

Nos. A05-1698 and A05-1701

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State of Minnesota  
**In Court of Appeals**

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MARY LARSON AND MICHAEL LARSON,

*Respondents,*

v.

JAMES PRESTON WASEMILLER, M.D.,

*Appellant (A05-1698),*

*Defendant (A05-1701),*

PAUL SCOT WASEMILLER, M.D. and DAKOTA CLINIC, LTD.,

*Defendants (A05-1698),*

ST. FRANCIS MEDICAL CENTER,

*Appellant (A05-1701).*

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**JOINT BRIEF AND ADDENDUM OF AMICI MINNESOTA HOSPITAL  
ASSOCIATION, MINNESOTA MEDICAL ASSOCIATION AND THE  
AMERICAN MEDICAL ASSOCIATION**

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## INTRODUCTION AND INTEREST OF AMICI

The three Amici Curiae submitting this brief have both public and private interests in this appeal.<sup>1</sup> All three Amici are directly involved in developing legislative policy to assist society in providing the highest quality healthcare. The Minnesota Medical Association [“MMA”] and the Minnesota Hospital Association [“MHA”] have been particularly involved in the unique and positive developments in the law and policy of Minnesota that have directly resulted in significant improvements in the quality of healthcare within this State. Both the MHA and the MMA have worked to distinguish Minnesota from every other state in the country by supporting legislative development of the strongest peer review and reporting systems in the nation, including most recently the Minnesota Adverse Health Event legislation, a unique statute designed to require reporting and self-analysis of unexpected adverse health events.<sup>2</sup> Minnesota’s Adverse Health Event legislation--the first of its kind in the country--draws heavily upon the strength of Minnesota’s peer review laws that are under attack in this case.<sup>3</sup> The

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<sup>1</sup> Pursuant to Rule 129.03, the undersigned counsel certifies that no counsel for a party to this case authored this brief in whole or in part and no one made a monetary contribution to the preparation or submission of this brief other than the Minnesota Hospital Association, the Minnesota Medical Association and the American Medical Association.

<sup>2</sup> Peer review statutes or common law protections exist in all 50 states. However, Minnesota’s law is unique in that it is the only state that imposes criminal penalties for releasing peer review material. *See* Minn. Stat. § 145.66.

<sup>3</sup> The *Wall Street Journal* described the legislation as a “path-breaking move” designed to prevent medical error. (Addendum at 1) The *Journal* described Minnesota and its employers as having “long been incubators of ideas for improving and containing health care costs.”

Minnesota Hospital Association, Minnesota Medical Association and American Medical Association [“AMA”] greatly fear that if a claim for “negligent credentialing” were recognized in this case, it would set back important quality advances within this State that separate Minnesota from the rest of the country.

***Minnesota Hospital Association***

MHA is a statewide organization comprised of almost all hospitals in the State of Minnesota, including 136 acute care hospitals and 22 health systems. MHA’s objective is to provide leadership toward the advancement of sound healthcare policy. MHA’s efforts focus on access to healthcare, consumer value, and improving the quality of care in the state. MHA serves its members as the State’s most influential, trusted and respected leader in healthcare policy and advocacy and is a valued resource for healthcare information. In 2003, MHA worked closely with the Minnesota Department of Health to develop and implement Minnesota’s Adverse Health Event legislation. This unique cooperative effort resulted in the creation of the first state legislation in the nation to mandate the reporting of adverse health events.

***The Minnesota Medical Association***

MMA is a professional association representing approximately 9,500 physicians, residents, and medical students in the State of Minnesota. MMA seeks to promote excellence in healthcare, to insure a healthy practice environment, and to preserve the professionalism of medicine through advocacy, education, information and leadership. For more than 150 years MMA and its members have worked together to safeguard the quality of medical care in Minnesota and the future of the medical profession.

### *The American Medical Association*

The AMA is an Illinois non-profit corporation, comprised of approximately 250,000 physicians, residents, and medical students. The AMA is the largest medical society in the United States. Its objects are to promote the science and art of medicine and the betterment of public health. Its members practice in every state, including Minnesota, and in every field of medical specialization.<sup>4</sup>

\* \* \*

The interests of the MMA, MHA and AMA in this case are primarily public in nature. These Amici have no interest whatsoever in the particular dispute between these litigants. Rather, our interests primarily focus on our concern that recognizing a claim of negligent credentialing would drastically erode Minnesota's legislatively-created peer review systems and other advances in healthcare legislation unique to this state.<sup>5</sup> From a public perspective, we believe that recognizing negligent credentialing as a cause of action under Minnesota law would significantly decrease the willingness of physicians to participate in peer review, as physicians involved in making credentialing decisions would increasingly become targets in credentialing lawsuits. Moreover, we fear that

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<sup>4</sup> The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition of the AMA and private, voluntary, non-profit state medical societies, including the MMA, formed to represent the views of organized medicine and the courts.

<sup>5</sup> At times, the parties and the trial court have referred to the potential claims as either negligent credentialing or negligent privileging. Our concerns would arise if the court were to recognize either claim. For the sake of uniformity, we refer to the claim as "negligent credentialing" throughout our brief.

recognizing negligent credentialing claims would result in physicians becoming less willing to speak openly and honestly about their concerns regarding a credentialing candidate, for fear that those concerns may later become the focus of a lawsuit.

Since the members of the MMA, MHA and AMA include hospitals and healthcare professionals who themselves may be sued for malpractice, a decision by this Court could implicate Amici's private interests as well. We believe that recognizing "negligent credentialing" claims would dramatically and improperly change the focus of medical malpractice lawsuits from whether a physician complied with the applicable standard of care in the community in treating a particular patient to events entirely irrelevant to that patient's care. From a hospital perspective, we are equally concerned that hospitals would effectively become excess insurers for underinsured physicians and be held liable for negligent hiring or retention even when the hospital did not employ the physician.

Nonetheless, our greatest concern remains that recognizing the cause of action will set aside 30 years of significant legislative advances in Minnesota's peer review laws and this state's nationally-acclaimed healthcare legislation.

Amici believe this Court ought to have a broader perspective of the legal policy issues raised by this case than what may be presented by the parties. The parties will naturally focus on the particular facts of the case as those facts bear on the ruling below. Amici do not intend to reargue or restate Appellants' arguments. Instead, Amici seek to provide some broader perspective on the issues of law and policy that should guide this Court's decision in analyzing what the law on the issue of negligent credentialing *should* be.

## ARGUMENT

Amici submit that this Court should not recognize negligent credentialing as a new cause of action under Minnesota law for four separate, critical reasons. First, creating such a cause of action would drastically erode successful legislatively-created peer review systems in Minnesota and would undermine unique healthcare legislation that has developed in Minnesota over the last 30 years. Second, as a practical matter, allowing such claims would impose liability upon hospitals for legislatively-imposed tasks performed by the Minnesota Board of Medical Practice, since hospitals would be exposed to civil damages simply for relying upon the investigation performed by the Medical Board. Perversely, hospitals would become liable for credentialing decisions where the State's Board of Medical Practice would not, despite the fact that the Legislature has directed that the Board of Medical Practice alone shall decide whether a physician should be allowed to practice medicine.

We also urge the Court not to recognize negligent credentialing as a viable cause of action because it would change the focus of medical malpractice law in this State away from whether the particular physician or nurse complied with the standard of care and instead direct that focus toward entirely irrelevant, prejudicial events that have nothing to do with whether the medical care complied with the applicable standard of care in the community. Finally, hospitals would become *de facto* excess insurers for physicians as hospitals become liable for the acts of an independent contractor whom they never employed.

**I. RECOGNIZING NEGLIGENT CREDENTIALING WOULD ERODE MINNESOTA'S PEER REVIEW LAWS.**

Since the enactment of the state's first peer review statute in 1971, the Minnesota Legislature has repeatedly taken steps to create unique confidentiality protections for information assembled by a hospital review organization (a/k/a peer review information):

[Peer review information] shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery.

Minn. Stat. § 145.64, subd. 1(a). The Minnesota peer review statute sets forth 23 recognized purposes of a review organization that are covered by the confidentiality protections of Minn. Stat. § 145.64. Significantly, the Legislature identified credentialing decisions as deserving of the statute's confidentiality provisions by recognizing those decisions as a legitimate purpose of a review organization, directing that statutory confidentiality shall extend to information used in:

Determining whether a professional shall be granted staff privileges in a medical institution . . . or whether a professional's staff privileges, membership, or participation status should be limited, suspended or revoked.

Minn. Stat. § 145.61, subd. 5(i). Moreover, in addition to specifically establishing credentialing decisions as a legitimate function of a review organization, the Legislature believed it was so important for those discussions to be kept private that it imposed *criminal* penalties upon any organization or individual who discloses the events that occurred within a review organization, an element to peer review that does not exist elsewhere in the country. Minn. Stat. § 145.66.

In their briefing to the trial court, the parties spent considerable time arguing about the holdings and analysis of courts in other jurisdictions on the question of negligent credentialing. We strongly believe this is not the appropriate focus for this Court. Rather, we urge the Court to realize that this case presents a uniquely Minnesotan issue, and to focus on the specific statutory language established by the Minnesota Legislature, the plain statutory intent to protect the integrity of the Minnesota peer review process, and the nationally-recognized advances in Minnesota healthcare legislation. Importantly, the Court should not focus on whether the common law of *other states* recognizes negligent credentialing but rather on whether establishing such a cause of action in Minnesota is appropriate given the overriding and broad scope of Minnesota's health care legislation.

Obviously, different states have created different mechanisms to assure that hospitals credential physicians appropriately. While some states police those activities through common law civil actions, the Minnesota Legislature has elected to allow hospitals to police those activities internally through its peer review programs. *Campbell v. St. Mary's Hospital*, 252 N.W.2d 581, 587 (Minn. 1977) (peer review is intended to "encourage the medical profession to police its own activities with a minimum of judicial interference"); *In re: Parkway Manor*, 448 N.W.2d 116, 119 (Minn. App. 1990) (same). No party has pointed to a statutory peer review program as well developed and unique as Minnesota's.

Amici are extremely concerned that recognizing negligent credentialing as a new cause of action would dissuade physicians and other professionals from participating in

the credentialing (or other review organization) processes. The Minnesota Supreme Court has repeatedly recognized similar concerns. See *Amaral v. St. Cloud Hospital*, 598 N.W.2d 379, 387 (Minn. 1999) (absent confidentiality, professionals will be reluctant to “participate freely” in peer review); *Campbell v. St. Mary’s Hospital*, 252 N.W.2d 581, 587 (Minn. 1977) (import of peer review is to encourage the medical profession to “police its own activities with a minimum of judicial interference”). See also *Konrady v. Oesterling*, 149 F.R.D. 592, 597 (D. Minn. 1993) (confidentiality in peer review is necessary “to protect the unimpeded flow of ideas and advice”). Until the trial court’s recognition of negligent credentialing in this case, there has been little question that Minnesota’s peer review laws protect the integrity of the peer review process by maintaining confidentiality. *Id.*; *In re: Fairview University Medical Center*, 590 N.W.2d 150, 153 (Minn. App. 1999) (peer review is designed to improve patient care “despite threats of malpractice and defamation actions”); *In re: Parkway Manor*, 448 N.W.2d 116, 120 (Minn. App. 1989) (same).

The statute-based peer review confidentiality provisions allow physicians to speak openly, honestly and frankly about all review organization functions, including credentialing. If this cause of action were recognized, however, physicians would quite naturally fear that their candor may ultimately be punished in a later civil lawsuit alleging negligent credentialing. In particular, if one physician voices concerns about an applicant’s qualifications, but is over-ridden by the balance of the committee, then that physician will unintentionally become the subject of (if not the plaintiff’s expert in) a subsequent negligent credentialing claim. This confidentiality concern arises because

hospitals and physicians would be forced to make the impossible choice of either not defending the negligent credentialing claim to escape criminal prosecution or else sharing the entire analysis of the credentialing committee, with the risk of criminal punishment and erosion of their peer review program. *See* Minn. Stat. § 145.66. Should a hospital find it necessary to defend the lawsuit (a reasonable decision with millions of dollars at stake), it will be forced to erode the integrity of its peer review program and share peer-review protected information, thereby subjecting itself to criminal prosecution.

The Minnesota Supreme Court has expressed grave concerns about the “chilling effect” the erosion of peer review confidentiality will have on a physician’s willingness to participate or to speak openly. *Amaral*, 598 N.W.2d at 388. Consequently, the Supreme Court has even rejected efforts by a physician to access a hospital’s credentialing records about that physician’s own credentialing application, recognizing that the statute favors the public interest of maintaining confidentiality over the physician’s interest in accessing his files. *Id.* Moreover, the Court recognized the critical importance of encouraging the most open candor possible:

In pursuit of their goal of improving the quality of health care through the use of the peer review system, state legislatures have recognized that professionals will be reluctant to participate freely in peer review proceedings if full participation includes: (1) the possibility of being compelled to testify against a colleague in a medical malpractice action, and (2) the possibility of being subjected to a defamation suit by another professional.

*Id.* at 387. The *Amaral* Court noted that medical professionals rely on collegiality with, and referrals from, their peers and that “the quality of patient care could be compromised if fellow professionals are reluctant to participate fully in peer review activities by

coming forward with candid and honest reports about a colleague.” *Id.* at 388. *See also* Owens, *Peer Review: Is Testifying Worth the Hassle?*, *Med. Econ.*, Aug. 20, 1984, at 168 (noting that 21% of physicians had lost referrals or had antagonized colleagues because of their participation in peer review procedures); P. Scibetta, Note, *Restructuring Hospital – Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 *U. Pitt. L. Rev.* 1025, 1034-35 (1990).

Consistent with Minnesota’s legislative construct and the interpretations by the Minnesota Supreme Court, it has been well-recognized in other venues that medical peer review is blunted when physicians engage in review activities with the fear that their identities, comments, records, and recommendations will be disclosed. As one commentator noted, “curtailing the candid deliberations of these committees because of a fear of the discovery process could eventually lead to the destruction of the benefits of committee review.” Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 *Am. J. L. & Med.* 245, 267 (1975); *See also* K. Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 *Mass. L. Rev.* 157, 162 (2002) (“the erosion of the medical peer review privilege leaves physicians without adequate assurance of the confidentiality of their participation in peer review activities, thereby undermining the effectiveness of peer review. . . Ultimately, physicians cannot be expected to participate candidly in peer review or error reporting activities if their identities, comments, records and recommendations are not afforded strict protection.”).

Consistent with the Supreme Court’s directive in *Amaral*, maintaining confidentiality of review organization functions is imperative to the success of the

process. Otherwise, physicians will either refuse to participate in the process or will be reluctant to speak honestly about the merits of credentialing a physician. Credentialing committee members would bite their tongue out of fear that their comments would be used against the hospital in a subsequent negligent credentialing claim or against the physician in a malpractice case.

Recognizing negligent credentialing would erode the legislatively-created confidentiality provisions and set aside significant legislative advances unique to Minnesota. For example, in August 2003 Governor Pawlenty signed the Minnesota Adverse Health Event Legislation that created mandatory reporting of adverse health events. *See* Minn. Stat. §§ 144.706-144.7069.<sup>6</sup> In addition to requiring mandatory reporting, the Adverse Health Event legislation also required hospitals to create and implement their own corrective action plans as part of their peer review programs. Minn. Stat. § 144.7065, subd. 8.<sup>7</sup> Under the new law, peer review information is voluntarily (and confidentially) provided to the Minnesota Department of Health, which makes recommendations for improving health care on a state-wide basis. In creating the Adverse Health Event legislation, the Legislature further strengthened Minnesota's peer

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<sup>6</sup> Governor Pawlenty called the legislation "an important step in improving patient safety." (Addendum 3) At a bill-signing ceremony, Governor Pawlenty described Minnesota as a national leader in creating the legislation to track and monitor events to improve patient safety. (Addendum 6) Likewise, the President of the National Quality Forum, a national leader in healthcare reform, identified Minnesota's model legislation as the "vanguard" of reporting error and improving patient care. *Id.*

<sup>7</sup> With the support of the National Quality Forum on Healthcare, Minnesota was the first to pass Adverse Health Event Legislation. New Jersey and Connecticut have already followed suit.

review statute by making the hospital's corrective action plan subject to the same confidentiality protections as the hospital's credentialing program. *See* Minn. Stat. § 145.61, subd. 5(q). But the success of the Adverse Health Event legislation hinges on a hospital's willingness to self-report an event, perform corrective action in the peer review system, and report process improvements to the Minnesota Department of Health.

The lessons learned from the Legislature's establishment of the Adverse Health Event legislation affect this case in two ways. First, the Adverse Health Event legislation is further evidence of Minnesota's progressive, legislative desire to improve the quality of healthcare. Second, and perhaps most important with respect to the issue of negligent credentialing, the success of the Adverse Health Event legislation hinges on the ability of the hospital to perform its own evaluation of a patient care situation without the fear that an honest evaluation will then become the subject of future litigation. By eroding the integrity of the peer review process in credentialing, claims of negligent credentialing will also erode the success of the Adverse Health Event legislation as well as 30 years of similar innovative legislative action including the joint efforts of Amici and the Minnesota Department of Health.<sup>8</sup> It would be the first step in destroying the Legislature's plain intention to protect peer review and the peer review system.

Finally, these peer review issues have obviously been directed and shaped by repeated Legislative action. Thus, unlike the *Lake v. Wal-Mart* case relied on so heavily

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<sup>8</sup> Appellants also address the immunity provisions of the peer review statute. A finding of immunity would obviously address many of Amici's primary concerns. Appellants' Briefs have fully addressed this issue and we have nothing to add on this point.

by the trial court, the creation of a new cause of action here would not just simply be a matter of evolving *judicial* law, but would in a very real sense be a direct usurpation of authority committed to, and already affirmatively exercised by, the Legislature. There is to that extent a serious separation of powers problem lurking here, a problem the trial court never really came to grips with. The states that have rejected negligent credentialing claims have largely based their analysis on statutory constructs similar to Minnesota's, recognizing the court should not impede constitutionally-appropriate legislative action. *See Gafner v. Down East Community Hosp.*, 735 A.2d 969, 979 (Me. 1999): "Before the expansion of tort liability into an area that has been significantly controlled by the Legislature, we should allow the Legislature to address the policy considerations and determine whether imposing such a duty constitutes wise public policy."; *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 509 (Tex. 1997) ("The legislature is free to set a course for Texas jurisprudence different from other states. Once the legislature announces its decision on policy matters, we are bound to follow it within constitutional bounds.").

The Minnesota Legislature has spoken, loudly and clearly – the confidentiality of peer review information is critical to Minnesota's healthcare system. A decision to recognize negligent credentialing would drastically undermine the Legislature's mandate on this issue and the Supreme Court's repeated recognition of the need to maintain the confidentiality of that information.

## **II. RECOGNIZING NEGLIGENT CREDENTIALING WOULD IMPOSE LIABILITY ON HOSPITALS FOR LICENSING DECISIONS MADE BY THE MINNESOTA BOARD OF MEDICAL PRACTICE.**

If negligent credentialing were to be recognized as a viable cause of action, it would unfairly impose liability on a hospital for tasks the Legislature declared to be the function of the State government. In creating the Minnesota Board of Medical Practice, the Legislature specifically stated that it is the Board's "primary responsibility" to protect the public from the "unprofessional, improper, incompetent and unlawful practice of medicine." Minn. Stat. § 147.001.

In fulfilling its purposes, the Minnesota Board of Medical Practice regularly evaluates precisely the same issues that would be the subject of a negligent credentialing claim. Those issues include a physician's malpractice history (Minn. Stat. § 147.035), qualifications, improper licensure, criminal history, actions against the physician in other jurisdictions, unethical conduct, mental impairments or chemical abuse, unprofessional behavior, or even failing to repay a student loan. *See* Minn. Stat. § 147.091, subd. 1.<sup>9</sup> In making credentialing decisions, hospitals throughout this state regularly rely in part on the Board's ability to evaluate a physician's ability to practice medicine safely before credentialing that physician.

Certainly, the Minnesota Board of Medical Practice takes its role very seriously. In performing its duties, the Board regularly assembles and evaluates the same types of

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<sup>9</sup> In the current fiscal year (July 1, 2005 – June 30, 2006), the Legislature allocated \$3,729,000 to the Board of Medical Practice to perform the responsibilities and obligations set forth in Minn. Stat. §§ 147.001-147.36. H.F. 139 1st Engrossment, 2005; 1st Spec. Sess. §§ 440.12-440.34 (Minn. 2005).

information that would form the basis of Plaintiffs' proposed negligent credentialing case here (i.e. malpractice claims history, prior disciplinary actions, etc.). Because some of a hospital's credentialing analysis relies heavily on the Board's expertise, a negligent credentialing cause of action would ultimately impose legal liability on hospitals for licensing decisions by the Board of Medical Practice (whom the Legislature directed to evaluate these issues). Of course, the law does not allow patients to sue the Minnesota Board of Medical Practice for its decision to license a physician. Nonetheless, that is precisely the type of action the Plaintiffs now seek to pursue against hospitals. If allowed to go forward, hospitals would be forced to accept liability risks for having relied, in part, upon the Board of Medical Practice in evaluating a physician's ability to practice medicine.

If recognized, negligent credentialing claims would impose an elevated threshold upon hospitals beyond that imposed upon the Board of Medical Practice. Hospitals would be forced to do more than the very agency whose "primary responsibility and obligation" is to protect the public in connection with the granting and subsequent use of a medical license. *See* Minn. Stat. § 147.001. Certainly, such an obligation would impose undue and, frankly, unfair obligations on hospitals and prevent them from relying at all upon the expertise of the Board of Medical Practice. It also would demand unlimited resource allocations for the hospital to complete that task because the Medical Board's analysis simply would not be deemed sufficient.

In sum, it is entirely appropriate for hospitals to be able to rely upon the expertise of the Medical Board as the Board works to maintain the public health, safety and

welfare and to protect the public from the unprofessional, improper, incompetent and unlawful practice of medicine.

### **III. RECOGNIZING NEGLIGENT CREDENTIALING WOULD DRASTICALLY AND UNFAIRLY PREJUDICE HOSPITALS AND PHYSICIANS.**

It is black-letter law that a plaintiff can prevail in a claim of medical malpractice only by establishing duty; breach of the standard of care; causation; and damage. *Plutshack v. University of Minnesota Hospital*, 316 N.W.2d 1, 5 (Minn. 1982). Thus, the liability aspects of a medical malpractice case focus on defining the standard of care, articulating whether the standard of care was breached by a particular physician or nurse, and whether that breach caused injury.

Because medical malpractice cases focus on the care of the patient at issue, tangential, irrelevant issues such as care provided to other patients is routinely held inadmissible, as events involving other patients are not probative on the question about whether the physician complied with the standard of care *in the case at issue*. Indeed, evidence of other lawsuits is generally not even discoverable, much less admissible. *Wood v. McCullough*, 45 F.R.D. 41 (S.D.N.Y. 1968).

Maryland's highest court correctly explained the significant prejudice that occurs when a jury in a medical malpractice case is tainted by information regarding other lawsuits. In *Lai v. Sagle*, 818 A.2d 237 (Md. App. 2003), the court reversed a jury verdict for the plaintiff, holding it was reversible, prejudicial error for the trial court to allow plaintiff's counsel to refer to prior suits against the defendant physician. *Id.* at 249. The court reached a similar conclusion with respect to the physician previously having

failed to become board certified. *Id.* at 246. The court held the prior suits had “little, if any, relevance to whether [the physician] violated the applicable standard of care in the immediate case,” finding that evidence of prior suits does not aid the jury but “tends to excite its prejudice and mislead.” *Id.* at 247.<sup>10</sup> The court acknowledged that it could not “conceive of a more damaging event in a medical malpractice trial” than disclosing prior suits. *Id.*

If negligent credentialing claims were recognized, the focus of medical malpractice litigation would drastically shift away from the relevant issues (whether the care of this patient complied with the standard of care) to the tangential and irrelevant. Here, for example, Plaintiffs focused primarily on a number of prior malpractice cases involving Dr. James Wasemiller (see Plaintiff’s Memorandum in Support of Motions to Amend Complaint and Compel Discovery at pp. 7-8). Then, due to the prior claims, Plaintiffs turned their focus to Dr. Wasemiller’s insurance history and discipline imposed by the Minnesota Board of Medical Practice. *Id.* at 9-11.

Plaintiffs even went so far as to try to support their negligent credentialing claim by offering evidence that the physician was behind in child support obligations and unpaid taxes. *Id.* at 11. Paying child support or taxes has nothing to do with whether the

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<sup>10</sup> The *Lai* Court cited at least six jurisdictions that recognized the fundamental principle that prior malpractice actions are neither relevant nor admissible. *See* 818 A.2d at 248. Additional courts from across the country have reached the same conclusion. *See Stottlemeyer v. Ghram*, 597 S.E.2d 191, 194 (Virg. 2004); *McGarry v. Horlacher*, 775 N.E.2d 865, 872 (Ohio App. 2002); *Lund v. McEnerney*, 495 N.W.2d 730, 734 (Iowa 1993); *Delgaudio v. Rodriguera*, 654 A.2d 1007, 1010 (N.J. App. 1995); *McKee v. McNeir*, 151 S.W.2d 268, 270 (Tex. App. 2004); *Weil v. Seltzer*, 873 F.2d 1453, 1461 (D.C. Cir. 1989).

physician complied with the standard of care. Certainly, the evidence of Dr. Wasemiller's debts, other malpractice history or insurance has absolutely nothing to do with whether Mary Larson received medical services consistent with the standard of care.

Recognizing a negligent credentialing claim would drastically change medical malpractice litigation in this State because the focus would shift entirely from whether the physician complied with the standard of care, to collateral, wholly unrelated cases and irrelevant evidence. No longer would the jury limit its analysis on the standard of care to whether medical care was appropriate; but it also would need to consider whether the entirely unrelated lawsuits involving the physician were valid claims. The end result is obvious -- the plaintiff will have successfully smeared the physician in the eyes of the jury with evidence that is entirely irrelevant to whether the physician complied with the standard of care in connection with this particular patient.

In Dr. Wasemiller's case, the parties would need to turn the focus of the litigation away from the care provided to Ms. Larson; defendants would, in essence, be forced to retry ten other cases involving separate plaintiffs and separate procedures to determine whether it was appropriate for the hospital to have credentialed the physician in the first place.<sup>11</sup> The plainly inadmissible would suddenly and unfairly become the centerpiece to the litigation.

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<sup>11</sup> This would raise a plethora of additional issues: How would those ten other cases be retried without the consent of the patients involved in the original claims? How many experts would be necessary? Would the patients from the prior cases be forced to testify? Would malpractice insurance adjusters be forced to testify about why a case was settled?

The prejudice to hospitals would be at least as egregious, as plaintiffs would rely on public information from outside the peer review process (e.g. prior suits or tax liens), yet the hospital defending that case would be completely unable to defend its analysis about why the decision to credential the physician was proper. In other words, the hospital would be completely prejudiced and unable to fairly defend the claim because state law categorically prohibits the hospital from telling a jury *what it actually did in evaluating the public information in its private meetings about the physician's credentials*. See Minn. Stat. §§ 145.64, 145.66. With all due respect, the trial court's comment about a hospital defending the claim "with one hand tied behind its back" is a rank understatement. The hospital would be *unable to defend the claim at all* since it could not legally provide the jury with any of the information supporting its decision to credential the physician.

Simply stated, recognizing a negligent credentialing claim under Minnesota law would drastically, unfairly and prejudicially change the face of medical malpractice litigation in this state. The entirely irrelevant and highly prejudicial evidence about prior claims or a physician's personal life will unfairly become more important than the events regarding the actual care provided to a particular patient. Hospitals would be equally prejudiced because they are prohibited from responding to, or explaining why, they credentialed a physician despite information otherwise available in the public arena.

#### IV. CORPORATIONS ARE NOT LIABLE FOR THE ACTS OF INDEPENDENT CONTRACTORS.

Allowing a negligent credentialing claim also would drastically change the law in the state with respect to a corporation's responsibilities for individuals who are not employed by the organization. Of course, it is black-letter Minnesota law that under the doctrine of *respondeat superior*, an employer is vicariously liable for the torts of its employees committed in the course and scope of the employee's employment. *Fahrendorff v. North Home, Inc.*, 597 N.W.2d 905, 910 (Minn. 1999). As the Supreme Court has recognized, imposition of liability on an employer due to the acts of its employees is a matter of public policy, for the courts have determined that "liability for acts committed within the scope of employment should be allocated to the employer as a cost of engaging in that business." *Id.* See also *Schneider v. Buckman*, 433 N.W.2d 98, 101 (Minn. 1988). Lacking an employment relationship, one entity is not responsible for the acts or omissions of an unrelated entity. See *Pacific Fire Insurance v. Kenny Boiler & Manufacturing Co.*, 277 N.W. 226, 228 (Minn. 1937).

But Amici greatly fear that recognizing a negligent credentialing claim will impose liability on hospitals for the acts of physicians who are *not* employed by the hospital. This would drastically change the law in this state. Credentialed physicians are generally not employees of the hospital, but are independent contractors. Thus, hospitals would become *de facto* employers or excess insurers for physicians who lack sufficient malpractice insurance coverage. In virtually every situation involving a potentially

underinsured physician, the plaintiff would assert claims of negligent credentialing against the hospital.

This Court has previously addressed vicarious liability in the medical malpractice context, holding that consistent with well-established Minnesota law, a hospital is not liable for the alleged acts of an independent contractor physician who is not employed by the hospital:

In Minnesota, a hospital can only be held vicariously liable for a physician's acts if the physician is an employee of the hospital.

*McElwain v. Van Beek*, 447 N.W.2d 442, 446 (Minn. App. 1988).

If recognized, negligent credentialing claims would hold hospitals to the standard of negligent hiring or negligent retention, as if the credentialed physicians were the hospital's employees. Of course, negligent hiring or negligent retention claims only occur when the employer has hired the employee and has received the financial benefit of that employee's services. That is simply not the case with credentialed physicians. As the Supreme Court recognized in *Fahrendorff*, *respondeat superior* requires the employer to bear the cost of the acts of its employees as that cost is incurred in the course of doing business. That is not the case in situations involving independent contractors. As the court recognized in *McElwain*, hospitals are not liable for the care of independently-contracted credentialed physicians. Recognizing negligent credentialing claims would drastically alter this well-established principle.

Recognizing negligent credentialing would overturn the well-established precedent in *McElwain* and would hold hospitals to a negligent retention standard *despite*

*the fact the hospital never hired the physician in the first place and the hospital does not receive revenue for the physician's services.* This court's analysis in *McElwain* is the law in Minnesota and should remain that way. Hospitals generally do not employ credentialed physicians and should not be held to the liability standard imposed on an employer, when the hospital does not employ that individual doctor. Recognizing claims of negligent credentialing would be completely inconsistent with the law and liability obligations imposed on employers in this state.

### **CONCLUSION**

Recognizing a claim of negligent credentialing would undermine 30 years of legislatively-created progress in peer review and would drastically change medical malpractice litigation and fundamental principles of principal/agent law. For these reasons, Amici request the Court to answer certified question A in the negative and hold that Minnesota does not recognize a common law cause of action of negligent credentialing against a hospital or other review organization.

**BASSFORD REMELE**  
*A Professional Association*

Dated: 9 Nov. 2005

By



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**CERTIFICATE OF COMPLIANCE**

Pursuant to Rule 132.01, subd. 3(c) of the Minnesota Rules of Civil Appellate Procedure, this certifies that Amici's Brief contains 5,816 words, which is in compliance with the 7,000 word limit. The brief was created using Microsoft Word 2003 and complies with the typeface requirements of Rule 132.01.

Dated: November 9, 2005

A handwritten signature in black ink, appearing to read "Mark R. Whitmore", written over a horizontal line.

Mark R. Whitmore (License #232439)

**ADDENDUM**

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# Minnesota Issues a Hospital Report Card

## *Tallying of Medical Errors Is Intended to Arm Patients And Spur Better Prevention*

By PAUL DAVIES

In a path-breaking move that other states may follow, Minnesota issued a report card intended to both provide patients with information about medical errors at individual hospitals in the state and spur those hospitals to prevent such mistakes in the future.

The report, released yesterday, identified 21 preventable deaths, 13 operations on the wrong body part and 31 cases of foreign objects left in patients after surgery among errors reported by the state's 139 hospitals. Though the numbers are relatively small, hospital officials and health-quality experts believe that collecting and disclosing the data will give patients information to guide health-care decisions and prompt hospitals to adopt strategies to improve safety.

"If you report, you can learn and then you can fix," says Barbara Balik, executive vice president for safety and quality for Allina Hospitals and Clinics, a Minneapolis health-care network that includes 11 hospitals.

Nationally, there has been a push for more disclosure and improved quality since the Institute of Medicine released its landmark report in 1999 that found hospital medical errors killed between 44,000 and 98,000 people nationwide each year. Most hospitals, however, have been reluctant to disclose such data for fear of increased lawsuits and a loss of public confidence in health-care providers.

"There is a lot of public demand for more disclosure," said Donald Berwick, president and chief executive at the Institute for Healthcare Improvement, a Boston nonprofit that advocates for improving

health-care quality. "I think there is a lot more fear in the hospitals than need be."

The Minnesota reports are broken down by individual hospital and available to the public via the Internet at [www.minnesotahealthinfo.org](http://www.minnesotahealthinfo.org).

The Minnesota report is the first since the state passed a law in 2003 requiring hospitals to provide detailed reports of medical mistakes to the public with the aim of providing usable information to consumers. Twenty-one other states require hospitals to report medical mistakes, but most don't make the information available to the public or in an easy-to-understand manner, and only a handful name the individual hospitals, said Jill Rosenthal, project manager at the National Academy for State Health Policy, a Portland, Maine, nonprofit that provides technical assistance to state governments. "I think Minnesota is a model in that sense," she said.

Minnesota and its private employers have long been incubators of ideas for improving quality and containing health-care costs and its effort to gather and report data on medical errors is likely to be closely followed elsewhere.

"I certainly think everyone will be looking at the reaction and response and if it is a success others will follow," said Michael Osborn, a cardiologist and chairman of quality oversight at the Mayo Clinic in Rochester, Minn.

The Minnesota report shows there were almost 100 adverse events across the state over the initial reporting period from July 2003 to October 2004. During the same period, the hospitals performed 378,544 surgeries. Among the 21 preventable deaths, there were three main causes: falls by patients (eight); medication errors (five); and the misuse or malfunction of a medical device (four).

Some hospitals are already using the data to help spot trends where mistakes occur and take preventive measures. For

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instance, to address the problem of falls, Fairview Health Services, a nonprofit network of seven hospitals, has started to put yellow bands on the wrist of patients who have had operations or are on medications that may lead to a fall. There are also alarms on beds to alert staff to patients trying to get up by themselves, said Alison Page, Fairview's vice president of patient safety.

Hospitals also found a cluster of mistakes surrounding operations on the wrong vertebrae. They determined that marking the skin where the surgery would take place led to errors because the skin may shift, especially with overweight patients. So now they are taking X-rays to indicate which vertebrae should be operated on, according to Bruce Rueben, president of the Minnesota Hospital Association.

The hospital association backed the law and hopes that increased public disclosure "will keep patient safety a top priority," Mr. Rueben said. But he admits hospitals are concerned about the fallout. "Hospitals are very worried and apprehensive," Mr. Rueben said.

The Minnesota reports suggests there

are fewer deaths from errors than what the Institute of Medicine report indicated, but some officials believe it may have undercounted the problem. The state collected information on only a subset of problems included in the Institute of Medicine report. Of the 139 hospitals in Minnesota, only 29 reported any adverse medical mistakes, although some of the hospitals are as small as 10 beds and don't generate a lot of volume. Still, those figures may be low, said Kenneth W. Kizer, president and chief executive officer of the National Quality Forum, a Washington nonprofit organization that designed the hospital-reporting standards used in Minnesota. He said the hospitals are probably still leery of reporting errors and may be unsure about what qualifies as a mistake.

"I think you will see higher numbers in the coming years," he said. "That doesn't mean there are more mistakes, just that there is better reporting."

The report divides the patient errors into six major categories, such as surgery, care management and products and devices. Each category is then divided by 27 separate events, such as wrong body part, wrong patient and wrong procedure. The National Quality Forum argues such basic mistakes under these 27 events are easily preventable.

"These are things that should never occur," says the National Quality Forum's Dr. Kizer. "We believe the public has a right to know when it does happen, just like when a plane falls out of the sky or a train jumps the tracks. These are the health-care crackups."

# News Release



Minnesota Hospital Association



FOR IMMEDIATE USE  
Wednesday, January 19, 2005

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## **Minnesota Department of Health publishes first-ever report on adverse events in Minnesota hospitals**

*New system aims to foster enhanced patient safety efforts*

The Minnesota Department of Health (MDH) today released the first-ever report on preventable adverse events in Minnesota hospitals. These events include errors that hospitals should always strive to prevent, such as wrong-site surgery, death from medication error, and serious disability from falls.

The legislation creating the adverse health event reporting system and calling for public reporting was championed by Minnesota hospitals and was signed into law in 2003. The Minnesota Hospital Association (MHA) and MDH have been working closely together to implement the new law.

“This report is an important step in improving patient safety for every Minnesotan,” said Governor Tim Pawlenty. “We’ve never had a report that measured this before and if you don’t measure something, you can’t improve it. Now we have a way to consistently measure, report and have accountability for events that we all agree should never happen.”

The law requires all Minnesota hospitals to report to MDH whenever any of 27 so-called “never events” occurs. The National Quality Forum, a Washington, D.C.-based healthcare consensus standards-setting organization, created this consensus-based list of adverse events in 2002 at the request of the federal government, after an Institute of Medicine report estimated that medical errors in hospitals cause 44,000 – 98,000 deaths every year in the U.S.

Kenneth W. Kizer, M.D., M.P.H., president and CEO of NQF, applauded Minnesota for being the first state to follow NQF’s recommendations for reporting adverse events. “Publication of this document demonstrates that Minnesota is in the vanguard of public reporting of medical errors,” Kizer said. “With the new law and its clearly defined list of adverse health care events, Minnesota’s state government is now able to provide more effective oversight and to make health care safer.”

The report summarizes the number and type of events that occurred in Minnesota hospitals during the start-up period of the law, between July 2003 and October 2004. According to the report, during that period, 99 adverse events were reported by 30 hospitals; and 21 deaths and three serious disabilities resulted from the events.

-more-

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## Adverse health events report—page 2

“Although one medical error is too many, Minnesotans should take comfort in knowing that hospital officials and health care experts have been working diligently to prevent errors,” Minnesota Commissioner of Health Dianne Mandernach said. “This report gives us the kind of information we can use to better focus our overall efforts at improving patient safety.”

In addition to reporting individual events, hospitals are required to report on the underlying cause of each event and the corrective actions being taken to prevent similar errors in the future. This law provides a forum to share the reported information with hospitals across the state so they can learn from one another.

The report notes that the most frequently reported adverse event was a foreign object left in a patient after surgery; the next most frequently reported event was stage three or four pressure ulcer. Almost a third of the “wrong body part surgery” reports occurred during spine surgeries (spinal surgeries are especially challenging because of the complexity of the spine).

Minnesota’s hospitals are already implementing a variety of proven strategies for preventing many types of errors. Such strategies include developing new ways to track objects used in surgical procedures, improving how patients are assessed for the risk of falling, regularly re-positioning patients at risk of pressure sores, and adding special labels to high-risk medications.

“While this reporting system has already lead to improvements, hospitals understand that these events can be devastating — for patients, their families and the caregivers involved,” said Bruce Rueben, president of the Minnesota Hospital Association. “That’s why Minnesota hospitals worked so hard to get the law passed and implemented.”

Mandernach suggests that the report should serve as a tool for consumers to become more involved in their health care. “Consumers should use this report to identify situations of interest to them and then ask their health care providers what they’re doing in their facilities to provide the safest care possible,” Mandernach said.

Mandernach added that it is difficult to compare hospitals using just the numbers in the report. “The errors documented in this report represent a very small fraction of all the procedures and admissions in Minnesota hospitals,” Mandernach said. She also pointed out that the number of events reported by hospitals can be influenced by a number of factors, including the size of the hospital, staff awareness of and dedication to reporting, and different interpretations of what should be reported.

Minnesota hospitals admit nearly 600,000 patients per year, with an average length of stay of over four days. In addition, in one year, Minnesota hospitals see 1.5 million patient visits in their emergency departments; 300,000 same-day surgery cases are treated and there are over 5.5 million visits for a variety of other hospital-based treatments or procedures, from kidney dialysis to follow-up x-rays.

A full copy of the report can be found at [www.minnesotahealthinfo.org](http://www.minnesotahealthinfo.org). More information about hospitals can be found at [www.mnhospitals.org](http://www.mnhospitals.org).

-MDH-

Note: See accompanying fact sheet and report.

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Minnesota Hospital Association

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## **Gov. Pawlenty Marks Creation of New System for Reporting Adverse Health Events in Hospitals**

*National Quality Forum's Ken Kizer delivers keynote at program held outside Methodist Hospital, putting Minnesota's efforts in national context*

**Aug. 19, 2003** — (St. Louis Park, Minn.) Gov. Tim Pawlenty, other state policy-makers and the health care community marked the creation of the state's new system for reporting adverse health events in Minnesota hospitals during a program today that featured a ceremonial bill signing of the legislation that passed this session.

"Minnesota is still a nation-leading state and we should be proud of that," Governor Pawlenty said. "We have got to be able to track and monitor these events and do it in a way that is fair. This system will accomplish that."

Hospitals will be better able to catch and fix problems thanks to the clear reporting requirements for 27 "never" events — medical errors and other adverse events that should never occur — thanks to the law authored by State Sen. Steve Kelley (D-Hopkins) and State Rep. Lynda Boudreau (R-Faribault). The legislation was supported by the Minnesota Hospital Association, along with the Minnesota Nurses Association, the Minnesota Medical Association and the Minnesota Alliance for Patient Safety.

Minnesota is the first state to fully adopt standards for reporting medical errors that were developed by the Washington, D.C.-based National Quality Forum (NQF). NQF established the reporting standards in response to a 1999 report by the Institute of Medicine.

"The National Quality Forum applauds Minnesota's health care and policy leaders on enacting this reform," said NQF President and CEO Kenneth W. Kizer, M.D., M.P.H. "The legislation we celebrate today will make Minnesota's already good health care system better — there is no question in my mind it will make it safer," Kizer said.

— more —

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Initial implementation is already starting, with a full-fledged transition period starting up this fall when funds are raised. At that point all Minnesota hospitals will be required to report the NQF 27 events using the MHA patient safety registry. The transition period will run for two years or less, depending on whether the needed additional funds are secured to move to full implementation more quickly. When the law is fully implemented the Department of Health will publish public annual reports describing reported adverse events by facility.

“It is in the best interests of patients for hospitals to report the occurrence of any defined adverse event, study its root causes and share the learning with all hospitals so that we can more quickly address the real causes of these events,” said David K. Wessner, Park Nicollet Health Services president and CEO and chair of the Minnesota Hospital Association.

Other speakers at the program included Department of Health Commissioner Dianne Mandernach; Rep. Lynda Boudreau (R-Faribault); Sen. Becky Lourey (DFL-Kerrick); Minnesota Medical Association president Gary Hanovich, M.D.; and Minnesota Nurses Association Executive Director Erin Murphy, R.N.

*The Minnesota Hospital Association is a trade association representing Minnesota's hospitals and health systems.*

MINNESOTA HOSPITALS

# 1st-time study finds 20 fatal hospital errors

Health officials hope 15-month, statewide report a prelude to reform

BY KERMIT PATTISON and TOM MAJESKI  
Pioneer Press

In the first public disclosure of its kind, Minnesota hospitals acknowledged medical errors that caused 20 deaths and four serious disabilities over a 15-month period, according to a report released Wednesday.

Thirty hospitals across the state reported preventable errors such as bedsores, fatal falls or surgery on the

wrong body part or patient. In all, there were 99 cases of preventable errors during the study period from July 1, 2003, to October 6, 2004.

The report, which was required by a new state law, provides a baseline in measuring a problem that so far has lacked reliable comparisons nationally. There is no way to compare Minnesota's results nationally because no state has conducted a similar report.

Hospitals, cont'd on p. 5

## How area hospitals fared

▼ Hospital	▼ City	▼ Total medical errors
Bethesda Rehabilitation Hospital	St. Paul	2
Fairview Ridges Hospital	Burnsville	2
Gillette Children's Specialty Healthcare	St. Paul	2
*Regions Hospital	St. Paul	5
St. John's Hospital	Maplewood	2
St. Joseph's Hospital	St. Paul	2
United Hospital	St. Paul	2

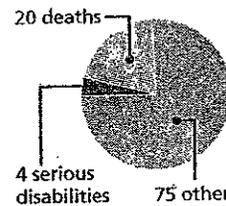
\*Regions was the only hospital of the ones above to record a death and a disability.  
Source: Minnesota Health Department

## NUMBERS

Events reported between July 1, 2003, and Oct. 6, 2004:

**99**

total medical errors or oversights that harmed or could have harmed a patient.



**52** surgical events  
Example: Performing on the wrong body part

**31** care management events  
Example: An event associated with a medication error

**9** environmental events  
Example: Electric shock, burn or fall during care

**4** product or device events  
Example: The use of contaminated drugs or devices

**2** patient-protection events  
Example: An infant discharged to the wrong person

**1** criminal event  
Example: Abduction or sexual assault of a patient

ILLUSTRATION, PHOTOS.COM

TO VIEW THE REPORT AND A CHART OF RESULTS BY HOSPITAL, VISIT [WWW.TWINCITIES.COM](http://WWW.TWINCITIES.COM)

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# Hospitals report

(continued)

State health officials hope the data and future reports will reveal systemic weaknesses and lead to reforms that reduce the likelihood and severity of errors.

"The true value of our new reporting system lies not in the numbers but in the underlying evaluation in the causes of the errors and the actions taken to prevent them from ever reoccurring in the future," said Minnesota Health Commissioner Dianne Mandernach. "One medical error is one too many."

The report represented the first tally of preventable medical errors at all 145 hospitals across Minnesota and one of the first such efforts in the nation. It counted 27 categories, including surgery on the wrong body part or patient, foreign objects left in the patient after surgery, electric shocks, burns or falls, errors in medication, abduction and assaults on hospital grounds.

Nearly three-quarters of the 99 events cited in the report did not result in serious disability or death.

The most common mishap was 31 cases of foreign objects left inside patients after surgery. The second most common was 24 cases of hospital-related bedsores.

Surgical errors accounted for slightly more than half of the cases. There were two deaths of previously healthy patients during or immediately after surgery for reasons not disclosed in the report.

Fatalities associated with falls were the leading cause of death. There also were four deaths from misuse or malfunction of medical devices and four deaths from errors administering medication.

Fairview-University Medical Center in Minneapolis reported 13 cases, the most of any hospital in the state.

Alison Page, vice president for patient safety for Fairview Health Services, said the hospital has taken steps to prevent reoccurrences. The hospital brought in experts from the University of Minnesota to help minimize operating room distractions such as noise or beepers, she said.

"We are committed to improving safety and chose to demonstrate that commitment in the most public way," said Bruce Rueben, president of the Minnesota Hospital Association.

But Minneapolis attorney Chris Messerly faulted the law for failing to count a number of medical errors that can leave patients with severe life-altering injuries.

"The tragedy of the law is that many serious mistakes are

not involved in the report," Messerly said. "Maybe it's a start. But I hope that (patients) don't bank on it as being full disclosure because it's not even close. It's letting hospitals off the hook."

One report by the Institute of Medicine estimated that medical errors kill an estimated 44,000 to 98,000 Americans each year. Officials said those esti-

About 20 states  
have some form of  
mandatory  
reporting laws.

mates used a different set of criteria than the Minnesota report.

The latest report was the result of a 2003 groundbreaking state law requiring hospitals to disclose the errors and take corrective action. Connecticut and New Jersey have since passed similar reporting laws and a number of other states are considering similar legislation, according to the National Quality Forum, a Washington-D.C.-based group that developed the 27-item list of reportable incidents.

About 20 states have some form of mandatory reporting laws, said Marie Dotseth, a senior policy adviser for patient safety with the Minnesota Health Department.

The Health Department's report contained no patient names. But it drew strong reaction from people living with the consequences of medical mistakes.

"Our health care system is a good system, but we need more accountability," said Susan Richardson, 53, of Ellsworth, Wis., whose husband Dennis, 59, sustained brain damage from massive bleeding caused by a broken stitch after surgery.

"He can't do anything," Susan Richardson said. "He

can't even clap his hands, snap his fingers; he can't read quickly, and he can barely write. The motor skills are gone almost entirely."

James Williams of Plymouth also applauded the reporting system.

Five years ago, his wife, Sharon, also sustained brain damage when she stopped breathing for several minutes because a nurse failed to engage an alarm on a monitor after routine surgery.

Williams said hospitals with high error rates might view the report as potentially harmful. But he hoped it would spur improvements in their systems.

"We're all in this together," he said. "We're all going to suffer as a result of this unless there are changes. This is a wonderful beginning."

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# Hospital errors revealed

30 hospitals reported 99 mistakes and 20 deaths in 15 months.

Health officials say the state's error registry can help reduce mistakes.

By Maura Lerner  
Star Tribune Staff Writer

Minnesota hospitals performed surgery on the wrong body parts, gave the wrong medications or made other mistakes that endangered patients 99 times in a 15-month period starting in the summer of 2003, according to the first such report in the nation.

The report, released Wednesday by the Minnesota Health Department, said that

## INSIDE

► A detailed look at the 30 hospitals and the mistakes reported. **A12**  
► Objects left in surgery patients and bedsores were frequent on the list of mistakes. **A12**

20 deaths were associated with hospital errors, including eight people who died after falls and four after medication errors. Until now, these kinds of numbers were among the most closely guarded secrets in medicine. Now, Minnesota hospitals are required by law to report 27 kinds of mistakes or preventable accidents known as "never events," which experts say never should happen.

In all, 30 of 145 hospitals reported at least one "never" event between July 2003 and October 2004. Some of the most respected — and largest — hospitals were among those reporting the most errors in the first of what will be an annual report.

Fairview-University Medical Center, the state's premier teaching hospital at the University of Minnesota, had the largest number of reported errors.

Fairview reported 13 errors, including one associated with a patient's death, according to the report. Another Minneapolis hospital, Abbott Northwestern, came in second, with nine errors and two associated deaths.

The Mayo Clinic reported six errors at its two Rochester hospitals, including two deaths associated with medication errors and one operation on the wrong body part.

Hospital officials say the disclosures, while painful, are intended to help them learn from each other's mistakes and to improve patient safety. Already, they say, they have taken steps to reduce the chances these mistakes will happen again.

"I'm sure all of us will be sobered by the report," said Barbara Balik, executive vice president for safety and quality at Allina hospitals and clinics, which owns Abbott Northwestern. She said that health officials are starting to learn the lessons of the airline industry. "The way you improve safety is by reporting, learning and then fixing the problems."

More than half the reported mistakes occurred during surgery. Of those, 31 involved foreign objects, such as sponges and needles, that were left inside patients after surgery.

There also were 13 cases of operations on the wrong body part, a third involved spinal surgery, and 24 cases of bedsores, which can be dangerous if they become infected.

Most of the patient deaths were associated with falls, medication errors and faulty or misused medical devices.

St. Luke's Hospital in Duluth reported the most deaths: one patient each in four categories: a fall, a burn, a medication error and a problem with a device. Fairview Southdale Hospital in Edina had three deaths.

Hospital officials say the reports do not necessarily mean that the errors caused the deaths. Jo Ann Hoag, a nurse who co-chairs St. Luke's patient safety program, said hospitals were required to report any death "associated with" an error. The hospital took the broadest possible view. If the error and the death occurred during the same hospital stay, it was reported, she said.

"We didn't look at cause and effect," she said. "We're not trying to explain this away. We're trying to say how we interpreted the intent of the law."

State officials said there was some ambiguity in the rules, but that the intent was to report errors that contributed to patient deaths or disabilities. Statewide, four patients were left with serious disabilities, the report showed.

"This is a ground-breaking day for health care in Minnesota," said Dianne Mandernach, state health commissioner. "The first step is learning why these events occur and then fixing the system so it won't happen again."

The report contained no patient names or details, and hospitals would not discuss individual cases. "What we're here to talk about is what we're learning from these situations and not individual events," Hoag said.

A spokeswoman at Fairview Health Services said hospital officials regret the errors and have taken elaborate steps to ensure that they don't happen again. "I don't want to make any excuses for any of these numbers," said Alison Page, vice president for patient safety. "We're only focused on getting to zero on these numbers, and none of these events should occur."

The state's largest hospitals generally reported the highest numbers of mistakes. But they also treated many more patients than community hospitals, and their error rates were lower than some smaller hospitals.

The good news was that there were no incidents reported in such categories as discharging an infant to the wrong person, or death or disability from electric shock. Only one reported case involved a criminal event: a physical assault on a patient at Hennepin County Medical Center. The hospital did not provide details. Hospital officials acknowledged that people may be surprised by the number of reported mistakes. But they noted that state hospitals treat nearly 600,000 inpatients each year, in addition to 1.5 mil-

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lion emergency-room visits and 300,000 outpatient surgeries.

"By definition, these events are rare," said Bruce Rueben, president of the Minnesota Hospital Association. Yet, he added, "they are measurable. They are preventable. They should never happen."

Mandernach said hospitals are required to investigate each error, and come up with a corrective plan. "The real crux of this is what the facilities are going to do as a result of it," she said.

Hospital officials admit that they're nervous about how the report will affect their reputations. "It would be tragic if patients become increasingly concerned about the care that they [receive]," said Dr. Michael Osborn, a cardiologist at the Mayo Clinic who chairs its quality oversight committee. "I hope that what it will show our patients is that we're serious about evaluating these episodes and we're serious about preventing them."

The Minnesota Hospital Association pushed for the state law that set the reporting in motion in 2003.

Minnesota was the first state to adopt a list of 27 reportable events proposed by the National Quality Forum, based in Washington, D.C. Two others, New Jersey and Connecticut, have followed suit but have not released results yet. The list was inspired by a 1999 Institute of Medicine report that estimated that 44,000 to 98,000 people die each year from hospital errors.

One problem, experts say, is that some mistakes are so rare, hospitals may not realize the danger until the numbers are tallied statewide.

That's the purpose of this kind of report, said Dr. Kenneth Kizer, president of the National Quality Forum. "If you've got human beings involved, you're going to have errors," he said. "The two go together. If so, then let's design

systems so you minimize those errors. Let's change the whole culture so we view these things as learning experiences."

*The report can be found at [www.minnesotahealthinfo.org](http://www.minnesotahealthinfo.org) or [www.health.state.mn.us](http://www.health.state.mn.us).*

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# Error registry law driving changes

Hospitals have devised new safeguards.

By Maura Lerner  
Star Tribune Staff Writer

At Mercy Hospital in Coon Rapids, no one gets knee surgery unless the surgeon signs his or her initials on the leg that's going under the knife.

And before the first cut, everyone in the operating room gathers for a ritual called "pause for the cause." Anyone can stop the operation if something seems amiss.

It's all part of a new wave of safeguards that several Minnesota hospitals have put in place since a 2003 state law required them to start reporting errors to a state registry.

Already, they say, the procedures are working to prevent the kind of mistakes that turned up in Wednesday's report, including wrong-site operations, falls and bedsores.

"These things happen at outstanding facilities," said Marie Dotseth, the patient-safety adviser for the Minnesota Health Department. "Which goes to show you these things don't happen because people aren't trying hard. This happens because human beings make mistakes."

The answer, she and others say, is to build the safeguards into daily routines.

That's what Dr. Michael Walker, a general surgeon at Mercy and Unity hospitals, did as part of a program called "Safest in America," a collaboration of Twin Cities hospitals and the Mayo Clinic.

He and his colleagues came up with a checklist for any type of surgery that could conceivably be performed on the wrong side of the body.

The first step, Walker says, occurs when patients are being prepped for surgery, before they are sedated. He grabs a black Sharpie marker and tells the patient: "I need to put my initials on this side so that everybody knows that you and I agree that this is the side that we're going to operate on." The rules require the doctor's initials; sometimes the patient marks the spot as well.

Later, in the operating room, everyone pauses as a nurse reads aloud the name of the pa-

tient, the operation, and what side it's on. If anyone has any doubts, the operation is called off.

So far, that's only happened to Walker once. But he heard of another case where one person spoke up and prevented the wrong operation. "In my opinion, it should be done in every operating room," he said.

Other changes are in the works.

To prevent falls, some hospitals are using magnetic tags that sound an alarm when fragile patients try to get out of bed. Others use lower beds to blunt the falls, or special tags to identify people at high risk.

To prevent bedsores, some hospitals adopted special skin-care techniques and rules for moving bedridden patients more frequently.

Recently, when hospitals noticed a spike in mistaken spinal operations, they started using X-rays in the operating room to ensure that the correct vertebra is fixed.

That's where the new error reports are paying off, said Shireen Gandhi, vice president of the Minnesota Hospital Association. People might assume it's one surgeon's fault, when it's really a trend. "If this is happening in different places, there must be something that's making it happen," she said. "And there must be a way to prevent that."

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