was physically capable of performing her job duties. At most, plaintiff presented evidence that she informed defendant that she had been tentatively diagnosed with multiple sclerosis and that he believed that this might substantially limit her major life activities in the future. Thus, the trial court properly granted summary disposition on plaintiff's claim that she was regarded as handicapped under the [Act].

463 Mich. at 733-34, 625 N.W.2d at 760-61 (footnotes omitted).

In dissent, Justice Kelly criticized the majority's focus on the present-tense language of the statute. She wrote that "[i]n interpreting the scope of subsection (iii) of the Act using a narrow 'present tense' standard, the majority gives it a meaning that the Legislature could not have intended." She added:

[D]espite being required to prove the manifest existence of actual symptoms, to succeed under subsection (iii), plaintiff would have to show an absence of the perceived handicapping disorder. Indeed, if she actually suffered from the handicap, recovery would be available under subsection (i), obviating any need for subsection (iii). Hence, the majority's holding leaves such a narrow avenue for recovery under subsection (iii) that it renders the "regarded as" prong of the [Act] a virtual dead letter.

463 Mich. at 738, 625 N.W.2d at 763 (Kelly, J., dissenting).

In response, the majority wrote that "while it may seem incongruous that the [Act] does not provide protection against discrimination on the basis of a possibility that one might become handicapped in the future, our duty is to apply the law. . . . Consequently, while the Legislature may, and perhaps should, amend the [Act] to include within its scope of protection discrimination based on the possibility of a future handicap, we decline to do so by construing the [Act] in a manner inconsistent with its plain language." 463 Mich. at 734 n.14, 625 N.W.2d at 761 n.14.

Question Presented

Should the Persons With Disabilities Act be amended to include within its scope of protection discrimination based on the possibility of a future disability?

Recommendation

The Commission recommends that the Legislature amend the Act to include within its scope of protection discrimination based on the possibility of a future disability.

IV. Apportionment of Worker's Compensation Benefits Between "Injury Employer" and Second Injury Fund Under the Dual Employment Provisions of the Worker's Compensation Act.

A. Background.

As part of a wide-ranging amendment of the worker's compensation act in 1980, the Legislature amended M.C.L. § 418.371; M.S.A. § 17.237(371) and enacted M.C.L. § 418.372; M.S.A. § 17.237(327) to address the payment of compensation where an injured employee holds "dual employment." Before the amendment, an injured employee holding more than one job was entitled to benefits based solely on the wages earned at the job causing the injury. *Finkbiner v. ITT Building Service*, 189 Mich. App. 560, 563, 474 N.W.2d 148 (1991). Thus, an employee injured while working at the lower paying of two jobs would be entitled to benefits based on the wages earned in the lower paying employment, even though the disability caused by that employment resulted in the loss of wages from a much higher paying job as well.

M.C.L. § 418.371; M.S.A. § 17.237(371) was amended so that an employee's rate of benefit is based on the earnings in all the employee's employments as of the time of the injury. In an obvious effort to avoid hardship to the "injury employer," the Legislature enacted M.C.L. § 418.372; M.S.A. § 17.237(372) to apportion the payment of benefits between the "injury employer" and the "noninjury employer." The Second Injury Fund is responsible for paying the portion of benefits attributable to wages lost from the noninjury employer. M.C.L. § 418.372(1)(b); M.S.A. § 17.237(372)(1)(b) provides:

If the employment which caused the personal injury or death provided 80% or less of the employee's average weekly wage at the time of the personal injury or death, the insurer or self-insurer is liable for that portion of the employee's weekly benefits as bears the same ratio to his or her total weekly benefits as the average weekly wage from the employment which caused the personal injury or death bears to his or her total weekly wages. The second injury fund is separately but dependently liable for the remainder of the weekly benefits.

M.C.L. 418.372(2); M.S.A. 17.237(372)(2) further provides that "[f]or purposes of apportionment under this section, only wages which were reported to the internal revenue service shall be considered, and the reports of wages to the internal revenue service are conclusive for the purpose of apportionment under this section." The effect of this language is at the heart of the *Gilbert v. Second Injury Fund* case.

B. The *Gilbert v. Second Injury Fund* Decision.

This worker's compensation case concerns the application of the dual employment provisions of M.C.L. § 418.372; M.S.A. § 17.237(372). Gilbert was injured on October 11, 1991, while working in a farm business owned by the Kerbers. Farm Bureau Mutual Insurance Company was the Kerbers' worker's compensation carrier. At the time of his injury, Gilbert was also employed by the Hexcel Corporation. Gilbert's average weekly wage from Hexcel was about \$875, while his average weekly wage from the Kerbers was about \$64. Because Gilbert was injured in the course of his employment with an employer that did not report Gilbert's wages to the Internal Revenue Service, the magistrate and the Worker's Compensation Appellate Commission concluded that it was impossible to apportion benefits between Gilbert's employments and that the "injury employer" was one hundred percent responsible for all benefits based on Gilbert's earnings from all employers. This result was reached even though the injury employer paid only about seven percent of Gilbert's wages.

The Court of Appeals' previous opinion in this case, *Gilbert v. Second Injury Fund*, 237 Mich. App. 101, 603 N.W.2d 104 (1999), was vacated by the Supreme Court. 463 Mich. 866, 616 N.W.2d 161 (2000). The order vacating the prior decision remanded the matter to the Court of Appeals for reconsideration in light of *Sun Valley Foods Co. v. Ward*, 460 Mich. 230, 596 N.W.2d 119 (1999), and *Tyler v. Livonia Public Schools*, 459 Mich. 382, 590 N.W.2d 560 (1999). The remand order directed the Court of Appeals to follow the principles articulated in *Sun Valley* and *Tyler* and to take note of a discussion in *People v. McIntire*, 461 Mich. 147, 156, n. 3, 599 N.W.2d 102 (1999), regarding the "problems inherent in the so-called 'absurd result' rule of statutory construction." 463 Mich. at 867, 616 N.W.2d 161. The order of remand pointed out that in its prior decision the Court of Appeals declined to apply M.C.L. § 418.372(2); M.S.A. § 17.237(372)(2) (dealing with the treatment of unreported income) without noting any ambiguity in the statutory language.

In its prior decision the Court of Appeals concluded that the results reached in the case by applying M.C.L. § 418.372(2); M.S.A. § 17.237(372)(2) were absurd because applying the statute did not lead to a result apportioning liability between the employer and the Second Injury Fund, contrary to the Court's perception that the Legislature

intended such an apportionment under Section 372. Under the statute the Fund would typically pay about 93% of Gilbert's benefits because that is the percentage of the employee's total wages paid by Hexcel, the noninjury employer. 244 Mich. App. at 331, 625 N.W.2d at 118. However, the injury employer (the Kerbers) did not report plaintiff's wages to the Internal Revenue Service. The Fund argued that because the Kerbers reported none of Gilbert's earnings to the IRS, there is nothing to apportion and, so it follows, the injury employer is 100% responsible for Gilbert's worker's compensation benefits. The Court of Appeals reached the opposite result, finding the Fund to be 100% liable for Gilbert's benefits.

The apportionment language of the worker's compensation statute provides that the injury employer is liable for the portion of the employee's weekly benefits equivalent to the portion of the employee's total wages paid by the injury employer. The statute describes the ratio as follows:

[T]hat portion of the employee's weekly benefits as bears the same ratio to his or her total weekly benefits as the average weekly wage from the employment which caused the personal injury or death bears to his or her total weekly wages.

M.C.L. § 418.372(1)(b); M.S.A. § 17.237(372)(1)(b). However, as the Court observed, when the apportionment provision is applied in the instant case, the wages paid by the injury employer are zero because those wages were unreported to the IRS. Under subsection 372(2) those wages are not to be considered for purposes of apportionment. Subsection 372(2) is not ambiguous, the Court of Appeals wrote. That subsection states:

For purposes of apportionment under this section, only wages which were reported to the internal revenue service shall be considered, and the reports of wages to the internal revenue service are conclusive for the purpose of apportionment under this section.

The "this section" referred to is M.C.L. § 418.372; M.S.A. § 17.237(372). "Apportionment" is provided for in subsection 372(1). Subsection 372(2) does not distinguish between injury and noninjury employers. Subsection 372(2) precludes consideration of unreported wages for purposes of apportionment. Thus, the Court concluded, the portion of Gilbert's weekly benefits that is equivalent to the portion of the wages paid by the Kerbers is zero, because the wages paid by the Kerbers were unreported and therefore cannot be considered. Consequently, the Fund was held liable

for the "remainder" of Gilbert's weekly benefits, which is one hundred percent of the weekly benefits.

Although not mentioned by the Court of Appeals, the result in the case creates a perverse incentive for employers to pay their employees and not report the wages to the Internal Revenue Service. By doing so, an employer can thereby avoid liability for worker's compensation benefits in cases involving dual employment by an injured employee.

Question Presented

Should the dual employment provisions of the worker's compensation act be amended to clarify how apportionment of benefits is to be made?

Recommendation

The Commission recommends that the Legislature review the *Gilbert v. Second Injury Fund* decision to ensure that its result accurately reflects the Legislature's intent when it enacted the dual employment provisions of the worker's compensation law.

V. Qualifications of Health Professional Signing Affidavit of Merit under M.C.L. § 600.2912d in Medical Malpractice Claim.

A. Background.

M.C.L. § 600.2912d(1) requires that "the plaintiff in an action alleging medical malpractice . . . file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under [M.C.L. § 600.2169]." M.C.L. § 600.2169(1) in turn states that

[i]n an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

* * * *

(c) If the party against whom or on whose behalf the testimony is offered

is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:

(i) Active clinical practice as a general practitioner.

(ii) Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed.

The issue before the Court of Appeals in *Decker v. Flood* was whether an affidavit of merit signed by a specialist satisfied M.C.L. § 600.2912d(1) in a medical malpractice case brought against a general practitioner.

B. The *Decker v. Flood* Decision.

In 1997, defendant Flood examined plaintiff Decker who was complaining of pain, determined that plaintiff needed a root canal on two of his teeth, and began the procedure on that date. On January 21, 1997, the same day that defendant completed the root canal procedure, plaintiff began to experience pain, telephoned defendant, and was instructed to return to defendant's office. According to plaintiff's complaint, after defendant administered three successive injections of Novocaine, plaintiff became cold, began to shake, and eventually stopped breathing. Plaintiff further alleged that defendant administered cardiopulmonary resuscitation. Plaintiff was taken by ambulance to a hospital and released the following day.

Attached to the plaintiff's complaint was an affidavit of merit signed by Michael J. Gallagher, DDS. According to the affidavit, Dr. Gallagher is a "doctor of dental surgery" and a member of the American Association of Endodontists Specialists Members. In the affidavit, Dr. Gallagher stated that he was familiar with the standard of practice for a dental surgeon treating a patient with plaintiff's complaints and opined that defendant breached the standard of practice by failing to properly drill, clean, fill, or pack the root canal or properly remove the tissue and filling material. Dr. Gallagher also claimed that defendant's breach of the standard of practice was a proximate cause of plaintiff's pain, and Dr. Gallagher "had to perform a root canal retreatment" on plaintiff's teeth to address plaintiff's pain.

Defendant filed a motion for summary disposition on the ground that defendant Flood was a dentist in general practice in January 1997 and that M.C.L. § 600.2912d required plaintiff to file with his complaint an affidavit of merit signed by a health professional who plaintiff's attorney reasonably believed met the requirements of M.C.L. § 600.2169. According to defendant, Dr. Gallagher specialized in endodontics and, therefore, plaintiff failed to file an affidavit of merit that met the requirements of M.C.L. § 600.2912d and M.C.L. § 600.2169.

In response to defendant's motion, plaintiff argued that both defendant and Dr. Gallagher are general practitioners who perform root canals with the sole difference being that Dr. Gallagher performs only root canals. Plaintiffs argued that the statute "did not make sense" because it precluded Dr. Gallagher, whose practice was limited to root canals, from giving expert testimony on the standard of practice for root canals. Plaintiffs further argued that the statute was intended to prevent a professional who has no experience at all in a given area from rendering an expert opinion.

The trial court rejected plaintiffs' argument that Dr. Gallagher was a general practitioner and found that the evidence was uncontroverted that he specialized in root canals. The trial court also stated that the statute clearly precludes an expert who is not a general practitioner from giving expert testimony on the standard of practice required for a general practitioner.

The Court of Appeals affirmed. Because the term "general practitioner" is not defined in the statute and does not appear to be a technical term, the Court looked to its plain and ordinary meaning. A general practitioner is commonly defined as "a medical practitioner whose practice is not limited to any specific branch of medicine." *Random House Webster's College Dictionary* (1997). By contrast, a specialist is defined as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." *Id.* It was undisputed that Dr. Gallagher is an endodontist, which is defined as "one who *specializes* in the practice of endodontics." *Stedman's Medical Dictionary* (26th ed.)(emphasis added). Applying the ordinary meaning of general practitioner as one who does not limit his practice to any particular branch of medicine, Dr. Gallagher clearly does not satisfy the requirements of M.C.L. § 600.2169, according to the Court. Therefore, he would not be qualified to offer expert testimony on the standard of practice of a general practitioner such as defendant Flood. Because Dr. Gallagher is precluded by M.C.L. § 600.2169 from testifying regarding defendant's standard of practice, the Court agreed that there is no genuine dispute that the affidavit of merit attached to plaintiff's complaint does not comply with the

requirements of M.C.L. § 600.2912d(1), and defendant was entitled to judgment as a matter of law.

In response to the plaintiff's argument that the trial court's interpretation of the statute leads to an absurd result, the Court noted:

[O]ur Supreme Court repudiated the use of the "absurd result" rule of statutory construction in a case such as this where the language of the statute is unambiguous. *People v. McIntire*, 461 Mich. 147, 155-158; 599 NW2d 102 (1999). The Supreme Court's decision in *McIntire* precludes this Court from utilizing rules of statutory construction to impose different policy choices than those selected by the Legislature. *Id.* at 152. "[I]n our democracy, a legislature is free to make inefficacious or even unwise policy choices. The correction of these policy choices is not a judicial function as long as the legislative choices do not offend the constitution." *Id.* at 159. Clearly, it is not within our authority to second-guess the wisdom or reasonableness of unambiguous legislative enactments even where the literal interpretation of the statute leads to an absurd result.

248 Mich. App. 74, 84, 638 N.W.2d 163, 167.

In a concurring opinion, Judge Neff expressed some reservations about the Court's result, recommending that the Legislature examine this question:

This Court has previously addressed the fading logic in standard of care distinctions between general practitioners and specialists in cases such as this, where there is an overlap between the procedures performed by general practitioners and those who have specialized practices. I concur with the well-reasoned opinion in *Vance, supra*, in which Chief Judge Doctoroff stressed the need for further consideration and modification of standard of care requirements in view of the prolific advancements in communication and technology in recent years. . . . Today's communication and technology capabilities render meaningless any distinction in the standard of care "where a general practitioner is providing a service that has become uniform throughout the nation such as a root canal. . . ." Accordingly, I would urge the Legislature to revisit these requirements.

248 Mich. App. 74, 87-88, 638 N.W.2d 163, 169.

Question Presented

Should the affidavit of merit standards of M.C.L. § 600.2912d be modified to better reflect meaningful distinctions between the standard of care for general practitioners and the standard of care for specialists?

Recommendation

The Commission makes no recommendation to the Legislature.

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**PRIOR ENACTMENTS PURSUANT TO MICHIGAN LAW
REVISION COMMISSION RECOMMENDATIONS**

The following Acts have been adopted to date pursuant to recommendations of the Commission and in some cases amendments thereto by the Legislature:

1967 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Original Jurisdiction of Court of Appeals	1966, p. 43	65
Corporation Use of Assumed Names	1966, p. 36	138
Interstate and International Judicial Procedures	1966, p. 25	178
Stockholder Action Without Meetings	1966, p. 41	201
Powers of Appointment	1966, p. 11	224
Dead Man's Statute	1966, p. 29	263

1968 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Possibilities of Reverter and Right of Entry	1966, p. 22	13
Stockholder Approval of Mortgage of Corporate Assets	1966, p. 39	287
Corporations as Partners	1966, p. 34	288
Guardians Ad Litem	1967, p. 53	292
Emancipation of Minors	1967, p. 50	293
Jury Selection	1967, p. 23	326

1969 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Access to Adjoining Property	1968, p. 19	55
Recognition of Acknowledgments	1968, p. 64	57
Dead Man's Statute Amendment	1966, p. 29	63
Notice of Change in Tax Assessments	1968, p. 30	115
Antenuptial and Marital Agreements	1968, p. 27	139
Anatomical Gifts	1968, p. 39	189
Administrative Procedures Act	1967, p. 11	306
Venue for Civil Actions	1968, p. 17	333

1970 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Land Contract Foreclosures	1967, p. 55	86
Artist-Art Dealer Relationships	1969, p. 41	90
Minor Students' Capacity to Borrow Act	1969, p. 46	107
Warranties in Sales of Art	1969, p. 43	121
Appeals from Probate Court	1968, p. 32	143
Circuit Court Commissioner Powers of Magistrates	1969, p. 57	238

1971 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Revision of Grounds for Divorce	1970, p. 7	75
Civil Verdicts by 5 of 6 Jurors In Retained Municipal Courts	1970, p. 40	158
Amendment of Uniform Anatomical Gift Act	1970, p. 45	186

1972 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Summary Proceeding for Possession of Premises	1970, p. 16	120
Interest on Judgments	1969, p. 59	135
Business Corporations	1970, Supp.	284
Constitutional Amendment re Juries of 12	1969, p. 60	HJR "M"

1973 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Execution and Levy in Proceedings Supplementary to Judgment	1970, p. 51	96
Technical Amendments to Business Corporation Act	1973, p. 8	98

1974 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Venue in Civil Actions Against Non-Resident Corporations	1971, p. 63	52
Choice of Forum	1972, p. 60	88
Extension of Personal Jurisdiction in Domestic Relations Cases	1972, p. 53	90
Technical Amendments to the Michigan General Corporations Act	1973, p. 37	140
Technical Amendments to the Revised Judicature Act	1971, p. 7	297

Technical Amendments to the Business Corporation Act	1974, p. 30	303
Amendment to Dead Man's Statute	1972, p. 70	305
Attachment and Collection Fees	1968, p. 22	306
Contribution Among Joint Tortfeasors	1967, p. 57	318
District Court Venue in Civil Actions	1970, p. 42	319
Due Process in Seizure of a Debtor's Property (Elimination of Pre-judgment Garnishment)	1972, p. 7	371

1975 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Hit-Run Offenses	1973, p. 54	170
Equalization of Income Rights of Husband and Wife in Entirety Property	1974, p. 12	288
Disposition of Community Property Rights at Death	1973, p. 50	289
Insurance Policy in Lieu of Bond	1969, p. 54	290
Child Custody Jurisdiction	1969, p. 23	297

1976 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Due Process in Seizure of a Debtor's Property (Replevin Actions)	1972, p. 7	79
Qualifications of Fiduciaries	1966, p. 32	262
Revision of Revised Judicature Act Venue Provisions	1975, p. 20	375
Durable Family Power of Attorney	1975, p. 18	376

1978 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Juvenile Obscenity	1975, p. 133	33
Multiple Party Deposits	1966, p. 18	53
Amendment of Telephone and Messenger Service Company Act	1973, p. 48	63
Elimination of References to Abolished Courts:		
a. Township By-Laws	1976, p. 74	103
b. Public Recreation Hall Licenses	1976, p. 74	138
c. Village Ordinances	1976, p. 74	189
d. Home Rule Village Ordinances	1976, p. 74	190
e. Home Rule Cities	1976, p. 74	191
f. Preservation of Property Act	1976, p. 74	237
g. Bureau of Criminal Identification	1976, p. 74	538
h. Fourth Class Cities	1976, p. 74	539
i. Election Law Amendments	1976, p. 74	540
j. Charter Townships	1976, p. 74	553
Plats	1976, p. 58	367
Amendments to Article 9 of the Uniform Commercial Code	1975, Supp.	369

1980 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Condemnation Procedures	1968, p. 8	87
Technical Revision of the Code of Criminal Procedure	1978, p. 37	506

1981 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Elimination of Reference to the Justice of the Peace: Sheriff's Service of Process	1976, p. 74	148
Court of Appeals Jurisdiction	1980, p. 34	206

1982 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Limited Partnerships	1980, p. 40	213
Technical Amendments to the Business Corporation Act	1980, p. 8	407
Interest on Probate Code Judgments	1980, p. 37	412

1983 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Elimination of References to Abolished Courts: Police Courts and County Board of Auditors	1979, p. 9	87
Federal Lien Registration	1979, p. 26	102

1984 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Legislative Privilege: a. Immunity in Civil Actions	1983, p. 14	27

b. Limits of Immunity in Contested Cases	1983, p. 14	28
c. Amendments to R.J.A. for Legislative Immunity	1983, p. 14	29
Disclosure of Treatment Under the Psychologist/Psychiatrist- Patient Privilege	1978, p. 28	362

1986 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Amendments to the Uniform Limited Partnership Act	1983, p. 9	100

1987 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Amendments to Article 8 of the Uniform Commercial Code	1984, p. 97	16
Disclosure in the Sale of Visual Art Objects Produced in Multiples	1981, p. 57	40, 53, 54

1988 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Repeal of M.C.L. §764.9	1982, p. 9	113
Statutory Rule Against Perpetuities	1986, p. 10	417, 418
Transboundary Pollution Reciprocal Access to Courts	1984, p. 71	517

1990 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Elimination of Reference to Abolished Courts:		
a. Procedures of Justice Courts and Municipal Courts	1985, p. 12; 1986, p. 125	217
b. Noxious Weeds	1986, p. 128; 1988, p. 154	218
c. Criminal Procedure	1975, p. 24	219
d. Presumption Concerning Married Women	1988, p. 157	220
e. Mackinac Island State Park	1986, p. 138; 1988, p. 154	221
f. Relief and Support of the Poor	1986, p. 139; 1988, p. 154	222
g. Legal Work Day	1988, p. 154	223
h. Damage to Property by Floating Lumber	1988, p. 155	224

1991 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Elimination of Reference to Abolished Courts:		
a. Land Contracts	1988, p. 157	140
b. Insurance	1988, p. 156	141
c. Animals	1988, p. 155	142
d. Trains	1986, pp. 153, 155; 1987, p. 80; 1988, p. 152	143
e. Appeals	1985, p. 12	144
f. Crimes	1988, p. 153	145
g. Library Corporations	1988, p. 155	146
h. Oaths	1988, p. 156	147
i. Agricultural Products	1986, p. 134; 1988, p. 151	148
j. Deeds	1988, p. 156	149
k. Corporations	1989, p. 4; 1990, p. 4	150
l. Summer Resort Corporations	1986, p. 154; 1988, p. 155	151

m. Association Land	1986, p. 154; 1988, p. 155	152
n. Burial Grounds	1988, p. 156	153
o. Posters, Signs, and Placecards	1988, p. 157	154
p. Railroad Construction	1988, p. 157; 1988, p. 156	155
q. Work Farms	1988, p. 157	156
r. Recording Duties	1988, p. 154	157
s. Liens	1986, pp. 141, 151, 158; 1988, p. 152	159

1992 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Determination of Death Act	1987, p. 13	90

1993 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Condemnation Procedures of Home Rule Villages	1989, p. 17	32
Condemnation Procedures Regarding Railroads	1989, p. 25	354
Condemnation Procedures Regarding Railroad Depots	1989, p. 26	354

1995 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Condemnation Procedures Regarding Inland Lake Levels	1989, p. 24	59
Condemnation Procedures of School Districts	1989, p. 24	289

1996 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Felony Murder and Arson	1994, p. 179	20, 21

1998 Legislative Session

<u>Subject</u>	<u>Commission Report</u>	<u>Act No.</u>
Condemnation Procedures of General Law Villages	1989, p. 16	254
Repeal of Article 6 of the Uniform Commercial Code	1994, p. 111; 1997, p. 131	489
Uniform Fraudulent Transfer Act	1988, p. 13	434
Uniform Trade Secrets Act	1993, p. 7	448

BIOGRAPHIES OF COMMISSION MEMBERS AND STAFF

RICHARD D. McLELLAN

Richard D. McLellan, is Chairman of the Michigan Law Revision Commission, a position he has filled since 1986 following his appointment as a public member of the Commission in 1985.

Mr. McLellan is a lawyer with the law firm of Dykema Gossett PLLC and serves as the Member-in-charge of the firm's Lansing Office and as the leader of the firm's Government Policy & Practice Group. He is responsible for the firm's public policy, administrative law and lobbying practices in Lansing, Chicago and Washington, D.C.

Mr. McLellan started his career as an administrative assistant to Governor William G. Milliken and as director of the Michigan Office of Drug Abuse.

Following the 1990 Michigan elections, McLellan was named Transition Director to then Governor-elect John Engler. In that capacity, he assisted in the formation of Governor Engler's Administration and conducted a review of state programs. He has also been appointed by the Governor as Chairman of the Corrections Commission, a member of the Michigan Export Development Authority, a member of the Michigan International Trade Authority, a member of the Library of Michigan Board of Trustees and a member of the Michigan Jobs Commission.

During the administration of President Gerald Ford, he served as an advisor to the Commissioner of the Food and Drug Administration as a member of the National Advisory Food and Drug Committee of the U.S. Department of Health, Education and Welfare.

In 1990, Mr. McLellan was appointed by President George Bush as a Presidential Observer to the elections in the People's Republic of Bulgaria. The elections were the first free elections in the country following 45 years of Communist rule. In 1996, he again acted as an observer for the Bulgarian national elections. And again in February, 1999, he acted as an observer for the Nigerian national elections with the International Republican Institute.

Mr. McLellan is a member of the Board of Governors of the Cranbrook Institute of Science, one of Michigan's leading science museums. He helped establish and served for 10 years as president of the Library of Michigan Foundation. He helped establish and served as both President and Chairman of the Michigan Japan Foundation, the private foundation providing funding for the Japan Center for Michigan Universities.

Mr. McLellan serves as member of the Board of Trustees of Michigan State University-Detroit College of Law.

Mr. McLellan is a former Chairman of the Board of Directors of the Michigan Chamber of Commerce, and is a member of the Board of Directors of the Mackinac Center for Public Policy, the Oxford Foundation and the Cornerstone Foundation.

McLellan served as a member of the Board of Directors of the Mercantile & General Life Reassurance Company of America and is a Trustee of JNL Trust established by the Jackson National Life Insurance Company. He is also Chairman of the Michigan Competitive Telecommunications Providers Association and Chairman of the Information Technology Association of Michigan.

He is a graduate of the Michigan State University Honors College and the University of Michigan Law School. He has served as an adjunct professor of international studies at Michigan State University.

ANTHONY DEREZINSKI

Mr. Derezinski is Vice Chairman of the Michigan Law Revision Commission, a position he has filled since May 1986 following his appointment as a public member of the Commission in January of that year.

Mr. Derezinski is Director of Government Relations for the Michigan Association of School Boards. He also serves as an adjunct professor of law at The University of Michigan Law School and at the Department of Education Administration of Michigan State University, and previously was a visiting professor of law at the Thomas M. Cooley Law School.

He is a graduate of Muskegon Catholic Central High School, Marquette University, the University of Michigan Law School (Juris Doctor degree), and Harvard Law School (Master of Laws degree). He is married and resides in Ann Arbor, Michigan.

Mr. Derezinski is a Democrat and served as State Senator from 1975 to 1978. He was a member of the Board of Regents of Eastern Michigan University for 14 years and currently serves on the Committee of Visitors of the University of Michigan Law School. He also is a member of the Boards of Arbor Hospice and Home Care and the Center for the Education of Women in Ann Arbor.

He served as a Lieutenant in the Judge Advocate General's Corps in the United States Navy from 1968 to 1971 and as a military judge in the Republic of Vietnam. He is a member of the Veterans of Foreign Wars, Derezinski Post 7729, the National Association of College and University Attorneys, the Michigan and National Councils of School Attorneys, and the American Bar Association.

WILLIAM C. WHITBECK

Judge William C. Whitbeck is a public member of the Michigan Law Revision Commission and has served since his appointment in January 2000.

Judge Whitbeck was born on January 17, 1941, in Holland, Michigan, and was raised in Kalamazoo, Michigan. His undergraduate education was at Northwestern University, where he received a McCormack Scholarship in Journalism. He received his LL.B. from the University of Michigan Law School in 1966, and was admitted to the Michigan Bar in 1969.

Judge Whitbeck has held a variety of positions with the state and federal governments, including serving as Administrative Assistant to Governor George Romney from 1966 to 1969, Special Assistant to Secretary George Romney at the U.S. Department of Housing and Urban Development from 1969 to 1970, Area Director of the Detroit Area Office of the U.S. Department of Housing and Urban Development from 1970 to 1973, Director of Policy of the Michigan Public Service Commission from 1973 to 1975 and Counsel to Governor John Engler for Executive Organization/Director of the Office of the State Employer from 1991 to 1993. He served on the Presidential Transition Team of President-Elect Ronald Reagan in 1980, and as Counsel to the Transition Team of Governor-Elect John Engler in 1990.

In private practice, Judge Whitbeck was a partner in the law firm of McLellan, Schlaybaugh & Whitbeck from 1975 to 1982, a partner in the law firm of Dykema, Gossett, Spencer, Goodnow and Trigg from 1982 to 1987, and a partner in the law firm of Honigman Miller Schwartz and Cohn from 1993 to 1997.

Judge Whitbeck is a member of the State Bar of Michigan, the American Bar Association, the Ingham County Bar Association, the Castle Park Association, and the Michigan Historical Commission and serves as the Chair of the Commission. He is a member of the board of the Michigan Historical Center Foundation and is a Fellow of both the Michigan State Bar Foundation and the American Bar Foundation.

Judge Whitbeck and his wife, Stephanie, reside in downtown Lansing in a 125 year old historic home that they have completely renovated. They are members of St. Mary Cathedral.

Governor John Engler appointed Judge Whitbeck to the Court of Appeals effective October 22, 1997, to a term ending January 1, 1999. Judge Whitbeck was elected in November of 1998 to a term ending January 1, 2005. Chief Judge Richard Bandstra designated Judge Whitbeck as Chief Judge Pro Tem of the Court of Appeals effective January 1, 1999. The Supreme Court appointed Judge Whitbeck as Chief Judge of the Court of Appeals effective January 1, 2002.

GEORGE E. WARD

Mr. Ward is a public member of the Michigan Law Revision Commission and has served since his appointment in August 1994.

Mr. Ward was the Chief Assistant Prosecuting Attorney in Wayne County in the administration of the Honorable John D. O'Hair. Prior to that, he was a clerk to a justice of the Michigan Supreme Court and in private civil practice for twenty years in the City of Detroit. He recently returned to private practice in Detroit.

He is a graduate of Sts. Peter and Paul High School, Saginaw, the University of Detroit, and the University of Michigan Law School. He is married and the father of five children.

Mr. Ward is an Adjunct Professor at the Detroit College of Law at Michigan State University, Wayne State University Law School, and University of Michigan-Dearborn; a member of the Boards of Directors of Wayne Center, Wayne County Catholic Social Services and Wayne County Neighborhood Legal Services; past President of the Incorporated Society of Irish American Lawyers; a former member and President of the Board of Control of Saginaw Valley State University; a former commissioner of the State Bar of Michigan; and a former commissioner and President of the Wayne County Home Rule Charter Commission.

BILL BULLARD, JR.

Mr. Bullard is a legislative member of the Michigan Law Revision Commission and has served on the Commission since July 1996.

Mr. Bullard is a Republican State Senator representing the 15th Senatorial District. He was first elected to the Michigan House of Representatives in 1982 and served in that body until his election to the Senate in July 1996. He is currently Chairman of the Senate Transportation and Tourism Committee, as well as the Senate Financial Services Committee. Mr. Bullard also serves as the Vice-Chairman of the Senate Hunting, Fishing and Forestry Committee. He is also the Vice-Chairman of the Senate Finance Committee. Mr. Bullard is also the only practicing attorney serving on the Senate Judiciary Committee.

Mr. Bullard is a graduate of the University of Michigan and the Detroit College of Law. He has three children.

Mr. Bullard is the recipient of the first annual Legislator of the Year award from the Michigan Townships Association. He has been recognized by the National Federation of Independent Business with the Guardian Award, the Oakland County School Board

Association with the Distinguished Service award, the Michigan Soft Drink Association with the Legislator of the Year award. In 1999, he was presented with the State Highway Safety Champion award from the Advocates of Highway and Auto Safety. Mr. Bullard was also recognized by the Michigan Safety Commission in 1999 when they presented him with the State Safety Award. Mr. Bullard was appointed to the Oakland County Business Roundtable, Transportation and Telecommunications Committee by Oakland County Executive L. Brooks Patterson. Mr. Bullard was also recognized for achieving the Michigan Sales Tax Exemption for Rare Coins and Precious Metals by the Industry Council for Tangible Assets. He was also named Legislator of the Year in 2000 by the Michigan Humane Society, as well as by the National Republican Legislators Association.

Mr. Bullard is a member of the National Conference of Commissioners on Uniform State Laws (NCCUSL), National Conference of Insurance Legislators (NCIL), the Fraternal Order of Police of Southwest Oakland County, the Oakland County Bar Association and the State Bar of Michigan.

GARY PETERS

Mr. Peters is a legislative member of the Michigan Law Revision Commission and has served on the Commission since June 1995.

Mr. Peters is a Democrat State Senator representing the 14th Senatorial District. He was elected to the Michigan Senate in November 1994. He serves as the Minority Vice Chair of the Senate Education, Finance, Judiciary, and Natural Resources & Environmental Affairs Committees, and is a member of the Economic Development, International Trade & Regulatory Affairs Committee.

Prior to being in the Legislature, Mr. Peters was Vice President, Investments, for a major national financial services firm. He serves as a Securities Arbitrator for the New York Stock Exchange, National Association of Securities Dealers, and the American Arbitration Association.

Mr. Peters taught Strategic Management and Business Policy at Oakland University, and was an instructor in the Finance & Business Economics Department at Wayne State University. His educational credentials include a B.A. from Alma College (Magna Cum Laude, Phi Beta Kappa), an M.B.A. in Finance from the University of Detroit, and a J.D. from Wayne State University Law School.

His previous government experience includes a term on the Rochester Hills City Council where he served as Chair of the Solid Waste Management Committee, Vice Chair of the Budget & Finance Committee, and a member of the Zoning Board of Appeals and Paint Creek Trailways Commission.

Mr. Peters' community involvement includes serving on the Board of Directors for Common Cause of Michigan, a member of the Environmental Policy Advisory Committee for the Southeast Michigan Council of Governments (SEMCOG) and as Chair of the Air Issues Committee for the Michigan Sierra Club. He recently received the Star Award from the Michigan Deputy Sheriff's Association for his support and dedication to law enforcement issues, and was named Environmentalist of the Year by the Mackinac Chapter of the Sierra Club.

Mr. Peters is also a commissioned officer in the U.S. Naval Reserve. He is married and has three children.

JAMES L. KOETJE

Mr. Koetje is a legislative member of the Michigan Law Revision Commission and has served on the Commission since January 2001.

Mr. Koetje is a Republican State Representative, serving the 74th House District in Michigan. Mr. Koetje was first elected to the Michigan House of Representatives in 1998. He is Chair of the Gaming and Casino Oversight Committee, vice-chair of Land Use and the Environment, and serves on the Civil Law and the Judiciary Committee as well as the Commerce Committee.

Mr. Koetje has an extensive business and legal background, being an attorney in private practice for more than twenty years. He holds a Bachelor of Science degree from Calvin College and a law degree from Valparaiso University School of Law.

Mr. Koetje is a former member of the Grandville City Council and Grandville Zoning Board of Appeals. He is also a former member of the Classis Committee of the Christian Reformed Church; is a member and past president of the American Business Clubs, and former member of WCET-TV Board of Directors. Mr. Koetje is also a former member of the board of the Grandville Friendship Homes, an organization dedicated to men and women's adult foster care. He serves as president of the Grandville Christian School Foundation and is a member of the Greater Grandville Chamber of Commerce.

Mr. Koetje is married and has four children.

STEPHEN ADAMINI

Mr. Adamini is a legislative member of the Michigan Law Revision Commission and has served on the Commission since January 2001.

Mr. Adamini represents the 109th District. He currently is serving his first term in the House.

Mr. Adamini has practiced law for over 32 years. He is senior partner at Kendricks, Bordeau, Adamini, Chilman & Greenlee, P.C., a Marquette law firm. He is a graduate of Negaunee High School, and received his Bachelor of Arts degree in political science from the University of Michigan in 1967 and his Juris Doctorate from the University of Michigan Law School in 1970.

Mr. Adamini serves as the Democratic vice-chair of the House Civil Law & Judiciary Committee, and he also sits on the House Health Policy Committee.

Mr. Adamini has a longtime civic commitment to the Central Upper Peninsula community. From 1971 to 1976, he served on the Michigan Boundary Commission. From 1973 to 1979, he served on the Alger-Marquette Community Mental Health Board, including one term as chair and two terms as treasurer. Mr. Adamini chaired the Marquette County Democratic Party from 1986 to 1992. He served on the Michigan Transportation Commission, appointed by former Governor Jim Blanchard, from 1987 to 1991. In 1991, he served on the Marquette County Re-Appportionment Commission. From 1994 to 1999, he served on the Marquette County Airport Board, including two terms as chairperson. From 1997 to 2000, he served on the Executive Committee of the Gwinn Area Chamber of Commerce.

Mr. Adamini and his wife Linda, a retired elementary school teacher, reside in Marquette. They have two adult children, Corrine Adamini Ricker and Stephen Jr. They also have three grandchildren, Alexandra, Marki, and Ryan.

JOHN G. STRAND

Since January 2001, Mr. Strand, as the Legislative Council Administrator, has served as the ex-officio member of the Michigan Law Revision Commission. The following agencies fall under his supervision: Legislative Service Bureau, Library of Michigan (until October 1, 2001), Legislative Council Facilities Agency, Joint Committee on Administrative Rules staff, Legislative Corrections Ombudsman, Michigan Law Revision Commission, Commission on Uniform State Laws, and the Sentencing Commission. He also served as a member of the Library of Michigan Board of Trustees and Foundation Board until October 1, 2001.

Prior to being appointed to the Legislative Council, Mr. Strand served as Chairman of the Michigan Public Service Commission since October 1993 and had been a Tribunal Judge for the Michigan Tax Tribunal from January 1993 to October 1993. He had previously served six terms as a state legislator beginning in 1981, serving in a leadership position and as vice-chairman of the Insurance and the House Oversight Committees and as a member of the Taxation and Judiciary Committees.

Mr. Strand is a member of the State Bar of Michigan. He holds a B.A. from the University of Pittsburgh in Economics and Political Science in 1973 and a J.D. from Case Western Reserve University in 1976.

Mr. Strand, his wife Cathy, and sons Michael and Matthew live in East Lansing, Michigan.

KEVIN C. KENNEDY

Mr. Kennedy is the Executive Secretary to the Michigan Law Revision Commission, a position he has filled since December 1995.

Mr. Kennedy joined the faculty of Michigan State University - Detroit College of Law in 1987 and has taught courses in civil procedure, conflict of laws, international trade, and international litigation.

He is a graduate of the University of Michigan, Wayne State University, and Harvard University. He was a law clerk at the U.S. Court of International Trade, was a private practitioner in Hawaii, and served as a trial attorney for the U.S. Department of Justice. He is married.

Mr. Kennedy is the author of nearly forty law review articles concerning international law, international trade, and civil procedure. He is the co-author of World Trade Law, a treatise on international trade law.

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