CHAPTER 2

Understanding the Hospital Structures and Actors

2:1 Overview

Read this chapter first! Hospitals are complex and expensive institutions intended to provide human health care. This book deals with many different aspects of the tort liabilities of these complex institutions. Other resources delve into the administration and management of hospitals in greater depth because of their general coverage of the topic.¹ This chapter explains the tort liability of the structure of the hospital and the principal professional groups, committees, and operational aspects. Counsel for an injured plaintiff or the estate of a former patient must seek first to understand the peculiar aspects of this organization, and then to discern where in the structure the alleged lapse of care had occurred.²

Hospitals are subject to an extensive regulatory overlay of controls, rules, and oversight systems. To do business, a hospital must be licensed by the state in which it operates,³ or in some cases to be part of official government establishments, such as veterans’ hospitals or the official state government institutions. The majority of U.S. hospi-

¹. See, e.g., HEALTH CARE ADMINISTRATION (Lawrence Wolper ed., Aspen 1999).
². The principal author of this chapter, Jolene Sobotka, served for many years as legal counsel to a large university medical center and applied her experience to the commentary in this chapter.
³. TEX. HEALTH & SAFETY CODE § 241.021; 210 ILL. COMP. STAT 4.
tals are private nonprofit entities organized under state laws, but are not “state actors” like government-owned hospitals. So counsel for the injured or ill plaintiff should study both the internal structure of the hospital and the external forces that control many of its decision processes, like the 2010 health-care legislation that impacts on hospitals.

2:2 Registering and Accreditation

The American Hospital Association has a process for registering hospitals and sets criteria prerequisite for registration:

1) accreditation by Joint Commission on Accreditation of Healthcare Organizations (JCAHO), called “Joint Commission” in this text;
2) certified as a provider of acute services under Title 18 of the Social Security Act (Medicare and Medicaid provider); or, in lieu of the foregoing; and
3) an institution licensed to do business by the appropriate state agency may be registered if it meets the general criteria listed below.

If an institution is Joint Commission accredited or is a certified provider under the federal Centers for Medicare and Medicaid Services (CMS), it will have satisfied the following criteria as well.

1. Has at least six inpatient beds that are continuously available for patient admission, which admission is on average greater than 24 hours.

4. This text will not cover the multiple state tests for “nonprofit” tax status because these state-specific details do not normally relate to the patient’s tort liability issues. Hospital exemption under state law was discussed in 2010 in, e.g., Dialysis Clinic Inc. v. Levin, 2010 WL 4260620 (Ohio 2010); Covenant Healthcare System, Inc. v. City of Wauwatosa, 2010 WL 3119800, (Wis. App., 2010); and Miriam Osborn Memorial Home Ass’n v. Assessor of City of Rye, 909 N.Y.S.2d 493, 2010 WL 4009658 (N.Y.A.D. 2 Dept., 2010).
5. 2008 American Hospital Association Annual Survey of Hospitals.
2. Is constructed, equipped, and maintained to provide for the health and safety of patients and to provide appropriate facilities for their treatment.

3. There is an identifiable governing authority legally and morally responsible for the conduct of the hospital.

4. There is a chief executive to whom the governing authority delegates the operation of the hospital in accordance with established policies.

5. Patient care services are provided by an organized medical staff of fully licensed physicians or other professionals permitted (by state law and the hospital) to provide services independently in the hospital. The medical staff is accountable to the governing body to maintain the proper standards of medical care and will be governed by bylaws adopted by the medical staff and approved by the governing authority.

6. Each and every patient is admitted on the authority of a member of the medical staff who has been granted privileges to admit inpatients under state law and hospital medical staff bylaws criteria for standards of medical care. When nonphysician members of the medical staff are granted privileges to admit patients, provision is made for prompt medical evaluation of these patients by a qualified physician member of the medical staff. The general medical condition of each patient is the responsibility of the qualified physician member of the medical staff who admitted the patient until transferred to a second qualified physician with privileges.

7. For any graduate of a foreign medical school who is permitted to assume patient care responsibilities, evidence of: a valid license to practice medicine; a certification by the Education Commission for Foreign Medical Graduates, or of qualification and successful completion of an academic year of supervised clinical training under direction of a medical school approved by the Liaison Committee on GAT Medical Education.

8. Registered nurse supervision and other nursing services are continuous.

9. For each patient, a medical record is maintained by the institution that is current and complete and is available for reference.

10. Pharmacy services are maintained and are supervised by a registered pharmacist.
11. Patients are provided with food service to meet their nutritional and therapeutic requirements and special diets shall be provided as needed.\(^{10}\)

An alternate form of accreditation has been recognized—the American Osteopathic Association certification\(^{11}\) or the European system Det Norske Veritas, which has been permitted by federal CMS officials to provide an equivalent accreditation review.\(^{12}\)

2:3 Types of Hospitals\(^{13}\)

There are four types of hospitals:

- general,
- special,
- rehabilitation and chronic disease, and
- psychiatric.

The first, third, and fourth are self-explanatory. The second group consists of those hospitals that limit their work to particular categories, e.g., cancer centers, orthopedic hospitals, maternity hospitals, etc., often co-located within a larger medical center that contains a conventional general hospital. Separately, hospitals may be classed as Level I, II, or III in their ability to handle trauma cases. Some states recognize a specialized trauma Level IV facility as well.

2:4 Accreditation Impacts on Funding

Most of these hospitals depend upon their participation in the federal health-care payment programs, Medicare and Medicaid.\(^{14}\) To qualify as a participating provider, hospitals must pass federal certification by a delegated accrediting entity or meet the requirements of the Joint Commission,\(^{15}\) the American Osteopathic Association, or the

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11. 42 C.F.R. § 488.1 et seq.
DNV\textsuperscript{16} accreditation process. Joint Commission accreditation gives the hospital “deemed status” as a qualified Medicare provider without the necessity of going through the specific scrutiny of the Center for Medicare and Medicaid Services certification process.\textsuperscript{17} A 2009 federal report observed: “Currently, there are approximately 4,072 Joint Commission–accredited hospitals, which is 83 percent of all hospitals (4,921) participating in the Medicare program.”\textsuperscript{18}

The Joint Commission accreditation standards, while consistent with the 10 general requirements above, are much more detailed. The Joint Commission was originally created by hospital organizations out of a belief that they were most qualified to create standards for themselves.\textsuperscript{19} The Joint Commission, however, operates completely separate from any health-care organization. The Joint Commission standard for accredited hospitals sets forth a reporting relationship between the governing authority and the chief executive of the hospital, and between the governing authority and the medical staff.\textsuperscript{20} These basic requirements set forth the typical governance structure within a hospital and are consistent with those found in CMS regulations, discussed further below.\textsuperscript{21} Failure to follow a Joint Commission standard like that on infection control\textsuperscript{22} is not a violation of law, so it is not negligence per se.

CMS maintains a broad body of rules known as the Medicare Conditions of Participation.\textsuperscript{23} Accreditation by the Joint Commission or by DNV does not relieve the accredited hospital from responsibility to comply with the Conditions of Participation; it merely creates an assumption that the hospital is “deemed” compliant with the Con-

\textsuperscript{16} This entity was permitted to accredit hospitals for CMS in 2009 and after, see \url{http://www.dnvaccreditation.com/pr/dnv/default.aspx}.
\textsuperscript{17} 42 C.F.R. Part 488.
\textsuperscript{19} \url{http://www.jointcommission.org/AboutUs/joint_commission_history.htm}.
\textsuperscript{20} The Joint Commission Standard LD.01.01.01 through LD.01.07.01, Introduction (2010)
\textsuperscript{21} 42 C.F.R. § 482.12; 42 C.F.R. § 482.22.
\textsuperscript{22} \url{http://www.jointcommission.org/PatientSafety/InfectionControl}.
\textsuperscript{23} 42 C.F.R. Part 482.
ditions without the need for a federal CMS team to perform an actual survey.

CMS and the Office of Inspector General of the Department of Health and Human Services still have the ability to investigate any report or suspicion that a hospital is out of compliance, to impose fines, and to require changes in practice and policy, up to and including revoking a hospital’s deemed status and terminating its ability to bill Medicare. In addition to the huge public relations problems for a health-care provider, this threat of denial of reimbursement can have a devastating, if not fiscally terminal, effect on a hospital.

2:5 Government-Owned Hospitals

Some of the key lessons for plaintiffs who consider lawsuits against government-owned hospitals are that the plaintiff must (1) research the right party defendant, (2) research the state or federal procedure for filing tort claims, and (3) be patient in awaiting responses because of the layers of approval needed for payment of a tentatively agreed settlement. These steps sound simple, but they are likely to be a profound surprise for any ill-prepared private litigator who is new to this type of defense. This section will necessarily be generalized, and readers should find their own state’s requirements and provisions in state statutes and administrative codes.

Governmental bodies at all levels own some hospitals because of the consensus among taxpayers that a “social safety net” of some kind makes sense for the community. The governmental decision has been that it is essential to ensure that everyone gets at least the minimum emergency stabilization care they need. Today, most of that care is done in reimbursed care at private entities, but there are hundreds of city, county, state, and federal health-care institutions that continue to reflect the desire to offer some health protections for those who need them most. The common-law analysis of negligence claims would not vary greatly from state to state, but statutory modifications of hospital liability introduce quite state-specific variables

24. 42 C.F.R. § 488.6(c)(2).
25. 42 C.F.R. Part 482.
26. Government hospitals are a significant minority; there were 1,318 government hospitals (out of 5,815 registered hospitals nationwide), according to 2008 survey of AHA. Registration is voluntary. According to the U.S. Census, there are 7,569 total hospitals in the nation as a whole.
into the equation of who bears responsibility, and how (and whether) to begin liability cases.

The characteristics that differentiate governmental from private hospitals are largely related to the interests and motivations of the owners. No stockholder dividends are paid by public hospitals, but likewise no large investors are accessible for a capital infusion to expand as the availability of costly new technologies rises.\(^27\) (This is true for nonprofit hospitals as well.) Taxpayers’ support will rise and fall in cycles of economic prosperity or decline. The government hospital will be very concerned about staying within state or local government policy constraints. The activities and behaviors that the funders wish to have money spent on are evident in legislative debates and in policy rules. For example, can the government-owned hospital in a conservative state refuse to allow doctors on its obstetrics service to provide abortions? Can family-planning clinics reach out and communicate their message from the hospital? Can homeless persons’ wellness and mental health programs have active outreach programs funded by the public hospital’s budget? Taxpayer oversight makes operation of the government hospital subject to subjective tests of permissible activities that private hospitals do not face.

Serving public-sector needs is a paramount issue for government hospitals. Their budgets are dependent upon political entities whose existence is dependent upon staying in favor with voters. Government hospitals will therefore be sensitive to how issues play out in the public media. Private disagreements take on a very public character when government hospitals are involved. Although such a situation would have received similar attention in a private hospital, the difference is in the need to be attentive both to public opinion and to legislators who need to get re-elected and who will control the public hospital’s budget.

Decisions about which injury liability cases to settle or fight are also impacted by the nature of the ownership of the hospital. The legislative body that is the “owner” has an implicit political stake in keeping good community relations while holding down costs. The city or county council may feel a sense of responsibility to micro-manage details of the hospital, including settling some liability issues. Embarrassing liability claims that hit the news in the week before a vote on a local hospital tax levy could have a direct impact on the

\(^{27}\) Periodicals such as Modern Healthcare cover these issues on a current basis.
future of the hospital’s senior management. While it is natural for elected officials to feel a need to direct public spending, those officials may not possess the expertise or objectivity to consider all aspects of a hospital’s operations.

A public university’s hospital is overseen by a state body, sometimes called a Board of Regents, and the hospital itself may have a local policy-setting board. Policy decisions are made for the whole university system at higher levels in state government. The extent to which a hospital gets support and consideration of its needs depends on members of the non-elected regents who oversee the whole system.

Government hospitals also enjoy different tax treatment and have different rules for financial reserves and different accounting, depending on the state statutes. In theory, the government hospital that does not operate at a loss will plug its earnings back into its operational needs or accumulate a surplus as part of its designated reserves.

2:6 Public Hospitals—Torts, Immunity, and Insurance

The theory underlying statutory procedures for implementation of limited governmental immunity is that the government is given a head start in investigation and, perhaps, settlement of potential claims against its hospital. The statutory process is specific in each state as to conditions of time for suits, method of claims, etc. The process could also be seen as beneficial for plaintiffs’ lawyers, because they can evaluate the likelihood of a large settlement before they invest in a lawsuit against the government entity. But it is arguably better for taxpayers to have these channels for claim resolution in order to avoid windfall verdicts against the tax-supported hospital. In this section, we speak generally, because states vary so greatly.

Research into the special statutory process of your state is essential. Not all tort lawyers understand the public sector’s use of mandatory claims resolution systems before plaintiffs sue a state hospital. While the tort claim process is relatively easy in the states, the unprepared lawyer who rushes in to file a lawsuit should beware missing the step that trips up the unwary. An early, easy dismissal would occur. This would be favorable to the public hospital, for omission of the mandatory claims stage of the case is embarrassing at least and a source of a bar grievance by a client at worst.

The great majority of hospitals have malpractice insurance today, even those with the state treasury as their “deep pocket.” In a serious negligence case, it is not likely that the public would feel bad about
an award of damages against a public hospital. Judges and juries are likely to treat all hospitals alike in terms of negligence compensation decisions. Insurance or its equivalent is normal, whether or not it is a requirement for state license and for accreditation or certification.

2:7 Teaching Hospitals and Liability

Teaching hospitals do not appear to have any greater exposure to malpractice issues than do other hospitals. No difference appears for the training hospitals in greater malpractice by medical trainees, such as medical students and residents. It would be too confusing to isolate the type of hospital reporting among all the actors. The insurance claims data on hospital liability seems to say that there are multiple factors causing injury and multiple people involved. Our research has not found definitive data either way, except that there are malpractice differences in litigation in different areas of the country. Statistics on claims are variable, and data from insurance carriers is not right on point for studying the classes of hospital providers. The National Practitioners Data Bank\textsuperscript{28} is one source of information concerning settlements or payments for physicians but not on hospitals, and the detailed reports in the NPDB are not readily accessible to private attorneys.

In summary, public hospitals have different levels of resources and sizes, but we cannot say that the care standard to which the public hospital will be held accountable is significantly different from that of a private sector hospital.

2:8 For-Profit Hospitals

These hospitals are businesses, governed by a board of directors that must answer to the investors, so their managers are actively trying to make profits by reduction of cost and increase in revenues. These hospitals have a motive to save money and increase volume in order to produce a higher rate of return.

Every for-profit hospital must provide quality services for which patrons will pay and that will earn an acceptable return on investment. Taxes on income, expenditures for marketing to draw in patients, discounting for more insurance carrier “preferential provider” business, etc., are all necessary balance sheet items. The for-profit hospital can’t set higher prices in an economic climate that is depen-

\textsuperscript{28} http://www.npdb-hipdb.com/.
dent on government-determined Medicare reimbursement rates of payment and fewer full-rate payers.

For-profit firms have certain specific advantages. Economies of scale, pricing of supplies, bidding and purchasing of equipment all can benefit from the private chain hospital’s focus on cost reduction. For example, it is easier for a chain to secure a top-notch legal defense team, providing experienced counsel and the same pool of expert witnesses for defense of similar claims in several hospitals within the chain. Uniform policies that can help the chain hospitals also may work well in comparable situations.

This may be less of an advantage in the age of information, however. The sharing of best practices and information about national safety standards—more than in the past—means chains have obtained less of a benefit from their movement toward uniform policies.

For-profit hospitals are motivated by their business models to reward shareholders. This means that they inevitably must funnel money away from health care to pay the shareholders; but in order to keep the entity strong and maintain its viability, resources will be necessarily invested back into the business, as with any ongoing business concern.

2:9 Nonprofit Hospitals

While the for-profit hospital is accountable for its shareholders’ rate of return, and the public hospital has a goal of treating its local residents, there are various motives for the other category of hospitals—nonprofits—that will not have same degrees of obligation to provide all forms of care at a maximum rate of income. Plaintiff’s counsel may wish to review the annual filing of the nonprofit hospital (IRS Form 990) in assembling data about the susceptibility of the defendant hospital to a large verdict. Federal tax laws deal with charitable institutions’ income and related issues; pressure to give more indigent care has been growing. Similarly, state tax laws deal with property exemptions for a particular hospital site. Nonprofits have been very concerned with the provisions in the 2010 health-care law that will require indigent care amounts to be publicly disclosed.

29. Accessible through guidestar.org.
Charitable legacies of the hospital may reduce the likelihood that a jury will award punitive damages in a tort case. Members of the jury pool with affiliations related to the charity, such as members of the same religious congregation, may have predispositions that influence their unwillingness to impose punitive damages against the hospital operated by the charity. Punitive damages against a popular local charity that has a record of long service to the community may be hard for the plaintiff’s counsel to achieve.

Some nonprofits have religious charitable purposes, with religious affiliations that will dictate how they react to certain social or religious issues, such as termination of pregnancy or end-of-life decision making. Tort claims for negligence would rarely, if ever, delve into the religious controls over hospital care decisions. A visible example arose in 2010, when a hospital owned by the Catholic diocese of Phoenix, Arizona, terminated a senior executive for granting emergency permission for an abortion in a high-risk stressful case; the bishop also excommunicated the executive, who was a Catholic religious sister. Religious policy controls the decisions on moral issues that are made inside the religious institution, even when it serves members of other faiths. But these decisions to withhold certain care, on moral grounds, are unlikely to shape the tort causes of action that may arise in the same hospitals.

2:10 Governance

The governance of a modern hospital has been described aptly as a “quagmire.” Hospital governing boards are a very important structure in making the hospital effective in its delivery of health care. Boards tend to be one of three types. The for-profit boards are well compensated, have rules and standards of disclosure set by rules of the SEC (if publicly held), and are elected by shareholders. Nonprofits select their own boards, often composed of donors and friends in their communities. Charitable rules for tax-exempt organizations must be followed by the management of the nonprofit hospital. The direction of the

hospital’s delivery of indigent care, for example, may be taken both from the historic roots of charity and from the IRS obligations for non-profit entities under the 2010 health-care reform statute.\textsuperscript{36} State charitable institution laws obligate those institutions to be fiduciaries of the charity’s assets. The boards of public hospitals are appointed by the governor or other elected officials.

Boards are responsible for setting the culture and climate for the hospital, and this is true whether the board is paid or not. Board members should understand the issues and be a part of the continuous effort for improvement of the safety culture within the hospital. The board will approve major expenditures, consider expansions and the development of outside clinics, and consider how the hospital can improve and expand its services to patients. For example, a board may be involved in negotiations with regulators and payers in support of the effort of management. The board may increase the services to be provided, such as alternative medicine and acupuncture,\textsuperscript{37} or diminish the resources devoted to a particular field of surgery. The board will deal with governmental pressures to increase the indigent care portion of the population served.\textsuperscript{38}

A hospital board probably will be unable to have specific control over day-to-day actions within the hospital, but members are susceptible to medical staff appeals and to public perceptions. Board members can become “disconnected” if they are not well educated by staff. Boards are also increasingly expected to assume oversight for a risk-management process within hospital organizations as a part of their duty of care-based oversight functions.\textsuperscript{39} Astute board members should have a real commitment to success of the patient-care purpose for the hospital. Board members must understand that the downside of negligence would be greater payments of verdicts, higher settlements, higher insurance premiums, etc. In most tort cases, settlements are delegated to the chief executive and need not be approved by the board. Of course, a responsible CEO will not ignore the board members, and they will be kept informed.

\textsuperscript{37} B. Basia Kielczynska, Consider the Alternatives, Modern Healthcare (Dec. 4, 2009).
\textsuperscript{38} Thomas Mayo, Tax Exempt Hospitals: Renewed Focus on Indigent Care, 4 J. Health & Life Sciences Law 140 (2010).
\textsuperscript{39} Michael Peregrine, ERM—It’s Baack! Fiduciary Duty and Enterprise Risk Management, 14:6 AHLA Connections 34 (June 2010).
2.11 Tort Case Trends and Governing Bodies

The negligence of hospital employees, physicians, and independent contractors may become the subject of liability lawsuits. When a suit is filed (or an administrative claim against a public hospital is received), the risk-management department notifies the liability insurer; senior management is briefed about the existence of the claim; the board may or may not be advised by the CEO about a claim. For private-sector hospitals, the risk-management department will work with the insurer and, for large claims, with the reinsurance carrier for amounts that could exceed the hospital’s principal coverage.

Though some boards of directors are “micro-managers,” most are not. The large verdicts and large settlements are material to the hospital’s year-end financial numbers, so they will be shared directly with the key board members. Boards are more likely to ask about trends of similar claims, alignment with the insurer, and the robust internal system that should prevent this from occurring in the future.

2:12 Hospital Managers

The chief executive of the hospital has been delegated the duty of operation of the hospital pursuant to established policy of the board for the institution.40 Paramount to those responsibilities to the board is the CEO’s duty to avoid surprises. The board should be given information that it is able to understand and to utilize in advising the management. The tort liability lawsuit is bad news; the risk manager and the senior administrator are very likely to be asked about the costs and the impacts of the litigation against the hospital, and what the likely defensive strategy will be.

The factual situation of the lawsuit might be the trigger of what the CEO wants to know and should know—lots of information flows in and out each day. The CEO will need to have the public affairs staff prepare a standby statement if the media or the board calls. This need for information is greatest when a decision must be made quickly and that decision will impact on operations. Hospitals, like most organizations, will have a policy on who comments on litigation. A “media relations” function within the hospital will work with hospital legal counsel, risk management, and administration to prepare information for the board and statements for the media at relevant stages of the process.

40. 42 C.F.R. § 482.12; Joint Commission Standard LD.01.04.01 (2010).
2:13 The Hospital Counsel

The successful hospital attorney works well under stress. A “good” hospital client is open and forthright and does not “kill the messenger.” A prudent lawyer has a sense of what the CEO needs to know; he or she expresses any findings to hospital managers in a manner clear enough to adequately advise the board and to trigger any necessary action or reaction.

2:14 The Medical Staff

The relationship of the hospital governing body to the doctors will be defined by a thick stack of hospital bylaws. The bylaws are adopted by the medical staff and approved by the board and set forth the “rules” for working within the hospital and for setting qualifications of physicians allowed to practice in the institution. Through the bylaws, the medical staff agrees to be accountable to the board to maintain the appropriate quality of medical care.

Bylaws include, e.g., what doctors can be credentialed, and what qualifications for requisite licensure, training, skill, and experience will have to be met and documented. Through medical staff policies, the medical staff sets criteria for conducting personnel evaluation, which is also known as the credentialing process. Hospital staff will check up on the data submitted by applicant doctors and prepare the files of backup data, and volunteer members of the medical staff will make the committee decision.

2:15 Hospital Relationships with Individual Physicians

For purposes of tort liability after an injury occurs, counsel for the plaintiff will have to be aware of the relationship of the physician or surgeon, as independent contractor (most frequent) or as employee of the hospital (an increasing minority of such physician roles), or as a volunteer (infrequent in the case law). The most common of the three models is that of the physician as an independent contractor. This is the individual physician who has an office and who has privileges to admit his or her patients to a specific hospital; she or he has

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41. Relationships among medical staff, administrators, and board are complex. See John Blum, The Quagmire of Hospital Governance, 31 J. LEGAL MED. 35 (2010).
42. 42 C.F.R. § 482.22; Joint Commission Standard MS.01.01.01 (2010).
43. See text Chapter 29, infra.
gone through a credentials check and has received the privileges to practice inside the hospital, but is not an employee of the hospital.

Employee status is increasingly replacing the independent single physician model with a practice structure of hospitals employing groups of physicians and enjoying the benefit of a steady patient flow to the employer’s inpatient units. Such direct employment facilitates the attribution of liability to the hospital. About 40 percent of states follow the “corporate liability” view; this theory regards most physicians in the non-differentiated manner that the individual emergency room patient might see them, as a part of the hospital team, and for whose errors the hospital is co LIABLE along with the physician. A 2008 New Jersey appeals court adopted the view that when a hospital provides a doctor for its patient, and the totality of circumstances created by hospital’s action would lead a patient to reasonably believe that the doctor’s care is rendered on behalf of the hospital, then the hospital has held out that doctor as its agent and shares in the liability. Likewise, the South Carolina Supreme Court has held the hospital liable where the emergency room scenario gave rise to a claim of apparent agency.

Hospitals meet their obligation to grant privileges and/or employ competent physicians and other licensed clinicians to admit and treat patients in the hospital through the credentialing process. Credentialing occurs on a routine basis, upon initial affiliation with the hospital and as part of an ongoing process of review. Chapter 28 discusses this process in more detail.

The Joint Commission requires that the medical staff handle the privilege issuance for all licensed independent practitioners. This means that the medical staff must delineate a process and eligibility criteria for assessing the individual qualifications required to provide patient care for any clinician who will be allowed to function independently, without supervision or direction, in the hospital.

44. See, e.g., Barkes v. River Park Hosp., 2010 WL 4117151 (Tenn. 2010).
48. 42 C.F.R. § 482.22; Joint Commission Standard MS.03.01.01; LD.01.05.01; and HR.01.02.05.
The hospital and medical staff make the determination of which types of licensed clinicians will be eligible for membership on the medical staff and which persons will be required to meet medical staff requirements in order to receive hospital privileges.\textsuperscript{49} The determination is based upon state licensure laws, the complexity of the clinical services required, and in part, the culture of the institution. Usually, this includes physicians (medical doctors and doctors of osteopathy), dentists, and perhaps podiatrists and clinical psychologists.

The Joint Commission also requires the hospital to evaluate the issuance of credentials for physician’s assistants (PAs) and advanced registered nurse practitioners (ARNPs) through the medical staff process or through some equivalent method. However, if state law allows these practitioners to provide care independently, and if they will do so within the organization, they must be credentialed by the medical staff process.\textsuperscript{50} ARNPs are defined by the state boards of nursing within a state and usually include certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists.\textsuperscript{51} State standards apply to the various roles, e.g., the nurse’s obligation for inpatient care, as part of licensure by the state board or agency.\textsuperscript{52} Data bank reports would be required under the federal rules if the hospital took disciplinary action suspending the privileges of the practitioner for serious misconduct.\textsuperscript{53}

These non-physician staff members, while they receive privileged status by action of the head of the hospital’s medical staff, need not be, and typically are not, members of the medical staff qualifying for the rights of medical staff membership. This group may be privileged either by the medical staff privileging process or by an alternate but equivalent mechanism defined in the bylaws of the hospital.

Upon affiliation with a hospital, the requesting clinician will submit an application for privileges to practice within a scope corresponding to the provider’s education, training, and experience. The initial grant of privileges is made by the governing body upon the recom-

\textsuperscript{49} 42 C.F.R. § 482.12(a)(1), 22(c)(4), 51(a)(1); Joint Commission Standards LD.01.01.01 through LD.01.07.01 Introduction (2010).
\textsuperscript{50} See note 48.
\textsuperscript{51} See, e.g., \textsc{Ohio Rev. Code} Ch. 4723, e.g., prescribing powers of specialized nurses, 4723.50.
\textsuperscript{52} \textsc{Ohio Admin. Code} 4723-4-03.
\textsuperscript{53} 45 C.F.R. § 60.9.
mendation of members of the medical staff, usually in the form of a committee of medical and administrative staff.\textsuperscript{54} A current member who requests new or modified privileges will go through a similar process, supplying verification of training and/or experience to support the scope of new privileges granted. For example, hospitals must maintain evidence of primary source verification of the practitioner’s current license and/or certification and of the applicant’s specific, relevant training (i.e., completion of medical school, internship, residency, fellowship, specialty board certifications); evidence of physical ability to perform the requested privileges; any available data from past or current practice reviews; past or current challenges to licensure, certification, or privileges; morbidity/mortality data, if available; peer and/or faculty recommendations; and, for current holders of privileges, review of current competence.\textsuperscript{55} In addition, the file will typically hold evidence of DEA authority to prescribe, proof of professional liability coverage, malpractice history, continuing medical education, National Practitioner Data Bank queries, and that the provider is not excluded from participation in federal health-care programs (HIPDB query).

The Joint Commission’s credentialing and privileging standards are based upon a series of “General Competencies” developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. Next, a focused professional practice evaluation (FPPE) is required for initial requests for privileges, for current member requests for new or modified privileges, and for members who are the subject of complaints or who have insufficient caseload for assessment requirements. Third, the Joint Commission moved from a biannual re-review to a practice of continuous review for current members. The Ongoing Professional Practice Evaluation (OPPE) monitors outcome and performance data, such as patterns for use of blood products and pharmaceuticals, length of stay and morbidity/mortality data practice patterns, patient complaints, peer review, and analysis of aggregate data from within the institution or from data registries aggregating data from specialties nationally.\textsuperscript{56}

Members of the medical staff are charged with the credentialing process, including members who have expertise in the areas covered.\textsuperscript{57}

\textsuperscript{54} Joint Commission Standard MS.06.01.01, Introduction (2010).
\textsuperscript{55} Joint Commission Standard MS.06.01.05 (2010).
\textsuperscript{56} Joint Commission Standard MS.06.01.01, Introduction (2010).
\textsuperscript{57} Joint Commission Standard MS.06.01.05, Introduction (2010).
For example, a hospital committee performing credentialing is typically composed of several physicians, with staff support to compile the review information. There is no formula for evaluating good/bad aspects of a clinician on malpractice history. State and federal laws giving privilege and qualified immunities can shield from discovery the deliberations of groups performing peer review. These laws are based on the theory that free and open discourse, free from the fear of retaliatory action on the part of the subject, is critical to successful credentialing. Typically, the credentialing committee deliberations have a peer review shield, but the decision of the group about the individual physician is open to discovery in a civil action.

Provisions of the hospital’s bylaws will typically set forth the process by which a physician’s privileges can be challenged. The subject physician’s rights of appeal will be outlined. The bylaws are designed to afford the physician due process while maintaining the hospital’s ability to manage the quality of the medical care provided to its patients.

Due diligence and credentialing efforts should not harm the physician by preventing him or her from practicing. Some challengers have claimed a group boycott or other antitrust violation. If there were a desire among current doctors to keep a certain specialty physician out, then questions of anticompetitive motives might arise.

Malpractice claims against a physician can be considered by the credentialing committee. Insurer settlement of past malpractice claims is not necessarily an admission of a real problem; the hospital’s defense lawyer can help to get more information about the claim, but lawyers should careful to leave decisions about the physician to the normal process of the credentialing committee, as described in the hospital bylaws. Chapter 28 addresses this issue.

The tort plaintiff’s counsel should determine the nature of the relationship between the treating physician and the hospital. Some states had been slow to allow the direct employment of staff physicians by the hospital, under an old interpretation that the hospital could not by itself practice medicine. Today, staff physicians are employed in many hospitals. The normal employer/employee relationship carries the normal liability attribution for these directly employed “workers.”

58. See, e.g., 63 Pa. C.S.A. ¶¶ 425.1-425.4 (Pennsylvania Peer Review Act)
59. See cases collected in Annot., 60 A.L.R.4th 1273.
When errors by a practicing physician need to be dealt with, the hospital might use a set of restricted privileges for an interim period. The alleged malpractice incident would have led to claims, then to investigation, then to temporary or permanent changes in status of the physician at that hospital.

Bylaws are the key to effective discipline; physicians’ livelihood is dependent on fair administration of the procedures. The credentialing committee must act in a reasonable manner. Some will be reluctant to be evidentiary witnesses. Sometimes individuals, such as other staff or patients, will share concerns but will be unwilling to provide testimony to back up the allegations. Hard work must be done; there is no magic pill—people must deal with people. This happens because it is the hospital’s obligation to do a proper inquiry into safety issues and to treat physicians fairly. The hospital should not be unreasonable or recklessly impair reputations or impose restraints on an individual’s rights to pursue his or her professional career, unless there is adequate evidence from which to support taking those actions.

2:16 Role of Medical Committees in Hospital Governance

Committees make many of the important decisions for the hospital, subject to the ultimate authority of the Board of Directors. The committee must have health professionals to set and measure policy.

In accordance with Joint Commission standards requirements discussed above, the credentials committee re-verifies qualification of the medical staff to provide patient care in the hospital. Inadequate reviews of credentials can be a serious problem, exposed later in tort cases.61

Bylaws govern the powers of the committees and the obligations of the physicians. These will typically require the clinicians to report adverse events through the hospital department chair, e.g., the department of psychiatry, and at least annually, the credentialing committee looks at any events that have occurred for each credentialed physician.

Not all members earn renewal of their hospital privileges. Some doctors have a bad record; some may not be effective; some don’t get along with others or some may make serious mistakes. Documentation matters, because a percentage of those who will be denied re-

credentialing will litigate the denial. Hospital counsel should be involved at the stages of review of the bylaws, when incidents occur, at the review of deliberations of the credentialing committee, and in the drafting of the letter terminating individual physician privileges.

Beyond the credentials committee, the institutional planning committee is important for the long-term growth of the hospital, but will probably not be examined in a malpractice case. The prudent plaintiff’s counsel asks for the hospital bylaws and its policy and procedure documents on the relevant topics, as those topical areas were set by Joint Commission.

When investigating documentation at a hospital, plaintiff’s counsel should not expect the hospital to volunteer the best set of documents. Novice counsel should retain services of a more skilled and experienced co-counsel, or get the best medical expert available. A nursing expert may be useful as well. The Joint Commission structure of reports and documents can serve as a resource for the plaintiff.

In case a plaintiff was harmed by an infection, the hospital’s infection control committee records would be reviewed. This group has a role in advising the hospital about such topics as infection control protocols and its MRSA reduction policies. Plaintiff’s counsel might ask, what are the procedures for disinfection? Where did the patient get into contact with the disease-conveying organism? Did the hospital monitor the rates of MRSA infection on that unit? Prudent plaintiff’s counsel considering a hospital case must get expert guidance early. This topic of infection avoidance or reduction is a complex situation involving special expertise. Rates of infection vary, so the plaintiff should understand that detection of the infection source varies. What cleaning steps were required, and what were actually done? What bacterial or viral cultures did the hospital take, and what results were found? Was the plaintiff’s infection nosocomial or not? Can you prove where the infection was acquired? What did all the blood cultures indicate? Was this infection transmitted patient to patient through a staff member?

2:17 Physician Discipline by Hospitals

A perennial debate in health care is the adequacy of hospital discipline of less competent surgeons and physicians. This debate is reflected in extensive litigation. Joint Commission accreditation requires the hospital to have credentialing committees of peer physicians\(^{62}\) who

\(^{62}\) See Chapter 28 on credentialing of physicians.
will communicate to the hospital board and CEO in writing about the decisions they make on credentialing denials.

In a typical hospital inquiry into allegations of physician misconduct, the investigator gathers lots of data, eliminates conjecture and hearsay, and relies upon real and very knowledgeable witnesses. Hospitals dislike being prosecutors of their employees or their doctors, and they often realize that to carry through on a misconduct charge, they will need evidence and witnesses. The hospital attorney walks a fine line between protecting patients and the hospital’s reputation and unjustifiably questioning the competence of a clinician and adversely affecting the person’s career.

States have enacted laws that shield the peer review process from liability. These vary, and summation is well presented elsewhere. Typically, these statutes cover professional eligibility, licensure, and fitness issues. The committee members receive statutory immunity from defamation lawsuits.

Decisions and outcomes are not protected, but deliberations would be. The statutory bar against plaintiff’s demand for discovery applies in many states under that state’s version of the peer review privilege. But an exception is recognized: a member of the panel may voluntarily disclose the deliberations. Although a statute barred discovery of a hospital medical staff committee proceeding, a physician committee member could voluntarily testify regarding his or her opinions.

Whether the clinician retains privileges to practice during an investigation depends on the seriousness of the incident or charges and whether there is a likelihood of risk to patients as well as a breach of the applicable conduct provisions in the bylaws.

In the event of a lawsuit, a plaintiff’s discovery efforts will be made, but disclosure will typically be denied under state laws creating a peer review privilege. The hospital attorney must be able to explain how each record is privileged; the attorney will need to show how and why it was a part of the peer review. However, transpar-

63. Annot., Scope and extent of protection from disclosure of medical peer review proceedings relating to claim in medical malpractice action, 69 A.L.R.5th 559.
64. See state statutes listed currently in Annot., 69 A.L.R. 5th 559.
66. Annot., supra note 63.
ency is in favor with many courts, and the courts are reluctant to shield information.\textsuperscript{67}

State “peer review” statutes must be followed to the letter. The strict compliance with these laws is essential to gain protection for documents.\textsuperscript{68} Hospitals should be prepared to demonstrate, via policy, bylaws, and through affidavits, that documents deserve the protection afforded by the statutes.

For example, in a 2010 case, a North Carolina court\textsuperscript{69} refused to protect from the risk manager e-mail that summarized a number of incidents of quality concerns, request for review of charts and summaries of incidents, actual chart reviews, and communications from outside peer review organizations. The documents were stamped with the typical “created for use by peer review committee” language, but the court refused to accept the mere assertion that the documents were peer review records and nothing more. A letter directed to the Board of Trustees was not an internal document sent to the peer review committee for its specific evaluation. So plaintiff’s counsel should not be deterred from asking, as long as there is hope of eventual release of the records.\textsuperscript{70}

After the lawsuit is filed, plaintiff’s discovery efforts will begin, but disclosure of the hospital’s internal deliberations will typically be denied under state laws creating a peer review privilege. The hospital attorney must be able to explain how each record is privileged and how/why it was categorized as peer review.\textsuperscript{71} Documents prepared before the peer review, and the documented decisions or conclusions of the review process, are not usually covered by such a peer review privilege.\textsuperscript{72}

A cause of action can be enhanced by showing that the hospital allowed the doctor to exceed the scope of privileges. Chapter 28 explains the credentialing process utilized by hospitals, a process that gives permission to a physician to practice at that hospital. If the doctor is permitted to practice beyond the scope of his or her

\begin{itemize}
  \item[68.] The many variables are included in Annot., 69 A.L.R.5th 559.
  \item[69.] \textit{Bryson, supra} note 67.
  \item[70.] \textit{Id.}
  \item[71.] \textit{Id.}
\end{itemize}
credentials, a claim could arguably be asserted of negligent oversight by the hospital.

The federal database that collects information on physician discipline, the National Practitioner Data Bank, was established in 1990 and is required to receive reports where privileges have been revoked or restricted for more than 30 days because of issues of competence or conduct. In 2009, the Public Citizen Health Research Group noted that nearly half of U.S. hospitals (2,845 of 5,823) and 69 percent of Louisiana hospitals had failed to file any reports during the 17 years surveyed. The number of NPDB reports declined from a high of 830 in 1991 to 531 in 2006. The group criticized “lax hospital peer review” practices. The American Medical Association testified in Congress against a proposal to allow patients and the public to see the contents of the database.

2:18 Other Medical Professions at the Hospital

There are at least a dozen patient care jobs in hospitals other than the role of the physician that are licensed and registered professions. Human resource interests of the hospital make it preferable to have some form of credential review to authorize their work inside the hospital. In Chapter 28, we explore this credentialing process as applied to physicians.

Some of these jobs may be involved with occurrence of a negligent act that causes harm. These are all likely to be employees or, in specialized cases, workers leased from a service, such as a staffing company. Technical staffing agencies provide nurses or technicians, do their credentialing, and have standard agreements.

Negligent hiring claims are less likely to be brought against hospitals. The health-care staff members (other than physicians) are not likely to be individually named as separate defendants and will be seen as agents of the hospital. Thus, less information is likely to be recorded regarding their specific actions. An employee is less likely to be named compared to a surgeon in an operating room error that caused harm, as the employee is not like the “captain of the ship,” as

74. Andis Robeznieks, Debate over docs being properly disciplined goes on, MODERN HEALTHCARE (June 2, 2009).
the surgeon in charge is sometimes called. Though the conventional supervisor’s negligence can be harmful to patients, it would be less so than one finds with a surgical error situation.

Accountability for supervisor negligence should be on par with the amount of discretion and control the individual employee or independent contractor possessed, or the level of responsibility they were given.

Volunteers at hospitals augment the paid workforce. Because they do not carry separate malpractice insurance, the hospital will be fully responsible for their actions that cause harm, and they may be covered under the hospital’s liability coverages.

2:19 Independent Contract Service Providers

Contractors providing services to a hospital have negotiated contractual indemnity or exclusion conditions that will govern their liability. The outsourcing of a service does not remove all liability from the hospital; it may spread the responsibilities and multiply the number of defendants, but a prudent hospital has a duty to use good care regarding whom it hires. Chapter 29 addresses this issue.

The hospital contract typically states that the medical staffing company provides the insurance for errors by the contract workers. It sets out rates of pay and various terms of notice of claims. Under these contracts, the hospital agrees to certain rates of use of the workers and often will be barred by contract from hiring away the leased employees. These contract working persons are usually state-licensed: nurse, physician’s assistant, pharmacist, psychologist, physical therapist, social worker, respiratory technician, radiology technician, or clinical laboratory technician. The underlying purpose of having state licensure and continued registration is to educate, set standards, fix criteria, and keep track of disciplined or penalized health-care workers seeking new positions.

In the event that the negligence claim involves the action of such a non-employee contractor, the hospital litigation team will probably interplead the service as a co-defendant. At that point, the plaintiff should ask for discovery of a copy of the staffing service’s contract. The indemnification clause is likely to cover the hospital, so the insurance status of the staffing agency will need to be examined as the plaintiff evaluates the viability of the case.

A frequent situation of negligence that touches a non-employee is the arrangement under which a medical practice group supplies the emergency room (ER) physicians. The ER doctor is unlikely to
avoid liability by claiming that she is not an employee; she may be deemed to be an employee because of “apparent agency.” Some hospitals have posted notices and delivered messages that the ER doctors are not the employees of the hospital but of a named service provider. For the plaintiff, the terms of the hospital’s ER staffing arrangement—a “rent-a-doctor” staffing contract—will not be known until the defense responds. The hospital will attempt to pass off legal accountability to those who provided the service; the court will decide whether the hospital had validly contracted away the liability. The insurer for the hospital could tender a defense under a reservation of rights until a claimed violation is confirmed to have been attributable to the hospital itself. Chapter 29 addresses these issues in more detail.

2:20 Balancing the Competing Interests

There is a balance in cases that probe the hospital’s accountability for certain injuries. Credentialing is a complex decision process for the larger hospital. There must be a balance of tough scrutiny, protection of individual clinician reputation, due diligence in finding capable health professionals, avoidance of sexual predators, or desire for fully competent professionals. The key is to protect both the reputational rights of the professional and the safety and compensation needs of the patient. The credentialing decision is an important gatekeeper function for hospital-based medical practitioners; it takes a lot of time diverted from patient care to be part of this lengthy process of proving misconduct and denying credentials. For the plaintiff’s counsel, an expert may seek access to both the peer review reports (or portions that are not covered by state privilege laws\(^{76}\)) and the credentialing file on the individual targeted defendant, such as the surgeon or the certified nurse practitioner who had prescribing powers under state law.

2:21 Suppliers and Hospitals

The hospital has ongoing relationships with the vendors of medical devices, large equipment, pharmaceuticals, and other products needed for patient care. The selection of a particular product may bring with it a training effort by the company for proper installation, servicing a

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repair of the product, or, in the case of medical devices, for the proper implantation, use, or installation of the product.

Training is appropriate; involvement with patient care is not. Operating room protocols usually exclude sales representatives. Sometimes they are permitted for those surgeries in which the surgeon is newly using the specific complex product or device on which the company representative is an expert. The companies will assert a need to train the medical users and to see how it is working in the operating room. The hospital’s decision will depend on the compliance officer whose job it is to act as the internal “police,” sometimes using HIPAA and the privacy of the patient as a reason to exclude the visitors if no legitimate treatment, payment, or hospital operational need for the individual’s presence can be established.

2:22 Suggested Steps for Advising Plaintiff’s Counsel

Advice to plaintiff: do your own due diligence; expect that the hospital will defend its own employees; make certain you can demonstrate a factual or evidentary basis for the charge of negligence before you go public with your case.

Discovery asks for lots of paperwork from the defendant hospital about its investigations and its evaluation of the surgeon or department. The department chair is responsible for the committee’s work; its decisions all get approved up to the level of the board. Plaintiff’s counsel must do the homework carefully: look at fact patterns in this and similar cases; talk to the expert witness; figure out which of these records might be relevant to your claim; ask the hospital for discovery of records showing what the expert wants to know.

2:23 Suggested Steps for Advising Hospital Defense Counsel

The risk manager of the hospital should have a process to go through whenever a patient care event arises; it is part of the mitigation of harm. The hospital, once notified of a potential incident, has a process. Typically, the involved patient care staff will continue to provide patient care first and foremost. The staff will next act to preserve or sequester evidence; communicate appropriately to contain the damages, i.e., take any suspect medical device out of service; and document their actions in the patient medical record and in the institutional incident reporting or patient safety network. The risk manager will notify supervisors. The risk manager or event investigator will advise clinical staff, oversee communication, and ensure that discussion
occurs with the patient or family, and that appropriate and adequate follow-up is initiated per agency policy.

While the process steps will be similar for each event, the outcome and the length and scope of the investigation or review, referred to as a root cause analysis, are highly fact-dependent and will vary each time. How significant is the harm? How likely is the error to recur, and if it does recur that it will again result in harm? Was there a policy violation, an intentional policy violation, a system error? All these will impact whether discipline results or solely a review process to identify and correct any system errors. The policy at some hospitals requires removal of involved staff from duty during an initial review; it is protective of patients and may give staff a needed emotional break from the event.

The hospital, once notified of a potential conflict, should take care of the patient so as to avoid further harm. Then the hospital investigator should sequester or secure the evidence and attempt to mitigate any adverse effects. The best analogy is to a product that has harmed other patients; you would, of course, stop using the product. You would limit or contain future harm by protecting the patient and stop further harm from occurring, based on what you know from this event. Each fact situation and each defendant will be different: How did it happen? Should you suspend the privileges of this doctor or put this nurse on paid leave pending investigation? Should you give him or her time off with pay? Errors made in this setting typically impact one person, a single patient who was harmed during her hospital stay, compared to the effect of negligence in aircraft impacting 200 or more in a plane crash. But negligence for one patient carries implications for the perceptions of jury members whose families may have been patients of this hospital.

In terms of litigation tactics, hospitals cannot deny the obligation to act reasonably. Most frequently, the plaintiff’s counsel will name the hospital and “John Doe” as defendant and amend the complaint when the true identities of the contractor or supplier become known. The plaintiff’s interest is in settlement, so the prudent plaintiff’s counsel would sue everyone and let the defendants sort it out. Most cases settle, so actual statistics of allocation are unavailable. In general, if the hospital gets information and knowledge about a dangerous condition or incompetent worker, it must act to protect its patients.