

Nos. A05-1698 and A05-1701

State of Minnesota
In Supreme Court

MARY AND MICHAEL LARSON,

Appellants,

v.

JAMES PRESTON WASEMILLER, M.D.,

Respondent (A05-1698),

Defendant (A05-1701),

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

Defendants (A05-1698),

ST. FRANCIS MEDICAL CENTER,

Respondent (A05-1701).

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

BASSFORD REMELE,
A Professional Association
Mark R. Whitmore (#232439)
Charles E. Lundberg (#6502X)
33 South Sixth Street, Suite 3800
Minneapolis, Minnesota 55402
(612) 333-3000

RIDER BENNETT, LLP
Diane B. Bratvold (#18696X)
33 South Sixth Street, Suite 4900
Minneapolis, Minnesota 55402
(612) 340-8927

*Attorneys for Amici Minnesota Hospital
Association, Minnesota Medical
Association and American Medical
Association*

*Attorneys for Amicus Minnesota Defense
Lawyers Association*

(Additional Counsel Listed on following page)

ROBINS, KAPLAN, MILLER &
CIRESI LLP
William Maddix (#188530)
Terry Wade (#113426)
2800 LaSalle Plaza
800 LaSalle Avenue South
Minneapolis, Minnesota 55402
(612) 349-8500

Attorneys for Appellants

LARSON • KING, LLP
Louise Dovre Bjorkman (#166947)
Mark A. Solheim (#213226)
2800 Wells Fargo Place
30 East Seventh Street
Saint Paul, Minnesota 55101
(651) 312-6500

and

VOGEL LAW FIRM
M. Daniel Vogel (#013496X)
218 North Pacific Avenue
P.O. Box 1389
Fargo, North Dakota 58107
(701) 356-6983

Attorneys for Respondent
James Preston Wasemiller, M.D.

MEAGHER & GEER PLLP
Rodger A. Hagen (#158860)
33 South Sixth Street, Suite 4400
Minneapolis, Minnesota 55402
(612) 338-0661

Attorneys for Defendant Paul Scot
Wasemiller, M.D. and Dakota Clinic, Ltd.

GERAGHTY, O'LOUGHLIN &
KENNEY, Professional Association
Robert M. Mahoney (#66643)
Mark W. Hardy (#0311121)
386 North Wabasha Street, Suite 1400
Saint Paul, Minnesota 55102-1308
(651) 291-1177

Attorneys for Respondent
St. Francis Medical Center

TABLE OF CONTENTS

| | Page |
|---|-------------|
| TABLE OF AUTHORITIES | ii |
| INTRODUCTION AND INTEREST OF AMICI | 1 |
| <i>Minnesota Hospital Association</i> | 2 |
| <i>The Minnesota Medical Association</i> | 2 |
| The American Medical Association | 3 |
| ARGUMENT | 5 |
| I. RECOGNIZING NEGLIGENT CREDENTIALING WOULD ERODE MINNESOTA’S PEER REVIEW LAWS. | 6 |
| II. RECOGNIZING NEGLIGENT CREDENTIALING WOULD IMPOSE LIABILITY ON HOSPITALS FOR LICENSING DECISIONS MADE BY THE MINNESOTA BOARD OF MEDICAL PRACTICE. | 15 |
| III. RECOGNIZING NEGLIGENT CREDENTIALING WOULD DRASTICALLY AND UNFAIRLY PREJUDICE HOSPITALS AND PHYSICIANS. | 17 |
| A. Consolidated Trials Would Further Prejudice Hospitals and Physicians. | 20 |
| B. The Original Source Exception Does Not Allow Fair Litigation of Negligent Credentialing Claims. | 21 |
| IV. CORPORATIONS ARE NOT LIABLE FOR THE ACTS OF INDEPENDENT CONTRACTORS. | 24 |
| CONCLUSION | 27 |
| ADDENDUM | 29 |

TABLE OF AUTHORITIES

| <u>Cases:</u> | <u>Page</u> |
|---|-------------|
| <i>Amaral v. St. Cloud Hospital</i> , 598 N.W.2d 379 (Minn. 1999)..... | 8, 10 |
| <i>Campbell v. St. Mary's Hospital</i> , 252 N.W.2d 581 (Minn. 1977)..... | 8 |
| <i>Delgaudio v. Rodriguera</i> , 654 A.2d 1007 (N.J. App. 1995)..... | 18 |
| <i>Fahrendorff v. North Home, Inc.</i> , 597 N.W.2d 905 (Minn. 1999)..... | 24, 26 |
| <i>Gafner v. Down East Community Hosp.</i> , 735 A.2d 969 (Me. 1999)..... | 14 |
| <i>In re: Parkway Manor</i> , 448 N.W.2d 116 (Minn. App. 1989)..... | 8 |
| <i>In re: Fairview University Medical Center</i> , 590 N.W.2d 150 (Minn. App. 1999)..... | 8, 14 |
| <i>Konrady v. Oesterling</i> , 149 F.R.D. 592 (D. Minn. 1993)..... | 8 |
| <i>Lai v. Sagle</i> , 818 A.2d 237 (Md. App. 2003)..... | 18 |
| <i>Lund v. McEnerney</i> , 495 N.W.2d 730 (Iowa 1993)..... | 18 |
| <i>McElwain v. Van Beek</i> , 447 N.W.2d 442 (Minn. App. 1989)..... | 25, 26 |
| <i>McGarry v. Horlacher</i> , 775 N.E.2d 865 (Ohio App. 2002)..... | 18 |
| <i>McKee v. McNeir</i> , 151 S.W.3d 268 (Tex. App. 2004)..... | 18 |
| <i>Pacific Fire Ins. v. Kenny Boiler & Mfg. Co.</i> , 277 N.W. 226 (Minn. 1937)..... | 24 |

| | |
|--|--------|
| <i>Plutshack v. Univ. of Minnesota Hosp.</i> , 316 N.W.2d 1 (Minn. 1982)..... | 17, 19 |
| <i>Schneider v. Buckman</i> , 433 N.W.2d 98 (Minn. 1988)..... | 24 |
| <i>St. Luke's Episcopal Hosp. v. Agbor</i> , 952 S.W.2d 503 (Tex. 1997)..... | 14 |
| <i>Stottlemeyer v. Ghramm</i> , 597 S.E.2d 191 (Va. 2004)..... | 18 |
| <i>Weil v. Seltzer</i> , 873 F.2d 1453 (D.C. Cir. 1989)..... | 18 |
| <i>Wood v. McCullough</i> , 45 F.R.D. 41 (S.D.N.Y. 1968) | 18 |

Statutes:

| | |
|-------------------------------------|---------------|
| Minn. Stat. § 144.7065..... | 12 |
| Minn. Stat. §145.54..... | 22 |
| Minn. Stat. § 145.61..... | 7, 13, 14 |
| Minn. Stat. § 145.64..... | 6, 21, 22, 23 |
| Minn. Stat. § 145.66..... | 7, 10, 23 |
| Minn. Stat. § 147.001..... | 15, 17 |
| Minn. Stat. § 147.035..... | 15 |
| Minn. Stat. § 147.091..... | 15 |
| Minn. Stat. §§ 147.001-147.36 | 16 |

Other:

| | |
|--|----|
| Hall, <i>Hospital Committee Proceedings and Reports: Their Legal Status</i> , 1 Am. J. L. & Med. 245, 267 (1975) | 11 |
| K. Kohlberg, <i>The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures</i> , 86 Mass. L. Rev. 157, 162 (2002)..... | 11 |

Owens, *Peer Review: Is Testifying Worth the Hassle?*,
Med. Econ., Aug. 20, 1984, at 168.....10

P. Scibetta, Note, *Restructuring Hospital - Physician Relations: Patient Care Quality Depends
on the Health of Hospital Peer Review*, 51 U. Pitt. L. Rev. 1025, 1034-35 (1990) 11

INTRODUCTION AND INTEREST OF AMICI

The three Amici Curiae submitting this brief have both public and private interests in this appeal.¹ All three Amici are directly involved in developing legislative policy to assist society in providing the highest quality health care. The Minnesota Medical Association [“MMA”] and the Minnesota Hospital Association [“MHA”] have been particularly involved in the unique and positive developments in the law and policy of Minnesota that have directly resulted in significant improvements in the quality of health care within this State. Both the MHA and the MMA have worked to distinguish Minnesota from every other state in the country by supporting legislative development of the strongest peer review and reporting systems in the nation, including most recently the Minnesota Adverse Health Event legislation (Minn. Stat. §§ 144.706-144.7069), a unique statute designed to require reporting and self-analysis of unexpected adverse health events.² Minnesota’s Adverse Health Event legislation--the first of its kind in the country--draws heavily upon the strength of Minnesota’s peer review laws that are under

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

² Peer review statutes or common law protections exist in all 50 states. However, Minnesota appears to be the only state that imposes criminal penalties for releasing peer review material. See Minn. Stat. § 145.66.

attack in this case.³ The Minnesota Hospital Association, Minnesota Medical Association and American Medical Association [“AMA”] greatly fear that if a claim for “negligent credentialing” were recognized in this case, it would set back important quality advances within this State that separate Minnesota from the rest of the country.

Minnesota Hospital Association

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

The Minnesota Medical Association

MMA is a professional association representing approximately 9,500 physicians, residents, and medical students in the State of Minnesota. MMA seeks to promote excellence in health care, to insure a healthy practice environment, and to preserve the

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

professionalism of medicine through advocacy, education, information and leadership. For more than 150 years MMA and its members have worked together to safeguard the quality of medical care in Minnesota and the future of the medical profession.

The American Medical Association

The AMA is an Illinois non-profit corporation, comprised of approximately 240,000 physicians, residents, and medical students. The AMA is the largest medical society in the United States. Its objects are to promote the science and art of medicine and the betterment of public health. Its members practice in every state, including Minnesota, and in every field of medical specialization.⁴

* * *

The interests of the MMA, MHA and AMA in this case are primarily public in nature. These Amici have no interest whatsoever in the particular dispute between these litigants. Rather, our interests primarily focus on our concern that recognizing a claim of negligent credentialing would drastically erode Minnesota's legislatively-created peer review systems and other advances in health care legislation unique to this state.⁵ From a public perspective, we believe that recognizing negligent credentialing as a cause of

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

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

action under Minnesota law would significantly decrease the willingness of physicians to participate in peer review, as physicians involved in making credentialing decisions would increasingly become targets in credentialing lawsuits. Moreover, we fear that recognizing negligent credentialing claims would result in physicians becoming less willing to speak openly and honestly about their concerns regarding a credentialing candidate, for fear that those concerns may later become the focus of a lawsuit.

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

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

Amici believe this Court ought to have a broader perspective of the legal policy issues raised by this case than what may be presented by the parties. The parties will naturally focus on the particular facts of the case as those facts bear on the ruling below.

Amici do not intend to reargue or restate Appellants' arguments. Instead, Amici seek to provide guidance on the issues of law and policy that should form this Court's decision in analyzing what the law on the issue of negligent credentialing *should* be.

ARGUMENT

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

We also urge the Court not to recognize negligent credentialing as a viable cause of action because it would change the focus of medical malpractice law in this State away from whether the particular physician or nurse complied with the standard of care and instead direct that focus toward entirely irrelevant, prejudicial events that have nothing to do with the patient/plaintiff's medical care. Finally, hospitals would become *de facto*

excess insurers for physicians as hospitals become liable for the acts of an independent contractor. As the Court of Appeals properly concluded, recognizing claims of negligent credentialing would distinctly change the legal relationship between a business and an independent contractor such that for the first time, businesses would become liable for the acts of independent contractors. (A. 17)

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

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

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

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

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

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

In their briefing, Appellants spent considerable time arguing about the holdings and analysis of courts in other jurisdictions on the question of negligent credentialing. We strongly believe this is not the appropriate focus for this Court. As the Court of Appeals recognized, we urge this Court to agree that this case presents a uniquely Minnesotan issue, and to focus on the specific statutory language established by the Minnesota Legislature, the plain statutory intent to protect the integrity of the Minnesota peer review process, and the nationally-recognized advances in Minnesota health care legislation. (A.16) Importantly, the Court should not focus on whether the common law of *other states* recognizes negligent credentialing but rather on whether establishing such a cause of action in Minnesota is appropriate given the overriding and broad scope of *Minnesota's* health care legislation.

Obviously, different states have created different mechanisms to assure that hospitals credential physicians appropriately. While some states police those activities through common law civil actions, the Minnesota Legislature has elected to allow hospitals to police those activities internally through their peer review programs.

Campbell v. St. Mary's Hospital, 252 N.W.2d 581, 587 (Minn. 1977) (peer review is intended to “encourage the medical profession to police its own activities with a minimum of judicial interference”); *In re: Parkway Manor*, 448 N.W.2d 116, 119 (Minn. App. 1989) (same). No party has pointed to a statutory peer review program as well developed and unique as Minnesota’s.

Amici are extremely concerned that recognizing negligent credentialing as a new cause of action would dissuade physicians and other professionals from participating in the credentialing (or other review organization) processes. This Court has repeatedly recognized similar concerns. *See Amaral v. St. Cloud Hospital*, 598 N.W.2d 379, 387 (Minn. 1999) (absent confidentiality, professionals will be reluctant to “participate freely” in peer review); *Campbell*, 252 N.W.2d at 587 (import of peer review is to encourage the medical profession to “police its own activities with a minimum of judicial interference”). *See also Konrady v. Oesterling*, 149 F.R.D. 592, 596 (D. Minn. 1993) (confidentiality in peer review is necessary “to protect the unimpeded flow of ideas and advice”).

Until the trial court’s recognition of negligent credentialing in this case, there has been little question that Minnesota’s peer review laws protect the integrity of the peer review process by maintaining confidentiality. *Id.*; *In re: Fairview University Medical Center*, 590 N.W.2d 150, 153 (Minn. App. 1999) (peer review is designed to improve patient care “despite threats of malpractice and defamation actions”); *In re: Parkway Manor*, 448 N.W.2d at 120 (same). Somewhat surprisingly, despite the unique peer

review statutes constructed by the Minnesota Legislature, Appellant's Brief *fails to cite even one decision* from this Court or the Court of Appeals that addresses *Minnesota's* peer review statute. In comparison, the Court of Appeals correctly addressed the directives from this Court and the Minnesota Legislature, in properly concluding that Minnesota's legislative construct and the strict confidentiality protections preclude the negligent credentialing cause of action that Appellants seek to assert. (A. 16) Appellant's sweeping arguments focus on legislative constructs and judicial interpretations from other states, rather than the Minnesota nature of the review organization statute and prior decisions from this Court that are actually at issue.

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

In light of the statute's confidentiality provisions, allowing negligent credentialing claims would force hospitals and physicians to make the impossible choice of either *not* defending the negligent credentialing claim or sharing the entire analysis of the credentialing committee, only to risk criminal punishment and erode the hospital's peer

review program. See Minn. Stat. § 145.66. Should a hospital choose to defend the lawsuit, it will be forced to erode the integrity of its peer review program and share peer-review protected information, thereby subjecting itself to criminal prosecution.

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

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

Id. at 387. The *Amaral* Court noted that medical professionals rely on collegiality with, and referrals from, their peers and that “the quality of patient care could be compromised if fellow professionals are reluctant to participate fully in peer review activities by coming forward with candid and honest reports about a colleague.” *Id.* at 388. See also Owens, *Peer Review: Is Testifying Worth the Hassle?*, Med. Econ., Aug. 20, 1984, at 168 (noting that 21% of physicians had lost referrals or had antagonized colleagues

because of their participation in peer review procedures); P. Scibetta, Note, *Restructuring Hospital – Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. Pitt. L. Rev. 1025, 1034-35 (1990).

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

Consistent with this Court’s directive in *Amaral*, maintaining confidentiality of review organization functions is imperative to the success of the process. Otherwise, physicians will either refuse to participate in the process or will be reluctant to speak honestly about the merits of credentialing a physician. Credentialing committee

members would bite their tongue out of fear that their comments would be used against the hospital in a subsequent negligent credentialing claim or against the physician in a malpractice case.

Recognizing negligent credentialing would erode the legislatively-created confidentiality provisions and set aside significant legislative advances unique to Minnesota. For example, in August 2003 Governor Pawlenty signed the Minnesota Adverse Health Event Legislation that created mandatory reporting of adverse health events. See Minn. Stat. §§ 144.706-144.7069.⁶ In addition to requiring mandatory reporting, the Adverse Health Event legislation also required hospitals to create and implement their own corrective action plans as part of their peer review programs. Minn. Stat. § 144.7065, subd. 8.⁷ Under the new law, peer review information is voluntarily (and confidentially) provided to the Minnesota Department of Health, which makes recommendations for improving health care on a state-wide basis. In creating the Adverse Health Event legislation, the Legislature further strengthened Minnesota's peer review statute by making the hospital's corrective action plan subject to the same confidentiality protections as the hospital's credentialing program. See Minn. Stat. §

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

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

145.61, subd. 5(q). But the success of the Adverse Health Event legislation hinges on a hospital's willingness to self-report an event, perform corrective action in the peer review system, and report process improvements to the Minnesota Department of Health.

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

Finally, these peer review issues have obviously been directed and shaped by repeated Legislative action. Thus, unlike the *Lake v. Wal-Mart* case relied on so heavily by Appellants, the creation of a new cause of action here would not just simply be a matter of evolving *judicial* law, but would in a very real sense be a direct usurpation of authority committed to, and already affirmatively exercised by, the Legislature. There is to that extent a serious separation of powers problem lurking here, a problem that

Appellants (and the trial court itself) never really came to grips with. The states that have rejected negligent credentialing claims have largely based their analysis on statutory constructs similar to Minnesota's, recognizing the courts should not impede constitutionally-appropriate legislative action. With respect to peer review challenges, "The legislature is free to perpetrate injustice so long as it does not violate the constitution; if a statute is clear the remedy is amendment not construction. Accordingly, if a remedy is called for, it is legislative rather than judicial." *In re: Fairview*, 590 N.W.2d 150, 154 (Minn. App. 1999); *see also Gafner v. Down East Community Hosp.*, 735 A.2d 969, 979 (Me. 1999) ("Before the expansion of tort liability into an area that has been significantly controlled by the Legislature, we should allow the Legislature to address the policy considerations and determine whether imposing such a duty constitutes wise public policy."); *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 509 (Tex. 1997) ("The legislature is free to set a course for Texas jurisprudence different from other states. Once the legislature announces its decision on policy matters, we are bound to follow it within constitutional bounds.").

The Minnesota Legislature has spoken, loudly and clearly – the confidentiality of peer review information is critical to Minnesota's health care system. In interpreting the Legislature's directive, this Court repeatedly and consistently has upheld the absolutely critical confidentiality provisions of Minn. Stat. §145.61 *et. seq.*⁸ A decision to recognize

⁸ Appellant's Brief offers the blanket, unsupported assertion that patient safety will be enhanced by allowing this cause of action. This bold statement simply disregards the well-established priorities from the Minnesota Legislature which have been repeatedly

negligent credentialing would drastically undermine the Legislature's mandate on this issue and this Court's repeated recognition of the need to maintain the confidentiality of that information.

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

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

In fulfilling its purposes, the Minnesota Board of Medical Practice regularly evaluates precisely the same issues that would be the subject of a negligent credentialing claim. Those issues include a physician's malpractice history (Minn. Stat. § 147.035), qualifications, improper licensure, criminal history, actions against the physician in other jurisdictions, unethical conduct, mental impairments or chemical abuse, unprofessional behavior, or even failing to repay a student loan. *See* Minn. Stat. § 147.091, subd. 1.⁹ In

acknowledged by this Court -- that patient safety improves through established review organization efforts when care providers can speak openly and freely about an event -- a candid discussion that would be destroyed if this Court were to recognize negligent credentialing claims.

⁹ In the State's fiscal year from July 1, 2005 – June 30, 2006, the Legislature allocated \$3,729,000 to the Board of Medical Practice to perform the responsibilities and

making credentialing decisions, hospitals throughout this state regularly rely in part on the Board's ability to evaluate a physician's ability to practice medicine safely before credentialing that physician.

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

If recognized, negligent credentialing claims would impose an elevated threshold upon hospitals beyond that imposed upon the Board of Medical Practice. Hospitals would be forced to do more than the very agency whose "primary responsibility and obligation" is to protect the public in connection with the granting and subsequent use of

obligations set forth in Minn. Stat. §§ 147.001-147.36. H.F. 139 1st Engrossment, 2005; 1st Spec. Sess. §§ 440.12-440.34 (Minn. 2005).

a medical license. *See* Minn. Stat. § 147.001. Certainly, such an obligation would impose undue and, frankly, unfair obligations on hospitals and prevent them from relying upon the expertise of the Board of Medical Practice. It also would demand excessive resource allocations for the hospital to complete that task because the Medical Board's analysis simply would not be deemed sufficient.

In sum, it is entirely appropriate for hospitals to be able to rely upon the expertise of the Medical Board as the Board works to maintain the public health, safety and welfare and to protect the public from the unprofessional, improper, incompetent and unlawful practice of medicine.

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

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

Because medical malpractice cases focus on the care of the patient at issue, tangential, irrelevant issues such as care provided to other patients is routinely held inadmissible, as events involving other patients are not probative on the question about whether the physician complied with the standard of care *in the case at issue*. Indeed,

evidence of other lawsuits is generally not even discoverable, much less admissible. *Wood v. McCullough*, 45 F.R.D. 41 (S.D.N.Y. 1968).

Maryland's highest court correctly explained the significant prejudice that occurs when a jury in a medical malpractice case is tainted by information regarding other lawsuits. In *Lai v. Sagle*, 818 A.2d 237 (Md. App. 2003), the court reversed a jury verdict for the plaintiff, holding it was reversible, prejudicial error for the trial court to allow plaintiff's counsel to refer to prior suits against the defendant physician. *Id.* at 249. The court reached a similar conclusion with respect to the physician previously having failed to become board certified. *Id.* at 246. The court held the prior suits had "little, if any, relevance to whether [the physician] violated the applicable standard of care in the immediate case," finding that evidence of prior suits does not aid the jury but "tends to excite its prejudice and mislead." *Id.* at 247.¹⁰ The court acknowledged that it could not "conceive of a more damaging event in a medical malpractice trial" than disclosing prior suits. *Id.*

If negligent credentialing claims were recognized, the focus of medical malpractice litigation would drastically shift away from the relevant issues (whether the care of this patient complied with the standard of care) to the tangential and irrelevant.

¹⁰ The *Lai* Court cited at least six jurisdictions that recognized the fundamental principle that prior malpractice actions are neither relevant nor admissible. See 818 A.2d at 248. Additional courts from across the country have reached the same conclusion. See *Stottlemyer v. Ghramm*, 597 S.E.2d 191, 194 (Va. 2004); *McGarry v. Horlacher*, 775 N.E.2d 865, 872 (Ohio App. 2002); *Lund v. McEnerney*, 495 N.W.2d 730, 734 (Iowa 1993); *Delgaudio v. Rodriguera*, 654 A.2d 1007, 1010 (N.J. App. 1995); *McKee v. McNeir*, 151 S.W.3d 268, 270 (Tex. App. 2004); *Weil v. Seltzer*, 873 F.2d 1453, 1461 (D.C. Cir. 1989).

Here, for example, Appellants focused primarily on a number of prior malpractice cases involving Dr. James Wasemiller. Then, due to the prior claims, Appellants turned their focus to Dr. Wasemiller's insurance history and discipline imposed by the Minnesota Board of Medical Practice. *Id.* at 9-11.

Appellants even went so far as to try to support their negligent credentialing claim by offering evidence that the physician was behind in child support obligations and unpaid taxes. *Id.* at 11. Paying child support or taxes has nothing to do with whether the physician complied with the standard of care. Certainly, the evidence of Dr. Wasemiller's debts, other malpractice history or insurance has absolutely nothing to do with whether Mary Larson received medical services consistent with the standard of care.

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

A. Consolidated Trials Would Further Prejudice Hospitals and Physicians.

Appellants argue that trials of negligent credentialing claims should be combined with the malpractice case. (Appellants' Brief, p. 33) Of course, such an argument entirely disregards the considerable prejudice that would negatively impact the abilities of hospitals and physicians to defend malpractice cases. Indeed, Appellants do not offer even one decision from anywhere in the country refuting the well-accepted principle that allowing evidence of other malpractice cases at the trial would drastically prejudice defendants. Rather, Appellants summarily contend that the jury would be able to sort through evidence about the credentialing claim that would not otherwise be admissible in the malpractice case.

With all due respect, Appellants go so far as to offer the almost bizarre argument that "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." (Appellants' Brief, p. 33) Nothing could be further from the truth. Indeed, how could the Plaintiff, in a combined malpractice/credentialing case, establish causation absent a finding of negligence against the physician? Would Appellants take the position then, that the hospital could be liable for damages in a negligent credentialing case even if the physician herself had complied with the standard of care in all respects? In such a situation, there would be absolutely no evidence of causation on the credentialing claim -- as a matter of law, a decision to credential could not cause damage to the patient, unless the credentialed physician had somehow acted negligently

and caused harm. We are deeply concerned that Appellants' proposed blanket elimination of the critical causation element required in every negligence case is made in a veiled attempt to further prejudice hospitals and physicians should this Court recognize negligent credentialing claims.

In Dr. Wasemiller's case, the parties would need to turn the focus of the litigation away from the care provided to Ms. Larson; defendants would, in essence, be forced to retry ten other cases involving separate plaintiffs and separate procedures to determine whether it was appropriate for the hospital to have credentialed the physician in the first place.¹¹ The plainly inadmissible would suddenly and unfairly become the centerpiece to the litigation. Contrary to Appellants' Brief, a jury could hardly just sift through this largely irrelevant and tremendously prejudicial evidence.

B. The Original Source Exception Does Not Allow Fair Litigation of Negligent Credentialing Claims.

Appellants' solution for resolving peer review concerns is simply to litigate the negligent credentialing claim based solely on "original sources." Such a proposed solution only exacerbates the already unfairly prejudicial scheme they propose. Appellants hinge their original source argument on one sentence contained within Minn. Stat. § 145.64 providing that original source documents are not immune from discovery or use in a civil action:

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

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.

Minn. Stat. §145.64 subd. 1(a).

Appellants contend that parties could litigate a negligent credentialing claim based solely upon public information or other original source materials. They suggest that these materials might include records about a physicians' malpractice or insurance history, or public information about the physician's failure to pay income taxes or other criminal violations. However, Appellants fail to recognize that the most relevant information in a negligent credentialing claim is not what might be dug up in the public domain, but precisely what was actually considered in allowing a physician to become credentialed at a hospital. That crucial information is not "original source" material and simply may not be disclosed nor introduced into evidence in any action. A discussion between the members of a credentialing committee as to whether to grant a physician privileges is the precise type of information Minn. Stat. §145.54 was designed to protect. *See* Minn. Stat. §145.64 subd. 1(a) ("[A] witness cannot be asked witness' testimony before a review organization or opinions formed by the witness as of its [review organization's] hearings.")

Litigating credentialing cases based solely on original sources would be especially unfair, as plaintiffs would rely on public information from outside the peer review process (e.g. prior suits or tax liens), yet the hospital defending that case would be completely unable to defend its analysis about why the decision to credential the

physician was proper. The hospital would be especially prejudiced and unable to fairly defend the claim because state law categorically prohibits the hospital from telling a jury *what it actually did in evaluating the public information in its private meetings about the physician's credentials*. See Minn. Stat. §§ 145.64, 145.66. The trial court's comment about a hospital defending the claim "with one hand tied behind its back" is a rank understatement. The hospital would be *unable to defend the claim at all* since it could not legally provide the jury with any of the information supporting its decision to credential the physician.

The original source exception does not allow the credentialing committee to share *what* it actually considered or *why* it reached its conclusion. Contrary to Appellants' Brief, how could an expert in a credentialing case criticize the deliberations of a credentialing committee when neither that expert (nor anyone else for that matter) can even know what was actually considered? These Amici strongly disagree with Appellants' assertion that the original source exception will somehow allow fair litigation of a purported negligent credentialing claim or will otherwise protect the confidential nature of the credentialing decision making process.

Simply stated, recognizing a negligent credentialing claim under Minnesota law would drastically, unfairly and prejudicially change the face of medical malpractice litigation in this state. The entirely irrelevant and highly prejudicial evidence about prior claims or a physician's personal life will unfairly become more important than the events regarding the actual care provided to a particular patient. Hospitals would be further

prejudiced because they would be prohibited from responding to, or explaining why, they credentialed a physician despite information otherwise available in the public arena.

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

As the Court of Appeals recognized, allowing a negligent credentialing claim also would significantly alter the law in the state with respect to a corporation's responsibilities for individuals who are not employed by the organization. (A.17) Of course, it is black-letter law that under the doctrine of *respondeat superior*, an employer is vicariously liable for the torts of its employees committed in the course and scope of the employee's employment. *Fahrendorff v. North Home, Inc.*, 597 N.W.2d 905, 910 (Minn. 1999). As this Court recognized, imposition of liability on an employer due to the acts of its employees is a matter of public policy, for the courts have determined that "liability for acts committed within the scope of employment should be allocated to the employer as a cost of engaging in that business." *Id.*; see also *Schneider v. Buckman*, 433 N.W.2d 98, 101 (Minn. 1988). Lacking an employment relationship, however, one entity is not responsible for the acts or omissions of an unrelated entity. See *Pacific Fire Ins. v. Kenny Boiler & Mfg. Co.*, 277 N.W. 226, 228 (Minn. 1937).

Despite Appellants' pleas to the contrary, the Court of Appeals correctly recognized that allowing negligent credentialing claims and recognizing a new cause of action would significantly alter the law of vicarious liability in Minnesota. Under Appellants' purported cause of action, corporations or other organizations would now become liable for the acts of individuals who are not employed. While Appellants

contend that this is really not a vicarious liability situation, the end result is the same -- corporations and other organizations would now become liable for the acts of individuals who are not employed.

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

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

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

McElwain v. Van Beek, 447 N.W.2d 442, 446 (Minn. App. 1989).

If recognized, negligent credentialing claims would hold hospitals to the standard of negligent hiring or negligent retention, as if the credentialed physicians were the hospital's employees. This also would completely alter well established precedent set forth by this Court and impose liability on corporations for the acts of independent

contractors. That has never been the case in Minnesota in the medical malpractice arena nor in any other context. Of course, negligent hiring or negligent retention claims only occur when an employer has hired the employee and has received the financial benefit of that employee's services. That is simply not the case with credentialed physicians. As this Court recognized in *Fahrendorff*, *respondeat superior* requires the employer to bear the cost of the acts of its employees as that cost is incurred in the course of doing business. As the Court of Appeals recognized in *McElwain*, hospitals are not liable for the care of independently-contracted credentialed physicians. Recognizing negligent credentialing claims would drastically alter this well-established principle.

Recognizing negligent credentialing would overturn the well-established precedent in *McElwain* and would hold hospitals (and other businesses) to a negligent retention standard *despite the fact the hospital never hired the physician and the hospital does not receive revenue for the physician's services*. The Court of Appeals' analysis in *McElwain* is entirely consistent with the law in Minnesota and should remain that way. Hospitals do not employ credentialed physicians and should not be held to the liability standard imposed on an employer.¹² Recognizing claims of negligent credentialing would be completely inconsistent with the law and liability obligations imposed on employers in this state.

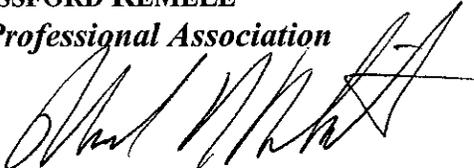
¹² From a public policy standpoint, imposing liability on hospitals for the acts of independent contractors also would interfere with the medical judgment of physicians. As the physician's *de facto* employer, hospitals would be impelled to exert the same level of control on an independently-contracted physician that they exert over their actual employees. Medical decisions would be made largely upon that control, rather than the physician's own medical judgments.

CONCLUSION

Recognizing a claim of negligent credentialing would undermine 30 years of legislatively-created progress in peer review and would drastically change medical malpractice litigation and fundamental principles of principal/agent law. The Court of Appeals held correctly that recognizing claims of negligent credentialing would defeat the well-reasoned, thorough analysis and priorities created by Minnesota's review organization statute and its progeny.

BASSFORD REMELE
A Professional Association

Dated: 22 Dec. 06

By 

Mark R. Whitmore (License #232439)

Charles E. Lundberg (License #6502X)

Attorneys for Amici Minnesota Hospital Association,
Minnesota Medical Association and the American
Medical Association

33 South Sixth Street, Suite 3800

Minneapolis, Minnesota 55402-3707

(612) 333-3000

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 132.01, subd. 3(c) of the Minnesota Rules of Civil Appellate Procedure, this certifies that Amici's Brief contains 6,931 words, which is in compliance with the 7,000 word limit. The brief was created using Microsoft Word 2003 and complies with the typeface requirements of Rule 132.01.

Dated: 22 Dec. 06



Mark R. Whitmore (License #232439)

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).