

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).

**REPLY BRIEF AND SUPPLEMENTAL ADDENDUM OF
APPELLANTS MARY LARSON AND MICHAEL LARSON**

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I. **THE ISSUE OF WHETHER MINN. STAT. §§ 145.63 AND 145.64 IMMUNIZE HOSPITALS FROM NEGLIGENT PRIVILEGING CLAIMS WAS NOT PRESERVED FOR APPEAL.**

The trial court and Court of Appeals agreed with appellants' contention that Minn. Stat. §§ 145.63 and 145.64 do not immunize hospitals from common law negligent privileging claims. (A.23; A.35-A.36).¹ Appellants' Petition for Review never sought review of this aspect of the Court of Appeals' decision:

As the Court of Appeals correctly noted, Minn. Stat. § 145.63 does not immunize hospitals from [negligent privileging] claims, and, when read in conjunction with Minn. Stat. § 145.64, contemplates that hospitals will be subject to such claims in civil actions.

(A.7; Petition at 4).

Respondents, likewise, never petitioned for review or requested conditional review of this issue. The issue, therefore, has not been preserved for review. *First Trust Co., Inc. v. Leibman, Inc.*, 445 N.W.2d 547, 549 (Minn. 1989) (respondent failed to preserve issue for review with untimely Rule 117 response to petition). Respondents, however, argue at length that the peer review statute immunizes hospitals from negligent privileging claims. (St. Francis Brief at 8, 9, 15-29, 31-36, 50-51; Wasemiller Brief at 7-8, 13-17, 20-21, 23-24, 32-34). The Court should not consider these arguments.

II. **MINN. STAT. §§ 145.63 AND 145.64 DO NOT IMMUNIZE HOSPITALS FROM NEGLIGENT PRIVILEGING CLAIMS.**

"If the legislature intends to enact a statute that abrogates the common law, the legislature will do so by express wording or necessary implication." *Goodyear Tire & Rubber Co. v. Dynamic Air, Inc.*, 702 N.W.2d 237, 244 (Minn. 2005). Respondents

¹ Any citations to A. are citations to the Appendix of Appellants' initial brief to the Court.

contend that the legislature, through enactment of the peer review statute, intended to bar common law negligent privileging claims against hospitals. Even if the Court entertains this argument, nothing in the statute evidences any legislative intent to restrict a hospital's liability to patients who are injured by incompetent doctors.

A. **MINN. STAT. § 145.67 PROVIDES THAT THE PEER REVIEW STATUTE CANNOT BE CONSTRUED TO BAR OR LIMIT A PATIENT'S CLAIM AGAINST A HOSPITAL.**

Respondents fail to cite the one provision of the peer review statute which is determinative of the point they argue. The applicable statute is as follows:

145.67 Protection of Patient.

Nothing contained in §§ 145.61 to 145.67 shall be construed to relieve any person of any liability which the person has incurred or may incur to a patient as a result of furnishing health care to such patient.

(Add. 10).²

Minn. Stat. § 145.61 provides the definitions for §§ 145.61 to 145.67. Section 145.61 does not define "person." Because "person" is not defined here, the legislature directs us to Minn. Stat. § 645.44 for the definition.³ That section defines "person" to include "bodies politic and corporate, and to partnerships and other unincorporated associations." Minn. Stat. § 645.44, subd. 7. Hospitals, therefore, are "persons" for purposes of Minn. Stat. § 145.67.

² Any citations to Add. are citations to the Addendum of Appellants' initial brief to the Court.

³ Minn. Stat. § 645.44, subd. 1 states that the "words, terms, and phrases used in Minnesota Statutes or any legislative act shall have the meanings given them in this section, unless another intention clearly appears."

Hospitals furnish “health care” to patients for purposes of Minn. Stat. § 145.67 because “health care” is defined to include “services furnished by a hospital.” Minn. Stat. § 145.61, subd. 4. One service hospitals provide to their patients is to protect patients from incompetent physicians through the credentialing process. As one court has noted, “a hospital’s credentialing of doctors is . . . an inseparable part of the health care rendered to the patient.” *Garland Comm. Hosp. v. Rose*, 156 S.W.3d 541, 545 (Tex. 2004).

By virtue of Minn. Stat. § 145.67, the legislature articulated its intent that nothing contained in Minn. Stat. §§ 145.61 through 145.67 shall be construed to relieve a hospital of any liability it may incur to a patient. There is nothing ambiguous about this language.

B. MINN. STAT. § 145.63 MUST BE CONSTRUED IN A MANNER THAT IS CONSISTENT WITH MINN. STAT. § 145.67.

The “Protection of Patient” provision set forth in Minn. Stat. § 145.67 must be and can be harmonized with the “Limitation of Liability” provision contained in Minn. Stat. § 145.63, subd. 1. The first sentence of subdivision 1 provides as follows:

No review organization and no person who is a member or employee, director, or officer of, who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization **shall be liable for damages** or other relief **in any action brought by a person or persons whose activities have been scrutinized or reviewed by a review organization**, by reason of the performance by the person of any duty, function, or activity of such review organization, **unless the performance of such duty, function, or activity was motivated by malice toward the person affected thereby.** (emphasis added).

The first sentence applies to credentialing and privileging decisions made by review organizations. The limitation contained in the first sentence does not apply to

claims brought by patients, but only to claims “brought by a person or persons whose activities have been scrutinized or reviewed by a review organization . . .” Limiting claims brought by patients would not comport with Minn. Stat. § 145.67.

The second sentence of subdivision 1 provides as follows:

No review organization and no person shall be liable for damages or other relief in any action by reason of the performance of the review organization or person of any duty, function, or activity as a review organization or a member of a review committee or by reason of any recommendation or action of the review committee **when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or the review organization after reasonable efforts to ascertain the facts** upon which the review organization’s action or recommendation is made . . . (emphasis added).

The second sentence of subdivision 1, to be consistent with Minn. Stat. § 145.67, can only be interpreted in one of two ways: (1) any limitation in the second sentence applies only to claims brought against hospitals for review activities other than credentialing and privileging decisions; or (2) the second sentence applies to claims brought against hospitals for all review activities including credentialing and privileging.

1. Alternative No. 1: Second Sentence of Subd. 1 Does Not Apply to Claims Based on Credentialing and Privileging Decisions.

Under the first alternative interpretation, the first sentence of subdivision 1 applies exclusively to claims arising from credentialing and privileging decisions made by hospitals. The only limitation on claims arising from such decisions is on claims brought by aggrieved physicians. No limitation is placed on claims brought by patients. This interpretation comports with Minn. Stat. § 145.67’s directive that nothing in Minn. Stat. § 145.63 be construed to limit a hospital’s liability to patients.

This interpretation is further buttressed by considering the implications of interpreting the second sentence of subdivision 1 as limiting claims arising from credentialing and privileging decisions. If the second sentence applied to such claims, then physicians aggrieved by such decisions could prevail in an action against the hospital by showing only that the hospital failed to act in the reasonable belief that its credentialing or privileging decision was warranted. The second sentence cannot be interpreted in this manner. If it could, then aggrieved physicians would not have to satisfy the malice standard set forth in the first sentence of subdivision 1. That would conflict with existing Minnesota case law requiring aggrieved physicians to show malice in such actions. *See Campbell v. St. Mary's Hosp.*, 252 N.W.2d 581, 587 (Minn. 1977).

Moreover, if the second sentence of subdivision 1 applied to credentialing and privileging decisions, then patients injured by such decisions would be required to show that the review organization failed to act in the reasonable belief that its decision was warranted. If this were so, then the second sentence arguably would limit the circumstances under which a patient could prevail on a negligent privileging claim and therefore would conflict with Minn. Stat. § 145.67's directive that Minn. Stat. § 145.63 not be construed to limit a hospital's liability to a patient.

To avoid these conflicts, the first sentence of Minn. Stat. § 145.63, subd. 1 can be interpreted to apply to all claims arising from credentialing and privileging decisions, and the second sentence of Minn. Stat. § 145.63, subd. 1 can be interpreted to apply to all other claims against review organizations other than claims based on credentialing and privileging decisions. Under this interpretation, only the first sentence applies to

credentialing and privileging decisions. As to those decisions, aggrieved physicians can prevail against hospitals only by showing malice; and injured patients can prevail by showing the hospital failed to exercise reasonable care, an interpretation that is in harmony with Minn. Stat. § 145.67. Any limitation in the second sentence of subdivision 1 would apply to persons other than aggrieved physicians or patients injured by the credentialing and privileging process.⁴

2. Alternative No. 2: Second Sentence of Subd. 1 Applies to Patient Claims Based on Credentialing and Privileging Decisions.

If the second sentence of Minn. Stat. § 145.63, subd. 1 could be interpreted to apply to patient claims for negligent privileging, then the sentence must be construed in a manner that comports with Minn. Stat. § 145.67. To do this, the second sentence can only be construed as a codification of the common law standard that hospitals must use reasonable care in making privileging decisions. This is precisely how the trial court interpreted the second sentence in light of Minn. Stat. § 145.67 (A.35-A.36), and it is an interpretation that harmonizes Minn. Stat. §§ 145.63 and 145.67.

Respondent St. Francis argues that the legislature could not have intended to “legislate” a reasonable care standard in Minn. Stat. 145.63 because doing so would be to simply codify the common law making that portion of the statute “superfluous.” (St. Francis Brief at 26). The legislature often does and will codify the common law. By

⁴ These persons would include health insurers, HMO’s, governmental agencies, vendors and a wide range of others who have a myriad of dealings with review organizations. Minn. Stat. 145.61, subd. 5.

way of example, the legislature for many years codified the common law relating to

Good Samaritans:

A person, who in good faith and in the exercise of reasonable care renders emergency care . . . is not liable for any civil damages as a result

Minn. Stat. § 604.05 (1982). When the legislature wanted to change the common law as it pertained to liability of Good Samaritans, it knew precisely how to limit liability to those circumstances where the Good Samaritan “. . . acts in a willful or wanton or reckless manner” Minn. Stat § 604.05 (1984).

Indeed, in other sections of Chapter 145 the legislature knew precisely how to limit certain tort actions. Minn. Stat. § 145.424, for example, is entitled “Prohibition of Tort Actions.” This section expressly prohibits wrongful life actions and wrongful birth actions. Had the legislature intended in Chapter 145 to prohibit or otherwise limit common law claims for negligent privileging, it could have said so and would have been required to say so expressly. *Goodyear Tire*, 702 N.W.2d at 244. It did neither. Instead, the legislature made it perfectly clear under the “Protection of Patient” provision of Minn. Stat. § 145.67 that nothing in Minn. Stat. §§ 145.61 through 145.67 shall be construed to limit a hospital’s liability to its patient. Accordingly, Minn. Stat. §145.63 does not and cannot immunize or otherwise limit a hospital’s liability under the common law to patients for negligent privileging.

C. **MINN. STAT. §§ 145.64 AND 145.66 MUST BE CONSTRUED IN A MANNER CONSISTENT WITH MINN. STAT. § 145.67.**

Respondents contend that Minn. Stat. §§ 145.64 and Minn. Stat. § 145.66 provide further evidence that the legislature intended to bar negligent privileging claims. Section 145.64 shields peer review records from disclosure, and section 145.66 makes it a misdemeanor to disclose such records. Respondents contend that these peer review provisions are unique when compared to other states, noting that no other state criminalizes disclosure of confidential peer review records.

Respondents, however, fail to explain how either Minn. Stat. §§ 145.64 and 145.66 can be construed to limit a hospital's liability to a patient for negligent privileging when Minn. Stat. § 145.67 expressly prohibits such a construction. Even if Minn. Stat. § 145.67 did not exist, nothing in sections 145.64 or 145.66 expressly or by necessary implication suggests a legislative intent to bar negligent privileging claims.

1. **Litigants in Other Jurisdictions Must Rely on Original Sources, Not Confidential Peer Review Records to Litigate Negligent Privileging Claims.**

Respondents fail to explain how the confidentiality provisions of Minn. Stat. § 145.64 are unique when compared to other states that recognize negligent privileging claims. Virtually every state that recognizes negligent privileging claims shields peer review records from disclosure. *Compare* Minn. Stat. § 145.64 *with* Ala. Code. §§ 6-5-333 & 22-21-8; Ariz. Rev. Stat. § 36-445.01; Cal. Evid. Code § 1157; Colo. Rev. Stat. §§ 12-36.5-104(10)(a) & 25-3-109; Del. Code Ann. tit. 24, § 1768(b); Fla. Stat. §§ 1395.0193(7) & (8); Ga. Code Ann. § 31-7-143; Haw. Rev. Stat. § 624-25.5; 735 Ill.

Comp. Stat. §§ 5/8-2101 & 5/8-2102; La. Rev. Stat. Ann. § 13:3715.3; Mass. Gen. Laws ch. 111, §§ 204(a)-(c); Mich. Comp. Laws §§ 333.20175(8) & 333.21515; Miss. Code Ann. § 41-63-9; Mo. Rev. Stat. § 537.035; Mont. Code Ann. §§ 50-16-203 & 50-16-205; Neb. Rev. Stat. § 25-12,123; N.M. Stat. § 41-9-5; N.Y. Educ. Law § 6527; N.C. Gen. Stat. § 131E-95; N.D. Cent. Code § 23-34-02 & 23-02-03; Ohio Rev. Code Ann. § 2305.252; 63 Pa. Stat. Ann. § 425.4; R.I. Gen. Laws § 5-37.3-7(c); S.C. Code Ann. § 40-71-20; Tenn. Code Ann. § 63-6-219; Tex. Health & Safety Code Ann. § 161.032; Wash. Rev. Code § 4.24.250; W.Va. Code Ann. § 30-3C-3; Wisc. Stat. § 146.38; Wyo. Stat. Ann. § 35-17-105. (Supp.Add.1-23).⁵ Confidentiality of peer review records in these states has not prevented litigants from relying on original sources to pursue and defend negligent privileging claims. These same original sources are available in Minnesota.

Indeed, the fact that peer review records are confidential will provide a far greater advantage to hospitals than to patients. In a negligent privileging case, the hospital has the enormous advantage of knowing what information it actually considered and why it granted privileges. The hospital can re-establish that at trial without ever disclosing what was done in peer review. The hospital, moreover, will be free to prove that its decision was reasonable based on any information the hospital could have gathered and considered even if the hospital did not gather, consider or base its decision on the information.

⁵ Any citations to Supp.Add. are citations to the Supplemental Addendum to Appellants' Reply Brief.

2. Hospital Officials in Other States Permitting Negligent Privileging Claims Can be Held Criminally Liable for Disclosure of Confidential Peer Review Records.

Contrary to assertions by respondents and amicus MHA, Minnesota is not the only state that criminalizes wrongful disclosure of confidential peer review records. Illinois, Michigan, New Mexico, and Rhode Island, all of which recognize negligent privileging claims, criminalize wrongful disclosure of confidential peer review records. *Compare* Minn. Stat. § 145.66 *with* 735 Ill. Comp. Stat. § 5/8-2105 (Supp.Add.8-9); Mich. Comp. Laws § 333.20199; (Supp.Add.11-12); N.M. Stat. § 41-9-6; (Supp.Add.14-15); R.I. Gen. Laws §§ 5-37.3-7(b) & 5-37.3-9(b) (Supp.Add.18-19). Criminal penalties for wrongful disclosure in these states have not prevented litigants from pursuing and defending negligent privileging claims.

Whether or not Minnesota or other states criminalize wrongful disclosure of peer review records is irrelevant to the issues before the Court. If a hospital finds itself in the rare circumstance where it can mount no credible defense and feels compelled to disclose confidential peer review information, why would the hospital do so when any such disclosure would be inadmissible as a matter of law and have no impact on negligent privileging cases.

D. MINNESOTA'S ADVERSE HEALTH EVENT LEGISLATION DOES NOT EVIDENCE A LEGISLATIVE INTENT TO BAR NEGLIGENT PRIVILEGING CLAIMS.

Respondents and amicus MHA contend that the legislature's intention to bar negligent privileging claims is further evidenced by the legislature's 2003 enactment of Minnesota's Adverse Health Event legislation, Minn. Stat. §§ 144.706 through 144.7069.

They proclaim that this legislation sets Minnesota apart from the rest of the nation and reflects Minnesota's national leadership on health issues and in particular peer review matters. The argument fails for four reasons.

First, nothing in this legislation expressly or by necessary implication bars common law claims for negligent privileging. Even if it did, the legislature enacted the law after appellant Mary Larson suffered her injuries. It has no retroactive application.

Second, Minnesota is not the only state to adopt adverse event legislation. "About 20 states have some form of mandatory reporting form" like Minnesota's. (MHA Brief, Add.8). Given that 35 states⁶ recognize negligent privileging claims, at least some of these states have adverse event reporting laws like Minnesota's.

Third, the impetus for adverse event reporting did not originate in the Minnesota legislature or even the state of Minnesota. According to a January 19, 2005, press release issued by amicus MHA:

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

(MHA Brief, Add.3).

⁶ Appellants' initial brief stated that only 32 states had formally recognized common law claims for negligent privileging claims. That was a mistake. As Wasemiller's brief correctly points out, at least 35 states recognize this common law claim.

Fourth, Minnesota hospitals are required only to report a small subset of preventable adverse events. Minn. Stat. §144.7065. As to surgical adverse events, for example, hospitals need only report the following events: surgery on wrong body part, surgery on wrong patient, wrong surgery on right patient, leaving foreign object in patient, and death during or immediately after minor surgery in otherwise healthy patient. *Id.* at subd. 2. This helps explain in part why Minnesota hospitals for the period July 2003 through October 2004 reported only 21 preventable deaths. (MHA Brief, Add.1). Those sparse numbers are substantially below what would be expected, given the Institute of Medicine's estimate of 44,000 to 98,000 deaths per year due to medical errors in U.S. hospitals. Officials acknowledged Minnesota's numbers were fewer than what would be expected, attributing the low numbers to underreporting by hospitals and Minnesota's legislative decision to collect "information on only a subset of problems included in the Institute of Medicine Report." (MHA Brief, Add.2).

Minnesota's adverse event legislation is neither unique nor particularly effective in identifying and reporting adverse events. It likely has little or no impact on identifying incompetent doctors. For example, even if this legislation had been in effect in 2002 when appellant Mary Larson suffered injuries at St. Francis Medical Center, St. Francis would not have been required to report this event. The same would be true for other patients of James P. Wasemiller who should not have died or suffered disabling injuries while under his care at St. Francis Medical Center.

III. PUBLIC POLICY CONCERNS RAISED BY RESPONDENTS AND AMICI ARE MISLEADING AND INACCURATE.

A. PEER REVIEW RECORDS CURRENTLY ARE NOT HELD IN STRICT CONFIDENCE.

Respondents and amici contend that physicians will not participate in the credentialing process if they do not have the guarantee of “strict confidentiality” afforded by the peer review statute. Respondents and amici fail to point out, however, that under current law any physician aggrieved by the credentialing process can initiate an action against the hospital and discover all peer review records and testimony considered by the review organization. Minn. Stat. § 145.64, subd. 2 (confidentiality provisions of Minn. Stat. § 145.64, subd. 1, do not apply to such actions).

Minnesota’s peer review process has not failed even though physicians participating in the process already know that their colleagues can discover anything and everything these participants have said or written about their colleagues. Patients pursuing negligent privileging claims have no right to the same information when they initiate suit, and there is no rational reason to believe that recognition of such claims will have any impact on the willingness of physicians to continue to participate and be candid when conducting peer review.

B. RECOGNITION OF NEGLIGENT PRIVILEGING CLAIMS WILL PROMOTE PUBLIC POLICIES OF IMPROVING HEALTH CARE.

Respondent St. Francis’ argument that requiring hospitals to exercise reasonable care in its credentialing decisions “. . . would conflict with the strong public policy goal of improving the quality of healthcare in Minnesota . . .” is not only counter-intuitive, it is

incorrect as a matter of common sense. (Wasemiller Brief at 28). Allowing hospitals to negligently grant privileges to incompetent and dangerous physicians would in fact conflict with the strong public policy goal of improving the quality of healthcare.

One could hypothesize that St. Francis delegated the credentialing of surgeons to a committee of surgeons comprised of Dr. Paul Scott Wasemiller, brother of defendant James P. Wasemiller, and Dr. E. R. Wasemiller, father of James P. Wasemiller (SR.41), and perhaps one or two other surgeons who practiced with the Wasemiller family at St. Francis Medical Center. One could hypothesize that St. Francis failed to insure that the credentialing committee was comprised of independent healthcare providers not biased or vested in protecting an incompetent practitioner from losing part of his livelihood. It is clear from the record that the only surgeons who ever assisted James P. Wasemiller in doing gastric bypass procedures were his brother and his father. (SR.42). One of the physicians supervising James P. Wasemiller's practice for some period of years, because St. Francis actually knew about his practice deficiencies, was his father. (SR.48-49). The ability of a patient to hold a hospital responsible for negligently allowing a physician the privileges to perform complicated major surgery on that hospital's patient would deter negligent, unreasonable and biased conduct in making credentialing decisions. It is a generally accepted principle of tort law that holding a tortfeasor liable for negligently induced harm will promote reasonable, responsible behavior.⁷

⁷ "When the decisions of the courts become known, and defendants realize that they may be held liable, there is of course a strong incentive to prevent the occurrence of the harm." [Emphasis added]. Prosser and Keeton on Torts, (5th Ed., 1984) p. 25.

C. RECOGNITION OF NEGLIGENT PRIVILEGING CLAIMS WILL PROMOTE THE IMPORTANT PUBLIC POLICY OF ASSURING FULL COMPENSATION FROM ALL WRONGDOERS.

Respondent St. Francis and Amicus MDLA argue that compensating the victims of hospital negligence would not be furthered by allowing a negligent privileging claim. (St. Francis Brief at 36-37; MDLA Brief at 3-14). Obviously, physicians with a dubious track record may not be able to afford insurance coverage and may have limited or no professional liability insurance coverage while seeing patients in the hospital. Indeed, physicians with the worst track records are those most likely to have inadequate or no insurance coverage. (SR.54-55 & SR.73-74). If a hospital negligently privileges an underinsured or uninsured incompetent physician to perform high risk surgery on its patients, good public policy goals are well served by holding the hospital liable contrary to the assertions of Amicus MHA. (MHA Brief at 25).

D. RECOGNITION OF NEGLIGENT PRIVILEGING CLAIMS WILL NOT OPEN A “FLOODGATE” OF LITIGATION.

Amicus MDLA states that “. . . negligent credentialing claims will likely arise in most, if not all medical malpractice claims . . .” (MDLA Brief at 22). This Court has previously rebutted such arguments:

There is no merit to the contention that allowance of recovery in cases of this kind would produce a Flood of litigation of the same sort. Assuming it to be true that to allow a right of recovery would increase litigation, that fact would be no valid reason for denying the right, for the plain reason that, if such [conduct] constitutes a legal wrong, there should be a remedy for redress.

Miller v. Monsen, 37 N.W.2d 543, 546 (Minn. 1949).

Appellants are aware of three Minnesota cases, including this one, in which a negligent privileging claim has been asserted. *Franke v. Dr. Donald B. Miller*, SR 187; *Toepfer v. Donald B. Miller*. (SR.196).⁸ Both *Franke* and *Toepfer* involved the same physician. This is the first case presenting a negligent privileging issue to come before this Court.

Lawyers who regularly handle medical negligence claims in Minnesota, though fully recognizing the claim for decades, simply have not asserted such claims except in the rarest of factual circumstances. Such claims will remain rare. Most hospitals do exercise reasonable care in granting privileges to competent, well-trained, well-credentialed, safe practitioners. As has been true historically, it will only be the rare case where a negligent privileging claim has the necessary factual support to ethically justify assertion. As suggested by Amicus MDLA, expert support for a negligent privileging claim would seem necessary and proper.

IV. HOSPITALS ARE NOT EXCUSED FROM LIABILITY FOR NEGLIGENT PRIVILEGING DECISIONS MERELY BECAUSE THE BOARD OF MEDICAL PRACTICES HAS LICENSED A PHYSICIAN.

Amicus MHA contends that the legislature has placed the primary responsibility on the Minnesota Board of Medical Practice to protect the public from incompetent physicians and that hospitals should not be held liable for privileging decisions because hospitals rely on the Board to determine which doctors are fit for practice. (MHA Brief at 15-17). This argument fails for several reasons.

⁸ Counsel notes an error in the Index to Appellants' Supplemental Record. The Index should be corrected as follows: Exhibit E to Maddix's Affidavit, MN Dist. Ct. Cases re: negligent credentialing . . . p. 187.

First, MHA misspeaks when it states that the legislature has placed the “primary responsibility” for assuring physician competence on the Board. Minn. Stat. § 147.001 states that “[t]he primary responsibility and obligation of the Board of Medical Practice is to protect the public.” This statute merely sets forth the purpose of the Board; it does not make the Board primarily responsible for assuring physician competence. Indeed, the legislature has squarely placed the responsibility of peer review, including credentialing and privileging decisions, upon hospitals.

Second, hospitals do not make privileging decisions by verifying whether a particular physician has a current license to practice medicine. Hospitals are required to gather information about a physician’s malpractice history, disciplinary history, patient outcomes, training, certifications and other information pertaining to a physician’s competence. (SR.8-10). If hospitals could grant privileges based solely on the fact of licensure, then hospitals could permit licensed family practice physicians to perform brain surgery without having to answer for the harm caused by granting such permission.

Third, whereas the legislature has placed specific responsibilities for assuring physician competence on both the Board and hospitals, the legislature chose to grant statutory immunity for civil damages claims only to the Board. Minn. Stat. § 147.121, subd. 2. The legislature chose not to grant such immunity to hospitals.

Fourth, Minn. Stat. § 147.162 provides that the Board’s issuance of a license under Chapter 147 does not grant “to any person the right to be admitted to the medical staff of a health care facility.” Minn. Stat. § 147.162 verifies that the legislature determined that hospitals, not the Board, would be responsible for deciding which physicians should be

granted staff credentials and what privileges the physician would have at the hospital. The Board has neither the resources nor the legal obligation to determine which doctors should be permitted to practice medicine and what procedures they should be permitted to perform at any given hospital.

Fifth, all other states have boards of medical practice similar to Minnesota's. That has not prevented 35 states from recognizing negligent privileging claims. Courts in some of these jurisdictions have addressed and squarely rejected the contention that the hospitals should be excused for negligent privileging simply because the state board had licensed the involved physician. *See, e.g., Joiner v. Mitchell Cty. Hosp. Auth.*, 186 S.E.2d 307, 309 (Ga.App. 1971), *aff'd* 189 S.E.2d 412 (Ga. 1972); *Johnson v. Misericordia Comm. Hosp.*, 301 N.W.2d 156, 167 (Wi. 1981); *Purcell v. Zimbelman*, 500 P.2d 335, 341 & n.9 (Az.App. 1972).

V. THE PUBLIC DUTY DOCTRINE DOES NOT APPLY.

Respondent St. Francis and Amicus MDLA argue that the public duty doctrine delineated in *Cracraft v. City of St. Louis Park*, 279 N.W.2d 801 (Minn. 1979) applies to this case and that hospitals owe only a general duty of care to the public, not a special duty to patients, when making privileging decisions. (St. Francis Brief at 41; MDLA Brief at 1-10). This Court, however, has already rejected this argument.

A. MINNESOTA HOSPITALS OWE SPECIAL DUTIES TO PATIENTS.

Our courts have recognized that hospitals owe the following duties to patients: hospitals must comply with accepted standards of care when providing medical care and

services to patients, *Sylvester v. Northwestern Hosp.*, 53 N.W.2d 17, 19 & n.1 (Minn. 1952); protect patients from dangers posed by other patients, *id.* at 19-20; protect patients from third-party trespassers within the hospital, *Roettger v. United Hospitals of St. Paul, Inc.*, 380 N.W.2d 856, 862 (Minn. 1986); and protect patients from themselves, *Tomfohr v. Mayo Foundation*, 450 N.W.2d 121, 125 (Minn. 1990).⁹

Credentialing and privileging decisions are inextricably intertwined with the medical care and services that hospitals provide to their patients. *Garland*, 156 S.W.3d at 545. Given that hospitals have a duty to patients to comply with accepted standards of care when providing medical care and services, *Sylvester*, 53 N.W.2d at 19 & n.1, recognition of a duty to patients to use reasonable care in granting privileges is fully consistent with existing case law.

This Court has already determined that hospitals have special relationships with patients that except hospitals from the general common law rule “that there is generally no duty to prevent the misconduct of a third person.” *Cracraft*, 279 N.W.2d at 804. In *Sylvester*, this Court has held that:

A private hospital . . . must exercise such reasonable care for the protection and well being of a patient as [her] known physical and mental condition requiresAs to the danger . . . reasonably to be anticipated from the acts of another person under the hospital’s control, the reasonable care to be exercised must always be in proportion to the patient’s inability to look after [her] own safety.

⁹ The MDLA apparently overlooked the *Sylvester* line of cases when it represented that “Minnesota courts have never recognized that [hospital-patient] special relationship outside the context of direct services given to a patient.” (MDLA Brief at 3).

Sylvester, 53 N.W.2d at 19; *Accord Roettger*, 380 N.W.2d 856 (Minn. App. 1986). In *Sylvester*, this Court held that a hospital has a duty to protect one patient from harm by another patient whom the hospital knew or should have known was intoxicated. Is this duty meaningfully different than the duty of a hospital to protect its patient from a physician it knew or should have known was incompetent? From a physician it knew or should have known to be a sexual predator? *Capithorne v. Framington Union Hospital*, 520 N.E.2d 139 (Mass. 1988). From a person it knew or should have known to be masquerading as a doctor? *Insinga v. LaBella*, 543 So.2d 209 (Fla. 1989).

Our courts have long recognized that hospitals have a special relationship and duty to patients that is akin to the duties owed by common carriers to passengers and by innkeepers to guests. *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); *Sylvester*, 53 N.W.2d at 20. Existence of the special relationship between hospital and patient is evidenced by the fact that patients have privileged relationships with hospitals, purchase medical care and services from hospitals, and enter hospitals and are accepted by hospitals with the expectation that the hospitals will provide quality medical care and services in exchange for monies paid.¹⁰

¹⁰ Amicus MHA's assertion that hospital's does not "...receive revenue for the physician's services..." is at least debatable if not simply wrong. Certainly hospitals and physicians receive revenue because of the services physicians provide to their common patient in the hospital. Hospitals and physicians have a symbiotic relationship, the revenue of each

Negligent privileging cases are merely a modern application of traditional tort law.

As this Court noted with approval in *Sylvester*, 53 N.W.2d at 19, the Restatement (Second) of Law Torts, § 320 provides:

One who . . . voluntarily takes the custody of another under circumstances such as . . . to subject him to association with persons likely to harm him, is under a duty to exercise reasonable care so to control the conduct of third persons as to prevent them from . . . so conducting themselves as to create an unreasonable risk of harm to him, if the actor:

- (a) knows or has reason to know that he has the ability to control the conduct of the third persons, and
- (b) knows or should know of the necessity and opportunity for exercising such control.

Comment a. to § 320 states that the Section applies to private hospitals. And it should. Hospitals are paid to exercise reasonable, or better, care of their patients. This is not a duty imposed by statute. It is a duty that St. Francis, like other hospitals, undertakes because it is paid to do so. St. Francis was paid. Patients of St. Francis, including Mary Larson, fully expect the hospital to execute its paid responsibilities with at least reasonable care for their well being.

B. PUBLIC DUTY DOCTRINE HAS NEVER BEEN APPLIED TO BAR CLAIMS BY PATIENTS AGAINST HOSPITALS.

Respondents and amicus MDLA fail to cite one case that supports their position that the public duty doctrine has ever barred any claims by a patient against a hospital.

being dependent upon the other and the joint services rendered to the common patient. Each ought have a duty to insist upon and assure competence in the other for the benefit of the common patient with whom each has a special relationship.

Certainly the public duty doctrine has not operated as a bar to negligent privileging claims in the 35 states that recognize negligent privileging claims.

Appellants have found only one reported case in which a hospital contended that it could avoid civil liability under the public duty doctrine. In *Stacy v. Truman Medical Center*, 836 S.W.2d 911 (Mo. 1992), a hospital patient was injured when a fire started in the hospital. The hospital argued that any responsibilities it had to inspect for fire hazards was a duty owed to the general public versus a special duty owed to hospital patients. *Id.* at 921-22. The Missouri Supreme Court rejected the argument:

If [Truman Medical Center] is arguing that hospitals owe only a duty to the general public, not to the individual patients, then no malpractice case could ever be brought against any hospital. . . . The fact is that TMC owes a duty of reasonable care to all of its patients. . . . [O]nce the hospital accepts a patient, it owes a patient a specific duty to use reasonable care The public duty doctrine is inapplicable to this case.

Id. at 922.

CONCLUSION

This Court should recognize a common law cause of action for negligent privileging. Thirty-five states have done so. By virtue of the decision by the Court of Appeals, Minnesota currently stands alone in failing to require hospitals to protect patients from incompetent physicians. This decision does not square with multiple controlling precedents issued by this Court. Recognition of this cause of action will supplement important legislative efforts to protect patients and improve health care, assure hospitals are held accountable for negligent privileging, and deliver the constitutional right of a remedy to patients harmed by the wrongful conduct of hospitals.

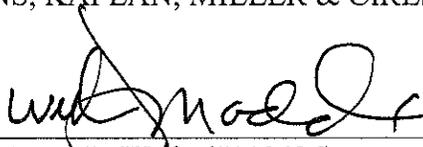
Unless hospitals are held accountable for negligent privileging, they have little incentive to comply with their legal duties to protect patients who have placed their trust in hospitals.

Respectfully submitted,

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

Dated this 4th day of January, 2007.

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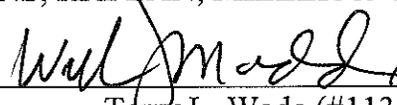
CERTIFICATE

Pursuant to Rule 132.01, subd. 3(b)(1), the undersigned set the type of the foregoing brief in Times New Roman, a proportional 13-point font, on 8 ½ by 11 inch paper with written matter not exceeding 6 ½ by 9 12/ inches. The resulting principal brief contains 5744 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.

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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).