SUPREME COURT RECOGNIZES HOSPITALS MUST PROTECT PATIENTS FROM INCOMPETENT DOCTORS – NOW WHAT?

By William J. Maddix

In *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007), the Minnesota Supreme Court recognized a new theory of recovery in medical negligence cases—a common law cause of action for negligent credentialing.[1] This landmark decision means that Minnesota hospitals will now be held accountable if they negligently grant credentials to incompetent doctors who later injure patients. Liability attaches to the hospital even if the doctor is not a hospital employee and is an independent contractor.

Although the Court's decision provides further incentive to hospitals to shield their patients from bad doctors, the Court provided little guidance on how to litigate negligent credentialing claims. Given that the work of credentialing committees is confidential, how does one prove the hospital acted negligently when you cannot discover precisely how or why the hospital granted credentials? How can the hospital defend itself when it may be barred from explaining the actual reasons for its decision to grant credentials? What is discoverable? Numerous other questions remain, and any attorney considering pursuit of a negligent credentialing claim will be well served by understanding what the Court said and what it did not say in the *Larson* decision.

FACTUAL AND PROCEDURAL BACKGROUND

In April 2002, Mary Larson underwent gastric bypass (weight loss) surgery performed by James P. Wasemiller, M.D. at St. Francis Medical Center in Breckenridge, Minnesota. Larson developed numerous post-operative complications and commenced suit in Wilkin County District Court. After suit was commenced, Larson discovered evidence that Dr. Wasemiller had

a history of serious practice deficiencies—failure to obtain board certification, multiple lawsuits and settlements, board discipline, and hospital discipline. Larson then amended the Complaint to add St. Francis Medical as a defendant, alleging St. Francis had negligently granted privileges to Wasemiller to perform complex bariatric surgical procedures.

St. Francis moved to dismiss for failure to state a claim, noting that no Minnesota appellate court had ever recognized a common law cause of action for negligent credentialing and that the peer review statute, Minn. Stat. §§ 145.61-.67, barred the claim. The district court judge, Honorable Gerald J. Seibel, denied St. Francis' motion, holding (1) that Minnesota would follow the many other jurisdictions that had recognized a common law cause of action for negligent privileging; and (2) that nothing in Minnesota's peer review statute Minn. Stat. §§ 145.61-.67 barred claims for negligent privileging. The trial court then certified as important and doubtful the following two questions:

1. Does the State of Minnesota recognize a common law cause of action of negligent credentialing/privileging of a physician against a hospital or other review organization?
2. Do Minn. Stat. §§ 145.63 and 145.64 grant immunity from or otherwise limit liability of a hospital or other review organization for a claim of negligent credentialing/privileging of a physician?

St. Francis and Wasemiller appealed. The Court of Appeals reversed. As to the first certified question, the court said "it is not our function to create new law" and declined to recognize the tort of negligent credentialing, stating that either the Supreme Court or the legislature should decide the issue. As to the second certified question, the court held that the peer review statute does not immunize hospitals from negligent credentialing claims but limited

the hospital's liability, if any, to those circumstances where credentialing decisions were "not made in the reasonable belief that the action is warranted by facts known to it after reasonable effort to ascertain the facts."[2] Larson petitioned the Supreme Court for review, and the Court granted the petition.[3]

SUPREME COURT DECISION

In deciding whether to recognize the tort of negligent credentialing, the Court addressed two primary issues: (1) Does Minnesota's peer review statute create a cause of action for negligent credentialing? and (2) Is there a common law cause of action for negligent credentialing?

I. DOES PEER REVIEW STATUTE CREATE CAUSE OF ACTION FOR NEGLIGENT CREDENTIALING?

As to the this issue, the Court considered the second sentence of Minn. Stat. § 145.63, subd. 1. This sentence provides that

> **No review organization and no person shall be liable for damages** or other relief in any action by reason of the performance of the review organization or person of any duty, function, or activity as a review organization or a member of a review committee or by reason of any recommendation or action of the review committee **when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made . . . .**

(emphasis added).

Larson contended that the statutory language indicates that the legislature contemplated the existence of a common law claim for negligent credentialing by recognizing that hospitals could be liable when it failed to act with a "reasonable belief" when granting credentials or failed to make a "reasonable effort" to ascertain the facts supporting a grant of credentials. The Court had a more expansive interpretation of the language, stating the legislature may have intended to

create a statutory cause of action for negligent credentialing where none possibly existed at common law. The Court ultimately was "reluctant to conclude that the statute affirmatively creates such a cause of action because the standard of care is stated in the negative" but agreed with Larson that the statute contemplated the existence of a common law cause of action for negligent credentialing and clearly did not abrogate the common law tort.[4]

II. IS THERE A COMMON LAW CAUSE OF ACTION FOR NEGLIGENT CREDENTIALING?

To decide this issue, the Court addressed four questions outlined below.

A. Is Tort of Negligent Credentialing Inherent in, or the Natural Extension of, a well-established Common Law Right?

Because doctors are generally independent contractors and not hospital employees, the hospital contended that recognition of the tort of negligent credentialing would conflict with long-established precedent that "a hospital can only be held vicariously liable for a physician's acts if the physician is an employee of the hospital."[5] Larson countered that negligent credentialing claims were not vicarious liability claims, but rather direct liability claims based upon the wrongful conduct of the hospital.[6] The Court agreed with Larson, noting that it had previously recognized that hospitals "owe a duty of care directly to patients to protect them from harm by third persons" and that the hospital/patient relationship is analogous to the innkeeper/guest and common carrier/relationship.[7]

The Court then pointed out that the tort of negligent credentialing was analogous with "two other generally recognized common law torts"—negligent hiring of an employee, which the Court had previously recognized,[8] and negligent selection of an independent contractor as outlined in the Restatement (Second) of Torts §411 (1965). Although the Court recognized it had not adopted this latter tort in its prior cases, the Court stated that it had "frequently relied on the Restatement of Torts to guide our development of tort laws in areas we have not previously

had an opportunity to address"[9] and that other jurisdictions had relied on §411 in recognizing the tort of negligent credentialing.[10]

Given the Court's prior recognition that hospitals owe a direct duty to patients to protect them from harm by third persons, recognition of the tort of negligent hiring, and general recognition of the Restatement of Torts as a guide to the development of the common law, the Court held that recognition of the tort of negligent credentialing "is inherent in and the natural extension of well-established common law rights."[11]

(Interestingly the Court foreshadowed that it may very well recognize the broader tort of negligent selection of an independent contractor if the issue squarely arose in a later case. If so, any entity engaged in the selection of independent contractors would be well served to assume that it must act reasonably in selecting independent contractors or be held accountable for harm caused to third parties by the independent contractor.)

B. Is the Tort of Negligent Credentialing Recognized as a Common Law Tort by a Majority of other Common Law States

The Court surveyed the common law of other states and found that at least 27 states recognized the tort of negligent credentialing, and at least three more states recognized the broader theory of corporate negligence, which encompassed the tort of negligent credentialing.[12] Only two states did not recognize the tort due to statutory bars on the claim.[13] The Court concluded that the tort of negligent credentialing was recognized as a common law tort by the substantial majority of other common law states.[14]

C. Would the Tort of Negligent Credentialing Conflict with Minnesota's Peer Review Statute?

The Court next considered whether the confidentiality and limitation of liability provisions of the peer review statute would conflict with the tort of negligent credentialing. The

confidentiality provision of the peer review statute is contained in Minn. Stat. § 145.64, subd. 1, which provides in relevant part:

> Data and information acquired by a review organization . . . shall be held in confidence . . . No person . . . . shall disclose what transpired at a meeting of the review organization . . . . The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional out of the matter or matters which are the subject of consideration by the review organization.

The hospital contended that the tort of negligent credentialing was not compatible with the confidentiality provisions of Minn. Stat. § 145.64, subd. 1 for two reasons. First, because a plaintiff would have to prove what a hospital actually knew when it granted credentials, a plaintiff could never meet that burden because plaintiff could never discover what the hospital actually knew. Second, the confidentiality provisions would bar the hospital from explaining the actual reasons why it granted credentials, therefore making it impossible for the hospital to defend itself.

The Court rejected both arguments. First, plaintiff's burden of proof could be met by showing what the hospital should have known at the time of its credentialing decisions.[15] Second, although Minn. Stat. § 145.64, subd. 1 shielded certain information from disclosure, the statute recognized that litigants could use information from "original sources," i.e., non-peer review sources, to pursue or defend negligent credentialing claims.[16] Minn. Stat. § 145.64, subd. 1 provides that

> Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings.

Both Ohio and Wyoming had peer review confidentiality provisions that mirrored Minnesota's, and the appellate courts in those states had addressed and squarely rejected the precise contentions now made by the hospital.[17] The Court next considered whether the limitation of liability provisions of Minn. Stat. § 145.63, subd. 1 conflicted with the tort of negligent credentialing. The first sentence of the provision applies to physicians who have been aggrieved by the credentialing process and initiate suit. They must prove the hospital acted with malice. The second sentence of the provision relates to others, such as patients. This second sentence provides as follows:

> **No review organization and no person shall be liable for damages** or other relief in any action by reason of the performance of the review organization or person of any duty, function, or activity as a review organization or a member of a review committee or by reason of any recommendation or action of the review committee **when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or the review organization after reasonable efforts to ascertain the facts** upon which the review organization's action or recommendation is made . . .

(emphasis added).

The hospital contended that this language required a plaintiff to show something more than simple negligence. Larson contended that the language merely codified the common law negligence standard. The Court agreed with Larson, holding that the "provision is a codification of the common law ordinary negligence standard."[18]

D. Do the Policy Considerations in favor of the Tort of Negligent Credentialing Outweigh any Tension Caused by Conflict with the Peer Review Statute?

The hospital argued that recognition of negligent credentialing claims would dissuade physicians from serving on credentialing committees, harm the health care system, generate unnecessary claims since patients could be adequately compensated by the insurer for the negligent physicians, and burden the trial courts with novel evidentiary issues and bifurcated

trials. Larson countered that patient safety would be promoted, peer review proceedings would remain confidential, incompetent physicians often cannot obtain liability insurance in the private market and are often underinsured, hospitals must be held accountable for their negligent acts, and trial courts decide challenging evidentiary and procedural issues on a routine basis.

The Court held that the policy considerations in favor of recognizing the tort outweighed those cutting against recognition of the tort. The confidentiality provisions or the peer review statute preserved the confidentiality of peer review process while allowing litigants to pursue or defends claims by using information from original sources.[19]

The Court ultimately recognized the common law cause of action for negligent credentialing, and remanded the case to the district court for trial. Trial is currently scheduled for January 2009.

LITIGATION OF NEGLIGENT CREDENTIALING CLAIMS

Although the *Larson v. Wasemiller* decision recognized the tort of negligent credentialing, the Court provided little guidance on how such cases will be litigated. The following discussion highlights some of the issues that will arise and discusses how those issues might be resolved.

I. INVESTIGATION OF POTENTIAL CLAIM.

If your investigation has determined that a meritorious malpractice claims lies against a doctor who has provided care in a hospital setting, you should do a background check on the physician. The Minnesota Board of Medical Practices maintains a website that contains information about public disciplinary and corrective actions involving the physician. Contact the relevant certification board for the physician's area of specialty to verify whether the physician is board certified. Check state and federal courthouse civil and criminal filings involving the physician. If you locate previous malpractice actions against the physician, contact the attorney

who represented the patient in case and obtain copies of expert reports and deposition transcripts from those cases.

The absence of a board discipline or court files does not end your inquiry. A doctor could have settled many malpractice claims prior to any litigation, or settled claims during the course of the case and managed to get the court file sealed as part of the settlement. In fact, you can expect that almost every claim that a doctor has settled has been done so confidentially to prohibit your access to the fact of the claim and resolution of the claim.

One clue to a trouble practice history may be that the doctor is insured by the Minnesota Joint Underwriter's Association, a creature of statute that offers malpractice insurance to doctors who are too high risk to obtain coverage in the private market. If you commence suit against the doctor on the underlying malpractice claim, you should always seek discovery about prior claims against the doctor. You may acquire information through discovery that is not otherwise available from other sources and position yourself to evaluate the possibility of pursing a negligent credentialing claim.

Keep in mind that negligent credentialing may not always involve a doctor with a history of serious practice deficiencies and lawsuits. Negligent credentialing claims include negligent privileging claims, and a hospital may have chosen to grant privileges to a doctor to perform procedures for which she or he lacks appropriate training and experience. A doctor with a perfect track record on general surgical procedures, for example, may not have met the training and experience guidelines established by the American Society for Bariatric Surgery to perform bariatric surgeries. Under those circumstances, a hospital ought not to grant privileges to that general surgeon to perform bariatric surgery at its facility.

II. NECESSITY OF EXPERT SUPPORT AND AFFIDAVIT.

Presume that your negligent credentialing claim will be subject to the expert affidavit requirements of Minn. Stat. § 145.682. Subdivision 1 of the section expressly includes hospitals within the definition of "health care provider." Failure to satisfy the affidavit requirements can be fatal to your case.

When selecting a reviewer, make sure that the reviewer has experience on a credentialing committee and in the area of medicine at issue. This experience will serve as the necessary foundation for your case because the reviewer will have to know what information a hospital typically considers when deciding whether to grant credentials and then look at what information the hospital likely would have had when making its decision about the defendant doctor. The reviewer likely will not have the actual information considered by the hospital due to the confidentiality provisions of peer review statutes.[20] The reviewer ultimately will have to opine that the hospital departed from accepted standards of care when granting credentials or privileges before you can proceed against the hospital, and you will need to comply with the statutory expert affidavit requirements through each phase of the litigation.

III. DISCOVERY.

No component of the litigation may be more challenging or perplexing than conducting discovery. The defense bar, justifiably so, has been particularly vigilant in preventing an improper disclosure of confidential peer review materials because such an act constitutes a misdemeanor.[21] An additional hurdle to discovery is that the confidentiality provisions, for the most part, are stated in general terms, leaving open to debate what is confidential and what is not. Defense counsel typically err on the side of safety and generally object to any request that may arguably seek confidential information. Although Minnesota's peer review statute mirrors those in most states, there are few reported decisions in Minnesota and elsewhere that provide

guidance on what is discoverable and what is not. The starting point to formulating a discovery plan is to consider the language of Minn. Stat. § 145.64, subd. 1. It places three primary constraints on the ability to gather otherwise relevant information:

> "data and information acquired by a review organization . . . shall be held in confidence [and] shall not be subject to subpoena or discovery. No person . . . shall disclose what transpired at a meeting of the review organization . . . . The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional out of the matter or matters which are the subject of consideration by the review organizations.

Minn. Stat. § 145.64, subd. 1 goes on to state, however, that

Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matter within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings.

A. DATA AND INFORMATION ACQUIRED BY A REVIEW ORGANIZATION.

Because "information, documents or records otherwise available from original sources shall not be immune from discovery," the logical starting point for discovery seemingly would be to request that the hospital produce all original sources materials it gathered when deciding whether to grant credentials to a physician. Other states with peer review statutes that mirror Minnesota's recognize that plaintiffs can discover this information directly from the hospital,[22] and Minn. Stat. § 145.64, sub. 1 does states that information "otherwise available from original sources shall not be immune from discovery or use in any civil action."

The Minnesota Court of Appeals, however, has previously held that the original sources gathered by the hospital are not discoverable from the hospital. *In re Fairview-University Hospital*, 590 N.W.2d 150, 153 (Minn.App. 1999). In that case, the Minnesota Board of Medical Practices had attempted to subpoena the peer review file, including all information gathered from original sources, pertaining to a specific doctor. The Board contended that information was discoverable under the original sources exception outlined in Minn. Stat. § 145.64, subd. 1. The Court of Appeals disagreed, stating that the statute barred disclosure of all "data and information acquired by a review organization." According to the Court, the original source exception contained in Minn. Stat. § 145.64, subd. 1, according to the Court, merely meant that a litigant seeking the information could acquire the information from the original source.

This Court of Appeals decision reveals the difficulties in understanding and construing Minn. Stat. § 145.64, subd. 1. At first blush, the Court of Appeals decision appears correct in its ruling: the first sentence of subdivision 1 unambiguously states that ""data and information acquired by a review organization . . . shall be held in confidence [and] shall not be subject to subpoena or discovery." Thus, the hospital cannot be compelled to produce any data or information in "acquired" in connection with a credentialing decision.

Subdivision 1, however, is not limited to its first sentence. The first sentence must be read in conjunction with the later sentence which states that "[i]nformation, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization . . . ." This sentence does not state that original sources must be obtained from original sources. It appears to state the opposite, that original sources "otherwise available" from original sources are not immune from discovery from the hospital in "any" civil action. Indeed, this is the only

meaning that could be attributed to the "otherwise available" phrase because civil litigants do not need legislative permission to go to original sources—court files, public board disciplinary file, and the like—to obtain the information. The Court of Appeals read the first sentence of subdivision 1 in isolation, and failed to read the subdivision as a whole to effect the intent of the legislature.

That the Court of Appeals decision is suspect is further evidenced by well-established rules of canons of construction that govern interpretation of statutes that purport to grant privileges. As the *Fairview-University Medical Center* court recognized:

> Courts should not interpret a statute to create a privilege going beyond the statute's purpose, when an equally plausible construction will create a privilege which, although narrower, serves the statute's purpose.[23]

Even if the original source language of subdivision 1 does not unambiguously set forth an exception to the first sentence of the subdivision, Minn. Stat. § 145.64, subd. 1 is ambiguous at best and invites two equally plausible constructions. One bars discovery, and one permits discovery of original source data acquired by the review organization. Because the law disfavors statutory privileges, the Court of Appeals should have opted for the construction that permitted discovery of original source information directly from the review organization. Indeed, making the patient waste time and money to obtain information that is clearly discoverable and already in the hands of the hospital does nothing to serve the underlying purposes of the peer review statute and only adds unnecessary delay and cost for no purpose. Other jurisdictions that have peer review statutes that mirror Minnesota's, and those jurisdictions permit the discovery of original source materials directly from the review organization.[24]

Even if defense counsel objects to production of original source materials gathered by the hospital on the basis of the *Fairview-University Medical Center* decision, nothing in the decision or in Minn. Stat. § 145.64 subd. 1 imposes an express bar on discovery of a list of original source

materials gathered by the hospital. Because the law disfavors statutory privileges, courts should not find a bar to discovery of this list which would facilitate plaintiff's effort to obtain original source materials from the original source.

If defense counsel objects to your efforts to discovery original source materials and information, you should move for relief to preserve these issues. The trial court will be reluctant to depart from controlling precedent established by the Court of Appeals, at least as to compelling the hospital to produce the original documents its acquired, but you will need to preserve these issues for the appellate courts with the hope that the *Fairview-University Medical Center* decision will be reversed.

At the legislative level, patient safety advocates would be well served to seek a legislative solution to the problems posed by the *Fairview-University Medical Center* decision.

B. PROCEEDINGS AND RECORDS OF A REVIEW ORGANIZATION.

Minn. Stat. § 145.64, subd. 1 also provides that "the proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional out of the matter or matters which are the subject of consideration by the review organization." As the Supreme did in the *Larson* case, courts and litigants may be too quick to assume that this provision bars the discovery of any record or transcription of credentialing committee proceedings and any records generated by the committee.

By its express terms, the prohibition on the discovery of "proceedings and records relates only to a claim against a "professional." Minn. Stat. § 145.61, subd. 2, defines "professional" to mean "a person licensed or registered to practice a healing art under chapter 147 or 148 . . ." Hospitals are not encompassed within the definition of professional. The prohibition against the discovery of proceedings and records, therefore, should not apply to a credentialing claim against

the hospital. This interpretation is consistent with the plain language of the statute, and would be consistent with the canons of construction that dictate that statutory privileges be construed narrowly.

This construction of the statute would eliminate many of the mysteries and obstacles to pursuing or defending a negligent credentialing claim. The litigants and ultimately the jury would know precisely why and how the doctor acquired credentials. Plaintiffs would not have to devote substantial time and money to locate information that the committee should have/might have considered, and defendant hospitals would be free to articulate the actual reasons for the credentialing decision. The jury's decision would be based on actual facts, not presumed facts, and any due process concerns about litigating negligent credentialing claims on the basis of presumed facts would vanish.

To a lawyer, we have developed a mindset that the words, "peer review" and "confidential" are synonyms. They are not. We are entering a new frontier in the field of medical negligence, and how we craft our arguments and the theories we pursue will define that landscape. The law disfavors statutory privileges, and any perceived restrictions on the right to marshal evidence to seek justice for our clients should be studied and dismantled though use of long-standing canons of statutory construction that favor disclosure.

C. NATIONAL PRACTITIONER DATA BASE INFORMATION.

When making credentialing decisions, hospitals are required by federal law to gather information about physicians from the National Practitioner Data Bank as part of the credentialing process. Congress created the National Practitioner Data Bank (NPDB) to improve the quality of medical care across the United States. According to the website maintained by the NPDB:

> The intent [of the legislation creating the NPDB] is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure of discovery of previous medical malpractice payment and adverse action history. Adverse action can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid.
>
> The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials.

Under regulations promulgated by the United States Department of Health and Human Services, hospitals have an affirmative obligation to gather information from the NPDB about any document applying for credentials to practice at the hospital. Hospitals must gather this information at least once every two years.[25] The regulations govern access to the data, and as a general rule only hospitals, boards of medical examiners or other state licensing boards have access to the information.[26] 45 C.F.R. § 60.11 An exception to this general rule exists under the following circumstances: when a medical malpractice claim has been made against a doctor and a hospital, the attorney representing the plaintiff, or the plaintiff, may request and receive specific information about the doctor from the NDPB:

> upon the submission of evidence that the hospital failed to request information from the Data Bank as required by § 60.10(a), and may be used solely with respect to litigation resulting from the action or claim against the hospital.[27]

When conducting discovery, including an interrogatory asking the hospital the hospital whether it requested information from the NPDB as required by 45 C.F.R.§ 60.10(a). If the hospital answers that it did not request the information, then you should submit this interrogatory answer to the NPDB to acquire data maintained by the NPDB about the physician at issue, much of which may contain information not available from any other source.

IV. TRIAL OF THE NEGLIGENT CREDENTIALING CASE.

In the *Larson* case, the Supreme Court declined to decide whether the jury must decide that the doctor committed malpractice as a precondition to imposing liability on the hospital for negligently credentialing the doctors. The Court recognized, however, that negligent credentialing claims are not vicarious liability, but rather direct liability claims against the hospitals arising from the wrongful conduct of the hospital. Other jurisdictions that have considered the issue have rejected the notion the claim against the hospital is contingent upon a finding of malpractice against the physician.[28] Negligent credentialing claims against hospitals, therefore, should not be contingent on a finding of malpractice against the physician.

Resolution of that issue will also affect the court's decision on any motion to bifurcate the trial. The defendant physician will likely move to bifurcate trial of the malpractice claim from the credentialing claim two grounds: (1) the hospital cannot be held liable unless the jury first determines whether the physician was negligent, thus time can be saved if the jury rules in favor of the physician, and (2) evidence relevant and admissible on the credentialing claim will be irrelevant and prejudicial on the malpractice claim.

Plaintiff should oppose any such requests. First, as noted above, the hospital should be liable for negligent credentialing irrespective of any finding of negligence against the physician. No time would be saved by bifurcating the trial, and in fact more time and expense would be incurred if the trial were bifurcated. Second, evidence against the hospital would be admissible against the physician as substantive evidence on an informed consent claim against the physician and otherwise could be used to impeach the physician's claims to competence.

As the Wisconsin Supreme Court recognized in *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996), a physician can be liable for failing to obtain the informed consent of a patient if the

physician fails to inform the patient of the physician's lack of experience, training, or skill in performing the procedure at issue. Certainly a patient cannot provide an informed consent to a procedure, and would not provide consent to a procedure, if the physician has a long and well-documented history of serious practice deficiencies, particularly in regards to the proposed procedure. The physician's deliberate choice to keep practice deficiencies secret from the patient while recommending a procedure the physician is not competent to perform gives rise not only to an informed consent claim, but possibly other claims including fraud and misrepresentation under both the common law and statutory law. In any event, the evidence against the physician on the informed consent claim would mirror that against the hospital on the credentialing claim, and the physician would suffer no prejudice by trying both claims in one trial.

Evidence relevant to the credentialing claim is also permissible impeachment material in the malpractice claim. The physician will certainly tell the jury that the he or she is well-trained, experienced and competent, and this should open the door to use the prior bad acts and shortcomings in the doctor's training and experience. Thus, there is no reason to bifurcate trials as the jury will hear the bad things that the physician has done to other patients.

As to the trial itself, counsel should assume that none of the parties can introduce evidence of how and why the hospital granted credentials to the doctor. This is a presumption that runs through the *Larson* decision and is an assumption that is deeply, if not wrongly, rooted in the mindset of attorneys and judges notwithstanding the discovery arguments set forth above. At the trial court level, seek, but do not expect to get, all the discovery to which this author claims you are entitled.

Until these discovery issues get clarified at an appellate level, assume that the credentialing trial will unfold as follows: plaintiff's credentialing expert will testify that

credentialing committees are required by law[29] to consider certain types of information and regularly considers other types of information. The expert will then discuss the specific information that has been gleaned about the defendant doctor and then opine that the defendant hospital departed from accepted standards of care in granting credentials to the doctor. Plaintiff likely will supplement this evidence with other witnesses and exhibits.

The defendant hospital, in turn, will employ a credentialing expert with relevant experience who will consider the same original source information reviewed by plaintiff's expert. The expert will conclude that the hospital could reasonably grant credentials to the docter. The defense will supplement this testimony with other witnesses and exhibits to support the defense view. Ultimately, the jury will decide whether the hospital acted negligently in granting credentials to the physicians without likely ever knowing the actual basis for the grant of credentials.

Win or lose, anticipate an appeal!

CONCLUSION

The *Larson* decision enhances patient safety by holding hospitals accountable for exposing patients to incompetent doctors. The greatest impact of the decision may not be in the courthouse, but rather in the hospitals across our state. Most hospitals need no reminder of the importance of protecting their patients from incompetent doctors. For those hospitals that have cut corners in the credentialing process and knowingly or carelessly exposed and knowingly or carelessly exposed their patients to bad doctors, the *Larson* decision, one hopes, will dispel those hospitals of the notion that they will not be held accountable for such decisions.

When negligent credentialing claims lead to the courthouse, many questions remain on how those claims will be handled during the discovery phase and at trial. Our statutes and case

law provide little guidance on how to litigate these claims, and now is the time for attorneys to be bold and creative. You are in a new frontier, and the level of your advocacy will ultimately establish precedent that will impact the litigation of negligent credentialing claims for years to come.

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[1] Negligent credentialing claims encompass both credentialing and privileging decisions made by hospitals. Physicians cannot treat patients at a particular hospital unless they demonstrate their competency to the hospital's credentials committee. The committee decides what physicians can practice at its facility and what procedures they can perform. Credentialing decisions relate to who can practice at the hospital, and privileging decisions relate to what specific procedures can be performed by the physician. Credentials might be denied because the physician has committed malpractice on an unusually high number of patients or is actively engaged in alcohol or substance abuse. Certain privileges might be denied because the physicians lacks the training, experience, or skill to perform a specific procedure. A general surgeon, for example, may have privileges to perform routine general surgical procedures, but the surgeon may be barred from performing more complex procedures like gastric bypass procedures.

[2] *Larson v. Wasemiller*, 718 N.W.2d 461 (Minn.App. 2006), *rev'd*, 738 N.W.2d 300 (Minn. 2007).

[3] *Amicus* briefs were filed on behalf of St. Francis and Wasemiller by the American Medical Association, Minnesota Medical Association, Minnesota Hospital Association, and Minnesota Defense Lawyers Association.

[4] *Larson*, 738 N.W.2d at 303-04.

[5] *McElwaiv v. Van Beek*, 447 N.W.2d 442, 446 (Minn.App. 1989).

[6] *Welsh v. Buler*, 698 A.2d 581, 585 (Pa. 1997); *Pastore v. Samson*, 900 A.2d 1067, 1082 (R.I. 2006).

[7] *Larson*, 738 N.W.2d at 304-05, citing *Sylvester v. Northwestern Hosp. of Mpls*, 53 N.W.2d 17, 20-21 (Minn. 1952) and *Erickson v. Curtis Inv. Co.*, 447 N.W.2d 165, 168 (Minn. 1989).

[8] *Larson*, 738 N.W.2d at 305, citing *Ponticas v. K.M.S. Invs.*, 331 N.W.2d 907, 909-11 (Minn. 1983).

[9] *Larson*, 738 N.W.2d at 306.

[10] *Id.*, citing *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1045 (Ohio 1990); *Corleto v. Shore Mem'l Hosp.*, 350 A.2d 534, 537-38 (N.J.Super. 1975).

[11] *Larson*, 738 N.W.2d at 306.

[12] *Id.* at 306-307 & nn.3 & 4 (citations omitted).

[13] *Id.* at 307 & n.5 (citations omitted).

[14] *Id.* at 309.

[15] *Id.* at 309-10.

[16] *Id.* at 310.

[17] *Id., citing Browning v. Burt*, 613 N.E.2d 933, 1007 (Ohio 1993); *Greenwood v. Wierdsma*, 741 P.2d 1079, 1088 (Wyo. 1987).

[18] *Id.* at 311-12.

[19] *Id.* at 312-13.

[20] There are circumstances in which you might be able to obtain information actually considered by the hospital, such as a case in which a hospital has disciplined a doctor and subsequently transmitted the information to the Minnesota Board of Medical Practice, which later publicizes the information in connection with a disciplinary action against the doctor.

[21] Minn. Stat. § 145.66.

[22] *See, e.g., Wilson v. Barnesville Hosp.*, 783 N.E.2d 554 (Ohio App. 2002); *Pastore v. Samson*, 900 A.2d 1067, 1081 (R.I. 2006).

[23] *In re Fairview*, 590 N.W.2d at 153, citing *Parkway Manor Healthcare Ctr.*, 448 N.W.2d 116, 118 (Minn.App. 1989) (citing *Larson v. Montpetit*, 147 N.W.2d 580, 586 (Minn. 1966).

[24] *See, e.g., Wilson v. Barnesville Hosp.*, 783 N.E.2d 554 (Ohio App. 2002); *Pastore v. Samson*, 900 A.2d 1067, 1081 (R.I. 2006).

[25] 45 C.F.R. § 60.10(a).

[26] 45 C.F.R. § 60.11.

[27] 45 C.F.R. § 60.11(a)(5).

[28] *Welsh v. Bulger*, 698 A.2d 581, 585 (Pa. 1997; *Pastore v. Samson*, 900 A.2d 1067 (R.I. 2006).

[29] Under 45 C.F.R. §§ 60.2 & 60.7-.9, insurers, boards of medical practice, hospitals, and other entities are required to report malpractice payments and the conduct surrounding the payment, board discipline, and adverse

actions on privileges to the National Practitioner Data Bank ("NPDB"). Under 45 C.F.R. § 60.10, hospitals must request this information from the NPDB when a physician initially applies for hospital privileges and every two years thereafter as long as the physician continues to have privileges at the hospital. Any hospital that fails to request the information as required "is presumed to have knowledge of any information reported to the Data Bank concerning this physician."