An Obligation to Vet

Hospitals that fail to meet their responsibility to thoroughly vet health care providers should be held accountable when those providers are negligent and injure patients.

By || **Mia I. Frieder**

Stacy Moran went to a hospital emergency room (ER) with severe swelling in his face, tongue, and throat that prevented him from swallowing. But what Stacy did not know was he had angioedema, a potentially fatal condition that required careful assessment and monitoring to prevent his windpipe from swelling shut. And he had no idea that the ER doctor who would ultimately examine, treat, and discharge him was addicted to opioid painkillers and was impaired while treating him.

Earlier that day, the doctor had obtained an illegal prescription for narcotic painkillers from a colleague that he filled at a local pharmacy only hours before starting his shift. The addicted doctor had been doing this for years and frequently sent ER staff to fill prescriptions for him during their shifts. Earlier that month, the hospital board had unanimously approved the doctor's application for recredentialing. With the hospital's seal of approval, this impaired physician went on to make life-and-death decisions, including the decision to discharge Stacy, who died.

Stacy's adult children filed a wrongful death lawsuit including various allegations of professional negligence against the addicted doctor, as well as a negligent credentialing claim against the hospital for its failure to adequately conduct a credentialing review of the impaired physician.[1] Hospitals have a duty and the authority "to examine the qualifications of any physician seeking staff privileges and to limit his or her practice to those procedures or areas it deems the physician qualified for, or to completely bar the physician from such practice because of incompetency, lack of qualifications, inexperience, or recklessness."[2]

Viewed in this context, physicians are the penultimate guardians of patient safety, since it is the hospital, acting through its governing body, that ultimately must provide a culture of safety for its patients. Even if the doctor is an employee of a separate corporation or health care group that the hospital contracts with, the hospital is ultimately responsible for the safety of its patients and must exercise independent judgment to ensure that physicians are qualified to practice medicine generally or specific medical procedures.

For jurisdictions that recognize a claim of negligent credentialing,[3] plaintiffs typically must show that

- the hospital has failed to meet the standard of reasonable care in granting medical staff privileges to physicians whose treatment provided the basis for the underlying medical negligence claim
- the physician has breached the applicable standard of care while practicing under negligently granted medical staff privileges

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- the negligent granting of medical staff privileges was the proximate cause of the plaintiff's injuries.[4]

A thorough discussion of all three elements is beyond the scope of this article; the focus here is on the first element of a negligent credentialing claim: establishing that a hospital failed to meet its obligation to provide competent medical staff—including a discussion of discovery techniques.

Accreditation and the Role of the Joint Commission

The Joint Commission is a private, nonprofit, federally approved organization that provides hospital accreditation.[5] Founded in 1951, the Joint Commission's primary role emerged in 1965 when President Lyndon B. Johnson signed the Social Security Act Amendments, which established Medicare and Medicaid and required hospitals to meet certain safety standards to receive money from these programs.[6] To prove their compliance, hospitals may hire a private accrediting organization such as the Joint Commission. The federal government relies on the Joint Commission's findings, and nearly all states incorporate its decisions into some aspects of their licensing process.[7] Today, the Joint Commission is the accrediting organization for more than 80% of hospitals in the United States[8] and is generally recognized as setting the basic national minimum standards for participation in Medicare.[9]

A Culture of Safety

A claim for negligent credentialing arises out of the established premise that "a hospital has a direct and independent responsibility to its patients to take reasonable steps to ensure that staff physicians using hospital facilities are qualified for privileges granted."[10] Hospitals must ensure that providers—whether employed, contracted, or credentialed—are competent to perform the duties of their position. The Joint Commission recognizes that the provision of safe, quality care is the responsibility of the hospital's leaders—typically the governing body.[11] Accredited hospitals are required to create and maintain a culture of safety and quality led by executive management.[12]

A culture of safety encompasses many aspects and activities, including the expectation that the hospital "effectively manages its programs, services, sites, or departments"; that "the governing body, senior managers and leaders of the organized medical staff regularly communicate with one another on issues of safety and quality"; and that "leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality."[13]

In practical terms, this means that the institution, leadership, and governing board have taken every possible step to create a safe practice environment, resulting in hospital policies and procedures designed to protect patients. Examples include policies and procedures that attempt to protect patients from self-harm or address the discharge of a patient with a life-threatening disease against medical advice and compliance programs that allow employees to voice concerns. The absence of these policies and procedures generally leads to more informal, relaxed standards, which is fertile ground for a negligent credentialing claim.

For example, in Stacy's case, one of the reasons the defendant doctor could conceal his drug addiction was because he was well known within the hospital and the community, and the process of recredentialing the doctor became casual (in other words, we don't need to do this evaluation because we know him). In these situations, informality supplants reliable information, and relying on someone's word replaces the need for objective evidence. Hospital employees who may question a superior's behavior do not have a formal channel to voice a complaint, so the subordinates' concerns are silenced. This eventually eats away at the hospital's culture of safety.

Discovery

At the beginning of discovery or in the first request for production of documents, include a request for all policies and procedures for the medical staff and the individual department involved in the underlying medical negligence claim. Obtain these documents before deposing relevant witnesses, such as members of the hospital board and the medical credentialing committee, including the chair of the board or committee during the relevant time period. If no documents exist, confirm that at those depositions.

Also request the hospital and the medical staff bylaws; any forms used in the application process for credentialing, recredentialing, and the granting of privileges; any agreements between the hospital and the physician or physician group implicated in the lawsuit; and all materials relating to the hospital's credentialing history. Examples include applications for credentialing, verification of the facts in the application, and verification that the physician can perform the requested procedures or medicine generally.

You should request the physician's complete credentialing file. Expect objections, especially based on medical and peer review. Such objections are valid to a point, but a credentialing file is considered discoverable to the extent that it does not involve a peer review or medical review committee's evaluation of medical services provided by the physician.[14] There may be laws that preclude a party from discovering the proceedings and records of a peer review organization, but a party usually is authorized to seek from original sources the documents that the peer review organization examined and to examine anyone who

appeared before or was a member of the peer review organization, so long as the witness is not asked about the peer review proceedings.[15]

Don't allow defendants to stand on blanket objections without grounds. Press opposing counsel for a privilege log and for case law that substantiates the objection. You also can ask for a redacted copy or press for an in camera review by the court to determine whether the information is privileged.

Request a hospital organization chart that identifies everyone involved in the credentialing and privileging process. Generally, the governing body of a hospital is the hospital board, which may have physician and nonphysician members. In most credentialing cases, the physician who is applying for credentialing or recredentialing fills out the application, including an attestation of truthfulness, which is given to a credentialing doctor or committee to make a recommendation to the full board.

The Joint Commission standards on credentialing require "an objective, evidence-based process," and Medicare Conditions of Participation specify that "the governing body must ensure the criteria for selection are individual character, competence, training, experience, and judgement."[16] Moreover, the Joint Commission standards clearly indicate that the hospital cannot delegate its duty with respect to medical staff matters.[17]

Documents obtained through discovery may present a picture of compliance; therefore, the only way to flesh out the negligent credentialing claim is by deposing hospital leaders (the board and its chair) and questioning them, in detail, about the procedural steps taken to examine credentialing files and the mechanism for granting, renewing, or revising clinical privileges. Potential questions include:

- To what degree does the hospital's governing body depend on medical staff recommendations when appointing and reappointing physicians?
- Do the hospital bylaws describe the processes for appointment and reappointment of medical staff members? If so, does the medical staff rely on those bylaws in making recommendations, and are they given any formal orientation to the bylaws?
- Are decisions regarding an application for medical staff membership and an application for clinical privileges made separately?
- Does the hospital ever obtain information on its own when assessing an applicant's education, training, and experience as part of the review process?
- What data banks or federal or state sources, if any, does the hospital board consult when evaluating an application?
- What information must applicants provide as part of the decision-making process? What information, if any, must be disclosed regarding challenges to licensure or registration and other hospitals' granting or suspension of medical staff membership or privileges?
- How does the governing body independently confirm the statements in the credentialing application?

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Rather than just accept the physician's word on an application, medical staff should investigate on their own, and hospital boards must exercise independent judgment, not merely "rubber stamp" the recommendation of medical credentialing committees.[18]

For example, a California hospital's board denied a physician's privileges, overruling the recommendation of its Medical Executive Committee. The surgeon was previously under investigation by the Texas State Board of Medical Examiners and failed to produce an exoneration letter. Despite this, the committee recommended advancing the surgeon to active status. After being denied privileges, the surgeon challenged the board's decision, and the appellate court noted that the board properly exercised independent judgement based on the information presented, all the while according weight to the committee's recommendation.[19]

Companies have policies and procedures in place to ensure they are running properly and that employees are qualified to do their jobs. Hospitals are no different: They must ensure that the physicians practicing within their walls are competent and credible—and when they fail to do so, people may die.

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Notes

1. *Moran v. Union Gen. Hosp., Inc.*, No. 16-CV-85-SG (Ga. Super. Ct. Union Cnty.).
2. *Otero v. Vito*, 2006 WL 871144, at *3 (M.D.

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Ga. Apr. 4, 2006); *Candler Gen. Hosp., Inc. v. Persaud*, 442 S.E.2d 775, 777 (Ga. Ct. App. 1994).

3. Approximately 16 jurisdictions have specifically recognized that hospitals have a duty to exercise reasonable care in granting privileges to physicians to practice generally or perform specific procedures at the hospital. *See generally Elam v. College Park Hosp.*, 183 Cal. Rptr. 156 (Cal. Ct. App. 1982); *Megrelishvili v. Our Lady of Mercy Med. Ctr.*, 291 A.D.2d 18 (N.Y. App. Div. 2002); *Carter v. Hucks-Folliss*, 505 S.E.2d 177 (N.C. Ct. App. 1998); *Albain v. Flower Hosp.*, 553 N.E.2d 1038 (Ohio 1990), *overruled on other grounds by Clark v. Southview Hosp. & Fam. Health Ctr.*, 628 N.E.2d 46, 53 (Ohio 1994); *Strubhart v. Perry Mem'l Hosp. Trust Auth.*, 903 P.2d 263 (Okla. 1995); *Welsh v. Bulger*, 698 A.2d 581 (Pa. 1997); *Rodrigues v. Miriam Hosp.*, 623 A.2d 456, 462 (R.I. 1993); *Domingo ex rel. Domingo v. Doe*, 985 F. Supp. 1241, 1245 (D. Haw. 1997), *aff'd, Domingo ex rel. Domingo v. T.K.*, 289 F.3d 600 (9th Cir. 2002).
4. *Frigo v. Silver Cross Hosp. & Med. Ctr.*, 876 N.E. 2d 697, 723 (Ill. App. Ct. 2007).
5. Formerly known as the Joint Commission on Accreditation of Health Care Organizations.
6. Pub. L. No. 89-97, 79 Stat. 286 (1965).
7. The Joint Comm'n, *Facts About Federal Deemed Status and State Recognition*, https://www.jointcommission.org/facts_about_federal_deemed_status_and_state_recognition.
8. *See* Stephanie Armour, *Hospital Watchdog Gives Seal of Approval, Even After Problems Emerge*, Wall St. J. (Sept. 8, 2017), https://www.wsj.com/articles/watchdog-awards-hospitals-seal-of-approval-even-after-problems-emerge-1504889146.
9. See Hospital Accreditation Standards promulgated by The Joint Commission and the Hospital Conditions of Participation. 42 C.F.R. §§482.1–482.104 (Westlaw current through June 20, 2019); The Joint Comm'n, *About Our Standards*, https://www.jointcommission.org/standards_information/standards.aspx.
10. *McCall v. Henry Med. Ctr.*, 551 S.E.2d 739, 742 (Ga. Ct. App. 2001).
11. The Joint Comm'n, Standard LD 01.03.01 (2009).
12. The Joint Comm'n, Standard LD 03.01.01 (2009).
13. The Joint Comm'n, Standards LD 04.01.05; 02.03.01; 03.06.01 (2016).
14. *Hosp. Auth. of Valdosta and Lowndes Cnty. v. Meeks*, 678 S.E.2d 71, 73 (Ga. 2009).
15. *See Cancel v. Med. Ctr. of Cent. Ga., Inc.*, 812 S.E.2d 592, 598 (Ga. Ct. App. 2018) (citing *Freeman v. Piedmont Hosp.*, 444 S.E.2d 796, 797 (Ga. 1994); *Claypool v. Mladineo*, 724 So. 2d 373, 385 (Miss. 1998).
16. 42 C.F.R. §482.12(a)(6).
17. The Joint Comm'n, Standard LD 01.05.01 (2014).
18. *See, e.g., Powell v. Bear Valley Comty Hosp.*, 231 Cal. Rptr. 3d 381, 392 (Cal. Ct. App. 2018).
19. *Id.*