THE KADELC APPEAL – DECISION AGAINST HOSPITAL REVERSED!
DOES THIS CHANGE HOW HOSPITALS SHOULD RESPOND TO CREDENTIALING INQUIRIES?

1. What's a responding hospital's duty to requesting hospitals and patients?
   A. The KADELC Decisions. In 2005, a federal trial court interpreting Louisiana law ruled that a hospital responding to a reference request had a duty not to misrepresent the physician's status at the hospital, either directly or by omitting important information. *Kadlec Medical Center v. Lakeview Anesthesia Associates*. Essentially, then, the trial court found that a hospital in Louisiana that chose to respond to a reference request had a duty to notify the requesting hospital of significant problems with the physician.

   The Fifth Circuit Court of Appeals reversed one important aspect of the trial court's decision. The Court of Appeals found that a hospital that chooses to respond to a reference request does not have a duty to disclose negative information about a physician to the inquiring hospital. Instead, the Court found that such hospitals have the much more limited duty of not making "affirmative misrepresentations."

   Does this now mean that there is no longer any potential for liability in responding to reference requests as long as no negative information is provided (i.e., by using the "name, rank and serial number" approach)? We think not! This isn't the last time plaintiffs' lawyers will make similar arguments, and courts in other states might follow the trial court's reasoning in *Kadlec* (rather than that of the Court of Appeals) and find that hospitals have a duty not to omit material information. Hospitals still should strive to do what's right – and fair.

   B. *Estate of Fazaldin v. Englewood Hospital & Medical Center* – The estate of a patient who died following a radical hysterectomy sued the hospital where the surgeon had
previously practiced and the surgeon's department chair at that hospital. The estate alleged that the defendants' failure to provide accurate information about the physician's resignation of clinical privileges, and to report that resignation to the state Department of Health and the federal National Practitioner Data Bank, led to the surgeon being granted privileges at the hospital where the surgery took place.

The Superior Court of New Jersey, Appellate Division concluded in 2007 that the hospital had a legal duty to report its termination of the physician's employment to the Department of Health, but had failed to do so. Further, the court held that the information, if it had reached the hands of the second hospital's credentialers, could have resulted in the physician being denied clinical privileges. Thus, the court ordered further proceedings to determine whether a report to the Department of Health, if it had been made as required, would have reached the second hospital.

2. **What should hospitals do in responding to reference requests?**

   A. Remember to check state law. For example, Washington law provides that a hospital receiving a request for information about a physician "shall" provide certain information about that physician, "including the reasons for suspension, termination, or curtailment of employment or privileges at the hospital or facility." Wash. Rev. Code Ann. § 70.41.230(4).

   B. If state law is silent, should hospitals and physician leaders respond to detailed questionnaires or send form letters with "name, rank and serial number"?

      (1) Remember that every hospital will be on the sending and receiving end of reference requests. This is particularly true in light of: (i) new Joint Commission requirements related to the assessment of ACGME competencies and (ii) the increasing number of low-volume practitioners.

      (2) On the other hand, some hospitals may not have the resources to respond in great detail for every inquiry. (See the tips for "Easing the Burden," below.)
C. Adopt guidelines for the release of negative information that identify the factors to be considered:

(1) The type of information available regarding the physician:
   - formal adverse action?
   - conditions of professional conduct?
   - focused review?
   - performance improvement plans?
   - collegial intervention (documented or undocumented)?
   - patient or staff complaints that have not yet been reviewed?

(2) The nature of the authorization and release that has been received:
   - generic release contained in requesting hospital's application form?
   - release that is limited to information provided "in good faith and without malice"?
   - specific release that names the responding hospital?

D. Generally, the more negative the information, the greater the need for a "special release." A special release is one that goes beyond the generic releases on application forms. It states that the applicant agrees not to sue, and provides absolute immunity to, the named hospital sharing the information and its employees, Medical Staff members, and agents.

E. When a special release is indicated, the blank special release form should be sent directly to the requesting hospital, and the requesting hospital should be asked to have the physician sign and return a copy to the responding hospital. The hospital requesting information can be told that no response will be forthcoming until an executed copy of the special release is received. This statement in and of itself should serve as something of a red flag to the requesting entity.

F. Ideally, the requesting hospital will hold the physician's application incomplete if the physician refuses to sign the specific release. This technique has been upheld in the courts. *Scott v. Sisters of St. Francis Health Svcs. Inc.*, 645 F. Supp. 1465 (N.D. Ill.)
A variation – add to the request for a special release a short factual statement that will raise a red flag:

Dr. X was appointed to the staff on [date]. His/her privileges expired on [date] and he/she did not seek reappointment. Dr. X did not exercise privileges after [date]. If further information is requested, please have Dr. X sign the enclosed special release.

H. Consider being open with the practitioner who is the subject of the inquiry – provide a copy of the proposed response and give the practitioner an opportunity to comment and suggest accurate changes. However, this does not mean the physician may veto an accurate statement!

I. In some cases, the response may be negotiated with the physician. This is most common when an investigation has been initiated and the physician and/or his or her attorney seeks to settle the matter. A negotiated response must, of course, be accurate. The physician and his or her attorney will likely push for a response that does not reveal much. The Kadlec and Fazaldin cases may actually provide a hospital with some leverage when negotiating such a response as they demonstrate why a hospital cannot misrepresent the physician's status or tenure at the hospital directly or by omission.

J. Watch out for settlement agreements with physicians specifying the manner in which credentialing inquiries will be handled.

(1) Private agreements cannot trump a duty owed to a third party.

(2) Work for a "win win" resolution that satisfies the settlement agreement while fulfilling the hospital's legal duties.
(3) Going forward, take care that settlement agreements do not misrepresent material facts directly or by omission.

3. What legal defenses and protections are available to hospitals and physician leaders completing reference requests?

A. Releases.
   (1) Form signed by physician (general provision in application or specific release identifying named hospital).
   (2) Release provision in Bylaws.
   (3) Are releases enforceable? Yes, often they will be. For example, in *Blume v. Marian Health Ctr.*, No. 07-1711 (Feb. 19, 2008), the Eighth Circuit Court of Appeals dismissed a physician's lawsuit against a hospital based on a release provision found in the Medical Staff Bylaws. *See also, Adeduntan v. Hospital Authority of Clarke County*, No. 3:04-CV-65 (CDL) (2006 WL 1934872 (M.D.Ga.)); *Vesom v. Atchison Hosp. Ass'n*, No. 04-2218-JAR, 2006 WL 2714265 (D.Kan. September 22, 2006); *Everett v. St. Ansgar Hosp.*, 974 F.2d 77 (8th Cir. 1992); *DeLeon v. Saint Joseph Hosp.*, 871 F.2d 1229 (4th Cir. 1989); *Seglin v. Old Orchard Hosp.*, 548 N.E.2d 626 (Ill. Ct. App. 1989); *King v. Bartholomew County Hosp.*, 476 N.E.2d 877 (Ind. Ct. App. 1985). However, it is worth noting that California law limits the extent of such releases. *See, Cal. Bus. & Prof. § 809.6(c).*

B. Health Care Quality Improvement Act.

C. State law peer review protection laws.

D. State "shield" laws for responding to employment reference requests.

E. Indemnification policy and D&O insurance.

F. Other case law involving responses to reference requests includes *Ironside v. Simi Valley Hospital*, 188 F.3d 350 (6th Cir. 1999), where the court ruled that the Tennessee Peer Review Law and the HCQIA provided immunity from damages to
protect a California hospital that responded candidly to a hospital in another state. Also, in Croy v. A.O. Fox Memorial Hospital, 68 F.Supp.2d 136 (N.D.N.Y. 1999), the court found that a communication from a hospital to the Alaska State Medical Board was presumptively privileged pursuant to the common law qualified privilege. However, in Simon v. Union Hospital of Cecil County, Inc., No. 98-2138, 1999 WL 957744 (4th Cir. Oct. 20, 1999), the court ruled that there was a "material issue of fact" as to whether a hospital defamed a physician "by indicating that his conduct had led the Health Care Financing Administration to impose a $100,000 fine on the hospital, and by stating that he had stolen equipment."

4. **How to avoid defamation when responding to reference requests.**
   A. Defamation is a written or oral statement that:
      (1) tends to injure the plaintiff's reputation and expose the plaintiff to public ridicule;
      (2) is made to third parties; and
      (3) the speaker knows, or should know, is false.
   B. Truth is an absolute defense to defamation.
   C. Threats of defamation lawsuits by physicians should not outweigh the risks to patient safety caused by inadequate responses to reference requests.

5. **What should hospitals do as senders of reference requests?**
   A. Carefully phrase questions (e.g., "is there an agreement between the physician and the hospital regarding how reference requests will be answered?").
   B. Hold an application incomplete until all reference requests are received.
   C. Remember that the burden is on the applicant to provide requested information.
   D. Don't process incomplete applications!

6. **Are there ways to ease the burden of responding to reference requests?**
A. Develop alternative, standardized communications to fit the most common situations, but recognize that careful wording will be required.

B. Can hospitals in a system – or even unaffiliated hospitals in a community – develop efficient ways to exchange information for reappointment verification for practitioners on multiple staffs without risking a waiver of state peer review protection?

C. Can hospitals take advantage of technology that allows a secure web site to be used by credentialers at other hospitals to obtain verification for the majority of applicants?

D. Should increased costs of responding (e.g., reference request fees) be passed on to applicants? Should your hospital begin charging a fee?