LAW & MEDICINE

The Perils of Credentialing

Worried about how to deal with physician credentialing in your office or hospital? Wondering which questions you should ask references about potential employees, or what to say when someone asks you for a reference? Well, a recent decision in a federal court may make you think twice about what you do.

BY MILES J. ZAREMSKI, J.D.

The case is called *Kadlec Medical Center v. Lakeview Anesthesia Associates* (2008 WL 1976591 [5th Cir 2008]). And since the decision was rendered, the blawgs (blogs for lawyers) and other medicolegal Web sites have been abuzz with discussion and commentary about the case and its impact on ensuring quality health care.

The case involves anesthesiologist Robert Berry, who practiced in Louisiana with Lakeview Anesthesia Associates (LAA). This group held an exclusive contract at Lakeview Medical Center. Dr. Berry had been abusing meperidine (Demerol), withdrawing excessive amounts of the drug from the hospital without providing any documentation for it.

Lakeview's chief executive officer discussed the situation with LAA, which agreed to control and monitor Dr. Berry. But Dr. Berry didn't go along with the plan and continued abusing the drug.

Some weeks later, Dr. Berry failed to answer a call page while on duty; he was discovered in the call room, asleep, groggy, and unfit to work. Hospital personnel immediately called LAA, which found Dr. Berry uncommunicative and unable to work; he admitted taking prescription medications.

As a result of this incident, Lakeview's CEO decided that Dr. Berry could no longer treat patients at the hospital. LAA, for its part, terminated Dr. Berry, but the hospital never took any action against him; after all, the hospital dealt directly with LAA regarding any staffing issues. Such an arrangement is not unusual.

What was odd, however, was the fact that neither LAA nor Lakeview reported Dr. Berry's impairment to the hospital's Medical Executive Committee, nor to its Board of Trustees. The hospital also failed to report Dr. Berry's conduct to the Louisiana Board of Medical Examiners or to the National Practitioner Data Bank. Instead, as the circuit court noted, Lakeview's CEO "took the unusual step of locking away in his office all files, audits, plans, and notes concerning Dr. Berry and the investigation."

After Dr. Berry left Lakeview and LAA, he applied for *locum tenens* work through a staffing firm. Through that firm, he applied for privileges at Kadlec Medical Center in Richland, Wash. Kadlec requested various materials, including referral letters from both LAA and Lakeview. This is where things start to get dicey.

The request by Kadlec to Lakeview for credentialing information included a detailed confidential questionnaire, which asked whether Dr. Berry had been subject to any disciplinary action, if he had the ability to perform the privileges requested, whether he had ever shown signs of behavior/personality problems or impairment, and whether he had satisfactory judgment. Nine days later, Lakeview responded to requests for credentialing information on 14 physicians, including Dr. Berry. That request was handled differently than the other 13.

Instead of completing the materials requested of it, Lakeview wrote a very short and simple letter listing Dr. Berry's dates of service. In addition, two LAA shareholder-physicians wrote letters of support for Dr. Berry. One described him as an excellent physician who would be an asset to any anesthesia service, and the other described him as a highly recommended anesthesiologist. These descriptions came a mere 68 days after LAA shareholders fired Dr. Berry for using narcotics while on duty.

On the basis of these materials, Kadlec credentialed Dr. Berry. He worked at Kadlec for several months without incident. Then he temporarily moved to Montana where he was involved in a car accident, suffering a back injury. When he came back to Kadlec, nursing personnel noticed that Dr. Berry's care and treatment appeared unusual; one patient was given too much morphine during surgery and had to be revived using naloxone (Narcan).

On another day, one nurse stated Dr. Berry was "screwing up all day"; he looked sick and almost passed out. That same day, Kimberly Jones went in for a routine tubal ligation. In the recovery room, a staff member noticed that Ms. Jones was not breathing. Dr. Berry had failed to resuscitate her, and she remains to this day in a persistent vegetative state.

After the Jones case was reported, Dr. Berry admitted he had been diverting and using Demerol since his car accident in Montana, and that he had become addicted to it. He immediately admitted himself to a drug rehabilitation program. The Jones family sued for malpractice; Dr. Berry's malpractice insurer settled his part of the claim. Kadlec was also sued and settled the case, as did its insurer.

Kadlec and its insurer then turned around and sued Lakeview and LAA in federal court in Louisiana for "intentional and negligent misrepresentation" based on the letters of recommendation from the LAA doctors and Lakeview's omission of critical information when it responded to the credentialing questionnaire. A jury awarded Kadlec and its insurer $8.24 million to cover its costs (including the settlement) in the Jones suit; this amount was later reduced to $5.52 million. The trial court held that Lakeview and LAA breached their duty to disclose Dr. Berry's drug problem, which resulted in Dr. Berry being allowed to treat Ms. Jones.

The 5th Circuit appeals court reversed that decision as it concerned Lakeview, but not as to LAA. It said that Louisiana law doesn't include a duty to disclose, except in certain circumstances such as a fiduciary duty or confidential relationship. Kadlec argued that a duty to disclose should and must exist, since a physician's drug dependence could pose a serious threat to patient safety.

In an incredible response, this federal appeals court said, "We do not predict that courts in Louisiana—absent misleading statements such as those made by the LAA defendants—would impose an affirmative duty to disclose." The court concluded that since Lakeview's letter was not materially misleading, and because the hospital did not have a legal duty to disclose its investigation of Dr. Berry and its knowledge of his drug problems, the case and verdict against Lakeview should be reversed. At the same time, the court upheld the verdict against LAA, because if a reference is going to disclose factual information, it must do so reasonably and not be misleading, as the LAA reference letters were.

Are there lessons to be learned from the *Kadlec* decision? Perhaps:

► The less you say in a response to a request for credentials, the better.

► A hospital protects itself more by not commenting upon an unqualified or impaired staff member where it takes no disciplinary action; the best approach is to be neutral in any response to a request for credentials.

► Whatever you say must be truthful and accurate.

► At least in Louisiana and states covered by the 5th Circuit, there is no affirmative duty to convey knowledge about a physician's ability to practice and render care and treatment, even if asked.

This decision raises critical legal and ethical issues for hospitals and physicians participating in the credentialing process, particularly regarding the dissemination of information. Rendering health care is not a regional or local concern, since physicians are trained and practice throughout the country, so when physicians wish to commence practice, relocate, or even reapply for staff privileges, it is of the utmost importance that they are qualified to do their jobs and pose no risk to patients.

► Hospitals must be mindful of their responsibility to ensure good patient care when it comes to responding to requests for credentialing information. Reply to requests accurately, truthfully, and completely with knowledge of all verified facts known by hospital management.

► Colleagues of physicians seeking appointment or reappointment who are asked to write letters of recommendation must do so accurately and truthfully, without any statements that might be considered false or misleading. ■

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Personal Health Records Should Ensure Privacy, Task Force Says

BY MARY ELLEN SCHNEIDER
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Privacy should be the top priority when developing certification criteria for personal health records, a task force created by the Certification Commission for Healthcare Information Technology has recommended.

Adequate security and interoperability also must be included in certification efforts, according to the task force.

The Certification Commission for Healthcare Information Technology (CCHIT) will use these recommendations as it prepares to begin certifying personal health records (PHRs) next summer.

Since the PHR field is still "rapidly evolving," the task force said that certification requirements should not be so prescriptive that they interfere with the progress of the technology.

The task force recommended that the voluntary certification process should apply to any products or services that collect, receive, store, or use health information provided by consumers. Certification should also apply to products or services that transmit or disclose to a third party any personal health information.

This would allow the CCHIT to offer certification to a range of products and applications, from those that offer a PHR application and connectivity as an accessory to an HER, to stand-alone PHRs.

CCHIT hopes that, just as it did in the EHR field, certification will create a floor of functionality, security, and interoperability, said Dr. Paul Tang, cochair of the PHR Advisory Task Force and vice president and chief medical information officer for the Palo Alto (Calif.) Medical Foundation.

The task force called for requirements to maintain privacy in monitoring and enforcement, and for consumer protection that would allow patients to remove their data if certification is revoked. The group also recommended that standards-based criteria be developed that would require PHRs to send and receive data from as many potential data sources as possible, including ambulatory EHRs, hospital EHRs, and labs.

In July, the task force made its recommendations and handed over responsibility for PHR certification to a CCHIT work group. That work group will develop the actual certification criteria that will be used to test PHR products starting next July, according to Dr. Jody Pettit, strategic leader for CCHIT's PHR work group. ■