

Nos. A05-1698 and A05-1701

**State of Minnesota
In Supreme Court**

Mary and Michael Larson,
Appellants,

vs.

James Preston Wasemiller, M.D.,
Respondent (A05-1698),
Defendant (A05-1701),
Paul Scot Wasemiller, M.D., et.al.,
Defendants (A05-1698),
St. Francis Medical Center,
Respondent (A05-1701).

**BRIEF, ADDENDUM AND APPENDIX OF APPELLANTS
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STATEMENT OF THE ISSUES

I. Does the State of Minnesota recognize a common law cause of action of negligent credentialing /privileging of a physician against a hospital or other review organization?

The Court of Appeals, in a published decision, held that as an intermediate appellate court, it could not or would not recognize a new common law cause of action, noting that the Supreme Court or legislature should decide the issue. It therefore held that Minnesota does not recognize a negligent privileging claim.

Apposite Authorities:

Lake v. Wal-Mart Stores, Inc., 582 N.W.2d 231 (Minn. 1998)
Welsh v. Bulger, 698 A.2d 581 (Pa. 1997)
Wheeler v. Central Vt. Med. Ctr., 582 A.2d 165 (Vt. 1989)

II. Do Minn. Stat. §§ 145.63 and 145.64 grant immunity from or otherwise limit liability of a hospital or other review organization for a claim of negligent credentialing/privileging of a physician?

The Court of Appeals held that these statutes do not immunize hospitals from claims of negligent privileging, but that Minn. Stat. § 145.63 limits hospital liability to circumstances where privileging decisions are “not made in the reasonable belief that the action is warranted by facts known to it after reasonable effort to ascertain the facts.”

Apposite Authorities:

Minn. Stat. §§ 145.61-.67¹
Minn.R.Civ.App.P. 145
Fedziuk v. Comm’r of Pub. Safety, 696 N.W.2d 340, 344 (Minn. 2005).
Wheeler v. Central Vt. Med. Ctr., 582 A.2d 165 (Vt. 1989)

¹ Copies of Minnesota’s Peer Review Statute, Minn. Stat. §§ 145.61-145.67, are contained in the Addendum.

STATEMENT OF THE CASE

In April 2002, Appellant Mary Larson underwent gastric bypass (weight loss) surgery performed by Respondent James P. Wasmiller, M.D. at St Francis Medical Center in Breckenridge, Minnesota. Larson developed numerous complications and later she and her husband, Michael Larson, commenced this medical negligence action against James P. Wasmiller, M.D., Paul S. Wasmiller, M.D., and Dakota Clinic, Ltd.

(A.48-55)

After suit was commenced, the Larsons moved to amend the Complaint to add St. Francis Medical as a defendant and to allege a claim that St. Francis had negligently granted privileges to James P. Wasmiller. (A.62). The Larsons' motion papers included a copy of the proposed Amended Complaint, which incorporated the following materials that provided the factual support for a negligent privileging claim against St. Francis: Dr. John Linner's expert opinion, James P. Wasmiller's deposition transcript, and exhibits used at Wasmiller's deposition. (SR.1, 4, 36, 117, 220, Maddix Aff., ¶ 12 & Exs. I, B, C, & D).² At the hearing, James P. Wasmiller's counsel opposed the motion and specifically asked the trial court to prohibit the Larsons from serving and filing any Amended Complaint that incorporated and attached copies of the foregoing evidence. The trial court granted the Larsons' motion to serve an Amended Complaint, but granted Wasmiller's request to bar the Larsons from incorporating into and attaching to the

² The Affidavit of William J. Maddix, October 7, 2004, and attached exhibits are contained in the trial court record and separately included in a Minn.R.Civ.App.P. 130.03 Supplemental Record for the convenience of the court.

Amended Complaint copies of Dr. Linner's opinions, Wasemiller's deposition transcript, and exhibits used at the deposition. (A.60-61).

The Larsons then served a revised Amended Complaint upon St. Francis, alleging that (1) St. Francis was negligent in granting privileges to James P. Wasemiller to perform gastric bypass procedures at its facility, and (2) St. Francis was engaged in a joint enterprise and joint venture with the other defendants. (A.48, A.56-57). St. Francis moved to dismiss all claims for failure to state a claim. (A.41)

By order dated June 29, 2005, the Honorable Gerald J. Siebel, Wilkin County District Court, denied St. Francis' motion, holding (1) that Minnesota would follow the many other jurisdictions that had recognized a common law cause of action for negligent privileging; (2) that nothing in Minn. Stat. § 145.63 and related provisions of the peer review statute barred claims for negligent privileging; and (3) that Minnesota had already recognized common law claims of joint enterprise and joint venture liability against hospitals. (A.25-40). The trial court then certified as important and doubtful the two issues set forth above in the Statement of the Issues. (A.26, A.37-40). St. Francis and James P. Wasemiller appealed.

On July 25, 2006, the Court of Appeals filed its decision answering the certified questions. (A.9). As to the first certified question, the Court of Appeals explained that, as an intermediate appellate court, "it is not our function to create new law." (A.16). The court noted that neither the trial court nor it was properly situated to address the policy and procedural issues surrounding recognition of a common law cause of action for negligent privileging, (A.16, 18, 20, 23), and that only the Supreme Court or the

legislature should decide the issue. (A.18, 20, 23). The Court of Appeals therefore declined to recognize a negligent privileging claim. (A.18, 20-21).

The second certified question contained two parts. As to the first part, the Court of Appeals affirmed the trial court in holding that Minn. Stat. §§ 145.63 and 145.64 do not immunize hospitals from negligent privileging claims. (A.23-24). As to the second part, the Court of Appeals held that the Minn. Stat. § 145.63 limits liability of hospitals for negligent privileging claims to privileging decisions “not made in the reasonable belief that the action is warranted by facts known to it after reasonable effort to ascertain the facts.” (A.23-24).

On August 17, 2006, the Larsons filed a petition for review. (A.2-8). Respondents did not petition for review, and urged the Supreme Court to deny the Larsons’ petition. By order dated October 17, 2006, the Supreme Court granted the Larsons’ petition. (A.1).

The Larsons seek review of the Court of Appeals answer to the first certified question wherein the court ruled that Minnesota does not recognize a common law cause of action for negligent privileging. As to the second certified question, the Larsons do not challenge the Court of Appeals’ ruling that Minn. Stat. §§ 145.63 and 145.64 do not immunize hospitals from negligent privileging claims. The Larsons also do not challenge the Court of Appeal’s ruling that Minn. Stat. §§ 145.63 limits a hospital’s liability to circumstances where privileging decisions were “not made in the reasonable belief that the action is warranted by facts known to it after reasonable effort to ascertain the facts.” As to the second certified questions, the Larsons seek review of the court’s dicta that

suggests that recognition of negligent privileging claims may violate the due process rights of litigants because of litigants' inability under Minn. Stat. § 145.64 to access and use peer review materials to pursue or defend a negligent privileging claim.

STATEMENT OF THE FACTS

I. NEGLIGENCE OF JAMES P. WASEMILLER.

On April 4, 2002, Mary Larson suffered from morbid obesity and underwent a gastric bypass surgery performed by Dr. James P. Wasemiller at St. Francis Medical Center in Breckenridge, Minnesota. James Wasemiller's brother and co-defendant, Dr. Paul Wasemiller, assisted. (A.50).

Gastric bypass surgery involves creation of a small pouch at the top of the stomach to limit food intake. The surgeon then connects the pouch to the small intestine. This connection is called an "anastomosis." A well-known known complication of the surgery is that the anastomosis will begin to leak after the surgery. If a leak develops, the gastric contents in the pouch seep into the peritoneal cavity and infection sets in, placing the patient at risk for peritonitis, sepsis, multi-organ failure, and death if the surgeon does not diagnose and correct the leak in a timely manner. During the post-operative phase, the surgeon must be vigilant for any signs of infection. (SR.24, "Gastrointestinal Surgery for Severe Obesity").

After Larson had surgery, she remained hospitalized at St. Francis Medical Center and under the care of James P. Wasemiller. During the next seven days, she started exhibiting signs of an anastomotic leak and developing peritonitis. These signs included tachycardia (rapid heart rate), elevated white blood count, bandemia, shortness of breath,

low urine output, copious purulent wound drainage, anxiety, and pain. (A.50-52).

Despite this constellation of symptoms, James P. Wasemiller failed to diagnose and treat the leak. (SR.5-8, Linner Aff.).

By April 12, 2002, Larson was in critical condition. Paul Wasemiller—James’ brother—performed emergent surgery that day and found a belly full of pus and inflammation throughout the abdomen. He irrigated and cleaned the area, but abandoned any effort to repair the anastomotic leak. (A.52-53). During the next several days at the hospital, Larson continued to show signs of unresolved leak and ongoing peritonitis. Rather than transfer Larson to a facility where she could receive a definitive repair of the leak, the Wasemillers transferred her to a long-term care facility with no plan to follow her or have a surgeon follow her progress. (A.53-54).

Within a few hours of her arrival at the care facility, Larson drank a glass of cranberry juice. The juice seeped out of her surgical wounds and drains. (A.54). The care facility arranged for Larson’s immediate ambulance transport to MeritCare Hospital in Fargo, North Dakota. Larson arrived at MeritCare in critical condition and underwent emergent surgery through the night and remained hospitalized for months, undergoing additional surgeries and enduring a long and rocky course of recovery that is not yet complete. (A.54-55).

II. NEGLIGENCE OF ST. FRANCIS MEDICAL CENTER.

A. CREDENTIALING AND PRIVILEGING PROCESS.

Hospitals decide which physicians can practice at their facilities and what procedures they can perform. Credentialing decisions relate to who can practice at the

hospital, and privileging decisions relate to what specific procedures can be performed by the physician. Credentials or privileges might be denied because the physician has a history of malpractice, poor patient outcomes, or discipline, or lacks the training, experience, and skill to perform certain procedures. Hospitals require physicians to go through the credentialing and privileging process every two years, but hospitals can revisit their decisions at any time as the need arises. (SR.56, JW Depo at 77; SR.8-9, Linner Aff; and SR.212, “Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals”, MS-1 to MS-12).

Although peer review statutes bar patients from knowing what specific information a hospital considered in connection with a specific physician’s application for credentials and privileges, it is well known that hospitals make credentialing and privileging decisions by considering a number of factors, including the physician’s training, experience and skills, patient outcomes, history of malpractice lawsuits and discipline³, and evidence of malpractice insurance coverage. Every hospital at which

³ Hospitals are required by federal law to gather information about physicians from the National Practitioner Data Bank as part of the credentialing process. Congress created the National Practitioner Data Bank (NPDB) to improve the quality of medical care across the United States. According to the website maintained by the NPDB:

The intent [of the legislation creating the NPDB] is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and **to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse action can involve licensure, clinical privileges, professional**

Wasemiller had privileges gathered this information from him every two years. (SR.56, JW Depo. at 77-80). Litigants can divine what information the hospital considered or should have considered by gathering background information about the physician from sources (i.e. “original sources”) other than the peer review process. With that information in hand, an appropriate credentialing expert can review the information and render opinions on whether credentials or privileges were appropriately granted by the hospital to a specific physician. (SR.9-10, Linner Aff.).

society membership, and exclusions from Medicare and Medicaid.

The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners’ professional credentials.

SR. 210 (Emphasis added).

Under regulations promulgated by the United States Department of Health and Human Services, hospitals have an affirmative obligation to gather information from the NPDB about any doctor applying for privileges to practice at the hospital. Hospitals must gather this information at least once every two years. 45 C.F.R. § 60.10(a). (Add. 16) The regulations govern access to the data, and as a general rule only hospitals, boards of medical examiners or other state licensing boards have access to the information. 45 C.F.R. § 60.11 (Add.16-17). An exception to this general rule exists under the following circumstances: when a medical malpractice claim has been made against a doctor and a hospital, the attorney representing the plaintiff, or the plaintiff, may request and receive specific information about the doctor from the NDPB

upon the submission of evidence that the hospital failed to request information from the Data Bank as required by § 60.10(a), and may be used solely with respect to litigation resulting from the action or claim against the hospital. 45 C.F.R. § 60.11(a)(5).

(Add. 16-17; Add. 19-22).

B. BACKGROUND INFORMATION FROM NON-PEER REVIEW SOURCES REGARDING JAMES P. WASEMILLER.

Public records show that prior to Larson's surgery in April 2002, James P. WaseMiller had a long and storied history of serious practice deficiencies, medical malpractice claims, board discipline, and an inability to obtain malpractice insurance in the private market since 1987 because he was too high risk. Patients harmed by WaseMiller included gastric bypass patients who had either died or suffered serious complications under circumstances similar to those involved in Larson's case. (SR.4, 36, 117, Exs. B, C, D).

Larson's expert, Dr. John Linner, is a world-renown authority on gastric bypass surgery and an expert on hospital credentialing. Dr. Linner has reviewed Mary Larson's medical records and the public records about James P. WaseMiller. He has rendered an opinion that St. Francis Medical Center departed from accepted standards of care by granting privileges to James P. WaseMiller to perform complex gastric bypass surgery at its hospital. (SR.9,10, Linner Aff.). Dr. Linner based his opinions on the public information set forth below.

1. Training.

James P. WaseMiller attended medical school at Loma Linda University. After medical school, he started a general surgical residency at Kettering Memorial Hospital in Ohio in 1972, but after only two years "left" the residency program. Loma Linda University allowed him to continue his surgical residency at its facility, and he completed two additional years of residency. (SR.39-40, JW Depo. at 12-13). During his residency,

Wasemiller had minimal exposure to gastric bypass procedures although he does not recall precisely how many. (SR.40-41, 42-43, JW Depo. at 15-18, 24-25).

2. Failure to Obtain Board Certification.

When Wasemiller ended his training at Loma Linda, he applied for board certification through the American Board of Surgery. Board certification demonstrates that the applicant meets the minimum requirements to comply with accepted standards of care in field in which the applicant seeks certification. Wasemiller failed his oral board exams in 1978, 1979, and 1980. After the third failure, the board informed him that he needed one more year of surgical residency before reapplying for certification. To this day, Wasemiller has chosen not to take another year of surgical residency and has not obtained board certification. (SR.43-45, JW Depo. at 25-33).

3. Establishment of Practice.

After leaving Loma Linda, Wasemiller set up a general surgical practice in Wahpeton, North Dakota. His father, E.R. Wasemiller, was already a surgeon in the community. Most surgeries were performed across the river at St. Francis Medical Center in Breckenridge, Minnesota. Because none of the local surgeons performed complex gastric bypass surgery when Wasemiller set up his practice, he decided that he would offer this procedure to patients. (SR.41, JW Depo. at 19-20).

Between 1976 and 1987, Wasemiller performed only one or two bariatric surgeries per year. (SR.41-42, JW Depo. at 20-22). In a 1987 deposition, Wasemiller admitted that some of his gastric bypass patients had suffered serious complications and that one

had died. (SR.65-66, JW Depo. at 115-18). None of these cases, to his recollection, resulted in malpractice claims. (SR.66, JW Depo. at 119).

4. History of Malpractice Claims.

Between 1979 and 2000, patients made at least ten malpractice claims against Wasemiller. Most were settled. (SR.121-122; JW Depo. Ex. 1, Answers to Interrog. No. 4). Two of the cases settled involved postoperative mismanagement of gastric bypass patients who developed peritonitis—one who died, and one who suffered catastrophic injuries. A third case involved post-operative mismanagement of a patient who suffered an esophageal leak and developed peritonitis. All three involved conduct similar to that which led to Mary Larson's injuries.⁴

⁴ In *Nicholson v. Wasemiller*, Vicki Nicholson, age 25, underwent a gastric bypass performed by James Wasemiller at St. Francis Medical Center in 1984. Postoperatively Ms. Nicholson exhibited signs of an anastomotic leak and developing infection that were not diagnosed and treated in a timely manner. She developed sepsis and died, leaving behind a five-year-old son. (SR.181, JW Depo. Ex. 60) & SR.63-64, 67, JW Depo. at 108-11; 122; 138-39). Wasemiller's malpractice carrier settled the case. (SR.179, JW Depo. Ex. 60).

In *Little v. Wasemiller*, Terri Little underwent a gastric bypass performed by James Wasemiller in 1999. Postoperatively Ms. Little exhibited signs of a anastomotic leak and developing infection that were not diagnosed and treated in a timely manner. She developed severe medical problems and ultimately was transferred to the Mayo Clinic where she remained for over two months. (SR.142, JW Depo. Ex. 5). She required additional surgeries and care, and by June 2000 had incurred over \$1 million in medical bills. (SR.174, JW Depo. Ex. 58). James Wasemiller's malpractice carrier settled the case. (SR.121-122, JW Depo. Ex. 1, Answer to Interrog. No. 4).

In *Metzen v. Wasemiller*, Celeste Metzen underwent a nissen fundoplication performed by James Wasemiller in 1994. After the surgery, she exhibited signs of an esophageal leak and developing infection. These signs included tachycardia, fever, chest pain, and x-rays suggestive of pleural effusions and air in Ms. Metzen's chest. Ms. Metzen required emergent surgery to repair the leak and stop the developing infection, but James Wasemiller did nothing for days. He ultimately transferred her care to a surgeon at MeritCare who later served as an expert witness for Ms. Metzen. (SR.176, JW Depo. Ex.

5. Restrictions of Privileges and Board Discipline.

Prior to performing surgery on Larson, Wasemiller also had a history of restrictions on his practice. On August 10, 1990, for example, St. Francis Medical Center imposed several restrictions upon Wasemiller. The hospital required him to (1) obtain medical consultation from a board-certified or well-trained internist or family practitioner on all hospitalized patients with a diagnosis or history of gastroenterology, cardiology, fluid and electrolytes, or infectious disease; (2) complete 80 hours of classes in the previously listed areas; (3) complete 80 hours of classes in basic surgical management and proper utilization of antibiotics; (4) comply with a number of other requirements to bring his conduct up to the standard of care, including submitting to the supervision of another physician who would monitor his conduct. (SR.148A, JW Depo. Ex. 9).

Wasemiller's father, E.R., reportedly supervised him during this period. (SR.48-49, JW Depo. at 48-49).

During 1991 and 1992, James Wasemiller did not comply with the restrictions placed by St. Francis. In 1992, the Minnesota Board of Medical Practices learned of Wasemiller's noncompliance and investigated. In November 1992, Wasemiller signed a stipulation allowing the board to restrict his privileges, order additional training, supervision, and audits, and suspend him if he did not comply with the restrictions placed by the board. (SR.48-49, JW Depo. at 48-49).

59). Wasemiller's malpractice carrier settled the case. (SR.121-122, JW Depo. Ex. 1, Answer to Interrog. No. 4).

In a separate disciplinary matter in 1992, the Minnesota Board of Medical Practices conditioned Wasemiller's license on his successful completion of a pharmacology course at the University of Minnesota, a chemical dependency awareness course at St. Mary's Hospital, and a pain management course at Sister Kenny Institute. He was given nine months to comply. (SR.149, JW Depo. Ex. 10).⁵

By January 14, 1994, Wasemiller still had not complied with the conditions imposed by the Minnesota Board in 1992. The North Dakota Commission on Medical Competency filed a complaint with the North Dakota Board of Medical Examiners, citing Wasemiller's non-compliance and asking that the board revoke his privileges to practice medicine. (SR.170, JW Depo. Ex. 49). Wasemiller believes his privileges were restricted, with supervision by other physicians required, continuously from 1990 through 1995. (SR.50-51, 54, JW Depo. at 53-59 & 69-70).

6. Inability to Obtain Malpractice Insurance.

Wasemiller had practiced medicine for less than ten years before his malpractice carrier in the private sector refused to cover him anymore. St. Paul Companies considered him too "high risk." (SR.153, JW Depo. Ex. 11). Since 1987, he has only been able to obtain limited coverage through the Minnesota Joint Underwriter's Association. (SR.155, 173, 172, 154, 153, 159, 163, 157, JW Depo. Exs. 29, 54, 53, 24, 11, 37, 38 & 34). MJUA is a creature of statute that must offer malpractice insurance to

⁵ The North Dakota Board of Medical Examiners learned of the latter instance of discipline by the Minnesota Board and ordered Wasemiller to comply with the conditions laid out by the Minnesota Board if he wanted to keep his license. (SR.165, JW Depo. Ex. 48).

“high risk” physicians who cannot obtain insurance in the private sector. (SR.172, JW Depo. Ex. 53).

7. Dr. Linner’s Expert Opinion.

After reviewing the above information, Dr. Linner opined as follows:

I am quite familiar with hospitals credentialing requirements, the NIH consensus statement on surgery for morbid obesity, and the American Society of Bariatric Surgeons. . . .

I have served on and even chaired credentialing committees in the hospital setting for a period of time. The credentialing process serves as a means for a hospital to assure that the doctors who want to practice medicine at the hospital are competent and able to provide safe and reasonable care to the patients served at the hospital. **Doctors who have been granted privileges to practice at the hospital must reapply for privileges every two years so that the hospital can verify that the doctor should be permitted to continue having privileges.**

In fulfilling its duties to its patients, the hospital credentialing committee gathers various types of information from and about the physician seeking privileges. The information gathered includes whether the physician has been disciplined by licensing authorities, the frequency of discipline, the reasons for the discipline, and what the physician has done to correct the deficiencies in his practice. The committee also gathers information about claims made against the physician, the types of claims made, and whether claims made against the physician have resulted in payments to the claimant. The hospital is required to check with a national data bank that records when payments have been made to a patient or a patient’s family when the doctor’s malpractice has injured the patient. The investigation as a whole seeks to assure that a physician granted privileges at the hospital will provide safe, competent, and reasonable care to the patients served by the hospital. . . .

Credentialing committees can certainly limit the surgical privileges granted to a surgeon, depending on the surgeon’s level of

competence and the hospital's ability to serve patients undergoing certain types of surgical procedures.

Gastric bypass surgery requires a high level of surgical expertise and experience, and any hospital allowing such surgeries should have available a host of other specialists ready to intervene in the event that complications develop, particularly in the post-operative setting. That is particularly true when a surgeon also performs a panniculectomy, another major surgical procedure, at the same time a gastric bypass is performed. The danger of post-operative complications in that setting multiplies four-fold, further endangering the patient if the appropriate teams of specialists are not readily available to care to the needs of the patient.

It is quite apparent from the information elicited at the deposition of Dr. James P. Wasemiller and many of the exhibits offered in that deposition that St. Francis Medical Center knew or should have known about Dr. James P. Wasemiller's serious practice deficiencies – particularly in complex surgical cases like surgery for morbid obesity. Dr. James P. Wasemiller did not meet minimum requirements reasonably necessary to have surgical privileges for procedures of morbid obesity. Allowing Dr. James P. Wasemiller to perform these surgeries was a departure from accepted standards of practice for St. Francis Hospital well before and certainly at the time Mrs. Larson had her surgery. St. Francis Medical Center's choice to allow Dr. Wasemiller to continue these surgeries as of April 2002 was a direct and substantial cause of injuries suffered by Mary Larson in this matter. The hospital clearly failed to protect patients from the catastrophic complications demonstrated in this and similar cases in Dr. James P. Wasemiller's practice history. Absent surgical privileges for this procedure, had Dr. James P. Wasemiller not operated on Mrs. Larson, and not have engaged in the negligent post operative management demonstrated in this case, Mrs. Larson would have been spared the devastating course she has experienced. Hospitals, like physicians and surgeons in practice with colleagues, have an obligation to police the health care profession and to protect patients from those not equipped to treat them properly. This case demonstrates a tragic failure of that obligation of the health care community.

(SR.8-10, Linner Aff. (emphasis added).

SUMMARY OF ARGUMENT

The Court of Appeals erred in not recognizing a common law cause of action for negligent privileging. Minnesota has long recognized that hospitals owe a duty of care in the provision of health care and services to their patients. Credentialing and privileging decisions are inseparably intertwined with the health care and services that hospitals provide to patients. Hospitals have assumed the duty to protect their patients from incompetent physicians, and when hospitals negligently expose their patients to incompetent doctors, the risk of harm to patients is foreseeable. Negligent privileging claims are direct liability, not vicarious liability, claims against the hospital for the hospital's wrongful conduct.

To decide whether to recognize negligent privileging claims, our courts look to other jurisdiction for guidance. Appellate courts in thirty-two other states have addressed the issue of whether to recognize negligent privileging claims, and all have recognized the cause of action. Minnesota should align itself with these states. Minnesota prides itself as a national leader in the field of health care, and Minnesota ought not tolerate a regime where hospitals can knowingly expose patients to incompetent doctors and not be held accountable for the harm caused by such conduct.

Negligent privileging claims can be litigated in a manner that assures the confidentiality of the peer review process, provides fairness to the litigants, and delivers the constitutional guarantee of a remedy for harm caused by the wrongful conduct of another. Negligent privileging and malpractice cases must be tried together to assure that

fault is properly allocated, and the Rules of Evidence can assure that evidence admissible against one party but not another is properly considered by the jury.

The Court of Appeals erred in suggesting in dicta that recognition of negligent privileging claims may violate the due process rights of litigants due to Minn. Stat. § 145.64's limitation on the use of evidence in when litigating such claims. Respondents never properly raised a due process challenge, never notified the Attorney General of the due process challenge to Minn. Stat. § 145.64 as required under Minn.R.Civ.App.P. 145, and never met their burden of proof that the peer review statute, as applied to them, violated their due process rights. Moreover, the Court of Appeals never explained why Minn. Stat. § 145.64 appeared to be unconstitutional, and never considered the appropriate remedy. Any remedy, if appropriate, would have been to declare as unconstitutional those parts of the peer review statute that impinged on the due process rights of Respondents. The remedy was not, as implied by the Court of Appeals, to refuse to recognize negligent privileging claims to protect the due process rights of the Larsons and Respondents. How are the Larsons "protected" by wiping out their right to a remedy while allowing the hospital a free pass from answering for the harm caused by its wrongful conduct?

ARGUMENT

I. MINNESOTA COURTS SHOULD RECOGNIZE A CAUSE OF ACTION FOR NEGLIGENT CREDENTIALING AND PRIVILEGING.

A. METHOD FOR RECOGNIZING COMMON LAW CLAIMS.

The Minnesota Supreme Court has stated that our courts possess the “power to recognize and abolish common law doctrines.” *Lake v. Wal-Mart Stores, Inc.*, 582 N.W.2d 231, 233 (Minn. 1998) (recognizing cause of action for invasion of privacy). If the issue is whether to recognize a new cause of action, our courts consider what other states have decided, *id.* at 233, with an eye toward identifying and following the majority rule, *see id.* at 235.

This inherent power of the judicial branch recognizes that the common law is a living body of principles that evolves over time to reflect and embody our collective sense of justice. As a society, our sense of justice springs from our innate sense of what is right and what is wrong, and to assure that those harmed by the wrongful conduct of another have recourse in our civil courts.

As the Minnesota Supreme Court explained:

the common law is the embodiment of broad and comprehensive unwritten principles, inspired by natural reason, an innate sense of justice, adopted by common consent, for the regulation and government of the affairs of men. It is the growth of the ages, and an examination of many of its principles, as enunciated and discussed in the books, discloses a constant improvement and development in keeping with advancing civilizations and new conditions of society. Its guiding star has always been the rule of right and wrong, and in this country its principles demonstrate that there is in fact, as well as theory, a remedy for all wrongs.

Id., quoting *State ex rel. City of Minneapolis v. St. Paul M & M Ry. Co.*, 108 N.W. 261, 268 (Minn. 1906).

B. THIRTY-TWO OTHER JURISDICTIONS RECOGNIZE THAT HOSPITALS OWE PATIENTS A DUTY OF CARE IN MAKING CREDENTIALING AND PRIVILEGING DECISIONS.

Thirty-two states have addressed the issue of whether to recognize a common law cause of action for negligent privileging, and all have recognized it. See *Humana Med. Corp. v. Traffanstedt*, 597 So.2d 667 (Ala. 1992); *Fletcher v. Peninsula Hosp.*, 71 P.3d 833, 843 (Alaska 2003); *Tucson Medical Ctr. Inc. v. Misevech*, 113 Ariz. 34, 545 P.2d 958 (1976); *Elam v. College Park Hosp.*, 183 Cal.Rptr 156 (Cal. 1982); *Kitto v. Gilbert*, 39 Colo. App. 374, 570 P.2d 544, 550 (1977); *Register v. Wilmington Med. Ctr.*, 377 A.2d 8 (Del. 1977); *Insinga v. LaBella*, 543 So.2d 209 (Fla. 1989); *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (1972); *Domingo v. Doe*, 985 F.Supp. 1241, 1245 (D.Hawaii 1997) (interpreting Hawaii state law); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. den., 383 U.S. 946, 86 S.Ct. 1204, 16 L.Ed.2d 209; *Johnson v. St. Bernard Hosp.*, 79 Ill. App. 3d 709, 399 N.E. 2d 198 (1979); *Sibley v. Board of Sup'rs of La. State Univ.*, 477 So.2d 1094 (La. 1985); *Copithorne v. Framingham Union Hosp.*, 520 N.E.2d 139 (Mass. 1988); *Ferguson v. Gonyaw*, 64 Mich. App. 685, 236 N.W.2d 543 (1976); *Taylor v. Singing River Hosp.*, 704 So.2d 75 (Miss. 1977); *Gridley v. Johnson*, 476 S.W.2d 475, 484 (Mo. 1972); *Hull v. North Valley Hosp.*, 498 P.2d 136 (Mont. 1972); *Foley v. Bishop Clarkson Mem. Hosp.*, 185 Neb. 89, 173 N.W.2d 881 (1970); *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super. 302, 350 A.2d 534 (1975); *Diaz v. Feil*, 881 P.2d 745

(N.Mex.App. 1994); *Sledziewski v. Cioffi*, 137 A. D. 2d 186, 528 N.Y.S.2d 913 (1988); *Bost v. Riley*, 44 N.C. App. 638, 262 S.E.2d 391 (1980); *Benedict v. St. Lukes Hosps*, 365 N.W.2d 499, 504 (N.Dak. 1985); *Browning v. Bert*, 613 N. E. 2d 993 (Ohio 1993) (subsequent history omitted); *Albain v. Flower Hosp.*, 50 Ohio St. 3d, 553 N. E. 2d 1038 (1990); *Strubhart v. Perry Memorial Hosp.*, 903 P.2d 263 (Ok. 1995); *Thompson v. Nason Hosp.*, 591 A.2d 703 (Pa. 1991); *Rodrigues v. Miriam Hosp.*, 623 A.2d 456 (R.I. 1993); *Strickland v. Madden*, 448 S.E.2d 581, 586 (S.C. Ct.App. 1994); *Crumley v. Memorial Hosp., Inc.*, 509 F.Supp. 531 (E.D.Tenn. 1978) (interpreting Tennessee law), *aff'd* 647 F.2d 164 (6th Cir. 1981); *Garland Comm. Hosp. v. Rose*, 156 S.W.3d 541 (Tex. 2004), *on remand*, 169 S.W.3d 353 (Tex.App. 2005); *Wheeler v. Central Vt. Med. Ctr.*, 582 A.2d 165 (Vt. 1989); *Pedroza v. Bryant*, 677 P.2d 166, 170 (Wash. 1984); *Roberts v. Stevens Clinic Hosp., Inc.*, 176 W. Va. 492, 345 S.E.2d 791 (1986); *Greenwood v. Wirdsma*, 741 P.2d 1079 (Wyo. 1987).

These state court decisions evidence a broad national consensus that hospitals owe a common law duty to patients to exercise reasonable care when making privileging decisions. These decisions reflect the citizenry's most fundamental notions of right and wrong, and give substance to the constitutional promise that every citizen shall have a remedy for harm caused by the wrongful conduct of another.

Minnesota provides a constitutional guarantee to its citizenry that each person shall have a remedy for harm suffered by the wrongdoing of another. Minn. Const., Art. I, § 8. That constitutional guarantee finds expression in over 100 years of jurisprudence that provides compensation to those injured by the negligent conduct of

others. By recognizing negligent privileging claims, the court will deliver the constitutional guarantee of a remedy given to each Minnesotan citizen by our founders and remain true to over 100 years of our state's jurisprudence.

C. THE DUTY OF CARE ARISES BECAUSE THE HARM CAUSED BY NEGLIGENT PRIVILEGING DECISIONS IS FORESEEABLE.

Existence of a duty to another is inexorably linked to the foreseeability of injury to another. *Molloy v. Meier*, 679 N.W.2d 711, 719 (Minn. 2004). As expressed by Judge Cardozo, and so recently reaffirmed by the Supreme Court, “the risk reasonably to be perceived defines the duty to be obeyed, and risk imports relation; it is risk to another or to others within the range of apprehension.” *Id.* at 719, citing *Connolly v. Nicollet Hotel*, 254 Minn. 373, 381, 95 N.W.2d 657, 664 (Minn. 1959) quoting *Palsgraf v. Long Island R.R.*, 248 N.Y. 339, 162 N.E. 99, 100 (1928).

When hospitals make privileging decisions, they are deciding which doctors can safely treat the hospital's patients and which doctors cannot. If hospitals are negligent when making privileging decisions, the risk of harm stemming from those decisions is foreseeable. As explained in *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 301 N.W. 2d 156, 164 (1981):

The failure of a hospital to scrutinize the credentials of its medical staff of applicants could foreseeably result in the appointment of unqualified physicians and surgeons to its staff. Thus, the granting of staff privileges to these doctors would undoubtedly create an unreasonable risk of harm or injury to their patients. Therefore, the failure to investigate a medical staff applicant's qualifications for the privileges requested gives rise to a foreseeable risk of unreasonable harm.

Id. at 164.

When hospitals like St. Francis knowingly permit an inadequately trained and incompetent doctor to perform complex surgical procedures on the hospital's patients, the risk of harm to the patients is foreseeable. Under these circumstances, hospitals owe a duty to their patients to use reasonable care when making privileging decisions.

D. HOSPITALS ALREADY OWE A DUTY OF CARE TO PATIENTS.

Minnesota has long recognized that hospitals owe patients a duty of care when providing health care and services. *Erickson v. Curtis Inv. Co.*, 447 N.W.2d 165, 168 (Minn. 1987) (“The duty to protect may be found in the innkeeper-guest and common carrier relationship. Analogous to the innkeeper-guest case is the hospital-patient relationship.”); *H.B. by & through Clark v. Whittermore*, 552 N.W.2d 705, 707 (Minn. 1996) (same). Negligent privileging claims are not “new” claims but rather one type of general negligence claim. *Lemuz v. Fieser*, 933 P.2d 134, 142 (Kans. 1997).

The credentialing and privileging process is one means by which hospitals provide health care and services to their patients. *Garland Comm. Hosp. v. Rose*, 156 S.W.3d 541, 545 (Tex. 2004) (“a hospital’s credentialing of doctors is necessary to that core function and is, therefore, an inseparable part of the health care rendered to the patient”). Because Minnesota already recognizes that hospitals owe patients a duty of care when providing health care and services, recognition of negligent privileging claims will be fully consistent with existing case law.

E. HOSPITALS HAVE ASSUMED THE DUTY TO PROTECT PATIENTS FROM INCOMPETENT DOCTORS.

When a person assumes a duty where one did not exist, the person will be liable for the failure to exercise due care in the performance of that duty. *State by Humphrey v. Philip Morris, Inc.*, 551 N.W.2d 490, 493 (Minn. 1996). This tort doctrine extends to hospitals that have assumed an obligation to protect patients. *See Tomfohr v. Mayo Foundation*, 450 N.W.2d 121, 125 (Minn. 1990).

Virtually all hospitals, including St. Francis, have the duty to protect patients from incompetent physicians when they seek accreditation from the Joint Commission on Accreditation of Health Care Organizations (“JCAHCO”). This accrediting body has placed the ultimate responsibility for the competency of medical staff squarely on hospitals. JCAHCO standards place an affirmative duty on hospitals to collect relevant data regarding the issuance of credentials and privileges to physicians. (SR.212, “Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals”, MS-1 through MS-12).⁶

⁶ *Johnson v. Misericordia Comm. Hosp.*, 301 N.W.2d 156, 159 n.8 (Wisc. 1981) (“The Joint Commission on Accreditation of Hospitals (JCAH) was organized in 1952 by the American Hospital Association, American Medical Association, American College of Physicians, American College of Surgeons, and Canadian Hospital Association. Its purpose was to establish minimum hospital standards for patient care. Requests for a survey for accreditation purposes are voluntary, but since internship and residency programs as well as participation in the federal Medicare and Medicaid programs are often contingent upon JCAH approval, most hospitals seek JCAH accreditation. Copeland, “Hospital Responsibility for Basic Care Provided by Medical Staff Members.” *Am I My Brother's Keeper?*, 5 N. Ky. L. Rev. 27, 41 n. 77 (1978); Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence*, 32 Rutgers L. Rev. 342, 369 n. 194 (1979)).

This includes a duty to gather information at least once every two years from the National Practitioner Data Bank, which gathers data about each payment made on behalf of a physician to settle a malpractice claim and each disciplinary action taken by a state's board of medical practice. This information, along with information requested from the physician, allows the hospital to determine whether a physician should be granted credentials to treat the hospital's patients and what privileges the physician should or should not be granted.

Because hospitals have assumed the duty to protect their patients from incompetent physicians, Minnesota law holds that hospitals owe a duty to their patients to use reasonable care when screening physicians.

F. NEGLIGENT PRIVILEGING CLAIMS ARE DIRECT LIABILITY CLAIMS, NOT VICARIOUS LIABILITY CLAIMS.

Throughout this litigation, Respondents have contended that the Larsons seek to make hospitals vicariously liable for the negligent actions of independent contractor physicians. The Court of Appeals gave credence to this contention when it stated that “[w]e are not aware of any authority for the proposition that Minnesota has recognized a negligence claim against the employer of an independent contractor.” (A.17). Both Respondents and the Court of Appeals mischaracterize or misunderstand the nature of the negligent privileging claim. The claim is not a vicarious liability claim seeking to hold a non-negligent hospital liable for the malpractice of an independent physician, but rather a direct liability claim against the hospital for harm caused by the hospital's negligence in permitting an incompetent or unqualified doctor to care for the hospital's patients.

Vicarious liability involves imposition of liability on a non-negligent entity because of the entity's unique relationship with a tortfeasor, such as the relationship between an employer and employee. See *Fahrendorff v. N. Homes, Inc.*, 597 N.W.2d 905, 910 (Minn. 1999). Direct liability, conversely, involves imposition of liability on a negligent entity for its own acts of negligence independent of any negligence on the part of a co-defendant.⁷

Welsh v. Bulger, 698 A.2d 581, 585 (Pa. 1997), a case involving negligent privileging, is instructive on the point. In *Welsh*, the Pennsylvania Supreme Court recognized that the hospital is "held directly liable, as opposed to vicariously liable, for its own negligent acts." *Id.* To recover against the hospital, the patient "need not rely on the negligence of a third party, such as a doctor or nurse, to establish a cause of action." *Id.* The Larsons assert a direct liability claim against St. Francis because St. Francis itself owed a duty of care to its patient and was negligent in permitting James P. Wasemiller to perform bypass procedures on its patient.

The Rhode Island Supreme Court recently reaffirmed this point:

A corporate negligence⁸ claim differs from a respondeat superior claim in that it imposes on the hospital a nondelegable duty owed directly to the patient that is independent of the doctor-hospital relationship. A

⁷ It is black letter law that there can be more than one cause of an injury. Our state recognizes that the negligence of multiple tortfeasors, as we have in this case, can be a concurrent cause of the plaintiff's injury. CIVJIG 27.15. Our state also recognizes that a tortfeasor's actions can be a substantial cause of the injury without being the only cause of the injury. CIVJIG 27.10.

⁸ The Rhode Island Supreme Court, like some other jurisdictions, calls negligent privileging claims "corporate negligence" claims.

hospital . . . may be liable for the failure to exercise
reasonable care . . . in extending staff privileges to a doctor.

Pastore v. Samson, 900 A.2d 1067, 1082 (R.I. 2006); accord *Johnson v. Misericordia
Comm. Hosp.*, 301 N.W.2d 156, 163 & n.3 (Wisc. 1980).

**G. NEGLIGENT PRIVILEGING CLAIMS WILL SERVE IMPORTANT
POLICY GOALS.**

1. Patient Safety Will be Enhanced.

The Institute of Medicine estimates that medical errors result in the death of
between 44,000 to 98,000 American citizens each year. Hospitals serve as gatekeepers to
protect their patients from dangerous and unqualified physicians. If hospitals are not held
accountable to patients for negligent privileging decisions, they have little incentive to
protect patients from incompetent doctors. More complications, longer hospital stays,
and greater morbidity and mortality can be expected. Only the patients of bad doctors are
harmed by the negligent granting of privileges by hospitals and only patients have the
ability or incentive to correct such wrongs.

2. Patient's Constitutional Right to a Remedy will be Preserved.

Article I, Section 8 of the Constitution of the State of Minnesota provides as
follows:

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

Recognition of negligent privileging claims will assure that patients who are injured by the wrongful conduct of hospitals will be guaranteed their constitutional right to a remedy.

II. LITIGATION OF NEGLIGENT CREDENTIALING CLAIMS.

A. PEER REVIEW PROCEEDINGS WILL REMAIN CONFIDENTIAL WHILE AFFORDING LITIGANTS A FAIR OPPORTUNITY TO PURSUE OR DEFEND THEIR POSITIONS.

Litigants can pursue or defend negligent privileging claims without running afoul of the confidentiality provisions of Minnesota's peer review statute or the requirements of due process. Minn. Stat. § 145.64, entitled "Confidentiality of records of review organization," shields from discovery all records and proceedings of the review organization. The statute provides, however, that

Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings.

Both patients and hospitals, when litigating negligent privileging claims, can use information from "original sources" as permitted under Minn. Stat. § 145.64. Although the statute precludes the discovery of and use at trial of one subset of evidence otherwise available to the parties, all litigants face this challenge by virtue of the existence of privileges and the rules of evidence.

1. Experience of Other Jurisdictions.

Other jurisdictions have recognized that similar peer review statutes in those states permit the parties to litigate negligent privileging claims in a manner that assures peer review proceedings remain confidential and comports with due process.

In *Browning v. Bert*, 613 N.E.2d 993 (Ohio 1993), for example, the Ohio Supreme Court rejected the hospital's contention that it could not defend itself against a negligent privileging claim because the state's peer review statute barred the use of any evidence considered by the hospital in granting privileges to a doctor who later harmed a patients. The court rejected the contention, stating that the peer review statute expressly permitted litigants to use evidence from other sources to pursue or defend the case. Ohio's peer review statute, like Minnesota's, provided as follows:

Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented during proceedings of a committee nor should any person testifying before a committee or who is a member of the committee be prevented from testifying as to matters within his knowledge, but the witness cannot be asked about his testimony before the committee or opinion formed by him as a result of the committee hearing.

Id. at 1007.

Similarly, in *Wheeler v. Central Vt. Med. Ctr., Inc.*, 582 A.2d 165 (Vt. 1989), the Vermont Supreme Court rejected the hospital's contention that it could not adequately defend itself against a negligent privileging claim where the peer review statute precluded the hospital from revealing what information it considered when granting privileges.

In *Wheeler*, the patient had undergone gastroplasty (weight-loss surgery) performed by Dr. Arthur Wright. Postoperatively, Ms. Wheeler showed numerous symptoms of complications and Dr. Wright did nothing until she went into a coma. Ms. Wheeler sued Dr. Wright and the hospital, alleging that the hospital negligently granted privileges to Dr. Wright. Dr. Wright was not a hospital employee, but an independent contractor. *Id.* at 166.

Peer review information was confidential under Vt. Stat. § 1443, and like Minn. Stat. § 145.64, provided that:

Information, documents, or records otherwise available from original sources are not to be construed as being immune from discovery or use in any such action merely because they were presented during the proceedings of such committee, nor shall any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge, but such witness shall not be asked about his testimony before such committee or about opinions formed by him as a result of such committee hearings.

Id. at 88.

Ms. Wheeler gathered evidence from original sources showing that Dr. Wright had a long and storied history involving failure to diagnose, improper treatment, and incompetent surgery. Her expert, Dr. John Potterfield, had experience in serving on credentialing committees and how the process worked. He considered the evidence gathered from original sources and he opined at trial that the hospital was negligent for granting privileges to Dr. Wright. *Id.* at 88.

When the hospital's attorney attempted to cross-examine Dr. Potterfield with confidential peer review records, the trial court barred the use of the records. On appeal,

the hospital argued that it should have been permitted to use the confidential records because Dr. Potterfield's testimony "left the clear impression that nothing had been done by the peer review committees." *Id.* at 88-89. The court rejected the appeal, noting that Dr. Potterfield's opinions were based on information from original sources, not confidential materials. The court also held that the plaintiff need only show what a reasonable hospital would have done about Dr. Wright, not what the hospital actually did or did not do. *Id.* at 90-91.

Other jurisdictions have rejected similar arguments by patients who allege that the confidentiality provisions of the peer review statute impinge on their right to present adequate evidence to prosecute a negligent privileging claim. For example, in *Ex Parte Qureshi*, 768 So.2d 374 (Ala. 2000), the patient alleged a negligent privileging claim against a hospital. The patient sought discovery of confidential peer review materials.

The records sought were confidential under Alabama Stat. § 22-21-8(b). The Alabama statute provided, however, that

Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or use in any civil action merely because they were presented or used in preparation of accreditation, quality assurance or similar materials nor should any person involved in preparation, evaluation, or review of such materials be prevented from testifying as to matters within his knowledge, but the witness testifying should not be asked about any opinions or data given to him in preparation, evaluation, or review of accreditation, quality assurance or similar materials.

Id. at 376-77. This statute mirrors Minn. Stat. § 145.64.

The court rejected the patient's argument, holding that the statute permitted the patient a means to gather evidence from original sources to pursue her claim. *Id.* at 380.

Accord Humana Desert Valley v. Superior Court, 742 P.2d 1382 (Ariz.App. 1987);
Shelton v. Morehead Mem. Hosp., 347 S.E.2d 824 (N.C. 1986).

2. Litigation of Larson v. St. Francis and Wasemiller.

Like the plaintiff in *Wheeler*, the Larsons have obtained their evidence from original sources and had that evidence reviewed by a credentialing expert. The Larsons can prove the following: St. Francis granted privileges to James P. Wasemiller to perform highly complex bariatric surgical procedures. St. Francis did so even though it either actually knew or should have known that Wasemiller was not a board-certified surgeon because he had failed the exam three times, was not “eligible” to take the board exam again without more training, had minimal training in bariatric procedures, had a number of bariatric patients suffer severe complications or die, and was so “high risk” that private insurers refused to cover him starting in the 1980’s. In addition, St. Francis had actual knowledge⁹ of all malpractice claims against Wasemiller resulting in payments and the circumstances surrounding these claims, all instances of board discipline in Minnesota and North Dakota, and all restrictions placed on his privileges, including restrictions placed by St. Francis itself. A jury will have ample evidence to decide whether St. Francis acted reasonably in granting privileges to Wasemiller.

⁹ Under 45 C.F.R. §§ 60.2 & 60.7-9, insurers, boards of medical practice, hospitals, and other entities are required to report malpractice payments and the conduct surrounding the payment, board discipline, and adverse actions on privileges to the National Practitioner Data Bank (“NPDB”). (Add. 11, 13-15). Under 45 C.F.R. § 60.10, hospitals must request this information from the NPDB when a physician initially applies for hospital privileges AND every two years thereafter as long as the physician continues to have privileges at the hospital. Any hospital that fails to request the information as required “is presumed to have knowledge of any information reported to the Data Bank concerning this physician.” (Add. 16).

Similarly, St. Francis can defend itself by gathering evidence from original sources. Hospitals, in fact, have a decided advantage over patients in identifying, locating and using original sources to defend themselves. St. Francis can have Wasemiller explain his training, experience and skills to the jury. St. Francis can have other physicians and health care providers testify that Wasemiller is a skilled, well-trained, well-credentialed and safe physician. St. Francis can employ a credentialing expert to review information from original sources and opine that the hospital could reasonably grant privileges to Wasemiller on the basis of information that would have been considered by the hospital.

3. Hospital's Negligence is Not Dependent on a Finding That the Physician Committed Malpractice.

The trial court held that the St. Francis' liability would be dependent upon a finding of negligence against Wasemiller. (A.39-40). The Court of Appeals elected not to decide this issue because it felt that either the Supreme Court or legislature should decide it. (A.20).

Negligent credentialing claims are direct liability claims against the hospital. *Welsh v. Bulger*, 698 A.2d 581, 585 (Pa. 1997). The hospital's liability, therefore, should not be conditioned on a finding of negligence against Wasemiller. The hospital must answer for its wrongful conduct and the harm caused by it. *Pastore v. Samson*, 900 A.2d 1067, 1082 (R.I. 2006).

4. Trials of Negligent Privileging Claims Should be Combined With Trials on Malpractice Claims.

Malpractice claims and negligent privileging claims should be tried together. The hospital's liability is not dependent on a finding of malpractice against the physician, and the jury must be assigned the task of allocating fault between and amongst all defendants. *Johnson v. Misericordia Comm. Hosp.*, 301 N.W.2d at 158 & n.6. Allocating fault in separate trials would be impossible.

It is possible there is some limited evidence admissible against the hospital that will be admissible against the physician, but the Rules of Evidence provide that the court can admit evidence for a limited purpose and, upon request, "shall restrict the evidence to its proper scope and instruct the jury accordingly." Minn.Evid.R. 105. Our jurisprudence presumes that jurors will comply with the instructions provided by the court. *State v. Forcier*, 420 N.W.2d 884, 885 n.1 (Minn. 1988); *Witzel v. Zuel*, 96 N.W. 1124, 1125 (Minn. 1903).

Additionally, most if not all of the evidence will be applicable to both the claims against James P. Wasemiller and against St. Francis Medical Center. Obviously Wasemiller will be testifying in this case. His credentials are extremely relevant to the credibility a jury ought accord his testimony and opinions.

Similarly, Wasemiller's failure to inform his patients about his dubious credentials and frightening experience is directly relevant to the Larsons' informed consent claim. *Johnson v. Kokemoor*, 545 N.W.2d 495, 504-05 (Wisc. 1996) (physician's failure to inform patient of his lack of training and experience in proposed surgery relevant to

informed consent claim). The Larsons respectfully submit that Wasemiller's record would be incredibly "significant" because "[a] reasonable person in the patient's position would not have consented to the . . . operation . . ." had the person been apprised of Wasemiller's record. CIVJIG 80.25.

III. MINN. STAT. §§ 145.63 AND 145.64 DO NOT IMMUNIZE HOSPITALS FROM NEGLIGENT CREDENTIALING CLAIMS.

The Court of Appeals affirmed the trial court in holding that Minn. Stat. §§ 145.63 and 145.64 do not immunize hospitals from negligent privileging claims. (A.23-24). The Larsons do not challenge this ruling. To find that a statute has abrogated the common law, the language of the statute must evidence an unequivocal legislative intent to abrogate the common law; otherwise the court will presume that the legislature had no intent to abrogate the common law. *Summers v. R & D Agency, Inc.*, 593 N.W.2d 241, 245 (Minn.App. 1999). The plain and unambiguous language of Minn. Stat. §§ 145.63 and 145.64 contains no evidence of a legislative intent to abrogate common law claims for negligent privileging.

IV. MINN. STAT. § 145.63 DOES LIMIT THE LIABILITY OF HOSPITALS AS SET FORTH IN THE STATUTE.

The Court of Appeals held that the plain and unambiguous language of Minn. Stat. § 145.63 limits the liability of hospitals for negligent privileging claims to privileging decisions "not made in the reasonable belief that the action is warranted by facts known to it after reasonable effort to ascertain the facts." (A.23-24). The Larsons do not challenge this ruling.

The Court of Appeals declined to elaborate on the parameters of the limitation (A.23), but the statute provides that hospitals can be found negligent for privileging decisions if they were “not made in the reasonable believe that the action was warranted by facts known to it” or if the decisions were made without making “reasonable effort to ascertain the facts.”

Although Minn. Stat. § 145.64 precludes the patient or hospital from introducing into evidence “[t]he proceedings and records of a review organization,” the parties can introduce “[i]nformation, documents, or records otherwise available from original sources” Dr. James P. Wasemiller’s practice history has generated ample evidence from original sources for both the hospital and the Larsons.

V. THE COURT OF APPEALS ERRED IN ITS DUE PROCESS ANALYSIS.

The Larsons challenge only one aspect of the Court of Appeals’ consideration of the second certified question. That aspect relates to the court’s consideration and acceptance of Respondents’ due process arguments. (A.24).

Respondents have contended that hospitals cannot adequately defend themselves against negligent privileging claims for two reasons: first, because Minn. Stat. § 145.64 prohibits hospitals from disclosing what information the hospital actually considered in granting privileges, and second, because Minn. Stat. § 145.66 makes it a misdemeanor to disclose such information. Although Respondents have scrupulously steered clear of labeling this as a due process attack on Minn. Stat. §§ 145.64 & 145.66, Respondent Wasemiller specifically argued that the hospital’s right to due process would be violated

because of the statutory restrictions on the use of information to defend itself.¹⁰ The Court of Appeals agreed with Respondents that their due process rights would be violated:

Section 145.64 limits the evidence that could be used to support or defend against such a claim in a manner that appears to affect the fundamental fairness of recognizing such a claim as the most effective means of monitoring the credentialing or privileging process.

(A.24).

The Court of Appeals erred on several points in its analysis. First, the court had already correctly ruled that nothing in Minn. Stat. §§ 145.63 or 145.64 immunized hospitals from negligent privileging claims. Minn. Stat. § 145.63, by its plain terms, merely limits the circumstances under which hospitals can be liable. The court so found. The subsequent due process ruling, however, effectively overturned the legislature's recognition that negligent privileging claims lie against hospitals. The ruling also provided support for the court's determination that Minnesota, unlike every other state that has addressed the issue, should not recognize negligent privileging claims.

The Court of Appeals erred in its consideration and analysis of the due process issues raised by Respondents for several reasons: first, because Respondents were alleging that the peer review statute violated their due process rights, they were required to provide notice of this constitutional challenge to the Attorney General.

¹⁰ Respondent Wasemiller, in his Reply Brief to the Court of Appeals, stated that “[d]ue process would be denied by requiring a committee to defend against a claim without the ability to present any evidence concerning the process being criticized.” Reply Brief of Wasemiller at 7.

Minn.R.Civ.App.P. 145. They never did this. Second, even if the Respondents had notified the Attorney General, Respondents had a duty of “demonstrating beyond a reasonable doubt” that the peer review statute, as applied to them, would violate their rights to due process. *Fedziuk v. Comm’r of Pub. Safety*, 696 N.W.2d 340, 344 (Minn. 2005). They made no such attempt. Even if they had attempted to meet this onerous burden, the Court of Appeals never explained how the Respondents had met this burden. Third, even if the Court of Appeals had explained how the burden was met, the Court of Appeals never attempted to construe the peer review statute in a manner to uphold its constitutionality, as required under long-standing canons of construction. *Id.* Fourth, even if all the above conditions had been met, the remedy was to declare as unconstitutional those provisions of the peer review statute that violated the Respondents’ due process rights. The remedy was not to refuse to recognize negligent privileging claims. The claim does not impinge on Respondent’s due process rights; if anything impinges on their rights, it is the provisions of the peer review statute that restrict their right to use evidence to defend themselves.

Assuming arguendo that Minn. Stat. § 145.64 violates the due process rights of the parties, then the Court of Appeals should have granted license to all parties to use all information that St. Francis had about Wasemiller before granting him privileges. That would have been the appropriate remedy. Refusing to recognize negligent privileging claims to protect the due process rights of the Larsons and St. Francis is an absurd and horrific remedy because the Court of Appeals has wiped out the Larsons’ remedy against the hospital in order to protect the due process rights of the Larsons and the hospital. The

hospital gets a free pass on its wrongdoing, and the Larsons get nothing. Where is the justice in that? The Larsons can take little comfort in the fact that their due process rights will be protected by wiping out their negligent privileging claim and extinguishing their constitutional right to a remedy for the harm caused by St. Francis' wrongdoing.

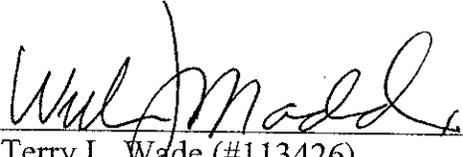
CONCLUSION

Respondents Mary and Michael Larson respectfully request the following: (1) that this court reverse the Court of Appeals and recognize a common law cause of action for negligent credentialing and privileging ; (2) that the court provide guidance to the trial court on the procedural and evidentiary issues raised herein by adopting the positions set forth above; (3) that the court discard the Court of Appeals' dicta that litigation of negligent privileging claims would raise due process concerns in light of the peer review protections set forth in Minn. Stat. § 145.64; and (4) that the court grant such other relief as it deems just and appropriate.

Respectfully submitted,

ROBINS, KAPLAN, MILLER & CIRESI L.L.P.

Dated this 16th day of November, 2006.

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CERTIFICATE

Pursuant to Rule 132.01, subd. 3(a)(1), the undersigned set the type of the foregoing brief in Times New Roman, a proportional 13-point font, on 8 1/2 by 11 inch paper with written matter not exceeding 6 1/2 by 9 1/2 inches. The resulting principal brief contains 10,350 words, as determined by employing the word counter of the word-processing software, Microsoft Word 2003, used to prepare it.

Respectfully submitted,

ROBINS, KAPLAN, MILLER & CIRESI L.L.P.

Dated this 16th day of November, 2006.

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The appendix to this brief is not available for online viewing as specified in the *Minnesota Rules of Public Access to the Records of the Judicial Branch*, Rule 8, Subd. 2(e)(2) (with amendments effective July 1, 2007).