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Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians

Whitney Foster

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I. INTRODUCTION

When a person goes to a hospital seeking medical aid and is harmed during the course of treatment due to someone else's negligence, who is at fault? The answer might be the person who directly caused the harm, such as a physician who amputates the wrong leg. What happens, though, when a hospital's governing body or administrators are aware of the physician's previous acts of incompetence? In addition, what happens when the hospital welcomes a physician to its staff without a thorough background check or without fully ascertaining the doctor's abilities?

In cases where the hospital's thoroughness in hiring and monitoring the skill of its physicians is unclear, plaintiffs may find that a negligent credentialing claim is appropriate. A medical malpractice victim may file a claim of negligent credentialing when the victim of medical malpractice suspects or discovers the offending doctor's prior instances of incompetence or malpractice and brings suit against the hospital that allowed the physician to continue practicing medicine.¹

*Larson v. Wasemiller,*² decided by the Minnesota Supreme Court in 2007, is the latest case to address this issue, continuing a debate that began in 1965 with the Illinois Supreme Court's landmark decision in *Darling v. Charleston Community Memorial Hospital.*³ Many other state courts have considered this issue during the years between *Darling* and *Larson,* basing their decisions on various theories of direct and vicarious liability. Arkansas, however, is not one of those states, and the issue remains one of first impression. This note contends that Arkansas should prepare to address this issue, as a plaintiff will almost certainly assert a negligent credentialing claim at some point in the future. In order to prevent the negligent credentialing of physicians in Arkansas hospitals, the legislature and the Arkansas State Medical Board (ASMB) should thoroughly research this issue to en-

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¹ James W. Gustafson Jr. & Thomas D. Masterson, *Challenging Hospitals That Tolerate Incompetent Doctors,* 39 TRIAL 18, 21 (May 2003). Negligent credentialing "should be reserved for cases in which a hospital unreasonably exposed its patients to harm by granting staff privileges to a physician with a demonstrable history of questionable conduct or inadequate training." *Id.*

² 738 N.W.2d 300 (Minn. 2007). Mary Larson filed suit against Drs. Paul and James Wasemiller after a botched gastric bypass procedure that ultimately required more surgery and a stay at a long-term care facility. *Id.* at 302.

³ 211 N.E.2d 253 (Ill. 1965).
sure that all necessary steps are taken to prevent negligent credentialing from occurring, and the court system should prepare itself to analyze this issue carefully. The background of this note will consider the development of the theory of negligent credentialing, including various theories of liability upon which negligent credentialing may be based, the hiring process of physicians, safeguards put in place to prevent negligent credentialing, and Arkansas’s approach to negligent credentialing. If and when a negligent credentialing case is presented in Arkansas, this note proposes that the Arkansas courts should recognize negligent credentialing as a tort action.

II. BACKGROUND

A hospital’s knowledge of a doctor’s misdeeds from which a negligent credentialing action may arise is almost irrelevant. Under the negligent credentialing theory, a plaintiff may argue either that the hospital knew the physician was incompetent and turned a blind eye, or that the hospital did not know but should have discovered the incompetence during thorough evaluation and re-evaluation procedures.\(^4\) In proving the basic elements of a negligent credentialing claim,\(^5\) a plaintiff must show that:

- [(1)] The hospital had a duty to select and retain competent physicians seeking staff privileges;
- [(2)] The hospital was negligent in granting staff privileges to the physician, by either failing to perform an adequate investigation or simply ignoring facts uncovered by its investigation;
- [(3)] The incompetent physician was negligent in treating the patient and caused his or her injury; and
- [(4)] The incompetent physician’s negligence took place at the hospital.\(^6\)

\(^4\) Gustafson & Masterson, \textit{supra} note 1, at 19–20 (citing Insigna v. LaBella, 543 So. 2d 209, 214 (Fla. 1989); Albain v. Flower Hosp., 553 N.E.2d 1038, 1040 (Ohio 1990), \textit{overruled on other grounds}, Clarke v. Southview Hosp.’s Family Health Ctr., 628 N.E.2d 46 (Ohio 1994)).

\(^5\) Martin C. McWilliams, Jr. & Hamilton E. Russell, III, \textit{Hospital Liability for Torts of Independent Contractor Physicians}, 47 S.C. L. Rev. 431, 467–68 (1996). The plaintiff is required to prove negligence on the part of the hospital in the selecting or supervising process. Particularly where the hospital’s alleged negligence is not active, but constitutes a failure to act, foreseeability of the harm that resulted is required. The hospital’s negligence must also be causally related to the plaintiff’s injury.

\(^6\) Gustafson & Masterson, \textit{supra} note 1, at 19–20 (citing Insigna v. LaBella, 543 So. 2d 209, 214 (Fla. 1989); Albain v. Flower Hosp., 553 N.E.2d 1038, 1040 (Ohio 1990), \textit{over-
In other words, plaintiffs must prove that they "would not have been injured had the hospital taken reasonable care in determining the competence of physicians granted medical staff privileges."\(^7\)

This section begins by discussing how the negligent credentialing claim came about and the theories under which courts uphold the tort. Next, this section covers the process by which potential or current employees are evaluated before they are hired or re-hired. It also discusses the suggestions of state or national agencies and other administrative precautions that hospitals may consider in order to combat negligent credentialing. Finally, this section concludes by detailing Arkansas's current approach to hiring and credentialing physicians.

A. Development of the Theory of Negligent Credentialing

The importance of properly credentialing physicians is obvious: if a hospital does not diligently investigate applicants for privileges, the mistakes made by those physicians will almost always result in legal action against the hospital.\(^8\) A question, however, arises from this statement: under what legal theories would the hospital be liable for the acts of a physician? Unfortunately, there is a "lack of uniformity among courts" addressing the concept of negligent credentialing, giving rise to many different theories of recovery.\(^9\)

1. The Independent Contractor Problem

In order to determine the applicable legal theory in a negligent credentialing case, the roles of both the hospital and the physician must be defined. Some state courts have previously been inclined to adjudge the physician to be an independent contractor—an individual who is allowed to work on a hospital’s premises but over whom it wields no control and, thus, has no liability.\(^10\)

The importance of a physician’s status as an independent contractor hinges on the theory upon which the plaintiff bases his or her case. For in-

ruled on other grounds, Clarke v. Southview Hosp.'s Family Health Ctr., 628 N.E.2d 46 (Ohio 1994)).
9. McWilliams & Russell, supra note 5, at 462.
stance, in *Oehler v. Humana Hospital Sunrise*, the Nevada Supreme Court noted that patients had difficulty pursuing hospitals under a respondeat superior theory because physicians were usually found to be independent contractors. The Arizona Supreme Court, in *Fridena v. Evans*, concluded that while a physician usually falls into the independent contractor category, the true issue in negligent credentialing cases is not the hospital's alleged vicarious liability for the acts of an independent contractor physician—rather, the issue is whether the hospital negligently supervised its independent contractors.

In *Johnson v. Misericordia Community Hospital*, the Wisconsin Supreme Court further eliminated any bearing the independent contractor theory had on negligent credentialing. The *Johnson* court emphasized the physician's status as an independent contractor but pointed out that the physician's status was irrelevant, explaining that the hospital was liable under the duty it owed the plaintiff itself, not for the breach of duty by the physician under the theory of respondeat superior.

In the wake of negligent credentialing suits, hospitals have attempted to clearly define relationships with physicians as principal-independent contractor alliances. One way of creating the appearance of a principal-independent contractor relationship is by drafting a contract between the hospital and physician that stipulates that the physician is not on salary at the hospital and that the hospital "has no right of control over the physician in providing professional services." Despite the general rule that principals

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12. Id. at 350.
13. 622 P.2d 463 (Ariz. 1980). This case arose when Sharon Evans, a fifteen-year-old girl, was injured in a motorcycle accident. Id. at 464. Dr. Fridena performed two surgeries on Sharon; the first was for a leg injury directly related to the accident, and the second was because the first surgery had left one of Sharon's legs shorter than the other. Id. The second surgery increased the discrepancy in length between the two legs to an additional inch and a half. Id. at 465.
14. Id. at 465.
15. 99 Wis. 2d 708 (1981). *Johnson* involved a patient whose orthopedic surgeon left a fragment of a pin in the plaintiff's hip while attempting to remove the pins, which the surgeon inserted during a previous surgery. Id. at 710. During a subsequent surgery to remove the fragment, "the plaintiff's common femoral nerve and artery were damaged, causing a permanent paralytic condition of his right thigh muscles." Id. at 709–10.
16. Id. at 722.
19. Id.
are not liable for independent contractors, several doctrines have been used to circumvent the rule.\textsuperscript{20}

2. The Corporate Liability Approach

An action alleging negligent credentialing under a corporate liability theory is one way of circumventing the physicians-as-independent-contractors problem because this theory allows the hospital—as an institution—to bear the liability.\textsuperscript{21} The theory that the hospital owes a duty to patients reflects the idea that the public looks to the hospital, and not individual physicians, for treatment.\textsuperscript{22} This is particularly true of hospital-based physicians, such as pathologists, anesthesiologists, and emergency room physicians.\textsuperscript{23} The majority of state courts that have addressed this question based their decisions on corporate liability, also referred to as corporate negligence or corporate responsibility.\textsuperscript{24}

The Illinois Supreme Court, in \textit{Darling}, was the first state court to recognize the error of unequivocally viewing physicians as independent contractors.\textsuperscript{25} \textit{Darling} involved a patient with a broken leg that ultimately was amputated below the knee due to the physician’s mistakes when putting on the cast.\textsuperscript{26} The hospital argued that its status as a corporation rendered it incapable of practicing medicine.\textsuperscript{27} The court held that the hospital was not simply the provider of work space for medical personnel, but rather that the hospital assumed certain responsibilities to the patients admitted upon its premises.\textsuperscript{28} The effect of \textit{Darling} was to establish both a direct connection between hospital and patient and the duties that accompany such a relationship.

\begin{footnotes}
\item[20] \textit{Id.} at 438.
\item[21] George E. Newton II, \textit{Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection}, 52 ALA. L. REV. 723, 737–38 (2001). See also Johnson 99 Wis. 2d at 725, ("One of the leading cases introducing the concept that a hospital, as an institution, has a responsibility for the quality of medical care provided by members of its medical staff was \textit{Darling v. Charleston Community Memorial Hospital} . . . ").
\item[22] McWilliams & Russell, supra note 5, at 468.
\item[23] McWilliams & Russell, supra note 5, at 468.
\item[26] \textit{Darling}, 211 N.E.2d at 255. "[T]he plaintiff, who was 18 years old, broke his leg while playing in a college football game." \textit{Id.} at 255–56.
\item[27] \textit{Id.} at 256. See also Dallon, supra note 8, at 619–20.
\item[28] \textit{Id.} at 257. "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact." \textit{Id.}
\end{footnotes}
Many states, including Alaska,29 California,30 Florida,31 Washington,32 and Wisconsin,33 have considered corporate liability in the wake of the Darling decision. In Johnson v. Misericordia Community Hospital,34 the Wisconsin Supreme Court clarified the acts and omissions that would place hospitals at risk for a negligent credentialing claim.35 The plaintiff alleged that the hospital was negligent in the following way:

(a) by being imprudent and careless in [selecting members] . . . of its staff; (b) in allowing [physicians] to perform . . . surgery within its operative facilities when it knew, or should have known, that [the physician] was not qualified to perform such diagnostic and operative procedures; [and] (c) in failing to investigate the abilities and qualities of [the physician's] capabilities . . . when said hospital knew, or should have known, that [the physician] did not possess such proper capability.36

The Johnson court also noted decisions from other jurisdictions and summarized the various holdings as stipulating that a hospital "has a direct and independent responsibility to its patients . . . to take reasonable steps to (1) insure that its medical staff is qualified for the privileges granted and/or (2) to evaluate the care provided."37

Adopting the corporate liability theory, in Strubhart v. Perry Memorial Hospital Trust Authority,38 the Oklahoma Supreme Court imposed a duty of ordinary care, requiring hospitals to "take reasonable measures to ensure patient safety when they are on notice or should be on notice [that] they have granted staff privileges to an incompetent doctor . . . [and this approach] is generally known as corporate negligence or responsibility."39 The Strubhart court stressed that what the hospital knew or should have known of the doctor's conduct was an important factor in deciding cases that applied this theory.40 The court also expressed doubt that the duty created re-

29. See Fletcher v. South Peninsula Hosp., 71 P.3d 833 (Alaska 2003). In Fletcher, a lower court issued summary judgment that dismissed Fletcher's corporate negligence theory for negligent credentialing, and the Alaska Supreme Court reversed and remanded. Id. at 845.
31. See Insigna, 543 So.2d 209. Insigna involved a man who stole a physician's identity and was then issued privileges and credentialed by a Miami hospital. Id. at 210.
34. 99 Wis. 2d 708 (1981).
35. Id. at 710.
36. Id.
37. Id. at 724.
39. Id.
40. Id. at 273.
quired hospitals to review a physician’s work in all cases; rather, the court limited the duty to the use of ordinary care in situations involving (1) the granting of staff privileges only to competent physicians, and (2) the reevaluation of physicians holding privileges when the hospital knows or should know the physician “has engaged in a pattern of incompetent behavior.”

The Minnesota Supreme Court is the most recent state court to address this issue. In *Larson v. Wasemiller,* the court considered the corporate liability approach before recognizing a common law cause of action for negligent credentialing. In doing so, the court determined that Minnesota’s peer review statute implied a cause of action for negligent credentialing because the immunity provisions would be unnecessary if not for the possibility of a negligent credentialing case.

3. Direct Liability

Direct liability is the opposite of vicarious liability—direct liability is liability for harm caused by one’s own actions, but vicarious liability is one entity’s liability for harm caused by the actions of another person or entity. Thus, direct hospital liability is liability for a “breach by the hospital of some duty owed directly to the patient.” Where there are established duties for a hospital, a breach of that direct duty may be easier to prove than the hospital’s vicarious liability for the malpractice of an independent contractor physician. The direct liability of the hospital arises regardless of whether the physician who causes the harm is a hospital employee, an independent contractor, or the patient’s personal physician.

The direct liability aspect of a negligent credentialing claim does not encompass a claim for malpractice against a physician because the hospital did not commit malpractice; instead, the hospital is responsible for its own negligence. For example, if the patient proves that the hospital’s negligence in hiring the physician, whether he or she is an independent contractor or a hospital employee, is a proximate cause of the harm to the patient, the

41. *Id.* at 275–76.
42. 738 N.W.2d 300 (Minn. 2007).
43. *Id.* at 307–08.
44. *Id.* at 302.
46. *Larson,* 738 N.W.2d at 304.
48. *Id.* at 462.
49. *Id.* at 463.
50. *Id.*
51. *Id.* at 464.
patient may bring suit directly against the hospital on a direct liability claim.\textsuperscript{52} There are two types of direct duties at issue in a negligent credentialing claim: either the duty to patients “to exercise care in selecting physicians to practice on the premises” or the duty of care “in renewing staff privileges.”\textsuperscript{53}

4. \textit{Vicarious Liability: Apparent Agency}

Rather than face the independent contractor issue that would negate liability on behalf of the hospital, some state courts that wanted to establish or increase liability for hospitals began considering whether they could do so on the basis of apparent agency,\textsuperscript{54} reasoning that patients viewed hospitals and the physicians who worked in them as two parts of one whole—rather than as independent entities—neither having control over the other.\textsuperscript{55}

In \textit{Shuler v. Tuomey Regional Medical Center Incorporated},\textsuperscript{56} a South Carolina court, using prior South Carolina precedent, determined that there is a three-part test for proving apparent agency.\textsuperscript{57} The plaintiff must prove the following: “(1) that the purported principal consciously or impliedly represented another to be his agent; (2) that there was a reliance upon the representation; and (3) that there was a change of position to the relying party’s detriment.”\textsuperscript{58} In \textit{Shuler}, the court determined that the reliance necessary to prove apparent agency did not exist and found for the hospital.\textsuperscript{59}

5. \textit{Vicarious Liability: The Theory of Non-Delegable Duties}

The doctrine of non-delegable duties is sometimes incorporated into a corporate negligence theory; although the term non-delegable duty has “traditionally been used to describe a form of vicarious liability,” some courts have used the phrase when a hospital’s negligence is proven and has a causal relationship to the patient’s injury.\textsuperscript{60} For example, in \textit{Thompson v. Nason}

\begin{itemize}
\item \textsuperscript{52} \textit{Id.}
\item \textsuperscript{53} McWilliams & Russell, \textit{supra} note 5, at 464–65.
\item \textsuperscript{54} \textit{Id.} at 446. “Decisions holding hospitals liable on the basis of apparent agency date at least from the California Supreme Court’s decision in 1955 in Seneris v. Haas.” \textit{Id.}
\item \textsuperscript{55} Newton, \textit{supra} note 21, at 738. “Consequently, in cases of negligent credentialing, courts will treat the hospital as if it is the ultimate caregiver and hold it responsible for failure to meet its duty to properly credential physicians.” \textit{Id.}
\item \textsuperscript{56} 437 S.E.2d 128 (S.C. Ct. App. 1993).
\item \textsuperscript{57} \textit{Id.} at 129.
\item \textsuperscript{58} \textit{Id.} at 129. \textit{See also}, McWilliams & Russell, \textit{supra} note 5, at 471.
\item \textsuperscript{59} \textit{Shuler}, 437 S.E.2d at 130. \textit{See also} McWilliams & Russell, \textit{supra} note 5, at 471. McWilliams and Russell note that this is a “relatively rigorous application of apparent agency in the hospital context,” but that the holding was consistent with similar Georgia cases. \textit{Id.}
\item \textsuperscript{60} McWilliams & Russell, \textit{supra} note 5, at 468.
\end{itemize}
the Pennsylvania Supreme Court used the phrase, non-delegable duty, to explain that hospitals cannot “escape liability for their own negligence in performing directly owed duties” by leaving the credentialing process to their medical staffs. This admonition, however, illustrates the desire of many courts to address the general public’s growing reliance on the hospital itself as the health care provider. As one commentator put it, “non-delegable duties are those that the employer is not allowed to transfer to another because the responsibility to the community is considered so important.”

A hospital’s non-delegable duties fall into one of four categories:

1. A duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;
2. A duty to select and retain only competent physicians;
3. A duty to oversee all persons who practice medicine within its walls as to patient care; and
4. A duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.

An Alaska negligent credentialing case, Fletcher v. South Peninsula Hospital, addressed the non-delegable duty theory in relation to different services the hospital provides. The plaintiffs in Fletcher alleged that an earlier case implied that hospitals owe patients an absolute, non-delegable duty of care when choosing emergency room physicians. The court held that the previous case applied only to emergency room physicians who were

63. Id. at 470–71.
64. Id. at 453–54.
65. Id. at 462–63.
67. Id. at 838. The court noted the following:
   We did not extend our holding “to situations where the patient is treated by his or her own doctor in an emergency room provided for the convenience of the doctor. Such situations are beyond the scope of the duty assumed by an acute care hospital.” Rather, we limited our holding of vicarious hospital liability “to those situations where a patient comes to the hospital, as an institution, seeking emergency room services and is treated by a physician provided by the hospital.”
   Id.
69. Fletcher, 71 P.3d at 837.
assigned randomly to patients by the hospital and declined to extend the rule to a patient who sought out a specific physician.\textsuperscript{70}

In another case, \textit{Joiner v. Mitchell County Hospital Authority},\textsuperscript{71} the court specified that delegating the screening of physicians applying for staff privileges to the current medical staff does not absolve the hospital of liability as an institution because "these members of the staff are agents of the [hospital] and it is responsible for any default or negligence on its part in properly selecting new members of the staff."\textsuperscript{72} This does not mean that the hospital's governing board may not delegate the duties of investigating and credentialing physicians to a smaller committee formed for such a purpose, but the board must delegate at its own risk, as it will bear the responsibility if its duty to prevent the hiring of incompetent and unqualified physicians is breached.\textsuperscript{73}

6. \textbf{What About Hospital Immunity?}

Depending on its organization and funding, hospitals traditionally enjoyed immunity from suit under the doctrines of charitable immunity or governmental immunity.\textsuperscript{74} Non-profit hospitals enjoy charitable immunity,\textsuperscript{75} and government-operated facilities enjoy governmental immunity.\textsuperscript{76} These immunities are not as absolute as they once were, however,\textsuperscript{77} and plaintiffs may overcome a hospital's claim of immunity, depending upon whether the jurisdiction in which the plaintiff files his or her claim does or does not rec-

\begin{footnotesize}
\begin{enumerate}
\item \textit{Id.} at 845.
\item 186 S.E.2d 307 (1971).
\item \textit{Id.} at 308.
\item Dallon, \textit{supra} note 8, at 617. \textit{See also} McWilliams & Russell, \textit{supra} note 5, at 434.
\item McWilliams & Russell, \textit{supra} note 5, at 434–35. There is a public policy "favoring charity and charitable hospitals, reflecting the view that by benefiting such public-purpose institutions, the public as a whole was benefited. Charity hospitals were accordingly granted the public subsidy of immunity." \textit{Id.}
\item Dallon, \textit{supra} note 8, at 617.
\item \textit{Id.}
\item By the 1940s . . . courts began to explicitly reject the charitable immunity doctrine, rendering hospitals liable for their own negligent acts and the negligent acts of their employees . . . . Charitable immunity was, after all, an exception to the general rule that entities are liable for their own actions and the acts of their employees committed within the scope of the employees' employment. The protection of governmental immunity is applicable, if at all, only to federal, state, county, or municipal hospitals. This immunity persists, but, as with charitable immunity, the doctrine has substantially eroded. \textit{Id.} at 617–18.
\end{enumerate}
\end{footnotesize}
ognize charitable immunity.  

Darling also dismissed the idea that a charitable corporation such as a hospital could effectively limit its liability to the amount of insurance coverage it chose to carry, and the court declined to limit the judgment to the amount of coverage the hospital held.

B. Elements of Hiring and Subsequent Re-evaluation

"A physician's livelihood is dependent on acquiring and maintaining hospital staff privileges."  

To continue to practice medicine, physicians must maintain a relationship with at least one hospital. Before a physician gains privileges at a hospital, however, he or she must be properly evaluated and approved by the hospital's credentialing committee.

Hospitals may have numerous procedures in place for the purpose of evaluating their personnel to ensure that a certain degree of care is maintained. These procedures are used in various instances: when physicians apply for privileges or the right to work in the facility; when their performance is reviewed, usually at specific intervals after they are hired; and in instances when an error is made and the need for re-evaluation is necessary.

1. The Application

When applying for privileges, hospitals require a physician, similar to others applying for a new job, to submit his or her application to work in that facility. At the conclusion of the application process, as with any other job interview, the applicant may ultimately be offered a position or rejected. This process of reviewing the application and the outcome of awarding or denying privileges is referred to as "credentialing." Credentialing typically involves a committee formed for the particular purpose of reviewing the physician-applicant's training, certifications, and previous

78. See, e.g., Gridley v. Johnson, 476 S.W.2d 475, 484 (Mo. 1972) (stating that the doctrine of charitable immunity was abolished in Missouri in Abernathy v. Sisters of St. Mary's, 446 S.W.2d 599 (Mo.1969)).
80. Sheree Lynn McCall, A Hospital's Liability for Denying, Suspending and Granting Staff Privileges, 32 BAYLOR L. REV. 175, 175 (1980).
81. Id.
83. Id. at 610-11.
84. Id. at 599.
85. Id.
work history, all of which attests to his or her competence. For example, part of the credentialing process typically includes contacting other hospitals that previously employed the physician-applicant. If another hospital denied privileges to the physician-applicant, this may be a sufficient reason for the committee to deny the applicant privileges and reject their application.

Subsequent re-evaluations of a physician’s work will also be conducted periodically after the physician has been granted privileges and has begun working in the hospital. Re-evaluation usually occurs once every one or two years, depending on the length of the physician’s contract for privileges with the hospital. These re-evaluations are equally as important as the evaluation conducted during the application process and are based on quality assurance data and the physician’s performance in the current hospital. Re-evaluation is necessary to determine whether physicians have become lax after securing privileges and, thus, is also a very important step in ensuring continuous quality care. Moreover, hospitals may find it easier to explain a prior incident that was overlooked when the physician applied than to explain away incompetence occurring on its watch. The physician may also be re-evaluated “whenever the committee has reason to believe that a physician’s conduct warrants immediate review.”

When a physician’s evaluation is assessed and found deficient, the evaluating committee may recommend that privileges be “limited, revised, suspended, revoked, or not renewed.” The rationalization for review after an incident of possible malpractice is obvious: if patient safety is at stake, the hospital would be negligent in failing to review the physician’s actions.

2. Peer Review

One method of conducting periodic re-evaluation of a physician’s performance is through a process known as “peer review,” during which the work of physicians is assessed by peer review boards or committees in order to determine if proper care is being administered. Hospitals are required to have a peer review process in place and to use it during the appointment and

87. Id.
89. Id.
90. Id. at 599.
91. Id. at 611.
92. Newton, supra note 21, at 725
93. Griffith & Parker, supra note 17, at 207–08.
94. Newton, supra note 21, at 725.
95. Dallon, supra note 8, at 612.
96. Dallon, supra note 8, at 612.
97. Newton, supra note 21, at 723.
reappointment processes that occur every two years.\textsuperscript{98} The American Medical Association (AMA) also encourages physicians to take part in peer review.\textsuperscript{99}

Peer review is premised on the theory that "practicing physicians are in the best position to determine the competence of other practicing physicians as they regularly observe one another's work and have the expertise to effectively evaluate that work."\textsuperscript{100} The main goal of peer review is to determine whether physicians "should be providing certain health care services [in the hospital] and, if so, which procedures and treatments they are qualified to perform."\textsuperscript{101} Once this analysis is made, the solution is either to "prevent [the] physician with quality problems from continuing to provide such services or to cause the physician to improve the quality of services rendered."\textsuperscript{102} Although the privileges and immunity provisions relevant to peer review may hinder a plaintiff's negligent credentialing case, the idea is that the increase in the quality of care provided as a result of peer review outweighs the harm to plaintiffs.\textsuperscript{103}

The peer review boards are made up of other physicians who are members of the hospital's medical staff,\textsuperscript{104} "who are not in direct economic competition with the individual physician under review."\textsuperscript{105} In addition to the staff physicians participating in peer review, the committee might also include an impartial hearing officer.\textsuperscript{106} The peer review process, however, is not the final step in determining whether physicians are awarded or maintain privileges. The final decision is made by the hospital's governing body.\textsuperscript{107}

\begin{itemize}
  \item \textsuperscript{98} Scheutzow, \textit{supra} note 7, at 20.
  \item \textsuperscript{99} Scheutzow, \textit{supra} note 7, at 26. In its 1998 Policy Compendium, the AMA states that it
    
    "(1) strongly reaffirms its continuing commitment to the development and maintenance of voluntary, professional directed peer review of medical care; and (2) encourages physicians to expand their efforts to ensure that such care is of high quality, appropriate duration and reasonable cost." The AMA also contends that it is the ethical duty of a physician to share truthful information about the quality of care a colleague gives to his or her patients when such information is requested by a credentialing body, provided that sharing the information is not prohibited by a statute or regulation.

  Scheutzow, \textit{supra} note 7, at 20.
  \item \textsuperscript{100} Newton, \textit{supra} note 21, at 723.
  \item \textsuperscript{101} Scheutzow, \textit{supra} note 7, at 12.
  \item \textsuperscript{102} Scheutzow, \textit{supra} note 7, at 13.
  \item \textsuperscript{103} Scheutzow, \textit{supra} note 7, at 55.
  \item \textsuperscript{104} Scheutzow, \textit{supra} note 7, at 12.
  \item \textsuperscript{105} Newton, \textit{supra} note 21, at 725.
  \item \textsuperscript{106} Newton, \textit{supra} note 21, at 725.
  \item \textsuperscript{107} Newton, \textit{supra} note 21, at 725.
\end{itemize}
The governing body, such as a Board of Trustees, however, relies very heavily on the committee’s recommendation.\textsuperscript{108}

In order to persuade physicians to participate in the peer review process, most states give participants some sort of statutory protection.\textsuperscript{109} These laws may do one or many of three things: (1) stipulate that the information obtained during peer review is privileged and inadmissible in court; (2) grant participants, and sometimes the hospital, immunity from suit; and (3) require that the information be kept confidential.\textsuperscript{110}

a. Privilege

Privilege refers to the "discoverability and admissibility of evidence" in a legal matter.\textsuperscript{111} Because of privilege, records used in the peer review process are not discoverable in a lawsuit.\textsuperscript{112} The theory behind privileging this information is that "[c]onstructive professional criticism cannot occur in an atmosphere of apprehension that one doctor’s suggestion will be used as a denunciation of a colleague’s conduct in a malpractice suit."\textsuperscript{113}

Privilege is only offered through state statutes; there is presently no federal peer review privilege statute.\textsuperscript{114} These statutes vary from state-to-state—the protection differs depending on the types of committees and hospital authorities the statute covers.\textsuperscript{115} Some privilege statutes also govern who may testify in a court proceeding\textsuperscript{116} and whether peer review documents may be released to state licensing boards for disciplinary procedures.\textsuperscript{117}

b. Immunity

In order to function most effectively and to ensure honest participation, peer review statutes offer varying degrees of immunity to certain persons

\textsuperscript{108} Newton, supra note 21, at 725. See also Scheutzow, supra note 7, at 13.
\textsuperscript{109} Scheutzow, supra note 7, at 16–17.
\textsuperscript{110} Scheutzow, supra note 7, at 17.
\textsuperscript{111} Scheutzow, supra note 7, at 17.
\textsuperscript{112} Gustafson & Masterson, supra note 1, at 23. See also Newton, supra note 21, at 730 ("Most states offer peer review participants immunity from civil liability. The strongest of these statutes offer immunity to committee members, institutions, and individuals providing information to the committee. On the other side of the spectrum, the weaker of the statutes grant immunity for few or specific individuals in the process.").
\textsuperscript{114} Id. at 33.
\textsuperscript{115} Id.
\textsuperscript{116} Id.
\textsuperscript{117} Id.
and entities involved in the peer review process.\textsuperscript{118} For instance, most states give peer review committee members immunity from civil liability.\textsuperscript{119}

Usually, this kind of immunity is narrowly construed and limited to the express language of the statute.\textsuperscript{120} "Good faith" is a common term in these immunity statutes, which does allow a plaintiff some leeway if he or she can prove "that the peer review was not conducted in good faith."\textsuperscript{121} This seems more applicable, however, to a suit brought by a physician after being denied privileges rather than a suit between the hospital and a patient based upon negligent credentialing.\textsuperscript{122} Also, the statutes that require good faith do not always define "malice" or "bad faith."\textsuperscript{123}

c. Confidentiality

The confidentiality provisions generally do not come into play during a lawsuit—the privilege statutes serve that purpose.\textsuperscript{124} Instead, confidentiality is necessary in instances when the peer review information may be released to third parties.\textsuperscript{125} Because the confidentiality requirement only applies to non-judicial third parties, it usually does not arise when a patient decides to bring a negligent credentialing claim.\textsuperscript{126} Privilege statutes—not confidentiality statutes—remove peer review information from the purview of the legal system.\textsuperscript{127}

Participants in the peer review process are expected to maintain confidentiality regarding the evaluations, which allows all of the participants the

\textsuperscript{118} Id. at 28–29.
\textsuperscript{121} Id.
\textsuperscript{122} Id. at 23. For example, Scheutzow also noted that:

[i]f a hospital engages in peer review but decides not to curtail a physician's privileges, and later that physician harms a patient in a manner that could have been avoided had the physician's privileges been modified, the hospital may nonetheless be shielded from liability unless the plaintiff can prove that failure to sanction a physician was performed in "bad faith."

\textit{Id.}
\textsuperscript{123} Id. at 30. Scheutzow also notes "bad faith arguably could include the hospital's failure to sanction a physician with known deficiencies because the physician admits significant numbers of patients to the hospital and generates large amounts of revenue for the hospital."

\textit{Id.} at 23.
\textsuperscript{125} Id.
\textsuperscript{126} Id. at 53–54.
\textsuperscript{127} Id.
freedom to evaluate honestly and without fear of retribution.\textsuperscript{128} The reasoning behind the need for strict confidentiality is that such confidentiality will result in honest assessments, which will bring about needed change and, consequently, an increase in the quality of care given.\textsuperscript{129}

The confidentiality requirement may be made through contract or by law.\textsuperscript{130} Many states, however, do not have a statute requiring confidentiality, making confidentiality the prerogative of the hospital and the physicians with whom it contracts.\textsuperscript{131} Most of the states that have enacted statutes require confidentiality but fail to define repercussions or sanctions in the event that confidentiality is breached.\textsuperscript{132}

d. Health Care Quality Improvement Act

Congress recognized the value of peer review by enacting the Health Care Quality Improvement Act (HCQIA)\textsuperscript{133} with the goal of promoting the quality of health care that patients receive and, thereby, decreasing malpractice.\textsuperscript{134} As one commentator noted, by enacting HCQIA, Congress "specifically acknowledged that the practice of medicine by incompetent physicians was a significant problem, that peer review was a way to remedy this problem[,] and that there should be federal protection of the peer review process."\textsuperscript{135}

\begin{thebibliography}{9}
\bibitem{128} Lawson & Blanchard, supra note 115, at 123.
\bibitem{129} Lawson & Blanchard, supra note 115, at 124.
\bibitem{130} Scheutzow, supra note 7, at 35.
\bibitem{131} Scheutzow, supra note 7, at 35.
\bibitem{132} Scheutzow, supra note 7, at 35–36.
\bibitem{133} 42 U.S.C. § 11111–11152. (West 2008).
\bibitem{134} Dallon, supra note 8, at 625.
\bibitem{135} Susan O. Scheutzow, State Medical Peer Review: High Cost But No Benefit—Is It Time For A Change?, 25 Am. J.L. & Med. 7, 17 (1999). In stating its intent in passing the legislation, Congress noted that:

\begin{enumerate}
\item The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State. (2) 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. (3) This nationwide problem can be remedied through effective professional peer review. (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review. (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

\end{enumerate}
HCQIA, grants immunity to peer review participants and entities "engaging in good faith peer review." HCQIA also addresses confidentiality, but only with regard to information reported to the National Practitioner Data Bank, the formation of which is the second purpose of the statute. The immunity provided by HCQIA applies only when the protected individuals or entities "engage in a 'professional review action.'" The idea is to promote this "professional review activity by providing peer review members with qualified immunity" if and when a private cause of action is filed against them. Also, to qualify for HCQIA immunity, certain due process requirements must be met. Immunity may also be denied if a hospital has "substantially failed" to report required information to the National Practitioner Data Bank (NPDB). Regardless of state law immunity provisions, peer review participants are entitled to at least the level of immunity provided by HCQIA. If a state statute contains broader immunity provisions, however, the participant is entitled to the higher level of immunity. HCQIA does not grant a federal evidentiary privilege with regard to information obtained during the peer review process.

136. *Id.* at 17.
137. *Id.* at 36. "In so doing, Congress refrained from creating a federal cause of action for breaching the confidentiality of the peer review process." *Id.*
138. *Id.* at 10. The NPDB is a national clearinghouse of information, and the idea behind its formation was to "prevent physicians who had their clinical privileges at a hospital limited due to quality problems from moving to other hospitals with impunity. *Id.*
139. *Id.* at 30. Professional review actions are defined as activities of a health care entity "(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity, (B) to determine the scope or conditions of such privileges or membership, or (C) to change or modify such privileges or membership."


To qualify for immunity, a professional review action must be taken: (1) in the reasonable belief that the action was in the furtherance of quality healthcare, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain the facts and after meeting the requirement of paragraph (3).

*Id.* at 31.
142. *Id.* at 31.
143. *Id.*
144. *Id.*
145. *Id.* at 9–10.
The impact of HCQIA on a negligent credentialing claim is unclear; the purpose of its enactment seems geared more towards disputes between a hospital and peer review participants. The statute, however, does contain the following language:

Nothing in this chapter shall be construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal of State Law to seek redress for any harm or injury suffered as a result of negligent treatment or care by any physician, health care practitioner, or health care entity, or as limiting any defense of immunities available to any physician, health care practitioner, or health care entity.

In St. Luke's Episcopal Hospital v. Agbor, however, the Texas Supreme Court rejected the idea that HCQIA immunity does not apply to negligent credentialing cases because of this language. The court explained that a claim for negligent credentialing "is not a claim related to 'treatment or care by any physician,' but is instead related to the failure of a hospital to review adequately a physician's qualifications."

Because the main job of the peer review committee is to credential physicians and to investigate suspect practices by a physician, the immunity given to committee members and the privilege that keeps the documents from being discoverable severely limits the ability of a plaintiff to prove negligent credentialing. The ultimate goal, however, of achieving high quality medical care, and the necessity of peer review for that exact purpose, almost always will keep peer review documents and information out of discovery.

146. Scheutzow, supra note 7, at 24.
147. Scheutzow, supra note 7, at 24 (quoting 42 U.S.C. § 11115 (d)) (emphasis in original).
148. 952 S.W.2d 503 (Tex. 1997)
149. Scheutzow, supra note 7, at 24.
150. Scheutzow, supra note 7, at 24.
152. Scheutzow, supra note 7, at 25.
153. Lawson & Blanchard, supra note 115, at 130.

It seems fairly predictable that once hospitals and physicians realize that heretofore privileged communications are now discoverable, meaningful peer review would soon become a thing of the past. If those clamoring for a wholesale evisceration of the peer review privileges in the name of physician accountability got their way, the long-term result would be only a worsening of the system they now decry. The chilling effect on full, fair, frank, "on the record" peer review would seem to be obvious.

Lawson & Blanchard, supra note 115, at 130.
C. Administrative Precautions Taken to Prevent Negligent Credentialing

Hospitals must meet certain requirements to remain in good standing with both state and national agencies. For example, most states require hospitals to report actions taken that adversely affect a physician’s staff membership or privileges. HCQIA also imposes requirements for reporting to the NPDB. Meeting the criterion or following the suggestions of other health organizations could decrease a hospital’s chance of negligently credentialing a physician before he or she causes harm.

1. Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an organization that evaluates the overall performance of healthcare organizations, formed with the purpose of establishing “minimum hospital standards for patient care.” Hospitals are not required to obtain JCAHO accreditation, but JCAHO accreditation allows hospitals to automatically participate in the Medicare program without additional certification. Depending on state statutes, JCAHO accreditation may also fulfill certain licensing requirements. Also, at least one court has recognized the importance of JCAHO accreditation when obtaining approval of internship and residency programs.

To qualify for accreditation, JCAHO requires hospitals to implement and maintain a peer review system. Hospitals must also “adopt uniform criteria for evaluating persons applying for medical staff membership and

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153. Scheutzow, supra note 7, at 20.
155. Scheutzow, supra note 7, at 38.
156. 42 U.S.C. § 11133 (West 2008). This section is entitled “Reporting of certain professional review actions taken by health care entities.” Id.
158. Formerly the Joint Commission on Accreditation of Hospitals. Scheutzow, supra note 7, at 13.
160. Scheutzow, supra note 7, at 20.
161. Scheutzow, supra note 7, at 20–21.
162. Jackson, 743 P.2d at 1383 (citing American Medical Association Directory of Accredited Residencies 3 (1975-76)).
existing staff members," and fulfill all other requirements necessary to qualify.\textsuperscript{164}

2. \textit{Reporting to the National Practitioner Data Bank and State Licensing Boards}

The National Practitioner Data Bank (NPDB) was formed by the enactment of 42 U.S.C. § 1320(a)-7(e) to establish a national system for reporting adverse decisions of a peer review committee.\textsuperscript{165} The purpose of this process is to prevent physicians whose privileges have been denied or revoked from moving to new hospitals in other states that are unaware of the physician’s past.\textsuperscript{166} HCQIA requires hospitals to make various reports to the NPDB,\textsuperscript{167} such as certain actions taken after peer review is conducted that result in limitations to a physician’s staff or clinical privileges for longer than thirty days.\textsuperscript{168} Hospitals also must report instances when physicians “voluntarily surrender their medical staff privileges” rather than undergo a peer review investigation.\textsuperscript{169} If hospitals do not complete these reports, their peer review participants may lose their HCQIA-provided immunity.\textsuperscript{170}

State licensing boards coordinate reporting between hospitals and the NPDB.\textsuperscript{171} During both the credentialing stage and reappointment procedures, HCQIA requires hospitals to request information on the applying physician from the NPDB.\textsuperscript{172} The goal is that if hospitals are diligent in both reporting to and using the NPDB, a physician who has been stripped of privileges at one hospital will not be able to move easily to a new hospital.\textsuperscript{173} Some peer review proceedings, however, are not reported to the NPDB because they do not fall into a category that requires reporting; for instance, “peer review proceedings not resulting in adverse decisions, peer review not based on a physician’s competence or professional conduct, [or] adverse actions resulting in suspension of privileges for thirty days or less.”\textsuperscript{174}

\begin{itemize}
\item[164.] Scheutzow, supra note 7, at 20.
\item[165.] Scheutzow, supra note 7, at 10.
\item[166.] Scheutzow, supra note 7, at 10.
\item[167.] Scheutzow, supra note 7, at 36.
\item[168.] Scheutzow, supra note 7, at 10, 36–37.
\item[169.] Scheutzow, supra note 7, at 10.
\item[170.] Scheutzow, supra note 7, at 37.
\item[171.] Scheutzow, supra note 7, at 37.
\item[172.] Scheutzow, supra note 7, at 37.
\item[173.] Scheutzow, supra note 7, at 37.
\item[174.] Scheutzow, supra note 7, at 37.
\end{itemize}
D. Arkansas’s Approach

Negligent credentialing is an issue of first impression in Arkansas, but there are statutes and administrative policies in place that will impact any future ruling on such a case.\textsuperscript{175} Arkansas law provides for licensure by the state medical board\textsuperscript{176} and peer review of medical staff members.\textsuperscript{177} Arkansas’s peer review statutes include provisions that render all information obtained during peer review privileged from discovery\textsuperscript{178} and that provide immunity for peer review participants.\textsuperscript{179}

Arkansas hospitals are also statutorily required to report any revocation, limitation, or termination of a physician’s privileges to the Arkansas legislatures.\textsuperscript{175,176,177,178,179}

\begin{footnotes}
\item[176] Ark. Code Ann § 17-95-303 (West 2008). This section states, in pertinent part, that “[t]he Arkansas State Medical Board shall...examine, as is provided for by law, all applicants for a license to practice medicine in this state” \textit{id.} at § 17-95-303(8).
\item[177] Ark. Code Ann. § 20-9-501 (West 2008). A peer review committee is defined as “a committee of a hospital medical staff or a committee of a state or local professional association” with the dual purposes of “evaluat[ing] and improv[ing] the quality of health care rendered by providers of health services [and]...determin[ing] that...health services rendered were professionally indicated or were performed in compliance with the applicable standard of care...or [t]he cost of health care rendered was considered reasonable by the providers of professional health services in the area.” \textit{id.}
\item[178] Ark. Code Ann. § 20-9-503 (West 2008). This section states, in pertinent part, (a)(1) The proceedings and records of a peer review committee shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are subject to evaluation and review by the committee. (2) No person who was in attendance at a meeting of the committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or any members thereof. (b)(1) However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such action merely because they were presented during the proceedings of the committee. \textit{id.}
\item[179] Ark. Code Ann. § 20-9-502 (West 2008). This section states, in pertinent part, (a) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a peer review committee for any act or proceeding undertaken or performed within the scope of the functions of the committee if the committee member acts without malice or fraud. (b) This subchapter shall not be construed to confer immunity from liability on any professional association or upon any health professional while performing services other than as a member of a peer review committee. \textit{id.}
\end{footnotes}
State Medical Board (ASMB). 180 Arkansas does not, however, have a statute that imposes a penalty upon hospitals for failing to make a report to the ASMB. 181

III. PROPOSAL

Negligent credentialing is an issue of first impression in Arkansas. When considering a remedy to this problem, the differences between enacting a solution through legislative means and leaving the issue to be resolved by the judicial system must be carefully weighed. A wait-and-see approach could prove dangerous; there is no guarantee that the right case is going to come along because the elements of a negligent credentialing claim are so specific and evidence is difficult to come by. 182 Moreover, most cases involving claims of medical negligence ultimately settle. 183 A statute that clarifies the duties a hospital owes its patients would aid both potential plaintiffs and hospitals in better understanding their respective rights and liabilities. Conversely, it is the responsibility of the judicial branch to determine precedent and interpret the law. This section examines these two approaches to determine which actions would be best for both Arkansas hospitals and patients, and it suggests several options the legislature and the courts could take when acting on the issue of negligent credentialing.

A. Statutory Remedies

A statutory solution is desirable because it is potentially a quicker solution to the problem. With proper research and drafting, a statute could go into effect within a legislative session, which is a much more expedient option than waiting for a cause of action to arise and make its way through the courts. Also, there are many steps the legislature could take that would benefit both hospitals and plaintiffs, such as defining the duties that hospitals owe patients and revamping the peer review statutes to increase effectiveness.

180. Ark. Code Ann. § 17-95-104 (West 2008). This section provides that hospitals must report these actions to the ASMB within sixty days. Id.

181. Scheutzow, supra note 7, at 58.

182. Interview with Diane Mackey, February 29, 2008. Professor Mackey is Director of the Juris Doctorate/Master of Public Health Dual Degree Program, and she has also been jointly appointed by the UALR Bowen School of Law and the UAMS College of Public Health to serve as Assistant Dean for Institutional and Organizational Affairs. Professor Mackey has taught health law, public health law, and was in the private practice of law with an emphasis on health law for many years.

183. Id.
1. **Hospitals’ Statutory Duty to Patients**

If and when the issue arises in Arkansas, a statute detailing the state’s policies regarding the liability of a hospital to its patient could be very helpful in guiding both a hospital in its everyday practice and the courts in deciding a case. In Alaska, for example, the statute has aided courts in making decisions in hospital liability cases. Although an Alaska Supreme Court case, *Jackson v. Power*, inspired the legislature to enact the statute, subsequent cases have been decided based on the statute rather than precedent. Given that a considerable number of jurisdictions in the United States have addressed this problem to varying degrees, the Arkansas legislature would have a plethora of resources from which to draft a statute.

Alaska Statutes Annotated Section 09.65.096 defines the liability of hospitals for emergency room physicians, namely clarifying what action a hospital must take in order to escape liability for the acts of an emergency room physician who is an independent contractor. It also defines a hospital’s responsibilities as to credentialing decisions and granting privileges.

Adopting a statute similar to Alaska’s would not only clarify the situations

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184. ALASKA STAT. § 09.65.096 (West 2008).
188. ALASKA STAT. § 09.65.096 (West 2008). The statute, entitled “Civil liability of hospitals for certain physicians” states, in pertinent part:

(a) A hospital is not liable for civil damages as a result of an act or omission by an emergency room physician who is not an employee or actual agent of the hospital if the hospital provides notice that the emergency room physician is an independent contractor and the emergency room physician is insured. . . . The hospital is responsible for exercising reasonable care in granting privileges to practice in the hospital, for reviewing those privileges on a regular basis, and for taking appropriate steps to revoke or restrict privileges in appropriate circumstances. The hospital is not otherwise liable for the acts or omissions of an emergency room physician who is an independent contractor. The notice required by this subsection must (1) be posted conspicuously in all admitting areas of the hospital; (2) consist of a sign at least two feet high and two feet wide, with print at least two inches high; (3) be published at least annually in a newspaper of general circulation in the area.

*Id.* The statute also provides an example of such a notice. *Id.*
in which a hospital becomes liable for an independent contractor emergency room physician, but it would also create statutory authority for hospitals who want to avoid liability but are unsure as to the steps to take in order to achieve that result.

Further, liability could be established to varying degrees: section 09.65.096 specifically addresses independent contractors performing emergency room services. The Arkansas legislature could follow Alaska's approach or, alternatively, broaden the hospital's liability by applying the no-liability standard to certain hospital-based independent contractor physicians, such as pathologists, anesthesiologists, and emergency room physicians. The legislature could also choose a middle ground between these two options.

2. Peer Review Statutes

Another positive step that the legislature could take to increase the efficiency of the process is to amend the peer review statutes. This step makes the process more efficient because the underlying goal is increased quality in patient care, and the peer review process is designed to ensure that the highest level of care is administered. The peer review process merits special attention because of the importance of preventing the exploitation of the privileges and immunities that go along with it. If the peer review process is not administered effectively, not only are patients unlikely to receive the highest degree of care, but also hospitals and physicians may gain an unfair advantage over the patient in a medical malpractice suit. The privileges and immunities section of peer review statutes could operate to conceal the work product of peer review, or lack thereof, and physicians and hospitals would merely have to claim immunity under the peer review statutes to hide their lack of effort, thus defeating the designed purpose of peer review statutes. The privileges and immunities peer review statutes, how-

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189. Id.
191. Id. "The purpose of peer review is to analyze critically the medical services rendered by physicians, and if deficiencies exist, either to prevent a physician with quality problems from continuing to provide such services or to cause the physician to improve the quality of services rendered." Id.
192. Id. at 20.
193. Id. "[A] recent trend indicates that peer review protection laws are used to protect hospitals from liability for failing to perform adequate peer review." Id.
194. Scheutzow, supra note 7, at 10.

Because legislatures attempt to encourage peer review by granting protections rather than requiring it through mandates, a strategy that represents the proverbial carrot as opposed to the stick approach, the question should be asked: Do these
ever, are the very reason peer review produces honest and forthright results. This process leads to improved patient care; eliminating the privileges and immunities could ultimately cause more harm than benefits.

Mandates, including the related penalties that would enforce reporting requirements, are one method that could be used to make the peer review process more effective. A potential area of concern with peer review is the frequency at which the peer review committee conducts reviews. If physicians are rarely reevaluated, the chance is small that the physicians who need to improve the quality of the care they give will actually do so. Because no penalty exists in Arkansas for failure to timely conduct peer review, the threat of a penalty could encourage more participation and more effective critiques.

**Peer review protection statutes effectively encourage peer review?** This question is significant because the protection offered by state legislatures results in a loss of legal recourse by aggrieved parties. If these peer review protection statutes are ineffective, the loss of legal recourse is unwarranted.

Scheutzow, supra note 7, at 10.


196. Id.

197. Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time For A Change?*, 25 AM. J.L. & MED. 7, 11 (1999). "If peer review is the key to enhanced quality of health care, stronger mandates to perform peer review and sanctions for failure to do so are necessary to cause effective peer review to take place." Id.

198. *Id.* at 16.

199. *Id.*

If peer review is not as effective as it could be in enhancing quality health care solely because it is not being used with sufficient frequency, peer review protection statutes, coupled with mandates sufficient to compel appropriate peer review, may be an answer. If legislatures want to encourage effective peer review, they must require it because protective legislation has been ineffective. If mandates are adopted, keeping the peer review protection statutes in place may be appropriate in the spirit of fairness to the physicians and hospitals required to perform peer review. Without such mandates, however, the existing protection statutes do not appear to benefit the public and instead burden the judicial process.

*Id.*


201. Scheutzow, supra note 7, at 56. The study upon which the author based her article supports "the contention that institutions and individuals held responsible to injured patients for failing to perform effective peer review will be more diligent in policing the profession and taking corrective actions." Scheutzow, supra note 7, at 56.
B. Administrative Precautions

Arkansas hospitals and the ASMB can also implement new policies that would ensure credentialing decisions are made properly, peer review is conducted efficiently, and the utmost degree of quality care is given to patients.

The authors of one article suggest that a detailed manual should be used during the credentialing process. The manual would include the following:

1. The application form;
2. The privilege form of each department and section of the hospital;
3. The definition of a completed application;
4. The definition of acceptable types of reference letters;
5. Procedures for the pre-application request for privileges;
6. Procedures for review at the department level;
7. Procedures for the recommendations of the Credentials Committee;
8. Procedures for the recommendations of the Executive Committee;
9. Procedures for the applicant’s interview at the Department and Credentials Committee levels;
10. Procedures for a “fair hearing,” that is, procedures for applicant access to adverse recommendations and appellate review;
11. Procedures for reporting of “professional review action” based upon competence and conduct;

Creating such a manual would undoubtedly simplify the process and render it more uniform. Providing such a manual would help the peer review committee in making consistent, fair decisions, and it would also offer protection for the hospital by ensuring that the peer review process is conducted efficiently and non-negligently.

202. Griffith & Parker, supra note 17, at 207.
203. Griffith & Parker, supra note 17, at 207.
204. Griffith & Parker, supra note 17, at 207.
C. Suggestions for a Judicial Approach

Thirty-four states have decided negligent credentialing cases by adopting the corporate liability doctrine. The remaining states have either looked to the other aforementioned theories or not addressed the issue at this time. While the vicarious liability approaches—for instance the non-delegable duty standard and the apparent agency theory—can be effective, the corporate liability doctrine advocated by Oklahoma is one of the strongest examples of the theory and best establishes a clear and uniform approach to negligent credentialing. Arkansas should follow Oklahoma's lead when the issue arises.

The Oklahoma Supreme Court, in Strubhart v. Perry Memorial Hospital Trust Authority, adopted the doctrine of corporate liability and stated that:

[to the extent [that the] doctrine imposes a duty of ordinary care on hospitals to ensure that: 1) only competent physicians are granted staff privileges, and 2) once staff privileges are granted to a physician the hospital takes reasonable steps to ensure patient safety when it knows or should know the staff physician has engaged in a pattern of incompetent behavior.

These parameters do not impose excessively harsh requirements on the hospital, as the duty is only one of ordinary care; rather, they clearly establish the existence of a duty between the hospital and its patients. These requirements also cover the instances during which physicians' credentials and behavior need to be monitored most closely—upon the granting of pri-

205. Gustafson & Masterson, supra note 1, at 19.
207. See, e.g., Fletcher v. S. Peninsula Hosp., 71 P.3d 833; Jackson v. Power, 743 P.2d 1376. See also McWilliams & Russell, supra note 5, at 468. "The term non-delegable duty has traditionally been used to describe a form of vicarious liability, liability on the part of the delegating party regardless of any fault on its part." Id.
208. See, e.g., Newton, supra note 21, at 738.
210. 903 P.2d 263 (Okla.1995). Plaintiff represented the Estate of Geoffrey B. Tearney, who died shortly after birth as a result of a "traumatic delivery by forceps" which caused internal bleeding. Id. at 266–67. Geoffrey's parents' private physician held staff privileges at the Defendant hospital. Id. at 266.
211. Id. at 266.
vileges and when the situation indicates that re-evaluation is needed. When evaluating this issue, Arkansas courts should also consider adding language that includes periodic re-evaluations after the physician is granted privileges in order to more fully address the entire evaluation process.\footnote{212}

The \textit{Strubhart} case is a classic example of corporate liability, particularly the failure to monitor incompetence after the granting of privileges.\footnote{213} In \textit{Strubhart}, the plaintiff had evidence that other hospital employees had concerns about the methods by which the physician treated his patients,\footnote{214} that he was an independent contractor;\footnote{215} and that an expert testified that, given the evidence of likely substandard treatment on more than one prior occasion, hospital personnel “knew they had a problem doctor on staff;” and the nurses “should have taken this information into consideration” when treating the patient.\footnote{216} The defendant hospital argued that any alleged negligent behavior was committed only by the physician, an independent contractor for whom it had no liability.\footnote{217}

Basing its opinion on \textit{Darling v. Charleston Community Memorial Hospital}\footnote{218} and \textit{Pedroza v. Bryant},\footnote{219} the Oklahoma Supreme Court rationalized that hospitals have an independent duty to patients to “supervise the medical treatment provided by members of its medical staff”\footnote{220} and that reasonable care must be exercised in order to maintain the high level of care characteristic of competent medical staffs.\footnote{221} The \textit{Strubhart} court also stressed the notion that hospitals are no longer free from liability for the negligence of independent contractors due to the “public’s perception of the modern hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered.”\footnote{222}

\textit{Strubhart} should serve as a leading example to Arkansas courts; it clearly sets forth the standards, providing the duty of a hospital, while leaving room for the Arkansas courts to add to or tweak the standards to fit a

\footnotesize{\begin{itemize}
\item \footnote{212}{See \textit{Id.} at 275. \textit{Strubhart}, in dictum, states that “[j]urisdictions adopting corporate negligence have also held that hospitals have a continuing duty to review and delineate staff privileges so that incompetent staff physicians are not retained.” \textit{Id.}}
\item \footnote{213}{\textit{Strubhart}, 903 P.2d at 267.}
\item \footnote{214}{\textit{Id.} “Plaintiff also presented evidence that Nurse Bowles and other hospital employees had previous concerns about Dr. Seal’s treatment of patients . . . .” \textit{Id.} This evidence, though admitted initially at the trial court stage, was deemed inadmissible at the conclusion of the trial because it prejudiced the hospital and deprived the hospital of a fair trial, a sentiment that was echoed by the Oklahoma Supreme Court on appeal. \textit{Id.} at 272.}
\item \footnote{215}{\textit{Id.} at 269.}
\item \footnote{216}{\textit{Id.} at 268.}
\item \footnote{217}{\textit{Strubhart}, 903 P.2d at 268.}
\item \footnote{218}{33 Ill.2d 296 (1965).}
\item \footnote{219}{677 P.2d 166 (Wash. 1984).}
\item \footnote{220}{\textit{Strubhart}, 903 P.2d at 275.}
\item \footnote{221}{\textit{Id.}}
\item \footnote{222}{\textit{Id.}}
\end{itemize}}
judge's particular understanding of the corporate liability doctrine and the varying facts of a negligent credentialing cause of action.

The majority of states that have addressed negligent credentialing appear to have adopted the best approach in allowing the judiciary to decide this question. A balanced attack, however, would include the legislature's exertion of some influence in the discussion. The passage of bills requiring more evaluations of competence or new procedures to monitor physicians' activities would prove helpful in both informing hospitals of the goals they should aspire to and in giving the hospitals greater ammunition to defeat a negligence claim. When a hospital can show evidence of procedures and steps it took to prevent negligence, malpractice, and general incompetence among its physicians, it has a better shot of establishing that it has maintained its duty of care to its patients. Legislative attention, addressing negligent credentialing, would be particularly invaluable before it becomes a problem, especially as we wait for a case to reach the courts.

IV. CONCLUSION

A negligent credentialing case eventually will present itself in the Arkansas court system. Therefore, the Arkansas legislature, in concert with the ASMB and hospitals within the state, seriously should consider implementing a system that would better convey a hospital's direct liability to its patients. Whether this is accomplished by enacting a statute or through administrative action by the ASMB, both hospitals and patients will benefit if they better understand the duties the hospital owes and the level of care the patient should expect to receive. If such preemptive measures are taken, perhaps negligent credentialing will cease, and the topic will remain an issue of first impression in Arkansas for many years to come.

Whitney Foster*


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