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The Problem With PRIVILEGES

Medical malpractice may reveal another tortfeasor—the hospital that negligently granted credentials and privileges to the physician. Because the tort may not be apparent when the malpractice case is filed, thorough discovery is important.

By || **Bruce J. Klores and Joseph A. Smith**

When a patient is injured by medical negligence, the focus is on the physician, but there may be more to the case than the doctor's errors. The prudent plaintiff attorney should also consider whether the hospital—the institution that gave the physician license to practice under its roof—was negligent in granting credentials and privileges.

The tort of negligent credentialing was first recognized nearly 50 years ago in *Darling v. Charleston Community Memorial Hospital*, where a hospital was found liable for negligently allowing a doctor to perform a procedure for which he was unqualified.[1] The court reasoned that by adopting standardized credentialing criteria into its medical bylaws, the hospital undertook the obligation of ensuring its doctors were qualified to exercise privileges granted to them.[2] Since then, the tort has become an increasingly common source of hospital liability, with more than 25 states recognizing it as a cause of action.[3]

Before a physician may practice at a hospital, he or she must go through a credentialing and privileging process. *Credentialing* is the process where the hospital obtains, assesses, and verifies the doctor's qualifications and competence to practice medicine in general. *Privileging* is the process of determining which services the doctor is allowed to

perform in the hospital. For example, an orthopedic surgeon may be qualified to perform hip but not knee replacements. Normally these two processes occur simultaneously and are reevaluated throughout the doctor's practice at the hospital; however, a hospital may make the credentialing decision before it makes its determination as to what privileges it will grant to the doctor. The decision about whether the doctor will be credentialed by the hospital is typically made by a credentialing board or peer review committee made up of medical staff and hospital administrators.[4]

Submitting an application to the hospital's credentialing board is the first step in the credentialing and privileging process.[5] In deciding whether a physician is qualified to practice at a hospital, credentialing boards consider the doctor's training, experience, education, certifications, and previous work history. The criteria can be adopted from statutes, outside organizations such as the Joint Commission, or designed independently by hospital or health care organizations.[6]

Federal law requires that the credentialing board request a report on the physician from the National Practitioner Data Bank (NPDB). If privileges are granted, the hospital must periodically request updated information from the NPDB.[7] If a hospital fails to request this information, it is presumed to have knowledge of all the physician's records on file with the NPDB.[8]

After reviewing the applicant's submitted qualifications, the credentialing board decides whether to grant privileges to the doctor or, if the doctor already has privileges, whether to reappoint him or her. In some instances, a credentialing board will issue limited privileges that allow a physician to perform only certain procedures.[9] The Joint Commission requires credentialing with the physician's initial application and at least every two years thereafter.[10]

Hospitals' duty to select and retain competent physicians has been established in court decisions[11] and is standardized by the Joint Commission. The Joint Commission's *Comprehensive Accreditation Manual for Hospitals* sets out a detailed process of credentialing, imposing a duty on a hospital to "verify information about the applicant's licensure, specific training, experience, and current competence provided by the applicant with information from the primary source(s) whenever feasible."[12] This duty requires creating adequate credentialing procedures, adherence to those procedures in deciding whether to grant or renew privileges, and withdrawing them when the hospital learns of a physician's misconduct or incompetence.[13]

To help define the standard of care required of hospitals, the Joint Commission requires that the process be consistently applied, be focused on whether the physician is qualified for the specific privileges he or she is seeking, have uniform standards for determining what form of monitoring should be performed once the physician is credentialed, and involve consultation with the NPDB.[14] While most hospitals adopt the Joint Commission's guidelines, additional requirements may be imposed by state statutes and regulations, as well as by state licensing boards.

Building Your Case

To successfully bring a claim for negligent credentialing, a plaintiff must prove that

- the hospital had a duty to select and retain competent physicians seeking credentialing or privileges,
- the physician was incompetent or unqualified,
- the hospital knew or should have known the physician was incompetent or unqualified,
- the physician was negligent when treating the patient,[15] and
- the physician's negligence was the cause of the plaintiff's injury.[16]

The last two elements, of course, are required as part of the underlying case against the physician.

A hospital breaches its duty to select and retain only competent physicians if it knew or should have known that the doctor was incompetent or unqualified for the privileges he or she was seeking.[17] Failure to exercise the degree of care, skill, and judgment that a "reasonably prudent" hospital exercises in granting an applicant's request for privileges is negligence.[18] As such, a hospital may be liable for failing to perform an adequate investigation or make a reasonable decision once it becomes aware of information that should have resulted in denying or withdrawing a doctor's privileges to treat patients.

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For example, a hospital may be liable if it fails to request a report from the NPDB and credentials the doctor, even though the report would have contained disqualifying malpractice or misconduct. Liability may lie under federal law because, by not requesting a report, the hospital is presumed to have known about the physician's full record (including any incompetence) and therefore failed to exercise reasonable care in granting privileges. The hospital may also be held liable on the ground that it should have known the physician was unqualified because an investigation would have revealed the disqualifying information. Similarly, a hospital may also breach its duty if it renews a physician's hospital privileges, or privileges to perform a specific procedure, after he or she had multiple instances of misconduct at the hospital.[19]

Generally, the plaintiff attorney will not identify a negligent credentialing claim until well into discovery. The process begins with fact-gathering before filing suit against a negligent physician.

The first and easiest step is to talk with your client. Ask the client questions that focus on the physician's conduct, his or her comments, and the comments of nurses and other health care providers that may expose problems with the physician's performance.

At the same time, use public sources to gather information about the physician. The hospital or physician's website will provide information about the doctor's qualifications and certifications that can be added to the framework created from conversations with the client. Because the plaintiff must prove that the hospital knew or should have known that the doctor was unqualified or incompetent, the inquiry should focus on public sources that potentially reveal negative information about the doctor. Review the records of the applicable state medical boards and societies (virtually all of which are online), which commonly require physicians to report malpractice claims or disciplinary actions against them.

A search of AAJ resources (such as the *Professional Negligence Law Reporter*), as well as legal publications and local trial association resources can help you stay up to date on case law and legal theories. Other verdict reporting services can also help determine whether the defendant has had other malpractice claims or has a troubled past, and a Google search is always useful. And consultations with other plaintiff attorneys, whether personally or through list servers, is time well spent.

If you have a sense in the presuit phase that the hospital negligently credentialed the doctor, retain a peer review or credentialing expert to assist in preparing the case and to later serve as an expert to establish the standard of care and to explain how the hospital violated it.[20] The expert should have extensive experience performing all functions related to credentialing, privileging, and reappointment of physicians, and preferably should be certified in fields such as a "certified medical services coordinator" or "certified provider credentialing specialist." Engaging the expert early on will also help tailor your discovery.

While prelitigation research may uncover enough information to allege a viable negligent credentialing claim, it is more likely that the claim will materialize once formal discovery is taken. Initial requests for documents or subpoenas to the hospital should be used to gather any documents the doctor submitted to the hospital during the credentialing process. These documents include the doctor's initial application for credentials and privileges, any supplemental applications, any applications for special privileges, and all supporting documentation submitted to the hospital.[21]

If peer review privilege statutes limit access to these documents, obtain a blank application for credentials so that you can use information from public sources and the discovery process to complete the application as much as possible. Once the application has been completed with the available information, submit it to a credentialing expert for evaluation and opinion as to whether the physician should have been credentialed and granted privileges.

Interrogatories to the doctor should

focus on whether he or she had any negative incidents such as malpractice suits, disciplinary proceedings (such as suspension or revocation of hospital privileges), or any other complaints regarding performance. The interrogatories should be accompanied by related document requests. Where these negative incidents occurred is important because it can help determine whether the hospital was negligent in its initial credentialing of the doctor or in reappointing him or her.

Thorough discovery in the initial suit against the doctor will not only lay the foundation for a negligent credentialing claim, but also reduce the amount of information needed once the hospital is joined on the negligent credentialing claim.

Interrogatories and other written discovery can also determine other helpful facts, such as the doctor's education, experience, certifications, and other qualifications; other hospitals that granted him or her privileges; how often the doctor has performed the procedure at issue in the case; and when credentials were applied for and renewed. It is important to determine how many incidents have occurred at the hospital where the patient was injured because the hospital may be liable for failing to withdraw staff privileges from repeat offenders.[22]

Depositions

A negligent credentialing claim often does not emerge until after the defendant physician is deposed. The following paraphrased testimony is from a defendant physician's deposition in a neurosurgical malpractice case where our client was left paralyzed and incontinent after spinal decompression surgery.

Q: Have you been named as a defendant in a medical malpractice case before this particular case?
A: Yes.
Q: On how many occasions has that happened?
A: 10 or 12.
Q: How many cases are now pending besides this case?
A: Four.
Q: How many of those cases are in Washington, D.C.?
A: Three.
Q: Do you know about the district's reporting requirement that physicians are to provide information so that the public can obtain a physician's malpractice litigation history?
A: I heard about it.
Q: Have you provided any information to the district about any of those malpractice cases?
A: No, I have not.
Q: Regarding the other 10 to 12 cases, do any of them involve surgery on the spine?
A: Yes.
Q: Have any of those cases gone to trial?
A: Yes.
Q: How many?
A: Three or four, I think.

Q: In the hospitals that you've either applied for or obtained privileges at over the years, have they ever been limited, suspended, or revoked, or any applications denied in whole or in part?
A: No.
Q: Pursuant to our notice of deposition duces tecum, have you brought your privileges applications with you today?
A: Yes, I have.

This testimony provided the basis for a negligent credentialing claim, and we amended the plaintiff's original complaint to include this claim against the

hospital that had granted the defendant privileges.

Third-party depositions—of members of the hospital's credentialing board—also can be used to build the record. While peer review privilege statutes may limit the ability to depose credentialing board members or prevent them from testifying as to a specific physician, members may still be able to provide information as to what the hospital's credentialing process includes and whether the process complies with the Joint Commission's standards.

Thorough discovery in the initial suit against the doctor will not only lay the foundation for a negligent credentialing claim, but also reduce the amount of information needed once the hospital is joined on the negligent credentialing claim. Because vital information to prosecute a negligent credentialing claim may not be discovered until after the initial suit against the physician is filed, it is important to file suit well within the statute of limitations so the complaint can be amended if needed.

A negligent credentialing claim may lurk in any medical malpractice case. Keeping this possibility in mind from the outset—and tailoring your discovery to include queries that may reveal the negligence of the hospital as well as the physician—will help ensure the best outcome for your client.

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Notes

1. 211 N.E.2d 253 (Ill. 1965).
2. *Id.* at 257–58.
3. In *Larson v. Wasemiller*, for example, the Minnesota Supreme Court recognized the tort of negligent credentialing, noting that 27 states had recognized the tort and only two had rejected it outright. 738 N.W.2d 300, 305 (Minn. 2007). States that have rejected the claim of negligent credentialing have done so primarily on the ground that hospitals are immunized from liability for negligent credentialing by a peer review statute. *See* Andrew R. deHoll, *Tort Law: Vital Surgery or Unnecessary Procedure? Rethinking the Propriety of Hospital Liability for Negligent Credentialing*, 60 S.C. L. Rev. 1127 (2009).
4. George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 Ala. L. Rev. 723, 725 (2001).
5. *See* Whitney Foster, *Health Law–Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians*, 31 UALR L. Rev. 321 (2009).
6. The Joint Commission has set forth several criteria to be considered in making a credentialing determination: current licensure, training and experience, physical and mental health, competence, previous and pending challenges to licensure, involvement in malpractice actions, withdrawal or reduction of privileges at another hospital, and peer recommendations. deHoll, *supra* n. 3; Jt. Commn., *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, §§MS.5.5–5.8 (2011).
7. deHoll, *supra* n. 3 at 1130. Doctors, hospitals, medical malpractice carriers, and government agencies must report investigations, adverse actions, malpractice verdicts, or settlements to the National Practitioner Data Bank. *Id.* at 1163, n. 28; 45 C.F.R. §60.8 (2012).
8. 42 U.S.C. §11135(b) (2011).
9. Foster, *supra* n. 5, at 332.
10. Calvin L. Raup, *Credentialing and Peer Review: A Primer for the Non-Health Care Attorney*, 46 Ariz. Atty. 30 (Mar. 2010).
11. *See Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989); *Bell v. Sharp Cabrillo Hosp.*, 212 Cal. App. 3d 1034 (Cal. App. 4th Dist. 1989).
12. Jt. Commn., *supra* n. 6, §MS-5.4.3.1.
13. deHoll, *supra* n. 3.
14. *See* Jt. Commn., *supra* n. 6, §§MS-05.01.01; MS-06.01.03; MS-08.01.01-.03; 42 U.S.C. §11111.
15. *See Hiroms v. Scheffey*, 76 S.W.3d 486 (Tex. App. 14th Dist. 2002).
16. *See Frigo v. Silver Cross Hosp. & Med. Ctr.*, 876 N.E. 2d 697 (Ill. App. 1st Dist. 2007); *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007).
17. *See Purcell v. Zimbelman*, 500 P. 2d 335, 351 (Ariz. App. 2 Div. 1972).
18. *See Thompson v. Nason Hosp.*, 591 A.2d 703 (Pa. 1991).
19. *See Copithorne v. Framingham Union Hosp.*, 520 N.E.2d 139 (Mass. 1988).
20. *See Frigo*, 876 N.E.2d 697; *Rose v. Garland Community Hosp.*, 168 S.W.3d 352 (Tex. App. 2005).
21. Some jurisdictions have peer review privilege statutes that limit or prevent the discovery of records used in the review. These statutes are often enacted to allow doctors involved in the credentialing process to be open and honest, without fear that their statements will be used against a colleague in a malpractice suit. *See* Foster, *supra* n. 5. Some states, including Arizona and Texas, greatly restrict the cause of action for negligent credentialing. *See* Ariz. Rev. Stat. §36-445.01 (2012); Tex. Health & Safety Code §161.032 (2012). Florida, however, passed a state constitutional amendment that removed much of the confidentiality protection for peer review processes. Fla. Const. Art. X §25. Other states, including Illinois, have concluded that a physician's application for credentials is created before any peer review process and therefore is not privileged. As such, it is critical for the attorney to review the applicable statutes and case law to determine what level of protection is provided to such documents and information.
22. *See Copithorne v. Framingham Union Hosp.*, 520 N.E.2d 139 (Mass. 1988).

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