Legal Strategies for MSPs & Physician Leaders

PREVENT NEGLIGENT CREDENTIALING AND PROTECT PEER REVIEW

Anne Roberts, CPMSM, CPCS
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HCPro
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Anne Roberts, CPMSM, CPCS

Anne Roberts, CPMSM, CPCS, is a healthcare administration consultant and author who specializes in assisting medical staff leaders address the legal and administrative aspects of medical staff leadership in a healthcare setting. As a consultant, Roberts works with healthcare organizations across the country to prepare for regulatory surveys, assist with bylaw revisions, draft policies and procedures, restructure medical staff services or graduate medical education departments, and help prepare new physician leaders for their role in administrative leadership positions.

Roberts holds dual certifications as a certified professional medical staff manager and a certified provider credentialing specialist through the National Association of Medical Staff Services (NAMSS). She is the senior director of medical affairs at Children’s Medical Center in Dallas, where she oversees medical staff governance, medical staff communication, medical staff services, continuing medical education, graduate medical education, research administration, and surgery administration.
About the Author

Roberts has been recognized as an accomplished author and has won editorial awards and other NAMSS awards for medical staff professionals. She has written numerous publications for several national organizations, including *The Medical Staff Professional’s Handbook* and *The Medical Staff Coordinator’s Guide to Reappointment* (both published by HCPro, Inc.).

Roberts has been a featured speaker at numerous conferences across the nation on topics including prevention of negligent credentialing lawsuits, Joint Commission standards, developing an effective medical staff orientation, and addressing disruptive physician behavior.
Legal Strategies for MSPs & Physician Leaders: Prevent Negligent Credentialing and Protect Peer Review provides medical staff leaders and other individuals in a healthcare setting who oversee medical administrative matters with the fundamental knowledge of the primary legal obligations they need to be aware of in their administrative leadership role. To be an effective medical or administrative leader in a healthcare setting, having this baseline knowledge is essential to not only protect yourself but also to protect your organization from any potential liability which could occur should someone's rights be violated in any way.

Some of the elements that will be covered in this book include:

- Legal pitfalls medical staff leaders should avoid
- How to investigate, document, and address medical staff performance issues and understanding when to afford due process
- Tips to defend your organization against negligent credentialing suits or claims of bias peer review
Introduction

- Effective strategies to limit liability for your organization and individuals who participate in peer review

- How to develop effective bylaws, policies, privilege forms, proctoring requirements, and release forms

This book examines topics that range from best practice credentialing to peer review practices to due process rights for practitioners. Medical staff leaders face daily challenges regarding behavior concerns, monitoring of clinical competency, and enforcing corrective action when needed. This guide will provide medical staff leaders and MSPs with the tools they need to protect themselves and their organizations from claims that may arise during peer review, due process proceedings, or in negligent credentialing suits.
### Commonly Used Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
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<tr>
<td>ABMS</td>
<td>American Board of Medical Specialists</td>
</tr>
<tr>
<td>AHP</td>
<td>Allied health professional</td>
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<tr>
<td>APP</td>
<td>Advanced practice professional</td>
</tr>
<tr>
<td>APRN</td>
<td>Advanced practice registered nurse</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief executive officer</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing medical education</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief medical officer</td>
</tr>
<tr>
<td>CMS</td>
<td>The Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CoP</td>
<td>Conditions of Participation</td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Agency</td>
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<tr>
<td>DOP</td>
<td>Delineation of privileges</td>
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<tr>
<td>ECFMG</td>
<td>Educational Commission for Foreign Medical Graduates</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic medical record</td>
</tr>
<tr>
<td>EMTALA</td>
<td>Emergency medical treatment and active labor act</td>
</tr>
<tr>
<td>EP</td>
<td>Element of performance (part of the Joint Commission standards)</td>
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## Commonly Used Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>FPPE</td>
<td>Focused professional practice evaluation</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate medical education</td>
</tr>
<tr>
<td>H&amp;P</td>
<td>History and physical</td>
</tr>
<tr>
<td>HCQIA</td>
<td>Health Care Quality Improvement Act of 1986</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Information Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>IPE</td>
<td>Individual practice evaluation</td>
</tr>
<tr>
<td>LIP</td>
<td>Licensed independent practitioners, as defined by The Joint Commission</td>
</tr>
<tr>
<td>LOA</td>
<td>Leave of absence</td>
</tr>
<tr>
<td>M&amp;M</td>
<td>Morbidity and mortality conference</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed care organization</td>
</tr>
<tr>
<td>MEC</td>
<td>Medical executive committee</td>
</tr>
<tr>
<td>MSP</td>
<td>Medical staff professional</td>
</tr>
<tr>
<td>NPDB</td>
<td>National Practitioner Data Bank</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>OPPE</td>
<td>Ongoing professional practice evaluation</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary care provider</td>
</tr>
<tr>
<td>PRC</td>
<td>Peer review committee</td>
</tr>
<tr>
<td>RCA</td>
<td>Root cause analysis</td>
</tr>
<tr>
<td>R&amp;R</td>
<td>Rules and regulations</td>
</tr>
<tr>
<td>VPMA</td>
<td>Vice president for medical affairs</td>
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Continuing Education Information

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HCPro, Inc., is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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<tr>
<th>Exam Quantity</th>
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<tr>
<td>1</td>
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<tr>
<td>2–25</td>
<td>$15 per person</td>
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<td>26–50</td>
<td>$12 per person</td>
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<tr>
<td>51–100</td>
<td>$8 per person</td>
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<tr>
<td>101+</td>
<td>$5 per person</td>
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Part I
Prevention—Negligent Credentialing
This chapter provides an overview of the legal liability that healthcare organizations have for implementing thorough credentialing and privileging practices. Medical staff professionals (MSP) and medical staff leaders are charged with developing, supporting, carrying out, and monitoring these practices.

**Credentialing and Privileging Basics**

Hospital administrators, with the support of medical staff leaders and MSPs, are responsible for thoroughly credentialing all providers prior to granting clinical privileges. By doing so, they ensure that they retain only qualified and competent providers as members of their medical staff or other practitioners granted clinical privileges. Failure to exercise this duty can result in legal liability for the organization, ranging from negligent credentialing claims to corporate negligence. If a member of the medical staff or a practitioner granted clinical privileges provides negligent care that results in patient harm, the organization can be held liable for damages. Organizations can also be held accountable if they are aware of concerns...
regarding a physician’s competency, yet fail to address the concerns in a timely and thorough manner.

To recruit and retain qualified and competent providers, medical staff leaders must first establish minimum threshold criteria for all clinical privileges. This criteria outlines the level of education, training, and clinical experience the organization expects a practitioner to have completed before he or she is granted privileges. Once the criterion is set, applicants undergo a thorough screening and verification process called credentialing. Credentialing includes the verification directly from the primary source of the applicant’s education, training, licensure, certification, and other required elements. Thorough credentialing practices are described in Chapter 4.

The granting of clinical privileges requires that organizations also verify the practitioner’s current clinical competence. Verification of current clinical competence involves:

- Obtaining clinical evaluations from the applicant’s supervisors (such as a training program director or clinical department chief)
- Gathering and verifying clinical peer references
- Gathering and analyzing quality performance data, volume, and utilization data from the practitioner’s current and/or prior practices
- Reviewing the applicant’s continuing medical education (CME) information
Tort Law and Basics Regarding Negligent Credentialing

Organizations should have very clear criteria established for all clinical privileges that are offered, and medical staff leaders, with the support of MSPs, should carefully evaluate all applicants to ensure that they meet or exceed these competency requirements.

Additionally, during the credentialing process, MSPs should obtain a practitioner’s claims history, including any and all prior malpractice cases. MSPs should obtain all details of the cases, including:

- The allegations
- Current status (open, closed, dismissed, etc.)
- The findings in the case
- Amount that may have been paid on behalf of the applicant

Civil Litigation and Tort Law

It is important that medical staff leaders, MSPs and all other hospital staff that participate in the process of credentialing and privileging, peer review, and other medical staff leadership functions have a clear understanding of the basics of civil litigation that affect such important processes.

Negligent credentialing, corporate negligence, and other types of negligence claims are civil litigation suits referred to as tort law. An injury to one person caused by
another, either through a wrongful act or failure to act, is called a tort. Torts may be intentional, such as an injury caused to another person during a physical altercation, or negligent, such as a significant misdiagnosis. A key point is that the harm must be “legally recognized.” For example, hurting another person’s feelings is not a legally recognized harm, no matter how rude a physician was or how badly a patient’s feelings were hurt; but, a physician who misdiagnoses a case and informs the patient that he has a form of cancer, when in fact he does not, creates a form of emotional distress that is legally recognized in many states.

**Types of torts**

There are three basic types of torts:

- Intentional torts
- Negligence
- Strict liability

An intentional tort occurs when someone purposefully does something to harm another person. The person committing the act knew, or should have known, that the consequences of his or her actions (or failure to act) could cause harm to another individual. The harm may not have been intended, but the act itself was intended. This intent—not merely a careless or reckless action—must be proven for the action to be considered intentional tort.
Intentional torts can cause injury to a person. These torts include:

- Assault
- Slander
- False imprisonment
- Embezzlement
- Libel
- Intentional infliction of emotional distress

Intentional torts also can cause harm to a person’s property. These torts include:

- Interference with a business practice (sometimes alleged by physicians who have had their privileges revoked at a hospital)
- Trespass
- Copyright infringement

The most common defense to intentional tort allegations is consent. A patient who gives informed consent to an operation would not be able to bring battery charges against a physician for injuries incurred during surgery; the patient would have to prove negligence and sue for alleged negligence, not intentional injury. Another
example would be if a patient consents to admission. The patient could not file a complaint against the hospital for false imprisonment since he or she consented to the admission.

Intentional torts are rarely seen in healthcare. However, some circumstances fit the definition. For example, forcing unwanted care on a patient—even if the care may benefit the patient and unless a practitioner has a state mandate to force care on the patient—would constitute an intentional tort. Another example of an intentional tort in healthcare is unwanted touching, which would be considered battery.

**Negligence**

Most malpractice claims are based on negligence. Negligence is the type of tort that most people think of when they hear the term “malpractice.” Most courts define negligence using four elements that must be proved by the plaintiff:

- Duty, or the obligation that one person owes to another person. For example, a physician has a duty to only perform procedures that he or she is properly trained and qualified to perform; a pharmacist has a duty to accurately fill a patient’s prescription; a hospital has a duty to provide safe, quality patient care.

- Breach of duty by a practitioner or an organization by failing to abide by a reasonable duty or standard of care; a determination that the practitioner/hospital failed to fulfill their duty to the patient.
Tort Law and Basics Regarding Negligent Credentialing

- The cause of injury. The breach was the actual and proximate cause of the plaintiff’s injury. Proximate cause reflects whether the patient’s outcome was changed as a direct result of a breach in the standard of care. The most complicated part of proving negligence is proving proximate cause.

- Damages/harm the patient suffered (physical or emotional) as a result of the negligent act. Was the damage within the scope of duty owed by the practitioner/hospital?

Duty is often described as what a reasonably prudent person would or would not do in similar circumstances. For example, a reasonably prudent physician would not perform an operation without the appropriate education, training, and competency. When establishing standard of care in healthcare, courts look to national clinical guidelines, established standard competency and education requirements, and prior case law. In regard to a credentialing case, the court might ask whether the organization implemented recognized credentialing standards such as those established by The Joint Commission when considering liability.

Duty can also be imposed by statutes, an organization’s bylaws, etc. Failure to follow the organization’s bylaws can result in potential corporate negligence claims if the plaintiff is able to prove that the failure to follow the organization’s bylaws (or policies) “caused” the harm to the patient.
Types of Liability

Normally, a person is only liable for his or her own actions. However, there are some types of liability that hold other people or organizations liable for an individual’s actions. These include:

- Vicarious liability. The legal doctrine that a principal, such as an employer, can be held liable for the action of its agent, such as an employee. Vicarious liability allows a plaintiff to hold a hospital liable for the negligent actions of a member of the medical staff or for its employees, even if the hospital itself was not negligent. It also allows for a supervising physician or organization to be held liable if a resident participating in training causes harm to a patient, even though neither employed the resident.

- Contributory negligence. This is a defense in which the defendant tries to prove that the plaintiff contributed to injuries suffered. For example, a patient’s
failure to follow doctor’s orders or to take medication as prescribed could have contributed to the patient’s injury.

• Strict liability. This is a type of tort that is rarely used in healthcare and is typically reserved for highly hazardous products or other high risk materials in which individuals or organizations are held accountable if proper safety requirements are not in place.

Hospital Liability

There are three general theories of hospital liability:

• Corporate negligence

• Ostensible agency

• Respondeat superior

Under the theory of corporate negligence, the hospital has an independent duty to patients to ensure their safety and well-being while in the hospital. The hospital is not vicariously liable for the physician’s act; rather, the hospital is liable for its own negligence in failing to either monitor and supervise the medical staff or in failing to properly select and retain qualified, competent staff.

With ostensible agency, the hospital may be held vicariously liable for the negligent actions of practitioners on its staff if the patient was seeking care from the organization
and held a reasonable belief that the practitioner was employed by the hospital and, therefore, was representing and acting on behalf of the hospital. This theory is often used to hold hospitals accountable and liable for the acts of independent contractors providing services within their organization, such as nonemployed physicians with clinical privileges.

Respondeat superior is Latin for “let the master answer,” meaning let the master (organization) answer for the action of those who serve (employees/contractors/staff). An organization has a responsibility to supervise its employees and members of its medical staff through vicarious liability.

Prior Cases

The following section provides an overview of cases that medical staff leaders and MSPs should review to begin the critical examination of their own credentialing, privileging, and peer review practices. Although many case outcomes are state court decisions that set precedent for the state in which the case was argued and decided, other states often rule in similar fashions when considering cases with similar circumstances. Remember that medical staff leaders and MSPs should always consult with legal counsel to determine appropriate actions based on state law and organizational bylaws, rules, and policies.

Failure to disclose

In 2001, Lakeview Anesthesiology Associates (LAA) terminated Robert Berry, MD, over concerns related to substance abuse that affected his work. Six months
after his termination, Lakeview Medical Center (LMC), a hospital where Berry held clinical privileges and where LAA was the exclusive provider for anesthesiology services, allowed Berry’s clinical privileges to expire without taking formal corrective action even though they were aware of the prior concerns, some of which were reported to have occurred at the hospital. After his departure from LMC, Berry moved to Washington and applied for privileges at Kadlec Medical Center. As a part of its credentialing process, Kadlec sent an affiliation verification request to LMC and peer reference letters to physicians at LAA. Neither organization disclosed prior concerns with Berry and the peer reference letters were glowing.

In 2002, a patient at Kadlec Medical Center suffered extensive brain damage while undergoing a routine tubal ligation. Berry was the anesthesiologist on the case and was deemed to be under the influence of Demerol at the time the error occurred. The patient’s family sued and Berry paid $1 million. The court found Kadlec responsible under respondeat superior and Kadlec paid $7.5 million to settle with the family. Afterwards, Kadlec filed suit against both LMC and LAA (*Kadlec Medical Center v. Lakeview Anesthesia Associates*) for intentional misrepresentation, negligent misrepresentation, and general negligence.

The letter provided to Kadlec from LMC was a generic template that did not provide details regarding Berry’s performance or identify quality concerns, nor did it provide recommendations to Kadlec. The letter simply indicated that Berry previously held clinical privileges and was a member of LMC’s staff. LMC’s CEO participated in the investigation against Berry and had significant documentation
regarding the concerns related to his clinical practice. The court found LMC liable for intentional misrepresentation. However, the appeals court later exonerated LMC stating that the individual who completed the template letter was unaware of the prior investigation and therefore did not intentionally provide false information with the intent to deceive.

One of the physicians at LAA who provided the glowing peer reference evaluation was found guilty of negligent misrepresentation and ordered to pay $8.2 million in total damages to Kadlec. The physician then hoped to cover damages through his malpractice carrier, however, his carrier refused to pay, indicating that the policy only guaranteed payment for “covered bodily injury.” His insurance company argued that he did not personally commit any bodily injury and therefore the coverage did not apply. A U.S. district court reviewed this determination and initially ordered the insurance company to pay. However, a federal appeals court reviewed and reversed the decision, indicating “the economic damages Kadlec sought for the tortious misrepresentation are distinct from the damages sought by the original plaintiffs for bodily injury;” therefore, the physician who completed and provided a misleading peer reference recommendation, not the insurance company, was required to pay the $8.2 million.

There are many lessons to take away from this case. First, organizations should disclose information when they receive the appropriate request and release forms. Additionally, physicians who complete clinical peer reference requests should be forthcoming to avoid potential claims of intentional misrepresentation.
Second, MSPs should always use caution when releasing confidential information to outside organizations. Always read the release of information submitted with the request (see Chapter 2 for additional information on release forms) to ensure that it specifically releases you and your organization from liability for providing information in good faith. If a physician or other practitioner has a history of disciplinary action, failure to share that information restricts the other organization from performing a thorough review. However, legal counsel should review the information that your organization releases to avoid the risk of disclosing too much information.

The type of disciplinary action that your organization is willing to share with other organizations should be consistent. For example, if an organization places a physician on suspension for delinquent medical records one time in the previous three years, it is not likely that the information is pertinent enough to report to other entities; however, if that suspension was due to numerous delinquencies that resulted in disruption of or unsafe patient care, that suspension is more pertinent and falls into a separate reporting category. Additionally, at the time that the practitioner receives the disciplinary action, MSPs should make sure that the practitioner understands that this is something he or she is required to disclose when completing credentialing applications and that the hospital is also required to disclose.

As mentioned previously, it is all too common for medical staff offices to use general letters verifying the minimum amount of information (such as what was used at LMC) when replying to external inquires regarding past medical staff members. This standard practice is acceptable when the organization knows of no issues related to the practitioner’s competency. However, MSPs should ask themselves
whether they would accept the information that they provide to others, or if they would want more detailed information/disclosure from other entities for their own credentialing process.

If you use an automated response system or electronic database to automatically provide information on practitioners, make sure practitioners on your reportable actions list are not included in that search or include a disclosure that instructs them to contact your office for further information regarding those practitioners. You should then follow the process of obtaining a release of information form and respond appropriately. Again, failure to disclose the information puts your organization at risk for a lawsuit.

MSPs should review their organization’s affiliation verification letter to make sure it asks the right questions. If the question is too vague, the responding organization may not disclose the disciplinary action or investigation. For example, if the verification request asks whether a practitioner had any disciplinary action or went under any review “during the previous two years,” the responding hospital may not disclose that the practitioner was investigated three years ago and disciplined internally.

**Failure to conduct unbiased peer review**

One of the most publicized cases regarding peer review is *Poliner v. Texas Health Systems*, in which Lawrence Poliner, MD, an interventional cardiologist, alleged that a hospital’s temporary restrictions and later suspension of his medical staff privileges were improper and injured his reputation and career. He was on a voluntary abeyance for 14 days, which was then extended for an additional 14 days, after
which point his privileges were summarily suspended for reasons cited as substandard medical care. During the abeyance, 44 of Poliner’s cases were reviewed, of which more than half were found to have not met the hospital’s standard of care. A hearing panel at the hospital later found that the suspension was justified based on the information presented at the time, but later reinstated his privileges with conditions.

Poliner sued the hospital and members of the peer review committee claiming defamation and improper peer review, federal and state antitrust claims, and other tort claims. Poliner alleged that he was forced into agreeing with a temporary abeyance of his privileges under the threat that if he did not agree to the voluntary abeyance, his privileges would be summarily suspended. He stated that the peer review actions were not done for reasons related to healthcare, rather done so under bias and political motivations. The trial court found that the summary suspension met the requirements for statutory immunity for the peer review action, however, found issues with the two abeyances.

This concern was presented before a jury who unanimously concluded, and the trial court affirmed, that the defendants were not immune from liability. Further, the jury found that the defendants acted with malice and rendered a verdict of $366 million (later reduced to $33 million) to Poliner. The case was then appealed to the U.S. Court of Appeals for the Fifth Circuit. The court of appeals reversed the decision and rendered an opinion in favor of the defendants indicating:
• The hospital and physician who chaired the committee that made the decision to suspend Poliner did so in the reasonable belief that abeyance of privileges furthered healthcare quality and therefore met the Health Care Quality Improvement Act of 1986 (HCQIA) immunity requirements (see Chapter 6 for further details on the requirements).

• Although the original trial court found that the hospital did not follow its medical staff bylaws in regard to an abeyance versus a suspension, the peer review actions met the criteria as outlined in state statutes for an act that qualifies as a professional review action.

• That the actions from the peer reviewers should be judged based on whether its conclusions were reasonable based on the information/facts that were available at the time that the professional review action was taken, not whether or not they are later proved right or wrong. Taking immediate action in the belief that it is in furtherance of healthcare quality qualifies under HCQIA immunity.

The court found that the reviewers satisfied the requirement of conducting a reasonable investigation.

By overturning the jury’s extraordinary monetary award, the court of appeals reinstated the original intent behind the HCQIA statutes and therefore set further precedent for future immunity cases.
Failure to implement best practice credentialing

The family of Jennifer Abshire brought a healthcare liability claim against Renaissance Healthcare Systems, Inc. (Swan v. Renaissance) for allegations of negligent credentialing and gross negligence. The family also brought suit against the referring physician and the surgeon for gross negligence.

John Q. A. Webb, MD, who was treating Abshire for a herniated disk, referred Abshire to Merrimon Baker, an orthopedic surgeon. The allegations contend that Webb was “acting as an agent and/or employee of and/or on behalf of” the hospital. The family asserts Baker performed a bilateral lumbar laminectomy and diskectomy on Abshire at Renaissance Hospital and, during the surgery, Baker transected Abshire’s “right internal iliac artery, failed to recognize that he had done so, and thus failed to repair the artery prior to closing.” Abshire suffered massive internal hemorrhaging, which led to cardiac arrest and death.

According to the petition, because Webb was acting as the “agent, employee, member, officer, and/or director” of Beaumont Spine Pain & Sports Medicine Clinic, Inc., and the healthcare system allegedly owned and operated Beaumont Spine, the allegations of negligence against Webb also applied to the healthcare system under the doctrine of respondeat superior. According to the petition, the healthcare system failed to maintain an appropriate standard of care by permitting a physician who was known by the organization to be incompetent and unqualified to operate on Abshire.
Public records that were available at the time that Webb referred Abshire to Baker indicate that there were complaints filed against Baker and an investigation by the state medical board alleging incompetence and substance abuse. Additionally, Baker had lost his privileges at two other area hospitals, and the investigation at those organizations was widely publicized. Therefore, the allegation against Webb was that he referred a patient to a surgeon with known competency concerns and substance abuse problems. The allegation against the hospital was that it failed to conduct thorough credentialing that met the basic standardized and recognized practices for ensuring a physician’s current clinical competency.

There were two expert opinions in the case that were challenged and the case was heard by the court of appeals in Texas. The court of appeals denied the defendants’ (both the referring physician and the hospital) request to dismiss based on the challenges of the expert opinions, citing that they affirm the trial court’s opinion that there is merit to the allegations. As the motion to dismiss was denied, this case is still pending.

Referring physicians have a responsibility to ensure that the practitioners they refer their patients to are competent. For MSPs who oversee or participate in physician relations departments or CME planning, this is a good example to educate referring physicians on their responsibilities during referrals.

This case also is an example of how important it is for MSPs to gather all relevant and pertinent information during the credentialing process. Failure to do so opens the organization up to potential negligence claims.
Failure to prove negligent credentialing

In Beswick v. Floyd Memorial Hospital, the plaintiffs sought to have Floyd Memorial Hospital held liable for alleged negligent surgery that was performed by an orthopedic surgeon who had an independent contract with the hospital. The plaintiffs alleged that the hospital failed to ensure that the surgeon performed the procedure competently, failed to approve the prosthesis through appropriate procedures, and failed to train the operating room staff for the procedure. The plaintiffs also argued that the hospital was negligent with respect to determining that the surgeon had “sufficient experience” with the prosthesis in question. The trial court granted the hospital’s motion for summary judgment on these claims.

The Indiana Court of Appeals found that the hospital was not liable for the surgeon’s act because he was an independent contractor and he had a nondelegable duty to perform a surgical operation within the expected standard of care.

With respect to the plaintiffs’ argument that the hospital failed to ensure the physician was sufficiently trained and experienced, the court also found in favor of the hospital. There was no documentation to prove that the hospital was aware that the surgeon’s practice had ever deviated from the standard of care or that it had not done its due diligence in credentialing the surgeon. There were no prior complaints or allegations against the surgeon for negligence or failure to meet the standard of care.

This case established precedent for state law in Indiana regarding negligent credentialing. If a hospital is aware, or should be aware, of evidence of prior claims or
allegations against a physician, the hospital could be held liable if the physician deviates from the standard of care and the hospital allows him or her to continue to practice at its organization.

In this case, the court found that the hospital followed its credentialing practices and did not have any documentation of competency concerns for the physician in question.
Litigation from credentialing and privileging disputes is on the rise and has allowed physicians to challenge long-standing credentialing and privileging policies and processes. This new, comprehensive guide from HCPro is designed to educate MSPs and physician leaders about the legal issues that can arise from their everyday tasks and how to avoid exposure to multimillion-dollar lawsuits.

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