

CANDOR AFTER KADLEC: WHY, DESPITE THE FIFTH CIRCUIT'S DECISION, HOSPITALS SHOULD ANTICIPATE AN EXPANDED OBLIGATION TO DISCLOSE RISKY PHYSICIAN BEHAVIOR

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I. INTRODUCTION: THE CASE FOR AN EXPANDED HOSPITAL DISCLOSURE DUTY

Kimberly Jones, a healthy thirty-one-year-old mother of three, suffered massive, incapacitating brain damage while undergoing a short, uncomplicated surgery at Kadlec Medical Center.¹ The anesthesiologist for the surgery, Robert Lee Berry, M.D., later admitted having been impaired by diverted Demerol during the surgery. This tragic incident was foreshadowed by events at a hospital at which Dr. Berry practiced previously. He had been strongly suspected of on-duty narcotics use while working at Lakeview Regional Medical Center in Louisiana, and his anesthesia practice group there had terminated him for “put[ting] our patients at significant risk” by “report[ing] to work in an impaired physical, mental, and emotional state.”²

In granting Dr. Berry hospital privileges, one of the items Kadlec had relied upon was a short letter from Lakeview Medical; that letter stated simply that the doctor had been a

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1. See generally *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

2. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 415 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008); Plaintiff's Exhibit 18, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (E.D. La. May 19, 2005) (Mar. 27, 2001 letter captioned “Termination of Employment” to Dr. Berry from Lakeview Anesthesia Associates (A Professional Medical Corporation) by Mark Dennis, M.D., William Preau, III, M.D., Allan Parr, M.D., and David Baldone, M.D.).

member of its active medical staff with anesthesia privileges for the past four years.³ It did not disclose the concerns about his on-duty drug use. It did not disclose his termination from the practice group. It did not disclose that the termination effectively precluded him from exercising his hospital privileges. The letter justifies its failure to reply to Kadlec's detailed inquiry in full by referring to "the large volume of inquiries received in this office."⁴ Credentialing responses sent the same day to other hospitals regarding thirteen different physicians, however, were more extensive and some did include the completion of forms similar to the one Kadlec had included in its request for information.⁵ In addition to Lakeview Medical's response, Kadlec also received laudatory letters from two physicians with Dr. Berry's prior practice group in Louisiana, and a clean report from the National Practitioner Data Bank.

Lakeview Medical's credentialing letter might have been unethical, the Fifth Circuit ruled in May 2008, but it was not illegal. Reversing the district court on this point, the Fifth Circuit held that, under Louisiana law, the hospital had no affirmative duty to disclose the negative information to Kadlec.⁶ The hospital did have a duty not to mislead Kadlec in its response. Noting that the question was a difficult one,⁷ the court concluded that Lakeview Medical's letter was not misleading; thus Lakeview Medical was not liable to Kadlec, and the jury's verdict to the contrary was reversed.⁸ By contrast, the laudatory reference letters sent by two members of the anesthesia practice group were affirmatively misleading, and thus the practice group was liable to Kadlec.

This Article argues that, the Fifth Circuit's decision notwithstanding, hospitals should anticipate being held to a duty of greater candor in responding to physician credentialing inquiries than would be found in the usual business context. Recognition of this obligation follows from converging trends

3. *Kadlec Appeal*, 527 F.3d at 416; Plaintiff's Exhibit 23, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (Oct. 26, 2001 letter to Kadlec from Lakeview Medical signed by Associate Administrator Todd Steward).

4. *Kadlec Appeal*, 527 F.3d at 416.

5. *Id.*

6. *Id.* at 418, 427.

7. *Id.* at 420.

8. *Id.* at 420, 427.

in health law theory, institutional liability, and hospital practice. Furthermore, although *Kadlec* was the first case of its type, given the increased stake hospitals have in sound credentialing decisions, it is unlikely to be the last. A limited response such as Lakeview Medical's might well be the basis for liability in a case not grounded in Louisiana law, particularly if the injured patient were also a party, if the hospital could be shown to have violated a mandatory reporting duty, and if the court focused on ways in which the credentialing of physicians differs from standard employment arrangements.

The *Kadlec* district court held that the unique nature and key function of the credentialing process create a "special relationship" between hospitals.⁹ This special relationship gives rise to "a duty to disclose information related to a doctor's adverse employment history that risks death or bodily injury to future patients."¹⁰ Given the importance of informed credentialing to patient safety, the district court stressed that "policy considerations weigh heavily in favor of imposing [such] a duty."¹¹ The Fifth Circuit acknowledged these strong policy considerations,¹² but noted as well the practical challenges of determining which negative information would have to be disclosed and the risks of defamation lawsuits. Ultimately, the Fifth Circuit rooted its decision in standard employment law analyses.

This Article first reviews the facts underlying the *Kadlec* case and how they fit into the existing legal web that informs physician review. After discussing the Fifth Circuit decision and the district court's unpublished decision, this Article then considers credentialing obligations in light of an empirical, patient-centered framework. This framework views the central purpose of health law as the improvement of patients' lives, and assumes that automatic application of doctrines from other areas of law is not necessarily appropriate given certain essential features of medicine and treatment relationships. "Sometimes, it matters fundamentally, even profoundly, that a legal matter involves physicians caring for patients, rather

9. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *7 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

10. *Id.*

11. *Id.*

12. *Kadlec Appeal*, 527 F.3d at 422.

than providers servicing generic consumers.”¹³

Just as physicians are not simply service providers, and patients not simply courted consumers, hospitals are not simply doctors' workshops. As this Article will explain, hospitals are increasingly being held liable for the negligent actions of non-employee physicians. They are increasingly viewed as having a duty to their patients to appropriately monitor the quality of care provided by staff physicians, employed or not, and to credential only those who practice safely and competently. In addition, hospitals face increased obligations to monitor the quality of care provided within their facilities and to report impaired or unsafe physicians. When hospitals can be held responsible under the theories of vicarious liability or negligent credentialing, they have a heightened need for complete credentialing information.

Furthermore, as this Article then notes, because of changing institutional practices and accreditation standards, hospitals are likely to possess more information about the safety and competence of their staff physicians than they have in the past. In recent years, hospitals have been the focus of a multifaceted effort to reduce medical errors and improve quality. Supporting this movement, the Joint Commission's revised standards aim to make the physician review process more evidence-based and less episodic. With more information and greater responsibility will come increased challenges. It will be a challenge to determine how the law can ensure fair, good-faith physician review while requiring complete credentialing responses. The final section of this Article considers how an expanded hospital disclosure duty might be implemented.

I conclude that despite the Fifth Circuit's decision that Lakeview Medical is not liable to Kadlec, a requirement of greater candor is likely to be adopted either in a subsequent case, by statute, or through hospital accreditation standards. In deciding what a hospital's obligations ought to be, it matters fundamentally, even profoundly, that the primary purpose of the credentialing process should be the provision of safe and high-quality patient care.

13. Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 361 (2006).

II. THE KADLEC SITUATION HIGHLIGHTS THE ISSUE¹⁴A. *The Injury to Kimberly Jones*

On November 12, 2002, Ms. Jones gave birth to her third child, a full-term girl. The birth was uncomplicated, and the baby healthy.¹⁵ Ms. Jones delivered at Kadlec Medical Center, a mid-size, private, non-profit hospital located in south-central Washington State.¹⁶ That afternoon, as planned, Ms. Jones had a tubal ligation under full anesthesia. Dr. Robert Lee Berry was the assigned anesthesiologist; it was his fifth case of the day.¹⁷ The surgery itself was straightforward, taking about ten minutes, with no complications noted. Following the surgery, anesthesiologist Dr. Berry removed the breathing tube. Shortly thereafter her breathing stopped, and her heart stopped beating. Dr. Berry and the surgical nurse initiated resuscitation procedures, and they ultimately did get her heart beating again.¹⁸

14. *Kadlec* is also a superb teaching case for a number of reasons. The basic situation and how it arose are easy to grasp. All the parties have “bad facts” and “bad documents,” and the corresponding need to address them in their jury trial strategy. There are rich legal issues regarding duty, causation, and damages, as well as significant policy and practical questions. Furthermore, there is the jurisdictional point that this case is in federal court on diversity jurisdiction and was resolved based on the law of Louisiana, with its Napoleonic Code roots. Although the roots of Louisiana law do not have much consequence here, it is always nice to have a reason to dredge up high school history and discuss civil law systems. It might even be possible to incorporate a recent television show. A 2008 episode of *Eli Stone* featured one hospital suing another for providing a credentialing letter that covered up the troubled history of an anesthesiologist whose negligence allegedly resulted in a patient’s death. *Eli Stone: Heal the Pain* (ABC television broadcast Mar. 13, 2008). The jury found in favor of the patient’s orphaned son and the hospital that received the misleading letter. See Posting of Jason Hughes, to <http://www.tvsquad.com/2008/03/14/eli-stone-heal-the-pain> (Mar. 14, 2008, 12:00 PST) (blog about the show).

15. Agreed Order at 3, Robert Lee Berry, No. 04-03-A-1016MD (Wash. Med. Quality Assurance Comm’n Aug. 18, 2004). This order describes what Dr. Berry did wrong during the Jones surgery as well as in surgeries earlier that day. Dr. Berry stipulated to the facts and waived his right to a hearing before the Commission.

16. Originally called Richland Hospital, it was established as a government facility during World War II to support the workers at the nearby Hanford Nuclear Reservation. As work on the Manhattan Project escalated, the population of Richland Village grew from nearly 1,000 to more than 15,000 in less than two years. In 1944, the hospital was renamed in honor of Lt. Col. Harry R. Kadlec, a key figure at Hanford, and the first patient to die at the new hospital. Kadlec, Our History 1943-1960, http://www.kadlecmed.org/about/our_history.html (last visited May 1, 2008).

17. Agreed Order, *supra* note 15.

18. Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (*Kadlec Appeal*), 527 F.3d 412, 417 (5th

Ms. Jones had suffered, however, massive, incapacitating brain damage, and remained unconscious and unable to breathe on her own. Kadlec transferred her to Harborview Medical Center, a Level I trauma center and county hospital in Seattle. After six weeks with no improvement, she was moved to a long-term care facility in Michigan, near her parents' home. She remains there today in a vegetative state. It is highly unlikely that she will ever regain any cognitive or physical abilities.¹⁹

Although anesthesia complications are always a possibility, there have been impressive advances in the field over the decades, and poor outcomes are increasingly rare.²⁰ What happened to Ms. Jones was highly unusual, a "sentinel event" in Joint Commission parlance. On November 14, 2002, two days after the surgery, Kadlec's pharmacy director analyzed the prior month's data from the Pandora anomalous usage report. Pandora is a proprietary computer software program that interfaces with the Pyxis medication storage and inventory system. The Pyxis system tracks who withdraws what medication for which patient; the Pandora program analyzes usage patterns and highlights anomalies.²¹

The Pandora report suggested that Dr. Berry had been withdrawing significantly more Demerol than would have been expected given the patients he had been caring for. The pharmacy director and operating room supervisor pulled the

Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008); *see also* Agreed Order, *supra* note 15, at 5 (concluding that during the Jones surgery Dr. Berry "failed to capably administer anesthesia [to the patient] and to capably monitor [her] vital signs during surgery. Nor did [he] capably respond to her anesthesia event that resulted in severe brain damage.").

19. *Kadlec Appeal*, 527 F.3d at 417; *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *2 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

20. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 144-45 (Linda T. Kohn et al. eds., 2000); W.L. Lanier, *A Three-Decade Perspective on Anesthesia Safety*, 72 AM. SURGEON 985, 985 (2006).

21. Additional information about the systems is available on the companies' websites: Pandora Data Sys., Inc., <http://www.pandoradatasystems.com> (last visited May 1, 2008); Pyxis Products, <http://www.cardinal.com/us/en/providers/products/pyxis/index.asp> (last visited May 1, 2008). These systems have a variety of purposes, including efficient inventory management. One of their purposes is also to detect and therefore deter medication diversion by hospital personnel. The American Board of Anesthesiology has taken steps to increase awareness of the potential for diversion among anesthesiologists and to encourage treatment. *See, e.g.*, DVD: Wearing Masks II (All Anesthesia 2005), available at http://www.allanesthesia.com/Wearing_Masks_Programs.html.

charts of several of Dr. Berry's patients, confirming a mismatch between medication withdrawals and documented delivery to patients. Dr. Berry was pulled from the operating room, where he was in the middle of a case, and confronted. He admitted that he had been withdrawing the medication for his own use (to treat back pain, he said, that stemmed from a traffic accident a few months before) and signed a statement saying so.²² The Washington Physicians Health Program was notified,²³ Dr. Berry went into treatment, relinquished his Washington State medical license, and has not practiced since.²⁴ Dr. Berry later admitted that he had diverted medication ordered for the patients he anesthetized earlier in the day of the Jones surgery, and that he "was impaired by misuse of controlled drugs."²⁵

Ms. Jones's family filed a medical malpractice suit in Washington State against Kadlec and Dr. Berry. Ruling on a summary judgment motion, the superior court held that although Dr. Berry was an independent contractor, he functioned as an apparent agent of the hospital and therefore Kadlec could be liable on a vicarious liability theory.²⁶ Shortly thereafter, the parties settled. Kadlec paid \$7.5 million; Dr. Berry paid \$1 million. Both parties had insurance coverage for the amounts

22. *Kadlec Appeal*, 527 F.3d at 417; Plaintiff's Exhibit 14, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (Nov. 14, 2002) handwritten statement signed by Dr. Berry and witnessed by two Kadlec representatives).

23. The legislatively recognized Washington Physicians Health Program helps identify, refer for evaluation or treatment, and monitor the recovery of medical professionals with substance abuse, physical, or mental problems. See Washington Physicians Health Program, <http://www.wphp.org> ("[The Washington Physicians Health Program (WPHP)] is a non-profit corporation, founded by the Washington State Medical Association (WSMA) in 1986, to reach out to troubled colleagues. WPHP helps identify, refer for evaluation or treatment, [and] monitor the recovery [of medical professionals with substance use, physical, and/or mental disorders].") (last visited May 1, 2008); see also WASH. REV. CODE ANN. § 18.130.175 (West 2005 & Supp. 2008).

24. *Kadlec Appeal*, 527 F.3d at 417; Agreed Order, *supra* note 15, at 8.

25. Agreed Order, *supra* note 15, at 7.

26. *Kadlec Appeal*, 527 F.3d at 417; Order granting Plaintiffs' Motion for Partial Summary Judgment on Vicarious Liability, *Jones v. Kadlec Med. Ctr.*, No. 03-2-0048-2 (Benton County Ct., Wash., Aug. 22, 2003). This is not a surprising ruling given long-standing Washington State case law. See *Adamski v. Tacoma Gen. Hosp.*, 579 P.2d 970, 978 (Wash. Ct. App. 1978) (hospital can be vicariously liable for actions of independent contractor emergency room physician). Hospitals are increasingly being held liable under a variety of theories for the in-hospital negligence of non-employee physicians. This type of vicarious liability is most likely to be recognized where the physician is of a type, such as an anesthesiologist, whose selection is largely in the control of the hospital rather than the patient. See *infra* Part III.B.

they paid to settle the case.²⁷

In the course of discovery for this malpractice suit, the hospital learned that Dr. Berry had been strongly suspected of on-duty narcotics use while working at Lakeview Regional Medical Center (Lakeview Medical) in Louisiana, and that he had been terminated from his anesthesia practice group there for "report[ing] to work in an impaired physical, mental and emotional state."²⁸ Lakeview Medical's credentialing letter, sent to Kadlec the year prior to Ms. Jones's surgery, did not mention the hospital's concerns or the practice group's action. The two letters from physicians in the practice group referred to him as an "excellent anesthesiologist" who "will be an asset to [your] anesthesia service."²⁹

While the typical medical malpractice case would have ended with the remittance of the settlement checks, this one took an unprecedented turn. Kadlec and its insurer, Western Professional Insurance Company, sued Lakeview Medical, Lakeview Anesthesia Associates (LAA), and the LAA doctors for misleading Kadlec during the credentialing process. This Article focuses particularly on the case against Lakeview Medical and the larger context of a hospital's role in ensuring safe physician practice.

B. *The Legal Web That Informs Physician Review*

Underlying and informing this case is the complex web of constitutional law, statutes, case law and private guidelines that shape the physician review processes at hospitals. A bit of background is thus in order. At the beginning of the twentieth century, most hospitals were private charitable institutions that focused on caring for the poor without charge. They usually did not employ physicians, but allowed them to use the facilities as their "workshop," with little systematic review of the physicians' educational backgrounds or technical skills.³⁰

27. *Kadlec Appeal*, 527 F.3d at 418; *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *2 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008); All Parties' Joint Stipulations, *Kadlec*, No. Civ.A 04-0997 (E.D. La. Mar. 8, 2006).

28. *Kadlec Appeal*, 527 F.3d at 415; Plaintiff's Exhibit 18, *supra* note 2.

29. *Kadlec Appeal*, 527 F.3d at 419.

30. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 147-79 (1982) (dis-

The early decades of the 1900s saw an increase in the medical value of hospitalization, the rise of surgical specialties, and the standardization of medical education. All of these changes pushed hospitals' medical staffs to perform at least a minimal review of physician "credentials" to determine, for example, whether a physician had graduated from an accredited medical school. The changes also pushed for the granting of different types of "privileges," such as allowing some physicians to perform in-hospital surgery. Those privileges could be limited or revoked based on a "peer review" conducted by fellow physicians.³¹ These processes do not, in themselves, create an employment relationship. Even now, most physicians are not employees of the hospitals where they hold privileges.³²

Today, these physician review processes involve both a hospital's governing body and also its organized medical staff. The ultimate responsibility for granting, restricting, and revoking privileges rests with a hospital's governing board, which is often comprised primarily, or entirely, of non-physicians. The analysis of information supporting a credentialing or privileging decision, however, rests with the organized medical staff. It is the medical staff that directly oversees the quality of care, treatment, and services delivered by physicians who are credentialed and privileged through the medical staff process. This is typically facilitated by delegation of authority to the medical staff executive committee. A credentials committee of the medical staff typically reviews relevant materials on a physician seeking privileges, and then makes a recommendation to the executive committee; the governing board of the hospital grants final approval. The medical staff bylaws address physician review processes as well as other governance matters.³³

Evolving from other hospital standard-setting entities, the

cussing early charity hospitals and standard-setting); ROSEMARY STEVENS, IN *SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY 17-89* (1999) (discussing hospitals in the early twentieth century).

31. See Craig W. Dallon, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 599-617 (2000) (discussing historical development of hospital-physician relations).

32. William D. Marder et al., *Physician Employment Patterns: Challenging Conventional Wisdom*, HEALTH AFF., Winter 1988, at 137, 141 (76.6% of nonfederal patient care physicians were self-employed in 1988; 3.4% were employed by a private hospital).

33. BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 811 (2004).

Joint Commission on the Accreditation of Hospitals was established in the 1950s and has become extremely influential in establishing physician review standards.³⁴ In the mid-1980s, its name changed to the Joint Commission on the Accreditation of Health Care Organizations, reflecting its broadened accreditation scope; in 2007, its name shortened to simply the Joint Commission, which is how it will be referred to here. The hospital accreditation standards have evolved significantly and are now detailed in the *Comprehensive Accreditation Manual for Hospitals*.³⁵ Most general hospitals are Joint Commission-accredited,³⁶ and attaining that accreditation can be deemed compliance for Medicare accreditation purposes³⁷ and also for many aspects of state hospital licensing programs.³⁸

The Joint Commission's standards have long required that hospitals review a physician's credentials and performance, not only at initial appointment, but also every two years thereafter, as well as when the physician requests additional privileges, or when there are concerns suggesting that a physician's privileges should be revoked or limited.³⁹ As described later

34. See Dallan, *supra* note 31, at 602-03; see also Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 845-60 (1983). In 1919, the American College of Surgeons (ACS) designed and implemented the first program to accredit hospitals. In 1951, the American Medical Association (AMA), American College of Physicians, and American Hospital Association (AHA) joined ACS to form the Joint Commission on the Accreditation of Hospitals. The board of this new commission included members of both the AMA and the AHA. RAND E. ROSENBLATT ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 916-18 (1997).

35. See generally JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK (CAMH Update 2)* (2006) (including Medical Staff Standards (MS)).

36. "The Hospital Accreditation Program has been in existence in some form for more than 50 years. Today, it accredits approximately 4,250 general, children's, long term acute, psychiatric, rehabilitation, and surgical specialty hospitals. Approximately 91% of the nation's hospitals (including critical access hospitals) are currently accredited by The Joint Commission." The Joint Comm'n, *Facts about Joint Commission Accreditation and Certification*, http://www.jointcommission.org/AboutUs/Fact_Sheets/facts_jc_acrr_cert.htm (last visited May 1, 2008).

37. 42 U.S.C. § 1395bb(a) (West 2003 & Supp. 2008) (accreditation by recognized national accreditation body deemed to meet the Medicare Conditions of Participation); see also Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275 § 125, 122 Stat. 2494, 2519-20 (hospital deeming authority to be granted by the Centers for Medicare and Medicaid Services); 42 C.F.R. §§ 448.5-448.6 (2008).

38. See, e.g., WASH. REV. CODE ANN. § 70.41.030 (West 2002) (Washington State Department of Health required to make hospital licensing standards consistent with applicable Joint Commission standards).

39. See JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 35, at MS.4.00-

in this Article,⁴⁰ in an effort to increase quality oversight by hospitals, the Joint Commission is shifting re-privileging from an episodic to a more ongoing, thorough process. The Joint Commission standards also require that the general professional criteria for granting or continuing staff membership be specified in the medical staff bylaws.

Under the Joint Commission standards, credentialing requires the collection, verification, and assessment of information relating to three parameters: state licensure; education and relevant training; and experience, ability, and current competence to perform the roles, tasks, and procedures that comprise the requested privileges.⁴¹ The first two are largely a matter of confirming objectively verifiable details included in the application materials submitted. The third, though, requires opinions from other hospitals where the physician has had privileges and from other physicians familiar with the applicant's work. Thus, at initial credentialing, a hospital will send letters to other hospitals and physicians asking about a physician's experience, ability and current competence to perform the requested privileges. Increasingly, this request is accompanied by a detailed questionnaire, although that is not specifically required by the Joint Commission. Hospitals typically require applicants for privileges to execute a hold-harmless and release agreement.⁴²

A credentialing hospital is also required to query the National Practitioner Data Bank (NPDB) when a physician initially requests privileges and at re-privileging every two years.⁴³ Congress created the NPDB under the Health Care

.45. States have also enacted physician-review laws that jibe with those of the Joint Commission. See Jost, *supra* note 34, at 844.

40. See *infra* notes 209-13 and accompanying text.

41. See JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 35, at MS.4.10, MS.4.15.

42. These have been upheld by courts. See, e.g., *Stitzell v. York Mem'l Osteopathic Hosp.*, 754 F. Supp. 1061, 1065-66 (M.D. Pa. 1991) (agreement shields hospital from liability for good faith disclosures).

43. See 42 U.S.C. § 11135 (2000) (describing the duty of hospitals to query the Data Bank). HHS is testing a new system "in response to the growing interest of healthcare entities in ongoing monitoring of practitioner credentials." Announcement of Proactive Disclosure Service (PDS) Opening Date and User Fees, 72 Fed. Reg. 10,227 (Mar. 7, 2007). Under the Proactive Disclosure Service, a prototype of which was introduced in April 2007, eligible queriers can be notified within one day of the NPDB's receipt of a report on any of the queriers' enrolled practitioners. *Id.*

Quality Improvement Act of 1986 ["HCQIA" or the "Act"].⁴⁴ The HCQIA had two primary, interrelated aims: first, to restrict the ability of incompetent physicians to leave their pasts behind by moving to a different state;⁴⁵ second, to encourage vigorous physician peer review.⁴⁶ Under the Act, vigorous peer review is meant to be encouraged by the provision of qualified immunity from money damages for professional review activities that meet the Act's standards of fundamental fairness. Under the Act, knowledgeable credentialing and privileging are meant to be encouraged by NPDB querying and reporting. The ultimate purpose of the Act is to protect patients, although patients do not have access to the NPDB.

HCQIA requires hospitals to report to the NPDB certain adverse actions. These include a professional review action based on a physician's professional competence or conduct that adversely affects his or her clinical privileges for a period of more than thirty days or any surrender or voluntary restriction of clinical privileges while an investigation is pending or in return for not conducting an investigation.⁴⁷ The NPDB also collects information relating to adverse state licensing decisions and malpractice judgments and settlements.

Failure to report events as required can result in loss of

44. 42 U.S.C. §§ 11101-52 (2000). The NPDB does not concern itself solely with physicians and hospitals. It maintains information on dentists and, in some cases, other health care providers. Mandated reporters and queriers include state licensing boards and other health care entities such as some managed care organizations. This article focuses on physicians and hospitals.

45. "There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." 42 U.S.C. § 11101(2) (2000).

46. All the states have also enacted statutes that protect peer review participants through immunity, privilege, confidentiality or some combination of the three. See Susan O. Scheut-zow, *State Medical Peer Review: High Cost but No Benefit - Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 9 (1999) (analyzing information from the NPDB, concluding that the peer review protection statutes do not actually encourage peer review activities, and recommending that states encourage effective peer review through mandates and recognition of a negligent credentialing cause of action).

47. 42 U.S.C. § 11133(a)(1) (2000); see also DIV. OF QUALITY ASSURANCE, UNITED STATES DEP'T OF HEALTH & HUMAN SERVS., PUBL'N NO. HRSA-95-255, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK, Ch. E (2001), available at http://www.npdb-hipdb.hrsa.gov/pubs/gb/NPDB_Guidebook.pdf. This obligation applies to other health care entities besides hospitals. It also applies to "an entity (including a health maintenance organization or group medical practice) . . . that follows a formal peer review process for the purpose of furthering quality health care." 42 U.S.C. § 11151(4)(A)(ii) (2000).

HCQIA immunity for three years.⁴⁸ Conversely, a hospital that fails to query the NPDB when credentialing a physician is presumed to have knowledge of any information in the NPDB about that physician.⁴⁹ This could make it difficult to defend a negligent credentialing suit in the increasing number of states that allow such a cause of action.⁵⁰ State law typically requires similar reports to the state medical licensing agency, sometimes based on a broader category of adverse actions than the federal law.⁵¹

Another available legal process is referral of an impaired or distressed physician to a program recognized by state law. Under these programs (typically known as “physician health programs” or “impaired physician programs”) a physician’s medical license and privileges can be retained contingent upon compliance with an individualized treatment and monitoring plan.⁵² While the percentage of physicians impaired because of psychiatric illness, alcoholism, or drug dependency may not be higher than rates among other professionals,⁵³ the consequences of impairment can be much higher given the type of work they do. For that reason, the consequences of admitting and dealing with addiction can also be much higher. As the Fifth Circuit noted in its *Kadlec* decision, “addicts try to hide their disease from their co-workers, and that particularly in the case of narcotics-addicted anesthesiologists, for whom livelihood and drug supply are in the same place, colleagues may be the last to know about their addiction and impair-

48. 42 U.S.C. §§ 11133(c), 11111(b) (2000); 45 C.F.R. § 60.9 (2008). Before this sanction is applied, the hospital must have notice and an opportunity to be heard, as well as an opportunity to correct noncompliance.

49. 42 U.S.C. § 11135(b) (2000).

50. See *infra* Part III.B.

51. See Scheutzow, *supra* note 46, at 9; see also *infra* notes 224-30 and accompanying text (regarding *Estate of Fazaldin v. Englewood Hosp. & Med. Ctr.*, No. L-3572-02, 2007 WL 2126832, at *10, *12 (N.J. Super. Ct. App. Div. July 26, 2007) (finding it “fairly debatable” whether hospital required to report to the NPDB adverse actions taken against surgeon, but clear “as a matter of law” that report to the New York licensing authority was required).

52. See Marie R. Baldisseri, *Impaired Healthcare Professional*, 35 CRITICAL CARE MED. S106, S107-114 (2007) (summarizing data on impaired physicians and impaired-physician programs); see also A.C. Gualtieri, J.P. Cosentino & J.S. Becker, *The California Experience with the Diversion Program for Impaired Physicians*, 249 J. AM. MED. ASSOC. 226, 226-29 (1983).

53. Baldisseri, *supra* note 52, at 108-109 (citing data that ten to fifteen percent of healthcare professional will misuse drugs or alcohol at some time during their careers, and that a few specialties, including anesthesia, have a higher rate of drug abuse).

ment.”⁵⁴ These state programs aim to encourage treatment by providing a way to seek help without loss of licensure or privileges.

A challenge with any physician review process is to make it fundamentally fair, focused on quality, and not driven by anti-competitive agendas or personal vendettas. A decision to deny, suspend, or revoke hospital privileges, either at the initial credentialing phase or subsequently, can have enormous consequences for the physician involved. Particularly for those specialties that are tied to hospital practice, an adverse credentialing decision can have a profound personal and financial impact. While quality medical practice is the ostensible goal of these processes, in practice anticompetitive motivations can creep in and lead to alleged “sham privileging” decisions.

The prominent and influential early case in this area is *Patrick v. Burget*.⁵⁵ Timothy A. Patrick, M.D. moved to Astoria, Oregon, a small coastal town that had (and still has) just one hospital, where he obtained surgical privileges. Dr. Patrick joined the Astoria Clinic, a multi-specialty group whose members made up a majority of the hospital staff. After a year, he was asked to become a partner with the Astoria Clinic, but he declined and set up his own practice. Difficult relations between the clinic doctors and Dr. Patrick, and an incident involving complications with one of his patients, culminated in the hospital’s medical executive committee recommending termination of his privileges and a referral to the state medical licensing board.⁵⁶

Dr. Patrick resigned his privileges and sued the Astoria Clinic and several individual doctors, arguing that they had conspired to destroy his practice and made unwarranted attacks on his competence because he competed with them. The jury agreed with him and awarded damages of nearly \$2 million against the physician defendants.⁵⁷ The case sent shockwaves throughout the medical community. Who would par-

54. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 424 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

55. 486 U.S. 94 (1988) (Justice Harry A. Blackmun, who was once general counsel of the Mayo Clinic, did not participate in the case).

56. *Id.* at 96-97.

57. *Id.* at 98.

ticipate in peer reviews with the threat of being dragged into a lengthy court battle and subject to huge fines? Shouldn't there be protection for the physicians who serve on peer review committees and for the hospitals where this crucial review takes place?

The fact that this particular peer review had been found severely lacking – the Ninth Circuit noted it could be considered “shabby, unprincipled and unprofessional”⁵⁸ – did not negate the concerns.⁵⁹ The concerns were further heightened when the United States Supreme Court ruled in the *Patrick* case that use of federal antitrust law was not precluded in this area by the state action doctrine because the state simply required that hospitals adopt and utilize a peer review process and did not actively supervise that process.⁶⁰ The *Patrick* jury verdict predated and reinforced the arguments in favor of HCQIA's grant of immunity from money damages for peer review actions that meet the federal law's standards of fundamental fairness. Despite this federal standard and similar state laws, privilege suspension and revocation can lead to complicated, expensive litigation, with allegations that anticompetitive motivations and unfair procedures caused extensive damage to targeted physicians.⁶¹

C. *Dr. Berry Falls Through the Web*

In the summer of 2001, Kadlec needed additional anesthesia coverage and found Dr. Berry through a *locum tenens* agency, Staff Care, Inc.⁶² In his application for privileges, Dr. Berry noted that he had worked as an anesthesiologist at Lakeview

58. *Patrick v. Burget*, 800 F.2d 1498, 1509 (9th Cir. 1986), *rev'd*, 486 U.S. 94 (1988).

59. See Stuart Taylor, Jr., *Doctors Can Sue in Peer Reviews, Justices Declare*, N.Y. TIMES, May 17, 1988, at A1 (quoting the AMA's general counsel as saying “there are very few doctors in America today who don't know about *Patrick v. Burget*,” and arguing that “the threat of giant Federal lawsuits” will have a “chilling effect” on efforts to discipline incompetent doctors).

60. *Patrick*, 46 U.S. at 105.

61. See *infra* notes 235-44 and accompanying text (regarding *Poliner v. Texas Health Systems*, 537 F.3d 368, 385 (5th Cir. 2008) (a lengthy “sham privileging” case holding that the HCQIA's immunity provisions applied; the Fifth Circuit in *Poliner* overturned a \$33 million verdict in favor of a cardiologist whose privileges had been suspended), *cert. denied*, 129 S. Ct. 1002 (Jan. 21, 2009)).

62. *Locum tenens* is Latin for “holding the place.” In the healthcare industry, it refers to a physician who is working on a temporary basis. Several agencies connect physicians wanting to work as *locums* with health care facilities that need temporary physician services. See, e.g., Staff Care, Inc., <http://www.staffcare.com> (last visited May 2, 2008).

Regional Medical Center. Lakeview Medical, a mid-size, private, for-profit hospital located in southeast Louisiana, is part of HCA, Inc.⁶³ HCA, Inc. is one of the largest healthcare corporations in the world, with approximately 180 hospitals and 100 free-standing surgical centers throughout the United States and Europe.⁶⁴

Kadlec sent a letter to Lakeview Medical requesting, among other things, "evidence of current competence to perform the privileges requested" and "a candid evaluation of [Dr. Berry's] training, continuing clinical performance, skill, and judgment, interpersonal skills and ability to perform the privileges requested."⁶⁵ Kadlec also included with this letter an "Appointment Reference Questionnaire," which included several specific questions and was to be signed by the department chair. Among the questions posed were: "Has the applicant shown any signs of behavior/personality problems or impairments?" or "been subject to any disciplinary actions?"⁶⁶ The packet from Kadlec included a consent for release of information signed by Dr. Berry.⁶⁷

By letter dated October 26, 2001, Lakeview Medical responded. The responsive letter reads as follows:

This letter is written in response to your inquiry regarding the above referenced physician. Due to the large volume of inquiries received in this office, the following information is provided.

63. Lakeview Reg'l Med. Ctr., <http://www.Lakeviewregional.com> (last visited May 2, 2008).

64. Hosp. Corp. of America, <http://www.hcahealthcare.com> (last visited May 2, 2008).

65. Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (*Kadlec Appeal*), 527 F.3d 412, 416 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008); Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., No. Civ.A 04-0997, 2005 WL 1309153, at *1 (E.D. La. May 19, 2005) (describing request and noting that the Washington State Department of Health and Staff Care, Inc. also sent questionnaires to Lakeview requesting Dr. Berry's professional history and received the same responsive letter as did Kadlec), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008); Plaintiff's Exhibit 20, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (Oct. 17, 2001 letter with enclosures from Rachel Wilson, Kadlec Credentials Specialist, To Whom it May Concern, Lake View Regional Medical Center Re: Robert L. Berry, MD. The enclosures are: confidential questionnaire, consent for release of information, delineation of privileges, envelope). This letter includes at the top the phrase "Please Expedite!" *Id.*

66. *Kadlec Appeal*, 527 F.3d at 416; Plaintiff's Exhibit 20-2, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153.

67. *Kadlec Appeal*, 527 F.3d at 416.

Our records indicate that Dr. Robert L. Berry was on the Active Medical Staff of Lakeview Regional Medical Center in the field of Anesthesiology from March 04, 1997 through September 04, 2001.

If I can be of further assistance, you may contact me at .

⁶⁸
...

Kadlec also received from Staff Care, Inc. two reference letters written by physicians with Lakeview Anesthesia Associates (LAA), the anesthesia practice group that had an exclusive contract with Lakeview Medical and with which Dr. Berry had been affiliated. As received by Kadlec, they were both undated; both of the originals, however, are dated June 3, 2001.⁶⁹ One, signed by Dr. William Preau III, reads:

This is a letter of recommendation for Dr. Lee Berry. I have worked with him here at Lakeview regional medical center [sic] for four years. He is an excellent anesthesiologist. He is capable in all fields of anesthesia including OB, peds, C.V. and all regional blocks. I recommend him highly.⁷⁰

The other letter is signed by Dr. Mark Dennis, who in addition to being a partner at LAA was also the chief of the anesthesiology department at Lakeview Medical and a member of Lakeview Medical's medical executive committee.⁷¹ Dr. Dennis's letter reads:

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. Thank you.⁷²

Thus, Kadlec had in its credentialing file three letters relat-

68. *Id.*

69. Compare Plaintiff's Exhibits 1 & 2, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153, with Defendant's Exhibits 47 & 46, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (identical letters; defendant's exhibits undated).

70. Defendant's Exhibit 46, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (June 3, 2001 letter from William Preau, III, M.D. to "Dear Sirs"); *Kadlec Appeal*, 527 F.3d at 419 (summarizing letter).

71. All Parties' Joint Stipulations, *supra* note 27.

72. Defendant's Exhibit 47, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (June 3, 2001 letter from Mark Dennis, M.D. to "Dear Sirs"); *Kadlec Appeal*, 527 F.3d at 419 (summarizing letter).

ing to Dr. Berry's time at Lakeview Medical.⁷³ In the course of discovery for the Jones malpractice case, Kadlec discovered a fourth. This fourth letter is dated March 27, 2001, a few months prior to the LAA letters described above. It is signed on behalf of LAA by Drs. Dennis and Preau, who wrote the letters described above, as well as by two other LAA physicians.

This fourth letter is captioned "Termination of Employment," and is addressed to Dr. Berry. It reads:

Please consider this correspondence your written notice of termination "with cause." As we have discussed on several occasions, you have reported to work in an impaired physical, mental, and emotional state. Your impaired condition has prevented you from properly performing your duties and puts our patients at significant risk. As we previously discussed, please consider your termination effective March 13, 2001.

If you have any questions or would like to discuss this matter further, please contact our attorney Thank you for your cooperation.⁷⁴

This is the letter that prompted Kadlec and its insurer, Western Professional Insurance Co., to sue Lakeview Medical,

73. On the two letters from the LAA physicians someone in Kadlec's credentialing office wrote "can't use." Under Joint Commission rules for credentialing, these letters could not be relied upon as primary evidence in the credentialing process because they were not sent directly to Kadlec and because they were undated. Kadlec had other credentialing information relating to Dr. Berry including positive references related to Dr. Berry's work at a different hospital and a report from the National Practitioner Data Bank indicating no adverse privileging actions against him and no malpractice settlements or judgments against him. *See, e.g., Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ. A 04-0997, 2005 WL 1155768, at *2 (E.D. La. May 6, 2005) (denying LAA's motion for summary judgment and noting evidence that the letters were relied upon despite the "can't use" notation), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008). Kadlec granted him anesthesia privileges and, pursuant to its rules for *locum tenens* physicians, re-privileged him several times over the year leading up to the Jones surgery. Plaintiff's Exhibit 7, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (seven letters, sent between Nov. 2001 and Nov. 2002 to Dr. Berry from Kadlec granting him *locum tenens* privileges for anesthesia). These are among the facts that LAA and Lakeview Medical pointed to in arguing that the case should be dismissed for lack of reliance and lack of legal cause.

74. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *1 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008); Plaintiff's Exhibit 18, *supra* note 2; *Kadlec Appeal*, 527 F.3d at 415 (quoting part of letter).

LAA, and the four doctors associated with LAA who signed Berry's dismissal letter. Soon after settling with the Jones family, Kadlec filed suit in federal district court in Louisiana on diversity jurisdiction. As to Lakeview Medical, the suit asserted claims for intentional misrepresentation, negligent misrepresentation, strict responsibility misrepresentation, and negligence.⁷⁵

Why was Dr. Berry terminated from LAA and what did Lakeview Medical know about those reasons? These were key issues during the jury trial in Louisiana; some important facts are not in dispute. In January 1997, Dr. Berry joined LAA and a few months later obtained privileges at Lakeview Medical.⁷⁶ In what is not an uncommon arrangement, LAA had an exclusive contract to provide anesthesia services at the hospital.⁷⁷ In late 2000, nurses raised concerns about Dr. Berry's behavior, and about a mismatch between the amounts of Demerol he was withdrawing and the amount documented as having been given to patients or wasted.⁷⁸ As did Kadlec, Lakeview Medical had a Pyxis system to inventory medications; the hospital's subsequent review of Pyxis and patient records supported the nurses' concerns.⁷⁹

Lakeview Medical CEO Max Lauderdale discussed the results of the investigation with Dr. Berry and Dr. Dennis (the chief of the anesthesiology department, member of the Lakeview Medical medical executive committee, and a shareholder at LAA). Dr. Berry did not admit to diverting medications for his own use nor to practicing while impaired. An "Action Plan" that emerged from this meeting called for weekly audits

75. *Kadlec*, 2005 WL 1309153, at *3. The strict responsibility cause of action was dismissed as not having support in Louisiana law. *Id.* at *11. The negligence claim was dismissed in a later district court decision because it was based solely on violation of the HCQIA and Louisiana's diversion of medication regulations, neither of which, the court held, was intended to protect hospitals or their insurers. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2006 WL 1328872, at *1-*4 (E.D. La. 2006) (further noting that Louisiana courts have rejected the common law concept of negligence per se), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008). The Fifth Circuit upheld this ruling, agreeing that the complaint rests on HCQIA and Louisiana regulations and, further, that a claim under general negligence law "should be dismissed because any duty the law imposes does not reach these plaintiffs." *Kadlec Appeal*, 527 F.3d at 427.

76. *Kadlec Appeal*, 527 F.3d at 415.

77. *Id.*

78. *Id.*

79. *Id.*; *Kadlec*, 2005 WL 1309153, at *1.

of his medication withdrawals for ninety days and limitations on his access to the Pyxis machines.⁸⁰ This document was kept in the CEO's office, and apparently the weekly audits did not take place.⁸¹

On March 13, 2001, more than three months after the meeting described above, Dr. Berry was on call for a twenty-four hour shift and failed to respond to a page. One of his LAA partners found him in the on-call room; Dr. Berry "appeared to be sedated" and the other anesthesiologist took over the rest of the shift.⁸² As the Fifth Circuit relates, "Lauderdale, Lakeview Medical's CEO, decided that it was in the best interest of patient safety that Dr. Berry not practice at the hospital."⁸³ The LAA partners fired Dr. Berry and sent the March 27, 2001 termination letter.⁸⁴

Lakeview Medical did not initiate a formal peer review, did not revoke or suspend Dr. Berry's privileges, and did not

80. Plaintiff's Exhibit 43-1, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153. This one-page typed document has a handwritten notation "File Dr. Berry/Anesthesia Group" and reads as follows:

Failure to meet the Standard of Practice:

1. Failure to document medication obtained via pyxis as evidenced through chart audit.
2. Failure to document medication "waste" via pyxis as evidenced through chart audit.
3. Failure to follow hospital policy and procedure in the documentation of medication administration as evidenced through chart audit.

Action plan:

1. Dr. Berry will not obtain medication from pyxis machines outside of the operating room suite.
2. Dr. Berry will order medication but will delegate the administer [sic] of the medication to an R.N. as defined by his/her scope of practice.
3. Dr. Berry will document medication usage and medication wastage according to Lakeview Medical policy and procedure.

Monitoring/Conclusions:

1. Dr. Berry will agree to the above via his signature. Failure to sign this action plan will result in immediate termination.
2. Dr. Berry will immediately adhere to the above action plan. Failure to do so will result in immediate termination.
3. Weekly audits will be conducted for ninety (90) days and periodically thereafter.

81. *Kadlec Appeal*, 527 F.3d at 415-16; *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2006 WL 1328872, at *1 n.4 (E.D. La. May 9, 2006), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

82. *Kadlec*, 2005 WL 1309153, at *1.

83. *Kadlec Appeal*, 527 F.3d at 415.

84. *Id.*

make a report to the NPDB, the Louisiana State Board of Medical Examiners (which licenses physicians), or the Physicians Health Foundation of Louisiana (which works with impaired physicians).⁸⁵ However, since LAA had an exclusive contract to provide anesthesia services at the hospital and Dr. Berry was no longer with LAA, he never again worked at the facility. Additionally, as the Fifth Circuit relates, "Lauderdale took the unusual step of locking away in his office all files, audits, plans, and notes concerning Dr. Berry and the investigation," and "ordered the Chief Nursing Officer to notify the administration if Dr. Berry returned."⁸⁶

Notes of an August 2001 Lakeview Medical board meeting, at which the Lakeview Medical CEO and Dr. Dennis were present, state that Dr. Berry voluntarily resigned his privileges "for personal reasons and not due to any concerns at Lakeview."⁸⁷ Dr. Berry's formal resignation letter was dated October 1, 2001.⁸⁸ Lakeview Medical's October 26, 2001 credentialing response letter to Kadlec listed the type of privileges Dr. Berry held and the dates; referring to the "large volume of inquiries" it did not provide more information. The questionnaire Kadlec had sent was not returned.⁸⁹

Lakeview Medical maintained that the people in its credentialing office who wrote and signed the letter to Kadlec did not know about the action plan or any other adverse information about Dr. Berry. There was evidence introduced at trial, however, that this credentialing inquiry was handled differently than others received in the same week. First, the letter itself was worded a bit more guardedly than other responses which typically indicated that the doctor's file had been reviewed and included phrases such as "[t]here is no information of a derogatory nature contained in Dr. [X]'s file."⁹⁰ Additionally,

85. *Id.* at 416, 420; *Kadlec*, 2006 WL 1328872, at *1 n.4.

86. *Kadlec Appeal*, 527 F.3d at 416.

87. Plaintiff's Exhibit 10, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (Aug. 7, 2001 Lakeview Medical Board of Trustees Meeting notes) Dr. Berry's letter officially resigning his privileges is dated October 1, 2001. Defendant's Exhibit 22, *Kadlec*, No. Civ.A 04-0997, 2005 WL 1309153 (Oct. 1, 2001 letter to Medical Staff Office from R. Lee Berry). This letter reads as follows: "Due to an upcoming move from the area, I hereby resign my privileges at Lakeview Regional Medical Center. Thank you for your kind attention to this matter." *Id.*

88. *Kadlec Appeal*, 527 F.3d at 420.

89. *Id.* at 416.

90. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *11 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th

for the thirteen other credentialing responses sent out the same day, the credentialing office responded fully, including completion of forms similar to that sent by Kadlec.⁹¹

D. Rejection of Duty Based on Hospitals' "Special Relationship" in Credentialing Process

Lakeview Medical moved for summary judgment, arguing that it should be dismissed from Kadlec's lawsuit as a matter of law for two primary reasons.⁹² The first focuses on duty. Lakeview Medical argued that it had no duty to tell Kadlec Medical Center anything because it had not revoked the doctor's privileges, had not taken any reportable action, had not employed Dr. Berry, had no pecuniary interest in responding to Kadlec's credentialing request, and had no contractual or fiduciary relationship with Kadlec. Additionally, Lakeview Medical argued, the credentialing letter it did provide to Kadlec was accurate as far as it went, not misleading, and in accordance with standard business practice.⁹³ Furthermore, as a matter of policy, requiring hospitals to disclose negative information about physicians would expose the hospitals to a great deal of uncertainty and potential liability.

Second, Lakeview Medical argued that even if a duty were found, too much "time, space, people, and bizarreness" had intervened for it to be the legal cause of Ms. Jones's injuries.⁹⁴ Rather, Dr. Berry's negligence and Kadlec's negligence in failing to detect and act on his impairment during the year he practiced intermittently at the Washington State hospital were both intervening causes. Had Kadlec checked the Pyxis records according to its schedule, Lakeview Medical argued, or followed up on staff impressions that on a couple of occasions Dr. Berry did not seem well, Ms. Jones would not have been

Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

91. *Id.* at *9, *11; *Kadlec Appeal*, 527 F.3d at 416.

92. It also argued that, as a matter of law, its omissions could not be found to be material, Kadlec did not rely on its letter, there was no evidence of intent to deceive, and the statute of limitations had run. Lakeview Medical, and LAA in particular, also argued that the case should be dismissed because it was actually a disguised claim for tort contribution or indemnity, which should not be allowed in this context. The Fifth Circuit was not convinced by these arguments. *Kadlec Appeal*, 527 F.3d at 425; *Kadlec*, 2005 WL 1309153, at *9, *11.

93. *Kadlec Appeal*, 527 F.3d at 422; *Kadlec*, 2005 WL 1309153, at *1, *4-5.

94. *Kadlec*, 2005 WL 1309153, at *10 (quoting *Louviere v. Louviere*, 839 So. 2d 57, 65 (La. Ct. App. 2002)).

injured. Lakeview Medical pointed particularly to concerns about Dr. Berry's practice and appearance during the four surgeries immediately before Ms. Jones's. According to the order terminating Dr. Berry's Washington State license, three of his four preceding patients that day experienced anesthesia-related complications (all apparently quickly resolved), many of his notes that day were atypically illegible, and "nursing staff noted that [Dr. Berry] looked ill, and that he appeared diaphoretic [sweaty] and congested."⁹⁵ He was "screwing up all day" according to one nurse.⁹⁶

On both the duty and causation issues, the district court ruled against Lakeview Medical and allowed Kadlec's intentional misrepresentation and negligent misrepresentation claims to go to the jury. The jury found in favor of Kadlec, and awarded damages of \$8.2 million. Lakeview Medical was assigned twenty-five percent of the fault, Dr. Dennis twenty percent, Dr. Preau five percent, Dr. Berry thirty-three percent, and Kadlec seventeen percent.⁹⁷ Both Lakeview Medical and LAA (Drs. Dennis and Preau) appealed to the Fifth Circuit. While the causation question is an interesting one, this Article focuses on the duty issue, with its broader applicability and consequences. In addition, the Fifth Circuit fairly easily disposed of the causation issue, finding the requisite "ease of association" between the harm and conduct.⁹⁸

1. *Were There "Affirmative Misrepresentations"?*

The Fifth Circuit began its analysis under Louisiana law by holding that "after choosing to write referral letters, the defendants assumed a duty not to make affirmative misrepresentations in the letters."⁹⁹ Quoting a 1944 Louisiana Supreme Court case, the court noted that "if [a party] volunteers to speak and to convey information which may influence the conduct of the other party, he is bound to [disclose] the whole truth."¹⁰⁰ While not every misstatement warrants the imposi-

95. Agreed Order, *supra* note 15, at 6.

96. *Kadlec Appeal*, 527 F.3d at 417.

97. *Id.* at 418.

98. *Id.* at 424 (holding that the harm to Kadlec is easily associated with LAA's misleadingly favorable recommendation letter).

99. *Id.* at 418.

100. *Id.* at 419 (quoting *Am. Guar. Co. v. Sunset Realty & Planting Co.*, 23 So. 2d 409, 455-

tion of liability, the Fifth Circuit noted that here the “defendants were recommending an anesthesiologist, who held the lives of patients in his hands every day.”¹⁰¹ Thus, if they volunteer to write, they have a duty not to mislead the letter recipients “into thinking that Dr. Berry was an ‘excellent’ anesthesiologist, when they had information that he was a drug addict.”¹⁰²

The Fifth Circuit readily concluded that the LAA doctors’ letters were affirmatively misleading. Dr. Preau wrote that Dr. Berry was an “excellent anesthesiologist” and that he “recommend[ed] him highly”; Dr. Dennis characterized him as an “excellent physician” who “will be an asset to [his future employer’s] anesthesia service.”¹⁰³ These letters were sent to Staff Care—with the knowledge that they would be forwarded to credentialing hospitals—less than seventy days after Drs. Preau and Dennis signed the letter terminating Dr. Berry for reporting to work in an impaired state and putting “patients at significant risk.”¹⁰⁴

As to whether Lakeview Medical’s letter was affirmatively misleading, however, the court found that a “more difficult” question.¹⁰⁵ Staff in the Louisiana hospital’s credentialing office wrote to the Washington hospital that Dr. Berry was on the active medical staff with anesthesia privileges from March 1997 through September 2001 (the month before the credentialing response letter was sent and five months after Dr. Berry was terminated by LAA). The letter does not comment on his skills or specifically recommend him. Citing the “large volume of inquiries received in this office,” Lakeview Medical did not return the detailed questionnaire Kadlec had included in its request.¹⁰⁶

Kadlec argued that this letter was affirmatively misleading in two ways. First, there is strong evidence that the press of work was not the reason for the perfunctory response. Notably, the thirteen other credentialing letters sent the same day

56 (La. 1944) (second alteration in original)).

101. *Id.*

102. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 419 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

103. *Id.*

104. *Id.* at 416, 419.

105. *Id.* at 420.

106. *Id.* at 416.

did include detailed responses, including the return of completed forms similar to that which Kadlec had sent. “Whatever the real reason” for the incomplete response, concluded the Fifth Circuit, Kadlec did not present enough evidence to show that this could have misled it into thinking Dr. Berry had “an uncheckered history” at Lakeview Medical.¹⁰⁷

Second, Kadlec argued that the letter was misleading in stating that Dr. Berry was on the active medical staff until September 2001, when he was effectively barred from exercising those privileges after March 2001. Had the letter reflected the actual date he stopped practicing, Kadlec maintained, it would have been suspicious and made further inquiries. The court does not directly address this argument but concludes that because Dr. Berry technically did hold active privileges until he voluntarily resigned them (actually in October 2001) it was not misleading to say so. Given that Lakeview Medical had not terminated his privileges, “it did not mislead Kadlec into thinking that he had less of a gap in employment than he actually had.”¹⁰⁸

The court is correct that this is a close question; a reasonable court, or a jury, could certainly conclude that Lakeview Medical’s response is affirmatively misleading. This is not a situation in which a physician holds active privileges at a hospital but, for reasons of scheduling or practice pattern, has not treated a patient at that hospital for months. Although the Louisiana hospital had not taken any formal action against Dr. Berry’s privileges, that was not because it lacked cause. Rather, given the nature of the agreement with the anesthesiology practice group, it could ensure he did not return without taking formal privileging action. Indeed, this seems to have been the plan. If he did return, the CEO had instructed the Chief Nursing Officer to notify administration.¹⁰⁹

The Fifth Circuit phrased the duty here as an obligation not to mislead letter recipients “into thinking that Dr. Berry was an ‘excellent’ anesthesiologist, when they had information that

107. *Id.* at 420.

108. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 420 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008). This is a bit of odd phrasing, as Dr. Berry was never employed by Lakeview Medical. *See id.* at 415 (noting Dr. Berry was a shareholder of Lakeview Anesthesia Associates which, in turn, was the sole provider of anesthesiologists to Lakeview Medical).

109. *Id.* at 416.

he was a drug addict.”¹¹⁰ While Lakeview Medical’s letter would not mislead to a presumption of excellence, it does suggest that Dr. Berry was at least a “privilegable” anesthesiologist who would be allowed to practice at the hospital, when actually he would not have been. That is a significant shading of the truth, particularly where, as the Fifth Circuit stressed, “[the] defendants were recommending an anesthesiologist, who held the lives of patients in his hands every day.”¹¹¹ Technically, Dr. Berry’s privileges had not been suspended or revoked and his resignation of them did not coincide with a formal investigation. As a practical matter, however, the hospital had investigated well-founded concerns of drug diversion, and Dr. Berry did not exercise active privileges after he was fired from his practice group for strongly suspected drug abuse that put patients at risk of serious harm.

2. *Was There a Pecuniary Interest and Special Relationship?*

The court then went on to consider whether, even assuming no misleading statements, Lakeview Medical and LAA had an affirmative duty to disclose negative information about Dr. Berry in their referral letters. The district court had found such a duty, based on Louisiana law and sound policy arguments.¹¹² Before a duty to disclose is imposed, Louisiana law requires both a pecuniary interest in the transaction and also a contractual or other close relationship between the parties which, under the circumstances, justifies imposition of the duty.¹¹³ This standard applies not only to a negligent misrepresentation claim, but also to an intentional misrepresentation claim that rests on silence or inaction.¹¹⁴

A duty to disclose does not arise unless the defendant has a “pecuniary interest” in the transaction.¹¹⁵ The Restatement

110. *Id.* at 419.

111. *Id.*

112. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A. 04-0997, 2005 WL 1309153, at *7 (E.D. La. May 19, 2005), *aff’d in part, rev’d in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

113. *Barrie v. V.P. Exterminators, Inc.*, 625 So. 2d 1007, 1014-16 (La. 1993); *Hardy v. Hartford Ins. Co.*, 236 F.3d 287, 292 (5th Cir. 2001).

114. *Kadlec Appeal*, 527 F.3d at 418; *see also S. Serv. Corp. v. Tidy Bldg. Servs., Inc.*, No. Civ.A. 04-1362, 2004 WL 2784909, at *4 (E.D. La. Dec. 1, 2004) (finding that a duty to disclose is also a required element of a claim of intentional misrepresentation by omission).

115. *Hardy*, 236 F.2d at 292.

(Second) of Torts, section 552(1) supports this requirement.¹¹⁶ Lakeview Medical argued that there was no pecuniary interest because it “received no compensation, either direct or indirect, from sending the letter,” and the act was “entirely gratuitous.”¹¹⁷ The commentary to the Restatement, however, provides that the pecuniary interest “may, however, be of a more indirect character” than classic consideration or payment and that information provided “in the course of the defendant’s business” can be indicative of a pecuniary interest.¹¹⁸ The Fifth Circuit noted that although the Restatement is not binding on Louisiana courts, they do look to it for guidance and Louisiana appellate courts have endorsed the “course of business” commentary.¹¹⁹

The district court had held that Lakeview Medical had a “pecuniary interest both in omitting the type of information at issue and answering inquiries of the type made by Kadlec.”¹²⁰ First, the court noted that there was evidence in the record that the medical center omitted the information out of concern that it might be liable “to Dr. Berry for defamation and other causes of action based on disclosure.”¹²¹ Second, if Lakeview Medical stopped responding to credentialing inquiries, it would likely have difficulty getting needed responses to its own credentialing requests, and thus difficulty obtaining and retaining physicians.¹²² Third, it might have had “a pecuniary interest in avoiding public disclosure . . . that Dr. Berry had been practicing medicine while impaired.”¹²³

Overruling the district court, the Fifth Circuit concluded that on the issue of pecuniary interest, “[t]he defendants have the

116. RESTATEMENT (SECOND) OF TORTS § 552(1) (1977) (“One who, in the course of his business, profession or employment, or in any other transaction in which he has a pecuniary interest, supplies false information for the guidance of others in their business transactions, is subject to liability for pecuniary loss caused to them by their justifiable reliance upon the information, if he fails to exercise reasonable care or competence in obtaining or communicating the information.”).

117. *Kadlec*, 2005 WL 1309153, at *5.

118. RESTATEMENT (SECOND) OF TORTS § 552 cmt. d (1977).

119. *Kadlec Appeal*, 527 F.3d at 421 (citing *Anderson v. Heck*, 554 So. 2d 695, 705 (La. Ct. App. 1989)); see also *Nicholas v. Allstate Ins. Co.*, 765 So. 2d 1017, 1021 n.4 (La. 2000).

120. *Kadlec*, 2005 WL 1309153, at *6.

121. *Id.* Lakeview’s concern was apparently not assuaged by the standard waiver of liability form that Dr. Berry had signed. See also Plaintiff’s Exhibit 20, *supra* note 65.

122. *Kadlec*, 2005 WL 1309153, at *6.

123. *Id.* at *6 n.28.

better argument.” In reaching this conclusion, the court did not specifically address the arguments that convinced the district court—arguments that focus on the credentialing process and a hospital’s obligation to monitor quality of care. Rather the appellate court took a more general view grounded in standard business relations. The Lakeview and LAA letters are characterized as “information provided to future employers” that was provided “purely gratuitously.”¹²⁴

The Fifth Circuit then went on to consider whether there was “the requisite ‘special relationship’ between the defendants and Kadlec, necessary to impose a duty to disclose” (assuming there was a sufficient “pecuniary interest”).¹²⁵ Lakeview Medical argued that such a duty arises only in the context of a “contractual or fiduciary relationship,” a relationship it and Kadlec did not have.¹²⁶ Kadlec countered that Louisiana courts have not taken such a narrow view and will impose a disclosure duty in other contexts where the circumstances warrant.¹²⁷

One of the key Louisiana cases on this point involves, coincidentally, a couple with the last name Barrie.¹²⁸ The Barries sued a termite inspector whose report said that the house they bought did not have termite problems, when it actually did.¹²⁹ The report was prepared for the house sellers, although the termite inspector knew it would be passed along to the purchasers.¹³⁰ In *Barrie*, the Louisiana Supreme Court recognized that “Louisiana is a jurisdiction which allows recovery in tort for purely economic loss caused by negligent misrepresentation where privity of contract is absent.”¹³¹ As stated in an unreported district court case applying Louisiana law, “[a] duty to disclose information will not exist absent some confidential, fiduciary, or other special relationship which, under the cir-

124. *Kadlec Appeal*, 527 F.3d at 421 (quoting RESTATEMENT (SECOND) OF TORTS § 552 cmt. c (1977)).

125. *Id.* (citing *Barrie v. V.P. Exterminators, Inc.*, 625 So. 2d 1007, 1016 (La. 1993)).

126. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *6 (E.D. La. May 19, 2005), *aff’d in part, rev’d in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

127. *Kadlec Appeal*, 527 F.3d at 422-23.

128. *Barrie*, 625 So. 2d at 1007.

129. *Id.* at 1008-09.

130. *Id.* at 1010 n.7.

131. *Id.* at 1014.

cumstances of the case, justif[ies] the imposition of a duty to disclose information.”¹³²

The district court had held that Louisiana law would recognize Kadlec’s connection with Lakeview Medical as a “special relationship” that gives rise to a duty to disclose. This holding was rooted in the purposes of the credentialing system. “Kadlec and [Lakeview Medical] have a unique ‘special relationship’ which existed in part to further communication between health care providers so that future patients could be protected.”¹³³ Therefore, the district court concluded that if a hospital chooses to respond to a credentialing inquiry, it has “a duty to disclose information related to a doctor’s adverse employment history that risks death or bodily injury to future patients.”¹³⁴ The district court noted that “policy considerations weigh heavily in favor of imposing [such] a duty.”¹³⁵

The Fifth Circuit recognized the “compelling policy arguments” but reversed, holding the requisite “special relationship” was lacking and that Louisiana courts would not impose an affirmative duty to disclose, “absent misleading statements such as those made” in the LAA letters.¹³⁶ Lakeview Medical “might have had an ethical obligation to disclose [its] knowledge of Dr. Berry’s drug problems,” but it did not have a legal duty under Louisiana law.¹³⁷

In the 2002 case, *Louviere v. Louviere*, for example, the Louisiana Appeals Court held that a police department was not liable for negligent referral of a police officer who later went on a violent crime spree; the victims sued several entities, including the officer’s prior employer.¹³⁸ “Since there is no Louisiana case finding a set of facts that constitute negligent referral, a logical argument can be made” that opinion states, “that

132. S. Serv. Corp. v. Tidy Bldg. Servs., Inc., No. Civ.A. 04-1362, 2004 WL 2784909, at *5 (E.D. La. Dec. 1, 2004).

133. Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., No. Civ.A 04-0997, 2005 WL 1309153, at *6-7 (E.D. La. May 19, 2005), *aff’d in part, rev’d in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

134. *Id.* at *7.

135. *Id.*

136. Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (*Kadlec Appeal*), 527 F.3d 412, 421-22 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

137. *Id.* at 422.

138. *Louviere v. Louviere*, 839 So. 2d 57, 61, 66 (La. Ct. App. 2002).

Louisiana law does not recognize such a cause of action."¹³⁹ The court, however, did proceed to analyze whether the facts would support a negligent referral case and found that they would not: the referral letter was not misleading; the hiring department possessed the allegedly missing information (about an excessive force complaint and the fact that the police officer himself had been sexually abused as a child); and there was no "ease of association" between the letter and the violent crime spree.¹⁴⁰

In addition to the lack of case law from Louisiana, the Fifth Circuit wrote in its *Kadlec* decision, "we have not found a single case outside of Louisiana where a court imposed an affirmative duty on an employer to disclose negative information about a former employee."¹⁴¹ In those cases that held employers liable for foreseeable physical harm caused by a former employee, "the former employer had made affirmative misrepresentations in its referral."¹⁴²

One of the cases cited on this point by the Fifth Circuit is *Randi W. v. Muroc Joint Unified School District*.¹⁴³ This California Supreme Court case is considered the seminal negligent misrepresentation case in the employment reference context. Randi W., a 13-year-old student, alleged that she was sexually assaulted by Robert Gadams, the vice principal at her school. She sued, among others, three school districts where he had worked previously. While at each of the three prior districts, Gadams had been the subject of complaints of sexual misconduct; at two of them he allegedly resigned while charges were pending; all three provided letters to the district that hired him to be a vice principal. The letters included phrases such as "dependable [and] reliable," "pleasant personality," "high

139. *Id.* at 62.

140. *Id.* at 62-65; see also *Francioni v. Rault*, 518 So. 2d 1175, 1177 (La. Ct. App. 1988) (declining to impose duty to disclose embezzlement history of former employee who later murdered a co-worker).

141. *Kadlec Appeal*, 527 F.3d at 423.

142. *Id.* at 422-23.

143. *Id.* at 423 n.23 (citing *Randi W. v. Muroc Joint Unified Sch. Dist.*, 929 P.2d 582, 592-93 (Cal. 1997)). Other courts have recognized a cause of action for negligent referral. See, e.g., *Fluid Tech., Inc. v. CVJ Axles, Inc.*, 964 P.2d 614, 616 (Colo. App. 1998); *Davis v. Bd. of County Comm'rs of Dona Ana County*, 987 P.2d 1172, 1179 (N.M. Ct. App. 1999). Louisiana has not. See *Louviere*, 839 So. 2d at 62 ("Since there is no Louisiana case finding a set of facts that constitute negligent referral, a logical argument can be made that Louisiana law does not recognize such a cause of action.").

standards,” and “relates well to the students.”¹⁴⁴ The California Supreme Court characterized these as “misleading half-truths.”¹⁴⁵

With a nod to *Tarasoff v. Regents of the University of California*,¹⁴⁶ the *Randi W.* Court noted that the plaintiff had *not* alleged a duty of care based on a “special relationship” between the parties.¹⁴⁷ The Court restated the general rule that “ordinarily a recommending employer should not be held accountable to third persons for failing to disclose negative information regarding a former employee.”¹⁴⁸ “[N]onetheless liability may be imposed if, as alleged here, the recommendation letter amounts to an *affirmative misrepresentation* presenting a foreseeable and substantial risk of physical harm to a third person.”¹⁴⁹ In dicta, the Court suggests that the school districts could have avoided liability by “merely verifying basic employment dates and details.”¹⁵⁰

That, of course, was precisely Lakeview Medical’s argument: it should not be liable for merely listing the dates during which Dr. Berry had anesthesia privileges, which is standard business practice, partly driven by fear of defamation liability.¹⁵¹ The Fifth Circuit recognized this policy concern.

As a general policy matter, even if an employer believes that its disclosure is protected because of the truth of the matter communicated, it would be burdensome to impose a duty on employers, upon receipt of a employment referral request, to investigate whether

144. *Randi W.*, 929 P.2d at 585, 592 (first alteration in original).

145. *Id.* at 592.

146. 551 P.2d 334, 342-43 (Cal. 1976) (finding the requisite “special relationship” supporting a duty to warn).

147. *Randi W.*, 929 P.2d at 588. Note that in *Randi W.* the plaintiff was not the school district that received the misleading references; it was the girl who was injured by the employee. *Id.* at 585. Kimberly Jones’s family did not sue Lakeview Medical, LAA, or any of the doctors in Louisiana. *Kadlec Med. Ctr. V. Lakeview Anesthesia Assocs.*, No. Civ.A. 04-0997, 2005 WL 1309153 (E.D. La. May 19, 2005), *aff’d in part, rev’d in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

148. *Randi W.*, 929 P.2d at 584.

149. *Id.*

150. *Id.* at 589.

151. *Kadlec*, 2005 WL 1309153, at *1, *6. See generally John Ashby, Note, *Employment References: Should Employers Have an Affirmative Duty to Report Employee Misconduct to Inquiring Prospective Employers?*, 46 ARIZ. L. REV. 117 (2004) (describing cases and arguing that there should not be an affirmative duty to warn of violent or sexual misconduct).

the negative information it has about an employee fits within the courts' description of *which* negative information must be disclosed to the future employer.¹⁵²

The court also acknowledged concerns about protecting employee privacy.¹⁵³

These concerns are phrased as relating to general business practices and general employment contexts, and do not specifically focus, as the district court did, on whether the relationship between hospitals in the privileging context is of a character that warrants imposition of an affirmative disclosure duty. The Fifth Circuit did stress that the protection of patients is a compelling policy concern.¹⁵⁴ It noted that the Louisiana legislature in 2007 enacted legislation requiring "health care entities to 'report . . . adverse action against a health care professional due to impairment or possible impairment.'" ¹⁵⁵

Ultimately, though, the Fifth Circuit held that Lakeview Medical "did not have a fiduciary or contractual duty to disclose what it knew to Kadlec" and that the Louisiana courts would not venture into uncharted territory by finding a "special relationship" mandating disclosure, particularly in light of the burden doing so would impose on employers.¹⁵⁶

III. TRENDS IN LEGAL THEORY, INSTITUTIONAL LIABILITY, AND HOSPITAL PRACTICE POINT TOWARDS AN EXPANDED DISCLOSURE DUTY

A. *An Empirical, Patient-Centered Theoretical Framework*

The *Kadlec* case presents a opportunity to consider practical application of an emerging health law framework. In 2005, leading health law scholars gathered to "rethink health law's paradigms," ¹⁵⁷ to consider what is distinctive about health care and how that distinctiveness translates into legal theory.

152. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 422 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

153. *Id.*

154. *Id.*

155. *Id.* (quoting LA. REV. STAT. ANN. § 37:1745.14 (2007)).

156. *Id.* at 421-22.

157. Mark A. Hall, Carl E. Schneider & Lois Shepherd, *Introduction: Rethinking Health Law*, 41 WAKE FOREST L. REV. 341, 342 (2006).

One theme that emerges prominently from the resultant law review articles is the value of a patient-centered empiricism. This patient-centric framework both considers the distinctive features of treatment relationships and also acknowledges the complex and sometimes contradictory nature of the existing web of health law.

Professor Mark Hall posits that a central purpose of health care law is to improve the lives of patients. With this perspective as a focus, the law should be led to acknowledge and accommodate certain essential features of health care delivery including the experience of being a patient, the vulnerability in that role, the professionalism of the providers, and the high stakes of medical care. "Medical law is about the delivery of an extremely important, very expensive, and highly specialized professional service provided in situations of tremendous personal vulnerability."¹⁵⁸ This analytical framework "views health care law as a law of relational webs [with patients at the center] rather than a law of transactions" and is offered as an "antidote[]" to basing medical law and regulation on individual rights or undiluted market theory."¹⁵⁹ Under this framework, automatic application of doctrines from other areas of law is not necessarily appropriate.

Applying this framework to credentialing recognizes that the process by which physicians are considered for hospital privileges is one of the primary means by which hospitals promote safe and high-quality patient care. As the Joint Commission notes, "[d]etermining the competency of practitioners to provide high quality, safe patient care is one of the most important and difficult decisions an organization must make."¹⁶⁰ The process is uniquely dependent on complete information from other hospitals and physicians because of the highly specialized nature of the information, and because of the stakes involved in the treatment relationship. Although they are likely to be unaffiliated businesses, in the credentialing process hospitals are part of a relational web that aims to ensure high-quality patient care.

158. Hall, *supra* note 13, at 358.

159. *Id.* at 359, 60 (quoting Mark A. Hall & Carl E. Schneider, *Where Is the "There" in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 103 (2004)).

160. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 35, at MS.4.00 (Medical Staff Standard Overview).

As a practical matter, hospitals need to interact with each other in the credentialing process. They need to request information from other hospitals to satisfy Joint Commission requirement, state law, and internal bylaw requirements. Of course, whether they need to respond to requests is a different question. The *Kadlec* district court is certainly correct in stating that a facility which refused as a matter of policy to respond to any credentialing inquiries would likely encounter significant difficulty getting its own inquiries answered and thus difficulty retaining physicians.¹⁶¹ (It also might be violating a state law.¹⁶²) Simply failing to respond to an inquiry regarding one physician might not have the same facility-wide practical impact. It would, however, raise questions at the inquiring hospital and should prevent the credentialing of that physician. In one reported case, a physician sued his prior hospital for failing to respond to a credentialing inquiry and thus preventing a grant of privileges. The court held that the prior hospital had no duty to respond (and reveal that the physician's privileges had been terminated there because of patient care issues) without a release from the physician.¹⁶³

Allowing hospitals to evade disclosure of a physician's serious problems by citing "standard business practice" ignores essential features of health care delivery. Hospitals are not standard businesses; physicians are not generic service providers. Hospitals are uniquely dependent upon the professionalism of physicians who are often not employees and who provide care in situations involving trust and vulnerability. Given the intricacies of physician-hospital relationships it is possible, as happened at Lakeview Medical, for the actions by an outside entity to obviate the need for formal action on the hospital's part. After LAA fired Dr. Berry, Lakeview Medical did not need to take any explicit privileging action to ensure that he would not practice at its facility.

Physician credentialing is the first line of protection for pa-

161. See *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A. 04-0997, 2005 WL 1309153, at *6 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

162. See, e.g., WASH. REV. CODE ANN. § 70.41.230 (West 2002) (hospital or facility that receives request for information as part of the credentialing or privileging process shall respond; immunity provided for good faith release of information).

163. *Chalal v. Nw. Med. Ctr., Inc.*, 147 F. Supp. 2d 1160, 1168-69, 1177-78 (N.D. Ala. 2000), *aff'd without opinion*, 250 F.3d 749 (11th Cir. 2001).

tient safety, and applying this emerging theoretical framework (apart from the particulars of any state's laws) it seems appropriate to recognize that responding to credentialing inquiries hospitals are in a "special relationship" that requires a greater duty of candor than might be required in other transactional settings.¹⁶⁴ Is health care, though, truly unique in this type of legal context? Are there other relationships characterized by a high degree of trust and vulnerability in which a duty of greater candor might be warranted? The care of children would seem to be such a relationship warranting affirmative disclosure about a former employee's history of sexual misconduct. The California Supreme Court decision in *Randi W.*, discussed above, did not explicitly reach the "special relationship" question (which was not raised by the plaintiff), but found that the prior employers "misleading half-truths" in reference letters constituted affirmative misrepresentations that made the former employers potentially liable to the sexual assault victim.¹⁶⁵ Certainly the *Randi W.* court's analysis of the misleading nature of the letter was informed by the grade-school context of the employment.

A patient-centered empiricism also would attend more closely to how law and public policy initiatives actually impact patients.¹⁶⁶ In his wide-ranging Wake Forest essay, Professor Timothy Jost describes the complicated, sometimes contradictory hodgepodge of laws that govern our health care system, and argues for a "unified and coordinated framework of health care law based on a coherent and evidence-based understanding of the problems that plague our health care system."¹⁶⁷ Among these problems is a lack of uniformly high-

164. This recognition has echoes of the *Tarasoff* doctrine. In *Tarasoff v. Regents of the University of California*, the California Supreme Court considered the general "no duty to warn" rule in the context of a psychotherapist's failure to warn Tatiana Tarasoff or her parents that his patient had told him he was going to kill an unnamed girl "readily identifiable" as Tarasoff when she returned from vacation. 551 P.2d 334, 341 (Cal. 1976). "[T]he courts have carved out an exception to this rule [of no duty to warn] in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct." *Id.* at 343. The court held that "the relationship between a therapist and his patient satisfies this requirement." *Id.*

165. *Randi W. v. Muroc Joint Unified Sch. Dist.*, 929 P.2d 582, 592-93 (Cal. 1997).

166. Defining these types of impacts is a focus of the emerging field of empirical health law. See Michelle M. Mello & Kathryn Zeiler, *Empirical Health Law Scholarship: The State of the Field*, 96 GEO. L.J. 649, 679-81 (2008).

167. Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on*

quality care, in spite of the expanding reach of medical malpractice litigation through theories of corporate negligence and vicarious liability, the requirements of state licensure, Joint Commission accreditation standards, NPDB reporting, and myriad other quality-related legal efforts.¹⁶⁸ “Despite the fact that quality is the oldest health care policy concern of the law, it remains the one that we are least able to address.”¹⁶⁹

The *Kadlec* case provides an example of how serious quality issues can remain unaddressed despite laws meant to require action. HCQIA’s reporting and querying requirements coupled with its peer review protections were intended to result in an increase in safe, high-quality medical care for patients. Doctors would refer colleagues whose practice fell below standard, peer review committees would fairly and objectively review the evidence, privileges would be appropriately limited or revoked, the state licensing authority would be notified, and a report would be sent to the NPDB. After all this, another hospital would not subsequently credential a physician unawares. That is how this professional self-regulation, bolstered by the law, was supposed to happen.

It turns out, though, that what might be more likely to happen is no referral, no review, no notification, no report, but rather, as described by Atul Gawande, M.D., “a Terribly Quiet Chat.”¹⁷⁰ Interpersonal professional dynamics coupled with the high consequences of an adverse privileging action and consequent NPDB report and licensing board referral can lead to inaction, or action that does not trigger a report. A doctor or a group might take a colleague aside and ask if something is wrong or suggest he brush up on skills. Collegiality is maintained; the potential consequences of a peer review action are avoided; the difficulties of suggesting a colleague might have addiction or emotional problems are side-stepped. The problem of incompetent practice, however, can then go unremedied. A 2007 study published in the *Annals of Internal Medicine* found that with regard to reporting medical incompetence and mistakes by peers, there is a disconnect between

Health Law and Policy, 41 WAKE FOREST L. REV. 537, 539 (2006).

168. *Id.* at 569-72.

169. *Id.* at 596.

170. ATUL GAWANDE, COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE 94-96 (2002) (citing the work of sociologist Marilynn Rosenthal).

what many physicians say they think is the right thing to do and what they actually do.¹⁷¹

Although close to one hundred percent of the 1662 physicians who responded to the survey agreed that physicians should report incompetent or impaired colleagues to relevant authorities, nearly half of the doctors who had direct knowledge of impaired or incompetent colleagues in their practice or who knew of a serious medical error did not make a report through official channels.¹⁷² Other studies have similarly shown significant underreporting to the NPDB, and actions—such as twenty-nine day privilege suspensions—that fall just below the reporting trigger.¹⁷³

With regards to Dr. Berry's time in Louisiana, there was no peer review, no privilege revocation, no program referral, no NPDB Report. There were, however, serious concerns, both at the hospital and within the practice group about whether he was diverting medications for his own use and about his competency to practice.¹⁷⁴ While the meeting in the CEO's office and the ninety day action plan are more than a Terribly Quiet Chat, Lakeview Medical seems not to have taken any further action.¹⁷⁵

One issue that was raised, though not decided in the Kadlec case, was whether Lakeview Medical violated its obligation to report to the NPDB or the Louisiana authorities. Kadlec argued that the action plan constituted a reportable limitation on privileges and that the facility had a legal obligation to report Dr. Berry's impaired practice to the Louisiana physician licensing board; Lakeview Medical disagreed. The Fifth Circuit affirmed the district court's holding that "any duty the law imposes does not reach [Kadlec]."¹⁷⁶ Of course, in a differently pled case involving different state laws, a negligence cause of action based on failure to report might fare differently, par-

171. Eric Campbell et al., *Professionalism in Medicine: Results of a National Survey of Physicians*, 147 ANNALS INTERNAL MED. 795 (2007).

172. *Id.* at 797-99.

173. See Scheutzow, *supra* note 46, at 57 (study analyzing information from the NPDB suggests underreporting of adverse peer review actions to both the NPDB and the states).

174. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.* (*Kadlec Appeal*), 527 F.3d 412, 415 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

175. *See id.*

176. *Id.* at 427.

ticularly if the patient were a party.¹⁷⁷

Lakeview Medical's credentialing letter could truthfully state that Dr. Berry held anesthesia privileges for several months after he had to stop practicing there, although certainly many people (including the head of the anesthesiology department and the CEO) knew he had been terminated from LAA and why. Keeping the information out of the credentialing file allowed plausible deniability in responses to other hospitals' inquiries, but allowed Dr. Berry's problems to become those of the next hospital.

If there were liability for passing the buck in this type of situation, hospitals might be encouraged to address potential problems at an early stage. Even if they avoid the legal requirements for a HCQIA report, they might have to comply with the spirit and expectation of that law in response to a credentialing inquiry. That fact alone might prompt real, effective efforts to address competency problems—by program referral or required additional training or privilege restrictions—even if those efforts were not reportable to the NPDB. It might also encourage impaired physicians to seek help, knowing that once their problems were known, it would be difficult for them to simply move elsewhere without seeking treatment for their impairment.

This does not address the question of an individual physician's obligation in responding to credentialing inquiries. Under the Joint Commission standards, in undertaking a credentialing review, the medical staff is to consider information provided by peers.¹⁷⁸ Individual physicians or physician groups, however, do not have as strong a practical need to respond to credentialing inquiries as do hospitals. Furthermore, the *Kadlec* case itself may discourage physicians from individually writing credentialing letters for less than stellar colleagues out of fear of litigation if not liability. The *Kadlec* jury found the LAA physicians twenty-five percent responsible for

177. See *infra* notes 224-30 and accompanying text (regarding *Estate of Fazaldin v. Englewood Hosp. & Med. Ctr.*, No. L-3572-02, 2007 WL 2126832 (N.J. Super. Ct. App. Div. July 26, 2007) (pending case brought by patient's estate alleging prior hospital liable for failing to disclose problems with surgeon to NPDB, state authorities, and to hospital in credentialing letter)).

178. See JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 35, at MS.4.70.

the \$8.2 million damages;¹⁷⁹ that amount is almost certainly not covered by their malpractice insurance. (In addition, the LAA physicians' actual damages might ultimately be higher. Having reversed the judgment against Lakeview Medical, the Fifth Circuit remanded the case to determine whether a redetermination of damages is required.¹⁸⁰)

The district court judge noted in his closing remarks to the jury that Dr. Dennis had testified he may never write another letter of recommendation again.¹⁸¹ While hospitals may have the same fear of litigation and liability, they do not have the same practical ability to forgo comment given their own need to credential physicians. In addition, physicians designate their physician-referrals, which arguably allows more selectivity than would be the case with a list of hospitals where privileges have been granted.¹⁸²

Adoption—by subsequent case, by statute, or by private regulation—of a “Kadlec duty” might, of course, add to the uncoordinated hodgepodge of sometimes contradictory health care laws that Professor Jost rightly criticizes. A federal statutory adoption or incorporation into Joint Commission accreditation standards would increase uniformity, but would still be another patch on a patchwork legal framework.

A requirement of greater candor will certainly complicate the practical steps required to respond to credentialing letters. Professors Jost and Hall rightly urge attention to the actual impact and consequences of health law proposals. If credentialing questionnaires are to be answered and information beyond bare privileges held and dates of service are to be provided, more work will be required of staff physicians and hospital personnel. As described in the next sections, however, for legal and policy reasons, they are already doing more work in the quality monitoring area. Greater attention to credentialing letters is not a big leap given hospitals' increasing respon-

179. *Kadlec Appeal*, 527 F.3d at 418.

180. *Id.* at 427.

181. Transcript of Record at 1959, *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997-“I”, 2006 WL 6030548 (E.D. La. May 26, 2006).

182. Of course, physicians applying for privileges can wrongfully fail to list on their applications hospitals that they do not want contacted. If there were no NPDB report from that hospital, the credentialing hospital might never learn about serious problems that may have occurred there. The requirements of NPDB reporting and querying were meant to prevent this sort of “leaving under the cover of darkness,” but clearly there are holes in the system.

sibility for quality monitoring and improvement.

B. An Increase in Institutional Liability for Physician Negligence

Under a variety of legal theories, hospitals are now more likely to be found liable for actions of non-employee physicians than in the past.¹⁸³ Historically, hospitals were shielded from liability for the negligent actions of physicians. Nineteenth and early twentieth century hospitals—predominantly organized as charities with a high percentage of nonpaying patients—were generally protected by the charitable immunity doctrine.¹⁸⁴ In addition, physicians were typically not employees of hospitals, and even if they were the courts generally viewed them as more akin to independent professionals whose negligence was not attributable to an employer that did not undertake to monitor or direct care, but merely served as a passive charity providing the “physician’s workshop.”¹⁸⁵

Hospitals were also shielded by the “captain of the ship” and “borrowed servant” doctrines. Even if an operating room nurse or operating room policy was the primary cause of negligence during surgery, for example, the surgeon would be liable as “the captain of the ship” who was in charge of the “borrowed servants” of the hospital.¹⁸⁶ The charitable immu-

183. FURROW ET AL., *supra* note 33, at 414-62; ROSENBLATT ET AL., *supra* note 34, at 914-34.

184. See *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 92 (N.Y. 1914). Describing the hospital at issue in this case, Justice Cardozo writes for the court: “It has no capital stock; it does not distribute profits; and its physicians and surgeons, both the visiting and the resident staff, serve it without pay. Those who seek it in search of health are charged nothing if they are needy, either for board or for treatment. The well-to-do are required by its by-laws to pay \$7 a week for board, an amount insufficient to cover the per capita cost of maintenance. Whatever income is thus received is added to the income derived from the hospital’s foundation, and helps to make it possible for the work to go on. The purpose is not profit, but charity, and the incidental revenue does not change the defendant’s standing as a charitable institution.” *Id.* at 92-93. A number of factors account for the shift away from this classic charity model, not the least of which were the increasing costs of hospital care, the heightened medical value of hospitalization, and the widespread availability of employer-provided health insurance as well as the Medicare and Medicaid programs (which transformed many charity or near charity patients into paying patients).

185. *Id.* at 94 (“[A]dministrative staff of the hospital . . . gave to the operating surgeons the facilities of the surgical ward. . . . The wrong was not that of the hospital [in allowing surgery without consent]; it was that of the physicians, who were not the defendant’s servants, but were pursuing an independent calling, a profession sanctioned by a solemn oath, and safeguarded by stringent penalties. . . . There is no distinction in that respect between the visiting and the resident physicians.”).

186. Stephen H. Price, *The Sinking of the “Captain of the Ship”: Reexamining the Vicarious Liability of an Operating Surgeon for the Negligence of Assisting Hospital Personnel*, 10 J. LEG. MED.

nity, independent professional, captain of the ship, and borrowed servant doctrines have largely disappeared in this context, opening up the possibility of hospital liability for its own negligence and for that of its employees. Despite the lingering and uncertain applicability of the corporate practice of medicine doctrine in some states, hospitals are increasingly likely to employ physicians, particularly in the new specialty of hospitalist.¹⁸⁷

More importantly for the purposes of hospital liability, courts have recognized institutional responsibility for the negligent actions of non-employee physicians under a variety of theories. These include that the negligent physician was an "ostensible agent" of the hospital, or was fulfilling an "inherent function" or "nondelegable duty" of the hospital.¹⁸⁸ These theories of vicarious liability are more likely to attach where the physician is of an in-hospital specialty, such as emergency medicine or anesthesia, and not selected by the patient.¹⁸⁹ Recall that the superior court in the underlying medical malpractice case involving Kimberly Jones ruled that although Dr. Berry was an independent contractor and not a Kadlec employee, he functioned as an apparent agent of the hospital and Kadlec could be liable for his negligence under a vicarious liability theory.¹⁹⁰

In addition, many state courts have recognized a cause of action for corporate negligence based on negligent credentialing. This theory posits that hospitals owe a duty to their patients to appropriately monitor the quality of care provided by their staff physicians, employed or not, and to grant privileges only

323, 326-28, 330-39 (1989); see also *Schloendorff*, 105 N.E. at 132 ("[I]n treating a patient [nurses] are not acting as the servants of the hospital . . . nurses are employed to carry out the orders of the physicians, to whose authority they are subject.").

187. *AM. MED. ASS'N, PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE U.S.* v, xix-xx, 311 (2007); see also *FURROW ET AL.*, *supra* note 33. In most states the corporate practice of medicine doctrine is the product of antiquated, rarely enforced case law. It prohibits corporations from providing professional medical services on the theory that only a human being can sustain the education, training, and character screening necessary to receive a license. Even in those jurisdictions that continue to recognize the doctrine, however, licensed hospitals are typically exempted. See, e.g., *Berlin v. Sarah Bush Lincoln Health Ctr.*, 688 N.E.2d 106, 107, 114 (Ill. 1997); *FURROW ET AL.*, *supra* note 33.

188. *FURROW ET AL.*, *supra* note 33, at 414-36.

189. *Id.*

190. See *supra* note 26 and accompanying text.

to qualified practitioners.¹⁹¹ Illinois was the first to recognize this cause of action;¹⁹² at least one state, Kansas, has rejected it;¹⁹³ Minnesota became, in 2007, the most recent to reject it.¹⁹⁴ At least twenty-seven states, not including Louisiana, recognize the common law tort of negligent credentialing, and three other states recognize the broader theory of corporate negligence.¹⁹⁵

As the Minnesota Supreme Court explained, the states that have recognized the tort rely on a variety of rationales, from "the broad application of common law principles of negligence" to "negligent selection of independent contractors."¹⁹⁶ The Washington State Supreme Court in *Pedroza v. Bryant* reasoned that "[t]he hospital's role is no longer limited to the furnishing of physical facilities and equipment" and that it "is in a superior position to monitor and control physician performance," particularly given the mandates of the Joint Commission, state regulation, and staff bylaws.¹⁹⁷ The court took note of evidence that most medical malpractice claims arise in hospitals and reasoned that "[f]orcing hospitals to assume responsibility for their corporate negligence may also provide those hospitals a financial incentive to insure the competency of their medical staffs."¹⁹⁸

191. See generally, Mark E. Milsop, Comment, *Corporate Negligence: Defining the Duty Owed by Hospitals to Their Patients*, 30 DUQ. L. REV. 639 (1992) (analyzing the development and future application of the doctrine in Pennsylvania); Steven R. Weeks, Comment, *Hospital Liability: The Emerging Trend of Corporate Negligence*, 28 IDAHO L. REV. 441 (1992) (discussing the development of the doctrine in various jurisdictions and arguing for adoption of the doctrine by the Idaho Supreme Court).

192. *Darling v. Charleston Hosp.*, 211 N.E.2d 253, 257-58 (Ill. 1965).

193. *McVay v. Rich*, 874 P.2d 641, 645-46 (Kan. 1994) (holding that state statutes bar claim against hospital for negligence of non-employee physician).

194. *Larson v. Wasemiller*, 738 N.W.2d 300, 309-10 (Minn. 2007) (recognizing the tort of negligent credentialing while acknowledging that the state's peer review statutes present some obstacles to both proving and defending such a case).

195. *Id.* at 306-07 (listing cases from other states). Louisiana is not among the states listed in this opinion as having recognized or rejected negligent credentialing or corporate negligence as a cause of action. The question seems not to have been squarely addressed in Louisiana. See, e.g., *Bickham v. Inphynet, Inc.*, 899 So. 2d 15, 17 (La. Ct. App. 2004) (alleged negligent credentialing not within scope of state's Medical Malpractice Act, which was amended after this case arose).

196. *Larson*, 738 N.W.2d at 307-09.

197. *Pedroza v. Bryant*, 677 P.2d 166, 169 (Wash. 1984) (quoting *Moore v. Board of Trustees*, 495 P.2d 605, 608 (Nev. 1972)).

198. *Pedroza*, 677 P.2d at 169.

C. *A Greater Focus on Systemic Quality Improvement in Hospitals*

Tracking this legal trend, in the past decade hospitals have been a focus of multifaceted efforts to reduce errors and increase quality. This patient safety movement was spurred, certainly, by studies in the 1990s suggesting that a high number of preventable medical errors occur in the United States, resulting in perhaps as many as 44,000 - 98,000 unnecessary deaths per year.¹⁹⁹ The reports—particularly the Institute of Medicine's *To Err Is Human*,²⁰⁰ published in 2000—and public concern have inspired new federal and state legislation and regulation.

These legal mandates will require, in the coming years, the collection and dissemination of increasing amounts of quality-related data. For example, the federal Patient Safety and Quality Improvement Act of 2005 aims to improve patient safety by encouraging voluntary and confidential reporting of adverse events and by establishing Patient Safety Organizations to analyze and aggregate the provided information.²⁰¹ As authorized by this law, the federal Agency for Healthcare Research and Quality in February 2008 published a proposed rule to establish a process by which medical errors can be reported without fear of liability based on the reports.²⁰²

In a similar vein, under Medicare rules that went into effect in late 2008, the Medicare program will no longer reimburse hospitals for certain arguably preventable errors.²⁰³ Thus, for example, if a sponge were retained after surgery, the hospital will not be reimbursed for the surgery to retrieve it. These rules do not apply to physician reimbursement under Medicare. A primary rationale for the new reimbursement rule is that hospitals are well-placed to impact the quality of care provided within their walls, and that the possibility of denied reimbursement will add additional incentives to adopt policies that will catch or prevent errors.

199. INST. OF MED., *supra* note 20.

200. *Id.*

201. Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424; *see also* Public Health Service Act, 42 U.S.C. § 299 (2000).

202. Patient Safety and Quality Improvement, 73 Fed. Reg. 8112 (proposed Feb. 12, 2008).

203. Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, 73 Fed. Reg. 48,433, 48,490-91 (Aug. 19, 2008) (to be codified at 42 C.F.R. pts. 411, 412, 413, 422, 489).

Many of the recent efforts at improving quality have focused on instituting in hospitals evidence-based best practices, and learning from the aviation industry's use of system redundancies, study of "near misses," ongoing quality monitoring, and blame-free reporting. This focus underlies the Institute for Healthcare Improvement's "100k Lives" and "5 million Lives" campaigns, which involved hospitals throughout the country in adopting specific practices.²⁰⁴ An assumption behind blame-free reporting and the study of "near misses" is that mistakes will happen and that systems should be put into place to address this inevitability. As the ground-breaking study is titled: *To Err Is Human*.²⁰⁵

Thus, tracking the successful "aviation model," it is best to acknowledge mistakes promptly, study them, avoid focusing on blame, resist the assumption that more training is always the solution, and try to institute systems that will catch errors before they cause problems.²⁰⁶ This perspective theorizes that a root cause analysis of a preventable medical error is likely to uncover more than one "cause." The delivery of much medical care is complicated, involving many people, medications, and machines. There are many opportunities for error, and many opportunities to catch, prevent, and correct errors before they do harm.

It is a challenge, of course, to implement blame-free reporting in a context where, despite recognition of system-wide responsibility and the inevitability of mistakes, an individual physician can be to blame for a bad outcome and can individually suffer privilege revocation, loss of licensure, malpractice litigation, monetary damages, and loss of livelihood. While hospitals have an increasing duty, in law and in practice, to their patients, they need to also attend to physicians' rights to fair process. A negative privileging action or negative credentialing response can have profound implications for a physician's career.

While focusing on systems improvement, the *To Err Is Human* report recognizes the challenges of addressing unsafe in-

204. See, e.g., Inst. for Healthcare Improvement, Campaign, <http://www.ihi.org/IHI/Programs/Campaign> (quality improvement campaigns directed at hospital practices) (last visited May 2, 2008).

205. INST. OF MED., *supra* note 20, at 14.

206. *Id.* at 155-82.

dividual behavior. “[S]ome individuals may be incompetent, impaired, uncaring, or may even have criminal intent. Although these represent a small proportion of health care workers, they are unlikely to be amenable to the kinds of approaches described in detail in this chapter.”²⁰⁷ The report notes that historically the health system has not had a way of handling these situations in a timely and effective manner, and expresses the hope that good safety systems and monitoring will lead to early identification that heads off serious threats to patient safety. Furthermore, the report argues that “health care organizations should use and rely on proficiency-based credentialing and privileging to identify, retrain, remove, or redirect physicians [and others] who cannot competently perform their responsibilities.”²⁰⁸

These theories underlie the Joint Commission’s recently revised physician review standards.²⁰⁹ An aim of the revisions is to make the credentialing and privileging processes more evidence-based and less episodic. The revisions introduce three new concepts into the required processes. First, to assure a more comprehensive evaluation of a physician’s practice, the review process should specifically evaluate six areas of general competencies. These six are: patient care; medical/clinical knowledge; practice-based learning and improvement; interpersonal and communications skills; professionalism; and systems-based practices. This requirement of arguably more intensive credentialing went into effect January 1, 2007.²¹⁰

Second, accredited hospitals are expected to implement processes for a “focused professional evaluation” if a physician has the credentials to suggest competence but additional information is needed or if questions arise regarding a physi-

207. *Id.* at 169. Regarding criminal intent, see *infra* note 214.

208. INST. OF MED., *supra* note 20, at 169; see also Lucian L. Leap and John A. Fromson, *Problem Doctors: Is There a System-Level Solution?*, 144 ANNALS OF INTERNAL MED. 107, 114-15 (2006). This article concludes: “Performance failures of one type or another are not uncommon among physicians, posing substantial threats to patient welfare and safety. Few hospitals manage these situations promptly or well. It is time for a national effort to develop better methods for assessing performance and better programs for helping those who are deficient.” *Id.* at 114.

209. See JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 35, at MS.4.00-.70. The Joint Commission, as its name change indicates, accredits more than just hospitals. Its performance review measures are not limited to physicians, but also reach other health care providers. This article, though, focuses on hospitals and physicians.

210. *Id.* at MS.3.20 (Credentialing and Privileging Overview).

cian's practice.²¹¹ Third, rather than relying simply on recertifying every two years, accredited hospitals are expected to have in place systems for "ongoing professional practice evaluation."²¹² With this continuous evaluation, the hope is that hospitals will identify and resolve potential problems at an early stage and will also engage in a more efficient and evidence-based privilege renewal process. Most elements of these requirements also went into effect January 1, 2007, although the shift to these types of evaluations is likely to take a few years.²¹³

These changes will require a great deal of hospitals and their medical staffs. The focused and ongoing professional evaluations will need to be objective, timely, fair, and transparent. There needs to be a process that clearly defines the triggers that indicate the need for further monitoring or evaluation of a particular physician. This could be a single incident or practice trends. Ideally it would occur at an early stage of concern, when the focus can be on improvement of skills rather than on punishment. Whether or not these revised Joint Commission standards achieve their stated ends, they certainly will provide hospitals with a great deal more information about the practice patterns of their staff physicians.

These trends in hospital liability and hospital quality management are mutually reinforcing: hospitals will have both more data on physician practices and also a heightened interest in performing fully informed credentialing. An obligation of greater candor in credentialing responses would link well

211. *Id.* at MS.4.30.

212. *Id.* at MS.4.40.

213. The period of focused professional practice evaluation for all initially requested privileges is explicitly effective January 1, 2008. See *id.* at MS-21 (Elements of Performance for MS.4.30). The Joint Commission has also changed its survey methodology. Hospitals are re-accredited every three years by The Joint Commission based on a "survey." This on-site inspection used to be scheduled in advance and focus significantly on a paper review of hospital policies and patient medical records. The Joint Commission now arrives at hospitals unannounced or on very short notice (during the reaccreditation year) and focuses more on a "tracer" methodology, by which the surveyors pull a selection of medical records and follow those patients' paths through various hospital departments, reviewing relevant policies and procedures and talking to hospital staff along the way. Andrea Hall, *State of the Surveys: 18 Months of Joint Commission Unannounced Visits*, 41 BIOMEDICAL INSTRUMENTATION & TECH. 309, 309-10 (2007); see also Toni C. Smith & Joann M. Popovich, *Using Incident Management Strategies to Guide Preparation for Site Visits/Surveys*, 23 J. NURSING CARE QUALITY 6, 6-7 (2008); Richard E. Thompson, *The Joint Commission Is Coming! The Joint Commission Is Coming! (Accreditation)*, 29 PHYSICIAN EXECUTIVE 38, 38-40 (2003).

with these trends. It would add a further incentive not to pass the buck. It would recognize the reality of underreporting, of avoiding referrals, and of the Terribly Quiet Chat.

D. An Expanded Disclosure Obligation Is Likely and Warranted

While the *Kadlec* case is apparently the first of its type, it is unlikely to be the last.²¹⁴ Given the trend of increasing attention by hospitals to the quality of care delivered within their walls and increasing potential for institutional liability if that care is delivered negligently, it is to be expected that there will be more cases similar to *Kadlec*. Either another hospital will sue over an arguably misleading credentialing letter or a patient will. The lawsuit might include, as did *Kadlec*, an allegation that the first hospital violated its reporting duties under the HCQIA or a state statute and that that failure to report provides a basis for liability in addition to claims relating to an arguably misleading credentialing letter.

In the next case, the arguments *Kadlec* raised might well be successful. A court might find that a similarly perfunctory credentialing response is affirmatively misleading, or that its state laws do support an affirmative duty to disclose based on a "special relationship" between the hospitals, or that a failure to file a report supports a negligence claim. *Kadlec*, a diversity jurisdiction case, was resolved under Louisiana law and with the admonition that a court sitting in diversity jurisdiction is to "apply the law of Louisiana as it currently exists rather than to 'adopt innovative theories of recovery.'"²¹⁵ Other states' laws arguably provide a firmer basis for this type of lawsuit.

214. One hopes that the facts in the *Kadlec* case are extreme and unusual, and that hospitals and physicians would deal with concerning behavior and not merely look to be rid of the problematic physician. Studies, as described earlier, *see supra* Part III.A., however, suggest a hesitancy to address physician performance concerns. *See also* JAMES B. STEWART, BLIND EYE: HOW THE MEDICAL ESTABLISHMENT LET A DOCTOR GET AWAY WITH MURDER (1999) (about Michael Swango, M.D., currently in prison for murdering several patients, and allegations that he fatally injected dozens of patients at several hospitals in the United States and Africa despite repeated concerns about his behavior and a conviction for non-fatally poisoning several colleagues); Michael McCarthy, *US Doctor Pleads Guilty to Murdering Patients*, 356 LANCET 1010, 1010 (2000).

215. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *12 (E.D. La. May 19, 2005) (dismissing strict responsibility misrepresentation claim as having no precedent in Louisiana) (quoting *Mitchell v. Random House, Inc.*, 865 F.2d 664, 672 (5th Cir. 1989)), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

For example, Louisiana has not adopted the theory of negligent credentialing, which has a long history in some states and is a recognized cause of action in most.²¹⁶ In states where prior cases have adopted this cause of action, and thus recognized the unique nature and key function of the credentialing process, a requirement of greater candor in that process seems more likely. Such a requirement would also seem more likely in those states, unlike Louisiana, that have long recognized a cause of action for negligent referrals.²¹⁷ The *Kadlec* court also noted that under Louisiana law, Lakeview Medical had no duty to respond to the credentialing request at all. Some states, such as Washington, do have such a requirement.²¹⁸

In addition, because Louisiana courts "have repudiated the concept of negligence per se," a violation of the HCQIA does not, in itself, establish negligence.²¹⁹ Kadlec Medical Center had argued that the ninety day limitation on Dr. Berry's medication practices (the "Action Plan") should have been reported to the NPDB because it constituted a restriction on his privileges that continued for more than thirty days. The district court did not decide the question. A decision on this point was not necessary for two reasons. First, given Louisiana law, even if it were violated that would not establish negligence.²²⁰ Second, the court held that the HCQIA was intended to protect patients not hospitals, so the statute did not allow recovery by one hospital based on another's violation of the statute.²²¹ The Fifth Circuit agreed that Kadlec's negligence claim rested solely on alleged violations of the HCQIA and Louisiana's diversion of medication regulations.²²² Neither of these, the court held, is explicitly intended to protect hospitals nor

216. See *supra* notes 191-98 and accompanying text.

217. See *supra* note 132.

218. See, e.g., WASH. REV. CODE ANN. § 70.41.230 (West 2002) (hospital or facility that receives request for information as part of the credentialing or privileging process shall respond; immunity provided for good faith release of information).

219. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. 04-0997, 2006 WL 1328872, at *2 (E.D. La. May 9, 2006), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008). The district court here applied a similar analysis to the negligence cause of action based on violation of the Louisiana diversion of medications regulations, finding that it was not intended to protect subsequent hospitals. *Id.* at *4.

220. *Id.* at *2-*4.

221. *Id.*

222. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 426-27 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

their insurers.²²³ Ms. Jones's family was not a party to the lawsuit against Lakeview Medical.

A deceased patient's family is a party to an unreported New Jersey case that alleges negligence based on a failure to notify federal and state authorities. *Estate of Fazaldin v. Englewood Hospital and Medical Center*, which is pending as of late 2008, provides another example of how a hospital's attempts to quietly be rid of a problem physician might rebound, with potential liability for a patient's death.²²⁴ In May, 2000, Phuoc (also known as Kathy) Fazaldin, a fifty-two-year-old woman with cervical cancer, bled to death on the operating table at Englewood Hospital and Medical Center following a radical abdominal hysterectomy that had taken fifteen hours.²²⁵ Ms. Fazaldin's estate sued the surgeon, Robert Stenson, Jr., M.D., and several others, including Beth Israel Medical Center and Allen Jacobs, M.D., its former chief of obstetrics and gynecology. The theory against Beth Israel and Dr. Jacobs was that they had improperly failed to disclose documented concerns that Dr. Stenson's surgeries were often too aggressive and took too long, as well as the fact that he had resigned his privileges at Beth Israel after being told that his academic appointment was being terminated and that his surgical practice would be monitored more closely.²²⁶

Ms. Fazaldin's estate argued disclosures should have been made to the federal NPDB, to the New York medical licensing authorities, and to Englewood Hospital when it sought credentialing information. The trial court precluded the jury from considering Beth Israel's failure to report to the federal and state authorities. The jury did find that "Beth Israel had negligently misrepresented [Dr. Stenson's] record to Englewood Hospital, but that the misrepresentation had not been a

223. *Id.*

224. *Estate of Fazaldin v. Englewood Hosp. & Med. Ctr.*, No. L-3572-02, 2007 WL 2126832, at *1 (N.J. Super. App. Div. July 26, 2007).

225. The parties stipulated that "[Ms.] Fazaldin had an eighty-five percent or greater chance of attaining a complete cure of cancer and a ninety-nine percent chance of surviving the surgery. They also stipulated that Dr. Stenson was negligent in the manner that he performed the surgery and that his negligence was the cause of [Ms.] Fazaldin's death." (It is unclear from the decision if Dr. Stenson joined in this stipulation; he died while the case was pending.) *Id.*

226. *Id.* at *3, *7 (describing letter to Dr. Stenson and complaint's amendment to allege negligence and misrepresentation against Beth Israel and Dr. Jacobs).

proximate cause of [Ms.] Fazaldin's death."²²⁷

The appeals court held that, as a matter of law, Beth Israel had a duty to report under the New York law, which is broader than the NPDB reporting obligation.²²⁸ Thus in 2007 the court remanded the case for an evidentiary hearing into whether a report to the New York licensing authorities would have been forwarded to the NPDB, and thus available to Englewood Hospital when it queried the NPDB.²²⁹

As of this writing, *Fazaldin* has not been fully resolved. Its course to date, however, demonstrates another example of how a "Kadlec duty" case might present. In *Fazaldin*, it was the patient's estate and not the hospital that challenged an arguably misleading letter and an arguable failure to file a mandatory report. Despite the different posture of the cases, the legal and ethical arguments are similar, as is the underlying effort to avoid a report and avoid a negative letter.²³⁰ Drawing on the lessons of *Kadlec* and *Fazaldin*, the next case will probably focus early and clearly on federal and state reporting obligations as well as state law arguments that might create a duty to disclose or support an argument that a perfunctory letter is misleading.

In addition to case law development, it is likely that, following the current legal trend and perhaps prompted by these cases, various statutory and regulatory changes will support

227. *Id.* at *1. The finding of no proximate cause could be related to two different arguments raised at trial. First, Arnold Friedman, M.D., chief of Englewood's ob/gyn department, "testified that even if he had been told that Dr. Stenson [was] fired from his faculty position at Beth Israel, . . . [concerns about] academic deficiencies would have been inconsequential given that Englewood is not an academic hospital." *Id.* at *4. Secondly, Englewood Hospital itself later initiated a peer review based on concerns about overly aggressive and unnecessary surgeries. As Dr. Friedman wrote to Dr. Stenson "you have repeatedly demonstrated exceedingly poor judgment in performing prolonged and overly aggressive procedures on patients whose condition[s] clearly warranted only simple palliation." *Id.* at *6 (quoting from April 12, 1999 letter).

228. *Id.* at *10-12. Whether Beth Israel had an obligation to report Dr. Stenson to the NPDB "is fairly debatable" the court found. *Id.* at *12. In addition, the plaintiffs did not raise the issue until the first day of trial and never made a specific request for the judge to take judicial notice of the alleged non-compliance with the statute. *Id.* at *13.

229. *Estate of Fazaldin v. Englewood Hosp. & Med. Ctr.*, No. L-3572-02, 2007 WL 2126832, at *15 (N.J. Super. App. Div. July 26, 2007).

230. The letter of recommendation was bargained-for as part of Dr. Stenson's agreement to leave Beth Israel. It was agreed that the letter would be accurate and not disparaging. The letter included statements that Dr. Stenson was "an indefatigable worker" who was "extremely conscientious in the care of his patients" and that he was "in good standing" at the time of his departure. *Id.* at *3.

an increased disclosure obligation. In remarks in open court following the jury's verdict in *Kadlec*, Judge Lance Africk expressed "this Court's hope that Congress investigate the health care credentialing process and related matters."²³¹ Indeed, during the pendency of the case, the Louisiana legislature passed the Louisiana Health Care Professional Reporting Act, which expands the duty to report impaired physicians to the state licensing board.²³²

Reporting obligations under the HCQIA could be expanded or clarified. In addition, it is possible that the federal law could be amended to explicitly allow for a hospital to be liable to another if it fails to make a required NPDB report. These certainly would be major, difficult, and controversial changes. Perhaps more likely at the federal level would be changes to the Medicare conditions of participation regulations²³³ to include more specificity regarding the credentialing process. State law could also create a requirement to respond to credentialing inquiries, with regulations to frame the types of queries, and immunity for good faith responses.

In a quasi-regulatory change, the Joint Commission could revise its manual to specifically require hospitals doing credentialing inquiries to submit a standardized questionnaire. The Joint Commission could also require hospitals to respond to that questionnaire. These changes would support the recent revisions to the credentialing and privileging standards.²³⁴ Joint Commission systemization on this point would not only facilitate informed credentialing but would also encourage early attention to physician problems. Given the Joint Commission's reach and its ongoing physician review revision, this seems a more straightforward tack than more complicated federal revisions or less comprehensive state revisions.

It is also possible, now that the precedent has been set of one hospital suing another over a perfunctory letter, that hospital practices will be changed regardless of any widespread legal

231. Transcript of Record, *supra* note 181.

232. The law, which passed in 2007, requires health care entities to report to the appropriate professional licensing board when it "[t]akes an adverse action against a health care professional due to impairment or possible impairment[.]" or when it "[a]ccepts . . . the resignation of employment or a contractual relationship" while an investigation into impairment is underway. LA. REV. STAT. ANN. § 37:1745.14 (2007).

233. 42 C.F.R. § 482.22 (2007).

234. See *supra* Part III.C.

mandate. The Fifth Circuit reversed the judgment against Lakeview Medical, but, as explained in this Article, the court's analysis does not provide a vast safe harbor for hospitals. Liability could certainly be found in a case with slightly different facts, a different procedural posture, and on different state laws. If nothing else, the case warns hospitals that a perfunctory credentialing letter might not be of much value. Hospitals are likely to insist, and rightly so, on receipt of completed questionnaires before proceeding with credentialing.

Furthermore, having gone through a lengthy court case and been admonished in a published opinion that its actions could be considered unethical, Lakeview Medical might change its practices to discourage the sending of perfunctory responses. Given the publicity of the case and the change in Louisiana law regarding reporting of impaired physicians, Lakeview Medical will likely be less hesitant to refer or report an impaired or unqualified physician. Lakeview Medical is part of HCA, Inc., a chain of approximately 180 hospitals, most of them in the United States. Any change adopted by HCA is likely to have significant ripple effects.

Although recognition of an expanded disclosure obligation seems likely, it does present clear challenges in theory and practice. Not the least of these is what to do about the *Poliner* peril. As virtually anyone involved in physician peer review knows, cardiologist Lawrence Poliner, M.D., won an eye-popping \$360 million in damages (later reduced by the judge to \$33 million) after a Texas jury concluded that a Dallas hospital improperly suspended his cardiology privileges.²³⁵ Of the \$360 million, \$90 million were attributable to Dr. Poliner's defamation claims; these claims stemmed partly from the hospital's credentialing responses, which stated that Dr. Poliner's privileges had been suspended.²³⁶ Perhaps the Fifth Circuit had this case in mind when it wrote: "[the *Kadlec* defendants] were also rightly concerned about a possible defamation claim if they communicated negative information about Dr. Berry."²³⁷ The highly publicized *Poliner* case was pending be-

235. *Poliner v. Tex. Health Sys.*, 537 F.3d 368, 369-70, 375 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 1002 (Jan. 21, 2009). Note that this is the same federal appeals court (though a different panel), which had issued its opinion in *Kadlec* two months earlier.

236. *Id.* at 370, 375.

237. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 422

fore a different panel of the Fifth Circuit at the same time as was *Kadlec*; the panels issued their published opinions within a few months of each other.²³⁸

Poliner highlights the challenges of protecting patients with vigorous peer review while protecting physicians with fair processes. Dr. Poliner sued several individual physicians and the hospital for claims arising out of two events. The first was a “voluntary” abeyance of his cardiology privileges in the face of a threat of summary suspension (which, according to the medical staff bylaws at his hospital, could occur when a physician’s conduct “constitutes a present danger to the health of his patients”). The second was a permanent suspension of those privileges (which were later restored following an internal hearing). Dr. Poliner argued that the decisions made in the peer reviews were unsupported by quality concerns and instead driven by personal animus and anticompetitive motives.²³⁹ As to the second peer review action, the district court found that the HCQIA standards had been satisfied and granted summary judgment. As to the first, the court held that there was sufficient evidence for the jury to find that the requirements for HCQIA immunity were not met.²⁴⁰ The district court reduced the damage award to \$33 million and the defendants appealed.

In 2008—ten years after the suspension at issue—the Fifth Circuit reversed the district court, holding that the hospital and peer review participants were entitled to immunity from monetary damages under the HCQIA and the case should have been dismissed.²⁴¹ Applying an objective standard, the court noted that “[n]ot only has Poliner failed to rebut the statutory presumption that the peer review actions were taken in compliance with the statutory standards, the evidence dem-

(5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

238. *Kadlec Appeal* was issued in May 2008, 527 F.3d 412, and *Poliner* in July 2008, 537 F.3d 368.

239. *Poliner v. Tex. Health Sys.*, No. Civ.A.3:00-CV-1007-P, 2003 WL 22255677, at *9 (N.D. Tex. Sept. 30, 2003), *rev’d*, 537 F.3d 368 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 1002 (Jan. 21, 2009).

240. *Poliner v. Tex. Health Sys.*, No. Civ.A.3:00-CV-1007-P, 2006 WL 770425, at *1, *4-*5 (N.D. Tex. March 27, 2006), *rev’d*, 537 F.3d 368 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 1002 (Jan. 21, 2009). Difficulties with the initial suspension included the facts that Dr. Poliner was given little information about the specific concerns, only a few hours to accept the “voluntary” abeyance, and the suggestion that he not consult an attorney. *Id.* at *7.

241. *Poliner*, 537 F.3d at 385.

onstrates that the peer review actions met the statutory requirements.”²⁴² In considering whether the peer reviewers made a reasonable effort to obtain the relevant facts as required by the federal statute, the court noted that Dr. Poliner “was entitled to a reasonable effort, not a perfect effort.”²⁴³ Whether the abeyance violated the hospital’s bylaws was not dispositive because “HCQIA immunity is not coextensive with an individual hospital’s bylaws.”²⁴⁴ Although the Fifth Circuit’s opinion should assuage many concerns about potential liability for peer review actions, the case did drag on for many years, at great cost to all the parties.

Taken together the *Poliner*, *Fazaldin*, and *Kadlec* cases do raise the question of whether a hospital will find itself in a Catch-22: facing a physician’s lawsuit if it discloses too much; facing a patient or hospital’s lawsuit if it discloses too little; and unsure what level of disclosure is just right. The Fifth Circuit is certainly correct that where there is a risk of liability based on failure to affirmatively disclose negative information in a credentialing response letter, it will be burdensome and difficult to figure out what information to release.²⁴⁵ There are very significant, and conflicting, interests and policy considerations at issue when it comes to disclosing unproven adverse information that could both protect future patients and also ruin a physician’s career.

It would seem easier to manage an impaired or unqualified physician’s exit so there is no duty to file a report with federal or state authorities and then to draft a perfunctory letter stating simply the dates privileges were held and the type of privileges. This easier course would significantly limit the risk of a defamation lawsuit from the physician in question.²⁴⁶ This easier course, however, increases the risk of physical harm to future patients and financial harm to other hospitals.

Ultimately, the words of the *Kadlec* district court judge reso-

242. *Id.* at 381, 385 (noting that violation of the bylaws could support an action for injunctive relief rather than monetary damages).

243. *Id.* at 380.

244. *Id.*

245. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs. (Kadlec Appeal)*, 527 F.3d 412, 423 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

246. That risk can be mitigated by requiring complete release from the physician and including that release with credentialing request materials (as *Kadlec Medical Center* did). See *supra* notes 42, 65 and accompanying text.

nate: "Has society become so afraid of lawsuits that we are willing to hide from the truth in matters affecting life and death?"²⁴⁷ The easier course of avoiding disclosure may also be the socially and ethically irresponsible course. As the Fifth Circuit opined, although Lakewood Medical did not violate a legal duty, it might have violated its ethical duty to other hospitals and, more importantly, to patients. The existence of a legal duty or the potential that one might be found in the next case can provide a justification for meeting a hospital's ethical obligation to, in the *Kadlec* district court's formulation, "disclose information related to a doctor's adverse employment history that risks death or permanent injury to future patients."²⁴⁸

It will be a challenge to determine how the law can support laudatory changes in hospital culture, facilitate fair peer review for physicians, and address the needs of the many other actors in the health care arena, all the while keeping as a central focus the improvement of patients' lives. The importance of meeting this challenge is highlighted, though, by the devastating injury unnecessarily suffered by Kimberly Jones. It is supported by the ethical and societal obligation to promote safe medical care, and not just in one's own hospital.

IV. CONCLUSION: THE *KADLEC* CASE AND CONVERGING TRENDS SUPPORT MORE INFORMED CREDENTIALING

Despite the Fifth Circuit's ruling in *Kadlec*, law, theory, and practice are converging to support an expanded hospital disclosure duty. Emerging case and statutory law, legal theory, and hospital practice emphasize the hospital's role in ensuring quality patient care, and focus on the patient as the center of a complicated relational web. A duty of greater candor in credentialing responses is likely to be adopted either in a subsequent case, or by statute, or through Joint Commission standards. Such a requirement addresses limitations in the current legal framework and dovetails with the movement for greater hospital responsibility in quality monitoring. It also resonates

247. Transcript of Record, *supra* note 181.

248. *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, No. Civ.A 04-0997, 2005 WL 1309153, at *7 (E.D. La. May 19, 2005), *aff'd in part, rev'd in part, remanded*, 527 F.3d 412 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 631 (Dec. 1, 2008).

with an emerging health law paradigm that focuses on a patient-centered empiricism and recognizes that distinctive features of health care delivery may require distinctive legal theories.

After the jurors had delivered their verdict in *Kadlec*, Judge Lance Africk addressed them. He said, in part:

Your verdict is important because it will generate discussion about what occurred in this case, why it occurred and what can be done to prevent it from ever happening again. Now that your verdict has been made public, what happened during this credentialing process, whether intentional or negligent, will be publicly debated.

It is this Court's hope that Congress investigate the health care credentialing process and related matters. For example, as a non-expert, it appears to me that there needs to be some uniformity regarding the credentialing process and the questions that must be answered. There must be some way of making certain that relevant information regarding the physician's competence makes it into a file which is accessible to those who need the credentialing information. Kim Jones deserved no less. It is too late for her, but it is not too late for the rest of us.²⁴⁹

249. Transcript of Record, *supra* note 181.