

Health Law ADVISORY

Current legal insights for healthcare executives

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Julie A. Knutson, Editor

The Pendulum Swings on Peer References; The Kadlec Decision

There is a maxim in the law that “bad facts make bad law,” meaning courts are sometimes inclined to stretch the law to find a remedy in bad fact scenarios. One wonders if that is the result in the recent U.S. District Court decision and jury verdict in the case of *Kadlec Medical Center v. Lakeview Anesthesia Associations, et. al.*¹ Rightly or wrongly, the court may have opened the door to a rule whose time has come.

The Decision

A federal district court in Louisiana ruled that a hospital that omitted material adverse information about a physician when responding to a second hospital’s credentialing inquiry could be held liable for harm the second hospital suffered because of the omission. This is new, and if it is picked up by other courts in other states, the ruling may significantly change the way hospitals

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“close their files” on problem physicians on their way out the door and later respond to credentialing inquiries.

The Facts

We do not have all the facts, because of the

limited nature of the published opinion.

However, from what we know and from what we can infer, the case appears to be a classic example of a hospital and an employing medical practice passing on a “problem” physician to another hospital through their silence and even affirmative responses. The important facts are:

1. Lakeview Anesthesia Associates, L.L.C. (LAA) was a group practice that employed Dr. Robert Berry in 1997. Lakeview Regional Medical Center (LRMC) was a general hospital in Louisiana that granted Dr. Berry privileges in anesthesiology that same year. LAA held the exclusive anesthesia contract with LRMC and furnished Dr. Berry as one of its physicians.

2. In the year 2000, presumably based on some suspicion, LRMC conducted an audit of Dr. Berry’s narcotic medication records and discovered that he had failed to properly document withdrawals of the drug Demerol. In March 2001, Dr. Berry failed to respond to hospital pages during a twenty-four-hour shift at LRMC. It is alleged that, LRMC staff found Dr. Berry sleeping in a chair and that he “appeared to be sedated.” Apparently in response to this incident, and based on suspicion Dr. Berry was diverting Demerol, LAA terminated Dr. Berry from

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its group that same day. No other facts about LAA and LRMC problems and suspicions with Dr. Berry are reported.

3. Dr. Berry could not thereafter exercise his privileges at LRMC after his termination by LAA, because of the exclusive contract arrangement. LRMC apparently took no corrective action itself. It merely permitted Dr. Berry's privileges to expire at the end of their term.

4. Dr. Berry relocated and some seven months later applied for privileges at Kadlec Medical Center in Richland, Washington. Kadlec sent letters requesting information about Dr. Berry to *both* LRMC and LAA. Two LAA physicians provided reference letters on behalf of LAA *as employer*, and LRMC responded as a hospital at which Dr. Berry had exercised privileges.

5. Kadlec requested, among other things: (i) "evidence of current competence to perform the privileges requested" and (ii) a "candid evaluation of [Dr. Berry's] training, continuing clinical performance, skill and judgment, interpersonal skills and ability to perform the privileges requested."

LRMC responded only that Dr. Berry was on the active staff in the field of anesthesiology between certain dates. LRMC did not respond to the other questions and said that it only provided limited information "due to the large volume of inquiries received in the office." In fact, LRMC typically did answer credentialing inquiries in more detail. The unavoidable inference here is that LRMC wanted to avoid litigation and turmoil with Dr. Berry through a carefully crafted reply.

6. It is worth pausing here to note that LRMC had not itself taken any adverse credentialing action against Dr. Berry. There had apparently been no "charges," no

hearing, and no "findings" about Dr. Berry. No action was necessary because Dr. Berry was effectively gone from the hospital once terminated by LAA. However, LRMC did have the results of its own Demerol diversion study and knew the facts of the triggering incident.

7. With LRMC's (and LAA's) references in hand, Kadlec awarded Dr. Berry privileges. Predictably, about a year later, he was the anesthesiologist in a tubal ligation surgery in which a patient suffered extensive brain damage, allegedly due to Dr. Berry's gross negligence and the fact that he was impaired by drugs during the surgery.

8. Kadlec Medical Center was sued and settled with the patient for \$7.5 million. When it learned the true facts regarding Dr. Berry's tenure at LRMC and LAA, Kadlec and its malpractice carrier sued LRMC, LAA, and certain physicians at LAA, claiming that their false and incomplete information was a proximate cause of the harm Kadlec had suffered by privileging Dr. Berry.

The case came before the federal district court in Louisiana on LRMC's motion for summary judgment. LRMC argued that there was no genuine issue to submit to a jury and the court should toss the case, because it owed Kadlec no *duty* to provide credentialing information in the first place; it did so gratuitously, and gratuitous responses are not actionable. The court, in an opinion that seems to stretch Louisiana law, found that Kadlec could sue under three theories: (i) intentional misrepresentation; (ii) negligent misrepresentation; and (iii) negligence.

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LRMC argued that there was no genuine issue to submit to a jury and the court should toss the case...

The Court then allowed the case to go to the jury, which returned a verdict against LRMC. The jury allocated blame for Kadlec's injury among the parties as follows:

20% Dr. Dennis (LAA physician for his evidently incomplete or inaccurate response)

5% Dr. Preau (LAA physician for his evidently incomplete or inaccurate response)

25% (LRMC for its incomplete and misleading response)

17% Kadlec Medical Center itself – presumably it bore some culpability in privileging Dr. Barry

33% Dr. Berry

Thus, fully 50% of the liability was assigned to the three parties who had supplied incomplete or misleading responses to Kadlec.

Significance of the Holding

There was no precedent and no clear path to the holding under Louisiana Law. However, while the legal analysis may be stretched, the public policy underlying it has appeal, and for this reason the holding is likely to be picked up and applied by other courts in other jurisdictions. Kadlec could well be a landmark holding like the original *Darling v. Charleston Community Hospital*² (the “new” corporate duty to credential and supervise staff effectively) or *Canterbury v. Spence*³ (the “new” duty to obtain informed consent), however tenuous the route taken by the first court to get there.

HCQIA

As a matter of public policy and law, hospitals are encouraged to engage in effective

peer review. To remove one key barrier to this difficult work, hospitals and their medical staffs have been given broad immunity for peer review activities. This immunity extends to sharing information and candid assessments with other entities engaged in the peer review process. The most important protection for sharing information is the witness protection provision of the Health Care Quality Improvement Act (“HCQIA”), which provides in part:

“(2) Protection for Those Providing Information to Professional Review Bodies

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.”⁴

This is extremely broad protection. It carries none of the “in good faith” and “without malice” qualifiers common to many state law protections. The only conditions are that:

1. The information must be furnished *to a professional review body*. HCQIA defines this to mean:

“[a] health care entity and the governing body or any committee of a health care entity which conducts *professional review activity*, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.”⁵

“[t]he Court concludes that under the circumstances of this case, a duty existed to disclose information to [Kadlec].”

We regularly counsel clients, if concerned about a reference or recommendation they are about to give, to first get confirmation that the requesting party is a professional review body requesting the information in connection with professional review activity. We suggest asking the requesting hospital to use a simple form to document that this condition is satisfied.

2. The information must relate to the “competence or professional conduct” of a physician. These are not specifically defined terms, but we have always read them broadly. Professional conduct must adversely affect or have the potential to adversely affect patient welfare. LRMC’s information concerning the findings in the Demerol study and the incident that lead to Dr. Berry’s termination by LAA would relate to professional conduct (and very possibly “competence”) as the term is understood.

3. The party providing information cannot know that the information is false. We further suggest the party reporting information should not act recklessly, for example, by making a suspicion sound like proven fact.

Nebraska Law

The Nebraska Supreme Court has expressly applied the witness protections of HCQIA to mean that a physician suing for defamation based on information provided to a medical staff committee must prove “by a preponderance of the evidence” that the negative assessment report “was false” and that the party providing it “knew it was false.”⁶ The Court went so far as to note that HCQIA’s protection preempts and is broader than that provided under state law, holding that:

“HCQIA [and certain federal holdings] afford greater protection in defamation

actions to persons and medical peer reviewers than does state law.”

At the same time, Nebraska appears to go a step further in potentially *requiring* reporting, at least to another inquiring Nebraska hospital. At Neb. Rev. Stat. § 71-2047, Nebraska *obligates* a party with information to furnish it to a hospital medical staff committee upon request:

“Any physician ... hospital administrator ... and any other person engaged in work in or about a licensed hospital and having any information or knowledge relating to the medical and hospital care provided in such hospital ... shall be obligated, when requested by a hospital medical staff committee or a utilization review committee, to provide such committee with all of the facts or information possessed by such individual with reference to such care or use.”

Whatever affirmative duty is thus imposed in Nebraska is probably limited to requests from other *Nebraska* hospitals, although the witness immunity under HCQIA should reach qualifying reports to any professional review body.

Iowa Law

The Iowa Peer Review Statute provides immunity, but no other encouragement or requirement to report. The immunity is broad:

“A person shall not be liable as a result of filing a report or complaint with a peer review committee or providing information to such a committee, or for disclosure of privileged matter to a peer review committee.”⁷

The definition of “peer review committee” in the statute would apply well beyond state

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boundaries to include, among other things, “the medical staff of *any* licensed hospital” or the “board of trustees” of a licensed hospital when engaged in peer review.⁸ HCQIA would also be available in Iowa and, since it is apparently broader on its face, would provide even broader protection to Iowa hospitals and medical staffs responding to credentialing inquiries.

Conclusion

It is possible that a duty to report (or good defenses) can be found in other Nebraska and Iowa statutes or case law. This is not intended as a full analysis of how Nebraska and Iowa courts might decide the issue. What is important is to note that the “genie is out of the bottle.” There is strong public policy reason to reach the *Kadlec* result in other states, and hospitals (and their insurers) that are harmed by incomplete or inaccurate credentialing responses have a financial incentive to test the theory elsewhere.

Alex (Kelly) M. Clarke

¹ WL 1309153 (E.D. La.), not reported in F. Sup. 2nd.

² 211 N.E. 2nd 253 (III 1965).

³ 464 F.2d 772 (D.C.Cir 1972).

⁴ 42 U.S.C. § 11111(a)(2).

⁵ 42 U.S.C. § 11151 (11).

⁶ *Schilling v. Moore*, 545 N.W. 2nd 442 (Neb. 1996).

⁷ Iowa Code Section 147.135-2.

⁸ Iowa Code Section 147.1-2e.

Kelly Clarke, along with Barbara Person, will be discussing the *Kadlec* decision and related credentialing and peer review matters at the upcoming Health Law Forum scheduled for October 27, 2006 at the Marriott Regency, Omaha.

Deficit Reduction Act of 2005 Requires Certain Entities to Provide Fraud and Abuse Education

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005 (DRA). Among other aims, the DRA seeks Medicare and Medicaid spending reductions of nearly \$5 Billion each.

Lesser known, but of more direct import to health care entities, is the DRA's section entitled “Employee Education About False Claims Recovery.” This section requires, beginning January 1, 2007, that all entities that make or receive at least \$5 Million in annual Medicaid (not Medicare) payments must establish written policies and procedures that inform employees about federal and state false claims and whistleblower laws. Entities who fail to implement such policies and procedures may be rendered ineligible for Medicaid payments. Unfortunately, the government has provided no guidance specifying particular terms or levels of detail in such policies and procedures.

The DRA's employee education requirements are as follows:

1. The new or updated policies and procedures must provide information on the following laws and their roles in preventing and detecting waste, fraud, and abuse in federal health care programs:

- Federal False Claims Act;
- Federal administrative remedies for

...all entities that make or receive at least \$5 Million in annual Medicaid (not Medicare) payments must establish written policies and procedures that inform employees about federal and state false claims and whistleblower laws.

- false statements and claims;
 - State laws relating to penalties for false statements and claims; and
 - Federal and state whistleblower protections.
2. The new or updated policies and procedures must also detail the entity's policies and procedures for preventing and detecting waste, fraud, and abuse in federal health care programs.
 3. The new or updated policies and procedures must be in writing.
 4. Through the new or updated policies and procedures, entities must inform, though not specifically train, their employees, management, and all others who could be considered a contractor or agent of the entity.
 5. Each entity must also include in its employee handbook:
 - Details regarding the fraud and abuse laws described in paragraph 1 above;
 - Rights of employee whistleblowers to be free from retaliation for whistleblowing activities; and
 - The entity's policies and procedures for preventing and detecting waste, fraud, and abuse in federal health care programs.

The DRA's Employee Education About False Claims Recovery section seeks to broaden the reach of the government's enforcement arm by making employees and other contractors aware of fraud and abuse laws and their rights as whistleblowers.

Subject entities must tread carefully. Enti-

ties will not want to unnecessarily encourage whistleblower activity while complying with mandatory training requirements.

Ultimately, Congress has, through the DRA, made specific compliance plan requirements a condition of participation in the Medicaid program. Each entity's new or revised policies and procedures (including revisions to the employee handbook) must be in place by January 1, 2007. Such updates would likely require updates to existing internal complaint processes as well.

David W. Tomlinson

Newsletter Survey Indicates Electronic Format Preferred

Eighteen percent (165) of our readers responded to the newsletter survey. We appreciate your responses and comments and have already begun to use them to guide our decisions about the newsletter.

Ninety-five percent of those responding preferred the electronic delivery format. Sixty-seven percent of responses requested a frequently published (monthly or every other month) newsletter with a variety of articles directed to different client groups—hospitals, physician practices, urban and rural facilities.

One hundred percent of the readers responding indicated that they were satisfied, very satisfied or extremely satisfied with the newsletter and nearly half indicated that they forward or route their copy of the newsletter to someone else.

...entities will not want to unnecessarily encourage whistleblower activity while complying with mandatory training requirements.

Based on your responses, we have decided to publish a monthly newsletter and continue electronic delivery. We will endeavor to offer a variety of articles pertinent to all categories of health care providers that is responsive to both Iowa and Nebraska, and rural and urban providers.

We welcome your ongoing communication and encourage you to respond directly to the e-mail transmitting the newsletter with your ideas, requests, concerns and comments. We would be happy to forward complete survey results to you at your request. Ed.

Save the Date!

The 18th Annual Baird Holm Health Law Forum will be held on October 27, 2006 at the Marriott Regency, Omaha.

*The contents of this advisory are intended for general informational purposes only and should not be construed as legal advice. Readers are urged not to act upon the information contained in this publication without first consulting an attorney.

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