



## Coupling Evidentiary and Procedural Tools

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**B**ifurcation presents an opportunity to defuse the prejudice created by the introduction of “other acts” evidence.

# Defending Negligent Credentialing Cases

Actions against hospitals asserting negligence in granting medical staff credentials and privileges to physicians have been recognized since the seminal case *Darling v.*

*Charleston Community Memorial Hospital*, 211 N.E.2d

253, 257 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1965). Large jury verdicts have resulted in these cases. *See, Frigo v. Silver Cross Hospital*, 876 N.E.2d 697 (Ill. App. Ct. 2007) (\$7.775 million dollar verdict).

Sometimes a plaintiff finds that including these direct claims against a hospital to a medical malpractice action attractive because it potentially broadens the evidence admissible at trial, forcing a defendant to defend not only its actions in the case, but also its reputation, and it also adds a “deep pocket” corporate defendant. Depending on the state, statutory limitations

on medical negligence cases may not apply to actions for negligent credentialing. *Compare, Browning v. Burt*, 613 N.E.2d 993 (Ohio 1993) (Ohio limitations did not apply) with *Garland Community Hospital v. Rose*, 2004 WL 2480381 (Tex. 2004) (Texas reform act applied). It sometimes follows that plaintiffs’ counsel, looking for opportunities to strengthen medical negligence cases, will initiate or investigate direct claims against hospitals for negligence in the credentialing and oversight of physicians.

Some commentators suggest credentialing actions against hospitals have surged. For instance, two commentators have written, “The number of negligent credentialing claims filed in conjunction with traditional medical malpractice claims has increased significantly. Lawyers for plaintiff patients view healthcare organizations as having ‘deep pockets,’ particularly now that some physicians carry less malpractice insurance than in the past.” Michael A. Chabraja and Monica C. Wehby, *Negligent Credentialing: Hospital Must Monitor Its Doctors’ Qualifications*, *Surgical Activities*, Bulletin (American Association of Neurological Surgeons), Summer 2007, at 38; Wayne J. Guglielmo, *Negligent Credentialing: Is the Danger Growing?* MODERN MEDICINE, May 4, 2007.

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One reason for this strategy is that plaintiffs' attorneys may view prevailing as difficult in jury trials of medical liability actions. Of medical liability cases that proceed to jury verdicts, most statistics show that health care providers win around 70 percent of the time. "Several studies indicate that a large number of claims brought to trial are very weak, in the estimation of the defense insurers. The largest to date examined a study of 976 malpractice verdicts... in which the reviewers found that 10 percent of claims involved negligent care, 11 percent were too close to call, and 78 percent involved weak claims. The strong claims were outnumbered roughly eight to one. Other studies have shown a 4:1 or 5:1 ratio of weak claims to legitimate ones, in the view of defense insurers." Jonathan Glauser, *Are Juries Biased Toward Physician Defendants?* EMERGENCY MEDICINE NEWS, Oct. 2007, available at [http://journals.lww.com/em-news/Fulltext/2007/10000/Are\\_Juries\\_Biased\\_Toward\\_Physician\\_Defendants\\_.29.aspx](http://journals.lww.com/em-news/Fulltext/2007/10000/Are_Juries_Biased_Toward_Physician_Defendants_.29.aspx); See also, Tom Baker, *The Medical Malpractice Myth* 898 (Univ. of Chicago Press 2005). The National Judicial Center has estimated that plaintiffs won only 36.7 percent of cases in 2002–03. Plaintiffs' attorneys understand these statistics: "Believe it or not, reputable trial lawyers who specialize in litigating malpractice cases do not relish taking every case to court. Why? Because 'we're likely to lose....'" Shirley Grace, *The Law: Trial Lawyers Tell All*, THE ADVOCATE (Fla. Bar Trial Lawyers Section), Spring 2009, [http://www.flatls.org/index.php?option=com\\_rubberdoc&view=category&id=38&Itemid=60](http://www.flatls.org/index.php?option=com_rubberdoc&view=category&id=38&Itemid=60); then follow "Spring 2009" hyperlink.

This article offers suggestions on dealing with these lawsuits, particularly focusing on requesting bifurcation and dealing with "other acts" evidence when representing hospitals and other health care providers.

### The Process

A hospital grants credentials and privileges through a detailed process designed to ensure that a physician has the background, education, training and skill to practice medicine and perform procedures in the hospital. The Joint Commission defines credentialing as "the collection, verification, and assessment of information regarding three critical parameters: current licensure;

education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Verification is sought to minimize the possibility of granting privilege(s) based on the review of fraudulent documents." The Joint Commission Accreditation Manual, MS.06.01.03 (2009). Credentialing is "the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Verification is sought to minimize the possibility of granting privilege(s) based on the review of fraudulent documents." The Joint Commission Accreditation Manual, MS.06.01.03 (2009). See, Nancy E. Gregor, *Credentialing Decisions: Keeping the Hospital Off Of the Target List*, DRI Medical Liability and Health Care Law Seminar (course materials) (2009).

This peer review process requires a physician to submit information and a hospital or health care organization to confirm the information before the physician can practice with the institution. All hospitals must complete this process because obtaining and keeping Joint Commission or other certification depends on it, as does billing state and federal governments and private insurers. See, *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253, 257 (1965), cert. denied, 383 U.S. 946 (1965) ("The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.")

### Negligent Credentialing and Privileging: Cause of Action

Courts have recognized causes of action against hospitals for negligence in performing this Joint Accreditation process, finding that hospitals have a duty exercise care in granting medical staff credentials and privileges to physicians.

In regard to staff privileges, a hospital has a direct duty to grant and to continue such privileges only to competent physicians. A hospital is not an insurer of the skills of private physicians to whom staff-privileges have been granted. In

order to recover for a breach of this duty, a plaintiff injured by the negligence of a staff physician must demonstrate that but for the lack of care in the selection or the retention of the physician, the physician would not have been granted staff privileges, and the plaintiff would not have been injured.

*Albain v. Flower Hospital*, 553 N.E.2d 1038 (Ohio 1990); see also, *Johnson v. Misericordia Community Hosp.*, 301 N.W. 2d 156 (Wis. 1981); *Ferguson v. Gonyaw*, 236 N.W. 2d 543 (Mich. Ct. App. 1976).

Many courts, applying basic negligence principles, have found a duty on the part of hospitals to ensure that physicians allowed to practice are qualified and to reasonably monitor their competence. One court lumped credentialing and privileging together, referring to credentialing as "the granting or retention of a doctor's hospital privileges." *St. Luke's Episcopal Hosp. v. Agbor*, 952 SW 2d 503 (Tex. 1997).

While hospitals are liable for the acts of their agents and employees, they are typically not liable for the actions of physicians privately employed by patients just because they have medical staff privileges. *Cross v. Trapp*, 294 S.E.2d 446 (W. Va. 1982). However, this rule has myriad exceptions based on principles of ostensible agency. In *Albain v. Flower Hospital*, 553 N.E.2d 1038 (Ohio 1990), the Ohio Supreme Court stated:

A hospital may, in narrowly defined situations, under the doctrine of agency by estoppel, be held liable for the negligent acts of a physician to whom it has granted staff privileges. In order to establish such liability, a plaintiff must show that: (1) the hospital made representations leading the plaintiff to believe that the negligent physician was operating as an agent under the hospital's authority, and (2) the plaintiff was thereby induced to rely upon the ostensible agency relationship.

*Id.* at 1040.

Courts have applied principles of ostensible agency to hold hospitals liable for negligent emergency room physicians, *Torrence v. Kusminsky*, 408 S.E.2d 684 (W. Va. 1991), *Simmons v. Tuomey Regional Medical Center*, 533 SE 2d 312 (S.C. 2000), for negligent physicians providing services in which the patient had no choice, such as radiology and anesthesiology, *Thomas v.*

*Raleigh General Hospital*, 358 S.E.2d 222, 225 (W. Va. 1987), and based on advertising. *Dolen v. St. Mary's Hospital*, 506 S.E.2d 624 (W. Va. 1998). See, *Hardy v. Brantley*, 471 So. 2d 358 (Miss. 1985); Thomas J. Hurney, Jr., *Hospital Liability in West Virginia*, 95 W. VA. L. REV. 943 (1993); See generally, Annotation, *Liability of Hospital or Sanatorium for Negligence of Physician or Surgeon*, 51 A.L.R.4th 235 §5 (1987).

A grant of credentials and privileges provides an independent basis of liability, not dependent on an agency relationship. Once privileges have been granted, the hospital must take reasonable steps to ensure the safety of its patients if it knows, or should know, that a physician has exhibited a pattern of incompetent behavior. *Strubhart v. Perry Mem'l Hosp. Trust Auth.*, 903 P.2d 263, 273 (Okla. 1995). Hospitals have been found liable for allowing "incompetent" or unqualified physicians to practice as part of their medical staffs. See, *R.K., M.D. v. Ramirez*, 887 S.W.2d 836, 838-39 (Tex. 1994) (known substance abuse by a physician may result in a hospital being found negligent); *Strubhart v. Perry Mem'l Hosp. Trust Auth.*, 903 P.2d 263 (Okla. 1995) (physician with a pattern of incompetent behavior); *Blanton v. Moses H. Cone Mem'l Hosp., Inc.*, 354 S.E.2d 455 (N.C. 1987) (unqualified physician allowed to perform surgery); *Phelps v. Physicians Ins. Co. of Wisconsin, Inc.*, 744 N.W.2d 880 (Wis. 2007) (lack of oversight over inexperienced physician); *Longnecker v. Loyola Univ. Med. Ctr.*, 891 N.E.2d 954 (Ill. 2008) (duty to train and supervise physicians); *Fletcher v. South Peninsula Hospital*, 71 P.3d 833 (Alaska 2003).

In *Bost v. Riley*, 262 SE 2d 391 (N.C. App 1980), the court found North Carolina hospitals had a duty to properly credential and supervise physicians:

Since all of the above duties which have been required of hospitals in North Carolina are duties which flow directly from the hospital to the patient, we acknowledge that a breach of any such duty may correctly be termed corporate negligence, and that our State recognizes this as a basis for liability apart and distinct from *respondeat superior*. If, as our Supreme Court has stated, a patient at a modern-day hospital has the reasonable expectation that the hospital will attempt to cure him, it seems axi-

omatic that the hospital have the duty assigned by the *Darling* Court to make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the facility.

In *Schelling v. Humphrey*, 916 N.E.2d 1029 (2009), the Ohio Supreme Court stated that hospitals have "a direct duty to grant and to continue staff privileges only to competent doctors.... [and] a duty to remove 'a known incompetent.'" *Id.* at 1033. Discussing the elements of a negligent credentialing claim, the court stated:

To prove a negligent-credentialing claim, a plaintiff injured by the negligence of a staff doctor must show that but for the lack of care in the selection or retention of the doctor, the doctor would not have been granted staff privileges and the plaintiff would not have been injured.

*Id.*

To prove causation, then, a plaintiff must demonstrate that a physician committed malpractice that injured the patient. In other words, the malpractice of the physician is the causal link between the hospital's negligence in allowing the physician to practice and the injury to the patient. Absent a negligent act by the physician, a plaintiff cannot prove causation to establish the hospital's negligence in granting credentials or privileges. See *Purcell v. Zimelman*, 500 P.2d 335 (Ariz. App. 1972). ("We believe it reasonably probable to conclude that had the hospital taken some action against Dr. Purcell, whether in the form of suspension, remonstration, restriction or other means, the surgical procedure utilized in this case would not have been undertaken by the doctor and Mr. Zimelman would not have been injured."); *Rodrigues v. Miriam Hosp.*, 623 A.2d 456 (Rhode Island 1993).

### Limiting the Admissibility of "Other Acts" in Negligent Credentialing Cases

A key tool in the briefcase of a lawyer defending against a negligent credentialing claim is the general inadmissibility in medical negligence cases of a physician's "other acts." Rule 404(b) of the Federal Rules of Evidence and its state counterparts generally state that evidence of character and "other acts" are not admissible to

prove an "action in conformity therewith." In medical negligence trials, Federal Rule of Evidence 404(b) is typically the basis for excluding evidence of other lawsuits, disciplinary actions, license suspensions, failure to pass certification examinations and comparable evidence, including evidence of a hospital's credentialing process. Coupled with Rule 404(b) is Federal Rule of Evidence 403, which states that a court may exclude evidence, even if relevant, "if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Courts often weigh the admissibility of evidence of "other acts" under both Rule 404(b) and Rule 403.

Medical negligence cases may involve a wide variety of potentially inflammatory and prejudicial evidence that plaintiffs may seek to admit against physicians or other health care providers. However, as long as a medical negligence case stands alone, without being combined with a negligent credentialing or negligent supervision case, courts largely exclude "other acts" as irrelevant and inadmissible. The position that defense counsel should take is that the medical liability case against the physician should stand on its own merits, without the collateral evidence of "other acts," under the authority of Federal Rules of Evidence 404(b) and 403 or state equivalents, when applicable. In the sections that follow we discuss the major areas of "other acts" that plaintiffs have attempted to use to establish the negligence of physicians in "stand alone" medical negligence claims.

### Prior Civil Actions

In *Gray v. Allen*, 677 S.E.2d 862, 867 (N.C. Ct. App. 2009), the court affirmed the trial court's decision to exclude evidence of prior lawsuits against the defendant, a physician, in the plaintiff's malpractice case. Citing Rule 404(b) of the North Carolina Rules of Evidence, the appellate court held that prior malpractice suits against the physician were irrelevant to determining whether the physician had been negligent in the case at hand. *Id.* Moreover, the court noted that evidence of prior negligence actions against the defendant threatened substantial prejudice. *Id.*



Likewise, in *Lai v. Sagle*, 818 A.2d 237 (Md. 2003) the Maryland Court of Appeals reversed a malpractice award after the plaintiff's counsel, in his opening statement, informed the jury that the defendant physician had been sued five times for malpractice in another state, and the trial court failed to grant the defendant's motion for a mistrial. Under Maryland Rule of Evidence

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404(b), the court found "the admission of evidence of prior suits, instead of aiding the fact finder in its quest, tends to excite its prejudice and mislead it." *Id.* at 247.

#### **Failure to Pass a Board Certification Exam**

In *Beis v. Dias*, 859 S.W.2d 835 (Mo. Ct. App. 1993), a Missouri court held a physician's inability to pass a certification licensure examination did not make probable his negligent performance of a specific procedure. The plaintiffs had attempted to connect the defendant's "intellectual inability to pass medical test examinations" to the negligence alleged against him. The court ruled that evidence of the defendant's performance on the various examinations, even if logically relevant, had no probative force regarding the defendant's alleged negligence. *Id.* at 840.

#### **Felony Convictions**

A Missouri court held in *Moran v. North County Neurosurgery, Inc.*, 714 S.W.2d 231 (Mo. Ct. App. 1986), that a physician's admission that he had been convicted of some unidentified felonies was irrelevant to determining whether he had been negligent in treating a patient. *Id.* at 233.

#### **Substance Abuse and License Suspension**

In *Taylor v. Cabell Huntington Hospital,*

208 W.Va. 128, 538 S.E.2d 719 (W.Va. 2000). The court found, under West Virginia Rule of Evidence 404(b), that evidence of a nurse's prior substance abuse and her license suspension and probation had been properly excluded by the trial court. The court reasoned that evidence of the nurse's prior Morphine addiction was irrelevant to determining whether she had negligently combined two incompatible drugs.

In *King v. Ahrens*, 16 F.3d 265 (8th Cir. 1994), the court reasoned that courts must view Federal Rule of Evidence 404(b) alongside the balancing requirements of Federal Rule 403. The plaintiffs sought to introduce evidence of the physician's past medical license suspension for overprescribing Percodan in a medical negligence case. The evidence was proffered to show that Dr. Ahrens, the defendant, had not innocently overlooked the omission of Percodan from the medical chart, but rather that he intentionally tried to hide the prescription of Percodan because of his past license suspension for overprescribing the drug. The plaintiffs argued that the prior license suspension was admissible under Federal Rule 404(b), because it showed that Dr. Ahrens had not made a "mistake" in failing to note critical information in the medical chart. Their theory was that Dr. Ahrens did not list the Percodan in the chart because he had been in trouble for overprescribing it before and wanted no record to show that he was questionably prescribing it again.

The ultimate issue at trial was whether Dr. Ahrens had provided negligent treatment by failing to properly diagnose and hospitalize Mr. King, the plaintiffs' relative, two days before his death. The past license suspension was not directly related to the ultimate issue of negligence because the Percodan prescription was never indicated as a cause of Mr. King's death. Nevertheless, the plaintiffs argued that the past license suspension tended to show that Dr. Ahrens would have had a reason to choose information to record about a given case. They further claimed that an intentional omission assumed relevance to a person's character, specifically, truthfulness. Therefore, the license suspension had bearing to whether Dr. Ahrens had made a mistake or intentionally omitted Percodan from the chart or his credibility.

The court found that the evidence "argu-

ably" met the relevancy requirements of both Federal Rules 404(b) and 608(b). However, the court stated that further analysis of the probative value as opposed to its unfairly prejudicial effect under Rule 403 was "integral" to ultimately determining admissibility. It noted that "the district court "can and should exclude otherwise relevant evidence 'if its probative value is substantially outweighed by the danger of unfair prejudice....'" Evidence is unfairly prejudicial for purposes of Rule 403 "when it would influence the jury to decide the case on an improper basis." *King v. Ahrens*, 16 F.3d at 269 (citations omitted).

Applying Federal Rule 403, the court concluded that admitting the evidence posed great danger that the jury might have improperly inferred that the doctor's professional judgment and conduct must have been substandard solely because his license had been suspended in the past. "Given the danger that this evidence might influence a jury to decide the case on an improper basis and the great deference with which we reviewed this evidentiary ruling," the court wrote, it found that the lower court had not "abused its discretion in determining that the danger of prejudice outweighed the probative value of the license suspension." *Id.* at 270.

In the same vein, in *Maraziti v. Weber*, 185 Misc. 2d 624, 713 N.Y.S.2d 821 (Sup. Ct. Dutchess Co. 2000), a New York state court confronted whether a plaintiff suing a doctor for medical malpractice could admit evidence of prior, unrelated, Department of Health, Office of Professional Misconduct (OPMC) disciplinary proceedings against a defendant. In ruling the evidence inadmissible, the court explained that information from reports of the OPMC unrelated to the case would have marginal relevance, at best, but likely would unduly prejudice the jury. The court concluded that the jury should have the opportunity, or receive implicit encouragement, to assume that the facts underlying one incident would necessarily govern a finding about a subsequent incident, solely because the two events were substantively similar. To force the defendant "to justify any and all prior acts of alleged medical misconduct regardless of how serious, trivial, or relevant they might or might not be" would be fundamentally unfair and distracting to the jury. *Id.*

More importantly, the court reasoned that admitting that evidence would unduly prejudice the physician and threaten to confuse or distract the jury, forcing the physician to simultaneously defend against two separate sets of claims and inviting a distracting “mini-trial” into the main proceedings. Under those circumstances, whatever significance the evidence might have had was “substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury,” which warranted excluding the evidence under evidentiary principles.

### Peer Review Evidence

A couple of Florida appellate decisions show the care courts exercised to prevent plaintiffs from improperly injecting peer review proceeding information into medical negligence actions. In *Lingle v. Dion*, 776 So. 2d 1073 (Fla. Dist. Ct. App. 2001), the court reversed a verdict against a physician after the trial court had allowed cross-examination of the physician, who had been *pro se*, over whether his privileges had been suspended by the hospital. The trial court erred in “in permitting testimony to be presented concerning [the physician’s] peer review process, and... in instructing the jury that the lack of staff privileges was negligence per se.”

Similarly in *Liberty Mutual Insurance Co. v. Wolfson*, 773 So. 2d 1272 (Fla. Dist. Ct. App. 2000), although strictly speaking a dispute between an insured and insurer rather than a medical liability case, a verdict was reversed after defense counsel for the insurer questioned a treating physician for the insured, in an attempt to impeach him, about peer review and his suspended privileges. The court found error because the questioning had improperly attacked the physician’s credibility and information about the peer review process was privileged under Florida Statute §766.101(5).

Federal Rule of Evidence 404(b) does not always preclude evidence of “other acts.” In *Macsentis v. Becker*, 237 F.3d 1223 (10th Cir. 2001), the rule did not preclude admission of a dentist’s drug use during the two weeks leading up to the medical care at issue. In that case a dental assistant testified that approximately 12 days before the event that led to the suit, she had witnessed the defendant passed out in a dental chair with a

nitrous oxide mask on his face. The dentist argued that the trial court only should have admitted evidence of events occurring on the day of the plaintiff’s appointment, but the Tenth Circuit found that the trial court had not abused its discretion in finding the alleged drug relevant and had not unduly prejudiced the defendant. *Id.* at 1236–7. See also, *Linton v. Davis*, 887 N.E.2d 960 (Ind. App. 2008) (“[W]e conclude that the licensure status of a physician who gives an expert opinion is admissible to impeach the doctor’s opinion. The Board’s specific findings regarding the care of a particular patient, however, are not admissible in a judicial proceeding.”).

### Using Federal Rule 404(b) or State Equivalents to Limit Admissibility of “Other Acts” in Negligent Credentialing Cases

Lawyers defending negligent credentialing cases should use Federal Rule of Evidence 404(b) or state equivalents to limit the admissibility of the “other acts” of credentialed physicians. The cases described above clearly indicated that courts are sensitive to the prejudicial nature of physicians’ and health care providers’ prior “bad acts.” Evidence of a physician’s prior lawsuits, substance abuse, disciplinary actions or felony convictions are highly inflammatory if a plaintiff seeks to argue that this evidence is in some way relevant to the alleged negligence in his or her specific case. So, the position counsel in a negligent credentialing case should take is that a court should not allow a plaintiff to circumvent the limits that rules of evidence establish in a “stand alone” medical liability case by then allowing a plaintiff to introduce that “other acts” evidence in a negligent credentialing case. One commentator has succinctly described the issue:

[N]egligent credentialing cases have moved forward successfully, which has not only made hospitals nervous but doctors as well. Certainly, because of them, physicians face a higher degree of scrutiny, whichever side of the credentialing review desk they find themselves sitting behind. And if they end up in a combined malpractice-negligent credentialing case, they face an even grimmer prospect: defending themselves against evidence that most courts would

have ruled out of bounds in a straight-up malpractice trial—prior malpractice verdicts and settlements, past disciplinary actions, and so forth. Unless the malpractice and negligent credentialing claims are decoupled and tried separately, as some defense attorneys have succeeded in doing, such evidence is very much in bounds.

Wayne J. Guglielmo, *Negligent Credentialing: Is the danger growing?* *Medical Economics*, May 4, 2007.

Defense counsel should prepare for a plaintiff’s counsel to argue that “other acts” evidence is admissible for purposes related to proving other elements of a claim against a hospital. Federal Rule of Evidence 404(b) and similar state rules provide the basis for admission of “other acts” evidence “for other purposes, such as proof of motive, opportunity, intent, preparation, plan, knowledge, identity, or absence of mistake or accident,....” As a negligent credentialing claim is based on a hospital’s knowledge or failure to obtain knowledge of a physician’s shortcomings, “other acts” evidence can loom large. For example, an Arizona appellate court affirmed the admission of evidence of prior suits against a physician because they were relevant to prove notice to the hospital. *Purcell v. Zimbelman*, 500 P.2d 335 (Ariz. App. 1972). In *Purcell v. Zimbelman* the court wrote, “Since the negligence of the hospital was predicated upon failure to perform its obligation to Zimbelman to see to it that only professionally competent persons were on its staff, it follows that its knowledge, actual or constructive, of Dr. Purcell’s shortcomings, was an essential element for consideration in determining whether or not the hospital exercised reasonable care or had been guilty of negligence.” *Id.*

The strongest and most effective position defense counsel can take to exclude evidence of a physician’s “other acts” in a negligent credentialing case is to couple Federal Rule of Evidence 404(b) or state equivalents with bifurcation, discussed below.

### A Procedural Tool: Requesting Bifurcation of a Negligent Credentialing Claim

Evidence of “other acts” in a negligent credentialing case can create significant prejudice that can overshadow the fundamental



medical negligence issue that is at the core of the action. As discussed above, a physician's negligent act is the causal link between the grant of credentials or privileges and the patient's injury.

Bifurcation presents an opportunity to defuse this prejudice, fairly try the issue of medical negligence and lessen or eliminate the bias presented by the evidence supporting the claim of negligent credentialing and privileging. In *Schelling v. Humphrey*, 916 N.E.2d 1029 (Ohio 2009), the Supreme Court of Ohio faced a negligent credentialing claim against a hospital, and the physician involved did not participate in the trial because he had declared bankruptcy and the trustee reached a settlement with the plaintiffs.

The hospital sought dismissal, arguing that the plaintiffs could not sue the hospital for negligent credentialing for three reasons: (1) they must first, through either "adjudication or stipulation," achieve a finding of fact that the physician had caused injury to the patient at issue; (2) they could not sue for negligent credentialing because the physician was not a party to the case; and (3) they no longer had a claim against the physician. The question was, "when" must a plaintiff prove a defendant's negligence? The Ohio Supreme Court held that the plaintiffs could pursue the negligent credentialing action in the absence of the physician, proving his malpractice as a causal element of the claim against the hospital, even though the physician was not a party to the case. Based on the unusual fact pattern—the doctor's bankruptcy and absence—the court found the impeded plaintiffs "should be permitted to prove that [the physician] committed medical malpractice and that the alleged malpractice caused the [patient's] injury, as an element of their negligent credentialing claim against the hospital."

The *Schelling* court, however, held that bifurcating the medical negligence claim from the credentialing and privileging claim would avoid "the problem of jury confusion or prejudice that may result from admitting evidence of prior acts of malpractice in a combined trial on both claims. Evidence of prior acts of malpractice by the doctor may be relevant to a negligent credentialing claim... but present the risk of unfair prejudice in determining whether the doctor committed malpractice." More-

over, if the jury found against the plaintiffs in the medical negligence action, the negligent credentialing claim against the hospital would not have to proceed. *See also, Dicks v. U.S. Health Corporation*, 1996 WL 263239 (Ohio Ct. App. 1996), *appeal denied*, 77 Ohio St. 3d 1480, 673 N.E.2d 142 (1996).

Two holdings in *Schelling* are significant to defending hospitals against claims of negligent credentialing and privileging: (1) a plaintiff must prove negligence of a physician as a causal element of a negligent credentialing claim; and (2) the courts should bifurcate the medical negligence claim from the credentialing claim to "appropriately" determine malpractice "before the hospital must defend against the rest of the negligent-credentialing claim." *Schelling v. Humphrey*, 916 N.E.2d at 1037.

If a physician is not a case party, as in *Schelling*, a hospital is required to defend the underlying medical negligence action, regardless of bifurcation, however. And if a court does bifurcate a trial, the court should permit the hospital to participate in all phases of the trial. *See, Patterson v. Marshall*, No. 2008-CA-000157, 2009 WL 2341448 (Ky. Ct. App. July 31, 2009),

Whether or not an allegedly negligent physician is a party to an action, the bifurcation issue is extremely significant to the way an action is tried and to the potentially prejudicial effect of evidence supporting a credentialing and privileging allegation.

The consensus among courts is that decisions about bifurcating these cases involve trial management, and as such, are "best left" to a trial court to decide. *See, Larson v. Wasemiller*, 738 N.W.2d 300, 313 (Minn. 2007); *Prissel v. Physicians Ins. Co. of Wisconsin, Inc.*, 269 Wis. 2d 541, 2004 WI App 21, 674 N.W.2d 680 (Wis. Ct. App. 2003), *review denied*, 273 Wis. 2d 655, 684 N.W.2d 136 (Wis. Ct. App. 2004); *Beavis ex rel. Beavis v. Campbell County Memorial Hosp.*, 2001 WY 32, 20 P.3d 508 (Wyo. 2001); *Neeble v. Sepulveda*, 1999 WL 11710 (Tex. App. Houston 1st Dist. 1999), *reh'g denied*, 989 S.W. 390 (Tex. App. 1999); *see also, Talavera v. Arbit*, 795 N.Y.S.2d 708 (N.Y. App. Div. 2005) (affirming denial of motion to bifurcate where malpractice and negligent credentialing claims were tried before different juries).

In some jurisdictions, a court may decide to bifurcate a trial *sua sponte*. *Andrews*

*v. Reynolds Memorial Hospital, Inc.*, 499 S.E.2d 846 (W. Va. 1997). It follows that defense counsel should make a strong case for bifurcation before a trial court as it will prove difficult to overturn an adverse ruling on appeal. Several cases offer guidance about how to convince a trial court that bifurcation will avoid prejudice, expedite the action and advance judicial economy. It goes without saying that most plaintiffs' counsel will vigorously oppose bifurcation.

In *Prissel v. Physicians Ins. Co. of Wisconsin, Inc.*, 269 Wis. 2d 541, 2003 WL 22998133 (Wis. Ct. App. 2003), the court indicated that courts deciding whether to bifurcate must consider the potential prejudice to the parties, the complexity of the issues, the potential for jury confusion, and convenience, economy and delay. Ultimately, the court upheld the trial court's decision to bifurcate, noting that it would "shorten things up a lot, depending upon what the result is on the liability of the physician." *Id.* at \*4. *Compare, Purcell v. Zimbelman*, 500 P.2d 335 (Ariz. Ct. App. 1972) (within discretion to deny severance). Similarly, in *Beavis v. Campbell County Memorial Hospital*, 20 P.3d 508, 515 (Wyo. 2001), the Supreme Court of Wyoming addressed bifurcation under Rule 42(b) of the Wyoming Rules of Civil Procedure, which stated, "The court, in furtherance of convenience or to avoid prejudice, or when separate trials will be conducive to expedition and economy, may order a separate trial of any claim... issue... or issues." The *Beavis* court held that physician negligence combined with the standard of care instruction presented a "distinct issue" for the jury to consider. *Id.* Additionally, the court found that the physician negligence and the negligent credentialing issues were not so interwoven that bifurcating them denied the plaintiff a fair trial. *Id.* Rather, bifurcation met the objectives of Wyoming Rule 42, "to avoid prejudice (omitting potentially unfairly prejudicial evidence of [the physician's] qualifications and training)" and furthered "the general objectives... to assist in the just, speedy and inexpensive determination of litigation." *Id.*

In *Neeble v. Sepulveda*, 1999 WL 11710 (Tex. App. 1999), *reh'g denied*, 989 S.W. 390 (Tex. App. 1999), the court noted that a claim was properly severable if: "(1) the controversy involves more than one cause

of action; (2) the severed claim is one that would be the proper subject of a lawsuit if independently asserted; and (3) the severed claim is not so interwoven with the remaining action that they involve the same facts and issues.” *Id.* at \*6. Likewise, the court indicated the objective of severance was “to do justice, avoid prejudice, and further convenience.” *Id.*

The *Neeble* court noted that Rule 404(b) of Texas Rules of Evidence precluded a party from using evidence of prior acts to prove that a person acted “in conformity with the past conduct.” *Id.* Thus, prior malpractice suits against the physician were inadmissible in the malpractice portion of the trial, but admissible to prove negligent credentialing against the hospital in that portion of the trial. *Id.* Noting the undue prejudice that would result in trying the claims simultaneously, the court affirmed the trial court’s decision to bifurcate them.

In *Patterson v. Marshall*, No. 2008-CA-000157, 2009 WL 2341448 (Ky. Ct. App. July 31, 2009), arising from a surgical malpractice allegation, the court affirmed “trifurcation”: “The trial court ordered that the trial proceed in three stages before the same jury. The medical negligence claim against Dr. Marshall would be tried first, including compensatory damages, without reference to the negligent credentialing claim against Methodist Hospital. If the jury found for the Pattersons, then Methodist Hospital’s statute of limitations defense would be heard next. Then, if the defense was not sustained, the negligent credentialing claim would be tried.”

The judge’s trial plan involved presenting the issues to the same jury in three phases, and all parties were allowed to participate in each phase of the trial. The plaintiffs challenged the order allowing the hospital to participate in the first stage, which involved the negligence claim against the physician.

The trial court had also excluded all matters regarding the physician’s employment history, “including his loss of credentials at other hospitals and his credentialing files,” during the *first* phase, on the physician’s medical negligence, and denied the plaintiffs’ motion to compel the hospital to produce the physician’s credentialing files and peer review files.

The appeals court, dealing with the chal-

lenge to the trial plan, stated that the trial court had properly exercised its discretion. As to the hospital’s participation in the first trial stage, the court stated:

To prevent Methodist Hospital from introducing evidence of Dr. Marshall’s compliance with the standard of care would have prevented Methodist Hospital from defending itself against the negligent credentialing claim under the procedure utilized by the trial court. Moreover, review of *voir dire* belies the contention that the jury was confused by Methodist Hospital’s presence in the case. The jury panel was informed that the case involved claims against both Dr. Marshall and Methodist Hospital. Counsel informed the jury that the trial would occur in two phases and that the same jury would hear both claims. The trial court did not abuse its discretion by allowing Methodist Hospital to participate in the medical negligence portion of the trial.

On the trial court’s decision to exclude employment and peer review evidence in the first phase, the appeals court again held that the trial court had properly exercised discretion, noting that

The issue in the first phase of the trial was whether Dr. Marshall deviated from the standard of care in his post-operative treatment of Claressia. There was no evidence that Dr. Marshall experienced any disability during the time period of Claressia’s treatment. The loss of Dr. Marshall’s privileges at two Alabama hospitals likewise had no bearing on his particular treatment of Claressia. The circumstances underlying Dr. Marshall’s prior loss of privileges would have confused the issues of medical negligence and negligent credentialing. Dr. Marshall did not designate himself as an expert witness nor was he qualified as such. Dr. Marshall did not provide expert opinion testimony. Dr. Marshall simply related his factual observations regarding the treatment of Claressia. The trial court did not abuse its discretion.

Although its analysis was substantially similar to decisions discussed above, at least one court has found bifurcation unnecessary. *See, Corrigan v. Methodist Hospital*, 160 F.R.D. 55, 56 (E.D. Pa. 1995) (denying physicians’ motion to sever). In

*Corrigan*, the court cited the following three factors that it considered in deciding whether to bifurcate: (1) whether separate trials would further the convenience of the parties; (2) whether separate trials would promote judicial economy; and (3) whether separate trials would avoid substantial prejudice to the parties. *Id.* (citing *Tri-R Sys. v. Friedman & Son*, 94 F.R.D. 726, 727 (D. Colo. 1982)) (holding the “mere possibility of some prejudice does not justify separate trials where such prejudice is not substantial and there are strong countervailing considerations of economy”).

Relying on federal authority, the court noted that federal courts generally order separate trials only when “clearly necessary,” and single trials “generally lessen the delay expense, and inconvenience to the parties and the courts.” *Id.* Despite the obvious evidentiary concerns—that evidence of a physician’s prior malpractice actions will “spill over” from a negligent credentialing claim to an underlying malpractice claim—the court found only minimal potential prejudice minimal. *Id.* at 58. Instead, the court held that a jury could easily differentiate the claims and issuing cautionary instructions to the jury could easily manage potential, lingering confusion. *Id.*

When defending these cases, counsel should consider bifurcating both discovery and trials. It makes sense to argue to bifurcate discovery, limiting the initial phase to the issues involved in the medical negligence claims. This approach would focus discovery on the critical issue common to both claims—determining whether a physician has been negligent. It would also lessen credentialing discovery expense by postponing the need to depose those involved in the credentialing process, witnesses testifying on the physician’s alleged defects and experts. In effect, stay the credentialing and privileging claim until the underlying malpractice case has been resolved. If trying the underlying case results in a verdict for the plaintiff, then the second phase including discovery related to the hospital claims, could commence.

Splitting discovery, however, is often easier said than done, particularly with trial judges who hesitate to deny plaintiffs the opportunity to advance their claims. In **Credentialing**, continued on page 91

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**Credentialing**, from page 51

contrast, the argument to bifurcate a trial, however, is very compelling because of the danger of prejudice to the hospital and the specter of reversible error. Managing a trial in two phases, as mentioned above, does not take more time than otherwise since a case against a hospital can start immediately after a verdict favoring a plaintiff. It saves time, in fact, because a defense verdict obviates the need for a trial altogether.

**Conclusion**

Counsel defending negligent credentialing claims should couple the power of Federal Rule of Evidence 404(b) or similar state rules with the power of bifurcation. Your argument for bifurcation is strong because plaintiffs can introduce evidence of “other acts” once they have cleared the causation hurdle of proving negligence, in the second, negligent credentialing phase of a trial. And, a trial court should find your

argument persuasive that it will not have to skirt the traditional protection Federal Rule 404(b) or equivalent state rules provide to “other acts” evidence, knowing that plaintiffs can introduce that evidence later on, without prejudicing a jury on the “stand alone” medical liability claim. One tool, the evidentiary rule or bifurcation, is unlikely to succeed without the other. A sound strategy is to find a way to use both. 