Peer Review in the Courtroom: How a Jury Views the Work of Your Medical Staff Office and Medical Staff

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Peer Review in the Courtroom
How a Jury and Judge View the Work of the Medical Staff and Your Medical Staff Services Office
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What We Will Cover Today
• Types of medical malpractice lawsuits
• Negligent credentialing/peer review claims
• Hospital and medical staff office duties
• The impact of peer review confidentiality
• Medical staff information typically disclosed in a medical malpractice action
• What the defense wants; what the plaintiff wants
• Case study – with you as the jury
• Questions/Take-Aways

Types of Medical Malpractice Lawsuits
• In every medical malpractice lawsuit, the plaintiff must prove that:
  – The defendant had a duty of care to the patient
  – The defendant breached that duty (was negligent/committed malpractice)
  – The breach caused harm to the patient
• The defendant, specific claim, and damages vary based on the facts of the case.
Types of Medical Malpractice Lawsuits

Generally, 4 types of medical malpractice suit:

1. Suit against the physician or other practitioner alleging negligent care
2. Suit against the hospital alleging direct negligence in its care of the patient
3. Suit against the hospital’s agents alleging negligence by the in their care of the patient
4. Suit against the hospital alleging negligent credentialing or peer review of the practitioner who negligently cared for the patient

1. Suit Against the Physician for Negligence

Aggrieved patient/family members sue the patient’s physician(s) alleging negligent treatment

- Hospital is not a defendant
- But hospital personnel involved in the patient’s care are affected
  - Depositions, trial testimony as fact witnesses
- Medical staff office is not directly affected
  - But the lawsuit may trigger peer review
  - Or the lawsuit may trigger professional board review, which may trigger peer review and requests for peer review documents
2. Suit Against the Hospital for Direct Negligence

Aggrieved patient/family members sue the hospital for direct negligence in its treatment of the patient

2. Suit Against the Hospital for Direct Negligence

- Alleged negligence:
  - by hospital's employees, including nursing, employed physicians
  - equipment malfunction
  - Failure of a hospital system
- When the hospital is directly negligent, no need to sue for negligent credentialing/peer review
- Medical staff office typically is not affected
  - But if the employee is a physician, there may be later peer review, professional board action

3. Suit Against the Hospital Based on Negligence of its Agents

- Alleged negligence by
  - Persons or entities the hospital has granted authority to act on the hospital's behalf
  - Grant of authority may be by word or deed
  - Hospital control over the agent
  - Includes non-employees if they are acting on the hospital's behalf
- A medical staff member's care for a patient in the hospital does not automatically mean the practitioner was the hospital's agent
3. Suit Against the Hospital Based on Negligence of its Agents

Agency may be **actual** or **ostensible**

- **Actual Agency:**
  - Is the non-employed medical staff member acting on behalf of the hospital? Does the hospital exercise control? If so, she is the hospital’s actual agent

- **Ostensible agency:**
  - Does the patient reasonably believe the doctor is the agent of the hospital? If so, the doctor is the hospital’s ostensible agent

3. Suit Against the Hospital Based on Negligence of its Agents

**Actual Agency:**
Actual agency requires hospital control. With OPPE/FPPE, physician report cards and practice protocols, plaintiffs will increasingly argue that the hospital has control.

**Ostensible agency:**
Does the patient reasonably believe the doctor is the agent of the hospital because she is:
- wearing a name badge with the hospital’s name and logo on it?
- Wearing a lab coat with the hospital’s name and logo on it?
- The assigned physician on call to the emergency department?
- Listed in the Hospital’s website as a surgeon?

• If the doctor is the hospital’s actual or ostensible agent, hospital is directly responsible for the doctor’s negligence
• The increase in hospital-employed physicians means an increase in direct/agency liability – and may bring a corresponding decrease in negligent credentialing/peer review claims
4. Suit Against the Hospital for Negligent Credentialing/Peer Review

- Aggrieved patient/family members sue the hospital for:
  - negligently credentialing the negligent treating physician(s)
  - insufficient/ineffective ongoing peer review of the negligent treating physician(s)

4. Suit Against the Hospital for Negligent Credentialing/Peer Review

- Most physicians have 1M/$3M policy limits
- Means a big incentive for the plaintiff to sue the "deep pocket"
- Especially when malpractice reform makes it ever harder for plaintiff to win

4. Suit Against the Hospital for Negligent Credentialing/Peer Review

Hospital is liable for negligent credentialing/peer review if the plaintiff proves:

1. A medical staff member negligently treated the patient in the hospital, causing harm
2. The hospital owed the patient a duty to perform reasonable credentialing/peer review sufficient to keep the patient safe
3. The hospital breached that duty by granting privileges or failing to adequately supervise the physician
4. The breach caused harm to the patient
4. Suit Against the Hospital for 
Negligent Credentialing/Peer Review

In other words: The malpractice plaintiff must prove that the hospital knew or should have known the physician was not competent to treat the patient in question.

... And but for the hospital’s negligent credentialing/peer review, the physician would not have negligently treated the patient.

In more others words: The patient or family must demonstrate that if the Hospital had properly credentialed /peer reviewed the physician, he or she would not have been a medical staff member or had privileges to treat the patient.

Sounds almost impossible to prove, huh! Don’t be so sure...

Hospital’s Duties

- Hospital has a duty to have a process which provides:
  - that only professionally competent physicians are credentialed and granted medical staff privileges; and
  - that physicians on staff continually provide care in accordance with accepted and established medical practices.
Suit Against the Hospital for Negligent Credentialing/Peer Review

- State laws/CMS/TJC/many state laws require delegation of credentialing/peer review to the medical staff
- But hospital board makes the final decisions: the buck stops at the hospital

The Impact of Peer Review Confidentiality

Credentialing/peer review information is confidential to some extent in most states

In Arizona, for example:

- All proceedings, records and materials prepared in connection with peer reviews, including all peer reviews of individual health care providers practicing in and applying to practice in hospitals or outpatient surgical centers and the records of such reviews, are confidential and are not subject to discovery...
- No member of a committee or any person furnishing information to a committee performing peer review may be subpoenaed to testify in any judicial or quasi-judicial proceeding...

The Confidentiality Conundrum

How is the plaintiff to prove his or her claim of negligent credentialing/peer review when the credentials/ongoing peer review files are confidential and not subject to discovery?

... and how is the hospital to defend itself when peer review confidentiality prevents it from disclosing the good work its medical staff has done?
Limits of Peer Review Confidentiality

- Fact that information is in the credentials/peer review file may or may not insulate non-confidential information from discovery
- Non-traditional peer review venues may be more difficult to fit into the confidentiality rubric
  - Root cause analyses, M&M conferences, system-wide quality review, data, report cards

The Impact of Peer Review Confidentiality

Peer review confidentiality can both help and hurt the hospital in a negligent credentialing/peer review suit

Medical Staff Information Typically Disclosed

- The hospital defends itself by presenting non-confidential information to the jury to show that the hospital (via the medical staff) acted reasonably
Medical Staff Information Typically Disclosed

- The hospital must decide whether or not to defend the doctor's care in the case at issue
  - If the jury finds that the doctor was not negligent, the negligent credentialing claim fails automatically
- If the doctor's conduct was negligent, the hospital must show that:
  - The doctor's conduct was not something the hospital had a duty or ability to foresee
  - The hospital took appropriate peer review action with respect to the doctor

Medical Staff Information Typically Disclosed

- The core non-confidential information used to defend the hospital: good processes
  - Good processes: Bylaws, rules and regulations, policies, expert testimony
  - “Good” = compliant with CMS, state rules, TJC
  - Hospital shows that it followed its processes by presenting fact witnesses to testify that medical staff practice was to follow its bylaws, etc., and expert witnesses to confirm the process is reasonable

4. Suit Against the Hospital for Negligent Credentialing/Peer Review

Medical staff services makes sure proper processes are followed!
- Ensure all appropriate credentialing information is gathered
- Highlight all concerns in the file
- Ensure that concerns are addressed by the committee
- Ensure that ongoing peer review is occurring in accordance with governance documents
- Prepare chronology of all concerns and actions
- Attempt to expedite reviews
- Raise concerns
  - Discuss concerns about applicant/staff member with Department Chair, Chief of Staff, CMO
  - Raise with the CEO if necessary
- Keep up with new developments
Medical Staff Information Typically Disclosed

- The hospital also defends itself with positive facts about the hospital
  - Joint Commission or other agency accreditation
  - Honors, awards for quality, magnet status, etc.

- And the hospital defends itself with positive facts about the physician:
  - Education, training, employment
  - Awards, society memberships, publications
  - Previous employment
  - Previous/other hospital medical staff membership
  - Board certification
  - Professional board record
  - Restrictions on privileges at other hospitals (or none)
  - History of malpractice cases (or none)
  - Armed forces service, charity work, good deeds generally

- Dates of credentialing/peer review meetings
  - Hospital may use dates to demonstrate that it followed its bylaws and met its peer review duties
  - Plaintiff may use dates to demonstrate pattern of delay, or rush to decision
Negligent Credentialing/Peer Review:
Key Duty of Reasonable Review & Action

- Jury assumes that in credentialing, a thorough, lengthy analysis should be done; but in ongoing peer review, a hospital should "fire" a physician right away
- BUT: Too-typical peer review
  - Month 1: initial review of poor outcome
  - Month 2: full committee review
  - Month 3: invite physician for an interview
  - Month 4: interview rescheduled because of summer vacations
  - Month 5: concerns forwarded to MEC, which initiates investigation
  - Month 6: investigation
  - Month 7: physician interview; adverse recommendation to MEC
  - Month 8: MEC meeting cancelled
  - Month 9: MEC concurs with ad hoc committee
  - Months 10-11: hearing preparations
  - Months 12-13: fair hearing
  - Month 14: Appeal
  - Month 15: reconciliation, if necessary, with MEC: Board decides

What happens to peer review information in litigation?

- Information is exchanged through the process of "discovery:"
  - Hospital’s lawyer produces non-confidential documents:
    - Non-confidential documents from credentials file
    - Policies and procedures
    - Redacted meeting minutes
  - And objects to the production of confidential documents
  - And answers interrogatories
  - And provides a comprehensive disclosure statement
  - And upon request, provides a witness to authenticate and answer questions about everything produced

Key witness for the hospital:
medical staff services director

- Describe the credentialing and peer review processes, OPPE and FPPE
- Validate that the medical staff complies with the process
- Interpret medical staff bylaws, rules, policies
- Explain and justify any variations
- Explain peer review confidentiality and how it works in the hospital
What happens to peer review information in litigation?

Medical staff services director deposition:
• Can be contentious
• There is so much the MSS Director cannot talk about
• And there may be some uncomfortable questions that can be answered
• Typically, hours of preparation ...
• No personal liability, but plenty of stress

Medical staff office also helps answer interrogatories, gather documents, provides history

What happens to peer review information in litigation?

• The role of expert witnesses for and against the hospital:
  – Retired CEOs, CMOs, CFOs, TJC surveyors, etc.
  – Reviews all materials
  – Reaches conclusions and testifies about:
    • What standards the Hospital followed/should have followed
    • Whether the Hospital’s policies were reasonable
    • Whether the Hospital was reasonably compliant
    • If not, how the Hospital breached the standards
    • Whether any breaches really mattered
    • Whether any breaches caused the patient’s harm

What the Plaintiff’s Lawyer Looks For

• Anything negative about the doctor:
  – Prior malpractice cases
  – Professional board actions
  – Relinquishment of license
  – Lack of board certification
  – Prior loss of privileges
  – History of moving from hospital to hospital
  – Available data
  – Doctor’s writing that contradicts actions in case
  – Healthgrades, Vitals, US News Health
  – Fact that physician’s peer review is “secret”
What the Plaintiff’s Lawyer Looks For

• Anything negative about the hospital:
  – Medicare, health department, TJC deficiencies
  – Financial information (“rich hospital,” “desperate hospital”)
  – Website language
  – News stories
  – Prior malpractice cases
  – The fact that the Hospital won’t tell all
  – Missed deadlines, delays
  – Healthgrades, Vitals, US News Health, Yelp...

Now let’s look at how the credentialing/peer review process plays to a jury

A Case in Point (Hypothetical)

Neurosurgeon, Dr. Tim Cutter, performed surgery on a 33 year old woman, Lotta Patience.

Ms. Patience presented to Best Hospital’s emergency department with acute vertigo and weakness. An imaging study was performed, and it was determined that she had a schwannoma, which required urgent surgery.

The ED physician called in Dr. Cutter, the neurosurgeon on call.

During the surgery, Dr. Cutter cut Ms. Patience’s facial nerve, leaving her face paralyzed. Paralysis was a known risk of the surgery but was rare.

Dr. Cutter took 30 days to complete his operative note, which did not mention that he had cut the facial nerve.

Dr. Cutter’s post-operative progress notes said the patient was progressing well.
Where are the vulnerabilities?

The Patient

Lotta Patience was the weatherwoman on CNN, where she had worked for seven years. She was married and had three children.
One of Ms. Patience’s children was autistic and had ongoing special needs.
After the surgery, she was no longer able to work on television. Her husband left her.

What facts might be compelling to a jury?
Dr. Cutter's History

Dr. Cutter began a residency at World's Finest Hospital in 1997. He was there for 6 months, then transferred to another residency program. He completed his residency in 2000 at Excellent University's residency program.

Dr. Cutter then practiced at Little Hospital in Pleasantville, Wyoming, where he was the only neurosurgeon on staff.

Dr. Cutter moved to Arizona in 2005, where he joined Everyone's Hospital. He had a malpractice case there in 2005 and paid damages in the amount of $300,000. The Medical Board issued a reprimand, finding that he had improperly nicked a nerve and that his records were inadequate. This was his only malpractice case.

Best Hospital's Recruitment of Dr. Cutter

Best Hospital did not have enough neurosurgeons. The CEO of Best Hospital had given an interview to the local paper some months earlier lamenting the national shortage, but still committing to become a Level 1 Trauma Center with full neurosurgical coverage.

Best Hospital's website contained accolades and pronouncements about its "cutting edge" and "advanced" neurosurgical services.

Best Hospital recruited Dr. Cutter in 2006 and provided him a signing bonus and income guarantee as well as a call-coverage agreement.

Dr. Cutter came to the community and joined another neurosurgeon in a private practice. He applied for, and received, medical staff appointments at Best and two other hospitals.
Could any of this be a problem?

Medical Staff Review of Dr. Cutter’s Application

During the credentialing process, Best’s Credentials Committee interviewed Dr. Cutter. Dr. Cutter told the committee that he left the first fellowship program because of changes at that program, including the fact that the director had left. No references from the first program were available. His references from the program he completed were good.

Dr. Cutter said he moved to Arizona because of a personal relationship. Little Hospital in Wyoming gave him the highest marks. His reference from the neurosurgeon at the nearest acute care hospital, 160 miles from Pleasantville, was excellent.

At the time he joined Best Hospital, Dr. Cutter held medical licenses in good standing in three states, including Arizona.

• Were these the right questions?
• What, if any, follow-up was called for?
• Would your Credentials Committee follow up?
Dr. Cutter’s Medical Staff Appointment

Dr. Cutter applied to Best Hospital early November, was granted temporary privileges the following month, and was granted full membership and privileges in January.

The appointment letter from Best’s Board granted him unsupervised provisional privileges.

The Surgery Department no longer conducted concurrent supervision, but the Departmental rules had not yet been revised.

What’s wrong with this picture?

Dr. Cutter’s Provisional Staff Period

FPPE consisted of retrospective review at the end of the 1-year provisional period. Because of low meeting attendance, the Surgery Department did not consider Dr. Cutter for elevation from the provisional category until 15 months had passed.

During the provisional period, Dr. Cutter gave up his licenses in 2 states other than Arizona. He had forgotten to tell their licensing boards about the Medical Board reprimand, and both state boards had begun disciplinary actions. Best’s Medical Staff Office obtained the license surrender agreements from both states, one of which said Dr. Cutter had voluntarily surrendered his license because of “unprofessional conduct.” The Chief of Staff, sitting in the Medical Staff Office, instructed the Director that no action would be taken.

Dr. Cutter operated on Ms. Patience during the provisional period. The Surgery Department Chair reviewed Ms. Patience’s case in the QM office and trending it without going to Committee.
• Should Best have worried about the other two licenses?
• What action was appropriate?

The Lawsuit

Ms. Patience sued Dr. Cutter for negligence in the performance of the surgery and sued the Hospital for “negligent hiring and supervision” of Dr. Cutter.
Some Take-Aways

- Events that seem normal to you may be important to the jury
- Keep medical staff documents up-to-date
- And comply with them
- All relevant information must be gathered and considered
- Timeliness matters!
- Make sure to drill down when there are unusual circumstances
- Use chain of command when the medical staff fails to act or fails to take adequate actions
- Educate the medical staff. Conduct leadership retreats
- Some things are out of your control
Some Take-aways

Prior malpractice suits are very important to the jury! Medical staff committees need to take malpractice suits and medical board actions seriously.

• See Banner Health form for addressing medical malpractice suits during the credentialing process
  • More than a cursory look
  • Ask the doctor: what did you learn?

THANK YOU FOR ALL YOUR WORK, which is critically important and helps keep the Hospital and its patients safe!
PEER REVIEW IN THE COURTROOM:
HOW A JURY AND JUDGE VIEW THE WORK OF THE MEDICAL STAFF
AND YOUR MEDICAL STAFF SERVICES OFFICE

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I. Introduction

This program examines the legal claims of “negligent credentialing” and “negligent peer review” in relation to the work of the medical staff office. When these claims go to trial, juries look at much of the same information about physician qualifications and competence that medical staff committees review in credentialing and peer review. Juries also learn about the credentialing and peer review processes. Ultimately, they decide whether the medical staff’s decisions were reasonable.

The way a jury interprets all this information, however, can be worlds apart from the way the medical staff office and medical staff committees see things. Armed with a working knowledge of how these lawsuits work, we believe medical staff professionals can help their medical staffs make better decisions and help their institutions prevail when they are sued.

II. Types of Medical Malpractice Lawsuits

A. Who sues, and whom do they sue?

The people who sue their doctors and providers are generally patients who have suffered poor results in hospitals and other health care organizations and/or their families. These plaintiffs and their attorneys must decide whom to sue and what to claim. Various circumstances influence this choice, including which defendant appears to be most at fault, which defendant appears least sympathetic to a jury, and which defendant has the deep pocket to enable the plaintiffs to collect a large judgment.

To win a medical malpractice lawsuit, the plaintiff must prove that:

- The defendant (doctor, agent, and/or hospital) had a duty to provide reasonable care to the patient;

- The defendant breached that duty – was negligent – by providing care or failing to provide care worse than a reasonable person in the shoes of the defendant would not have provided;

- That breach/negligence caused harm to the patient. Lots of malpractice plaintiffs lose because although they can prove negligence, they cannot prove that the negligent conduct was the cause of the patient’s poor outcome.
As noted above, the defendant, claim and damages vary based on a wide variety of circumstances. For our purposes, we organize these choices into four general categories:

B. **Suit Against the Physician for Negligence:** The aggrieved patient/family members sue the treating or consulting physician (or other independent professional) alleging that the physician’s care was negligent.

1. The hospital (or other health care organization) is not a defendant.

2. Hospital personnel and physicians other who were involved in the case are fact witnesses in the case. Lawyers for both sides scour their documentation and memories through informal interviews, depositions, and trial testimony.

3. The medical staff office typically does not participate directly in this kind of case, but they may become involved indirectly.
   a. The lawsuit may trigger peer review activities.
   b. The lawsuit or the resulting peer review may trigger professional board review, which may trigger a subpoena to the medical staff office.
   c. Professional board review may give rise to peer review activities.

C. **Suit Against the Hospital for Direct Negligence:** The aggrieved patient/family members sue the hospital for direct negligence in its care of the patient.

1. These cases often involve criticism of equipment or clinical processes, including nursing actions or omissions, which the plaintiff claims caused harm to the patient.

2. When the hospital’s activities are the issue, there is no need for a plaintiff to sue for negligent credentialing of physicians.

3. The medical staff office is likely not affected in these cases.

D. **Suit Against the Hospital Based on Negligence of its Agents:** The aggrieved patient/family members sue the hospital alleging that its employees’ or other agents’ clinical care of the patient was negligent.

1. A hospital is automatically liable for the negligence of its employees if they are acting within the scope of their employment. With increasing numbers of hospital-employed physicians, hospitals take on additional risk.

2. A hospital also is also liable for the negligence of its agents who are not employees. These cases involve allegations of negligence by persons who are not employees, but the hospital has intentionally or unintentionally granted the person authority to act on its behalf. The grant of authority may be made by word or
deed. The hospital exercises control over its agents, and the hospital is responsible for their negligence.

3. Plaintiffs often argue that the treating physician is the agent of the hospital. This is a way of getting to the hospital’s “deep pocket.”

4. There are two kinds of agency relationships than can result in hospital liability: actual agency and ostensible agency.

a. Actual agency: A person is the actual agent of the hospital when the hospital has in fact granted that person authority to act on its behalf, usually by contract.

i. Physicians usually are not considered agents of the hospital just by virtue of being a medical staff member, since they do not act on behalf of the hospital.

ii. Plaintiffs sometime argue that a medical staff member is the hospital’s actual agent because of “control” factors like OPPE/FPPE, physician report cards and utilization review. These arguments usually do not work, but as hospitals increasingly oversee physician efficiency and develop required practice protocols, this argument might win more often.

b. Ostensible agency: A person is the ostensible agent of the hospital when a patient reasonably believes the person is the agent of the hospital. Plaintiffs use some surprising facts to establish that a physician is the “ostensible agent” of the hospital, including such matters as a name badge with the name of the physician and the hospital; a white coat with the hospital’s name and/or logo on it; statements on the hospital website like “our doctors provide cutting edge care;” or the physician’s name on the hospital’s surgical consent form.

E. Suit Against the Hospital for Negligent Credentialing/Peer Review: The aggrieved patient/family members sue the hospital for negligently credentialing the negligent treating physician or negligently peer reviewing the negligent treating physician.

1. The plaintiff must prove four elements to make a negligent credentialing claim against a hospital:

a. Underlying Physician Negligence: A medical staff member negligently treated the patient in the Hospital, causing harm to the patient. If the plaintiff cannot prove that the treating physician’s negligence caused the patient harm, it does not matter whether the hospital wrongly credentialled or peer reviewed the doctor – that negligence caused no harm.

b. Duty: The hospital had a duty to the patient to reasonably credential and peer review the physician. The existence of this duty is so well established in the law that it is assumed. In other words, the hospital has a duty to use the degree of care, skill and judgment usually exercised under the same or similar
circumstances by a reasonable hospital in credentialing and peer review. This duty is sometimes called “the duty of care.”

c. **Breach of Duty:** The hospital breached the duty of care by granting privileges to the treating physician or failing to restrict her privileges, either entirely or in part, after reasonable peer review. Put differently, the plaintiff must prove that the hospital knew or should have known the physician was not competent to treat the patient in question and did not act to keep the physician from treating the patient.

d. **Causation:** The hospital’s breach of its duty of due care in credentialing or peer review caused the patient harm. In other words, but for the hospital’s negligent credentialing/peer review, the physician would not have negligently harmed the patient. Similarly, if the hospital had properly credentialled /peer reviewed the physician, he or she would not have been a medical staff member or had the necessary privileges to treat the patient.

III. **Negligent Credentialing and the Medical Staff Office**

A. **Roles and Responsibilities**

1. In most states and most hospitals, the medical staff is not a separate entity from the hospital. Therefore, the hospital holds the duty to perform reasonable credentialing and peer review, even though the hospital board has delegated the work to the medical staff.

2. The hospital, via medical staff, must have a process which provides that:

   a. Only professionally competent physicians are credentialed and given medical staff privileges; and

   b. There is reasonable ongoing peer review of medical staff members to determine that they continue to provide care in accordance with accepted and established medical practices.

3. The hospital board is ultimately responsible by virtue of its oversight role. It, not the organized medical staff, approves or disapproves the appointment and reappointment of physicians and the Bylaws, rules and policies that guide credentialing and peer review. It also receives data documenting performance and, at least in a general sense, oversees physician performance.

4. The medical staff office, among other functions, assists the medical staff in performing its credentialing and ongoing peer review functions. It helps make sure the system that is in place is properly applied. This is a critical role that we think is in the center of the whole structure.
B. Proving Negligent Credentialing: The Impact of Confidentiality

1. Most states mandate at least some level of confidentiality for credentialing and peer review materials. For example, Arizona’s peer review statute states:

   All proceedings, records and materials prepared in connection with peer reviews, including all peer reviews of individual health care providers practicing in and applying to practice in hospitals or outpatient surgical centers and the records of such reviews, are confidential and are not subject to discovery.... No member of a committee or any person furnishing information to a committee performing peer review may be subpoenaed to testify in any judicial or quasi-judicial proceeding.... A.R.S. § 36-445.01.

2. To prove a negligent credentialing claim, a plaintiff must work around statutory confidentiality. The plaintiff seeks information about the physician’s credentials outside the confidential credentialing process. To prove a negligent peer review claim, the plaintiff seeks publicly available information about the physician’s complications, malpractice and professional board history and the like. Malpractice claims and board history are often available on the intranet.

3. In some instances, confidentiality is more of an impediment to the hospital’s defense than to the plaintiff! The hospital must prove that its evaluation of the plaintiff’s credentials and/or performance were reasonable without providing records of that evaluation. Particularly in negligent peer review claims, the hospital cannot describe its deliberative processes and intermediate steps it took to address negligent physician performance issues.

C. The Limits of Peer Review Confidentiality

1. The scope and extent of confidentiality protections from litigation discovery vary widely from state to state. In many states, the fact that information is in the credentials/peer review file does not insulate non-confidential information from discovery. Items that originated outside the process frequently are not confidential.

2. The setting in which the review has taken place also can have an impact on whether or not it must be disclosed in litigation. Review venues like root cause analyses, M&M conferences, system-wide quality review, data and report cards each must be analyzed by your counsel under your state law to determine whether information related to it is discoverable.

3. In most litigation, the hospital’s attorney who is withholding documents under a claim of "privilege" must list those documents on a “privilege log,” which describes the topic, discloses the identities of the writer and recipient and states the basis of the refusal to disclose. However, because disclosure of the identities of involved medical staff members could subject them to harassment or retaliation, peer review often is treated differently.
D. Medical Staff Information Typically Disclosed

1. The Hospital defends itself by presenting non-confidential information to the jury to show that the hospital (via the medical staff) acted reasonably. This information takes 3 forms:

   a. Physician credentials, from public sources, to demonstrate that she properly was allowed to work at the hospital. Useful information could include:

      • Education, training, employment
      • Awards, society memberships, publications
      • Previous employment
      • Previous/other hospital medical staff membership
      • Board certification
      • Professional board record
      • Restrictions on privileges at other hospitals (or none)
      • History of malpractice cases (or none)
      • Armed forces service, charity work, good deeds generally

   b. Information about the hospital’s credentialing and peer review/quality assurance processes, to demonstrate that the hospital had an appropriate, reasonable system in place to credential and monitor physicians. The medical staff bylaws, rules and regulations and policies, and testimony that it was the hospital’s practice to follow its processes help here, as well as Joint Commission accreditation, Medicare certification and any hospital honors or awards.

   c. The opinion of an expert in credentialing/peer review that (i) the hospital’s system was similar to that of systems nationwide; and (ii) based on available information about the physician, it was reasonable for the hospital to allow her to join and remain on the medical staff with her privileges intact. Experts in this area frequently are hospital administrators, chief medical officers, physician medical staff leaders. Medical staff services personnel also may serve as experts.

2. Sometimes the physician’s care in the case being litigated is indefensible. In such cases, the hospital may choose not to defend the care, but still has to convince a jury that it was not reasonably foreseeable that the physician would fail to provide adequate care to the patient. In such cases, it helps to be able to demonstrate that the hospital took prompt action after the case to address the physician’s negligent care.

E. The Medical Staff Office helps develop useful information by:

1. Ensuring all appropriate credentialing information is gathered

2. Highlighting all concerns in the file
3. Ensuring concerns are addressed in committee

4. Ensuring that ongoing peer review is occurring in accordance with governance documents

5. Preparing a chronology of all concerns and actions for committee review

6. Attempting to expedite reviews

7. Raising concerns
   a. Discuss concerns about applicant/staff member or the review process with Department Chair, Chief of Staff, CMO
   b. Raise with the CEO if necessary

F. The Key Hospital Duty of Reasonable Review/Action

1. Timing: Jurors, who are consumers, typically hold unrealistic views about credentialing and peer review. They may believe:
   a. Only world class physicians with perfect records should be allowed to join the medical staff.
   b. Hospitals should “fire” physicians who make a single mistake – ideally even before they make a single mistake.
   c. Juries have no patience with due process when it comes to physicians.

2. Jurors views do not comport with the too-typical peer review process, whose dates of beginning and completion are often discoverable:

   Month 1: initial review of poor outcome that generated a prior lawsuit
   Month 2: full committee review
   Month 3: invite physician for an interview
   Month 4: interview rescheduled because of summer vacations
   Month 5: concerns forwarded to MEC, which initiates a formal investigation
   Month 6: ad hoc investigating committee meets
   Month 7: Physician interviewed; adverse recommendation back up to MEC
   Month 9: MEC concurs with ad hoc committee
   Months 10-11: hearing preparations
   Months 12-13: fair hearing
   Month 14: appeal
   Month 15: reconciliation, if necessary with MEC

G. Key witness for the Hospital: Medical Staff Services Director

1. The Medical Staff Services Director is often asked to serve as a witness for the hospital in these cases. She is often expected to:
a. Describe the credentialing and peer review processes

b. Validate that the medical staff complies with the process as a matter of practice

c. Interpret bylaws, rules and regulations, and medical staff policies

d. Explain and justify any variations from bylaws and other documents

e. Explain the state confidentiality mandate and how it is applied in the hospital.

2. Usually, medical staff services director depositions are full of objections, as the plaintiff’s lawyer attempts to get the witness to talk about peer review of the physician in question, and the defense lawyer refuses to allow the testimony.

3. Preparation for deposition or trial testimony can take many hours over several months.

4. There is no personal liability associated with these depositions: the hospital provides counsel, and the medical staff services director is not named in the lawsuit. Still, there is time, trouble and stress!

5. The medical staff services office also gets involved in other litigation discovery efforts, like

   a. Answering interrogatories

   b. Providing non-confidential documents

   c. Answering endless questions about dates and details, and generally serving as historian.

H. How the Plaintiff Builds Her Case

1. Meanwhile, the plaintiff is looking for anything negative that can be used to support a claim that the hospital’s processes were poor or generally make the hospital look as greedy, uncaring and sloppy as possible. This information includes:

   a. Negative information about the physician, for example:

      • Prior malpractice cases

      • Professional board actions

      • Relinquishment of a professional license
- The lack of specialty board certification, especially if the physician failed the boards
- Prior loss of privileges
- A history of moving from hospital to hospital and/or residency to residency
- Any gaps in the physician’s record
- Any writings by the physician that differ from the conduct of the case in question
- Any discoverable data on the physician, for example, how many similar cases she has performed, how often she performs similar cases
- If available, the scope of the physician’s privileges, in case the physician’s care of the patient was outside that scope.
- Lack of an apology to the patient
- Poor documentation in the chart compared to the hospital’s medical records completion policy

b. Negative information about the hospital, for example:
- Medicare, health department or TJC deficiencies
- Financial information (“rich hospital,” “desperate hospital”)
- Website language that puffs up the hospital’s capabilities or seems to guarantee excellent care
- News stories about the hospital
- Prior malpractice cases
- A shortage of specialists
- How often the hospital handles similar cases
- Differences between the hospital’s bylaws and the current case
- Any statements in the bylaws about “high quality care” and the like
- Missed deadlines, delays.
IV. Practical Ideas for Preventing/Dealing With Negligent Credentialing/Peer Review Litigation

1. Events that seem normal to you may seem very important to the jury. For example, jurors hate malpractice suits. Medical staffs should review malpractice cases more carefully than many do.

2. Keeping the Medical Staff documents up-to-date is imperative.

3. It is also very important to help your medical staff follow the bylaws or document and explain variances.

4. In the credentialing process, be sure to flag any irregularities or concerns in the physician’s file.

5. Help your medical staff committees to take malpractice suits and medical board actions seriously. A sample information form for addressing a physician’s medical malpractice history is attached. This form is used during initial credentialing and reappointment.

6. Timeliness matters!

7. Encourage the Medical Staff to drill down when there are unusual circumstances.

8. Educate the Medical Staff. Conduct leadership retreats.

9. Use the hospital chain of command when the medical staff fails to act or fails to take adequate actions; enlist the CMO’s assistance.

THANK YOU!
PROFESSIONAL LIABILITY CLAIMS FORM
Confidential Information Report

Instructions: For initial applications, this form must be completed if in the previous 10 years, you have been named in currently pending or resolved (settled, dismissed, verdict) malpractice claims, suits, settlements, judgments, arbitration proceedings, or complaints filed involving your professional practice. For reappointments, this form must be completed for all pending complaints/lawsuits and for complaints/lawsuits resolved (settled, dismissed, verdict) during the previous appointment cycle. Please furnish the information below regarding each lawsuit or complaint and attach a copy of the complaint and your response answering the complaint. It is your responsibility to provide external verification with your response, i.e. statement from attorney, court records, etc. Please complete a separate form for each claim/suit you are submitting. Additional information may be required.

Date of incident: ___________________ Where incident occurred: ___________________ Date lawsuit was filed: ___________________

Patient’s Name: ___________________ Names of other Defendants, if any: ___________________

Nature of incident (Complaint, allegation):

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Your response to the allegations:

_____________________________________________________________________________________

_____________________________________________________________________________________

Current Status of the Claim: ___ Pending ___ Dismissed ___ Arbitrated ___ On Appeal ___ Verdict ___ Other: ___

If pending, please specify the amount being sought (if known)?

If settled, date and amount of settlement?

If dismissed, date and whether dismissed with or without prejudice?

If verdict, date of verdict ______ and judgment for: ___ Plaintiff ___ Defendant

If verdict for Plaintiff, amount attributed to you?

If the claim/suit was dismissed with no payment made or if a defense verdict was entered, do not complete the remainder of the form.

Name of Attorney: ___________________

Insurance Company that provided coverage: ___________________

Insurance Questions
- Did you consent to settlement?
- Did your carrier raise your rates based on this case? ______ If so, by how much? _______
- Did your carrier cancel or non-renew your policy based on this case? _______

Litigation Questions (Settlements/Trials)
- Did you have an expert who supported your care? ______
- Did your lawyer get any unfavorable opinions from reviewing experts? ______

Regulatory/ Medical Staff Questions
- Did your licensing board take any action based upon this case? ______
- Did any Medical Staff take any action based upon this case? ______

Self Critical Analysis
- What important lessons did you learn from this case? ______
- What changes have you made in your practice? ______
- How can you prevent recurrence of this type of outcome? ______

Other comments:

_____________________________________________________________________________________

_____________________________________________________________________________________

Initial Application – Medical Staff* (07/21/2014)
PEER REVIEW IN THE COURTROOM: HOW A JURY AND JUDY VIEW THE
WORK OF THE MEDICAL STAFF AND YOUR MEDICAL STAFF SERVICES OFFICE

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NAMSS Annual Meeting
October 5, 2015

HYPOTHETICAL

THE CASE

Dr. Tim Cutter, a neurosurgeon, performed surgery on a 33 year old woman, Lotta Patience.

Ms. Patience presented to Best Hospital’s emergency department with acute vertigo and weakness. An imaging study was performed, and it was determined that she had a schwannoma, which required urgent surgery.

The ED physician called in Dr. Cutter, the neurosurgeon on call.

During the surgery, Dr. Cutter cut Ms. Patience’s facial nerve, leaving her face paralyzed. Paralysis was a known risk of the surgery but was rare.

Dr. Cutter took 30 days to complete his operative note, which did not mention that he had cut the facial nerve.

Dr. Cutter’s post-operative progress notes said the patient was progressing well.

THE PATIENT

Lotta Patience was the weatherwoman on CNN, where she had worked for seven years. She was married and had three children.
One of Ms. Patience’s children was autistic and had ongoing special needs.

After the surgery, she was no longer able to work on television. Her husband left her.

THE SURGEON

Dr. Cutter began a residency at World’s Finest Hospital in 1997. He was there for 6 months, then transferred to another residency program. He completed his residency in 2000 at Excellent University’s residency program.

Dr. Cutter then practiced at Little Hospital in Pleasantville, Wyoming, where he was the only neurosurgeon on staff.

Dr. Cutter moved to Arizona in 2005, where he joined Everyone’s Hospital. He had a malpractice case there in 2005 and paid damages in the amount of $300,000. The Medical Board issued a reprimand, finding that he had improperly nicked a nerve and that his records were inadequate. This was his only malpractice case.

THE HOSPITAL

Best Hospital did not have enough neurosurgeons. The CEO of Best Hospital had given an interview to the local paper some months earlier lamenting the national shortage, but still committing to become a Level 1 Trauma Center with full neurosurgical coverage.

Best Hospital’s website contained accolades and pronouncements about its “cutting edge” and “advanced” neurosurgical services.

Best Hospital recruited Dr. Cutter in 2006 and provided him a signing bonus and income guarantee as well as a call-coverage agreement.

Dr. Cutter came to the community and joined another neurosurgeon in a private practice. He applied for, and received, medical staff appointments at Best and two other hospitals.
THE CREDENTIALING PROCESS

During the credentialing process, Best’s Credentials Committee interviewed Dr. Cutter. Dr. Cutter told the committee that he left the first fellowship program because of changes at that program, including the fact that the director had left. No references from the first program were available. His references from the program he completed were good.

Dr. Cutter said he moved to Arizona because of a personal relationship. Little Hospital in Wyoming gave him the highest marks. His reference from the neurosurgeon at the nearest acute care hospital, 160 miles from Pleasantville, was excellent.

At the time he joined Best Hospital, Dr. Cutter held medical licenses in good standing in three states, including Arizona.

MEDICAL STAFF APPOINTMENT

Dr. Cutter applied to Best Hospital early November, was granted temporary privileges the following month, and was granted full membership and privileges in January.

The appointment letter from Best’s Board granted him unsupervised provisional privileges.

The Surgery Department no longer conducted concurrent supervision, but the Departmental rules had not yet been revised.

REVIEW ONCE ON STAFF

FPPE consisted of retrospective review at the end of the 1-year provisional period. Because of low meeting attendance, the Surgery Department did not consider Dr. Cutter for elevation from the provisional category until 15 months had passed.

During the provisional period, Dr. Cutter gave up his licenses in 2 states other than Arizona. He had forgotten to tell their licensing boards about the
Medical Board reprimand, and both state boards had begun disciplinary actions. Best’s Medical Staff Office obtained the license surrender agreements from both states, one of which said Dr. Cutter had voluntarily surrendered his license because of “unprofessional conduct.” The Chief of Staff, sitting in the Medical Staff Office, instructed the Director that no action would be taken.

Dr. Cutter operated on Ms. Patience during the provisional period. The Surgery Department Chair reviewed Ms. Patience’s case in the QM office and trended it without going to Committee.

THE CLAIM
Ms. Patience sued Dr. Cutter for negligence in the performance of the surgery and sued the Hospital for “negligent hiring and supervision” of Dr. Cutter.