

# NEGLIGENT CREDENTIALING CLAIMS: THE BEST ATTACK

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## NEGLIGENT CREDENTIALING CLAIMS: THE BEST ATTACK

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The cases and materials presented here are in summary and outline form. To be certain of their applicability and use for specific claims, we recommend the entire opinions and statutes be read and counsel consulted.

## NEGLIGENT CREDENTIALING CLAIMS: THE BEST ATTACK

Improper credentialing of physicians can expose medical facilities to great risks, including adverse outcomes, costly lawsuits, regulatory enforcement, accreditation issues, non-payment for medical services, and adverse publicity. This paper discusses the history of negligent credentialing claims in Illinois, suggests ways to attack those claims and then provides suggestions for best practices which can either preclude claims or help entities defend against negligent credentialing lawsuits. While this paper focuses on hospitals, all types of managed care organizations can be subject to negligent credentialing claims, including practice associations, managed care organizations, and physician-hospital organizations.

### I. THE HISTORY BEHIND NEGLIGENT CREDENTIALING CLAIMS IN ILLINOIS

Over 50 years ago, the Illinois Supreme Court first adopted institutional negligence as an independent cause of action against a hospital. *Darling v. Charleston Community Memorial Hospital*, 33 Ill. 2d 326 (1965). In *Darling*, the Court held that hospitals have a duty, independent of the duties owed by physicians, nurses and other staff, to assume responsibility for the care of patients. *Darling*, 33 Ill. 2d at 339. The *Darling* plaintiff presented to the hospital with a broken leg. During his stay, the physician and other hospital staff allegedly failed to monitor the plaintiff's leg circulation, resulting in an amputation. The plaintiff alleged that the hospital had a duty to ensure adequate monitoring procedures, but failed in this duty. The Illinois Supreme Court upheld the verdict against the hospital, finding that an Illinois hospital could be liable for "institutional negligence." The court explained that "[t]he Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient." *Id.* at 332. These underlying responsibilities mandated a cause of action for institutional medical negligence. *Id.*

Illinois first recognized a claim for "negligent credentialing" in *Frigo v. Silver Cross Hospital & Medical Center*, 377 Ill. App. 3d 43 (1st Dist. 2007). In *Frigo*, a podiatric physician operated on the plaintiff's foot despite the presence of an infected ulceration. The patient's foot was later amputated. The patient claimed that the hospital should not have granted surgical privileges, as the podiatrist failed to meet the hospital's bylaws for Level II surgical procedures. The bylaws required postgraduate training, board certification and other qualifications and did not mention the issue of grandfathering. The physician never completed a 12 month podiatric surgical residency, obtained board certification, or submitted documentation of 30 procedures as required by the bylaws. Instead, in granting the privileges, the hospital relied on a grandfather provision to account for the physician's experience. The problem was that bylaws governing the Level II surgical procedures did not have a grandfather procedure.

The court affirmed a jury verdict in favor of the plaintiff on the claim of negligent credentialing. The court explained "that negligent credentialing is a cause of action that is a progeny of hospital

or institutional negligence, which is a cause of action that was first recognized by our supreme court in *Darling*." *Frigo*, 377 Ill. App. 3d at 47.

The court found the following elements necessary to state a negligent credentialing claim: (1) the hospital failed to exercise reasonable care in granting staff privileges; (2) the physician breached the applicable standard of care while rendering medical care and treatment to the plaintiff; and (3) the hospital's negligence in granting privileges was a proximate cause of the plaintiff's injuries. *Frigo*, 377 Ill. App. 3d at 72.

In reaching its decision, the *Frigo* court focused on the hospital's regulations and bylaws and the Joint Commission standards. The court did not focus on the actual process of the credentialing committee or the discussions undertaken by the credentialing committee. The court concluded that the hospital's regulations and bylaws and the Joint Commission standards were not within the purview of the Medical Studies Act, 735 ILCS 5/8-2101, and in any event, the Medical Studies Act did not preclude an action against a hospital for institutional negligence.

Likewise, the court rejected an argument that the negligent credentialing action was barred by the Illinois Hospital Licensing Act, 210 ILCS 85/10.2. This act provides that a hospital shall not be liable for civil damages as a result of the acts or omissions of any committee whose purpose is internal quality control or professional discipline. The court held that the purpose of this Act was to "regulate internal hospital controls" and was limited to "limitation[s] on the remedies available to physicians aggrieved by a hospital's peer-review process." *Frigo*, 377 Ill. App. 3d at 68. This Act did not preclude a negligent credentialing claim. *Id.*

Underlying the decision in *Frigo* is the notion that a "special relationship" exists between a patient and the hospital, whereby the patient expects the hospital to provide safeguards against harm from physicians. *Id.* at 70. (citing *Insinga v. LaBella*, 543 So. 2d 209 (Fla. 1989)). Courts have likened the claim to one of negligent hiring, even if the physician is an independent contractor, and not an employee. *Spalding v. Spring View Hospital, LLC*, No. 2013-CA-000842-MR, 2016 Ky. App. Unpub. LEXIS 742 (Ky. App. March 11, 2016) (imposing liability on hospital for credentialing decision of a physician it knew or should have known was incompetent); *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn 2007); *Johnson v. Misericordia Community Hospital*, 99 Wis. 2d 708 (1981) (considering claim where physician was an independent contractor). *But see Paulino v. QHG of Springdale, Inc.*, 2012 Ark. 55 (finding that cause of action not similar to negligent hiring since the hospital's credentialing process utilizes a peer-review committee and a state statute provided immunity to facilities for credentialing decisions). Thus, the theory of negligent credentialing also allows an imposition of liability without a finding of agency between the hospital and the physician.

## **II. DEFENDING NEGLIGENT CREDENTIALING CLAIMS**

Despite the fact that *Frigo* has been the law in Illinois for 10 years, there are still challenges which can be made to the underlying theory of negligent credentialing and to any claim of negligent credentialing.

### **A. Legal Challenge**

The appellate court's decision in *Frigo* does not discuss the Health Care Quality Improvement Act, 42 U.S.C. §11101 or this Act's presumption against liability. This Act created the method for reporting a physician's misconduct to a national data bank. An argument could be made that the HCQIA preempts an action for negligent credentialing.

The HCQIA requires the hospital and its professional review committee to meet certain standards when making credentialing decisions. These standards generally require the committee to make a factually supported decision to improve health care. Under the Act, the hospital shall be presumed to have met the standards "unless the presumption is rebutted by a preponderance of the evidence." 42 U.S.C. § 11112(a)(4). If "a professional review body meets all the standards specified in [the Act] . . . the professional review body . . . shall not be liable in damages under any law of the United States or of any State with respect to the action." 42 U.S.C. § 11111(a)(1). Thus, the HCQIA potentially grants immunity to hospitals and their peer review committees from liability for credentialing decisions. *See Manion v. Evans*, 986 F.2d 1036, 1039 (6th Cir. 1993) (finding immunity in antitrust case brought by doctor against a hospital and its peer review committee); *Kauntz v. HCA-Healthone, LLC*, 174 P.3d 813 (Co. App. 2007); *Jenkins v. Methodist Hospitals of Dallas, Inc.*, No. 3:02-CV-1823-M, 2009 U.S. Dist. LEXIS 78233 (N.D. Tex. Aug. 31, 2009).

While the HCQIA potentially provides immunity, this argument may be an uphill battle in Illinois as the court in *Frigo* concluded that the Medical Studies Act and the Hospital Licensing Act do not preclude a negligent credentialing claim. We anticipate that an Illinois court may liken the HCQIA to both of these acts. Moreover, a finding of HCQIA immunity may first require finding that a claim for negligent credentialing "is not a claim related to 'treatment or care by any physician,' but is instead related to the failure of a hospital to review adequately a physician's qualifications." *St. Luke's Episcopal Hospital v. Agbor*, 952 S.W.2d 503 (Tex. 1997). And, Illinois courts have already held that before there can be a finding of negligent credentialing, there must be an underlying finding of medical malpractice. *Frigo*, 377 Ill. App. 3d at 71.

### **B. Challenge Proximate Cause**

To prove a claim of negligent credentialing, the plaintiff must first prove the physician's negligence. *See Longnecker v. Loyola University Medical Center*, 383 Ill. App. 3d 874 (1st Dist. 2008). *See also Hiroms v. Scheffey, M.D.*, 76 S.W.3d 486, 489 (Tex. App. 2002); *Rule v. Lutheran Hospitals & Homes Society of America*, 835 F.2d 1250, 1253 (8th Cir. 1987); *Benedict v. St. Luke's Hospitals*, 365 N.W.2d 499, 505 (N.D. 1985).

In *Longnecker*, the plaintiff alleged that the hospital committed institutional negligence by failing to ensure that a physician harvesting donor organs understood his duties as part of a transplant team, including evaluating the organ for transplant, not simply harvesting it. The plaintiff's husband passed following a heart transplant. The plaintiff claimed that the harvesting physician failed to properly test and inspect the donor heart. At trial, the jury found in favor of the physician on a medical negligence claim, but against the hospital on a claim of institutional negligence. On appeal, the hospital argued that these verdicts were inconsistent. The appellate court affirmed the verdict finding that institutional negligence could apply even where the physician was found not to be negligent. The court found that the key issue was whether the hospital had adequately informed the doctor of his duties. The court acknowledged that in cases like *Frigo* where negligent credentialing was at issue, the plaintiff was required to prove the underlying medical malpractice by the physician to satisfy the proximate cause element. *Longnecker*, 383 Ill. App. 3d at 895.

As explained by another court, "a hospital has a direct duty to grant and to continue such privileges only to competent physicians. A hospital is not an insurer of the skills of private physicians to whom staff privileges have been granted. In order to recover for a breach of this duty, a plaintiff injured by the negligence of a staff physician must demonstrate that but for the lack of care in the selection or the retention of the physician, *the physician would not have been granted staff privileges, and the plaintiff would not have been injured.*" *Albain v. Flower Hospital*, 553 N.E.2d 1038 (Ohio 1990) (emphasis added).

Thus, a medical facility faced with a claim of negligent credentialing should consider defending the underlying alleged wrongful acts of a physician.

### **C. Demand Expert Testimony from the Plaintiff**

Expert testimony is required to prove a claim of negligent credentialing. As explained in *Frigo*, "[e]xpert testimony as to the applicable standard of care and what may constitute a violation of that standard has also been held to be required in negligent credentialing actions." *Frigo*, 377 Ill. App. 3d at 72 (internal citations omitted). A medical facility would be remiss not to demand that a court hold that without expert testimony, the plaintiff cannot prove his case.

In *Neff v. Johnson Memorial Hospital*, 93 Conn. App. 534 (Conn. App. 2006), the court found that a hospital's decision of whether or not to grant privileges was beyond the experience and understanding of a typical juror and expert testimony was required. Similarly, in *Johnston v. Christus Spohn Health System Corp.*, No. 13-14-00418-CV, 2016 Tex. App. LEXIS 3321, \*12 (Tex. App. March 31, 2016), the Texas appellate court held that "a negligent credentialing claim involves a specialized standard of care" and expert testimony is required to establish the claim since "procedures ordinarily used by a hospital to evaluate staff privileges are not within the realm of a juror's ordinary experience." See also *Brookins v. Mote*, 2012 MT 283 (since plaintiff did not provide expert testimony on credentialing, summary judgment for hospital appropriate).

#### **D. Move for Summary Judgment**

If your facility has followed all Joint Commission practices in credentialing the physician, move for summary judgment. In *Frigo*, the court noted that evidence of compliance with the Joint Commission regulations may be sufficient to support the entry of summary judgment. *Frigo*, 377 Ill. App. 3d at 73. Moreover, recall that the HCQIA contains a rebuttable presumption that the credentialing process has been followed when all of the standards set forth in the act have been met. If the evidence shows that the hospital's credentialing process is sound and was followed, then the hospital should consider moving for summary judgment.

#### **E. Remember Illinois Evidentiary Rules**

Finally, a medical facility should remember the evidentiary privileges arising from the Illinois Medical Studies Act, the Illinois Health Care Professional Credentials Data Collection Act, 410 ILCS 517/1 and the HCQIA which may preclude discovery and/or introduction of some evidence from the credentialing and peer review process. See *Klaine v. Southern Illinois Hospital Services*, 2016 IL 118217. Facilities should continue to assert that the inner workings of the credentialing committee are confidential and privileged, even if a physician's application for privileges may be discoverable.

### **III. SOUND CREDENTIALING PRACTICES**

#### **A. What Can Lead to a Negligent Credentialing Claim**

Under Illinois Joint Commission standards, each facility should have a reliable, clearly defined and consistent process in place to process applications and verify a physician's credentials as outlined in the medical staff bylaws. See Illinois Health Care Professional Credentials Data Collection Act, 410 ILCS 517/10, 15(a); Joint Commission Accreditation Manual M.S. 06.01.03. The medical staff must then review and evaluate the data collected. The medical staff then should make privilege recommendations to the governing body based on an assessment of the data. The credentialing request is then approved by a governing body.

Unsound practices can lead to claims of negligent credentialing. Those practices can generally be categorized as:

- A hospital having sound bylaws relating to the credentialing process and requirements, but failing to follow the process or enforce the requirements.
- A hospital having an unsound credentialing process that did not meet Joint Commission standards or its own by-laws.
- For physicians practicing telemedicine, the hospital relying on the credentialing and privileging information from a distant site (as now allowed by the Joint Commission), but the distant site's credentialing process or decision was flawed. Or, while the local site relied on the distant site's credentialing process, there was not a written agreement in place that all distant site telemedicine providers credentialing and privileging processes met the Medicare Conditions of Participation.

In surveying the case law across the country, the following scenarios have led to negligent credentialing claims:

- The physician was subject to numerous prior medical malpractice claims which were not reviewed by the credentialing committee. *Larson v. Wase Miller*, 738 N.W. 2d 300 (Minn. 2007), but see *Engelhardt v. St. John Health System—Detroit-Macomb Campus*, No. 292143, 2012 WL 1367543 (Mich. App. April 19, 2012) (credentialing committee’s mere knowledge of 17 prior lawsuits does not equate to liability where hospital presented evidence that injuries in past cases were recognized as known complications and that surgeon was board certified).
- The physician had problems obtaining malpractice insurance. *Larson*
- The physician had previously been subject to hospital discipline. *Larson*
- The physician failed his board certification three times before passing. *Larson*
- The physician had personal medical issues, including failing eyesight. *Rabelo v. Nasif*, 30 Mass. L. Rep. 547 (Sup. Ct. Mass. 2012).
- The physician had chemical dependency issues. *Spalding v. Spring View Hospital, LLC*; No. 2013-CA-000842-MR, 2016 Ky. App. LEXIS 742 (Ky. App. March 11, 2016).
- The physician lied about his credentials at other hospitals and the hospital failed to check his credentials.
- The physician read mammograms at an excessive rate out of line with other physicians in the practice and had a call back rate significantly less than his peers. *Burton v. Trover Foundation Clinic, Inc.*, No. 2009-CA-001595-MR, 2011 Ky. App. LEXIS 94 (Ky. App. June 10, 2011).

## **B. Ensure Your Credentialing Processes Are Sound**

There is no “best way” or “single way” to credential physicians. That being said, we recommend that hospitals and medical centers follow Joint Commission guidelines and these straightforward steps in the credentialing and bylaw process:

- Hospitals should follow their internal rules, regulations and bylaws in granting privileges to medical staff. Make sure the bylaws confirm that administrative procedures can be delegated to an administrative person rather than a member of the medical staff.
- Hospitals should periodically review and revise their medical staff bylaws to ensure that the bylaws are in compliance with applicable standards, including The Joint Commission standards and Medicare Conditions of Participation.
- If certain bylaws or criteria for privileges are changed and become more restrictive, the hospital should confirm that all physicians meet the more restrictive requirements. The hospital should consider including a grandfather clause to cover any physicians who may have practical experience as compared to board certification or a residency in a specific area. An example would be an emergency room physician with years of working in an emergency room and a board certification in internal medicine.
- Review with the medical staff the minimum number of cases to maintain privileges. Make sure a physician who has credentials is routinely seeing patients at your facility.



- Review the physician's credentialing applications and look for any gaps in timing or information.
- Complete and review background checks, including criminal, abuse and sex offender ones. Ask yourself – are all of those misdemeanor traffic tickets indicative of a larger problem?
- Review medical training and education, including whether any education was received at a foreign institution which may not be accredited in the United States. Check whether a change in residency was made or whether a post-graduate position was denied.
- Monitor lifetime licensing status in all states where a license is held and determine if there are any disciplinary proceedings or sanctions, including pending disciplinary proceedings.
- Confirm whether the physician had licenses other than as a physician (i.e. physician assistant, physical therapist, pharmacist) and whether those licenses are still effective or subject to discipline.
- Review whether the physician has ever had his privileges revoked or sanctioned at another facility.
- Confirm work history, board certification and National Practitioner Data Bank information, Drug Enforcement Administration status, checking for gaps in time periods. If a physician has had multiple jobs or appointments in a short time period, this may be a warning sign.
- Confirm incomplete data such as an incomplete training program (doing only 1 or 2 years of a residency).
- Obtain and analyze peer reviews.
- Require and review clinical activity and data for the privileges requested. Confirm that the physician has the ability to perform the privileges requested.
- Review past lawsuits to determine what happened and what the results were.
- Conduct an internet search on the physician.
- Re-review the credentialing application and confirm that the information supplied by the physician is consistent with the information you have collected and that the physician has completely and accurately completed the credentialing application. Going above and beyond the Illinois credentialing form is a sound practice.
- Ensure that any concerns by the medical staff about a physician's credentials have been resolved before privileges are granted.
- Organize credentialing files by year, creating a checklist for all materials which must be collected and following the checklist.
- Routinely monitor and evaluate physicians, including those who may have consistently poor outcomes. Initiate a formal peer review process if necessary.

If you suspect a physician is having personal or medical issues, take action.



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Ann concentrates her practice in civil litigation, including environmental and business-related disputes, nursing home litigation, and personal injury defense.

Ann joined Heyl Royster in 2013. Before joining Heyl Royster, Ann served as in-house counsel at Valero in San Antonio, TX, where she managed complex environmental, commercial, class action and tort litigation. While at Valero, Ann also served on the Information Governance Committee, and was responsible for electronic discovery and electronic records implementation, retention and destruction. Ann communicated regularly with senior management and provided day-to-day business counseling and advice. Her experience at Valero has given Ann an unparalleled ability to effectively interact with in-house counsel.

Ann began her legal career in 1994, serving as a law clerk to the Honorable James D. Heiple of the Illinois Supreme Court. After her clerkship, Ann worked for two law firms in the St. Louis area. She represented clients in environmental, class action, commercial, and personal injury matters pending throughout the country. Her clients included railroads, refiners, utilities, municipalities, health care entities, franchisors, and auto manufacturers. Ann has represented clients before the Seventh Circuit Court of Appeals, the Illinois Supreme Court and various appellate courts in Illinois and Missouri.

### **Significant Cases**

- *Wilson v. Norfolk and Western Railway Company*, 718 N.E.2d 172 - The Illinois Supreme Court ruled in case of first impression that a railroad employee must prove physical contact or the threat of physical contact to recover damages for intentional infliction of emotional distress under the FELA.

### **Public Speaking**

- “Case Law Update”  
Heyl Royster Governmental Seminar (2016)
- “21st Century Liability Issues: Drones, Cyber Liability, and Privacy Issue”  
Heyl Royster’s 30th Annual Claims Handling Seminar (2015)
- “How to Handle the Midnight Call and The Building Blocks of an Effective Defense”  
Heyl Royster 29th Annual Claims Handling Seminar (2014)

### **Professional Associations**

- Illinois State Bar Association
- Association of Corporate Counsel
- Madison County Bar Association
- The Missouri Bar Association

### **Court Admissions**

- State Courts of Illinois, Missouri and Texas
- United States Supreme Court
- United States Court of Appeals, Seventh and Eighth Circuits
- United States District Courts, Southern District of Illinois, Central District of Illinois, Northern District of Illinois, and Eastern District of Missouri

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