

# **Understanding Negligence in Credentialing**

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## **BIOGRAPHICAL SKETCH, KATHY MATZKA, CPMSM, CPCS**

Kathy Matzka, CPMSM, CPCS is a speaker, consultant, and writer with 25 years of experience in credentialing, privileging, and medical staff services. She holds certification by the National Association Medical Staff Services (NAMSS) in both Medical Staff Management and Provider Credentialing. Ms. Matzka worked for 13 years as a hospital medical staff coordinator before venturing out on her own as a consultant, writer, and speaker.

Ms. Matzka has authored a number of books related to medical staff services including Chapter Leader's Guide to Medical Staff: Practical Insight on Joint Commission Standards, Compliance Guide to Joint Commission Medical Staff Standards, and The Medical Staff Meeting Companion Tools and Techniques for Effective Presentations. For the past eight years, she has been the contributing editor for The Credentials Verification Desk Reference and its companion website The Credentialing and Privileging Desktop Reference.

She has performed extensive work with NAMSS' Library Team developing and editing educational materials related to the field including CPCS and CPMSM Certification Exam Preparatory Courses, CPMSM and CPCS Professional Development Workshops, and NAMSS Core Curriculum. These programs are essential educational tools for both new and seasoned medical services professionals. She also serves as instructor for NAMSS.

Ms. Matzka shares her expertise by serving on the editorial advisory boards for two publications - Briefings on Credentialing, and Credentialing & Peer Review Legal Insider.

Ms. Matzka is a highly-regarded industry speaker, and in this role has developed and presented numerous programs for professional associations, hospitals, and hospital associations on a wide range of topics including provider credentialing and privileging, medical staff meeting management, peer review, negligent credentialing, provider competency, and accreditation standards.

In her spare time, Ms. Matzka takes pleasure in spending time with her family, listening to music, traveling, hiking, fishing, and other outdoor activities.



## Table of Contents

Why Credentialing and Privileging are Important .....	2
What is Negligence? .....	2
Theories of Liability .....	3
Elements of Negligence .....	3
Duty to Exercise Due Care .....	4
Examples of Breach of Duty .....	4
Setting a Precedent.....	5
Darling v. Charleston Community Memorial Hospital.....	5
Johnson v. Misericordia .....	6
Recent cases .....	7
Frigo v. Silver Cross Hospital .....	7
Larson v. Wasemiller .....	7
Other Related Issues.....	8
Kadlec v. Lakeview Anesthesia Assoc. and Lakeview Medical Center.....	9
Decreasing the Chance.....	10

## **WHY CREDENTIALING AND PRIVILEGING ARE IMPORTANT**

There are a number of reasons for credentialing and privileging practitioners.

- Patient Protection is the number one reason. If you look at the mission or vision statement of most healthcare organizations, you will find language that refers to providing high quality patient care. This can only be accomplished by allowing only those providers who meet certain qualifications to provide this care. The
- Risk management and liability considerations are also important. If a patient suffers an adverse outcome, the facility can be held liable. If a practitioner has quality of care issues that would have been revealed by credentialing but credentialing was not performed, the facility may be found liable for patient harm caused by the clinician. This is known as “negligent credentialing”.
- Another reason healthcare organizations credential is that it is required by accrediting bodies, state hospital licensing regulations, and the Centers for Medicare and Medicaid Services (CMS). If these requirements are not met, the organization may risk losing accreditation status, licensure, and Medicare Certification.

## **WHAT IS NEGLIGENCE?**

Negligence is defined as conduct that is culpable because it falls short of what a reasonable person would do to protect another individual from a foreseeable risk of harm.

If the organization knew or should have known that a practitioner is not qualified and the practitioner injures a patient through an act of negligence, the organization can be found separately liable for the negligent credentialing of this practitioner.

Healthcare organizations have legal responsibility under a number of theories. Some have been held liable for “negligent credentialing” or, the failure to adequately screen a practitioner through the credentialing and privileging processes. There are at least 28 states which recognize the claim of negligent credentialing.

But there are some other theories under which Health Care organizations are held liable.

## THEORIES OF LIABILITY

In some states, negligent credentialing falls under the corporate liability or corporate negligence doctrine. The premise of this theory is that a patient who enters a hospital does so with the reasonable expectation that the hospital will attempt to cure him. The hospital has the duty to make a reasonable effort to monitor and oversee the care and treatment prescribed and administered by the physicians practicing in its property. A hospital's responsibility also includes extending privileges only to competent practitioners.

The governing body is given authority to make final decisions in credentialing matters. Although the board may delegate an activity, such as oversight of those with independent privileges to the medical staff, it maintains the ultimate responsibility for these decisions.

Respondeat Superior is a common-law doctrine that makes an employer liable for the actions of an employee when those actions take place within the scope of employment. This doctrine is often applied to contracted or employed practitioners.

Apparent or Ostensible Agency is a legal doctrine that is used to hold someone liable for the acts of a third party because the third party *looks like* the agent of that person. This theory is frequently applied to facility-based providers such as anesthesiologists and emergency physicians. The basis of this theory is, the patient has no choice in choosing these practitioners therefore, they are felt to be an agent of the hospital.

## ELEMENTS OF NEGLIGENCE

The fact that someone did not credential someone adequately, in itself, does not mean that the organization was negligent. For example, if an organization fails to verify a medical license for a qualified and competent practitioner within the prescribed requirements of the accreditation standards, this in itself is not negligence.

Specific elements need to be present in order to establish negligence. There has to be a duty to exercise due care, and that duty has to be breached. There has to be an injury, and the breach of duty has to be the reason or "proximate cause" of the injury. Finally, the person bringing the charges must establish that the injury resulted in compensable damages.

An easy way to remember elements of negligence are by remembering the "4 D's":

Deviation from Duty Directly causes Damages

## Understanding Negligence in Credentialing

Using the earlier example, suppose a Physician injured a patient, and it was found that this injury was a result of negligence on the Physicians behalf. If it was found that the organization failed to verify the license on initial appointment, and if it had done so, it would have found that the license was suspended, then it can be reasonably assumed that, had the organization credentialed the Physician appropriately, it would not have granted the Physician privileges. In this case it's pretty easy to connect the dots and see that the breach of the hospital's duty to appropriately credential the Physician could have resulted in the injury to the patient.

## **DUTY TO EXERCISE DUE CARE**

Within the healthcare organization, the duty to exercise due care is defined in a number of ways.

- State licensing regulations may include requirements for adopting criteria and for granting medical staff appointment and privileges.
- Accreditation standards specify what kind of primary-source verification must be completed and specify requirements for credentialing and privileging policies and procedures
- Medical staff and facility bylaws, R&R, policies may include additional requirements above and beyond regulations and accreditation standards.
- Finally, case law may address due care in credentialing and privileging.

### ***Examples of Breach of Duty***

In many cases in which organizations are found to be negligent in credentialing, the facility has the appropriate bylaws, policies and procedures, but fails to consistently apply the requirements. This emphasizes the importance of knowing the requirements of your facility's bylaws, rules and regulations and policies.

Another potential for breach of duty is the failure to address concerns identified in the credentialing/recredentialing process. Documentation in the credentials file should address all issues or concerns identified in the credentialing or recredentialing process. For example, if a verification letter comes back with a response that is different than the information provided on the application, such as different affiliation dates, there should be documentation in the credentials file of how you resolved this issue. In addition, medical staff and governing body minutes should document how these bodies addressed concerns. For example, suppose you are recredentialing an applicant a find that he was named in three medical malpractice suits since his last application. When your medical staff reviews this, they determine that none of these cases have settled or been tried, so they feel that there is no reason to not grant medical staff appointment and privileges based on outstanding cases. There should

## Understanding Negligence in Credentialing

be some documentation that this issue was discussed and addressed by the medical staff.

Finally, adopting credentialing policies and procedures or privileging criteria that do not reflect what a reasonable hospital would do to protect a patient from a foreseeable risk of harm may also be considered a breach of duty. For example, most hospitals verify all past medical staff appointments for all initial applicants. This is not required by Joint Commission accreditation standards. The fact that it is something that most hospitals do, means that it is the standard of care that all hospitals will be held to. It's essential that your policies meet the requirements of your organization's accreditation standards as well as state and federal regulations. If there is a difference between accreditation standards and a state and Federal requirements, you always have to follow the strictest requirement. When developing privileging criteria, the organization should take into consideration any guidelines that have been published by professional organizations.

## SETTING A PRECEDENT

A precedent-setting case is one which establishes a new legal principle. This principle is based on the court coming to a certain conclusion based on a certain set of facts. This finding is thereafter authoritative, meaning it is to be followed from that point on when similar or identical facts are before a court.

Let's take a look at some precedent-setting cases as well as some recent negligent credentialing cases. These will give you a better idea of how the courts apply the duty to exercise due care in the credentialing process.

### ***Darling v. Charleston Community Memorial Hospital***

This 1965 case is the very first case in which a hospital was found to be negligent in allowing a doctor to practice at the hospital. Prior to this case, hospitals were looked upon as charitable organizations and were immune from being sued under the Charitable Immunity Doctrine. This case set aside this doctrine.

Darling was a football player who broke his leg during a game. He had his leg placed in a cast by the on-call doctor, subsequently developed gangrene, and had to have his leg amputated below the knee. The plaintiff claimed—and the court agreed—that the hospital was negligent for two reasons: it failed to properly review the work of an independent doctor, and its nurses failed to administer necessary tests. Darling held that the hospital bylaws, licensing regulations, and standards for hospital accreditation were sufficient evidence to establish the standard of care. Therefore, a lay jury was able to conclude from the evidence that the hospital had breached its duty to act as a reasonably careful hospital.

### ***Johnson v. Misericordia***

In another negligent credentialing case – Johnson v. Misericordia Community Hospital, the hospital was found to be liable to a patient injured by physician who had failed to disclose pending malpractice cases and who lied about his privileges at other hospitals.

This action arose out of a surgical procedure performed at Misericordia by a Dr. Salinsky. Salinsky unsuccessfully attempted to remove a pin fragment from Johnson's right hip, and during surgery, damaged the common femoral nerve and artery. This caused permanent paralysis of Johnson's right thigh muscles, atrophy, weakness, and loss of function.

Johnson settled his claim against Salinsky for medical malpractice, and then sued the hospital alleging negligence in hospital's appointment of Salinsky to its medical staff and in granting him orthopedic surgical privileges.

When completing his application, Salinsky stated that his privileges at other hospitals had never "been suspended, diminished, revoked, or not renewed." He also failed to answer any of the questions pertaining to his malpractice insurance and stated that he had requested privileges only for those surgical procedures in which he was qualified by certification.

The hospital did not verify the information on the application. Had they done so, they would have found that Salinsky had experienced denial and restriction of his privileges, as well as never having been granted privileges at the hospitals he listed in his application.

This information was readily available to Misericordia and if the hospital had credentialed Salinsky appropriately, it would have been revealed that these hospitals had a concern regarding his competency. In addition, if the hospital would have verified medical malpractice information, they would have found that seven malpractice suits had been filed against Salinsky prior to his appointment date.

The court in this case instructed the jury that "a hospital is under a duty to exercise reasonable care to permit only competent medical doctors the privilege of using their facilities". The court also stated that reasonable care "meant that degree of care, skill, and judgment usually exercised under like or similar circumstances by the average hospital". Evidence in this case supported a finding that, had the hospital exercised ordinary care, it would not have appointed Salinsky to its medical staff.



## RECENT CASES

Now that we've discussed some precedent-setting cases let's look at some recent cases.

### ***Frigo v. Silver Cross Hospital***

This is an Illinois case from 2007. In this case, the patient alleged that podiatrist Dr. Kirchner's negligence in performing a bunionectomy on an ulcerated foot resulted in osteomyelitis and subsequent amputation of the foot.

When Dr. Kirchner applied for membership and Level II surgical privileges at the Hospital in 1992, a podiatrist was required to have either completion of an approved surgical residency training program or board eligibility or certification by the American Board of Podiatric Surgery. Dr. Kirchner did not meet these criteria.

To complicate matters, in 1993, the hospital's credentialing criteria was changed to require successful completion of a 12-month podiatric surgical residency training program, passage of at least the written portion of the board certification exam, and documentation of having performed a specific number of procedures. For Level II surgical privileges, which included bunionectomies, a podiatrist needed to document performing at least 30 procedures.

For every reappointment thereafter and at the time Dr. Kirchner performed the bunionectomy on Jean Frigo, he had not satisfied these requirements. He had only performed six Level II procedures, none of them at Silver Cross.

Based on these facts, Frigo argued that Dr. Kirchner never should have been given Level II privileges in the first place and certainly not in 1998, when he performed her surgery. Additionally, she maintained that the granting of privileges to an unqualified practitioner who was never appropriately grandfathered was a violation of the Hospital's duty to ensure that only those podiatrists who met the required criteria were granted Level II privileges.

Frigo claimed that the Hospital's breach of this duty caused her amputation because of Dr. Kirchner's negligence. The jury agreed and awarded her almost eight million dollars.

### ***Larson v. Wasemiller***

In August 2007, the Minnesota Supreme Court recognized, for the first time, that a cause of action exists against a hospital for the manner in which a hospital credentials a physician to

## Understanding Negligence in Credentialing

see patients within that facility. The Larson case stemmed from a medical malpractice claim initially asserted against two physicians who performed a gastric bypass surgery on the plaintiff, Mary Larson. Larson experienced a number of complications and remained hospitalized for approximately three months.

After initially suing only the physicians, the Larsons amended their Complaint to include a claim that St. Francis was negligent in credentialing Dr. James Wasemiller to perform surgery or see patients at the hospital. They base this upon the fact that Dr. James Wasemiller had been the subject of ten prior malpractice claims or lawsuits and had struggled to find malpractice insurance. He also had been disciplined by the Minnesota Board of Medical Practice and had failed his board certification examination three times before passing. Interestingly, they also claimed that the Physician should not have been credentialed for reasons apart from his professional experience – namely, that he was behind in his child support and income taxes. After a series of findings and appeals, the case eventually made it to the Minnesota supreme court. The supreme court compared the tort of negligent credentialing to one of negligent hiring and it concluded that negligent credentialing is “more directly related” to the negligent selection of an independent contractor. The supreme court concluded in favor of recognizing a negligent credentialing claim because “negligence could be shown on the basis of what was actually known or what should have been known at the time of the credentialing decision”.

## **OTHER RELATED ISSUES**

There are couple other things that need to be considered when credentialing providers and those are being sure not to give wrong information when answering verification requests and omitting key information when answering verification requests.

One way this can be avoided it is by maintaining all information in the credentials file. If there is important information that is not included in the credentials file, there should be some kind of cross reference in the credentials file so that the people who respond to verification requests will know where to find information. For example, I know of a case in which a Medical Services professional provided information to another hospital that said that a Physician had resigned in lieu of termination. Unknown to the Medical Services professional, the hospital had worked out a written agreement with the Physician which stated that the hospital would reply to any verification letters with a statement that the Physician had resigned in good standing. Unfortunately this information was not included in the credentials file. When the Medical Services professional researched medical staff minutes to find out what happened with the Physician, she only found reference to a recommendation for termination.

The case of Kadlec Medical Center v. Lakeview Anesthesia Associates also is an example of what can happen when wrong information is provided or pertinent information is omitted.

## ***Kadlec v. Lakeview Anesthesia Assoc. and Lakeview Medical Center***

According to court documents, Dr. Lee Berry was fired by Lakeview Anesthesia Associates for reporting to work in an “impaired” condition in March of 2001. Here is a copy of the termination letter which was signed four physicians, including Drs. Mark Dennis and William Preau, III.

The termination letter stated that Berry was being terminated “with cause” due to having “reported to work in an impaired physical, mental, and emotional state” that prevented Berry from properly performing his duties and put patients “at significant risk”.

After Berry was terminated by Lakeview Anesthesia Associates, he sought work as a locum tenens physician which eventually landed him at Kadlec Medical Center in Richland, WA.

Kadlec had credentialed Dr. Berry, but the letters they received failed to disclose his impairments. The letter from Dr. Dennis stated, “I have worked closely with Dr. Berry for the past four years. He is an excellent clinician with a pleasant personality. I am sure he will be an asset to your anesthesia service.” The letter from Dr. William Preau stated, “This is a letter of recommendation for Dr. Lee Berry. I have worked with him here at Lakeview Regional Medical Center for four years. He is an excellent anesthesiologist. He is capable and all fields of the anesthesia including obstetrics, pediatrics, cardiovascular, and all regional blocks. I recommend him highly.”

The Kadlec hospital had also written to Lakeview medical center to confirm Dr. Berry’s appointment there. They received a letter back that just gave the dates on staff. It was one of those letters that said “due to the volume of requests that we receive, we are responding with this form letter.”

Dr. Berry was granted privileges at Kadlec Medical Center where, after a routine tubal ligation procedure, he removed a patient’s breathing tube too early and she suffered a heart attack and massive brain damage. This resulted in a multimillion-dollar lawsuit against the hospital. During the course of discovery, these letters that you’ve seen here were provided to the plaintiff on order of the court. Kadlec first learned that Dr. Berry had been terminated by his anesthesia group during discovery for this case.

Kadlec sued Lakeview Anesthesia Associates and Lakeview Medical Center for failing to disclose Berry’s known impairments. The hospital won its cases against both, but the appeals court reversed the decision against Lakeview Medical Center.

Although the court found that the reference letters from Berry’s former partners were false and patently misleading, it felt that Lakeview Medical Center’s letter was not materially misleading. The court also found that, because Lakeview hospital did not have a legal duty to disclose its investigation of Dr. Berry and its knowledge of his drug problems, the judgment against Lakeview Medical must be reversed.

## **DECREASING THE CHANCE**

Making sure that Medical Services professionals and medical staff leaders are adequately trained is very important. It is helpful for Medical Services professionals to be involved in their state and local NAMSS chapters or to attend the NAMSS National conference. Medical staff leaders need to know what they're getting themselves into when they say yes to taking on a job as a department chair, credentials committee member, or medical executive committee member. They need to be trained in their responsibilities in reviewing the qualifications of their peers. This can be something as simple as sitting down with a department chairman and going over how to read a credentials file to something more complicated, and costly, such as, bringing someone into the hospital to train medical staff leaders or sending them to educational programs where they can receive intensive training about their roles and responsibilities.

Be sure to get the Medical Staff involved in all phases of credentialing and privileging. It is essential that your medical staff leaders review all information in the credentials file and, that they have sufficient information on which to base a reasoned decision regarding the competency of the practitioner.

Follow all policies, procedures, and bylaws. Many times, bylaws and procedures mirror language contained in accreditation standards. Over time the accreditation standards change, and so we change our practices to reflect the new accreditation standards. Sometimes, we neglect to make appropriate changes to our bylaws and policies to reflect the changes resulting in a failure to follow our own policies.

It is a good idea to audit bylaws, rules and regulations and policies to make sure they comply with state regulations and accreditation standards. If you find that, in practice, you are doing something that is not in compliance with bylaws, determine the basis for this bylaws requirement. If it is not required by a corporate policy, accreditation standards, or state or Federal regulations, confer with your legal counsel as to whether to change the bylaws to reflect your current practice. A good example of this is many hospitals have a requirement for all physicians to be board certified or actively participating in the board certification process. This is not required by state or Federal regulations, or accreditation standards. But if the hospital has such a bylaws requirement, it must follow and apply this requirement. If it finds it is making exceptions to this rule then it should consider changing the requirement.

## Understanding Negligence in Credentialing

When it comes to assuring that only qualified, competent practitioners are providing patient care services, the first line of defense is a thorough credentialing and privileging process that is consistently applied. If the process is circumvented, the very safeguards which are put in place to assure patient safety can be comprised.