CASE STUDIES

Case Study #1: Michael Swango

Former physician

- Sentenced to four life sentences in federal prison
- Deliberately killed around 60 patients over 16 years

Swango is believed to have begun killing in 1983

- Graduated from Southern Illinois University Medical School
- Began internship at Ohio State University Hospital
  - Cynthia McGee
  - 19-year-old gymnast
  - Admitted to OSU Hospital for bicycle accident injuries
  - In hospital, Swango gave McGee an overdose of potassium
  - Overdose caused cardiac arrest and death
    - Despite suspicious death, Swango, was not held responsible in a court of law until about 17 years later
    - After McGee’s death, investigation turned up as many as five other suspicious deaths at the hospital while Swango was there
  - Swango left and worked in other hospitals in:
    - New York
    - Illinois
    - South Dakota
    - Zimbabwe, Africa
  - Always, some of his patients suffered suspicious deaths
  - He continued to find jobs because he:
    - Made up fake work experience
    - Forged credentials

- Authorities suspected Swango and even before 2000, Swango had been convicted twice:
  - 1985 – Quincy, IL – *while waiting for medical license*
    - Swango poisoned two ambulance technicians
    - Techs were seriously ill, but did not die
    - Swango served two years
  - Swango caught lying about credentials after jail
    - By lying, he got into residency at State University of New York (SUNY) at Stony Brook
    - Swango was indicted and convicted in 1998 when lie uncovered
    - Federal investigation started regarding mysterious deaths at other hospitals where he had been

- After investigation, Swango was sentenced to four life sentences
  - Federal maximum security prison
    - Tiny cell
    - No contact with other prisoners
    - No possibility of parole

Case Study #2: Darling vs. Charleston Community Memorial Hospital (1965)

**Fact Summary**
Hospital liable for negligent treatment resulting in amputation of teenager’s leg. Nurses failed to monitor; physician failed to consult; hospital claimed that charitable immunity doctrine limited damages to its insurance.

**Key Finding**
Failure to have proper supervision; case set aside the Charitable Immunity Doctrine.

**Additional Case Information**
In this case, plaintiff contended that the hospital was negligent in permitting the on-call doctor to do orthopedic work of the kind required for Darling and not requiring him to review his operative procedures to bring them up-to-date.

They also charged that the hospital failed, through its medical staff, to exercise adequate supervision over the case, especially since Dr. Alexander had been placed on emergency duty by the hospital, and in not requiring consultation, particularly since Darling developed complications.

Darling had his leg placed in a cast, suffered gangrene, and had to have his leg amputated below the knee. The plaintiff claimed—and the court agreed—that the hospital was negligent for two reasons:
1. It failed to properly review the work of an independent doctor
2. Its nurses failed to administer necessary tests

Darling held that the hospital bylaws, licensing regulations, and standards for hospital accreditation were sufficient evidence to establish the standard of care. Therefore, a lay jury concluded (from the evidence) that the hospital breached its duty to act as a reasonably careful hospital.

**The Impact of This Case:**
If a patient suffers an adverse outcome, the organization that credentialed the practitioner can be held liable. In addition, if the practitioner has problems that would have been revealed by credentialing, but credentialing was not performed, the organization may be liable for any patient harm caused by the clinician. Proper credentialing not only helps protect the patient and health organization, it also protects the practitioner. If the organization follows the appropriate processes, and a practitioner is authorized to practice, then it is likely protected from allegations of non-compliance with credentialing criteria, i.e., negligent credentialing.

Case Study #3: Johnson vs. Misericordia Community Hospital (1981)

**Fact Summary**
Hospital liable to patient injured by physician who had failed to disclose pending malpractice cases and lied about privileges at other hospitals. Hospital should have verified information.

**Key Finding**
Negligent credentialing; failure of initial credentialing process.

**Additional Case Information**
This action arose out of a surgical procedure performed at Misericordia by Dr. Salinsky.
- Salinsky unsuccessfully attempted to remove a pin fragment from Johnson’s right hip, and during surgery, damaged the common femoral nerve and artery, causing a permanent paralysis of his right thigh muscles, atrophy, weakness and loss of function.
- Johnson settled his claim against Salinsky for medical malpractice, and then sued the hospital alleging negligence in hospital’s appointment of Salinsky to its medical staff and in granting him orthopedic surgical privileges.

When completing his application, Salinsky stated that his privileges at other hospitals had never “been suspended, diminished, revoked, or not renewed.” He also failed to answer any of the questions pertaining to his malpractice insurance and stated that he had only requested privileges for those surgical procedures in which he was qualified by certification.
The hospital did not verify the information on the application.

- Had they done so, they would have found that Salinsky had experienced denial and restriction of his privileges, as well as never having been granted privileges at the hospitals he listed in his application.
- This information was readily available to Misericordia and if the hospital had credentialed Salinsky, it would have been revealed that these hospitals had a concern regarding his competency.
- In addition, if the hospital would have verified medical malpractice information, they would have found that seven malpractice suits that had been filed against Salinsky prior to his appointment date.

The Circuit Court entered judgment in favor of Johnson. The hospital appealed the decision to the Supreme Court. This court held that the trial court properly instructed the jury that “a hospital is under a duty to exercise reasonable care to permit only competent medical doctors the privilege of using their facilities.” The trial court’s instruction that reasonable care “meant that degree of care, skill, and judgment usually exercised under like or similar circumstances by the average hospital” was proper; and evidence supported a finding that, had the hospital exercised ordinary care, it would not have appointed Salinsky to its medical staff.

Case Study #4: Gomez vs. West
St. Mary’s Hospital in Waylow, CA appointed Dr. West, an orthopedic surgeon. Dr. West was well-trained. After completing his medical education at Columbia University College of Physicians and Surgeons, he served an internship at the University of Wisconsin, a residency in general surgery at Milwaukee County Hospital, and a three-year residency in orthopedic surgery at Duke University while in the Air Force.

During the credentialing process, St. Mary’s Hospital did not inquire at previous hospitals as to Dr. West’s competence while on staff. Nor did St. Mary’s Hospital query Dr. West’s malpractice carrier regarding his history of previous claims. While Dr. West was on staff, there were “issues” identified in the peer review process.

Gomez was a 27-year-old man injured in an auto accident in California in 1967. Dr. West performed a laminectomy, which resulted in significant complications. Postoperatively, Gomez proved the indications for the surgery were questionable. Gomez sued both Dr. West and St. Mary’s Hospital for negligence.

Gomez presented evidence that over the course of the previous nine years, Dr. West had performed 36 unnecessary or injurious laminectomies.

Case Study #5: Patrick vs. Burget (1988)

Key Issues: Antitrust, violation of Sherman Act, anti-competitive peer review.

Timothy Patrick, MD was a general and vascular surgeon in Astoria, Oregon.

- After practicing for some time with the Astoria Clinic, he refused its offer of a partnership, instead going into private practice, and thus, competing with the clinic doctors.
- The clinic doctors reported an instance of alleged substandard practice to the state Board of Medical Examiners and used their positions on the hospital peer review committee to attempt to withdraw Dr. Patrick’s hospital privileges.
- Ultimately, Dr. Patrick resigned rather than face unfair proceedings.
- Dr. Patrick brought an antitrust action against the clinic doctors alleging a violation of the Sherman Act by initiating and participating in the peer review proceedings in order to reduce competition from petitioner, rather than to improve patient care.
- Patrick won his case and the jury returned a verdict against the peer-review committee and awarded damages of $650,000 to Dr. Patrick.
- The district court, as required by law, trebled the antitrust damages.
- The case was appealed to the Supreme Court, which concluded that the district court’s decision was correct—that the behavior of the peer review committee violated the antitrust laws.

The Supreme Court also found that there was no state-action exemption from the antitrust laws for peer-review committees.
Case Study #6: Dr. John Anderson King

Dr. King was a 1984 graduate of the University of the New England College of Medicine.

- He trained as a resident at five different institutions in three different specialties: orthopedic surgery, OB/GYN, and anesthesiology.
- From 1985 to 1987, he dropped out of two anesthesiology programs before completing a third at Case Western University Medical Center.
- In 1989, he resigned from Walker Regional Medical Center in Alabama after his privileges were suspended for falsifying patient records.

He trained as a resident in OB/GYN at Albert Einstein Medical Center in Philadelphia from 1990 to 1992, but never completed the program.

In 1995, Hillcrest Health Center in Ohio terminated Dr. King after two years of an orthopedic surgical residency program for marginal performance.

- He responded with a lawsuit alleging poor training.
- To settle the lawsuit, he was allowed to resign from the residency program, removing the black mark from his records there.

Dr. King spent the next two years “performing the duties of an orthopedic resident” at Lincoln Medical Center in the Bronx, but was never an approved resident so he didn’t receive formal credit for the educational program.

- Nonetheless, he was able to obtain privileges to perform orthopedic surgery at Jackson County Hospital in Marianna Florida in 1997. While working there, he was named in four malpractice suits, all of which were settled but none of which were reported.
- He moved on to Doctors Hospital in Groves, Texas, where he worked from 2000-2002 as an orthopedic surgeon. His privileges at that hospital and his Texas license were eventually suspended and ultimately revoked due to substandard medical care.

Even with this background, Dr. King was hired at Putnam General Hospital in Hurricane, West Virginia, in November 2002.

- Putnam is a for-profit hospital owned by HCA.
- In May 2003, the hospital became concerned about some of Dr. King’s surgeries.
- Dr. King resigned from Putnam before they completed the investigation. He surrendered his West Virginia license.
- In the 7 months he worked for Putnam, he performed approximately 500 orthopedic surgical procedures.
- By 2005, 100 malpractice suits had been filed against Dr. King and the hospital.

In September 2005, Dr. King had caught the attention of the The Wall Street Journal, which ran a front page article on Dr. King entitled “Weakness in Medical Vetting.”

Putnam General Hospital eventually closed and was sold to another nearby entity. The hospital is now called CAMC (Charleston Area Medical Center).

But, Dr. King was not through….he had filed for a name change in Houston County Alabama in March 2005 citing: “identity theft by a former co-worker” as the reason. He was granted his request and his name was changed to Christopher Wallace Martin.

In September 2008, the Medical Licensure Commission of Alabama revoked Dr. King’s license based upon the complaints of two patients Dr. King treated while working at American Family Care in the fall of 2006.

Both Alabama patients have also sued King. Those cases are on hold since King has filed for bankruptcy due to the West Virginia malpractice cases.

Oh, by the way, in November 2007, Christopher Wallace Martin changed his name back to John Anderson King.
Case Study #7: Hospital – Dr. McDreamy
XYZ Medical Center has received an initial application from Dr. McDreamy. A professional reference has indicated that Dr. McDreamy becomes a nightmare when requested to provide emergency department call coverage.

Case Study #8: CVO
In response to an affiliation request, a hospital supplies a form letter stating that Dr. C. Section was a member of the medical staff with OB/GYN privileges from mm/yy to mm/yy. This hospital affiliation is where the doctor spent the last two years of practice.

Case Study #9: Hospital – Dr. Happycut
Dr. Happycut has requested privileges for general surgery and special privileges for bariatric surgery at St. Elsewhere Hospital. The reference provided by his program director confirms his competence in general surgery, but does not support the request for bariatric surgery.

Case Study #10
Dr. Arrhythmia, an interventional cardiologist at Lutheran Medical Center, wants to perform septal ablation, a new way to treat heart damage without performing open-heart surgery. He learned how to do this procedure in his training program at Northwestern University Medical Center. Septal ablation is an alternative to open heart surgery. The procedure involves threading a catheter into the coronary artery to the heart. Use of special agents and ultrasound technology create a “controlled” heart attack.

Currently, no one is privileged to do this procedure at the Medical Center. The Medical Center does have an open-heart surgery program, but the cardiac surgeons are not recommending this procedure be initiated. Dr. Arrhythmia has provided the MSSD with a letter from the physician who trained him at Northwestern and has wants to schedule a patient five days hence.

Case Study #11:
Dr. Squint, a newly-appointed ophthalmologist, is in the process of trying to schedule a cosmetic surgical procedure for his patient the following week. The OR nurse manager has informed Dr. Squint that he does not have privileges for ophthalmologic cosmetic surgery. Dr. Squint is quite upset and has come to the MSSD for “answers.”

Case Study #12:
Dr. Aching Back is a well-trained anesthesiologist who specializes in pain management. Community Memorial has an exclusive contract with the Associated Anesthesiologists to provide anesthesia services and manage the pain clinic. Dr. Back is desirous of a part-time practice in pain management and not interested in joining the anesthesia group. (The group requires all members to take anesthesia call—including those practitioners with pain management privileges.)

Dr Back threatens the hospital and the anesthesia group that he will go to a lawyer if he is not given the pain management privileges he is requesting and that he is clearly competent to perform.

Case Study #13:
XYZ Medical Center has just converted their surgery department privileging system to criteria-based core privileging. Dr. Don’t Cross Me, a general surgeon, is trying to schedule a procedure that the nursing staff cannot find on Dr. Me’s new privilege form. Dr. Me is upset and states he has done this procedure a number of times and in his opinion, the procedure is included in the core under “small bowel surgery for benign or malignant disease.” The OR is calling the MSSD for direction as to whether the case can be scheduled.

Case Study #14:
Dr. Fatbody, an otolaryngologist, has just returned from a CME course on total body liposuction and is requesting privileges for that procedure. An influential plastic surgeon has heard of Dr. Fatbody’s request and unofficially told the surgery department chair that Dr. Fatbody is not competent for this procedure. However, the plastic surgeon has also stated that he will not get involved due to his concern of his risk of anti-trust allegations.
Case Study #15:
Memorial Hospital is a small community hospital with five family medicine physicians and one obstetrician on staff. The closest hospital is 30 miles away through the desert and is of similar size and resources. Urban Medical Center is an hour away by land and 45 minutes away by helicopter.

All the family physicians have privileges to do emergency caesarean sections. Dr. Smith has just completed her family medicine residency including the traditional obstetrical rotation and is asking for OB privileges to include emergency cesarean sections. Her new partner, also a family practitioner, has agreed to mentor Dr. Smith until she is sufficiently trained.

Case Study #16
Your hospital is accredited by The Joint Commission. There are two physicians, members of a large physician group, who have not submitted their reappointment application on time and so the application will not be submitted for approval by the board of directors prior to their reappointment date. Both doctors are heavy admiters to the hospital. Discuss options.

Case Study #17
Your hospital is surveyed by CMS. When evaluating reapplication forms, you see that a practitioner included information regarding a recent licensure disciplinary action. This action did not occur in the state in which the applicant currently has an office or in the state of your hospital. Discuss appropriate action.

Case Study #18
When you sent out the reappointment forms, you included a new privilege form. When comparing the new form to the current privileges, you see that the practitioner has requested additional privileges. What do you do?

Case Study #19
You are in the process of reappointment for a long time member of the medical staff. You are aware that there have been some discussions among the nursing staff regarding this doctor not being able to remember things. You have recently received an incident report regarding the physician appearing confused when they called him in the evening for orders concerning a critical patient. Rumors of alcohol abuse have surfaced as well. Discuss how this should be addressed.

Case Study #20
You are a hospital accredited by The Joint Commission. The hospital’s board of directors usually meets on the fourth Tuesday of the month. They inform you in September that they have decided to move their December meeting to the first Tuesday of January due to the meeting date falling on December 25, the Christmas holiday. You have 18 physicians whose current appointment will end on December 31. How do you handle this?

Case Study #21
Your medical staff bylaws require documentation of 25 hours of Category 1 CME that is relevant to the practitioner’s specialty to be provided at reappointment. In evaluating the CME sent in with the reappointment for a board certified pulmonologist, you find the following:

2011 Wilderness & Mountain Medicine
Conference, Canyons Resort, Park City, UT – 2/3/11 – 2/5/11, 12 Category 1 Credits

Pulmonary Medicine and Sleep Disorders Update
Continuing Medical Education Cruise
Conference on the MS Noordam 10/31/10 - 11/6/10, 16 Category 1 Credits

Primary Care: Breakthroughs in Preventive
Medicine, The Sands Golf Resort, San Antonio,
TX, 5/7/10-5/8/10, 12 Category 1 Credits

Is there follow-up necessary? If so, what needs to be done?
Case Study #22
During the reappointment process, you receive documentation from a practitioner that forgot to mail in her renewal form for her DEA certificate on time, resulting in her not having a current DEA. What should you do?

Case Study #23
At some time, every hospital and medical staff struggles with privileging low and no volume practitioners. This is an issue for healthcare organizations of all sizes and complexities. You are a member of the Credentials Committee and are tasked with resolving the question of how to determine competence of a variety of low and no volume practitioners.

Evaluate each of the scenarios listed below and develop an approach to the issue.

**Scenario 1**
Large, metropolitan, academic pediatric hospital has had an inclusive policy regarding staff membership and privileges for referring pediatricians. This has led to pediatricians appointed up to 100 miles away who never come to the organization. Competence cannot be established internally and the reality is that the pediatric hospital would essentially no longer allow independent management of a patient under these circumstances. What should the Credentials Committee do?

**Scenario 2**
Small, rural facility with a 30 member active staff. There are an additional 30 physicians who serve as consultants. Many of these physicians are on 10-15 medical staffs—most of these facilities also seldom see the practitioner. The MSP is wearing many “hats” and every moment counts. Must the MSP contact all the hospitals that the consultant lists as having membership or privileges?

**Scenario 3**
Large, suburban medical center with four other similar healthcare organizations within ten miles as well as two ambulatory surgery facilities. There are a number of specialists who are members of the staff with privileges but never come to the facility. They practice almost exclusively at their investor-owned surgery center. However, for managed care contracts, they must have privileges at a hospital. What issues should the Credentials Committee consider?

**Scenario 4**
A community hospital has a large number of family medicine practitioners as well as a few internal medicine specialists who no longer come to the hospital to care for their patients. There is a hospitalist group that provides good care to patients and accepts all referrals.

It is now reappointment time; these physicians have requested the same level of privileges as they have had in the past. However, only a handful of physicians have admitted any patients (2-4) and essentially referred them to specialists who managed the patient thereafter. Most of these practitioners have not admitted nor treated any patients in the facility for the past 2-4 years. What should the Credentials Committee do?

Case Study #24
The director of the medical staff services department at Community Hospital has received a request from another hospital for information about an anesthesiologist who had been on the Community Hospital medical staff, but had resigned in the midst of a clinical “evaluation” of his performance.

While no specific conclusions had been reached, peer review processes had identified several cases that appeared to have been mismanaged. The current surgery department chair was not involved in the peer review process regarding this physician and completed the evaluation essentially with “very good” comments. The director is concerned regarding the patient and organizational risk of sending the evaluation.

What should the director do?
What are some options for a short-term solution to this situation?
What are some needed tools for a long-term solution?