Eliminating Negligence in Physician Credentialing

Illinois Hospital Association White Paper
Legal Department
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Every hospital strives to select the best physicians available to perform to the best of their abilities. Perhaps now more than ever hospitals, through their trustees, administrators, and medical staff members, need to re-assess their credentialing practices to maximize their quality of care and minimize their legal exposure for substandard physician performance. Illinois law has recently heightened the legal risk hospitals face for getting credentialing "wrong."

This IHA White Paper is designed to help you get credentialing "right." It is the product of field-tested input of in-house hospital counsel from across Illinois and the expert input of outside attorneys. The IHA is particularly grateful to the following individuals who helped make this document possible:

- David Burtker, Partner, Cunningham, Meyer & Vedrine
- Michael Callahan, Partner, Katten Muchin Rosenman
- William McVisk, Partner, Johnson & Bell
- Ann Sayvetz, Vice President & General Counsel, Northwest Community Hospital

Their thoughtful input and commentary on the ideas developed in this White Paper were instrumental to the success of this project.

This White Paper, however, is ultimately the product of the IHA and we take full responsibility for its content. IHA's Thaddeus Nodzenski, Senior Associate General Counsel, served as its lead author and editor and received significant assistance in its preparation from the following IHA staff members:

- Ryan Asmus, Senior Claims Supervisor
- Jody Wittenberg, Senior Associate General Counsel

We commend this IHA White Paper to you and all of the trustees, administrators, in-house counsel, credentialing professionals and medical staff members who play a role in the physician credentialing and privileging practices at your institution. If you have any questions regarding this Paper, you may contact Ted Nodzenski at tnodzenski@ihastaff.org or (630)276-5472.

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Executive Summary

In *Frigo v. Silver Cross Hospital, and Medical Center,* 377 Ill.App.3d 43, 876 N.E.2d 697 (1st Dist. 2007) an Illinois appellate court held for the first time that a hospital could be sued for negligently credentialing a physician. The Medical Studies Act, which prevents discovery of peer review information, may pose a serious problem in defending these cases. In the fall of 2008, the IHA hosted a meeting of in-house hospital counsel and outside legal experts to consider possible hospital reactions to this decision. Based on this input the IHA has concluded that hospitals may consider pursuing the following approaches:

- *Maintain Status Quo.* Maintain current credentialing practices on the assumption that the risk of a negligent credentialing claim is too low to warrant revision.
- *Assess and Improve Current Credentialing Practices.* Revisit, reassess and reengineer the hospital's credentialing process to improve the hospital's decisions and actions, but do nothing to otherwise generate discoverable information or documents to defend credentialing actions.
- *Improve Credentialing and Selectively Develop Discoverable Information.* Assess and improve existing credentialing practices to minimize the risk of physician negligence and adopt a discoverable approach for select cases that may pose a heightened negligent credentialing risk for the hospital.
- *Improve Credentialing and Make the Entire Process Discoverable.* Improve existing credentialing practices and adopt a transparent approach that assumes the entire process is discoverable under the Medical Studies Act.

Each of these approaches has its own pros and cons which are discussed below in this White Paper after a general discussion of negligent credentialing claims against hospitals.

I. Legal Background

Two recent judicial decisions have placed renewed focus on the physician credentialing process of hospitals. This White Paper attempts to identify the legal and factual basis supporting a theory of negligent credentialing and seeks to offer guidance for improving the credentialing process and reducing the legal exposure of that process.

A. The *Kadlec* Decision

In *Kadlec Med. Ctr. v. Lakeview Anesthesia Assoc.*, No. 06-30745 (5th Cir. (La.), May 8, 2008), a federal appellate court in Louisiana addressed whether a hospital had a legal duty to share adverse information about a physician with another hospital upon request. It held that while no duty existed, the hospital (and anyone else who chose to provide information about a physician) had a legal duty to avoid affirmative misrepresentations in their reference letters. Accordingly, a neutral reference letter from the hospital to the requesting hospital in which only basic facts were provided was deemed not to be misleading, even though it withheld information about the physician's impairment. Conversely, letters sent by the physician's previous employer misrepresented significant facts and negligently and intentionally misled Kadlec about the physician's impairment.

The duty to avoid affirmative misrepresentations is consistent with current Illinois law. Future Illinois courts, however, may be persuaded to hold that hospitals have a "duty to share" information on the legal theory that hospitals have a "special relationship" with each other to protect patients from unqualified physicians.

Despite the fact that *Kadlec* essentially rewards silence about physicians with immunity from liability, the problem of collecting important credentialing information from other hospitals remains. **Appendix A** discusses approaches hospitals may wish to consider in addressing this challenge.

B. The *Frigo* Decision

Perhaps more significantly, in *Frigo v. Silver Cross Hospital,* an Illinois appellate court upheld a negligent credentialing verdict against a hospital for not following its bylaws. In *Frigo,* the hospital granted surgical privileges to a podiatrist who did not satisfy the hospital's criteria for such privileges. The plaintiff alleged that the hospital was negligent in renewing these surgical privileges, which allowed the podiatrist to injure the plaintiff. After hearing conflicting expert testimony over whether the surgical privileges were properly granted, the jury returned a verdict for the plaintiff, awarding approximately $7.8 Million in damages.

In upholding the jury verdict, the appellate court held the following:

- The Medical Studies Act does not shield hospitals from negligent credentialing claims even though credentialing deliberations and information are inadmissible in medical liability cases.
- The plaintiff's negligent credentialing claim did not have to meet the willful and wanton standard of proof required under the Hospital Licensing Act for hospital quality assurance actions because that standard only applied to physicians challenging adverse disciplinary, credentialing and staff membership decisions.
- Claims for negligent credentialing are a natural extension of the doctrine of institutional negligence of hospitals under *Darling v. Charleston Memorial Hospital,* 33 Ill. 2d 326 (1965).
- To establish a claim for negligent credentialing the plaintiff must prove that:
    - The hospital failed to exercise reasonable care in granting staff membership or clinical privileges to a physician;
    - The negligently privileged or credentialed physician treated the plaintiff negligently; and
    - The hospital's negligent credentialing of the negligent physician was the proximate cause of the plaintiff's injury.

Frigo is the first Illinois appellate ruling to recognize and apply the negligent credentialing cause of action in a medical liability lawsuit.

II. The Implication of *Frigo*

As a result of *Frigo,* credentialing presents a double-edged risk. One edge exposes hospitals to medical malpractice liability for unreasonably credentialing a physician who negligently treats a patient. This risk might cause hospitals to err in favor of denial or restriction of staff privileges. But in doing so, the hospital may be exposing itself to litigation from disgruntled physicians challenging the hospital's credentialing actions. Ultimately, the hospital's credentialing and privileging guidepost should be the promotion of patient safety and quality of care.

In addition, because of the confidentiality provisions of the Medical Studies Act, neither plaintiffs bringing negligent credentialing claims nor hospitals defending themselves against such claims can use confidential peer review or credentialing committee deliberations as evidence nor is such information subject to discovery.[1]

[1] The Patient Safety and Quality Improvement Act of 2005 recently adopted final rules relating to Patient Safety Organizations ("PSOs") which become final on January 19, 2009. Under these rules, information relating to medical errors, patient safety and quality improvement which is collected and reported to a PSO are privileged and confidential and therefore not subject to discovery or admissibility in a state or federal proceeding. Hospitals participating in a PSO need to be mindful of what peer review information is

As in all negligence cases, the plaintiff has the initial burden of proving that the hospital's credentialing decision was negligent and the Medical Studies Act keeps much of the evidence of the hospital's credentialing decision out of the plaintiff's hands except for final actions taken, if any, against a physician. As a result, future negligent credentialing claims are likely to be based on two scenarios where the evidence of credentialing negligence falls outside of the Medical Studies Act:

1. *Failure to Follow Procedures*. Similar to cases where a medical staff disciplinary decision may be reviewed and reversed because of procedural irregularities, a hospital must follow its bylaws, rules and procedures to limit its liability in negligent credentialing claims. They must also remain compliant with accreditation, licensure, Medicare Conditions of Participation and similar state and federal requirements relating to credentialing and privileging physicians. Courts and juries appear much more comfortable holding hospitals accountable for procedural mistakes than for substantive mistakes which are harder to gauge. For example, proof that the hospital failed to query a physician's medical liability and disciplinary data in the National Practitioner Data Bank (NPDB) would likely be more difficult to overcome than debating whether any "adverse" data in the Data Bank should have supported the denial or limitation of clinical privileges.

2. *Strong Suggestion of Incompetence (i.e., "red flags")*. Sometimes a plaintiff may have strong, non-Medical Studies Act protected evidence that the physician who treated him was unqualified. Such evidence might include repeated failures to get board certification, failure to complete a residency, history of adverse patient outcomes, medical malpractice claims history and licensing sanctions. If a hospital wishes to grant membership and clinical privileges to a physician who has some potential "smoking gun" problems in his or her background, it may be wise to develop a track record or rationale outside of the Medical Studies Act deliberations that would explain why those "problems" were not a barrier to staff membership and privileges for this physician.

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captured by these PSO procedures because, as was the case under the Medical Studies Act in Frigo, this information will not be available to either the plaintiff or the hospital in the context of a negligent credentialing claim.

III. Defending Negligent Credentialing Claims

Negligent credentialing is a subspecies of institutional negligence. To establish institutional negligence a plaintiff must show the following:

1. A duty owed to the plaintiff.
2. A breach of that duty.
3. Injury or death proximately caused by that breach.

Hospitals owe their patients a duty to act as a "reasonably careful" hospital would under similar circumstances. Plaintiffs typically need to establish this duty of reasonable care and its breach through expert witness testimony. This witness needs to identify what the defendant hospital did that a reasonably careful hospital would not have done under the circumstances.

To be successful, the plaintiff must also use expert testimony to show a causal connection between the breach of duty and the plaintiff's injury or death. In other words, the plaintiff must show within a reasonable degree of medical certainty that the hospital's failure to follow the standard of care is more probably than not the cause of the plaintiff's harm.

In the context of negligent credentialing, a hospital has a duty to use reasonable care to determine the qualifications of the physicians on its medical staff. It breaches that duty when it allows a physician to practice medicine in the hospital when it knows or should know that the physician is unqualified. A hospital, however, is not required to ensure that all of its physicians will always perform according to their duty of care.

Thus, a negligent credentialing plaintiff must show through expert testimony that the hospitals violated its reasonable standard of care and wrongly awarded practice privileges to an unqualified physician who exercised those privileges negligently. The plaintiff must also show that this breach of duty was the proximate cause of the plaintiff's injury by proving that the unqualified physician violated his or her standard of care in treating the plaintiff. In short, the hospital's negligent credentialing must have allowed the physician's negligence to injure the plaintiff.

These causal connections may not exist in every case. For example, failing to discover that a physician has a history of embezzlement should not result in a negligent credentialing claim for medical negligence. Similarly, if a physician did not fully disclose being impaired or disciplined and the hospital had no other reasonable source for such information, it will not likely be held liable for the physician's negligence under a negligent credentialing theory.

On the other hand, failing to learn that a gynecologist was convicted of sexual abuse and lost his license for a period of time could have a causal connection with

a claim that the physician made inappropriate sexual advances to patients because this information would have been available from the Illinois Department of Financial and Professional Regulation. Also, failing to learn that a physician was convicted of a drug offense could have an impact on a physician who was impaired at the time he treated the plaintiff.

Accordingly, one of the most basic ways for hospitals to defend themselves against a negligent credentialing claim is to break the causal chain between a questionable credentialing action and the underlying medical negligence of the physician.

A plaintiff challenging the reasonableness of a hospital's credentialing action is likely to base the claim on at least one of the following assertions against the hospital:

1. Negligent Information Gathering & Verification.
2. Negligent Failure to Follow Reasonable Internal Credentialing Procedures such as Medical Staff Bylaws and Policies relating to Appointment, Reappointment and Credentialing/Privileging Procedures.
3. Negligent Failure to Follow Standards of Accreditation, Licensing, Medicare Conditions of Participation or other Applicable Credentialing Requirements.
4. Negligent Failure to Assess the Credentialing Information Reasonably.
5. Negligent Granting or the Failure to Limit Privileges to an Unqualified Physician.
6. Negligent Failure to Take Appropriate, Remedial or Corrective Action Based on the Credentialing Information.

The first three charges are essentially failures in procedure or practice. The remaining charges, by contrast, attack the substantive reasonableness of the hospital's credentialing action.

A hospital that fails to obtain and verify reasonably available information that would have caused a reasonable hospital to limit or deny a physician's privileges is at risk of a negligent credentialing claim if that physician injures a patient in the hospital. Similarly, if a hospital fails to follow its credentialing bylaws, rules and practices and any regulatory credentialing requirements and if that failure allowed an unqualified physician to injure a patient at the hospital, a negligent credentialing claim against the hospital is likely.

But the liability risks of these procedural bases for negligent credentialing are much easier to manage than risks involving the substantive bases. If a hospital has reasonable rules and practices for gathering and verifying information and it can document its compliance with those rules and procedures, a "procedural" negligent credentialing claim should be unfounded. The challenge is to make sure

that these standards, rules and procedures are consistently and uniformly followed.

Defending against the substantive charges, however, is complicated by two factors: (1) the Medical Studies Act; and (2) the challenge of assessing clinical competence.

- *The Medical Studies Act Challenge*

Any discoverable "red flag" information that calls into question a physician's competence begs for a reasonable response from the hospital. For example, a physician's large number of medical malpractice claims, settlements or judgments may be the subject of some detailed review by the hospital's medical experts and peer review committees. Or, as a result of an ongoing monitoring program, a substandard pattern of care is identified involving one or more physicians which triggers a similar review. But none of that reasonable review is likely to make its way into the record of a negligent credentialing case given that these materials and discussions may not be discoverable or admissible under the Medical Studies Act.

- *The Substantive Credentialing Decision Challenge*

In a substantive challenge to a hospital's credentialing action the plaintiff must show that the hospital's decision was negligent "on the merits" through expert testimony. Practicing medicine well is both an art and a science. And reasonable physicians may differ over whether a particular candidate is qualified for a particular privilege. They may also differ on how the hospital might respond reasonably to address any concerns raised in the application or peer review investigation. This daunting medical assessment challenge is perhaps the primary reason most courts in the United States defer to the judgments of hospitals and their medical staffs in wrongful denial of privilege actions brought by disgruntled physicians. The task becomes no easier in a negligent credentialing case.

Because of the difficulty of mounting a substantive challenge to a credentialing decision, one might expect that this basis will be the least likely foundation for a negligent credentialing claim. Plaintiffs would need to hire a medical expert to opine that as a matter of medical substance the decision to grant or maintain privileges was unreasonable. And that testimony would be countered by a defense medical expert opining that the decision under the circumstances was reasonable. In close cases where the experts basically cancel each other out, the decision of the hospital might be given the benefit of the doubt as long as its procedures and privileging criteria were followed and "unprivileged" documents reveal the reasonableness of its decision. In any event, this battle of experts is a high stakes game that should discourage plaintiffs from taking this approach.

IV. Four Possible Hospital Responses to *Frigo*

1. *Maintaining the Status Quo*. Under this approach, the hospital would review the *Frigo* decision and conclude that the risk of a negligent credentialing claim is too low to warrant revising the hospital's practices and take steps to ensure that current procedures are being followed. The benefit of this approach is that it requires no substantial consumption of scarce hospital resources or staff time.

   The downside of this approach is that the hospital might have passed on improving its credentialing practices and avoided liability for a fraction of the cost of just one negligent credentialing judgment.

2. *Audit and Improve Credentialing*. Under an audit approach, the hospital would use the *Frigo* decision as an opportunity to revisit, reassess and reengineer the hospital's credentialing process to determine if the hospital is in compliance with its bylaws, policies and all legal requirements and to improve the hospital's decisions and actions, but do nothing to otherwise generate information or documents that are discoverable under the Medical Studies Act. The discussion in **Appendix B** spells out some of the factors a hospital might wish to consider in reevaluating its credentialing practices. The benefits of this exercise are obvious. If the hospital's credentialing and privileging approach is reasonable at the outset and produces reasonable decisions, the risk of physician negligence triggering a negligent credentialing claim is greatly reduced, if not eliminated. An improved process is better able to award privileges that will be exercised reasonably which, in turn, will lower the hospital's negligent credentialing exposure and improve the quality of patient care.

   The downside of this approach is that the time, effort and money involved in assessing and improving a hospital's credentialing practices may be substantial. The process involves reviewing and possibly changing several hospital bylaws, regulations, procedures and staff practices. Making formal and cultural changes to this process is no mean feat. Before launching such an initiative, each hospital must make its own cost-benefit decision regarding how much effort it wishes to devote to the improvement of its existing credentialing practices in light of the new *Frigo* liability risk. That being said, the current pay for performance (P4P) approaches being utilized by public and private payors almost compel health care providers to improve practices and therefore, hospitals may wish to consider going down this path.

3. *Improve Credentialing and Adopt Discoverable Processes for Special Cases*. Under this approach, the hospital would do every step described in (b) above, to assess and improve existing credentialing practices. But it would also adopt a discoverable approach to credentialing for select "red flag" cases that may pose a heightened risk of a negligent credentialing claim against the hospital.

   Hospitals that wish to grant privileges to such "red flag" physicians would need to consult legal counsel to explore the possibility of developing a second credentialing track or documentation that is not protected by the Medical Studies Act. The confidentiality under the Medical Studies Act is easily defeated if a hospital fails to follow the narrow confines of the Act. For example, the Act only protects information of a hospital "committee" or its "designee." And that committee must be qualified to provide professional self-evaluation of a physician's competence for the purpose of improving patient care.

   The appellate court decision in *Webb v. Mount Sinai Hospital and Medical Center of Chicago*, 347 Ill. App. 3d 817, 807 N.E. 2d 1026 (1st Dist. 2004) is a fine example of fragility of Medical Studies Act confidentiality. In *Webb*, the appellate court held that an "occurrence summary" and physician interview notes prepared by a risk manager were discoverable under the Medical Studies Act because these documents were generated for the additional purposes of obtaining legal opinions and assessing potential liability risk which fell outside the purposes of the Act.

   The first lesson of *Webb* is that any document generated for the purpose of assessing potential legal liability is discoverable under the Medical Studies Act even if that document is also used by a peer review committee covered under the Act. In addition, any document generated before the peer review process is initiated or after it ended may not be privileged. Only documents created or requested by the committee during the review process are protected so long as those documents are created or sought for the sole purpose of improving patient care or reducing morbidity or mortality of for purposes of professional discipline. By implication, any document a credentials committee creates for the dual purpose of improving care and assessing legal liability should be discoverable under the Act. *Webb* seems to support the development of such "multiple purposes" documentation being discoverable for negligent credentialing cases.

   So, one set of defense information that can be generated for a "red flag" application is to describe the pre-committee information the hospital gathered to provide to its credentialing committee. It would be particularly helpful to show that the hospital engaged in heightened information gathering in light of a particular red flag. For example, if the

applicant has an unusually high number of medical malpractice claims against him, it might be helpful to show that the hospital dug deeper into these cases to get a thorough assessment of the physician's competence. This disclosure would relate more to the process it followed and information obtained rather than the actual deliberations and therefore, should be discoverable.

Moreover, it may be possible for a medical department chairman to independently review the application and identify questions or topics for the committee before the committee convenes. That way the hospital could begin to show how seriously it took any "red flag" issues in a particular application without any Medical Studies Act impediments. Showing the court what questions the credentials committee was asked to consider should help show how seriously and thoroughly the hospital took the application. The expertise of the members of the committee could also be documented in advance to bolster the reasonableness of the hospital's credential practices and decision.

Perhaps more significantly, a plain reading of the Medical Studies Act provides confidentiality only for "information obtained" by a peer review committee "*used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care*." There is nothing in the Medical Studies Act that prohibits a peer review committee from generating another report for the express purpose of explaining the reasonableness of its credentialing recommendations for the purpose of limiting the hospital's legal liability. Thus, it may be possible for the very same credentials committee to conclude its confidential, Medical Studies Act protected work and re-convene to produce its discoverable defense of the reasonableness of its credentialing recommendation for the express purpose of creating a discoverable record on the "red flag" application or other peer review decision in the event that the decision is challenged as being negligent. It would seem difficult for a plaintiff to convince a court that such documents are confidential under the Medical Studies Act. And this approach arguably leaves intact the Medical Studies Act privilege for any documents prepared by a credentials committee for the sole purpose of improving quality of care. Also keep in mind that the actual hospital board decision or action following a recommendation of a peer review committee is discoverable. The documents describing the above process coupled with the ultimate Board decision or peer review committee recommendation may be enough to defeat a negligent credentialing claim.

The downside of this selective "red flag" approach is threefold. First, certain specialties may be difficult to recruit and not all physicians apply with unblemished records. So when does an application call for "red flag" treatment? Is a "red flag" simply having a certain number of prior or

pending lawsuits or judgments? For some specialties (e.g. obstetrics, neurosurgery, orthopedics), the number or type of lawsuits and payments may vary as to what constitutes rising to the level of "red flag."

Second, a single past lawsuit or payment that *arguably* involves the same or similar facts as the current claim may be sufficient for a negligent credentialing claim – and such "single similar claim" physicians would likely not have risen to the "red flag" level. So this selective approach runs the risk of being both over-inclusive (i.e., flagging too many applicants that pose no serious risk) and under-inclusive (not flagging enough applicants who may have an experience supporting a negligent credentialing claim). Fine tuning the sensitivity of the "red flag" selection process presents its own set of costs and concerns.

Third, the scope of who and what will be discoverable under the "red flag" approach is potentially unlimited. A plaintiff presented with a discoverable document that exonerates the hospital's credentialing process will likely want to do discovery on how the document came into being and everything that went into creating that document. Everyone involved in this discoverable process may be subject to deposition. At some point, the trail of discovery may lead to the Medical Studies Act protected discussions of the medical staff peer review committees. How will courts react to an argument that a discoverable document should be inadmissible because it cannot be properly examined and cross-examined in light of the Medical Studies Act?

Alternatively, Illinois courts might conclude that this nuanced approach to protecting some aspects of credentialing from discovery while exposing other aspects for the sole purpose of defending the hospitals credentialing actions ultimately defeats the Medical Studies Act protection. The Act's confidentiality cannot be waived, but if a court concludes that this dual approach takes the entire process outside of the Act, there might be not a privilege to waive in the first place.

Hospitals are urged to explore the legal and operational viability of such a dual approach to "red flag" applications and other peer review decisions with their internal credentialing and risk management experts and legal counsel.

4. *Improve Credentialing and Adopt a Universally Discoverable Process*. Under this approach, the credentialing process would be reassessed and improved. But the most radical feature of this approach is that the credentialing process would be fully transparent and discoverable in medical liability cases. Hospitals and their patients, however, benefit tremendously from open and candid peer review discussions made possible only due to the confidentiality of the Medical Studies Act. If a

hospital's physicians are not chilled or deterred in their evaluation of staff applicants and each other under such an approach, the hospital would be able to introduce and rely on everything used and done in the process to defend itself in a negligent credentialing lawsuit.

Besides the clear benefit of going through a credentialing improvement process, this approach is consistent with the latest trends in health care focusing on transparency. A fully discoverable credentialing process would give defense counsel the greatest amount of information needed to defend the hospitals actions and decisions.

However, the radical nature of this proposal may be too much to assume of physicians asked to participate in rigorous self-evaluation and peer review. It may be hard to find a situation where the benefits of having discoverable material to defend against a rare negligent credentialing case outweigh the negative effects of peer review transparency on the peer review process. Moreover, such a radical step may be viewed as a massive overreaction to the challenges presented to hospitals under *Frigo.* A final cost of such an approach is that it would fuel calls to repeal the Medical Studies Act as being unnecessary to promote physician peer review. On balance, this approach may have the least to offer to hospitals and the credentialing process.

Conclusion

The length of this White Paper strongly suggests that medical staff credentialing is a daunting task clinically, legally and operationally. The recent *Kadlec* and *Frigo* decisions have only made this activity more challenging. We hope this White Paper provides Illinois hospitals some thoughtful and effective ways to improve both the hospital's credentialing practices and the hospital's ability to defend their reasonableness. But this White Paper is not the end of the dialogue hospitals must have internally with administrative and medical staff members and legal counsel. On the contrary, this White Paper is simply a starting point for revisiting and possibly revising how Illinois hospitals identify and privilege high quality physicians for their medical staff.

APPENDIX A:
THE CHALLENGE OF GATHERING CREDENTIALING INFORMATION

Hospitals need to be mindful of the following provisions that affect the gathering and sharing of credentialing information:

1. *Credentialing Immunity*. The Hospital Licensing Act, 210 ILCS 85/10.2, which provides that "no hospital and no individual who is a member, agent, or employee of a hospital, hospital medical staff, hospital administrative staff, or hospital governing board shall be liable for civil damages as a result of the acts, omissions, decisions, or any other conduct, except those involving willful or wanton misconduct, of a medical utilization committee, medical review committee, patient care audit committee, medical care evaluation committee, quality review committee, credential committee, peer review committee, or any other committee or individual whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital, or the improving or benefiting of patient care and treatment." In order to maximize this immunity, hospitals should review their forms and bylaws to make sure that at a minimum, that they are consistent with this "willful and wanton" standard. Some bylaws may contain a lesser "good faith" or "actual malice" standard of protection.

2. *Credentialing Confidentiality*. The Medical Studies Act, 735 ILCS 5/8-2101, which provides that all "information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a health care practitioner's professional competence, or other data … used in the course of internal quality control … or for improving patient care …, shall be privileged, strictly confidential and shall be used only for …, the evaluation and improvement of quality care, or granting, limiting or revoking staff privileges." There is a great deal of case law interpreting the meaning and scope of the Medical Studies Act which should be followed to maximize the confidentiality under the Act.

3. *Uniform Application*. Health Care Professional Credentials Data Collection Act, 410 ILCS 517/1, which provides "each hospital that employs, contracts with, or allows health care professionals to provide medical or health care services and requires health care professionals to be credentialed or recredentialed shall for purposes of collecting credentials data only require:

    i. the uniform hospital credentials form;
    ii. the uniform hospital recredentials form;
    iii. the uniform updating forms; and
    iv. any additional credentials data requested."

    Many hospitals have adopted supplemental questions in addition to the mandated forms to collect more extensive information. The Act also requires physicians to

update certain changes within 5 days, such as a Medicare sanction, and all other changes within 45 days. If not already included, a hospital and medical staff should consider adding disclosure requirements to its bylaws as a reminder to physicians of this legal obligation.

In addition, a physician should be required to provide updated information in the event that there are substantive changes to an appointment or reappointment application before the Board makes a final decision. Moreover, the bylaws should include language that if the information is not updated or is false or misleading, the application will be considered withdrawn or that corrective action can be imposed if privileges already have been awarded.

4. *Credentialing Burden of Proof*. Hospital and medical staff bylaws, rules and procedures that commonly place the burden of supplying information to the hospital's satisfaction on the physician applicant at the time of appointment and reappointment. If the requested information is not provided, the application should be considered withdrawn with no right to a hearing.

5. *Additional Immunities, Waivers & Protections*. The various peer review immunities, waivers and protections contained in hospital and medical staff applications, bylaws, rules and procedures designed to protect the reviewing institution and those participating in the credentialing process from legal liability. Some bylaws include the additional obligation of requiring the physician to pay the hospital's legal expenses if his credentialing challenge is unsuccessful. At least one court has upheld this type of provision.

These provisions are designed to encourage a full and fair assessment of all of the reasonably available data and information a hospital may obtain in reviewing a medical staff application. Credentialing participants are generally well-protected from legal liability for credentialing actions taken in the absence of willful or wanton misconduct. And medical staff applicants in general have no reasonable expectation of having their applications processed until they supply the hospital with all reasonably requested information. Finally, the state mandated uniform forms provide a solid starting point for what information a hospital may deem reasonably relevant to the credentialing process.

Hospitals in the credentialing process are either data seekers or data providers. When they are seeking information about an applicant, relevant credentialing information can typically be obtained from the following sources: the National Practitioner Data Bank, the physician's application, professional licensing boards, and medical schools and residency programs. Information beyond these sources tends to be more subjective and difficult to gather.

For example, a physician's peer review records at another hospital may be governed by the Medical Studies Act making them legally inaccessible to other hospitals. The failure to obtain legally or practically inaccessible information arguably should not support a claim of negligent credentialing. The credentialing duty of care only asks hospitals to

pursue reasonable information gathering efforts consistent with industry standards. Taking extraordinary measures to collect credentialing information that is not reasonably available is arguably above and beyond the call of this duty. If a hospital refuses to provide certain Medical Studies Act protected information to another hospital, failure to obtain and consider that information should not provide sufficient grounds for accusing the requesting hospital of negligent credentialing.

It is too early to judge what other information efforts hospitals should reasonably pursue as part of the duty of care under the theory of negligent credentialing. A plaintiff would likely need the testimony of an expert witness claiming that the hospital failed to make a reasonable request for certain relevant information that was reasonably available. The plaintiff would further have to show that the information gathering breakdown proximately cause the plaintiff's mistreatment by the credentialed physician at the hospital.

So it is not clear what experts on both sides of the information-gathering issue might say about the nature and scope of the credentialing search efforts of hospitals. Common information gathering practices may be a good start for identifying what constitutes reasonable information gathering. For example, a hospital may try to supplement the more readily available data it collects by asking the applicant's hospitals, medical schools and residency programs to fill out questionnaires about the applicant. Letters of reference and recommendations may also be sought. These practices have met with varying degrees of success. From a negligent credentialing perspective, however, the point is not to be held accountable for not getting meaningful responses. The question is did the hospital make reasonable inquiries and requests for relevant information and act reasonably in light of the responses.

On the responding end of the equation, hospitals need to decide *who* shall respond to credentialing inquires and *what* shall be provided. *Kadlec* teaches us that giving objective and superficial responses (commonly referred to as "name, rank and serial number" responses) pose little, if any, legal liability risk. Hospitals that have internal policies or practices regarding responding to inquiries about medical staff members from other hospitals should strive to respond truthfully and objectively to such inquiries. If the information released could result in an adverse credentialing decision, the hospital should also consider requesting an absolute waiver of liability as a condition of release.

Narrow or limited responses may cause requesting hospitals to turn to the physician seeking staff privileges to supply the required information that is not forthcoming from other sources. Since the physician's application will not be acted on without the required information the physician may be willing to negotiate the terms under which non-privileged information is shared with the requesting hospital.

If a hospital decides to go beyond a simple or superficial response to a request for credentialing information, it should take into account the risk of liability for a response that is inaccurate, false or misleading. In the *Kadlec* case, the physician's former medical group gave glowing and inaccurate references about the physician. That group now faces

substantial legal exposure. The *Kadlec* lesson is twofold: There is no duty to speak; but if you do speak, speak truthfully based on known or documented facts.

At the end of the day, hospitals engaged in credentialing must hold firm to satisfying their reasonable information needs following their reasonable information gathering and verification procedures. Straying from these core principles may lead to a serious breakdown in the credentialing process. Since the physician bears the burden of submitting all requested information, if insufficient information is obtained, there is no obligation to process the application. And hospitals asked to provide credentialing information to other hospitals need to remember that they have no legal duty to provide such information, but if they do provide it, the information must be accurate and not misleading. Hospitals deciding to share credentialing information with other hospitals should also seek the advice of legal counsel to determine what may be shared under the Medical Studies Act.

APPENDIX B:
CONSIDERATIONS FOR IMPROVING THE CREDENTIALING PROCESS

Credentialing and privileging, the process of evaluating a physician's general qualifications for medical staff membership and current competency to treat hospital patients, is perhaps the single most important quality assurance activity a hospital and medical staff undertake. Physicians direct or order almost every aspect of a hospitalized patient's care and treatment. High quality hospital practitioners are the *sine qua non* of high quality hospital care.

But credentialing may very well be as *difficult* as it is *important*. It is often complicated by the following factors:

- *Interpersonal relationships*. Peer review, the process of physicians reviewing, helping, regulating, and correcting each other, is one of the best ways to focus the medical expertise of the hospital's medical staff on improving physician performance. But as is true of many human interactions and associations, physicians are loathe to criticize their colleagues. Physicians, like all human beings, make mistakes. Assessing and addressing those mistakes can make peer reviewers uncomfortable, particularly when the relationship between judges and the judged is ongoing. This process may be further complicated by social, professional and referral relationships of the involved physicians. In the judicial system, judges do not have to live with the defendants they sentence. And the roles of judge and judged are never switched. In peer review, the physician you evaluate today may be sitting next to you at tomorrow's department meeting. And the physician you judged yesterday may be judging you next week. Needless to say, these interpersonal dynamics complicate the credentialing process.
- *Imperfect Knowledge*. Credentialing is not a process for the timid. Hospitals must ultimately award practice privileges to physicians based on incomplete knowledge of the future and the capabilities of their physicians. There may be better and worse ways to address a physician's clinical competence, but there is no perfect way. Hospitals do the best they can with the data at hand. There is only so much "objective" information a hospital may gather about a physician before it is left with making certain assumptions and leaps of faith that a physician will perform up to the hospital's quality expectations. And the cost of "guessing wrong" about a physician can be disastrous for everyone involved particularly the hospital's patients. Credentialing and privileging is hospital risk management of the highest order.
- *Career Consequences.* Certain adverse credentialing decisions can unleash severe professional and financial consequences for affected physicians, particularly if the decision is reported to the National Practitioner Data Bank. Not only does an adverse decision have the real or potential effect of limiting or terminating a physician's privileges at the hospital, the decision also may follow the physician throughout his or her career. The sting and taint of adverse decisions which limit or deny privileges are so powerful that hospitals

and physician reviewers may err in favor of the reviewed physician where the evidence is mixed or in doubt. The hardship of an adverse action on the physician is much more apparent to the hospital and its reviewers than the future consequences on yet to be seen patients. Hospitals and reviewing physicians also are mindful of the possibility that an adversely affected physician may have little choice but to challenge the action all the way up and through the judicial process. Hospital administrators are also leery of being perceived as enemies of physicians when they seek to take adverse credentialing action.

- *Evolving Patient Safety Standards.* Now, more than ever, the general public, consumer advocates, accreditation agencies, legislators, regulators and public and private payers are seeking patient safety information and compliance with published protocols to improve patient care and patient outcomes. This heightened emphasis on quality care has triggered an unprecedented focus on how hospitals and medical staffs continuously monitor a physician's performance. The challenge for hospitals and medical staffs in this environment is to identify a balanced framework which allows for objective critical review and action which protects patients while imposing, where possible, graduated forms of remedial action that does not necessarily result in a loss of privileges that will trigger a hearing and Data Bank reports, unless absolutely necessary. Taking no action is the least acceptable alternative but finding the right balance between serving the goals of patient safety and fairness to physicians can be profoundly difficult.

Despite these substantial challenges, the credentialing process has rarely been challenged in court for failing to meet the legal duty hospitals owe to their patients. The lack of judicial review of credentialing decisions in the medical liability context suggests that for the most part the process is operating as reasonably expected.

Assessing Your Credentialing and Privileging Practices

There is no one right, correct or perfect way for hospitals to credential and privilege physicians. Instead, each hospital must develop, adopt and follow its own reasonable physician assessment practices that are appropriate for its unique facts and circumstances while keeping in mind industry practices and expectations which may serve as a "standard of care" for credentialing and privileging. In crafting and improving its own approach, each hospital is free to accept, reject, or modify the suggestions contained in this White Paper. Nothing in this Paper should be viewed as or considered to be evidence of what constitutes the "reasonable standard of care" for hospital credentialing and privileging under Illinois law. Every hospital is urged to share this document with its own legal counsel and its own credentialing and risk management experts if it decides to audit, review or improve its credentialing provisions, policies and procedures.

As part of this self-improvement process, we urge hospitals to consider the following credentialing suggestions:

1. *Quality First*. Although the legal risks of negligent credentialing may provide some motivation for revisiting a hospital's credentialing process, the main driver behind a hospital's credentialing efforts should be providing quality care to the hospital's patients. The hospital should strive to have a credentialing process that identifies high quality physicians and grants privileges commensurate with their qualifications and current competency. In doing so, the risk of a bad patient outcome is greatly reduced. And in the unlikely event of such an outcome, the hospital will be in a better position to defend itself if it reasonably assessed and privileged the involved physician. A hospital that compromises or lowers its quality standards because of physician shortages or recruitment difficulties is running an increased risk of breaching the duty of reasonable care in credentialing. Although some of this risk may be reduced by imposing various monitoring or proctoring requirements, it may be very difficult to defend a hospital's decision to bring a physician on staff who does not meet the hospital's standards on the basis that doing so is better than having no physician at all.

2. *Follow Hospital and Medical Staff Bylaws, Rules & Procedures*. One of the easiest ways to attack the reasonableness of the hospital's conduct in a credentialing case is to exploit the hospital's failure to follow its own established policies and practices. If you have a credentialing process or provision, follow it. In turn, these procedures need to be in compliance with state law, accreditation requirements and the Medicare Conditions of Participation. If processes or provisions no longer makes sense, or do not make sense in every case, consider revising them. If a physician does not satisfy credentialing or privileging requirements, privileges should not be issued unless a rational and justified exception applies and is documented. And do not forget to document compliance with your policies and procedures. If something is not documented, regulators and litigants will argue that it did not happen or does not exist. Also keep in mind that courts have looked to accreditation provisions as representing a "standard of care" for judging the reasonableness of the hospital's conduct.

3. *Develop a "Red Flag" System*. The vast majority of medical staff applications for appointment and reappointment raise no issues and present little risk of negligent credentialing. However, certain types of information submitted in an application may warrant greater scrutiny. For example, physicians with an extraordinary number of medical liability claims, judgments or settlements should be subject to a much greater review. Criminal convictions, hospital disciplinary actions and licensing sanctions, and patient and staff complaints in a physician's background should trigger a deep and thorough review of the physician's clinical and interpersonal competence in light of these issues. Naturally, rejecting "red flag" applicants presents no negligent credentialing risk. But if a hospital wishes to credential a physician with a "red flag" in his or her background, the hospital should consider additional analysis that explains why such action was reasonably

warranted under the circumstances. Doing nothing or failing to further address a red flag in an application may expose the hospital to negligent credentialing liability if the unaddressed concern leads to an adverse patient outcome.

4. *Applicant's Burden*. The hospital's controlling credentialing documents and forms should squarely and clearly place the burden of full disclosure and submission of all reasonably requested information on the applicant seeking clinical privileges. If the applicant fails to provide the hospital with all of the information relevant to assessing his or her clinical and interpersonal competence, the application should not be processed. Also, bylaws should contain a provision that physicians should be obligated to update their applications if any of their responses would have changed during the period of review and final board action.

5. *Gap Analysis*. Gaps in the application and superficial responses should be viewed with suspicion and follow-up requests for information may be warranted. An applicant with "red flags" in his or her background may try to avoid a hospital's "red flag" tracking system by omitting such information from the application. Naturally, such intentional omissions are clear grounds for rejecting an application. But the hospital must be reasonably diligent in identifying any "gaps" in the application responses and any suspiciously superficial answers. And once identified, the hospital needs to be reasonably assured that these gaps do not present a quality of care concern for the hospital and its patients.

6. *Verify Objective Facts*. Fact verification, a central component of all reasonable credentialing, probably takes up the bulk of staff time and effort devoted to the credentialing process. Remember to document what you have done to verify the information in the application. Documenting verification may sometimes be as important as doing the verification. If you cannot prove you did it, a court or regulator may conclude that you did not do it. Bylaws should incorporate a provision that if relevant information is withheld or proves to be false or misleading through the verification process then corrective action will be taken.

7. *Privileges Match Credentials*. Hospitals employ a variety of reasonable ways to grant clinical privileges to medical staff members. Some may grant a set of "core privileges" that all medical staff members may exercise and add specific specialty privileges based on the documented competence of each practitioner. Hospitals incur heightened risk of a negligent credentialing claim if a physician negligently exercises a particular privilege that he or she rarely used or where documented current competency is lacking. In light of the new exposure for negligent credentialing, hospitals should revisit the privileges awarded to their medical staff members to be reasonably assured that the privileges of physicians reasonably match their documented competence. In

particular, hospitals that "grandfather" physicians with certain privileges should be reasonably assured that these physicians are qualified to perform those procedures and be able to document their analysis and conclusions. Although the determination of current competency of a physician is supposed to be ongoing, it typically occurs at least at reappointment. Some physicians may accumulate privileges that they use rarely, if ever. Department chairs and section chiefs should evaluate whether a physician who has little or no activity at the hospital, or elsewhere, regarding certain privileges, is still qualified to exercise them. Keep in mind that a physician's voluntarily relinquishment of such privileges is not reportable to the Practitioner Data Bank.

8. *Consider the Adoption of Utilization Requirements*. One of the best ways to assess competency is to require some level of utilization via patient admissions, consultations or some other service which reflects a physician's qualifications. The suggested volume of utilization, however, should not be so high as to trigger anti-kickback concerns. If your medical staff will not adopt utilization requirements, consider the creation of a staff category which would allow physicians to have certain membership rights but without the ability to exercise clinical privileges.

9. *Engage Experts*. The credentialing process is only as good as the expertise brought to bear to review the applications. Typically, hospitals get that expertise from the voluntary contributions of medical staff members who serve on a department or medical staff credentialing committee and specialize in the area of the applicant. Peer review has been the hallmark of physician selection, review, improvement and discipline. It is critical to have physicians who know the applicant's specialty to review this physician vigorously and conscientiously with the full protection from liability offered to them under the Hospital Licensing Act.

   But why should physicians participate in the hospital's credentialing process or care about the hospital's credentialing liability? First, the quality of one's medical staff colleagues bears strongly on their overall experience of treating patients at the hospital. Indeed, most physicians take the process seriously because they want to have an important role in selecting their peers. The quality of their colleagues also reflects well on them as well as the hospital and serves their collective need to have quality peers care for their patients.

   But they should also share the hospital's concern for avoiding negligent credentialing claims because if one physician is accused of negligence the chance of other physicians being drawn into the case either as co-defendants or discovery respondents is substantial. Thus, while the hospital is the only entity that can be sued for negligent credentialing, all of the physicians on the medical staff are at risk of being caught up in the web of the alleged underlying negligent care. Once physicians understand that there is no negligent credentialing without a negligent physician they will see that these

claims are inherently interconnected. Therefore, physicians should be quite committed to promoting the quality and rigor of the hospital's credentialing process and to maintaining a high quality medical staff.

Nevertheless, in special cases, the hospital may wish to assist its medical staff reviewers with external expert peer review of an applicant especially when the applicant seeks new or cutting edge privileges not exercised by other physicians at the hospital. In even more extraordinary cases where the medical staff is unable or unwilling to review an application and make recommendations on an applicant, the hospital should consider engaging external expertise as well. A credentialing decision that is not based on a reasonable expert assessment of clinical and interpersonal competence is a substantial liability risk.

Also, it is important to remind physicians that Health Care Quality Improvement Act, the Hospital Licensing Act and the Medical Practice Act have the effect of providing broad immunity protection for peer review participants. The hospital's liability insurance may also cover their participation. In certain instances, the hospital may want to consider indemnifying physicians for their peer review activities.

10. *Board Involvement.* The hospital's governing body is ultimately responsible for the quality of care at the hospital. Few of its decisions are more important to the quality mission of the hospital than credentialing actions. Although it appropriately relies on medical expertise usually supplied by the medical staff to assess clinical skills of an applicant, those expert recommendations do not end the inquiry for a properly functioning board. Here are some critical questions that every board should ask about a medical staff application and any peer review recommendation:

    a. Were all of the applicable hospital and medical staff bylaws, rules, regulations and practices followed in this case and are these provisions compliant with licensing, accreditation and other related requirements?
    b. Does the application raise any "red flags?"
    c. If so, what has the hospital administration done or plan to do to address this concern?
    d. Have hospital management and medical staff taken reasonable steps to maximize confidentiality protection under the Medical Studies Act and peer review immunity under the Hospital Licensing Act?
    e. If the applicant for appointment or reappointment receives conflicting recommendations from the medical staff, the Board should ask management how it reconciled the conflict or selected the recommendation to the Board before the Board makes its final decision.

In addition to asking these sorts of questions, the trustees need to be reasonably satisfied with the responses.

To improve the quality and rigor of the board's oversight of credentialing, hospital management should consider periodically educating board members about the hospital's credentialing and privileging process in terms of applicable law, and its own bylaws, rules, regulations and practices.

11. *Ongoing Quality Improvement*. Hospitals should periodically review or audit their credentialing practices for compliance with applicable laws, accreditation standards and common practices. Credentialing, both substantively and procedurally, needs to be assessed for what works well and what may need to be improved or discarded. Streamlining should be considered to the extent substantive assessment of physician quality is not compromised. Both applicants and reviewers welcome a credentialing process that uses their time efficiently and wisely. A credentialing process that is not reviewed and reassessed periodically may be missing opportunities for greater credentialing efficiency and effectiveness. Quality assessment and improvement of physicians and hospital activities call for continuous attention.

12. *Change the Tone of Your Peer Review Process*. There is no other profession which is forced and expected to sit in judgment of their peers aside from physicians. For reasons given in this White Paper, this exercise is extremely difficult for personal and sometimes economic reasons. The various P4P initiatives and the emphasis on evaluation quality outcomes will likely generate increasing volumes of adverse reports and quality of care problems. It is therefore imperative that hospitals and medical staffs, in anticipation of this development, begin to identify proactive and supportive ways to address quality issues which emphasize remedial measures designed to educate and to identify steps which physicians can take to limit their errors and to improve substandard practices. These methods should be viewed and treated as intraprofessional ways to get physicians back on track with an emphasis on remedial measures such as continuing education, monitoring and proctoring rather than taking steps to reduce, suspend or terminate privileges. The more hospitals create an environment that makes physicians more likely to acknowledge mistakes and to seek assistance, the greater the chances of improving patient care services.

13. *The Role of Legal Counsel*. Hospitals should consider involving lawyers in four areas involving credentialing. First, an attorney can help the hospital make sure that its credentialing provisions and procedures comply with applicable law and related standards. Second, attorneys are particularly adept at helping hospitals make sure they are reasonably following their policies and procedures in particular cases. Third, an attorney should be consulted if the hospital wishes to develop a discoverable and admissible report system that

explains how a hospital reasonably addressed any "red flag" application issues of a physician seeking privileges at the hospital. Finally, attorneys can assist a hospital if it wishes to respond to third party appointment and reappointment inquiries to avoid a "*Kadlec*-type" liability for negligent or intentional misrepresentation.