

# NEGLIGENT CREDENTIALING AS A CAUSE OF ACTION IN INDIANA MEDICAL MALPRACTICE LITIGATION

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## I. INTRODUCTION

The concept of negligent credentialing has been around since the 1965 landmark decision by the Illinois Supreme Court in *Darling v. Charleston Memorial Hospital*.<sup>1</sup> However, the courts have slowly accepted negligent credentialing as a cause of action. As of June 2011, at least 28 states now recognize it as a valid cause of action.<sup>2</sup> Due to the slow growth in this cause of action, there is no clear guidance on how these cases should be handled by the courts. Unfortunately, state courts are not in agreement as to how negligent credentialing claims should be handled and litigated, and of those states that have adopted negligent credentialing as a cause of action, some state supreme courts have not even had the chance to render decisions on these claims.<sup>3</sup>

Negligent credentialing is “the theory in which the recipient of harmful service recovers from a gatekeeping entity for allowing the provider of that service to engage in the activities that caused the recipient harm.”<sup>4</sup> In order for doctors to treat their patients at a hospital, the hospital must grant the physicians credentials and privileges to admit patients and perform certain procedures.<sup>5</sup> The recent trend toward integration of health care facilities and offices has interrupted the privileges of immunity that once protected health care institutions, and has opened a new era of litigation involving hospital liability for physician errors.<sup>6</sup>

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<sup>1</sup> Elam v. Coll. Park Hosp., 183 Cal. Rptr. 156, 164 (Cal. Ct. App. 1982) (citing *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 258 (Ill. 1965)).

<sup>2</sup> Estate of Burton v. Trover Clinic Found., Inc., No. 2009-CA-001595-MR, 2010 WL 6816338, at 2 (Ky. Ct. App. June 10, 2011).

<sup>3</sup> See Andrew R. deHoll, *Vital Surgery or Unnecessary Procedure? Rethinking the Propriety of Hospital Liability for Negligent Credentialing*, 60 S.C. L. REV. 1127, 1132 (2009) (explaining that some states allow negligent credentialing claims, some states do not allow the action due to the state's privilege or immunity statutes, and some states recognize the cause of action, but effectively nullify it through granting peer review privileges to hospitals).

<sup>4</sup> *Id.* at 127.

<sup>5</sup> 42 C.F.R. § 422.204.

<sup>6</sup> Benjamin J. Vernia, Annotation, *Tort Claim for Negligent Credentialing of Physician*, 98 A.L.R.5th 533 (2002).

Historically, physicians working in hospitals were classified as independent contractors, meaning they were permitted to work at the hospital and were given use of the hospital's facility and equipment, but the hospital had no control over the physician, and therefore, no liability pertaining to the physician's actions.<sup>7</sup> However, the integration of healthcare has led to the formation of business relationships between hospitals and physicians, such that now physicians are sometimes employees of the hospitals they are credentialed to work in.<sup>8</sup> The problem with integration, as it pertains to medical malpractice claims, is that it is often unclear as to where the actions of the hospital end and where the actions of the physician begin when evaluating negligence actions and what could have been avoided.<sup>9</sup> Negligent credentialing is one cause of action that seeks to determine the liability of hospitals in medical malpractice claims.<sup>10</sup>

Currently, it is estimated that “[j]ust six percent of doctors are responsible for nearly sixty percent of all medical negligence.”<sup>11</sup> Additionally, “two-thirds of doctors who make ten or more medical negligence payments are never disciplined.”<sup>12</sup> Furthermore, since the creation of the National Practitioner Databank in 1990, created for hospitals to report adverse physician events, about half of all U.S. hospitals have not even reported a single event.<sup>13</sup> Based on these statistics, there is a clear discrepancy between what is happening and what is being reported. Hospitals have a duty of care to patients and allowing

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<sup>7</sup> Whitney Foster, Note, *Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians*, 31 U. ARK. LITTLE ROCK L. REV. 321, 323 (2009).

<sup>8</sup> Kevin Kavanagh, *Health Care Integration: Will Physicians Lose Their Voice?*, 96 BULL. OF THE AM. COLL. OF SURGEONS 28 (2011).

<sup>9</sup> Lyle Griffin Woodruff, *Hospital Liability*, WARSHAUER LAW GROUP, <http://www.warlawgroup.com/files/LGW-HospitalLiability.pdf> (last visited Oct. 5, 2012).

<sup>10</sup> Vernia, *supra* note 6.

<sup>11</sup> AMER. ASS'N FOR JUSTICE, *MEDICAL NEGLIGENCE: THE ROLE OF AMERICA'S CIVIL JUSTICE SYSTEM IN PROTECTING PATIENTS' RIGHTS*, 4 (2011), available at [http://www.justice.org/resources/Medical\\_Negligence\\_Primer.pdf](http://www.justice.org/resources/Medical_Negligence_Primer.pdf).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 4, 6.

negligent credentialing as a cause of action against hospitals promotes an additional layer of protection to patients against avoidable medical errors and helps to keep hospitals accountable in the role of patient safety.<sup>14</sup>

### *A. Roadmap*

This note discusses negligent credentialing as a cause of action in medical malpractice claims. Section II looks to Indiana case law as it pertains to negligent credentialing and the guidance that the decided cases in Indiana give in regard to defendant and plaintiff actions. In order to better understand negligent credentialing as a cause of action and the future of this type of claim, Section III explores current trends in negligent credentialing in other jurisdictions and argues for three changes to Indiana law: (1) the bifurcation of negligent credentialing claims; (2) a clarification on the peer review privilege; and (3) for a negligent credentialing statute to protect plaintiffs.

Indeed, Indiana has looked to neighboring jurisdictions for guidance on how to rule in this type of action and will be likely to do so as further issues arise in negligent credentialing actions.<sup>15</sup> Section IV looks to how the enactment of the Patient Protection and Affordable Care Act (PPACA) could impact negligent credentialing in Indiana cases.<sup>16</sup>

### *B. Background*

*Darling v. Charleston Community Memorial Hospital*, decided in 1965, was the first case to recognize negligent credentialing as a cause of action in medical malpractice claims.<sup>17</sup> The Indiana Court of Appeals was slow to recognize negligent credentialing as a cause of action, but

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<sup>14</sup> Vernia, *supra* note 6; see also Deborah LaValley, *Why Credentialing Matters for Patient Safety*, HARV. CRICO/RMF FORUM, Oct. 2006, at 1.

<sup>15</sup> Beswick v. Bell, 940 N.E.2d 338, 345 (Ind. Ct. App. 2010).

<sup>16</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119-1025 (2010).

<sup>17</sup> Elam v. Coll. Park Hosp., 183 Cal. Rptr. 156, 164 (Cal. Ct. App. 1982) (citing *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 258 (Ill. 1965)).

eventually ruled that there is a valid cause of action in medical malpractice claims in 2000.<sup>18</sup> In 2010, the Indiana Court of Appeals decided a case that broadened the scope of factual foundations under which a plaintiff can bring a negligent credentialing action.<sup>19</sup> The Indiana Supreme Court has not yet heard a case on negligent credentialing. Therefore, the only guidance afforded to the lower courts is from the few decisions that have been decided through the Indiana Court of Appeals, unless the lower court looks to another jurisdiction's rulings as demonstrated by the court in *Beswick v. Bell*.<sup>20</sup> The lack of guidance from the Indiana Supreme Court and the lack of cases involving this cause of action leave the issue of what exactly is required in a negligent credentialing claim, the adjudicative process that is afforded in these claims, and issues of privilege and discovery open for debate. Thus far, the decisions seem to render more questions than answers.

## II. INDIANA CASE LAW AND GUIDANCE IN NEGLIGENT CREDENTIALING ACTIONS

Since 1938, the common law rule in Indiana was that a hospital is generally not liable for the medical negligence of the doctors on its staff, since by law, doctors are considered to be independent contractors.<sup>21</sup> However, in 1986, *Yaney v. McCray Memorial Hospital* provided an exception to that common law rule.<sup>22</sup> The court in *Yaney* held that a hospital could be liable for medical malpractice of its physicians if the hospital was aware that the care provided by a physician had deviated from the normal practice.<sup>23</sup> In determining whether the hospital could be found negligent, the court looked to whether the hospital's acts or omissions could be a proximate cause of the plaintiff's injuries.<sup>24</sup> The

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<sup>18</sup> *Winona Mem'l Hosp. v. Kuester*, 737 N.E.2d 824, 828-29 (Ind. Ct. App. 2000).

<sup>19</sup> *Beswick v. Bell*, 940 N.E.2d 338 (Ind. Ct. App. 2010).

<sup>20</sup> *Id.*

<sup>21</sup> *Iterman v. Baker*, 15 N.E.2d 365, 370 (Ind. 1938).

<sup>22</sup> *Yaney v. McCray Mem'l Hosp.*, 496 N.E.2d 135 (Ind. Ct. App. 1986).

<sup>23</sup> *Id.* at 137.

<sup>24</sup> *Id.*

court stated:

The test for determining whether a negligent act or omission is the proximate cause of an injury is whether the injury is a natural and probable consequence, which in light of the circumstances, should have been foreseen or anticipated. The key is foreseeability of the ultimate injury as a natural and probable consequence of the act or omission.<sup>25</sup>

While this case did not include negligent credentialing as one of the causes of action, it opened the door for hospital negligence in medical malpractice claims and, eventually, the recognition of negligent credentialing as a cause of action.

*Winona Memorial Hospital v. Krueger* is the landmark Indiana case that adopted negligent credentialing as a cause of action in medical malpractice claims.<sup>26</sup> The issue here was whether a negligent credentialing claim fell within the purview of the Indiana Medical Malpractice Act (the Act).<sup>27</sup> The court looked to the definition of “malpractice” under the Act and then looked to the statute covering credentialing to determine if credentialing of a physician could fall under the Act.<sup>28</sup>

Since the credentialing process involves both medical and nonmedical personnel and expertise, the court stated that it was “neither clearly within the Act nor outside of it.”<sup>29</sup> In order for a negligent credentialing cause of action to continue, “[t]he credentialing process alleged must have resulted in a definable act of medical malpractice that proximately caused injury to [the plaintiff].”<sup>30</sup> The court reasoned that a complaint of negligent credentialing is subject to a medical review panel as required by the Act:

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<sup>25</sup> *Id.* at 138.

<sup>26</sup> Timothy C. Curess & Katherine Amy Lemon, *Recent Developments in Indiana Tort Law*, 35 Ind. L. Rev. 1583, 1591 (2002).

<sup>27</sup> *Id.* at 825.

<sup>28</sup> *Id.* at 826-27.

<sup>29</sup> *Id.* at 827.

<sup>30</sup> *Id.* at 828.

Because the act of credentialing and appointing licensed physicians to its medical staff is a service rendered by the hospital in its role as a health care provider, inclusion of negligent credentialing under the Act is consistent with use of the medical review panel to establish the standard of care owed by Winona in credentialing.<sup>31</sup>

Further, the court held that the credentialing of a physician was “directly related to the provision of health care, and is therefore, not excluded from the Act” as a cause of action in medical malpractice claims.<sup>32</sup> The importance of the *Winona* case lies not only in that it recognized negligent credentialing as a cause of action, but also gave courts the guidance that negligent credentialing claims have to follow the statutory requirements of medical malpractice claims as listed in the Act.

In 2007, the federal courts in Indiana revisited the matter of negligent credentialing in *Pike v. Decatur Memorial Hospital*.<sup>33</sup> This case turned on the issue of who could be considered a “health care provider” under the Act in order to satisfy the requirements for bringing a negligent credentialing claim.<sup>34</sup>

Since *Winona* established that negligent credentialing claim could be brought under the Act, it is only valid against “health care provider” as defined by the act.<sup>35</sup> In *Pike*, the hospital had contracted with a third party company, NES, to find and provide it the service of emergency room physicians.<sup>36</sup> The physician did not disclose that he had been previously licensed to practice in another state, nor that his license in California had been revoked

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<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> *Pike v. Decatur Mem’l Hosp.*, No. 1:04-cv-391-JDT-TAB, 2007 U.S. Dist LEXIS 32552, at 1 (S.D. Ind. May 1, 2007).

<sup>34</sup> *Id.* at 26-27.

<sup>35</sup> IND. CODE § 34-18-3-1 (2012) (providing that if a health care provider fails to “qualify,” it loses the protections afforded it under the Act).

<sup>36</sup> *Pike*, 2007 U.S. Dist LEXIS 32552, at 2.

due to a mental illness.<sup>37</sup> The physician was credentialed to perform emergency room services, despite previously having his medical license suspended in the State of California,<sup>38</sup> NES argued that it was not a “qualified provider” as required by the Act.<sup>39</sup> The court responded that NES’s contract:

[T]o be responsible for all physician emergency room services at Decatur makes it more than difficult for it to say it is not a “health care provider” when the statute provides that an agent of a facility authorized by the state to provide health care is a “health care provider.”<sup>40</sup>

Once the court determined that NES was considered a “health care provider” under the provisions of the Act, it turned to the specific claim of negligent credentialing.<sup>41</sup> NES attempted to shift the burden of negligent credentialing to the hospital since NES believed it was “insulated from liability . . . because Decatur had ultimate responsibility for issuing hospital privileges and regardless of what information NES may have provided.”<sup>42</sup> The court found that, at the time the hospital granted credentials to Dr. Angel, Dr. Angel had not yet obtained the California license so there was no evidence that Decatur knew he had a license in California or that it was revoked.<sup>43</sup> However, the evidence was clear that NES had Dr. Angel’s curriculum vitae, which listed his California license number, and NES had in place a policy of conducting two-year reviews for its physicians.<sup>44</sup> The court ultimately held that NES could be

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<sup>37</sup> *Id.*

<sup>38</sup> *Id.* at 9.

<sup>39</sup> *Id.* at 17; see IND. CODE §§ 34-18-2-24.5 and 34-18-3-2 (2012) (requiring that medical providers and their insurers file certain proofs with the commissioner to become “qualified”).

<sup>40</sup> *Pike*, 2007 U.S. Dist LEXIS 32552, at 26 (construing IND. CODE § 34-18-2-14(1) (2012)).

<sup>41</sup> *Id.* at 28.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *Id.* at 28-29.



held liable for the negligent credentialing claim, but there was not sufficient evidence for summary judgment.<sup>45</sup> This case is essential to the basis of case law for negligent credentialing since it expanded the realm of negligent credentialing liability to third party entities that contract with hospitals.

The next case to provide guidance on negligent credentialing in Indiana was *Beswick v. Bell*, which was decided in December of 2010.<sup>46</sup> The court noted that Indiana accepted negligent credentialing as a cause of action in the decision of *Winona* but went on to state that the elements needed for a negligent credentialing claim had not been defined in Indiana law.<sup>47</sup> The court looked to Ohio and Illinois law to determine what elements are needed to satisfy a negligent credentialing cause of action.<sup>48</sup>

In 2009, the Ohio Supreme Court held that “[t]o prove a negligent-credentialing claim, a plaintiff injured by the negligence of a staff doctor must show that but for the lack of care in the selection or retention of the doctor, the doctor would not have been granted staff privileges, and the plaintiff would not have been injured.”<sup>49</sup> The Indiana Court of Appeals read this as: “Ohio law contemplates some knowledge on the part of the hospital that would render its credentialing decision negligent.”<sup>50</sup>

The court also looked to a decision rendered by the Illinois Appellate Court, which looked to other federal and state courts on the issue of negligent credentialing.<sup>51</sup> The Illinois court decided that:

“[T]he elements needed to prove negligent credentialing” were as follows: that “the hospital failed to meet the standard of reasonable care in the selection of the

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<sup>45</sup> *Id.* at 29-30.

<sup>46</sup> *Beswick v. Bell*, 940 N.E.2d 338 (Ind. Ct. App. 2010).

<sup>47</sup> *Id.* at 344.

<sup>48</sup> *Id.* at 344-45.

<sup>49</sup> *Id.* at 345 (citing *Schelling v. Humphrey*, 916 N.E.2d 1029, 1033 (Ohio 2009)).

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

physician it granted medical state privileges to whose treatment provided the basis for the underlying medical mal-practice claim"; and that "while practicing pursuant to negligently granted medical staff privileges, the physician breached the applicable standard of care"; and that "the negligent granting of medical staff privileges was the proximate cause of the plaintiff's injuries."<sup>52</sup>

After reviewing the other courts' decisions, the Indiana Court of Appeals held that since there were no previous complaints or allegations from patients of negligence against Dr. Bell and since Dr. Bell held the appropriate state medical license and board certification for an orthopedic surgeon, there was no evidence that the hospital knew he had deviated from the standard of care, as required by the *Yaney* decision.<sup>53</sup> Furthermore, the court held that there was no evidence that but for the lack of care in the selection or retention of Dr. Bell, he would never had been given staff privileges, as required by *Schelling*.<sup>54</sup>

This decision is extremely important since it outlines the elements for a negligent credentialing cause of action. However, the decision leaves an ambiguous area of what exactly is required by a hospital to protect itself against negligent credentialing claims. Perhaps, more importantly, it leaves the question of how much importance hospitals should place on patient complaints in determining physician retention and how past complaints may affect in their defense of negligent credentialing claim.

This decision is also important because the court of appeals looked outside of Indiana for guidance on how to handle the issues presented in a negligent credentialing decision. Given the precedent of looking to other jurisdictions for guidance in negligent credentialing claims, it would be advantageous to be familiar with how these

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<sup>52</sup> *Id.* (citing *Frigo v. Silver Cross Hosp. & Med. Ctr.*, 876 N.E.2d 697, 723 (Ill. App. Ct. 2007)).

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

jurisdictions are deciding negligent credentialing decisions and any new areas of development in this area so as to gain a better understanding of how the Indiana Court of Appeals may address these issues in the future.

In December of 2011, the Indiana Court of Appeals once again addressed a claim of negligent credentialing.<sup>55</sup> The plaintiff filed a medical malpractice claim against the defendant doctor following issues from a bilateral breast reduction.<sup>56</sup> The medical review panel issued a unanimous opinion that the doctor failed to meet the standard of care in treating the plaintiff and that the defendant hospital failed to meet the standard of care in granting the doctor privileges.<sup>57</sup> However, the trial court granted summary judgment for both defendants because the plaintiff missed deadlines for admitting expert evidence.<sup>58</sup>

On appeal, the Indiana Court of Appeals held that “the trial court properly granted summary judgment to Dr. Park because Martinez failed to rebut the expert testimony that he did not breach the applicable standard of care in pre-operatively, surgically, or post-operatively treating Martinez.”<sup>59</sup> The court then held that the summary judgment on the negligent credentialing claim was also appropriate because the defendant cannot be liable “[w]ithout a showing of an underlying breach of the standard of care by [the doctor] proximately causing [plaintiff’s] injuries.”<sup>60</sup> While this case did not exactly create new law for lower courts to implement, it is important in that it reiterated the importance of establishing a medical malpractice claim against a defendant doctor in order to prove a negligent credentialing claim.

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<sup>55</sup> *Martinez v. Park*, 959 N.E.2d 259 (Ind. Ct. App. 2011).

<sup>56</sup> *Id.* at 260.

<sup>57</sup> *Id.*

<sup>58</sup> *Id.* at 266-67.

<sup>59</sup> *Id.* at 271-72.

<sup>60</sup> *Id.* at 272.

### III. CURRENT TRENDS IN NEGLIGENT CREDENTIALING FROM OTHER JURISDICTIONS

As noted above, the court in *Beswick v. Bell* looked to the court decisions from Ohio and Illinois for guidance on a negligent credentialing claim because of the lack of Indiana cases on the subject.<sup>61</sup> Given the importance other jurisdictional decisions can have on the Indiana court system, it is imperative to look at trends happening around the country in the area of negligent credentialing that could have an impact on Indiana law.

#### A. Bifurcation

In 2009, the Supreme Court of Ohio handed down a ruling in *Schelling v. Humphrey*, which pertained to bifurcation of negligent credentialing claims.<sup>62</sup> The plaintiff filed a claim against the surgeon for medical malpractice relating to two heel surgeries and also filed a claim against the hospital for negligently granting staff privileges to the surgeon.<sup>63</sup> The plaintiff subsequently dismissed her claim against the physician after the surgeon filed for bankruptcy and the plaintiff reached a settlement with the bankruptcy trustee.<sup>64</sup> However, the plaintiff continued with her negligent credentialing claim against the hospital.<sup>65</sup>

Prior to the surgeon filing for bankruptcy, the hospital moved to bifurcate the negligent-credentialing claim and the medical malpractice claim against the surgeon, arguing that “the negligent-credentialing claim did not become ripe until the doctor's negligence was determined”.<sup>66</sup> The trial court granted this motion.<sup>67</sup> Once the settlement was reached between the plaintiff and the surgeon, the hospital moved for dismissal of the claim arguing that without a finding of negligence, the negligent credentialing claim

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<sup>61</sup> *Beswick v. Bell*, 940 N.E. 2d 338, 344-345 (Ind. Ct. App. 2010).

<sup>62</sup> *Schelling v. Humphrey*, 916 N.E.2d 1029, 1031 (Ohio 2009).

<sup>63</sup> *Id.*

<sup>64</sup> *Id.* at 1031-32.

<sup>65</sup> *Id.* at 1031.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

could not be established.<sup>68</sup> The hospital did not believe the bankruptcy court found negligence in this case nor was the hospital aware that the surgeon had admitted negligence.<sup>69</sup>

The Supreme Court of Ohio ultimately held that the plaintiff could continue with the negligent credentialing claim, in the absence of the surgeon, so long as she could prove that his malpractice was a causal element of the claim against the hospital.<sup>70</sup> Given the unusual circumstances of the case, the court stated that the impeded plaintiff “should be permitted to prove that [the surgeon] committed medical malpractice and that the alleged malpractice caused the [plaintiff’s] injury, as an element of their negligent credentialing claim against the hospital.”<sup>71</sup>

The Supreme Court of Ohio gave further instruction regarding the bifurcation of the claims by stating that the bifurcation of the medical malpractice claim and the negligent credentialing claim would avoid “the problems of jury confusion or prejudice that may result from admitting evidence of prior acts of malpractice in a combined trial on both claims.”<sup>72</sup> Evidence of prior malpractice by the surgeon would lend credibility to the negligent credentialing claim, but would provide for unfair prejudice in the jury determination of whether the doctor committed malpractice.<sup>73</sup> Additionally, the court reasoned that bifurcation was appropriate because if the medical malpractice claim against the doctor did not prevail, the negligent credentialing claim could be dismissed.<sup>74</sup> The court stated that “[i]f the fact-finder determines that negligence of the doctor is not the cause of the plaintiff’s injury, then a hospital’s grant of staff privileges to a doctor is not the cause of the plaintiff’s injuries.”<sup>75</sup>

The Kentucky Court of Appeals has also ruled on the

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<sup>68</sup> *Id.* at 1032.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* at 1036-37.

<sup>71</sup> *Id.* at 1036.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

issue of bifurcation in *Patterson v. Marshall*.<sup>76</sup> In that case, the court actually affirmed trifurcation of the claims and ordered that the trial proceed in three separate stages before the same jury with the medical negligence claim against the physician first, followed by the hospital's statute of limitations defense if the physician was found guilty, and then ending with the negligent credentialing claim if the defense was not sustained.<sup>77</sup> In addition to the proposed plan, the trial court excluded all matters relating to the physician's employment history during the phase pertaining to the physician's medical negligence claim and also denied the plaintiff's motion to compel the hospital to produce the physician's credentialing files and peer review files.<sup>78</sup>

The appellate court held that the trial court had not abused its discretion in regard to the challenged trial plan.<sup>79</sup> In regard to a challenge to the hospital's participation in the first trial state, the appellate court reasoned that "to prevent [the hospital] from introducing evidence of [defendant's] compliance with the standard of care would have prevented [the hospital] from defending itself against the negligent credentialing claim under the procedure utilized by the trial court."<sup>80</sup> In regards to the challenge of the trial court excluding evidence of the physician's employment and peer review, the court reasoned that the physician's prior loss of privileges held no bearing on the standard of care he provided to the plaintiff, and allowance of this evidence would only confuse the two issues of medical negligence and negligent credentialing in this case.<sup>81</sup> While allowing for the bifurcation of the claims, the Kentucky Court of Appeals did not formally recognize negligent credentialing as a cause of action in this claim.<sup>82</sup>

In June 2010, the Kentucky Court of Appeals revisited the issue of bifurcating claims in negligent

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<sup>76</sup> *Patterson v. Marshall*, No. 2008-CA-000157, 2009 WL 2341448, at 1 (Ky. Ct. App. July 31, 2009).

<sup>77</sup> *Id.* at 2.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 3.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.* at 2.

credentialing cases in *Estate of Burton v. Trover Clinic Foundation, Inc.*<sup>83</sup> In delivering the opinion, the court began by first recognizing negligent credentialing as a valid tort in the State of Kentucky.<sup>84</sup> In this case, the defendant doctor and the defendant hospital joined together and filed a motion, granted by the trial court, to bifurcate the case into two phases which would include the medical negligence issues first, followed by all other issues in the case including the claim of negligent credentialing.<sup>85</sup> The court stated that in determining bifurcation of these claims, trial court should “consider potential prejudice to the parties, potential confusion to the jury, and the relative convenience and economy which would result.”<sup>86</sup> The court then held that bifurcation in this instance was not an abuse of discretion by the trial court.

The plaintiff argued that bifurcation of the trials was a reversible error on the grounds that bifurcation was in violation of a state statute requiring that a jury consider all issues concurrently and bifurcation deprived the plaintiff of his constitutional right to conduct a full voir dire.<sup>87</sup> The relevant statute in this appeal is KRS § 411.186 which states that “[i]n any civil action where claims for punitive damages are included, the jury . . . shall determine concurrently with all other issues presented, whether punitive damages may be assessed.”<sup>88</sup> The court held that the statute was not violated because the trial court only bifurcated the claims between the defendants, but did not bifurcate the damages claims in relation to each individual defendant.<sup>89</sup>

In relation to the voir dire argument, the plaintiff only submitted voir dire questions on the first phase of the trial for the medical negligence claim.<sup>90</sup> The court held that

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<sup>83</sup> *Estate of Burton v. Trover Clinic Found., Inc.*, No. 2009-CA-001595-MR, 2010 WL 6816338, at 2 (Ky. Ct. App. June 10, 2011).

<sup>84</sup> *Id.* at 2.

<sup>85</sup> *Id.* at 1.

<sup>86</sup> *Id.* at 3.

<sup>87</sup> *Id.* at 2.

<sup>88</sup> KY. REV. STAT. Ann. § 411.186 (West 2012).

<sup>89</sup> *Estate of Burton*, 2010 WL 6816338, at 3.

<sup>90</sup> *Id.*

the plaintiff should have been allowed to conduct a full voir dire in the initial phase that concerned both phases of the bifurcated trial.<sup>91</sup> However, the court went on to note that there was no reversible error because the jury did not find the defendant doctor negligent in the first phase of the trial, so the second portion of the trial was never conducted.<sup>92</sup>

The Indiana courts should adopt bifurcation of medical malpractice claims and negligent credentialing claims. The bifurcation of these claims saves hospitals the unnecessary expense of defending a claim that may be dismissed prior to adjudication. In December 2011, the American Medical Association released a medical liability reform report indicating that the average cost of defending a physician in a medical liability claim in 2010 was \$47,158.<sup>93</sup> Further, the report noted that in 2010, 63.7% of closed claims against physicians were dropped, withdrawn, or dismissed without any payment, and that each of these claims costs an average of \$26,851 to defend.<sup>94</sup> Hospitals and the physicians are both paying these amounts to defend medical liability claims that involve negligent credentialing complaints. It may even be advantageous to allow bifurcation of not only the trial, but also the discovery phases of these claims, limiting the initial phase to the issues involved in the underlying medical negligence claim against the physician. Bifurcating the discovery phase would, in effect, focus on determining the underlying issue of whether the physician was negligent.<sup>95</sup> Moreover, it would “lessen credentialing discovery expense by postponing the need to depose those involved in the credentialing process, witnesses testifying on the physician’s alleged defects and experts.”<sup>96</sup> Since over half of medical malpractice claims against physicians are

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<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> Morgan Lewis, Jr., *Medical Malpractice Costs Continue to Climb*, MOD. MED. (Jan. 11, 2012), <http://www.modernmedicine.com/modernmedicine/article/articleDetail.jsp?id=755739> (last visited Sept. 27, 2012).

<sup>94</sup> *Id.*

<sup>95</sup> Thomas J. Hurney, Jr. et al., *Defending Negligent Credentialing Cases*, FOR THE DEF. 44, 51 (July 2010), available at <http://www.moser.com/Firm-News-and-Events/FTD-1007-HurneyStiegerWillmanPozzo.pdf>.

<sup>96</sup> *Id.*



dropped, it would be advantageous to bifurcate the claims and, at least, save the hospital the expenses of defending a claim that can only be adjudicated on after the physician has been found negligent.<sup>97</sup>

In instances of bifurcation, the court should permit the hospital to participate in all phases of the trial since the hospital is a defendant in an underlying claim.<sup>98</sup> Bifurcation also allows for protection against jury bias against a physician defending himself in a medical malpractice suit. Moreover, bifurcating claims is in conformity with the Federal Rules of Evidence. Federal Rule of Evidence 404(b) provides that “[e]vidence of a crime, wrong, or other act is not admissible to prove a person’s character in order to show that on a particular occasion the person acted in accordance with the character.”<sup>99</sup>

By following the holding and guidance in *Estate of Burton v. Trover Clinic Foundation, Inc.*,<sup>100</sup> the Indiana courts would give guidance to the lower courts of what issues to consider when bifurcation is presented. Further, this decision helps to direct how to deal with voir dire in instances of bifurcating a negligent credentialing claim and what needs to be included in the initial voir dire process.

### *B. Qualified Immunity*

Some jurisdictions have looked to state statutes to give qualified immunity from negligent credentialing so long as the hospital is compliant with credentialing procedures. In *Huntsman v. Aultman Hospital*, the Ohio Court of Appeals provided that the defendant hospital was not subject to

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<sup>97</sup> Dwight Golann, *Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, and Potential Remedies*, SOC. SCI. RES. NETWORK (July 19, 2011), <http://ssrn.com/abstract=1896181> (last visited Sept. 27, 2012).

<sup>98</sup> See *Patterson v. Marshall*, No. 2008-CA-000157, 2009 WL 2341448, at 3 (Ky. Ct. App. July 31, 2009) (holding that “to prevent [defendant hospital] from introducing evidence of [the doctor’s] compliance with the standard of care would have prevented [defendant hospital] from defending itself against the negligent credentialing claim under the procedure utilized by the trial court”).

<sup>99</sup> FED. R. EVID. 404(b).

<sup>100</sup> *Estate of Burton v. Trover Clinic Found., Inc.*, No. 2009-CA-001595-MR, 2010 WL 6816338 (Ky. Ct. App. June 10, 2011).

liability for alleged negligent re-credentialing since there was a state statute that granted the hospital qualified immunity from liability based on the hospital's compliance with credentialing procedures.<sup>101</sup> Here, a deceased patient's estate brought a negligent credentialing claim against the hospital subsequent to the patient passing away one day after a hernia repair procedure.<sup>102</sup> The trial court granted summary judgment to the defendant hospital concluding that "R.C. 2305.25 does not allow for a cause of action for negligent credentialing against a hospital where a credentialing process was in place."<sup>103</sup> The trial court also stated that "a hospital cannot be held liable for 'sloppy' credentialing, so long as the proper credentialing process was followed."<sup>104</sup>

The relevant statute at issue in this case was R.C. 2305.25, which stated, in part, that "[n]o hospital . . . shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the committee."<sup>105</sup> Committee was statutorily defined as: "A board or committee of a hospital . . . of which the hospital . . . is a member reviewing professional qualifications or activities of the medical staff as the hospital . . . or applicants for admission."<sup>106</sup>

Since there were regulated, specific credentialing procedures in place at the time of credentialing, and the procedures were followed by the hospital in the re-credentialing process of the physician in this instance, the hospital was shielded from a negligent credentialing claim.<sup>107</sup> The court did further provide that "R.C. 2305.25 does not provide blanket immunity to a hospital for negligence in granting and/or continuing staff privileges of

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<sup>101</sup> *Huntsman v. Aultman Hosp.*, No. 2010CA00211, 2011 WL 884107, at 5 (Ohio Ct. App. Mar. 14, 2011).

<sup>102</sup> *Id.* at 2.

<sup>103</sup> *Id.*

<sup>104</sup> *Id.* at 5.

<sup>105</sup> OHIO REV. CODE ANN. § 2305.25 (West 2012).

<sup>106</sup> *Huntsman*, 2011 WL 884107, at 3 (citing OHIO REV. CODE ANN. § 2305.25 (West 2012)).

<sup>107</sup> *Id.*

an incompetent physician.”<sup>108</sup>

Codifying regulations for credentialing procedures in Indiana would place hospitals on notice as to what is specifically required in the credentialing process to avoid a negligent credentialing claim. Also, not affording blanket immunity to the hospital maintains the ideal of hospital responsibility in regard to ensuring patient safety through its actions, but does afford the hospital protection against liability for acting in accordance with standards ensuring patient safety. It is important to note that the Ohio statute cited in this claim is no longer a statute. Ohio has now put in to place R.C. 2305.251, which specifically provides that there is a presumption of no negligence in credentialing and provides immunity for hospitals as long as they follow a laid out process in credentialing physicians.<sup>109</sup>

### *C. Negligent Credentialing and the Peer Review Process*

One recent trend in negligent credentialing litigation is the determination of whether peer review privilege extends to negligent credentialing claims. In general, the peer review process is “a process by which health care providers evaluate their colleagues' work to determine if it complied with the standard of care by understanding the root cause of why a preventable adverse event occurred.”<sup>110</sup> This process is generally used in the credentialing process with the governing body of the hospital overseeing the finalized recommendations of the peer review committee.<sup>111</sup> The peer review committee is involved in reviewing initial applications from medical professionals who do not yet have current membership in the medical facility, reappointments for staff members who are currently privileged or credentialed for the facility, and situations in which a

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<sup>108</sup> *Id.*

<sup>109</sup> OHIO REV. CODE ANN. § 2305.251 (West 2012).

<sup>110</sup> Patricia A. Sullivan & Jon M. Anderson, *The Health Care Debate: If Lack of Tort Reform Is Part of the Problem, Federalized Protection for Peer Review Needs to Be Part of the Solution*, 15 ROGER WILLIAMS U. L. REV. 41, 45 (2010).

<sup>111</sup> Craig W. Dallan, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 610 (2000).

problem is identified with an existing privilege.<sup>112</sup> Inherent with the peer review process and negligent credentialing is the problem that most states, including Indiana, provide immunity to peer review committees in disclosing information.<sup>113</sup> Indiana Code Section 34-30-15-1 provides: “(a) All proceedings of a peer review committee are confidential. (b) All communications to a peer review committee shall be privileged communications.”<sup>114</sup>

Some defendant hospitals will argue that immunity provided for in peer review statutes precludes negligent credentialing as a cause of action. Indeed, invoking the peer review privilege in a negligent credentialing claim could be a crucial move for defendant hospitals since it would protect any documents the peer review committee used in the credentialing process, thus frustrating the efforts of the plaintiff to obtain evidence through discovery methods.<sup>115</sup> A hospital can adopt a medical staff bylaw specification that defines “peer review” or “peer review committee” in an extensive way that is still consistent with the language of the state’s peer review statute in an effort to protect even more information under peer review confidentiality provisions.<sup>116</sup>

Most hospitals have their credentialing process outlined in their bylaws and policies. Bylaw, policies, procedures, and guidelines are all discoverable since they are available through original sources and are not protected by any peer review privilege.<sup>117</sup> Thus, if a hospital follows its own policies and bylaws, and they are in accordance with credentialing and peer review statutes, the hospital should not be found to be negligent in the credentialing process. By blocking the discoverability of the actual peer review

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<sup>112</sup> *Id.*

<sup>113</sup> *Id.* at 611.

<sup>114</sup> IND. CODE § 34-30-15-1 (2012).

<sup>115</sup> Katten Muchin Rosenman, LLP, *Current Issues in Negligent Credentialing Part II*, JDSUPRA (June 14, 2011), <http://www.jdsupra.com/post/documentViewer.aspx?fid=9c44f04d-7376-4d74-91fd-da9c9288b114> (last visited Sept. 27, 2012).

<sup>116</sup> *Id.*

<sup>117</sup> Charles David Creech, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 229 (1988).

process that was used in the credentialing, the hospital has the upper hand on the claim. Since every state has its own peer review statute, it is important to examine how different states have interpreted the role of these statutes in negligent credentialing claims.

1. *Minnesota's Interpretation of the Peer Review Privilege in Negligent Credentialing Claims.*

*Larson v. Wasemiller* is a landmark case, in which the Minnesota Supreme Court recognized, for the first time, that the tort of negligent credentialing of a physician by a hospital exists under the common law and is reinforced, not precluded, by Minnesota's peer review statute.<sup>118</sup> *Larson* is important to review since it reasons through several portions of Minnesota's peer review statute, and the statute is very similar to the Indiana statute on peer review.<sup>119</sup>

The court in *Larson* looked at several issues with the Minnesota Peer Review Statute as it pertained to negligent credentialing. First, the court looked to whether the statute created a cause of action for negligent credentialing. The statute provides:

No review organization and no person shall be liable for damages . . . when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.<sup>120</sup>

The court found that the "language of this statute implies that a review organization shall be liable for granting privileges where the grant is not reasonably based on the facts that were known or that could have been known

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<sup>118</sup> *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007).

<sup>119</sup> *Id.* at 303-04 (discussing Minnesota's peer review statute).

<sup>120</sup> MINN. STAT. § 145.63 (2012).

by reasonable efforts.”<sup>121</sup> The court declared that while the statute did not affirmatively declare a negligent credentialing cause of action, it indicated the existence of a cause of action.<sup>122</sup>

Next, the court looked to whether negligent credentialing as a cause of action would conflict with the section of Minnesota’s peer review statute that provided a provision for confidentiality.<sup>123</sup> The confidentiality provision states, in part:

[D]ata and information acquired by a review organization, in the exercise of its duties and functions . . . shall not be subject to subpoena or discovery . . . The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization.<sup>124</sup>

The defendant hospital argued that the statute prohibited it from disclosing information the credentialing committee relied on in making its decision.<sup>125</sup> Therefore, the statute precluded a claim of negligent credentialing since the issue in negligent credentialing claims is whether the hospital was negligent in credentialing the physician on the basis of what he actually knew at the time of the decision.<sup>126</sup> The court responded that this interpretation was too narrow since negligence is decided on “what was actually known or what *should have been known* at the time of the credentialing decision.”<sup>127</sup>

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<sup>121</sup> *Larson*, 738 N.W.2d at 304.

<sup>122</sup> *Id.*

<sup>123</sup> *Id.* at 309-10.

<sup>124</sup> MINN. STAT. § 145.64 (2012).

<sup>125</sup> *Larson*, 738 N.W.2d at 309.

<sup>126</sup> *Id.*

<sup>127</sup> *Id.* at 310. See also *Diaz v. Feil*, 881 P.2d 745, 750 (N.M. Ct. App. 1994) (should have known); *Corleto v. Shore Mem’l Hosp.*, 350 A.2d 534, 538 (N.J. Super. Ct. App. Div. 1975) (had reason to know); and *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1046 (Ohio 1990) (had reason to know).

There is a provision of the statute indicating that information available from the original source is not immune from discovery or use in civil actions.<sup>128</sup> The court determined that while the statute prevents hospitals from disclosing specific information used by the credentialing committee, it does not prevent hospitals from introducing the same information, so long as it could be obtained from the original sources.<sup>129</sup> The court acknowledged that this does, in fact, further burden the plaintiff since the plaintiff has no way of discovering what exact information was used by the hospital in the credentialing process.<sup>130</sup> However, it does provide the plaintiff with the cause of action and a chance to demonstrate what the hospital should have known at the time of the credentialing process.

The court then looked to whether the immunity from the liability portion of the Minnesota peer review statute precluded negligent credentialing claims. The court reasoned that while the statute limited liability of hospitals and credentialing committees, there was no indication of intent to immunize hospitals from liability or to nullify a common law claim for negligent credentialing.<sup>131</sup> The court further noted that “[i]f the legislature had intended to foreclose the possibility of a cause of action for negligent credentialing, it would not have addressed the standard of care applicable to such an action.”<sup>132</sup>

*Larson* reconciled the disparities that can exist between peer review statutes and negligent credentialing claims. However, one result of this decision is that “[a]ttorneys and trial court judges must walk a fine line between allowing the case to proceed within the parameters established by the Minnesota Supreme Court while maintaining the strict confidentiality established by the Minnesota Legislature.”<sup>133</sup> While this was a Minnesota case, the ramifications of the

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<sup>128</sup> MINN. STAT. § 145.63 (2012).

<sup>129</sup> *Larson*, 738 N.W.2d at 310.

<sup>130</sup> *Id.*

<sup>131</sup> *Id.* at 311.

<sup>132</sup> *Id.*

<sup>133</sup> Mark R. Whitmore, *A Survivor's Guide to Larson v. Wasemiller: An Aid to Eliminating Reversible Error in Managing Negligent Credentialing Claims Under Minnesota Law*, 1 WM. MITCHELL J.L. & PRAC. 2 (2008).

decision could reach to other jurisdictions since every state has similar peer review statutes. Since negligent credentialing as a cause of action is still being developed in some areas, courts may look to this decision to develop their areas of common law. This decision is important for Indiana to adopt since the statutes at issue in the case are similar to Indiana's statutes. The courts need to recognize the potential issues presented through the peer review statutes and provide guidance in how these statutes will be followed in case determinations.

## *2. Texas's Interpretation of the Peer Review Privilege in Negligent Credentialing Claims*

Another example of peer review protection in negligent credentialing is found in the Texas Medical Malpractice Act.<sup>134</sup> Through the Texas Medical Malpractice Act, health care providers are given immunity from determinations made in the course of peer review, so long as those decisions were made without malice.<sup>135</sup>

Further complicating the process of proving negligent credentialing through the Texas Medical Malpractice Act's immunity provision of peer review committees is that the initial credentialing information is not discoverable.<sup>136</sup> The court in *St. Luke's Episcopal Hospital v. Agbor* determined that malice, within the context of negligent credentialing, involved a showing not that the hospital acted with malice toward the patient but that it acted with malice, in general.<sup>137</sup> In determining what behavior constituted malice, the court looked to the Civil Practices and Remedies Code and held that to support a negligent credentialing claim, a showing of malice requires demonstrating that:

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<sup>134</sup> TEX. OCC. CODE ANN. § 160.010 (West 2012).

<sup>135</sup> *Id.*

<sup>136</sup> See *Brownwood Reg'l Hosp. v. Eleventh Cir. Ct. App.*, 927 S.W.2d 24 (Tex. 1996); *Irving Health Care Sys. v. Brooks*, 927 S.W.2d 12 (Tex. 1996).

<sup>137</sup> See *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 506 (Tex. 1997).



(A) a specific intent by the defendant to cause substantial injury to the claimant; or

(B) an act or omission:

(i) which when viewed objectively from the standpoint of the actor at the time of its occurrence involves an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and

(ii) of which the actor has actual, subjective awareness of the risk involved, but nevertheless proceeds with conscious indifference to the rights, safety, or welfare of others.<sup>138</sup>

In 2005, The Texas Supreme Court revisited negligent credentialing through *Romero v. KPH Consolidation, Inc.*<sup>139</sup> The court stated that since peer review communications and proceedings were generally confidential, “a plaintiff must prove that a hospital acted maliciously without access to evidence of what happened, or did not happen, in the credentialing process.”<sup>140</sup> In this case, the plaintiff underwent an elective back surgery during which he lost a significant amount of blood before Dr. Baker, the treating surgeon, or anyone else noticed, and “in the 45 minutes it took to prepare a transfusion, he lost almost all of the blood in his body.”<sup>141</sup> As a result of the blood loss, the plaintiff went into cardiac arrest and suffered severe, permanent brain damage, leaving him “profoundly disabled and unable to care for himself.”<sup>142</sup>

The plaintiff brought a claim for negligent credentialing of Dr. Baker. Despite not having access to the peer review committee records involved in the credentialing process, the plaintiff presented evidence that at the time of credentialing, the hospital had access to information involving Dr. Baker’s involvement in ten malpractice

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<sup>138</sup> *Id.* at 507.

<sup>139</sup> *Romero v. Consol., Inc.*, 166 S.W.3d 212 (Tex. 2005).

<sup>140</sup> *Id.* at 215.

<sup>141</sup> *Id.* at 218.

<sup>142</sup> *Id.*

actions from 1988 to 1993, including one action for operating on the wrong hip of a patient.<sup>143</sup> The plaintiff also presented evidence that the peer review committee had information pertaining to Dr. Baker's prescription drug abuse.<sup>144</sup> In light of this evidence, the Texas Supreme Court accepted the court of appeals' assumption that the plaintiff established an objective showing of malice, as required by the statute, since "a physician engaged in drug abuse presents an extreme risk to patients."<sup>145</sup> The Supreme Court also accepted the Court of Appeals' assumption that the plaintiff established the first prong in the subjective component of malice by showing that the hospital "had actual, subjective awareness of the risk posed by Baker's drug abuse, at least at one point in time."<sup>146</sup>

However, despite all of this, the court concluded that a showing of malice as an element of a negligent credentialing claim required a higher burden of proof at the trial level and a higher standard of review at the appellate level.<sup>147</sup> At trial, the plaintiff must prove malice by clear and convincing evidence, and on appeal the Court must determine based on the evidence at trial that a reasonable trier of fact could have formed a firm belief or conviction that the reviewing entity acted with malice in credentialing the doctor.<sup>148</sup> The Texas Supreme Court may have decided the case differently if the plaintiff had offered testimony that Columbia would have suspended Dr. Baker if it knew of the drug problems, the lawsuits, and the suspension.<sup>149</sup>

The Texas standard of proof in a negligent credentialing claim, in light of its peer review privilege, is almost impossible to meet. As indicated above, despite alarming evidence presented by the plaintiff in *Romero*, the burden of proof of "firm belief or conviction" is almost impossible to

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<sup>143</sup> *Id.* at 216-17.

<sup>144</sup> *Id.* at 216-17.

<sup>145</sup> *Id.* at 221.

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at 220-21.

<sup>148</sup> *Id.* at 221.

<sup>149</sup> Casey L. Moore, Note, "In the Wake of *Rose*" and "Life After *Romero*": The Viability of a Cause of Action for Negligent Credentialing in Texas in Light of Recent Texas Supreme Court Decisions, 58 BAYLOR L. REV. 549, 576 (2006).

prove without access to the peer review committees' records. By adopting this type of standard in relation to protecting the peer review committee and their actions, Indiana courts would essentially negate the option of negligent credentialing as a cause of action. While the integrity of the peer review committee needs to be afforded protection, that protection must be weighed with the safety of patients and allowing patients an appropriate remedy when that safety has been compromised.

### *3. Iowa's Interpretation of the Peer Review Privilege in Negligent Credentialing Claims*

In December of 2011, the Iowa Supreme Court ruled on a negligent credentialing case involving the peer review privilege relating to a doctor's credentialing file.<sup>150</sup> The plaintiff filed a medical malpractice suit, which included a negligent credentialing claim against the hospital, after he suffered complications from two back surgeries performed in 2000.<sup>151</sup> Specifically, the plaintiff alleged that the hospital failed to properly investigate the doctor's qualifications, negligently extended surgical privileges to the doctor, and allowed the doctor to continue to perform surgeries after the hospital had reason to know that questions had been raised concerning the surgeries and procedures that the doctor was performing.<sup>152</sup> During the course of the case, the plaintiff served a request for production for the complete copy of the doctor's credential file.<sup>153</sup> The hospital objected to the request since the credential file was subject to the peer review privilege laid out in Iowa Code § 147.135.<sup>154</sup> Despite this, the trial judge entered an Order Compelling Discovery and the hospital produced almost the entire contents of the doctor's credentialing file.<sup>155</sup> The case went to trial and the jury

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<sup>150</sup> *Cawthorn v. Catholic Health Initiatives Iowa Corp.*, 806 N.W. 2d 282 (Iowa 2011).

<sup>151</sup> *Id.* at 283.

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> *Id.* at 284.

<sup>155</sup> *Id.*

found in favor of the plaintiff, and both parties appealed on different grounds.<sup>156</sup> Based on these appeals the Supreme Court remanded the case for a new trial.<sup>157</sup>

After the case was remanded but prior to the new trial taking place, the Iowa Court of Appeals handed down the decision in *Day v. Finley Hospital*, where the court held that the contents of a hospital's credentialing file fell within the scope of the Iowa Code § 147.135 peer review protection to the extent that those documents were in the custody of a peer review committee.<sup>158</sup> At that time, the defendant hospital filed for summary judgment arguing that the new ruling barred production of the credentialing file and without these documents the plaintiff did not have sufficient evidence to prove a prima facie case.<sup>159</sup> The trial court ruled that the defendant was not barred from asserting the peer review privilege, even though the documents had been submitted previously, since the new ruling was an "intervening change or clarification of the law."<sup>160</sup> The case was appealed to the Iowa Supreme Court.

The Iowa Supreme Court looked to the peer review statute and determined that the statute set forth three restrictions: (1) peer review records are "privileged and confidential"; (2) peer review records are "not subject to discovery, subpoena, or other means of legal compulsion"; and (3) peer review records are "not admissible in evidence."<sup>161</sup> The court then held that this privilege could not be voluntarily waived by a hospital, and as a result, the hospital was able to claim the privilege even though it had previously submitted the credentialing file.<sup>162</sup>

This case is important since the hospital was able to assert the peer review privilege after it had submitted the credentialing file for review. It would seem that most hospitals would be given adequate legal advice to bar discovery of these documents in the first place, but this rule

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<sup>156</sup> *Id.*

<sup>157</sup> *Id.* at 283.

<sup>158</sup> *Day v. Finley Hosp.*, 769 N.W.2d 898, 902 (Iowa Ct. App. 2009).

<sup>159</sup> *Cawthorn*, 806 N.W. 2d at 285.

<sup>160</sup> *Id.* at 283.

<sup>161</sup> *Id.* at 289 (quoting Iowa Code § 147.135 (2009)).

<sup>162</sup> *Id.* at 291.

could add an additional layer of protection against hospitals who fail to assert the privilege. This ruling essentially further frustrates a plaintiff's attempts to access credentialing documents to establish a prima facie case for negligent credentialing.

#### 4. *Missouri's Interpretation of the Peer Review Privilege in Negligent Credentialing Claims*

In December of 2010, the Missouri Court of Appeals ruled on *State ex rel. Kirksville Missouri Hospital Company, LLC v. Jaynes*, a negligent credentialing case on whether the peer review privilege protected from discovery documents relating to credentialing of a surgeon.<sup>163</sup> In this case a doctor, Dr. John Bailey, was given temporary privileges to practice back surgery at the defendant hospital in mid-1997.<sup>164</sup> However, at the time the privileges were granted, there was a question as to whether the doctor had actually completed training with the Columbia Spine Fellowship.<sup>165</sup> The hospital's director of surgery gave a recommendation to the hospital's executive committee which advised having an independent, fellowship trained, spine surgeon review the doctor's first twenty-five spinal instrumentation cases.<sup>166</sup> Subsequent to approval of this recommendation, Dr. John Flood, the independent, fellowship trained spine surgeon chosen by the executive committee, prepared a written report on his review of the surgeries and submitted this report to the hospital.<sup>167</sup>

In 2004, the plaintiff filed a lawsuit against Dr. Bailey alleging negligent treatment and performance of surgery, along with a claim that the hospital was negligent in granting Dr. Bailey privileges.<sup>168</sup> The plaintiff learned of the report by Dr. Flood and obtained Dr. Flood's deposition as a

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<sup>163</sup> *State ex rel. Kirksville Missouri Hosp. Co. LLC v. Jaynes*, 328 S.W.3d 418 (Mo. Ct. App. 2010).

<sup>164</sup> *Id.* at 420.

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

result.<sup>169</sup> The hospital filed objections claiming that Dr. Flood's deposition was barred by the peer review privilege in Missouri's Peer Review Committee statute.<sup>170</sup> In response to the objections, the plaintiff filed a motion for enforcement of discovery, which was granted in part by the trial court.<sup>171</sup> Prior to the second deposition, the plaintiff filed a motion for enforcement of discovery or in the alternative, an *in-camera* review, pertaining to documents that were alleged to be part of the report Dr. Flood had prepared for the hospital and had been identified on a privileged log prepared by the defendant hospital.<sup>172</sup> A Special Discovery Master examined the documents and decided that the applicable peer review statute offered no protection to the documents in question.<sup>173</sup> The court of appeals ordered that the documents be produced in order to be reviewed on appeal.

The court of appeals first reviewed the plain language of the statute which stated that an exception to the privilege was "information otherwise discoverable or admissible from original sources will not be immune from discovery merely because it was presented during proceedings before a peer review committee."<sup>174</sup> The court also reviewed the second exception which included "any person appearing before such a committee, cannot be prevented from testifying about matters within their personal knowledge, though they cannot testify about the proceedings of a committee, including about any testimony they may have provided to a committee."<sup>175</sup>

Upon review of the materials submitted by both parties, the court found that a portion of Dr. Flood's original report, which included his concerns about seven of the twenty patient charts which he had reviewed, was already in the plaintiff's possession and that the motion to enforce only included portions of the report that plaintiff did not already

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<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *Id.* at 420-21.

<sup>173</sup> *Id.*

<sup>174</sup> *Id.* at 422 (citing MO. ANN. STAT. § 537.035.4 (West 2012)).

<sup>175</sup> *Id.*

have in possession.<sup>176</sup> The defendant hospital failed to note this in its petition for writ of prohibition; and the court then determined that the hospital was “not entitled to a permanent writ of prohibition to protect itself from an alleged harm that has already occurred.”<sup>177</sup>

In determining whether the rest of the report was protected by the privilege, the court looked to a previous case stating that “[c]redentials committee findings and deliberations are not exempt from discovery, therefore, unless they specifically concern the health care provided a patient.”<sup>178</sup> The court then held that the report was not a “peer review committee report”, as it did “not fall into the plain and ordinary meaning” of the categories listed in the statute.<sup>179</sup> Instead, the report reflected “the knowledge and/or opinions held by an outside source,” since Dr. Flood was a private, outside physician hired by the executive committee of the hospital to review Dr. Bailey’s files.<sup>180</sup>

The court reasoned that since Dr. Flood’s activities were not sufficient for him to be characterized as a “peer review committee” as required by Missouri Statute § 537.035, then Dr. Flood’s report could not be characterized as a “peer review committee report.”<sup>181</sup> Additionally, the court held that the report was not protected by the peer review privilege because Dr. Bailey had already been granted privileges and the purpose of the report was to address the problem that he was granted privileges despite evidence that he had not completed a fellowship program in spine surgery.<sup>182</sup> Further, the letter to Dr. Flood indicated that the hospital wanted to use the report “to defend itself in later lawsuits.”<sup>183</sup> Due to this evidence, the court held that the hospital could not go back on its original stated purpose of the report and claim it was obtained for credentialing

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<sup>176</sup> *Id.* at 423.

<sup>177</sup> *Id.* at 424.

<sup>178</sup> *Id.*

<sup>179</sup> *Id.* at 425.

<sup>180</sup> *Id.*

<sup>181</sup> *Id.*

<sup>182</sup> *Id.* at 426.

<sup>183</sup> *Id.*

matters subsequent to seeing the contents of the report.<sup>184</sup>

The court further held that Dr. Flood was never in attendance of a peer review committee proceeding; therefore the information in his report could not be protected under the statute.<sup>185</sup> Further, the court held that the minutes from the actual Executive Committee Peer Review Meetings discussing the report were not protected because they did not contain information concerning the health care provided to a patient as required by the statute.<sup>186</sup>

The Missouri court's decision to allow consideration of information that the plaintiff already had access to protects the rights of patients and keeps hospitals accountable for negligently credentialing physicians. The Missouri case protects peer review committee information as it was meant to be protected, by providing immunity for the committee members and allowing open discussion among physicians' peers in determining disciplinary outcomes without worry of future litigation brought by the individual physician.<sup>187</sup> However, it also provides an avenue for plaintiffs in a negligent credentialing claim to obtain information that is essential in establishing a *prima facie* case of negligent credentialing. This case also sets out common law for how to interpret a third party expert opinion that a hospital might use in making credentialing or disciplinary decisions.

In interpreting the Indiana Peer Review Privilege Statute,<sup>188</sup> Indiana courts should adopt the Missouri interpretation of the privilege and permit discovery of any information prepared by an outsider for review by the committee. This would allow for protection of the peer review committee, as intended by the statute, but still afford plaintiffs the opportunity to obtain and use information they may already have or information that is readily available, and which could be used to establish a *prima facie* case. Hospitals would still be protected because

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<sup>184</sup> *Id.*

<sup>185</sup> *Id.* at 427-28.

<sup>186</sup> *Id.*

<sup>187</sup> Alissa Marie Bassler, *Federal Law Should Keep Pace with States and Recognize A Medical Peer Review Privilege*, 39 IDAHO L. REV. 689, 690 (2003).

<sup>188</sup> IND. CODE § 34-30-15-1 (2012).



they could hire an inside expert to perform reports or present the information to the peer review committee. Under this approach, the statute would also protect the expert.

#### *D. Statutory Immunity*

One recent trend, within the last two years, in negligent credentialing is for state legislatures to provide statutory immunity for hospitals against claims of negligent credentialing. In 2011, at least two states, Ohio and Utah, passed legislation that provides hospitals with immunity against negligent credentialing claims. Each state went about the immunity provision in entirely different ways.

##### *1. Utah's Negligent Credentialing Statute*

In 2010, the Utah Supreme Court decided a case, *Archuleta v. St. Mark's Hospital*, which ruled that negligent credentialing was a valid cause of action.<sup>189</sup> In this case, the defendant hospital argued that Utah Code Ann. § 58-13-5(7) barred a cause of action for negligent credentialing.<sup>190</sup> The language of Utah Code Ann. § 58-13-5(7) states:

An individual who is a member of a hospital administration, board, committee, department, medical staff, or professional organization of health care providers is, and any hospital, other health care entity, or professional organization conducting or sponsoring the review, immune from liability arising from participation in a review of a health care provider's professional ethics, medical competence, moral turpitude, or substance abuse.<sup>191</sup>

The Supreme Court of Utah held that the plain language of the statute is clear and that “read as a whole and in

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<sup>189</sup> *Id.*

<sup>190</sup> *Id.* at 1046.

<sup>191</sup> UTAH CODE ANN. § 58-13-5(7) (West 2012).

harmony with related provisions and chapters, it shows that the legislature did not intend to immunize hospitals from negligent credentialing claims brought by patients.”<sup>192</sup> The court further reasoned that “the immunity contemplated under the statute operates between a doctor whose credentials are under review and the suppliers of information and decision makers; it does not contemplate immunity between a patient and a hospital.”<sup>193</sup>

Senate Bill 150 of the 2011 Utah Legislative General Session was then proposed as an attempt to overrule the Utah Supreme Court decision and to provide hospitals with blanket immunity from negligent credentialing claims, no matter the specific circumstances to the case.<sup>194</sup> Utah passed Utah Code Ann. 1953 § 78B-3-425 in 2011, which provides that “[i]t is the policy of this state that the question of negligent credentialing, as applied to health care providers in malpractice suits, is not recognized as a cause of action.”<sup>195</sup>

## 2. *Ohio's Negligent Credentialing Statute*

Ohio passed Ohio Rev. Code Ann. § 2305.251 in 2011.<sup>196</sup> The Ohio statute is much more expansive than the version passed by Utah. Ohio Rev. Code Ann. § 2305.251 expands immunity for the peer review privilege without providing full blanket immunity against negligent credentialing. Section (B)(1) of the statute provides that a hospital is to be presumed to not be negligent in the credentialing of an individual who has, or has applied for, staff membership or professional privileges at the hospital, if the hospital proves by a preponderance of the evidence that, at the time of the alleged negligent credentialing of the individual, the hospital, health insuring corporation, or sickness and accident insurer was accredited by one of the following: the joint commission on accreditation of healthcare

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<sup>192</sup> *Archuleta*, 238 P.3d at 1046.

<sup>193</sup> *Id.* at 1047.

<sup>194</sup> Negligent Credentialing, S.B. 150, Gen. Sess. (UT 2011).

<sup>195</sup> UTAH CODE ANN. § 78B-3-425 (West 2012).

<sup>196</sup> OHIO REV. CODE ANN. § 2305.251 (West 2012).

organizations; the American osteopathic association; the national committee for quality assurance; or the utilization review accreditation commission.<sup>197</sup>

Section (B)(2) of the statute provides that the presumption that the hospital is not negligent in credentialing can only be rebutted by a preponderance of the evidence in any of the four following areas:

(a) The credentialing and review requirements of the accrediting organization did not apply to the hospital . . . or the type of professional care that is the basis of the claim against the hospital.

(b) The hospital . . . failed to comply with all material credentialing and review requirements of the accrediting organization that applied to the individual.

(c) The hospital . . . through its medical staff executive committee or its governing body and sufficiently in advance to take appropriate action, knew that a previously competent individual had developed a pattern of incompetence or otherwise inappropriate behavior, either of which indicated that the individual's staff membership, professional privileges, or participation as a provider should have been limited or terminated prior to the individual's provision of professional care to the plaintiff.

(d) The hospital . . . through its medical staff executive committee or its governing body and sufficiently in advance to take appropriate action, knew that a previously competent individual would provide fraudulent medical treatment but failed to limit or terminate the individual's staff membership, professional privileges, or participation as a provider prior to the individual's provision of professional

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<sup>197</sup> *Id.*

care to the plaintiff.<sup>198</sup>

The Ohio statute is effective in putting hospitals on notice because it gives hospitals clear guidance as to what actions they can take to protect themselves from negligent credentialing claims, but also preserves the right of an individual plaintiff to recover damages when there has been a clear negligence issue committed on the part of the hospital. Adopting a statute similar to the Utah statute would deprive individuals, who have been harmed, from collecting damages when the hospital has been negligent in its credentialing process. It would also protect the negligent behavior of hospitals and while failing to provide any incentive for hospitals to adopt thorough credentialing process. Instead, the Utah statute leaves the patient responsible for verifying the competency of a medical professional.<sup>199</sup>

Adopting a statute similar to the Ohio statute would be beneficial for Indiana. A clear, detailed statute would give hospitals notice as to what exactly is required of them in the credentialing process. It would also solve the issue presented by the court decision in *Beswick* which left many questions for defendant hospitals in how to protect themselves against negligent credentialing claims. Further, a statute similar to the Ohio statute would preserve the right of harmed individuals to collect damages for injuries that could have been avoided if not for the negligent behavior of the hospital.

#### IV. NEGLIGENT CREDENTIALING AND THE AFFORDABLE HEALTH CARE ACT

On July 1, 2011, the Value-Based Purchasing Act<sup>200</sup> went into effect. The Value Based Purchasing Act is an

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<sup>198</sup> *Id.*

<sup>199</sup> *Utah Senate Bill 150 Threatens Negligent Credentialing as a Valid Cause of Action*; CREDENTIALING & PEER REV. LEGAL INSIDER, April 2011, at 4, available at [http://user.xmission.com/~kirton/images/News\\_articles/credentialing\\_wride](http://user.xmission.com/~kirton/images/News_articles/credentialing_wride).

<sup>200</sup> 42 C.F.R. § 480 (2012).

attempt of health care reform to move health care toward a Pay-For-Performance model.<sup>201</sup> Through this Act, the Department of Health and Human Services (HHS), collects quality data from hospitals, compiles the data, and then rewards hospitals for meeting certain performance measures in quality and efficiency.<sup>202</sup> This Act calls for some disclosure of performance information.<sup>203</sup> One purpose of disclosing this information is that “reducing errors through improved medical practices and effectuating penalties against poorly performing physicians may benefit the overall performance of the medical malpractice insurance system.”<sup>204</sup> Currently, states have primary authority to administer medical licensing and to standardize medical practice. Unfortunately, this leaves the issue that each state has its own method of tracking physicians and there is a lack of uniformity among the states.<sup>205</sup> The Patient Protection and Affordable Care Act (PPACA) helps to unify the reporting and regulating requirements among the states and allows for better tracking and recording of adverse events and physicians.<sup>206</sup>

There are several ways that this requirement could impact negligent credentialing in Indiana claims. First, under the Value-Based Purchasing Act, the hospitals are required to disclose each physician’s performance with public or private review organizations.<sup>207</sup> This data is then compared to other providers’ performance levels.<sup>208</sup> This

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<sup>201</sup> Charles Fiegl, *Medicare Pay-for-Performance Plan Criticized Over Early Launch*, AMERICAN MEDICAL NEWS, September 19, 2011, <http://www.ama-assn.org/amednews/2011/09/19/gvl10919.htm>.

<sup>202</sup> *Hospital Value-Based Purchasing Program*, ICN 907664, Nov. 2011, available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital\\_VBPurchasing\\_Fact\\_Sheet\\_ICN907664.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf).

<sup>203</sup> *Id.*

<sup>204</sup> Bernadette Fernandez, Baird Webel, Vivian S. Chu, *Medical Malpractice Insurance and Health Reform*, CONGRESSIONAL RESEARCH SERVICE, April 15, 2010, at 4.

<sup>205</sup> *Id.*

<sup>206</sup> See Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727 (2011).

<sup>207</sup> 42 C.F.R. § 480.

<sup>208</sup> *Id.*

public information could be used as direct evidence against a hospital showing that it had knowledge that it should not have credentialed or re-credentialed a particular physician.<sup>209</sup> As mentioned above, peer review privilege protects the hospital from having to disclose what exact information was used in the credentialing process. However, this rule would make performance information available to the public making it easier for a plaintiff to obtain this information during discovery and to build a claim on what the hospital *should* have known.

Second, the rule requires external reporting of an adverse event.<sup>210</sup> It has been proposed that “external reporting of an adverse event that is separately the focus of a malpractice or other claim could result in the waiver of evidentiary privilege against discovery of this information.”<sup>211</sup> This could significantly affect hospitals in negligent credentialing claims since Indiana requires that there be an underlying medical malpractice claim to substantiate a negligent credentialing claim. The waiver of evidentiary privilege could give the plaintiff in these claims an added advantage. Unfortunately, the Act is so new that it is yet to be seen how the courts will interpret the mandatory reporting requirements in lieu of evidentiary and peer review privilege. It also remains to be seen as to what extent the mandatory reporting information will be made available for use in litigation and adjudication of medical malpractice claims.

## V. CONCLUSION

Since 1965, negligent credentialing as a valid cause of action in medical malpractice claims has been slow to be adopted throughout state courts. Although Indiana adopted negligent credentialing as a valid cause of action in 2000, it

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<sup>209</sup> Stacy L. Cook, *Will Pay for Performance Be Worth the Price to Medical Providers? A Look at Pay for Performance and Its Legal Implications for Providers*, 16 ANNALS HEALTH L. 163, 180 (2007).

<sup>210</sup> 42 C.F.R. § 480.

<sup>211</sup> Anne B. Claiborne, Julia R. Hesse & Daniel T. Roble, *Legal Impediments to Implementing Value-Based Purchasing in Healthcare*, 35 AM. J.L. & MED. 442, 468 (2009).

has been slow to rule on decisions and the Indiana Supreme Court has yet to hear a case involving this issue on appeal. The lack of rulings and case law on this topic leaves both defendant hospitals and plaintiffs unsure of how to proceed in these claims and what exactly is required to bring this type of claim. Indeed, the more recent cases have tended to leave more questions than answers regarding elements and evidence in these claims.

As more cases are decided on the topic, the Indiana courts should be aware of where other jurisdictions stand on this cause of action since they have historically looked to neighboring jurisdictions for reference in newer areas of law. The issues of bifurcating claims between physicians and hospitals should be addressed to protect the integrity of claims and efficiency of the court process. Also, the concern of how the peer review committee protections affect discovery in these claims will need to be clearly laid out in future decisions. The courts and counsel need to be cognizant of recent legislation on negligent credentialing in other states and how it could be implemented in the State of Indiana either to override or to protect court decisions. Lastly, the recent enactment of the Patient Protection and Affordable Care Act could have far reaching implications for negligent credentialing actions and the discovery process in these claims. As the Act is put into practice, it remains to be seen how the courts will interpret the reporting requirements and their use in medical malpractice adjudication. However the courts and legislature decide to rule out these concerns, the primary issue of balancing patient safety and recourse with hospital and physician responsibility needs to be at the forefront of the decision-making process.





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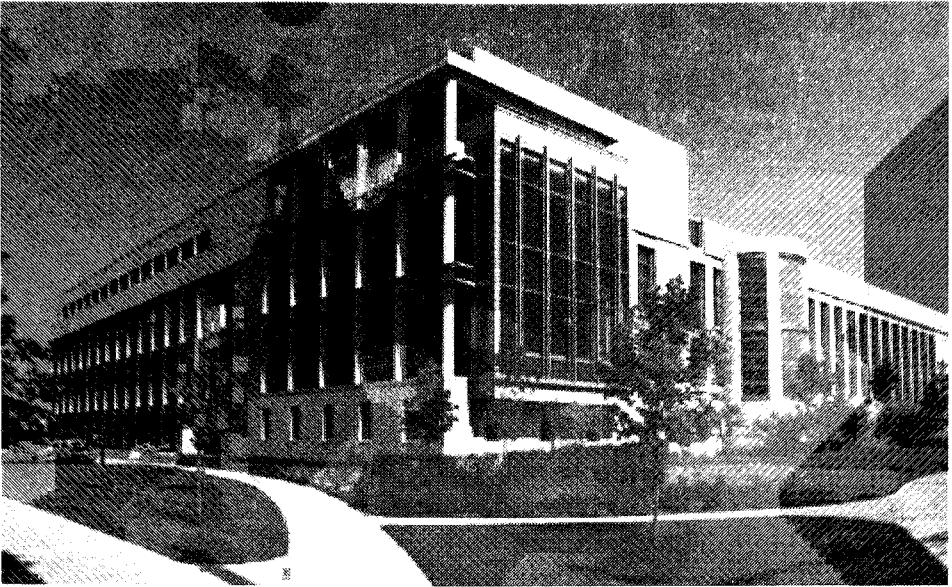
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