Recovery Against an Institutional Defendant:

The Negligent Credentialing Claim©

Part 1

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Hospitals, as institutions, have a legal duty to make health care as safe as is possible so that the hospital, through practitioners under its aegis, can offer the standard of care. When the hospitals fails in this regard, a lawyer may consider a negligent credentialing claim where the hospitals did not appropriately credential a practitioner and a direct claim of negligence against the hospital where the institution did not have sufficient policies and procedures, and carry them out, in order to protect patients.

In medical negligence litigation it is important to identify all defendants who caused or created the environment in which the patient sustained injury. If one calls the health care provider the primary defendant; the environment in which the injury occurred, is named the secondary defendant.

Let's start by taking an example from highway safety accidents in order to better understand this concept. One might view an innocent driver in vehicle one, V1, who approaches an intersection and is then struck by vehicle two. In V2, the brakes failed because of a manufacturing defect and there were tree branches which obscured the intersection. Proper defendants for V1 would become V2's driver who drove too fast and who entered the intersection in an incautious manner, but also, the brake manufacturer, V2's maintenance mechanic, and the State (or municipality) which did not cut the trees in order to allow motorists to properly visualize the intersection. V2 may derive defenses from the brake manufacturer, its mechanic, and from the municipality.

The same analysis applies in health care. Dr. A delivers a baby. The baby is injured because Dr. A exceeded his expertise; he is a Family Physician, delivering a large for gestational age baby (fetal macrosomia). Mom has insulin dependent diabetes, has gained 50 pounds in this pregnancy.

Dr. A knows this is a big baby; he ordered a consultation with a Perinatologist the day prior to delivery. The perinatologist warned about macrosomia…but he acted purely as a consultant — not offering obstetric treatment — he did not have privileges at the hospital; St. Victim's. Dr. A did not call for consultation.

The obstetric history is ominous; Baby 1 was macrosomic and the doctor who delivered her was Dr. A's partner who delivered Baby 2 in the same hospital. Because Baby 1 was so large, the partner fractured Baby 1's clavicle in order to extract Baby 1. Dr. A knew of this history — or should have known of this history.

In the second delivery, the first stage of labor was very long; the second stage was many hours … and nothing happened. Dr. A still did not call for obstetric consultation — a practitioner who was located in the hospital or very available within minutes.

Then, slowly, the baby descended, with ominous fetal monitoring parameters, and when the baby passed into the vaginal canal the left shoulder was pinned beneath the public ramus; Dr. A panicked.

Dr. A then tore the baby out of the mother's pelvis, literally ripping a hole up into the mother's rectum … but the hips hug up in the outlet, so he placed one foot on the delivery table and pulled the baby's arms … until delivery occurred.

The baby, Raven, sustained a complete avulsion of the left brachial plexus; mother sustained a fourth degree laceration well into the rectum which the doctor repaired in the delivery room … leaving her with rectal incontinence. Raven is as cute as any four year old but when you look at the videos of her playing with other children and on the monkey bars at school, it is remarkable how well she does with a completely flail left arm … an arm which is of no use other than for cosmetic appearances.

The arm has no muscular tone; the hand is a claw. Mother's injuries are not as apparent but she uses diapers because she has fecal incontinence and, although she would like to date, because of the obvious unappetizing consequences of this medical injury, she has not been able to find a mate.

Who is responsible for this catastrophe? One must look at both the practitioner and the environment which permitted this care to take place.

Dr. A. bears direct liability. He graduated from medical school in 1996 with a Family Practice Residency and then became board certified in Family Practice … but in his credentialing file there is NO documentation of obstetric experience; no documentation of any sort of high risk obstetric experience. He applied to St. Victim's when he graduated medical school in 1996 and underwent re-credentialing every two years. In these processes, 1999, and 2001 (the year in which this occurred), no one asked to see any sort of continuing medical education in obstetrics. In the five year period from medical school to the date of this delivery at the end of 2001, this practitioner took NO obstetric courses of any kind. His CME was primarily slanted to developing his other profit motivated interests in chiropractic manipulation and podiatric care … but no obstetrics.

In the initial credentialing in Obstetrics, the hospital approved level I, normal deliveries; no fourth degree laceration repair; no high risk. Members of the FP credentialing committee included only FP's, NOT Obstetricians…credentialing in another field. Subsequent credentialing never took place. In 1999, the committee did not have any documentation of competence, of continuing competence, and approved privileges again at the same level: basic uncomplicated obstetrics.

This incident occurred at the end of 2001 and this practitioner should have undergone credentialing in July 2001 … but it never got done…until well into 2002 … well after this disaster took place. This practitioner was not credentialed at all at the time of this incident. He should not have been practicing in this hospital at all. He had no privileges since the Bylaws state that all credentials expire two years and two months from the date of the last credentialing. In those extra two months, the practitioner must get his packet together and get credentialed. If no credentials, then no privileges. The hospital had no provisions to enforce this complete breakdown.

Why is Raven unable to play with other children? Why is Mom unable to find a mate? Dr. A's negligence is clear. He exceeded his privileges; ignored his duty to engage in credentialing and to restrain himself from exceeding his level of expertise. He knew or should have known that he needed obstetric consultation. This case took place in a jurisdiction where there is a tort cap and these injuries greatly exceeded that legislative cap. In many jurisdictions there may be no cap against the hospital and, if the violations are sufficiently egregious, punitive damages may become available. After all, the hospital makes a lot of money and when it cuts corners by avoiding patient safety obligations, a jury may not be very sympathetic.

The hospital, however, is also liable. Two claims are available: negligent credentialing; for allowing an unqualified practitioner to practice; and directly hospital liability; where the nurses recognized a dangerous situation and did not respond. When the nurses feared for the patient's life and for the baby's safety, they did nothing. The nurses did not call a supervisor; did not call the chief of staff … did nothing. They did not

have a book which delineated Dr. A's privileges. They were unable to look up his privileges to determine his level of credentialing.

The hospital never sought out any form of recommendations to document Dr. A's obstetric experience and did not require any sort of a demonstration of continuing competence. Had Dr. A called a board certified obstetrician, all would have been well: normal baby; normal Mother.

Discovery against the hospital was thorough. It is crucial to identify those who would be in a position to make a decision to make a difference. One mistake many lawyers make is that they bring a negligent credentialing claim and are then unable to "make it stick" when they are unable to find the personnel who would have made a difference. A court always asks, "How did this person directly and proximately *injure* the patient?" One doesn't injure patients by shuffling papers, a skeptical judge will observe, as he grants the Defendant summary judgment on this issue where there is faulty discovery. The lawyer must find those persons inside the hospital who are responsible for allowing this practitioner to injure this patient and show how their departures from accepted norms injured the patient. Who are they?

In my cases, I always look at "ground zero", where the incident happened, then work outward in the corporate structure, looking for those people who made the decisions. In this case, the unit manager, the floor RN, the treating bedside nurse, had a duty to call the Unit Manager, an RN, when she perceived that a practitioner was engaging in unsafe conduct. Above the Unit Manage was the Director of Nursing (often called DNS). She had a duty to "police" health care provider in actual care on the floor as the care took place.

Then there is the Department Chairman of the [Clinical] Department … in this case the FP's oversaw FP obstetrics, NOT the Obstetric Department … a very dangerous policy and practice. The Chairman of the Credentials Committee who signed off on Dr. A's credentials is responsible for the decision to credential this unqualified doctor. Then, the Medical Staff President, who signed off on the credentials packet, bears responsibility. The hospital CEO & President also signed off on the privilege form; he is responsible. Consider the partnership model; all of these persons are in the "stream of commerce" and all are responsible to the patient.

No one within the Hospital ever demanded any form of demonstration of competence. How many shoulder dystocia cases had this practitioner ever seen, much less handled? NONE!

Discovery is document intensive. One must request the credentialing packets beginning with the first application and any supplements. These are not peer review or protected in any way by privilege. Request all recommendations; any documentation in any form to document obstetric competence.

When a practitioner applies for specialty boards, often there is a list of procedures which the applicant must supply. In this case there was no list to document obstetric experience — this applicant had no significant obstetric experience.

Hospitals have a duty to make the care environment safe. When the institution does not do this, there is liability. The rules on governing the hospital environment derive from hospital JCAHO.[1] Read the manuals; know the rules. Always request copies of all

[1] JCAHO is the Joint Commission on Accreditation of Healthcare Organizations: http://www.jcaho.org. To learn "all about JCAHO: http://www.jcaho.org/about+us/index.htm. "Mission: To continuously improve the safety and quality of care provided to the public through the provision of health care

JCAHO surveys before and after an incident date. Have there been Sentinel Events? Sentinel Alerts? Adverse events? Focus on the practitioner's track record but also look at the hospital's track record. Has this hospital been JCAHO or Medicare / Medicaid decertified? Get state and federal inspections. What happened to this patient constituted a sentinel even yet the hospital engaged in no investigation. When an institution knows of a dangerous situation and does not react, in most cases, a jury will find liability.

Practice Tip: Obtain all policy and procedure manuals; internal regulations. Get Committee minutes.

A lawyer must understand the inner workings of an hospital in order to engage in this sort of discovery. There is, or should be, a chain of command. One plans discovery up and down the chain of command. Look for inconsistencies and absurd interpretations. In discovery, one hospital official had not read the Bylaws, was unaware of the Department policies and procedure manual and did not know whether there was any book or compendium which would contain health care provider's specific credentials. This pattern of ignorance in the hospital environment endangers patients.

Settling cases is always a challenge since many health care practitioners fear reporting to the NPDB.[2] Although the NPDB has been functioning for well over a decade and there are many practitioners who are in the Data Bank. But members, many doctors regard this reporting as a professional scar. When settlement does not include the health

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accreditation and related services that support performance improvement in health care organizations." http://www.jcaho.org/about+us/jcaho_facts.htm.

[2] National Practitioner Data Bank;POB 10832;Chantilly, VA 20153-0832;800-767-6732 (fx) 703-802-4109. The Health Care Quality Improvement Act of 1986; 42 U.S.C. § 1101 *et seq.*; 54 Fed. Reg. 42,722, codified at 45 C.F.R. Pt.60 *et seq.*. (including a requirement of compliance with Medicare statutes at state levels and granting immunity to persons or institutions which participate in peer review activities and created the National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 42 U.S.C.A. § 11131-11137; 45 C.F.R. §§ 60.2-.14.

care provider but the parent institution, the Hospital, it may be acceptable to avoid reporting to the NPDB. One must comply fully with the Act.

Whenever a hospital is involved in a medical scenario, consider adding negligent credentialing and direct hospital liability as causes of action but do not do this when there is no clear conduct which actually injured the patient.

Practice Tip: Many lawyers do not understand the chain of command in an hospital. Hire a knowledgeable health care provider who understands this environment to assist in framing discovery.

Suggested Search terms: “medical negligence” & “negligent credential!” & liability

PART 2:
NEGLIGENT CREDENTIALING:
CASE ANALYSES WITH COMMENTARY©

Introduction:

It is said that "doctors bury their mistakes." At one time that may have been more true than in modern times and when the original peer-review privileges case came out, it seemed as if it may have been more possible to bury culpable behavior in peer-review. That is not the case in modern times.

What is the reason for the change? Courts have been concerned about the learned professions' ability to cover or to obfuscate bad conduct by professional gibberish and deceptive practices. For this reason, courts have recognized the these liability theories and allow the negligent credentialing cause of action.

In general what is the reason that health care within health care institutions is safe? If health care were not, in general, very safe, the consequences would be catastrophic. The patient's assurance that there is safety within the hospital setting is that the hospital itself, under enactment and implementation of JCAHO standards, acts as a gatekeeper and defines the scope of practitioner privileges.

In general, when one attains a license to practice medicine, there is no state placed limit upon what a practitioner may do. An ophthalmologist could, theoretically, perform kidney transplants. The hospital credentialing process is the internal hospital governance which defines and sets individual physicians' scope of practice. Once a practitioner has been "credentialed," a term of art referring to this quality control mechanism, then that practitioner may practice within the limited scope of the grant of privileges.

When a practitioner exceeds the scope of his privileges or where a hospital fails to require the practitioner to adhere to the scope of privileges, then the hospital may be liable for that failure. Additionally, where there is an "outlier", a practitioner who repeatedly injures patients, then the hospital may be liable for its failure to appropriately monitor this physician. These types of conduct form the basis for a negligent credentialing claim against the hospital. The governing process within the hospital has failed and a patient has sustained injury; and the hospital should have prevented this injury by better credentialing.

In florid cases, a negligent credentialing claim may "cost" more than the underlying medical negligence action against the practitioner. Sometimes state tort caps insulate the practitioner; but not the hospital.

In negligent credentialing claims, as a plaintiff, one will notice that, in general, the more valid is the potential claim (i.e.- culpability), the harder the defense will fight to exclude or to torpedo, in some way, the claim. "The lady doth protest too much," to paraphrase Shakespeare.

Two Illustrative Cases:

Larson v. Wasemiller, 718 N.W.2d 461 (Minn.App.,2006) is a case in which the plaintiff added claims for negligent credentialing and "negligence in a joint venture." The Medical Center moved to dismiss arguing that Minnesota did not recognize the claims of either negligent credentialing or of negligent privileging. Further, the Defendant argued that Minn.Stat. § 145.63, subd. 1 limited the liability for a review organization and sought to protect much of the information the plaintiffs would need to prove its claim by invoking peer-review privilege under Minn.Stat. § 145.63.

In addition, the defense claimed that the physician and the hospital engaged in a joint enterprise and that the hospital should be liable on agency theory. The trial court denied; certifying two negligent credentialing questions to the appellate court where that court observed that this issue represented a novel question in Minnesota.

In Minnesota, is there a common law cause of action for either negligent credentialing or negligent privileging against a hospital or any other review organization?

The trial court concluded that there was such a cause of action. If so, is there some sort of institutional immunity which would limit liability under the Minnesota peer review statute, Minn.Stat. § § 145.63-.64? The trial court concluded that there was no immunity. 718 N.W.2d 461, 464.

This case involved a bariatric surgery in which the plaintiff sustained injury. The defendants operated in the Hospital under a grant of privileges which permitted them to perform these technical surgeries. The complaint asserted "that the hospital knew, or should have known, before" surgery one doctor "posed an unreasonable danger of harm to bariatric surgery patients at the hospital and that the hospital breached its duty to … [plaintiff] by granting privileges to" this physician.

Then, granting the privileges caused the patient injury because the doctor proceeded to injure her by various departures from the standard of care. 718 N.W.2d 461, 465. Note, that since this case presented a legal issue of first impression for review — whether a claim exists — the court applied *de novo* review, rather than abuse of discretion. Id.

Upon review, the appellate court examined the inherent powers of the court versus the legislature in creating new causes of action. 718 N.W.2d 461, 466.

The Court wrote:

> The springboard for adoption of the tort of negligent credentialing or privileging independent physicians has been case law permitting the employer of negligently retained independent contractors to be held directly liable to persons injured by such contractors. Id.

There is balance between judicial powers and legislative powers in creating torts. In declining to recognize this tort the appellate court concluded:

> The proposed recognition of a negligent credentialing or privileging tort represents a significant change in the law that should not be accomplished without considering (1) implications for other areas of law; (2) the effect of such a tort on the strong policy of confidential peer review evidenced in sections 145.61-.66; (3) resolution of issues such as whether the cause of action is dependent on a finding of medical malpractice; and (4) whether trials for negligent credentialing or privileging can fairly be combined with medical-malpractice actions. Neither a trial court nor an intermediate appeals court is in a good position to fairly and exhaustively consider the complex policy concerns involved. Even the supreme court may determine that the matter would be best handled by the legislature. 718 N.W.2d 461, 467-68.

Further, this intermediary court found inviolate the confidentiality and immunity within the Minnesota Peer Review Statute. 718 N.W.2d 461, 469-70. While there may not be immunity for negligent credentialing or privileging actions, "Section 145.64 limits the evidence that could be used to support or defend against such a claim in a manner that appears to affect the fundamental fairness of recognizing such a claim as the most

effective means of monitoring the credentialing or privileging process." 718 N.W.2d 461, 470.

Another case expands upon the nature of the peer-review privilege in the context of a negligent credentialing claim. In Rhode Island, Pastore v. Samson, 900 A.2d 1067 (R.I. 2006), that state's high court engaged in an exemplary analysis.

In Pastore, the plaintiff sought 750 pages of documents relating to one of its doctors. The hospital resisted by asserting peer review privilege, protected by Rhode Island statutes. In this medical negligence case, a wrongful death action, the plaintiff alleged a negligent credentialing claim. 900 A.2d 1067, 1071. A "discovery mêlée" began when the plaintiff served her third request for production of documents relating to the doctor's credentialing. Id.

The request included: "(1) information related to the credentialing or privileges" of the two defendants; "(2) documents sent to" the defendants "by any committee investigating or reviewing his request for, or renewal of, privileges;" and "(3) all items setting forth any limitation upon the privileges or credentials of" the defendants. What of this Request is protected? 900 A.2d 1067, 1071.

The hospital objected on peer-review privilege grounds and a justice sustained the hospital's objection but gave it 30 days to compile a privileges log; a compendium of documents. 900 A.2d 1067, 1072.

The hospital produced some documents as well as a log of those documents not produce and two and one half years passed; plaintiff compelled several more time. The hospital sought to quash and a protective order. Again the hospital submitted a second supplemental privilege log itemizing some 750 pages of documents and asserted four

bases for its position that all of this was privileged: peer-review, confidential health-care information, board of medical licensure and discipline, and attorney-client. Id.

The hospital then tried to sever the causes of action; denied … and granted the plaintiff's motion to compel production of documents but the judge would subject these documents to *in camera* inspection prior to release.

Practice Tip: When making these sorts of requests, as for *in camera* inspection. *In camera* inspection allows the judge to review the documents for relevancy and the judge decides if the opposing side will be permitted to examine these documents. In "heated" litigation, it is a good idea to request *in camera* inspection. This may allow the judge to feel secure in maintaining control over the litigation rather than risking a "knew-jerk" denial because the court feels the documents are "too confidential."

Here, the judge decided to sort the documents into four categories:

(a) documents that clearly were privileged; (b) documents that clearly were unprivileged; (c) documents of a questionable nature that the hospital needed to clarify; (d) and those that contained an individual's confidential information. 900 A.2d 1067, 1072.

This sorting scheme provides insights to the court's sensitivities of the kinds of information it may or may not release.

In terms of negligent credentialing, even if there were "protected health care information," that information could be redacted if there were other data which could be released.

In this case, following review, the court released 750 pages of these documents to the plaintiff; omitting personal information such as social security numbers or other patient information which would not advance the claim, one way or the other.[3]

In the trial court's opinion, the judge "did not consider information that was not 'generated in the peer review process,' such as a patient complaint, to be protected by

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[3] Precisely what did the plaintiff seek? "3. All documents, paper or digital, that set forth any limitation upon the privileges and/or credentials of Charles Samson, M.D., including but not limited to:
a. Disciplinary action;
b. Administrative action;
c. Voluntary action;
d. Limit to privileges[;]
e. Suspension of privileges;
f. Revocation of privileges;
g. Revocation of appointment;
h. Resumption of privileges[;]
i. Leave of absence without privileges;
j. Resignation of privileges;
k. Requirement of supervision[.]
"4. All information received in the course of reviewing the credentials and/or privileges of Richard San Antonio, M.D., from the time Dr. San Antonio first requested privileges to date, including but not limited to all applications for privileges, all communications received from the Rhode Island Board of Medical Licensure and Discipline and all letters from Dr. Samson [sic] and/or others.
"5. Any and all documents of any kind sent to Dr. San Antonio by any committee or board investigating and/or reviewing his request for privileges and/or renewal of privileges, from the time Dr. San Antonio first requested privileges to date.
"6. All documents, paper or digital, that set forth any limitation upon the privileges and/or credentials of Richard San Antonio, M.D., including but not limited to:
i. Disciplinary action;
ii. Administrative action;
iii. Voluntary action;
iv. Limit to privileges[;]
v. Suspension of privileges;
vi. Revocation of privileges;
vii. Revocation of appointment;
viii. Resumption of privileges[;]
ix. Leave of absence without privileges;
x. Resignation of privileges;
xi. Requirement of supervision." Id.

that privilege." Id. Don't forget that in this context "peer review" is very narrowly defined by the HCQIA[4] (Health Care Quality Improvement Act). Following the *in camera* review "the only document that the motion justice referred to expressly … was a transcript-numbered … in the hospital's second supplemental privilege log-that she determined was not privileged because it only related to quality control "in the broadest sense of the term [ ]." 900 A.2d 1067, 1073.

The Rhode Island Supreme Court carefully examined the nature of the peer-review privilege in the context of a negligent credentialing claim.

Rhode Island recognizes very strict peer-review privilege, 900 A.2d 1067, 1075, subject to some limitations:

> "[(1) A]ny imposition or notice of a restriction of privileges or a requirement of supervision imposed on a physician for unprofessional conduct * * * shall be subject to discovery and be admissible in any proceeding against the physician for performing, or against any health care facility or health care provider which allows the physician to perform the medical procedures which are the subject of the restriction or supervision during the period of the restriction or supervision or subsequent to that period[; (2)] Nothing contained in this section shall apply to records made in the regular course of business by a hospital or other provider of health care information [; and (3)] Documents or records otherwise available from original sources are not to be construed as immune from discovery or used

[4] The Health Care Quality Improvement Act of 1986; 42 U.S.C. § 1101 *et seq.*; 54 Fed. Reg. 42,722, codified at 45 C.F.R. Pt.60 *et seq.*. (including a requirement of compliance with Medicare statutes at state levels and granting immunity to persons or institutions which participate in peer review activities and created the National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 42 U.S.C.A. § 11131-11137; 45 C.F.R. §§ 60.2-.14.

> in any civil proceedings merely because they were presented during the proceedings of the committee." Id.

There is a general rule of privilege which this case follows. Privilege is a sword; never a shield and one my not avoid the legal process cowering under the privilege shield. While Rhode Island protects "all records and proceedings" before the peer-review board" Id., it protects only "only the records and the proceedings which originate with the peer-review board;" NOT other forms of information. Id. A defendant must answer interrogatories and must provide names of those who served on the peer-reviewing board; and answer whether "a hospital ever had "restricted, revoked, or curtailed" hospital staff privileges. Id.

In general, the law does not favor privilege and "this immunity from discovery is in derogation of both common-law and the general policy favoring discovery." Id. In Rhode Island, "[t]he burden of establishing entitlement to nondisclosure rests on the party resisting discovery." Id.

Thus:

> The public purpose of the peer-review privilege is not served when "the privilege created in the peer-review statute is applied beyond what was intended and what is necessary to accomplish the public purpose." … "The privilege must not be permitted to become a shield behind which a physician's incompetence, impairment, or institutional malfeasance resulting in medical malpractice can be hidden from parties who have suffered because of such incompetence, impairment, or malfeasance." [citations omitted] Id.

The Rhode Island Supreme Court then "drew the line" between that which is properly privileged and that which becomes discoverable in a medical negligence negligent credentialing cause of action. 900 A.2d 1067, 1076.

Now the stage is set and here the court struggled with the legal *stare decisis* doctrine. Could it; should it, buck the *status quo* which protects the volume of in hospital proceedings or should it allow the plaintiff to learn the hospital's innermost and protected secrets; each side having excellent arguments for its position? The tension builds…

Perhaps the most important and familiar argument for *stare decisis* is one of public legitimacy. The respect given the Court by the public and by the other branches of government rests in large part on the knowledge that the Court is not composed of unelected judges free to write their policy views into law. Rather, the Court is a body vested with the duty to exercise the judicial power prescribed by the Constitution. An important aspect of this is the respect that the Court shows for its own previous opinions." [citations omitted] 900 A.2d 1067, 1077.

It is important here to parse these statutes. The hospital wanted to protect documents which "originate" in the peer-review process; but that word does not appear in the statute. Id. The statutes protect "only" "records" and "proceedings" of peer-review boards but the statutes do not protect "[d]ocuments or records otherwise available from original sources." [citations omitted] Id. The statutes provide that "[c]onfidential health care information discoverable or admissible from original sources shall not be construed as immune from discovery or use in any proceeding." Id. Note, too, that "both statutes also include other limitations on the scope of the privilege that pertain to information generated by entities other than a peer-review board." In fact, there is an exemption for

"records made in the regular course of business by a hospital or other provider of health care information." Id. A witness before a peer-review board may not be prevented from testifying about matters with that witness' knowledge although the testimony at the peer-review board would be privileged.

The hospital argued that the statutes were "remedial" in nature and thus entitled to a liberal construction, 900 A.2d 1067, 1078, but the Court did not accept that analysis since any legislation is to be strictly construed. Id. In fact, in the preamble to the legislation, state policy is to "promote free flow of information between health care providers," and peer-review and disciplinary organizations in the health care field. Id. The Court interpreted such a potential limitation with skepticism and sided with the ascertainment of truth. Id.

In this case there was a question about the quality of medical care and the doctor's "bedside manner."

> The peer-review privilege was designed to alleviate an increase in medical malpractice lawsuits for substandard health care, not to reduce the number of rude or uncompassionate health-care professionals-although the latter is certainly a commendable objective. 900 A.2d 1067, 1079.

The Court released the transcript of the hospital committee meeting, 900 A.2d 1067, 1080, since the meeting concerned beside manners and not quality of medical care, rejecting the hospital's argument for broad construction. On the other hand, where there was a quality of care meeting, the Court protected this information, stating, "The meeting, therefore, clearly fits within the definition of a peer-review board because it pertained to whether health-care services "were performed in compliance with the

applicable standard of care." Id. The Court also protected a report summarizing the key items discussed at this meeting since it is a "record" of a peer-review board; thus protected by the peer-review privilege. Id.

One problem the hospital encountered upon judicial review was that it was indefinite in its brief in the identification of documents it wanted protected; citing a class of document; not letter specific. Id.

There is no privilege as to documents gathered from original sources. 900 A.2d 1067, 1081.

To what degree is hospital peer-review privilege incompatible with a negligent credentialing claim? 900 A.2d 1067, 1082. The court differentiated between a *respondeat superior*, corporate negligence, claim and a negligent credentialing claim.

A hospital may liable "for the failure to exercise reasonable care in hiring" one of its employees or in extending staff privileges to a doctor. Such a failure occurs when a hospital selects a person "unfit or incompetent for the employment, thereby exposing third parties to an unreasonable risk of harm." Id.

In this context the plaintiff must show that the hospital had actual or constructive knowledge of the defect" which injured the patient. Id. That being noted, the Court analyzed further, stating "we fail to see precisely how the privilege protecting the "proceedings" and "records" of a peer-review board disrupts a patient's ability to bring a corporate negligence claim against a health-care provider." Id. Whether a doctor's privileges have undergone sanction is not protected by peer-review. Patient complaint are not privileged as peer-review, perhaps most important, a hospital may not bury a patient complaint in privilege, making it undiscoverable by including the complaint to a peer-

review board. Id.

> To summarize, a plaintiff asserting a claim of corporate negligence against a health-care provider is entitled to discovery of patient complaints, even when those complaints lead to peer-review proceedings and ultimately to any possible limitations or restrictions placed on a doctor's privileges. Using that information and other relevant and unprivileged information, a plaintiff then must cultivate his or her claim that the health-care provider has hired or retained an incompetent or unfit employee and that the provider had actual or constructive knowledge of that incompetence or unfitness. 900 A.2d 1067, 1082-83.

Discussion:

State privilege and peer review statutes may create harsh results: no claim; immunity. Or, on the other, hand the Plaintiff may be entitled to inquire where there have been significant hospital concerns about a practitioner. These questions are state specific and one must anticipate the law in that state. Often, even without a negligent credentialing cause of action, it may be possible to show that the system breakdown created the negligent conditions which injured the patient and a jury will find liability against the practitioner on that basis. The practitioner did not heed the STOP sign.

One of the problems with bringing a negligent credentialing claim is that to get at the information — the hospital is negligent — one rubs dangerously close to peer review materials which my be confidential; or which the hospital will try to retain as confidential.

Do not lose the forest for the trees; thus, an important final point. Litigation's ultimate purpose is making money; not about "making law." Sometimes, however, one must "make law." When one attempts to bring a novel claim such as may be a negligent credentialing claim, one may wind up in the appellate court, as do these case, rather than settling the case. In some case, there is no alternative; either you "go there" or the cause of action is dismissed.

In what circumstances are negligent credentialing claim improper or impossible? First, when there is a private organization or entity, not JCAHO certified, not operating under state color, or a very small entity where they do not "credential", these claims will not succeed. That being said, where an organization does credential and does have bylaws, courts will require the entity to follow its own rules.

Once again, privilege is a sword; never a shield. Peer-review does not protect discovery of a fact; just the exact record of a peer-review proceeding properly convened. A party may not bury wrongdoing along with the patient mistakes which injured the patient.

Abbreviated CV Vers. Vers. 1.05.06

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- **Education**

1965 **Pennsbury High School**, Yardley, Pennsylvania

1969 **B.A**. **Occidental College**, Los Angeles, California 9/65-6/69

1973 **M.D**. **University of California, Irvine, School of Medicine**
Irvine, California 9/69-6/73 [with Clinical Clerkships at Oxford University (thoracic surgery) Harvard University (general surgery), Stanford University (cardiovascular surgery)]

1973-1974 **University of Washington** affiliated hospital -
7/73-6/74 **Providence Hospital**, Seattle, WA Surgical Internship (PGY-1)

1974-1975 **University of British Columbia**, Vancouver, BC, Canada
7/74-2/75 Vancouver General Hospital Surgical Residency - (6 months)

1995 **J.D.** **Michigan State University College of Law; E. Lansing, MI**
8/92-6/95 [formerly Detroit College of Law, Detroit, MI]
Recipient: Jurisprudence Prize in Constitutional Law

1993-summer school **University of Washington, School of Law**
Seattle, Washington

1995-summer school **Wayne State University, School of Law-**
Detroit, Michigan

1996 LL.M. HEALTH LAW **Loyola University School of Law**,
Chicago, Illinois

- *Thesis*: ***BEFORE AND AFTER:*** **Spoliation of Evidence in Medical Negligence Litigation**
- **Supervising Editor- Journal of the National Association of Administrative Law Judges**
- Note, *Calvin v. Chater: The Right to Subpoena the Physician in SSA Cases; Conflict in the Circuits over the Interpretation of 20 C.F.R. 404.950(d)(1)*, 15 J. NAT. ASSOC. ADMIN. L. JUDGES 143 (1996).

- **CURRENT**

CEO/President- coMEDco, Inc. - a *national* corporation specializing in *medical-legal analysis*, expert referral, medical and legal litigation related research including evidentiary problems, research support, discovery, and trial consultation in advocacy techniques and strategy.

- **MEDICINE**

Family Practice and Emergency Medicine- 18 years active practice (1974-1992); *formerly* BOARD CERTIFIED **American Board of Family Practice**, Diplomate No. 18445; ACLS, APLS, ATLS Certifications; Former Member ACEP, AAFP, AMA. Formerly licensed in California and Washington.

SIGNIFICANT MEDICAL-LEGAL CONSULTATION PROJECTS

1. *State v. Johnson*, No. 97-1-01564-9 SEA, SUP. CT. WA. (King Co., WA) (1997) - criminal defense of plastic surgeon charged with multiple felony counts of inappropriate conduct with patients. Convicted on only one misdemeanor count. (in consultation with Ms. Julie Spector, Attorney at Law of Seattle, WA).

2. *Cherukuri v. Shalala,* 175 F.3d 446, *(6th Cir. 1999)*- achieved dismissal of charges in defense of physician accused of violation of EMTALA. The doctor was fined $100,000! (in consultation with Mr. Chad Perry, Attorney at Law, Paintsville, KY) before the Departmental Appeals Board, Washington, DC - wrote both EMTALA appeal before DAB and the brief for United States Court of Appeals for the Sixth Circuit). ("We respectfully suggest that the Board should review cases like this one closely and should not simply pass them on to a federal appellate court without providing a reasoned disposition of the objections raised by the parties." 175 F.3d 446, 455).
3. *Annon. v. Annon.*, Dallas, TX (confidentiality agreement) (1999): $3.85 million recovered in medical negligence case concerning brain injury. Permissible details upon request. (in consultation with Ms. Alicia Slaughter, Attorney at Law, Dallas, TX).
4. *State v. Hudson*, Sedgewick Co. Dist. Ct. No. 00CR1399 (Wichita, KS) (2001) – criminal defense of man charged with child abuse / first-degree murder- acquittal on all charges. (in consultation with Mr. L.J.Leatherman, Topeka, KS).
5. State v. Ocaño, Pima Co., Tucson, AZ (Tucson, AZ) (2003)- defendant accused of CSC with 3 year old- acquittal. (in consultation with Mr. Jeff Buchella, Tucson, AZ).
6. Tornaquindici v. Keggi, 94 Conn.App. 828, --- A.2d ----, 2006 WL 941959 Conn.App. 2006, (April 18, 2006). (Complex litigation docket. Orthopedic surgeon required to pay plaintiff $557,000. Upheld on appeal. Mr. Paul Levin, Attorney at Law of Hartford, Connecticut).

Recent Medical or Law Publications

- *New JCAHO Standards to Create Affirmative Duty to Disclose Hospital Error*, 4 TRAUMA 79 (December 2004).
- *May the Police Practice Medicine?*, 8(1&2) J. MED. & LAW 35 (Fall 2003-Spring 2004).
- *Nursing Home Litigation: A Primer for Trial Lawyers*, 6(2) J.MED.L. 81 (2002).
- *Idaho Locality Rule in Medical Negligence Litigation: Grover v. Smith*, 31(2) IDAHO TRIAL LAWYERS ASSOC. J. 33, (2002).
- *New Standards Require Doctors to Admit Mistakes in Care*, NEW MEXICAN, July 2, 2001, B-1.
- *The Law and Ethics of Web Prescribing*, HIPPOCRATES, 44 (September 2000).
- *The Weighted Analysis of Medical Malpractice Cases*, 46(3) MED. TRIAL TECH. Q. 263 (2000).
- *New Rules on Electronic Records: HIPAA's Proposed Patient -Privacy Standards Focus on Principles*, HIPPOCRATES 22 (January 2000).
- *Staying out of Court: Cost-Free ways to Risk-Proof your* Practice, HIPPOCRATES 26 (December 1999).
- *The Law of Evidence and the Medical Record*, 2(2) J.MED.L. 167 (1999).
- *Released Against Advice*, HIPPOCRATES 20 (September 1998).
- The *Medical Record: A New Mexico Lawyer's Litigation Guide*, 4(2) BAR J. (NM) 15 (Summer 1998)
- *When Doctors Doctor the Doctor's Record: Spoliation of Evidence*, 26 N.M. TRIAL LAWYER 1 (1998).
- *A Doctor's Perspective on what the Law Should be for End-Of Life Issues*, 2(1) J.MED.L. 11 (1997).
- EMTALA: *Its First Decade; A Retrospective Analysis of 42 U.S.C. § 1395dd*, 43(4) MED. TRIAL TECH. Q. 77 (1997). Listed: http://www.uplaw.net/articles.htm.
- *Scoping Out the Medical Record: The Key to Understanding Medical Care*, 51 WA. ST. B.J. 22 (1997)
- *A Review of the Emergency Medical Treatment and Active Labor Act*, 85 ILL.BAR J. 212 (1997).
- *The Baseline: Detecting the Doctored Medical Record*, 14(1) Medical Malpractice Law & Strategy 1 (November 1996).
- A *Trial Lawyer's Guide to the Medical Record*, 84 ILL. BAR J. 637 (1996).

- *The Risks of Doctoring Records*, HIPPOCRATES 34 (September 1996).
- Note, *Calvin v. Chater: The Right to Subpoena the Physician in SSA Cases; Conflict in the Circuits over the Interpretation of 20 C.F.R. 404.950(d)(1)*, 15 J. NAT. ASSOC. ADMIN. L. JUDGES 143 (1996).
- Honorable Mention- National Writing Contest of International Association of Defense Counsel (1995) for *Physicians Against Their own Patients: What Happened to the Privilege?* 63(2) DEF. COUNSEL J. 254 (1996).
- *The Trial Lawyer's EMTALA Manual*, 11(4) PROF. NEG. L.REP. 73 (1996).
- *EXAMINING MEDICAL RECORDS: How to Know What is Said When you Read What the Doctor Wrote*, 82 ABA J. 88 (1996).
- *Keeping it on the Record*, 28(2) EMERGENCY MEDICINE 87 (1996)
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- *The Medical Record Explained, 6(3) OHIO TRIAL 7-12 (1995).*

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- Brad Burg, *Fined $100,000 for Dumping Patients he Couldn't Treat*, MEDICAL ECONOMICS 112 (November 22, 1999) (reporting the *Cherukuri* case).
- Tanya Albert, *Take care with patient e-mail policies: Electronic communication can enhance doctor-patient relationships, but already familiar legal traps lurk in the new revolution: privacy, malpractice and accuracy of information*, AMA NEWS (Jan. 22, 2001) at http://www.ama-assn.org/sci-pubs/amnews/pick_01/prsc0122.htm.
- Internet Pharmacy: Medicine's Third Rail; reviewed; http://www.natmedlaw.com/July%202000/internet_pharmacy.htm

PRESENTATIONS / TALKS:

- Brain Fingerprinting: Is it *Daubert*-Proof? 02 May 2001 – Harvard Medical School, Department of Psychiatry, Forensic Research Group; Cambridge, MA.
- Prescribing Psychologists Registry, Psychopharmacology- Los Angeles, CA - 14 hours; 2-3 March 2003.
- The Law of Prescribing Medicines, New Mexico Psychologists- Las Cruces, NM, 10 November 2002.
- New Mexico Public Defender Association Annual Meeting: The Offensive Use of Medical Record in Criminal Defense; Albuquerque, NM, 21 October 2005.

PERIODIC COLUMNS:

- Lexis Law Publishing: R_x Law & Medicine Report, Quarterly (1998-2002).
- Leader Publishing / New York Law Journal Publishing: Medical Malpractice Law & Strategy, Monthly (1997- present).

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EMTALA:** ***Its First Decade - A Retrospective Analysis of 42 U.S.C. § 1395dd **©** (Terra Firma, Santa Fe, NM 1996) (ISBN# 1-930263-00-7) 65 pages, 250 footnotes.

BEFORE AND AFTER:** ***Spoliation Of Evidence In Medical Negligence Litigation **©** (Terra Firma, Santa Fe, NM 1996)(ISBN# 1-930263- 03-1) 175 pages; 600+ footnotes

***The Law of Evidence and the Medical Record©** (Terra Firma, Santa Fe, NM 1997) (ISBN# 1-930263-01-5) 115+ pages; 325+ footnotes

*** SCIENTIFIC EVIDENCE IN PERSONAL INJURY LITIGATION: *DAUBERT*'S GHOST©** (ISBN# 1-930263-04-X) 240 pages; 900+ footnotes.

*Books/ Treatises / Chapters

MASTERING VEHICLE INJURY CASES: 500 pages (Litigation One Irvine, CA 2005) (Discussing the medical legal interface in this area of law.) To order: Litigation One 888-577-3771; http://www.litigationone.com

LAWRENCE NORDHOFF & ELLIOTT B. OPPENHEIM, **VEHICLE INJURY: DEPOSITION AND TRIAL QUESTIONS** (Litigation One 2003). (422 pp.) To order: Litigation One 888-577-3771; http://www.litigationone.com.

THE MEDICAL RECORD AS EVIDENCE, 900 pages, (Lexis Law Pub. Co., Charlottesville, VA 1998) (2003 supplement) (ISBN# 1-55834-889-1) *The definitive work in the field of medical evidence*. To order direct from Lexis Law Publishing: 800-562-1197; item # 66063; listed: in Evidence Law at: http://www.law.seattleu.edu/information/startingpoints/evidence.html.

in David W. Louisell & Harold Williams, *Evidence and Spoliation in Medical Records*, ch. 36, MEDICAL MALPRACTICE (Matthew Bender 2003) ISBN: 0820513709; 100 pages.

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