Michael R. Callahan, Esq., *senior partner at Katten, Muchin, and Rosenman LLP and nationally respected healthcare attorney, summarizes the legal precedents that inform the medical staff's, management's, and board's legal obligations when evaluating a prospective applicant for medical staff membership or privileges.*

How to Avoid Negligent Credentialing Liability

In the seminal decision *Darling v. Charleston Community Memorial Hospital* (1965), the Supreme Court of Illinois held for the first time in the United States that a hospital is legally responsible for making sure that a physician

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seeking appointment or reappointment to a medical staff is qualified to exercise each and every clinical privilege that is granted to him as determined through the hospital and medical staff's credentialing and privileging procedures. If the hospital fails in its duty and knew, or should have known, that the physician is unqualified and the physician subsequently commits an act of negligence that injures a patient, the court opined, the hospital can be held separately liable for compensatory damages under what is commonly known as the doctrine of corporate negligence.

Since the decision was issued, approximately 40 states have adopted this liability standard. Sometimes referred to as "negligent hiring or selection" or "negligent retention," this duty applies not only to hospitals but also to managed care entities, such as physician–hospital organizations and independent practice associations. Similarly, The Joint Commission, other hospital accrediting bodies, and state licensing boards impose clear and detailed obligations on hospitals and medical staffs to vet physicians' qualifications at the time of appointment and reappointment and to continuously monitor their practices to ensure ongoing compliance with accepted standards of patient care services.

Standards for a Negligent Credentialing Claim

To succeed in a negligent credentialing claim, a plaintiff must establish that the hospital had a duty to the patient, this duty was breached, the breach caused the patient's injury, and the patient suffered resultant damages. These standards, and the defenses that can be asserted by a hospital, are discussed in more detail next.

Duty

Hospitals owe a duty to make sure that physicians appointed and reappointed to the medical staff are qualified to exercise each and every clinical privilege granted to them. Consequently, this is the easiest element of the tort claim of corporate negligence to prove. This duty applies irrespective of whether the physician is employed or is independent. The only difference is that if an employed physician is found to be negligent when he injures a patient, the hospital will be held directly liable under the doctrine of respondeat superior, whereas if the physician is an independent member of the medical staff, the plaintiff must not only prove that the physician is negligent but further that the hospital either negligently appointed or reappointed him or that it knew, or should have known, he was unqualified but still permitted him to exercise clinical privileges.

Breach of Duty

If the plaintiff is able to show that the physician was negligent, the next requirement is to establish that the hospital was negligent in appointing, reappointing, or otherwise allowing the physician to render the patient care services on which the claim is based (*Darling v. Charleston Community Memorial Hospital* 1965).

An illustration of this breach-of-duty standard can be found in *Frigo v. Silver Cross Hospital* (2007). In this case, the plaintiff was a patient of a podiatrist who had been appointed to the medical staff and allowed to perform category 2 surgical privileges, which include bunionectomies. When the physician was first considered for appointment, the standard for granting membership and privileges for these procedures was that he have some postgraduate training or be board certified or deemed board eligible by the American Board of Podiatric Surgery. He was approved as a member of the medical staff even though he did not meet these established qualifications.

By the time he came up for reappointment two years later, the qualifications had been elevated to manage the high influx of applications from other podiatrists seeking surgical privileges. Now, podiatrists had to complete a 12-month surgical residency training program, complete and pass the written portion of the board-certification examination, and prove that they had participated in at least 30 category 2 surgical procedures within the previous 12 months. When it was pointed out that the podiatrist up for reappointment had not satisfied this higher eligibility standard, much less the previous standard, the decision was made to reappoint him anyway because the quality of the care he provided had been acceptable and he had received no patient complaints. No attempt was made to grandfather him or create a documented exception to his remaining on staff with his previously delineated privileges.

Two or three years later, the podiatrist performed a bunionectomy on a diabetic patient for whom he had successfully performed the same procedure on her other foot the previous year. At the time of the surgery, the patient had an infection near the surgical site. Rather than wait until the infection cleared, the podiatrist proceeded with the operation. Because her postoperative care was poorly managed, the patient's foot became infected and had to be amputated. The patient subsequently sued.

The plaintiff's theory against the hospital was simple and straightforward. She argued that the hospital was directly negligent because it granted

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surgical privileges to a podiatrist even though he had not satisfied the privileging standards established by the hospital. The fact that he had no prior lawsuits or patient complaints was seen as irrelevant.

Stated in legal terms, the hospital's duty to grant privileges only to qualified podiatric surgeons was breached when it failed to follow its own established eligibility standards. Had it done so, this podiatrist would not have been granted the privileges and the patient would not have lost her foot. The jury awarded the plaintiff nearly $8 million, and the verdict was upheld on appeal under the doctrine of corporate negligence.

Frigo and other similar decisions teach us several lessons for preventing hospitals from breaching their duty to patients, which include the following.

Create Robust Appointment and Reappointment Processes

Hospitals and medical staffs must expend reasonable efforts in determining whether a physician is qualified for membership and clinical privileges. Most application and reappointment forms contain detailed questions as a means of detecting any issues or concerns related to a physician's ability to exercise the requested privileges. During the appointment phase, the hospital has all of the leverage. The burden should be on the physician to answer all questions and concerns to the satisfaction of the hospital and medical staff.

Following are some steps to follow and suggested provisions to include in the bylaws:

1. Applications must be complete before they are processed by the hospital.
2. The application process should not go forward until all questions and issues are addressed.
3. A physician's failure to respond completely should result in the withdrawal of the application with no fair hearing or other procedural rights.
4. Bylaws should contain a provision stating that if the physician does not respond truthfully or completely or if the answers are misleading, the application will be terminated without action or access to procedural rights either at the time of initial processing or retrospectively if discovered after membership and privileges have been granted.

5. The hospital should seek to further evaluate and follow up on any and all substantive issues from the original source and not rely solely on the physician's representation of the circumstances.
6. The hospital must establish and comply with eligibility criteria for credentialing and privileging and apply them uniformly. Failure to follow them exposes the hospital to liability claims.
7. Physicians must be subject to continued monitoring. If adverse events or issues are identified, the hospital and medical staff must establish and follow appropriate peer review and quality improvement policies and procedures to address identified problems as soon as possible.
8. All relevant quality, utilization, and other data should be collected from all available sources and thoroughly reviewed at the time of reappointment (although they should also have been monitored throughout the two-year reappointment period).
9. Where necessary, if problems arise, remedial measures should be put into place. These include monitoring and proctoring, which do not trigger hearings under the bylaws or a data bank report, as set forth by the Healthcare Quality Improvement Act of 1986.
10. If remedial measures fail, the hospital should trigger an investigation or request corrective action.
11. To achieve medical staff buy-in to a rigorous privileging process, the hospital should adopt a just-culture environment in which the emphasis is on acknowledging issues without fear of reprisal or loss of membership or privileges.

Align Criteria and Qualifications with Best Practices

Delineation criteria and qualifications should be tied to industry practices and standards of care—and once adopted, they must be followed. If they are not followed, the hospital must document the objective basis for granting an exception.

Have Remedial Measures in Place

Courts and juries are more likely to rule against the hospital if no remedial measure has been imposed despite the existence of a clearly substandard pattern of practice.

Causation

The third prong of a tort claim is to establish that the patient's injury was caused by the breach. As noted in *Frigo*, the patient's need for an amputation

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was caused by both the physician's negligence and the hospital's act of granting privileges to an unqualified podiatrist based on a self-imposed standard. Most cases are not so straightforward. Hospitals do not guarantee outcomes and do not constantly look over the shoulders of their physicians. The fact that the physician was negligent does not mean that the hospital was negligent in granting him privileges. The outcome in *Frigo* likely would have been different if the podiatrist had met the established privileging standard even though he was found to be negligent. There was nothing in his record that otherwise would have suggested that he was not qualified: no patient complaints, no bad outcomes, and no previous malpractice suits. In fact, he had a reputation as an expert in treating podiatric patients with diabetes.

In addition to the earlier recommendations, some steps to consider when establishing lack of causation include the following:

1. Establish appropriate peer review and quality improvement policies and proof of compliance. Bear in mind that confidentiality statutes do not allow the hospital to introduce into evidence confidential peer review information, and therefore the hospital needs to develop a separate paper trail to establish that it abides by all required licensure and accreditation standards. Hospitals should consult with legal counsel on proper steps to take.
2. Introduce evidence that the physician has had no pattern of lawsuits, patient complaints, or other evidence to suggest he is unqualified.
3. Where evidence does exist, such as past lawsuits with similar claims, establish that the hospital and medical staff took appropriate remedial measures to improve care and avoid repeat behavior. The hospital is not legally required to terminate or suspend a physician for a single bad outcome.

Injury

The last prong is that the patient must have suffered some compensable injury as a result of the physician's and hospital's negligence. Using the *Frigo* case again as an example, if the patient's bunionectomy had been successful and the patient did not suffer an injury, even though the hospital had negligently granted surgical privileges, she would have no claim. (That being said, if no injury had occurred, it's likely that no lawsuit would have been brought in the first place.)

Maximize Your Confidentiality and Privilege Protections

Most states recognize the importance of protecting peer review discussions, meeting minutes, and analyses from discovery to improve patient care and reduce morbidity and mortality. Unless these open and frank assessments take place, physicians and other clinicians will be reluctant to engage in the types of meetings and take the actions necessary to address the adverse events and outcomes that inevitably occur. Although most courts support these statutory protections, the standards are strictly interpreted. Therefore, it is imperative that hospitals and medical staffs be completely familiar with the necessary steps for maximizing the protections afforded under these statutes and make sure they are abiding by these standards after consulting with legal counsel. Failure to follow these requirements could result in a waiver of the protections or a finding that they do not apply. If the hospital has opted to participate in a patient safety organization under the Patient Safety and Quality Improvement Act of 2005, their protections would have been even broader than most state statutes, but they are only effective if all requirements under the act are met.

Because private and governmental payers now make reimbursement contingent on compliance with stated quality metrics and outcomes, we expect that negligent credentialing claims will increase. Moreover, licensure, accreditation, and continued Medicare eligibility will be based on satisfying this growing list of quality standards, thereby placing even greater pressure on hospitals and medical staffs to make sure that physicians remain continuously qualified to exercise each of their authorized clinical privileges.