

Nos. A05-1698 and A05-1701

State of Minnesota
In Supreme Court

MARY AND MICHAEL LARSON,

Appellants,

v.

JAMES PRESTON WASEMILLER, M.D.,

Respondent (A05-1698),

Defendant (A05-1701),

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

Defendants (A05-1698),

ST. FRANCIS MEDICAL CENTER,

Respondent (A05-1701).

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STATEMENT OF INTEREST

The Minnesota Defense Lawyers Association (“MDLA”), founded in 1963, is a non-profit Minnesota corporation whose members are trial lawyers in private practice.¹ MDLA devotes a substantial portion of its efforts to the defense of civil litigation. MDLA is affiliated with the Minnesota State Bar Association and Defense Research Institute. Over the past 42 years, MDLA has grown to include representatives from over 180 law firms across Minnesota, with 800 individual members.

The MDLA has a public interest in protecting the rights of litigants in civil actions, promoting the high standards of professional ethics and competence, and improving the many areas of law in which its members regularly practice. Those interests translate into concerns regarding the practical impact of developing law within the civil justice system. To that end, and for the reasons articulated in this brief, the MDLA urges the Court to refuse to recognize a common law cause of action for negligent credentialing/privileging² of a physician against a hospital or other review organization.

¹ The undersigned counsel for Amici authored the brief in whole, and no persons other than Amici made a monetary contribution to the preparation or submission of the brief. This disclosure is made pursuant to Minn. R. Civ. App. P. 129.03.

² Throughout the remainder of this brief, MDLA will refer to the new cause of action sought by Plaintiffs as “negligent credentialing,” while recognizing the claim involves aspects of both credentialing and privileging.

ARGUMENT

I. RECOGNITION OF A NEGLIGENT CREDENTIALING TORT WOULD BE INCONSISTENT WITH MINNESOTA LAW AND CONTRARY TO PUBLIC POLICY

One fundamental principle underlying the common law is that, at some point, there must be an end to liability. “In delineating the extent of a tortfeasor’s responsibility for damages . . . courts must locate the line between liability and non-liability at some point,” recognizing that “[n]ot every loss can be made compensable in money damages, and legal causation must terminate somewhere.” *Salin v. Kloempken*, 322 N.W.2d 736, 737-38 (Minn. 1982). Whether to expand liability for medical malpractice to include a new cause of action for negligent credentialing is a question of policy. While the facts of this particular case have sympathetic appeal, the broad implications of accepting Appellant’s position cannot be ignored. *Id.* at 737 (when deciding whether to recognize a new cause of action, this Court “must take into account considerations in addition to logical symmetry and sympathetic appeal”); *see also Dougherty v. State Farm Mut. Ins. Co.*, 699 N.W.2d 741, 746 (Minn. 2005) (Anderson, J., concurring) (noting that “bad facts often make bad law”). Because negligent credentialing claims would be inconsistent with the direction taken by the Minnesota legislature and courts and an illogical extension of medical malpractice doctrine, this Court should decline to recognize this cause of action in Minnesota.

A. Negligent Credentialing Expands The Concept Of Assumed Duty Beyond Its Common Law Proportions

Appellants urge this Court to embrace a cause of action for negligent credentialing because the harm is foreseeable and hospitals already owe a duty of care to patients. (App. Br. at 21-22.)³ Appellants fail to carefully discuss the existing common law. Generally, there is no common law duty to prevent a third person from injuring another unless a special relationship exists. *Radke v. County of Freeborn*, 694 N.W.2d 788, 793 (Minn. 2005) (citing Restatement (Second) of Torts § 315 (1965)). While the common law has recognized that a special relationship exists in a number of circumstances, including hospital-patient, *Erickson v. Curtis Inv. Co.*, 447 N.W.2d 165, 168 (Minn. 1989), Minnesota courts have never recognized that special relationship outside the context of direct services given to a patient. Moreover, foreseeability of injury has never been the only consideration. In order to recover under a theory of negligence, plaintiffs

³ Appellants also argue that the Remedies Clause of the Minnesota Constitution requires this Court to recognize a cause of action for negligent credentialing. (App. Br. at 20-21, 26-27.) The clause provides:

Every person is entitled to a certain remedy in the laws for all injuries or wrongs which he may receive to his person, property or character, and to obtain justice freely and without purchase, completely and without denial, promptly and without delay, conformable to the laws.

Minn. Const. art. I, § 8. However, the Remedies Clause “does not guarantee redress for every wrong.” *Olson v. Ford Motor Co*, 558 N.W.2d 491, 497 (Minn. 1997). Instead, the clause merely “enjoins the Legislature from eliminating those remedies that have vested at common law without a legitimate legislative purpose.” *Id.*; see also *Hickman v. Group Health Plan, Inc.*, 396 N.W.2d 10, 14 (Minn. 1986) (the clause “assures remedies for rights that vested at common law”). Because the common law does not recognize a claim for negligent credentialing, Appellants have no support for their position under the Remedies Clause.

must show “a breach of some duty owed them in their individual capacities and not merely a breach of some obligation owed the general public.” *Cracraft v. City of St. Louis Park*, 279 N.W.2d 801, 804 (Minn. 1979) (quoting *Hoffert v. Owatonna Inn Towne Motel, Inc.*, 293 Minn. 220, 222, 199 N.W.2d 158, 159 (1972)). In other words, a purely “public duty” – as opposed to a “special duty” (i.e., assumed duty) – cannot give rise to tort liability. *Radke*, 694 N.W.2d at 793; *Cracraft*, 279 N.W.2d at 805 (noting that “the distinction between public duty and special duty applies to alleged private tortfeasors as well as alleged public tortfeasors”).

Appellants allege that hospitals have assumed the duty to protect the public from incompetent physicians by seeking accreditation from the Joint Commission on Accreditation of Health Care Organizations (“JCAHCO”) and gathering information from the National Practitioner Data Bank (“Data Bank”). (App. Br. at 23-24.) Based on this alleged “assumed” duty, Appellants essentially ask this Court to hold hospitals and review organizations liable for negligently investigating the credentials of physicians and, in turn, failing to prevent those physicians from causing harm to their patients. For example, Appellants’ argument about vicarious liability assumes a duty arises between the hospital and a specific patient when a hospital makes the decision to recognize a physician’s credentials, even though this decision is made long before any specific patient receives treatment from the physician in the hospital. (App. Br. at 24-25.)

This Court has previously addressed whether a cause of action can be maintained for negligent “investigation” under statutory or regulatory mandates. In *Cracraft v. City of St. Louis*, 279 N.W.2d 801, 840 (Minn. 1979), this Court held that “general duties

owed to the entire public rather than a specific class of persons cannot form the basis of a negligence action.” The court of appeals appropriately noted that *Cracraft* was “not limited in application to government tortfeasors.” *Larson v. Wasemiller*, 718 N.W.2d 461, 466 n.3 (Minn. Ct. App. 2006). In *Cracraft*, the plaintiffs argued that a municipality should be liable for negligently inspecting the conduct of third persons for fire code violations. 279 N.W.2d at 803. At the outset, this Court recognized that there is “no common-law duty imposed on any individual or any municipality to inspect and correct the fire code violations of a third person unless there is a ‘special relation’ between the parties.” *Id.* at 804. However, the Court also recognized that there were additional considerations at issue, stating:

The municipality’s own ordinances require that it undertake inspections for fire code violations. However, such inspections are required for the purpose of protecting the interests of the municipality as a whole against the fire hazards of the person inspected. The inspections are not undertaken for the purpose of assuring either the person inspected or third persons that the building is free from all fire hazards, just as the state’s issuance of a driver’s license is no assurance that the licensed person will be a safe driver. *Because the ordinances are designed to protect the municipality’s own interests, rather than the interests of a particular class of individuals, only a “public” duty to inspect is created.* It is a basic principle of negligence law that public duties created by statute [or administrative regulation] cannot be the basis of a negligence action even against private tortfeasors. . . .

. . . .

We hold, therefore, that a municipality does not owe any individual a duty of care merely by the fact that it enacts a general ordinance requiring fire code inspections or by the fact that it undertakes an inspection for fire code violations. *A duty of care arises only when there are additional indicia that the municipality has undertaken the responsibility of not only protecting itself, but also undertaken the responsibility of protecting a*

particular class of persons from the risks associated with fire code violations. . . .

Id. at 805-06 (emphasis added).

In determining whether the municipality had assumed a duty to act for the protection of others, as distinguished from acting merely for itself, the Court outlined several relevant factors, including (1) whether the municipality had actual knowledge of the dangerous condition, (2) whether the plaintiffs reasonably relied upon specific representations of the municipality, which caused them to forego other alternatives of protecting themselves, (3) whether an ordinance or statute created mandatory acts clearly for the protection of a particular class of persons, rather than the public as a whole, and (4) whether the municipality exercised due care to avoid increasing the risk of harm. *Id.* at 806-07.

Ultimately, *Cracraft* declined to create the new tort because it “would expand the concept of ‘assumed duty’ beyond its common-law proportions.” *Id.* at 808. Although noting that the constitution entitles every person to a remedy for injuries or wrongs, *see* Minn. Const. art. 1, § 8, the Court held:

In this situation, there exist viable defendants who allegedly violated the fire codes and may be held responsible at law if their negligence caused injury to the plaintiffs. We are being asked to add another defendant; namely, the municipality involved. If such an expansion and change of the law is to occur, it is better that the legislature act in this field where extensive hearings can be conducted to consider the extent of the financial impact of such a basic change. It is quite apparent that we are unable to comprehend the ramifications of imposing a duty to enforce the law with reasonable care. It is of little help to assume that the municipalities will not often be liable or that their financial exposure is limited by statute. This assumption may be false, and in any event, municipalities will often be named as defendants in a host of litigation where they presently have no

exposure. The cost of defense is a vital ingredient in procuring insurance or providing self-insurance for such litigation.

Manifestly, then, the creation of a new duty owed by municipalities and other governmental entities to enforce the law with reasonable care is a change which should be made by the legislature. We will not assent to such a change by the judiciary.

Id.

The principles outlined in *Cracraft* apply with equal force here. Appellants argue that “JCAHCO standards place an affirmative duty on hospitals to collect relevant data regarding the issuance of credentials and privileges to physicians.” (App. Br. at 23.) But Appellants fail to analyze this theory under the principles articulated in *Cracraft*. A duty of care arises only if there are “additional indicia” of a special duty – *i.e.*, that hospitals have undertaken the responsibility to protect a particular class of persons, rather than the general public. *See id.* at 806. No additional indicia exists in the context of credentialing decisions.

The third *Cracraft* factor—whether the mandatory acts clearly are for the protection of a particular class, rather than the public as a whole—is determinative. “[A] hospital’s credentialing decisions are made based on the interests of the hospital itself[,]” not on behalf of any particular class of individuals. Craig W. Dallon, *Understanding Judicial Review of Hospitals’ Physician Credentialing and Peer Review Decisions*, 73 *Temp. L. Rev.* 597, 666 (2000). “This self interest is particularly strong in the actions of private, for-profit hospitals who, like other for-profit businesses, presumably have their own economic interests foremost in mind.” *Id.* (concluding that credentialing does not

make private hospitals fiduciaries to the public). As Dallon explains, a hospital's self-interest in the credentialing process is motivated by several factors, including:

- (1) a genuine desire to fulfill the hospital's fundamental mission;
- (2) a desire to maintain and enhance the hospital's reputation in the community and among physicians, prospective patients, and the hospital's peers;
- (3) discharge of a hospital's legally imposed duty;
- (4) fear of liability to injured plaintiffs; and
- (5) the hospital's economic viability and ability to attract patients.

Id. at 616-17.

A special duty does not arise simply because hospitals seek accreditation from the JCAHCO or may gather information from the Data Bank. The purpose of hospital standardization through the JCAHO is to protect the public and to "assure the public that hospitals were safe and worthy of the public's patronage." *Id.* at 603. As Dallon notes:

JCAHO has continued to emphasize the necessity for independent, self-governing medical staffs at hospitals. . . . Although JCAHO is a private nonprofit corporation and hospitals are not required to obtain JCAHO accreditation, the great majority of hospitals do seek and receive accreditation. JCAHO accreditation affords substantial advantages to hospitals including eligibility to receive Medicare payments and recognition under state licensing requirements.

Id. at 603-04. Likewise, the Health Care Quality Improvement Act ("HCQIA") established a national reporting system to the Data Bank to protect the public, with the goal of "prevent[ing] incompetent physicians from moving from state to state without discovery." *Id.* at 614 (citing 42 U.S.C. § 11101, *et seq.*). The HCQIA encourages reporting to the Data Bank by providing complying hospitals with qualified immunity from damages resulting from the hospital's professional review actions. *Id.* at 614 (citing 42 U.S.C. §§ 11111, 11151(11)). The purpose of the JCAHO and HCQIA is to protect

the general public, and hospitals also act in their own self-interest by complying with these standards.

Finally, hospital review of physicians' credentials is mandatory as prescribed by the Minnesota legislature. Again, the statutes are devised for the protection of the public as a whole. The Minnesota Adverse Health Care Events Reporting Act of 2003 requires hospitals to report adverse actions involving a physician's privileges, and subjects the hospital to fines and/or loss of the hospital's license as a consequence for failure to cooperate. *See* Minn. Stat. §§ 144.706-7069. Thus, the third *Cracraft* factor is "overwhelmingly dominant" and demonstrates that only a public, rather than special, duty is involved in the credentialing process. *See Andrade v. Ellefson*, 391 N.W.2d 836, 843 (Minn. 1986).

Moreover, in a typical negligent credentialing case, the remaining *Cracraft* factors will not be present. It is unlikely that a hospital would credential a physician when it had actual knowledge of a dangerous condition, that a patient would rely upon specific representations of the hospital regarding a physician's credentials such that they would "forego other alternatives" for health care, or that a hospital would fail to exercise due care to avoid increasing the risk of harm. *See Cracraft*, 279 N.W.2d at 806-07. Here, appellants have not alleged any of these facts in the Complaint. (AA. 48-59.)

Consequently, as it did in *Cracraft*, this Court should reject Appellants' invitation to create a new tort that "would expand the concept of 'assumed duty' beyond its common-law proportions." *See id.* at 808. As discussed below, not only is such an expansion unnecessary since plaintiffs are already permitted to bring medical malpractice

claims against existing viable defendants (*i.e.*, physicians and hospitals who have breached the standard of care in medical treatment), but consideration of this issue is better left to the legislature.

B. Decisions In Other Jurisdictions Are Not Dispositive

Appellants point out that a majority of jurisdictions have extended liability to hospitals for negligent credentialing of their physicians. (App. Br. at 19-20.) Although this point is noteworthy, it is not dispositive. Appellants have failed to demonstrate that recognition of this tort will serve public policy in Minnesota. Moreover, there are compelling reasons to remain in the minority.

Proponents of the negligent credentialing tort offer a number of justifications in support of imposing additional liability upon hospitals. For example, courts have recognized that “hospitals are no longer viewed as the mere physical facilities in which doctors do their work, but are rather viewed as comprehensive healthcare centers that provide and monitor all aspects of health care.” *Gafner v. Down East Cmty. Hosp.*, 735 A.2d 969, 977 (Me. 1999) (citing David H. Rutchik, Note, *The Emerging Trend of Corporate Liability: Courts’ Uneven Treatment of Hospitals Standards Leaves Hospitals Uncertain and Exposed*, 47 Vand. L. Rev. 535, 538 (1994)). However, “[t]his evolving theory of liability . . . has not been universally embraced.” *Gafner*, 735 A.2d at 978.

The first rationale is that corporate credentialing liability is appropriate because “a hospital is in the best position to monitor and control its staff physicians,” despite the fact that most physicians are independent contractors who exercise highly specialized professional judgment. *See id.* (citations omitted); *Cf. Swigerd v. City of Ortonville*, 246

Minn. 339, 346-47, 75 N.W.2d 217, 222 (1956) (physicians' duties require "specialized medical knowledge"). But critics have argued that courts have imposed a broad general duty on hospitals to monitor and control their physicians through the credentialing process without providing "guidance as to the extent to which hospitals must now monitor staff physicians" or articulating "the standard of care to which hospitals must adhere." *Gafner*, 735 A.2d at 978 (quoting Judith M. Kinney, Casenote, *Tort Law-Expansion of Hospital Liability Under the Doctrine of "Corporate Negligence,"* 65 Temp. L. Rev. 787, 797 (1992)); see also Mark E. Milsop, Comment, *Corporate Negligence: Defining the Duty Owed by Hospitals to Patients*, 30 Duq. L. Rev. 639, 643 (1992) (noting that, despite the *Thompson* court's broad statement of the general rule, "the question remains as to exactly what the rule's boundaries are"). Because there is no consistent judicial application of the standards, corporate liability leaves hospitals "exposed to almost limitless liability without the reasonable ability to take preventive measures." Rutchik, *supra*, at 537. As one legal commentator explained:

When determining corporate liability for negligent physician selection and supervision, courts have relied on different standards and have imposed varying degrees of hospital duties. Unfortunately, courts have assessed hospital liability inconsistently, which has placed hospitals in a difficult and precarious situation because even diligent administrators realistically cannot determine whether their decisions regarding physician selection and supervision will result in corporate liability. Nor can a hospital administrator know what proactive steps to take to protect the hospital from liability. If a hospital is too careful in its physician selection or supervision, the hospital may face liability from the doctors who are denied staff privileges and who assert that the hospital acted improperly in deciding to deny or suspend privileges.

Id. at 559. This confusion over the extent of potential liability may have a chilling effect on hospital credentialing decisions, leading “hospitals to turn away candidates with even minor blemishes on their records or in cases where any doubt exists.” Dallon, *supra*, at 622. As a result, “[b]oth doctors and their patients can suffer if otherwise qualified doctors are wrongly denied staff privileges.” *Balkissoon v. Capitol Hill Hosp.*, 558 A.2d 304, 308 (D.C. Cir. 1989).

The second rationale is that imposition of corporate liability is justified in order to give hospitals added incentive to select and supervise its staff physicians carefully in order to avoid liability. *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156, 164-65 (Cal. Ct. App. 1982). The “incentive justification” for corporate liability is invalid because “the market provides more than an adequate incentive to select competent physicians and supervise them carefully.” Rutchik, *supra*, at 549-50. In the competitive market in which modern hospitals operate, the potential of losing business from bad publicity already provides enough incentive to select competent staff physicians. *See id.* Thus, the incentive justification inappropriately uses “the tort system to solve a problem that the free market could address more properly.” *Id.* at 550.

Likewise, legislation already promotes the use of “peer review” in order to “improve the quality of medical care by discouraging medical malpractice and exposing incompetent physicians.” Dallon, *supra*, at 625. In fact, Minnesota specifically encourages review organizations and credentialing bodies to participate in the peer review process as a matter of public policy, with the incentive that their proceedings and records will be kept confidential and by offering immunity from liability. *See Minn. Stat.*

§§ 145.63, 145.64. Thus, recognition of a negligent credentialing tort is not necessary to encourage hospitals to make careful staffing decisions.

The third rationale is that corporate liability is needed to provide a source of compensation for the injured claimant. *See, e.g., Pedroza v. Bryant*, 677 P.2d 166, 169 (Wash. 1984). But negligent credentialing as a tort should not be supported merely by the “judicial desire to place liability on the party most able to pay;” this Court should also consider whether a new tort places blame on the most appropriate tortfeasor. *Gafner*, 735 A.2d at 978 (quoting Gregory T. Perkes, Casenote, *Medical Malpractice-Ostensible Agency and Corporate Negligence*, 17 St. Mary’s L.J. 551, 573 (1986)). For example, in *Thompson v. Nason Hospital*, 591 A.2d 703 (Pa. 1991), Judge Flaherty filed a dissenting opinion and stated:

In adopting this new theory of liability, the majority is making a monumental and ill-advised change in the law of this Commonwealth. The change reflects a deep pocket theory of liability, placing financial burdens upon hospitals for the actions of person who are not even their employees. At a time when hospital costs are spiraling upwards to a staggering degree, this will serve only to boost the health care costs that already too heavily burden the public. Traditional theories of liability, such as respondeat superior, have long proven to be perfectly adequate for establishing corporate responsibility for torts.

Id. at 343-44, 591 A.2d at 709 (Flaherty, J., dissenting). “[T]his deep-pocket theory departs from the traditional fault-based tort system” by creating “a quasi-strict liability system” in which hospitals are at risk of being treated as “the ultimate insurers” of the actions of independent contractor physicians. *Rutchik, supra*, at 549-50.

Moreover, negligent credentialing claims are not needed to compensate victims of medical malpractice in Minnesota. The law currently provides adequate relief for

patients by allowing medical malpractice claims against physicians who have breached the standard of care in medical treatment. Additionally, hospitals may be found liable under respondeat superior for negligence caused by resident doctors who receive compensation from the hospital. *See Moeller v. Hauser*, 237 Minn. 368, 379, 54 N.W.2d 639, 646 (1952); *cf.* Steven J. Kirsch, 5A *Methods of Practice* §11.8 at 566-67 (3d ed. 1990) (recognizing that in Minnesota, hospitals are not liable under respondeat superior if physicians are independent contractors). Hospitals and private physicians may also be held liable for a nurse's negligence in performing "administrative or clerical acts," even if those acts constitute a part of the patient's treatment. *See, e.g., Swigerd*, 246 Minn. at 345-46, 75 N.W.2d at 222 (private or charitable hospital liable); *St. Paul-Mercury Indem. Co. v. St. Joseph's Hosp.*, 212 Minn. 558, 4 N.W.2d 637 (1942) (physician liable). Furthermore, a hospital can be liable for failing to maintain its premises in a safe condition, *see, e.g., Tackleson v. Abbott-Northwestern Hosp., Inc.*, 415 N.W.2d 733 (Minn. Ct. App. 1987) (fall from hospital bed) or for failing to exercise reasonable care for their patients' well-being and protection. *See, e.g., Trepanier v. McKenna*, 267 Minn. 145, 125 N.W.2d 603 (1963) (no help in returning to bed). Thus, injured plaintiffs already have numerous avenues of redress available to them.

In *Gafner*, the Supreme Judicial Court of Maine recognized that a new cause of action must be approached with caution, giving careful consideration to the "complex public policy affecting the process by which medical decisions are made, . . . the safety of patients, the welfare of the public, and the economic forces as yet unexplicated." 735 A.2d at 969. Although the plaintiffs in *Gafner* abandoned their general negligent

privileging claim in favor of a more narrow theory of corporate liability based on a hospital's failure to have explicit policies to control the actions of physicians, *see id.* at 979, *Gafner* articulates concerns that apply here as well.

In rejecting the new tort proposed by the plaintiffs, the Maine Supreme Court noted that private hospitals were extensively regulated by the legislature, and accordingly, concluded that the legislature should be given the opportunity to determine whether imposition of such a duty “continues wise public policy.” *Id.* Moreover, the court recognized that “creating a duty on the part of hospitals to control the actions of those physicians who have traditionally been considered independent contractors may shift the nature of the medical care provided by those physicians.” *Id.* Consequently, “[i]n an area as replete with the possibility of unexpected or unintended consequences as this,” the court held that it “should exercise restraint in the use of our authority to create new causes of action.” *Id.* at 979-80.

For similar reasons, this Court should also approach the adoption of a negligent credentialing tort with restraint and caution. Minnesota has traditionally afforded great deference to hospitals for internal staffing decisions. Like other private entities, private hospitals should continue to be viewed as autonomous and, as such, “should be permitted to decide who meets their particular standards and needs without judicial second guessing or, as one judge put it, ‘Monday-morning quarterbacking.’” *Dallon, supra*, at 678 (quoting *Oskooi v. Fountain Valley Reg’l Hosp.*, 49 Cal. Rptr. 2d 769, 776 (Cal. Ct. App. 1996) (Sills, J., concurring)). The criticisms of corporate liability for negligent credentialing are convincing, and provide an ample justification for this Court to resist

the majority view, especially in light of the Minnesota legislature's intent to keep peer review and mandatory reporting actions confidential.

In other situations, Minnesota courts have not hesitated to stand in the minority. For example, in *Oanes v. Allstate Insurance Co.*, 617 N.W.2d 401, 404 (Minn. 2000), this Court considered when an insured's action against its insurer for UIM benefits accrues for purposes of commencing the statute of limitations period. This Court declined to adopt the majority rule, and instead adopted a third option for the accrual date of such claims. *Id.* at 406. This Court has also held that a written offer of real estate must be accepted in writing, which places Minnesota "among a small minority of jurisdictions adhering to that rule." *Hehl v. Klotter's Estate*, 277 N.W.2d 660, 663 n.2 (Minn. 1979) (citing *Lake Co. v. Molan*, 269 Minn. 490, 496, 131 N.W.2d 734, 739 (1964)). Minnesota has also consistently followed the minority "out-of-pocket" rule in fraud and misrepresentation cases, see *Jensen v. Peterson*, 264 N.W.2d 139, 142 (Minn. 1978), and the minority view regarding the appealability of an order quashing service of a summons. See *Dieseth v. Calder Mfg. Co.*, 275 Minn. 365, 368-69, 147 N.W.2d 100, 102 (1966).

As these cases demonstrate, Minnesota courts do not simply follow the lead of other jurisdictions on issues that will greatly impact its citizens. This Court can, and does, decide to recognize or reject a new cause of action based on policy considerations and statutory and case law, even if Minnesota's rule differs from that in other jurisdictions. Thus, while a number of jurisdictions recognize negligent credentialing as a cause of action, those decisions should not weigh heavily in the Court's decision. No one disputes that this Court has the authority to develop common law principles as part of

its judicial powers, *see, e.g., Lake v. Wal-Mart Stores, Inc.*, 582 N.W.2d 231, 233 (Minn. 1998), but this Court has also declined to exercise this power when the “flexibility” of the legislative process has been deemed a more appropriate venue for a given decision. *See, e.g., Cracraft*, 279 N.W.2d at 808 (deferring decision whether to recognize new tort to legislature); *Schumann v. McGinn*, 307 Minn. 446, 467, 240 N.W.2d 525, 537 (1976) (“flexibility of the legislative process” may be a more appropriate avenue for certain decisions). With all due respect, the decision whether to recognize a cause of action for negligent credentialing should be left to the legislature.

C. The Minnesota Legislature Has Expressed An Intent To Limit Medical Malpractice Liability For Hospitals And Review Organizations, Not Expand It

The recognition of negligent credentialing as a cause of action is not the natural progression of existing medical malpractice doctrine. Years ago, Minnesota engaged in medical malpractice reform “[i]n an effort to reduce the costs associated with malpractice litigation as a means to increase the availability of reasonably priced medical insurance.” *Broehm v. Mayo Clinic Rochester*, 690 N.W.2d 721, 725 (Minn. 2005). In furtherance of this goal, “[t]he Minnesota legislature enacted expert-review and expert-disclosure requirements as a means of readily identifying meritless lawsuits at an early stage of the litigation.” *Id.* This Court has emphasized that plaintiffs must adhere to “strict compliance” with the affidavit requirement of Minn. Stat. § 145.682 so as not to undermine the legislature’s goals. *Id.* at 726.

The Minnesota legislature has been careful to avoid broadening the scope of liability in the context of medical malpractice cases. The expert-review and expert-

disclosure statutes effectively limit the potential blame that may be placed on review organizations when a physician allegedly commits malpractice. For example, guidelines established by review organizations are inadmissible in proceedings against a professional by a person to whom that professional rendered services. Minn. Stat. § 145.65. In addition, Minn. Stat. §§ 145.63 and 145.64 protect review organizations and credentialing bodies by providing confidentiality for their proceedings and records as well as immunity from liability. Accordingly, recognition of a negligent credentialing tort would be inconsistent with existing Minnesota law, which seeks to limit, rather than expand, liability for hospital and review organizations.

While Appellants extol the public interest in improving health care quality, they ignore the legislature's (and the public's) concern over the rapidly increasing cost of health care, which is in part attributed to the ever-rising number of medical malpractice cases. Allowing a claim for negligent credentialing would broaden the scope of liability for hospitals and other review organizations, foster additional litigation, and inevitably lead to higher health care costs. Health care costs would escalate not only because of more litigation, but also because hospitals would incur costs in added efforts to avoid litigation. Just like physicians who practice "defensive medicine" for fear of being sued for malpractice, hospitals and other review organizations will likely require more, but mostly unnecessary, supervision and review of physicians to whom they grant privileges. While Appellants argue that these added steps make hospitals safer, the new procedures also add costs that are passed on to insurers and patients. In the end, these new costs and related fees and premiums will likely limit access to health care.

Minnesota has worked hard to achieve a proper balance between public policy concerns that not only support recovery for medical negligence but also protect hospital and other review organizations from unnecessary liability. While the legislature has not specifically opined on the propriety of recognizing negligent credentialing as a cause of action, the enactment of Minn. Stat. § 145.63 and 145.64 implies that the legislature has decided to protect review organizations in different manner than ordinary physicians and others directly caring for patients. This Court should, therefore, decline to extend liability beyond what was intended by the legislature.

II. PROCEDURAL UNCERTAINTIES RELATED TO NEGLIGENT CREDENTIALING CLAIMS WILL RESULT IN SIGNIFICANT ADDITIONAL LITIGATION

Procedural problems and the impact a new cause of action may have on other substantive areas of law are vital considerations before adopting a new cause of action. *See, e.g., Lake*, 582 N.W.2d at 235-36 (considering how false light claims may impact constitutional right to free speech); *Salin*, 322 N.W.2d at 741 (noting the additional expense of litigation and settlement if claim allowed for loss of parental consortium); *see also Oanes*, 617 N.W.2d at 406 (adopting new rule for when a cause of action accrues for UIM action by considering interplay between the statute of limitations for UIM claims and the rule precluding a UIM claimant from proceeding with claim until resolution of the underlying tort action). Simply put, this Court may reject a new cause of action if the adverse effects will outweigh the potential benefits.

A negligent credentialing claim raises several procedural problems that this Court should consider before recognizing the claim. First, it is unclear what statute of

limitations applies. In other jurisdictions, negligent credentialing claims have spawned litigation over which statute of limitations – the statute of limitation for medical malpractice or personal injury – should apply to negligent credentialing claims. In Minnesota, different limitations periods apply to medical malpractice and personal injury claims. *See* Minn. Stat. § 541.076 (four year statute of limitations applies to medical malpractice claims); Minn. Stat. § 541.05, subd. 1(5) (six year statute of limitations applies to personal injury claims).

Several states have held that the medical malpractice statute of limitations applies to claims for negligent credentialing. In holding that a hospital's duty to select and review physicians arose under the medical malpractice statute, one court reasoned that negligent treatment was necessary and connected to the negligent credentialing claim against the hospital. *St. Anthony's Hosp., Inc. v. Lewis*, 652 So. 2d 386, 387 (Fla. Dist. Ct. App. 1995). Another court reasoned that providing health care services encompasses supervision, selection, and retention of staff physicians, and that the legislature intended the medical malpractice statute of limitations to govern all claims for negligent performance of medical services. *Bronson v. Sisters of Mercy Health Corp.*, 438 N.W.2d 276, 279-80 (Mich. Ct. App. 1989). Other states have held the negligence statute of limitations applies. *Browning v. Burt*, 613 N.E.2d 993, 1004 (Ohio 1993); *Sheehy v. Angerosa*, 488 N.Y.S.2d 371, 53-54 (N.Y. Sup. Ct. 1985). If negligent credentialing is created by common law instead of legislative enactment, future litigation on the applicable limitations period is inevitable.

Second, it is unclear whether a plaintiff must first establish liability for medical malpractice before the plaintiff can establish a negligent credentialing claim. The courts recognizing negligent credentialing as a cause of action are split on this issue, although it appears more courts have held that a claim for negligent credentialing must be predicated on physician negligence. See Benjamin J. Vernia, Annotation, *Tort Claim for Negligent Credentialing of Physician*, 98 A.L.R. 5th 533 (2002) (citing cases). For example, in *Trichel v. Caire*, 427 So. 2d 1227, 1233 (La. Ct. App. 1983), the court correctly reasoned that where a physician's negligence did not cause the injury, a hospital's grant of privileges to the physician could not be the cause of a plaintiff's complications. *Id.*; *Dicks v. U.S. Health Corp.*, No. 95 CA 2350, 1996 WL 263239, at **2, 4 (Ohio Ct. App. May 10, 1996) (noting previous Ohio decisions indicating injury resulting from physician negligence is a prerequisite to establishing a negligent credentialing claim). Appellants urge this Court to hold that liability for negligent credentialing is not dependent on a finding that the physician committed malpractice. (App. Br. at 32.) But that rule of law makes it possible for a hospital to be liable for the bad results of a medical procedure when a physician is not liable for the same, despite an obvious break in the chain of causation. See, e.g., *Welsh v. Bulger*, 698 A.2d 581, 585 (Pa. 1997) (holding a negligent credentialing claim is not contingent on negligence of a third party physician). If this Court recognizes a claim for negligent credentialing, then it also should hold that a hospital cannot be liable for negligent credentialing absent a finding of physician negligence.

The question logically following is whether negligent credentialing and medical malpractice claims require separate trials or a trial-within-a-trial. An Ohio court held severance is appropriate in cases in which a plaintiff asserts both a negligent credentialing and a medical malpractice claim. *Davis v. Immediate Med. Servs., Inc.*, No. 94 CA 0253, 1995 WL 809478, at *7 (Ohio Ct. App. Dec. 12, 1995), *rev'd in part on other grounds*, 684 N.E.2d 292 (Ohio 1997). The court reasoned that the plaintiff's negligent credentialing claim did not become ripe until a jury found the subject physician liable for medical malpractice. *Id.* Moreover, bifurcating the issues avoided undue prejudice and bias, and avoided further confusing the jury. *Id.* The Amicus Brief filed jointly by the Minnesota Hospital Association, Minnesota Medical Association, and American Medical Association contains a thorough discussion of the different issues and evidence that would be included in proving a negligent credentialing case, but which would also unduly delay and prejudice the defense in a medical malpractice trial.

These concerns are real, and probably justify separate trials for the two claims. *See Corrigan v. Methodist Hosp.*, 160 F.R.D. 55 (E.D. Pa. 1995). Two trials, however, would result in additional expense and delay, and require additional resources on the part of the plaintiff and the court. *Id.* at 57-58 (ordering single trial because severance of the issues would require the plaintiff to put on two trials and would result in delay for the plaintiff and the court). Because negligent credentialing claims will likely arise in most if not all medical malpractice claims, the judicial resources expended on medical malpractice claims may nearly double.

Finally, as discussed above, Minnesota imposes an affidavit requirement on patients who bring medical malpractice claims. *See* Minn. Stat. § 145.682. If Minnesota recognizes negligent credentialing as a cause of action, future litigation will inevitably arise as to whether the affidavit requirement also applies to that claim. States that recognize negligent credentialing claims and institute pre-suit requirements have reached differing conclusions. At least one court has held that plaintiffs seeking recovery under a negligent credentialing theory must first comply with a statutory certification requirement applicable to medical malpractice claims; the decision reasoned the plaintiff must first prove she suffered from medical malpractice. *See Winona Mem'l Hosp., Ltd. P'ship v. Kuester*, 737 N.E.2d 824, 828 (Ind. Ct. App. 2000). In contrast, in *Estate of Waters v. Jarman*, 547 S.E.2d 142, 145 (N.C. Ct. App. 2001), the court held negligent credentialing claims related to the administration or management of a hospital were not subject to a pre-suit certification requirement while claims arising out of clinical care were subject to the requirement.

Minnesota will also need to address whether complying with an affidavit or other pre-suit requirement for the medical malpractice portion of a plaintiff's complaint is sufficient compliance for any negligent credentialing claim. Other jurisdictions have resolved this issue with varying results. *See, e.g., Columbia/JFK Med. Ctr. Ltd. P'ship v. Brown*, 805 So. 2d 28, 29 (Fla. Dist. Ct. App. 2001) (holding compliance adequate for both claims); *Jacobs v. Rush N. Shore Med. Ctr.*, 673 N.E.2d 364, 367 (Ill. App. Ct. 1996) (holding compliance not adequate for negligent credentialing claim).

Minnesota courts are certainly capable of resolving the above issues. But one thing is certain: these and other new issues related to negligent credentialing claims will spawn time-consuming and expensive litigation beyond this case. In light of the adequate remedy already available for medical malpractice plaintiffs against both physicians and hospitals, these procedural issues will be resolved at some cost to our judicial system yet yield little benefit to medical malpractice plaintiffs. The adverse effects of recognizing negligent credentialing as a cause of action will outweigh the potential benefits.

CONCLUSION

Recognition of a cause of action for negligent credentialing is inconsistent with existing law and contrary to public policy. Minnesota common law has never imposed tort liability based solely on a public duty. While other states have recognized negligent credentialing as a cause of action, the justifications supporting their decisions are not compelling, especially in light of the landscape of medical malpractice law in Minnesota. Because existing law sufficiently protects patients by providing relief for the direct negligence of hospitals and physicians, expansion of liability is not justified. Moreover, adoption of this tort will have widespread consequences. Health care costs will increase as a result of expanding liability in medical malpractice cases. Legislative efforts to limit liability will be compromised, eroding practical limitations on medical malpractice litigation and protections for review organizations.

Furthermore, negligent credentialing claims pose procedural problems and will inevitably spawn additional litigation. Negligent credentialing does not present merely a one-time burden on the court system as legitimate legal questions are litigated, but

separate trials are likely for each and every medical malpractice and negligent credentialing claim. This will increase the burden on an already overloaded judicial system. With these concerns in mind, the MDLA urges this Court to decline to recognize a cause of action for negligent credentialing or, alternatively, to defer this decision to the legislature.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the Minn. R. Civ. App. P. 132.01, subd. 3, for a brief produced using the following font:

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