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S.C. Supreme Court

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

Diane S. Goodstein, Circuit Court Judge

Case No. 12-CP-22-1004
Appellate Case No. 2015-000331

Nadene Holliday, Individually and as Personal Representative of the Estate of David Holliday, ... Appellant

v.

Waccamaw Community Hospital and Kent M. McGinley, M.D., ... Defendants,

Of whom Waccamaw Community Hospital .... Respondent.

Amicus Curiae Brief

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***Amicus Curiae* Brief**

Pursuant to Rules 240 and 213 of the South Carolina Appellate Court Rules, the South Carolina Hospital Association ("the Hospital Association") hereby conditionally files this *amicus curiae* brief

INTEREST OF AMICUS CURIAE

The Hospital Association is the state membership organization for hospitals in South Carolina with approximately ninety-three members. Pursuant to Rule 213, SCRA, the interests of the Hospital Association in this case are set forth in its Motion for Leave to File *Amicus Curiae* Brief in Support of Respondent.

STATEMENT OF THE ISSUES ON APPEAL

Should South Carolina recognize a cause of action against hospitals for negligent credentialing?

STATEMENT OF THE CASE

SCHA adopts the Statement of Facts set forth by Respondent.

SUMMARY OF ARGUMENT

The relief requested by Appellant is extraordinary under the facts of this case. He seeks a judicial mandate that a hospital is responsible for every bad outcome of a physician whose hospital privileges were "negligently" granted, regardless of whether there was a breach of the standard of care, regardless of whether the determination to credential the physician had anything to do with the treatment of the patient, and regardless of the well-developed legislative and judicial standards governing the practice of medicine, the regulation of the medical staff, and the confidentiality and immunity of the peer review process that undergirds the credentialing decision. The result sought is at odds with both the rationale for a robust and meaningful peer review process, which is the enhancement of medical care in South Carolina.

The Hospital Association contends that recognizing a cause of action for negligent credentialing, even a cause of action more circumscribed than that which Appellant requests, would undermine the theoretical basis for the confidentiality of peer review. Further, it would put hospitals at a distinct disadvantage in a negligent credentialing case because they could not, due to the confidentiality required by the peer review statute, defend themselves adequately. Effective peer review requires broad immunity from tort liability both from

physicians disappointed with a denial of their privilege requests, *and* from patients disappointed in the outcomes of procedures by physicians that have been granted hospital privileges.

ARGUMENT

I PEER REVIEW IMMUNITY AND CONFIDENTIALITY UNDER SOUTH CAROLINA LAW

The Appellant's request for this Court to recognize a claim for negligent credentialing does not occur in a vacuum. The statutes and regulations governing the confidentiality and immunity of the peer review process, and the numerous judicial decisions in South Carolina establishing the policy of non-review of private hospital credentialing decisions, render inapposite the decisions from other states that allow negligent credentialing claims.

Hospitals do not confer the authority to practice medicine, do not control a physician's licensure, and do not practice medicine. Rather, under South Carolina law, physicians are highly regulated by the South Carolina Board of Medical Examiners, and evaluated and monitored by their peers, who are most likely to understand and address their medical capabilities. Allowing a claim for negligent credentialing would serve not to improve the quality of medical care, but to erode the confidentiality of the peer review system and thereby decrease the quality of care. In light of South Carolina's longstanding common law and statutory framework regulating the practice of medicine, this Court should not recognize a new cause of action for "corporate negligence" against a hospital. Appropriate remedies for medical malpractice already exist.

A STATUTORY FRAMEWORK FOR PHYSICIANS AND HOSPITALS

Hospitals were initially charitable entities that allowed private physicians to practice medicine. They had no control over the physician's medical decisions. Recognizing that there should be some check on the medicine actually practiced at hospitals, various methods of oversight arose over the years. Medical boards were created to regulate the quality of medical care. Eventually the Joint Commission published standards that have since become embedded in hospital regulations covering nearly every aspect of the delivery of healthcare. Part of those standards includes a robust peer review system that is the backbone of the credentialing process necessary for private physicians to obtain staffing privileges.

In South Carolina the authority to practice medicine is conferred and regulated by the state through the South Carolina Board of Medical Examiners (the "Medical Board"). S.C. Code §40-1-10 et seq. (2014). As a condition of being licensed by the state, doctors must meet certain statutory and regulatory requirements, including graduating from an approved medical school program, passing an examination, completing postgraduate education, passing a background check, and establishing financial responsibility to pay medical malpractice judgments. S.C. Code §§ 40-1-70 (2014); 40-47-32 (2014). By becoming licensed to practice medicine, physicians subject themselves to the authority of the Medical Board, which issues and renews medical licenses.

The Medical Board is also empowered to investigate a physician's practice, and to discipline a physician for substandard care, as well as for other acts meeting the definition of "misconduct" under S.C. Code §40-47-110 (2014). In particular, the Medical Board has the authority to investigate any person who may have violated board regulations (S.C. Code §§ 40-1-80 and 40-47-80 (2014)) and has general disciplinary authority over physicians (S.C. Code § 40-1-115 et seq. (2014)), including those who have "practiced the profession or occupation while under the influence of alcohol or drugs or uses alcohol or drugs to such a degree as to render him unfit to practice his profession or occupation." S.C. Code § 40-1-110 (i) (2014); see also S.C. Code § 40-47-110 (2014); *Osman v. South Carolina Dept. of Labor*, 382 S.C. 244, 676 S.E.2d 672 (2009) (recognizing statutory authority of medical board to restrict, suspend, or place conditions on individual's license to practice medicine). Settlements, judgments, agreements, and awards in malpractice cases also must be reported to the Medical Board. S.C. Code § 38-79-20 (2015). The Medical Board routinely investigates the circumstances of these settlements and judgments, and can impose discipline in such circumstances.

Of course, licensure does not guarantee private physicians the ability to admit patients or practice medicine at a hospital. South Carolina law sets forth the parameters for when physicians are allowed to practice medicine at hospitals:

> Each hospital must have a single organized medical staff that has the overall responsibility for the quality of medical care provided to patients.[1] Medical staff membership must be limited to doctors

[1] This reflects the truism that hospitals do not practice medicine, physicians do. Only physicians have the authority to diagnose, treat, and discharge patients. S.C. Code § 40-47-30 (2014); *Baird*

> of medicine or osteopathy who are currently licensed to practice medicine or osteopathy by the State Board of Medical Examiners ... No individual is automatically entitled to membership on the medical staff or to the exercise of any clinical privilege merely because he is licensed to practice in any state, because he is a member of any professional organization, because he is certified by any clinical examining board, or because he has clinical privileges or staff membership at another hospital without meeting the criteria for membership established by the governing body of the respective hospital. ....

S.C. Code § 44-7-260(D) (2011). Thus, a precondition for hospital licensure is a functioning medical staff, which is an association of independent and employed physicians with privileges to practice medicine at the hospital based on specific criteria typically (as in the instant case) set forth in the Medical Staff By-laws.

Credentialing decisions obviously do not start at the hospital board level. Rather, those decisions are made only at the end of an arduous process of multiple levels of professional evaluation: medical school, residency and clinical training, boards, licensure by the Medical Board, background checks, recommendations, professional peer review according to state and Joint Commission standards, and Medical Executive Committee evaluation. At each of these levels the physician's clinical knowledge and experience is reviewed and tested, primarily by other physicians who are experts in their fields. In particular, the peer review committee of the hospital will examine the current licensure of the applicant, his or her training and experience for the particular clinical privileges sought, any malpractice actions, any reports to the National Practitioners Databank, any withdrawal of privileges from other hospitals, and, for those re-applying for

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v. Charleston County, 333 S.C. 519, 536. 511 S.E.2d 69, 78 (1999) (common law prohibition of the corporate practice of medicine); *McMillan v. Durant*, 312 S.C. 200, 439 S.E.2d 829, 831 n.2 (1993).

privileges, any patterns of practice that raise quality of care concerns.[2] The most important component of the credentialing process is the peer review evaluation, which is by statute confidential, in order to encourage a full and robust professional evaluation of each applicant for medical staff privileges.

In other words, there are multiple levels of objective and subjective professional reviews of each physician, made by qualified experts, before a hospital board is asked to grant staffing and clinical privileges, or to reappoint a physician to the medical staff. This entire process is governed by various state and federal statutes and regulations, and reviewed periodically by the Joint Commission. The Appellant in this case is, in essence, asking this Court to allow juries to second guess the entire medical establishment, focusing on the least medically qualified decision-maker (*i.e.*, the hospital board) in the process.[3] To do this adequately would require juries to analyze and assess the medical history and treatment of numerous patients, as well as what is now the *confidential* peer review file, to determine whether a physician was medically qualified to be credentialed at a hospital. Not only are juries ill-equipped for this task, the peer review process itself is designed to avoid this sort of public scrutiny.

B THIS COURT HAS REJECTED THE EXPANSION OF HOSPITAL LIABILITY FOR CREDENTIALING DECISIONS

[2] If a peer review process results in a revocation, suspension, or other limitation upon a physician's hospital privileges, the chief of the medical staff must report that to the Medical Board. S.C. Code § 44-7-70(A) (2014).

[3] "In negligent credentialing liability, though, a court substitutes its own judgment not only for that of the hospitals' trustees but also for those of the medical executive committee, the peer review committee, department chiefs, the physician, and the patient who selected the physician." Note, *Vital Surgery or Unnecessary Procedure? Rethinking the Propriety of Hospital Liability for Negligent Credentialing*, 60 S.C. Law Rev. 1127, 1144 (2009).

The Appellant's analysis of South Carolina caselaw overlooks directly relevant and longstanding precedent. For nearly 80 years South Carolina has followed the principle that hospital credentialing claims are *not* subject to judicial review, absent exceptional circumstances. Appellant herein ignores this history, and in essence is asking this Court to overturn established precedent by specifically allowing judicial review of credentialing decisions. That other states allow judicial oversight of hospital credentialing determinations via a cause of action for "negligent credentialing" does not *ipso facto* compel the wholesale abandonment of this Court's longstanding principle that our Courts are ill equipped to judge complex and multifaceted decisions on whether or not to grant clinical privileges to specific physicians.

The earliest decisions in this area simply stated that policy that credentialing decisions are not reviewable. *See Strauss v. Marlboro County General Hospital*, 185 S.C. 425, 194 S.E. 65 (1937) (plaintiff conceded that private hospital staffing decisions are not judicially reviewable); *Gowan v. St. Francis Community Hospital*, 275 S.C. 203, 268 S.E.2d 580 (1980), *cert. denied*, 449 U.S. 1062, 101 S.Ct. 786, 66 L.Ed.2d 605 (1980) (noting "long-standing principle" that private hospital's medical staff credentialing process "is not subject to judicial review."). In addition, this Court has also acknowledged that hospital immunity for credentialing decisions is a matter of *jurisdiction*. In *Wood v. Hilton Head Hosp., Inc.*, 292 S.C. 403, 356 S.E.2d 841 (1987), the plaintiff

physician challenged the revocation of his staff privileges. The Court refused to reinstate the plaintiff onto the medical staff:

> Appellant contends that the trial court erred in concluding that it lacked jurisdiction to review the Hospital's actions. It is well settled in South Carolina, and throughout the country, that it is improper to review the decisions of governing boards of private hospitals concerning the staff privileges of practitioners. This Court adopted the majority rule many years ago in the case of *Strauss v. Marlboro County General Hospital*, 185 S.C. 425, 194 S.E. 65 (1937). In the recent decision of *Gowan v. St. Francis Community Hospital,* … we affirmed our view that the implementation of the regulations of a private hospital which are initiated to restrict a practitioner's practices are not subject to judicial review. We stated that we would not "depart from the longstanding principle that such action [by the hospital] is not subject to judicial review.

Id. at 405, 356 S.E.2d at 842 (citations omitted); *see also, Holmes v. East Cooper Community Hospital, Inc.*, 408 S.C. 138, 158-159, 758 S.E.2d 483, 494 (2014) (discussing non-review of credentialing decisions in terms of subject matter jurisdiction).

There can be no doubt then, that South Carolina has a long history of refusing to review the denial of staffing privileges by private hospitals. There are two bases for this policy. First, a physician does not have a *right* either to join or be readmitted to a hospital's medical staff.[4] But more importantly for the present

[4] *Public* hospitals, of course, are governmental entities subject to the due process clause. *See Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 349 (1974) (noting essential dichotomy of the Fourteenth Amendment between deprivation of property by state action or by private conduct, "however discriminatory or wrongful…"). But the Courts will *not* review the credentialing decision of a public hospital beyond the minimum due process requirements. *Huellmantal v. Greenville Hosp. System*, 303 S.C. 549, 553, 402 S.E.2d 489, 492 (App. 1991) ("*It is not the function of the court to examine a hospital's administrative decision* if the hospital has granted the physician procedural due process and has not acted in an arbitrary or capricious manner.") (emphasis added); *In re Zaman*, 285 S.C. 345, 347, 329 S.E.2d 436 (1985); *Wood v. Hilton Head Hosp., Inc.*, 292 S.C. 403, 356 S.E.2d 841 (1987) (following the public/private distinction for

case, the Courts have recognized that they are ill-equipped to evaluate the various medical judgments that underlie every credentialing decision. For example, in *Lee v. Chesterfield General Hosp., Inc.*, 289 S.C. 6, 344 S.E.2d 379 (App. 1986), a physician claimed that the hospital had conspired with certain members of the medical staff that competed with him to deny him reappointment to the staff. The Court acknowledged the broad immunity for hospital credentialing decisions:

> We agree that a private hospital is free, in the absence of controlling legislation or regulatory provisions, to decide the nature and extent of medical practice permitted to persons it grants staff privileges. *Ordinarily, such decisions involve matters of expert medical judgment not subject to judicial review*....A medical professional has no right, simply because he is licensed by state authority to perform certain procedures, to claim unrestricted staff privileges in a hospital...*Within the confines of the law, a hospital may set professional standards for staff according to its own conception of good medical practice.*

Id. at 9, 344 S.E.2d at 381 (emphasis added) (citations omitted). Although the Court in *Lee* held that the complaint stated a cause of action that the credentialing decision was based on a conspiracy to injure the plaintiff, the rationale for judicial immunity relevant here is clearly stated: hospital credentialing decisions are a matter of expert medical judgment based on the hospital's own conception of good medical practice. As the Fifth Circuit has noted,

> In the instant case there was considerable evidence regarding Dr. Sosa's ethical and professional competency. *No court should substitute its evaluation of such matters for that of the Hospital Board.* It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility.

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review of credentialing decisions). In this case, Waccamaw Community Hospital is a private hospital not subject to due process standards for denying privileges.

> Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. *The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance.*

Sosa v. Board of Managers of Val Verde Mem. Hosp., 437 F.2d 173, 177 (5th Cir. 1971) (emphasis added).

The principles that undergird judicial deference to credentialing decisions set forth by the Court of Appeals in *Lee* were acknowledged and adopted by this Court just last year. In a case involving a long and drawn out dispute between a disgruntled physician and a hospital that had denied her staffing privileges, the Court extensively quoted from *Lee*, and reviewed the basis and limitations for judicial deference:

> ...the import of *Lee* is that any claim involving staffing decisions made by a private hospital must require review beyond the internal procedures, e.g., bylaws, of a private hospital, to fall within an exception to *the general rule that courts will not delve into a hospital's internal affairs with regard to credentialing or other staffing decisions.*

Holmes v. East Cooper Community Hospital, Inc., 408 S.C. 138, 159, 758 S.E.2d 483, 494 (2014) (emphasis added). In other words, when a physician challenges a private hospital's credentialing decision, our courts will not second guess the expert medical judgments that form the bases for that decision unless there is an allegation that the hospital violated some state or federal law beyond the application of the credentialing review process itself.

Here, though, the Appellant is asking this Court to jettison the longstanding policy that expert credentialing decisions are not subject to judicial

review. There is no reason to do so. If the Court defers to the hospital review process when a physician is *denied* privileges, it should also defer to the hospital review process when a physician is *granted* privileges. That the policy of non-review emanates from a *physician's* challenge to a denial of privileges as opposed to a *patient's* challenge to the granting of privileges is a distinction without a difference. The stated basis for the longstanding policy of judicial deference to the hospital's staffing decisions is that such decisions are based on the medical judgment of expert professionals. Whether that medical judgment is in the negative, and a physician desires to challenge it, or in the positive, and a patient wants to challenge it, the decision-making process by the hospital is the same in both instances. The Court therefore should decline the invitation to adopt a negligent credentialing cause of action.

Finally, this is not an apparent agency case as in *Simmons v. Tuomey Regional Med. Center*, 341 S.C. 32, 533 S.E.2d 312 (2000) (*Simmons II*). *See* Appellant Br. at 8. Rather, Appellant is inviting the Court to find Respondent directly liable for the medical decisions of Dr. McGinley. Like the plaintiff in *Newell v. Trident Medical Center*, 359 S.C. 4, 597 S.E.2d 776 (2004), Appellant is attempting to re-allocate responsibility and liability between hospitals and physicians with staff privileges beyond the *Simmons/Osborne* apparent agency theory. In *Newell*, this Court reversed a judgment against Trident Medical Center based on the theory that a private physician with staff privileges acted as the hospital's agent when he allegedly failed to provide informed consent. The Court rejected an "actual agency" theory of liability against the hospital for the conduct

of a private physician with staff privileges. This Court flatly rejected an extension of liability to the hospital in that situation:

> If [Respondent] is correct, then hospitals are potentially more responsible for the acts of admitting physicians than for the actions of physicians who are independent contractors as in *Osborne* and *Simmons*. We find neither precedent nor public policy support such a re-allocation of responsibility and liability between hospitals and physicians with staff privileges. We decline to adopt such a rule, and emphasize that hospital liability for non-employee physician negligence is limited to apparent agency situations.

Id. at 14, 597 S.E.2d at 781. In other words, this Court has specifically rejected the expansion of hospital liability beyond the *Simmons II* apparent agency theory. In the present case, the adoption of "negligent credentialing" sought by Appellant would likewise expand hospital liability beyond *Simmons II*, as under the Appellant's theory Respondent would be liable for every bad outcome for Dr. McGinley's patients. Such an expansion of liability is flatly contradicted by the precedent of this Court.

C PEER REVIEW CONFIDENTIALITY AND IMMUNITY IN SOUTH CAROLINA

The judicial policy of deference to credentialing decisions is consistent with the legislative policy both of protecting the confidentiality of the peer review process and of granting broad immunity for credentialing decisions. Although other states may recognize a cause of action for negligent credentialing,[5] none

[5] In fact, some states do not recognize claims for negligent credentialing. *See, e.g., Paulino v. QHG of Springdale, Inc.*, 2012 Ark. 55, 386 S.W.3d 462 (2012); *McVay v. Rich*, 255 Kan. 371, 874 P.2d 641 (1994) (Plaintiff "cites cases from numerous jurisdictions in her brief that have adopted the corporate negligence theory in imposing liability on hospitals for their negligence in retaining independent contractor physicians. None of the cases cited address statutes that are even remotely similar to K.S.A. 65-442(b) or 40-3403(h);" also noting that a health care provider is not liable for claims arising out of the negligence of another health care provider); *LeBlanc v.*

have South Carolina's statutory framework concerning peer review confidentiality and immunity. Moreover, the General Assembly has already so circumscribed the peer review process that a cause of action for negligent credentialing would be effectively unworkable.

1 PEER REVIEW CONFIDENTIALITY

The confidentiality of the peer review process, as codified in S.C. Code § 40-71-20(A) (2008) and later in §44-7-392 et seq. (2012), compels the rejection of a negligent credentialing cause of action in South Carolina. It is the judgment of the General Assembly, and confirmed by the Courts, that the peer review process must be confidential in order for it to be effective. That confidentiality, however, would make a negligent credentialing claim unworkable, and ultimately would undermine the entire peer review process.

Research Belton Hosp., 278 S.W.3d 201 (Mo. Ct. App. 2008) (recognizing statutory immunity for hospital's good faith reliance on peer review committee's recommendation); Utah Code Section 78(B)-3-425 ("Prohibition on cause of action for negligent credentialing: It is the policy of this state that the question of negligent credentialing, as applied to health care providers in malpractice suits, is not recognized as a cause of action."); *see also Trover v. Estate of Burton*, 423 S.W.3d 165 (Ky. 2014) (leaving decision on negligent credentialing for "another day"); *Gafner v. Down E. Cmty. Hosp.*, 1999 ME 130, 735 A.2d 969 (1999) (deferring to legislature since it has "significantly controlled" the area); *Hall v. Jennie Edmundson Mem'l Hosp.*, 812 N.W.2d 681 (Iowa 2012) (deferring decision on negligent credentialing). In addition, Appellant cited some cases erroneously for recognizing a negligent credentialing cause of action. *See Register v. Wilmington Med. Ctr., Inc.*, 377 A.2d 8, 10 (Del. 1977) (corporate negligence claim for *employee's* misconduct, not private physician); *Foley v. Bishop Clarkson Mem'l Hosp.*, 185 Neb. 89, 173 N.W.2d 881 (1970) (related to reasonable care of detecting patient illness, but not mentioning negligent credentialing); and *Benedict v. St. Luke's Hospitals*, 365 N.W.2d 499 (N.D. 1985) (case limited to exercising reasonable care in staffing the hospital's emergency room; not applied generally to private physicians on staff). In addition, although *Denton Reg'l Med. Ctr. v. LaCroix*, 947 S.W.2d 941 (Tex. App. 1997), cited by Appellant, does mention negligent credentialing, it ruled only that the hospital owed a duty to plaintiff for anesthesiologist to provide or supervise all of anesthesia care. Texas has not "formally" recognized a negligent credentialing as an independent cause of action, but in any event, a plaintiff must prove by statute *malice* by the hospital in the credentialing process. *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 506 (Tex. 1997), *see also Moreno v. Quintana*, 324 S.W.3d 124, 134 (Tex. App. 2010) (distinguishing claim against physician assistant and against physician under the malice requirement). Thus, there are numerous positions on the issue taken in other states, many of which are dependent upon the particular statutory framework within the state.

The old peer review statute, apparently applicable when Dr. McGinley was readmitted to the Active Staff at Waccamaw, provides as follows:

> All proceedings of and all data and information acquired by the committee referred to in Section 40-71-10 in the exercise of its duties are confidential unless a respondent in the proceeding requests in writing that they be made public. These proceedings and documents are not subject to discovery, subpoena, or introduction into evidence in any civil action except upon appeal from the committee action. Information, documents, or records which are otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during the committee proceedings, nor shall any complainant or witness before the committee be prevented from testifying in a civil action as to matters of which he has knowledge apart from the committee proceedings or revealing such matters to third persons.

S.C. Code § 40-71-20(A) (2008). This provision has been applied by the Courts to hospital peer review committee's evaluation of a credentialing application or re-application. *See, e.g., McGee v. Bruce Hospital System*, 312 S.C. 58, 439 S.E.2d 257 (1993). By its terms, all the information used by a hospital's peer review committee to recommend a physician's admission or readmission to the medical staff, and for application for certain clinical privileges, are not discoverable and not to be used in "any civil action" unless the information is "otherwise available" from original sources.

Likewise, the new peer review statute has even more expansive confidentiality provisions:

> (A)(1) All proceedings of, and all data, documents, records, and information prepared or acquired by, a hospital licensed under this article, its parent, subsidiaries, health care system, committees, whether permanent or ad hoc, including the hospital's governing body, or physician practices owned by the hospital (its parent or subsidiaries), relating to the following *are confidential*:

. . .

(b) investigations into the competence or conduct of hospital employees, agents, members of the hospital's medical staff or other practitioners, relating to the quality of patient care, and any disciplinary proceedings or fair hearings related thereto;

. . .

(d) *the medical staff credentialing process*;

. . .

(f) reviews or investigations to evaluate the quality of care provided by hospital employees, agents, members of the hospital's medical staff, or other practitioners; or

(g) reports or statements, including, but not limited to, those reports or statements to the National Practitioner Data Bank and the South Carolina Board of Medical Examiners, that provide analysis or opinion (including external reviews) relating to the quality of care provided by hospital employees, agents, members of the hospital's medical staff, or other practitioners; or

(h) incident or occurrence reports and related investigations, unless the report is part of the medical record.

(2) The proceedings and data, documents, records, and information described in subsection (A)(1) may be shared with a parent corporation, subsidiaries, other hospitals in the health care system, directors, officers, employees, and agents of the hospital and if shared, remain confidential. *These proceedings and data, documents, records, and information in subsection (A)(1) are not subject to discovery, subpoena, or introduction into evidence in any civil action unless the hospital and any affected person who is a party to such action waives the confidentiality in writing...*

. . . .

(E) Any data, documents, records, or information of an action by a hospital to suspend, revoke, or otherwise limit the medical staff membership or clinical privileges of a practitioner that is submitted to the South Carolina Board of Medical Examiners pursuant to a report required by Section 44-7-70, or the National Practitioner

> Data Bank must not be considered a waiver of any privilege or confidentiality provided for in subsection (A).

S.C. Code § §44-7-392 et seq. (2012) (emphasis added). This statute makes clear that every aspect of the internal hospital evaluation of physicians is confidential and not discoverable, and further that the confidentiality of the peer review process cannot be waived unless *both* the physician and the hospital waive it in writing.

In enacting the new peer review statute, the General Assembly struck a balance between a litigant's need to know with the public's interest in quality health care through meaningful peer review. Effective peer review provides the backbone of quality health care. Confidentiality is necessary for physicians to feel free to voice concern or criticism of their peers in private, with potential ramifications for the physician's credentials. Peers are not likely to criticize another physician honestly and openly if their determinations will be used to impose civil liability on other physicians, or the hospital. Confidential peer review thus encourages higher quality healthcare, by enabling the medical staff to discover problems in the clinical practice or behavior of a physician, so that such problems can be quickly identified, addressed and fixed through proctoring, additional training, and, if necessary, limitation, suspension, or revocation of clinical privileges. The longstanding judgment of this Court and the General Assembly is that if the peer review process becomes "open" to review in civil litigation, then the quality of the peer review will be concomitantly diminished.[6]

[6] The legislative determination that the need for confidentiality in the peer review process, and the granting of immunity, is mirrored in the federal Healthcare Quality Improvement Act ("HCQIA"):

In *McGee v. Bruce Hospital System*, this Court explained the rationale behind the need for confidentiality in peer review:

> The overriding public policy of the confidentiality statute is to encourage health care professionals to monitor the competency and professional conduct of their peers to safeguard and improve the quality of patient care. *The underlying purpose behind the confidentiality statute is not to facilitate the prosecution of civil actions, but to promote complete candor and open discussion among participants in the peer review process.*

312 S.C. 58, 61, 439 S.E.2d 257, 259 (1993) (citations omitted) (emphasis added); *Durham v. Vinson*, 360 S.C. 639, 649, 602 S.E.2d 760, 765 (2004) (noting that peer review confidentiality serves "the policy goals of promoting candor and open discussion among participants in the peer review process."); *Wieters v. Bon-Secours-St. Francis Xavier Hosp., Inc.*, 378 S.C. 160, 173, 662, S.E.2d 430, 437 (2008) ("The Peer Review Statute serves the important public policy goal of ensuring quality medical care to citizens of South Carolina by protecting confidences revealed to committees evaluating the qualifications of physicians practicing in hospitals."), *vacated on other grounds*, 381 S.C. 332, 673 S.E.2d 417 (2009).

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.
> (2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.
> (3) This nationwide problem can be remedied through effective professional peer review.
> (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
> (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

42 U.S.C.A. § 11101.

Important here is that the investigation, review, analysis, and determination by the peer review committee and Medical Executive Committee of a hospital is precisely what would be "in issue" in a negligent credentialing case. The analyses of the medical staff through these committees "directs the committee's recommendation to [the] governing body" of the hospital. Note, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 Ala. L. Rev. 723, 725 (2001). Although the hospital board has the ultimate authority on credentialing decisions, it is dependent upon the medical staff to accurately assess the qualifications and competence of applicants. Given that peer review process is confidential, not discoverable, and not admissible in court, the very analysis upon which a hospital board is to be judged for negligence in the credentialing process would normally be unavailable by either the plaintiff or the defendant at trial. *See, e.g.*, *Kauntz v. HCA–Healthone, LLC*, 174 P.3d 813, 818 (Col. App. 2007) ("If such a claim were allowed, both patients and hospitals would be at distinct disadvantages in proving their claims or defenses.") Further, if the plaintiff is able to discover facts independent of the peer review process, the hospital may not able to defend itself by utilization of the evidence which is the very heart of a negligent credentialing cause of action.

This case provides a good example of how unworkable peer review confidentiality would be for a hospital defendant in a negligent credentialing case. Appellant has uncovered through various sources the admitted difficulties of Dr. McGinley. What is missing from the record is the evaluation of the peer review

committee and Medical Executive Committee, and their analyses of his clinical abilities, as Dr. McGinley overcame his dependence on illegally prescribed medication. The jury would hear highly prejudicial evidences of addiction problems, but would not hear or consider the analysis of Dr. McGinley's peers after he overcame those problems, which the hospital board relied upon in its credentialing decision. The deck is stacked against a hospital in such a situation, putting pressure on the hospital to waive the privilege. But Dr. McGinley may not want to waive the privilege for strategic purposes in order to have a co-defendant share in a damage award or settlement.

Should the confidentiality be waived by mutual consent, however, what then becomes of the very foundation of the peer review process? It is the correct judgment of the General Assembly and this Court that confidentiality provides the framework that makes the peer review process effective. If that confidentiality is removed in one case, will the hospital then lose open and honest evaluations for future peer reviews? Appellant claims that allowing a negligent credentialing cause of action to proceed will encourage hospital boards to more closely scrutinize marginal physicians, thus increasing the overall quality of healthcare. The real outcome, however, is to force a hospital to choose between Scylla and Charybdis, by either waiving confidentiality (with the physician's consent) and thus eroding the foundation for future peer reviews, or not defending itself with the best evidence of the reasonableness of its actions. Such a choice is unnecessary given the other avenues of recovery by an injured plaintiff, and runs counter to the public policy of this State.

2 IMMUNITY FOR CREDENTIALING DECISIONS

At the time of that Waccamaw Hospital acted on Dr. McGinley's application for reappointment to the medical staff, the hospital's peer review committee and Medical Executive Committee enjoyed immunity from tort liability. "Hospital medical staff on a committee conducting peer reviews of patient medical and health records are protected from tort liability for their work if they "act[ ] without malice, [make] a reasonable effort to obtain the facts relating to the matter under consideration, and act[ ] in the belief that the action [they take] is warranted by the facts known to [them].""" *Prince v. Beaufort Memorial Hosp.*, 392 S.C. 599, 607, 709 S.E.2d 122, 126 (App. 2011), quoting S.C. Code Ann. § 40–71–10(B) (Supp.2009). If limited immunity is applied to the hospital's Medical Executive Committee, there is no logical reason *not* to extend that immunity to a *hospital board* when considering the identical application for staffing privileges based on the confidential peer review file. The hospital board, made up primarily of laymen, acts upon the expert medical peer review analysis and information reviewed by active staff physicians, who enjoy peer review immunity. It would be anomalous that laymen acting on the same information as the Medical Executive Committee would not also receive the same level of immunity from tort liability. See Note, *Vital Surgery or Unnecessary Procedure? Rethinking the Propriety of Hospital Liability for Negligent Credentialing*, 60 S.C. Law Rev. 1127, 1140-1141 (2009).

With the adoption of a new peer review statute, there is no doubt that tort immunity for hospital credentialing decisions extends to the hospital board. As

Respondent has argued, S.C. Code §44-7-390 et seq. (2012) has made explicit that the implicit tort immunity for hospital boards found in the prior version of S.C. Code Ann. § 40–71–10(B) (Supp.2009) now applies[7]:

> There is no monetary liability on the part of, and no cause of action for damages arising against, *a hospital licensed under this article*, its parent, subsidiaries, health care system, physician practices owned by the hospital (its parent or subsidiaries), directors, officers, agents, employees, medical staff members, external reviewers, witnesses, or a member of any committee of a licensed hospital, whether permanent or ad hoc, *including the hospital's governing body*, for any act or proceeding undertaken or performed without malice, made after reasonable effort to obtain the facts, and the action taken was in the belief that it is warranted by the facts known, *arising out of or relating to*:
>
> ....
>
> (2) investigations into the competence or conduct of hospital employees, agents, members of the hospital's medical staff or other practitioners, relating to the quality of patient care, and any disciplinary proceedings or fair hearings related thereto, provided the medical staff operates pursuant to written bylaws that have been approved by the governing body of the hospital;
>
> ....
>
> (4) *the medical staff credentialing process*, provided the medical staff operates pursuant to written bylaws that have been approved by the governing body of the hospital;[8]
>
> ....

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[7] The act applies to investigative actions in which the underlying event giving rise to the investigation occurred on or after June 26, 2012. Assuming that this statute does not apply under the facts of the present case, however, the statute certainly reflects the policy of the General Assembly relevant to this Court's determination of whether or not to adopt a new negligent credentialing cause of action.

[8] Appellant argues in its Reply Brief that the Second Amended Complaint alleges that Waccamaw Hospital failed to provide a pathologist that "met" the hospital's bylaws, and therefore can avoid the immunity set forth in the statute. The allegation is insufficient, as §44-7-390 (4) merely requires that the hospital "operate" pursuant to written bylaws that have been approved by the governing body of the hospital. Whether the hospital "met" or did not meet those bylaws is of no moment. What is in view is whether the hospital *operates* according to bylaws, and the statute leaves no room for second-guessing the hospital's *decision* under those bylaws.

> (6) reviews or investigations to evaluate the quality of care provided by hospital employees, agents, members of the hospital's medical staff, or other practitioners; or
>
> (7) reports or statements, including, but not limited to, those reports or statements to the National Practitioner Data Bank and the South Carolina Board of Medical Examiners, that provide analysis or opinion (including external reviews) relating to the quality of care provided by hospital employees, agents, members of the hospital's medical staff, or other practitioners.

(emphasis added). On its face, the statute provides immunity to hospitals for credentialing decisions, regardless whether the hospital was "negligent" in making its determination, "for any act or proceeding undertaken or performed without malice, made after reasonable effort to obtain the facts, and the action taken was in the belief that it is warranted by the facts known."

Appellant argues that the Second Amended Complaint alleges facts sufficient to meet the statutory standards to avoid immunity. Reply Brief at 2. This reading of the statute would mean that in essentially every case there will be a jury issue whether the board's actions were taken without malice, made after reasonable effort to obtain the facts, and were taken was in the belief that it is warranted by the facts known. Rather, specific *facts* must be pled as to each of these elements to avoid the statutory immunity. In any event, even if the Court adopts a negligent credentialing cause of action, a plaintiff would have to establish each of these three exceptions to obtain a damages award against a hospital. If nothing else, the peer review statute reflects the obvious legislative policy in this area: hospitals are not liable for garden variety "negligence" (by whatever standard of care is established) in South Carolina.

II NEGLIGENT CREDENTIALING AND THE LAW OF UNINTENDED CONSEQUENCES

One of the stated policy justifications for extending liability for negligent credentialing decisions is to utilize potential tort liability as an incentive to encourage greater diligence in considering the qualifications of physicians for staffing privileges. This will lead, so the argument goes, to higher quality medical care. Leaving aside the unstated rationale of finding another deep pocket for recovery, inviting scrutiny for credentialing decisions carries with it likely unintended consequences that will be detrimental to the delivery of quality healthcare in South Carolina.

First, the Appellant's request for negligent credentialing under the facts of this case would amount to making hospitals insurers for any bad outcome related to any medical procedure overseen by a physician that "should not" have received staffing privileges according to some unstated standard. Here Appellant alleges that Dr. McGinley's moral failures disqualify him to practice medicine entirely, despite the judgment of the each level of the medical establishment that has considered his situation and rehabilitation. That means that every time one of his patients has a "bad outcome" at the hospital, even for a known risk factor, and even if there was no malpractice in the treatment that led to some injury, the hospital is liable. Causation is a given under Appellant's preferred methodology. Expansion of hospital liability on these grounds results in higher costs in the delivery of healthcare, costs which especially rural hospitals would have difficulty bearing. Even if the Court would require at least a finding of malpractice that

caused the plaintiff's injuries as an element in a negligent credentialing claim, the hospital then becomes the ultimate insurer for malpractice. Higher healthcare costs, when there is already an existing remedy against the physician that directly caused the injury, does not comport with the goal of increasing the quality of healthcare.

Second, focusing on the results of the credentialing process skews the purpose of peer review. The peer review process is designed to determine if particular physicians are "competent" to practice medicine, or "competent" to perform particular medical procedures. With "negligent credentialing," the peer review process would be skewed to focus on whether it was likely that a particular physician can avoid malpractice claims. This is a higher standard, and would mean that fewer doctors will be credentialed. Again, that is a result that few rural hospitals can reasonably withstand.

Third, as noted above, strengthening confidentiality of, and immunity for, peer review, increases the effectiveness of peer review by encouraging full participation of physicians and boards. *Kauntz v. HCA–Healthone, LLC*, 174 P.3d 813, 819 (Col. App. 2007) (Peer review "protects the public inasmuch as negligence claims are likely to be reduced when the medical community polices its own conduct."). Allowing negligent credentialing suits to proceed will put tremendous pressure on hospitals to seek to waive confidentiality of the peer review process. To the extent confidentiality is breached in particular cases (e.g., when both the hospital and the physician agree to waive the privilege in particular cases), physicians may elect not to fully and completely participate in the process

or not participate at all. The lack of candor and openness that would result would ultimately hinder hospitals in their efforts to effectively monitor physicians, and hence negatively impact the quality of patient care provided to patients in South Carolina.

Fourth, to the extent that hospitals are forced into denying privileges to physicians who, *simply based on the nature of their practice rather than based on their competence*, may be subject to future malpractice claims, then other issues arise. A hospital that has denied privileges may then be faced with litigation by the physician for the wrongful denial of privileges, based on slander or some other legal theory. Further, the denial of privileges is reportable to the National Practitioners Databank, and therefore every subsequent hospital will be "on notice" that the physician has been denied privileges. Such hospitals then are in the untenable position: can they "reasonably" appoint such a physician to the staff after he or she has been "rejected" by another hospital? This creates a ready-made lawsuit against the hospital any time there is a bad outcome from such a physician.

Fifth, what is a realistic "standard of care" for negligent credentialing? Appellant suggests that the hospital by-laws become the standard, or perhaps the Joint Commission rules become the standard. As noted in *Strickland v. Madden*, 323 S.C. 63, 448 S.E.2d 581 (Ct.App.1994), this is no small issue. What is in view in the credentialing decision is whether the physician in question is "competent," based on his background, training, clinical knowledge, and experience. Competence is a sliding scale, and may mean one thing for a new

graduate with limited clinical experience and something quite different for a seasoned surgeon. That is why the Joint Commission defers to the peer review committees of hospitals in making this determination. Credentialing decisions are, as this Court has repeatedly recognized, decisions for *professional medical experts* based on a wide variety of factors. Allowing juries to second guess the collective wisdom of a peer review committee will undoubtedly lead not only to more litigation, but also to highly questionable verdicts.

Finally, as discussed above, allowing a claim for negligence in the credentialing process would mean that a hospital could not readily defend itself through the introduction of evidence *from that very process*. Plaintiff's counsel would be free, perhaps, to argue that the hospital is hiding behind "confidentiality," when in fact maintaining confidentiality of the peer review process is a statutory *requirement*. That is not just crying wolf; rather, that is what happens in litigation. *See, e.g., Durham v. Vinson*, 360 S.C. 639, 602 S.E.2d 760 (2004); *Wieters v. Bon-Secours-St. Francis Xavier Hospital, Inc.*, 378 S.C. 160, 173, 662 S.E.2d 430, 437 ("As occurred here, the exercise of the statutory right not to disclose the information would be used against the physician as evidence the physician is hiding something. Allowing this to occur does not serve the policy goals of promoting candor and open discussion among participants in the peer review process."), *vacated on other grounds*, 381 S.C. 332, 673 S.E.2d 417 (2009). The practicalities of litigation, therefore, put hospitals in an unfair

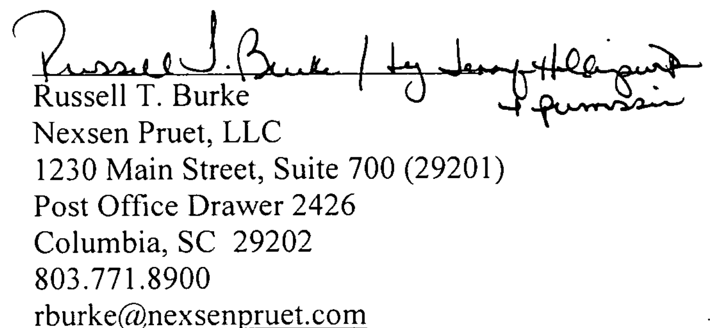
litigation posture, which has direct and deleterious effects on the fundamental nature of the peer review process.

CONCLUSION

South Carolina has long recognized that the peer review process is the best mechanism to determine whether a physician is competent to practice medicine. This is borne out by the statutes and judicial decisions noted above. Allowing "negligent credentialing" suits, on the other hand, would do nothing to deter hospitals from credentialing incompetent physicians because hospitals have no reason to grant admitting privileges to physicians that lack the requisite skills.

Thus, adding a negligent credentialing cause of action does nothing additional to foster quality healthcare than is already present in the economic structures and legal system now in place. In fact, the existence of potential liability in the form of negligent credentialing has the distinct likelihood of *decreasing* quality healthcare.

Therefore, the Hospital Association requests that the Court deny Appellant's request to recognize a new cause of action for negligent credentialing, and affirm the decision below.



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THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

Diane S. Goodstein, Circuit Court Judge

Case No. 12-CP-22-1004
Appellate Case No. 2015-000331

Nadene Holliday, Individually and as Personal Representative of the Estate of David Holliday, ... Appellant,

v.

Waccamaw Community Hospital and Kent M. McGinley, M.D., ... Defendants,

Of whom Waccamaw Community Hospital .... Respondent.

PROOF OF SERVICE

I certify that I have served the foregoing Motion For Leave to File Brief as *Amicus Curiae*, and Conditional Brief, on the Appellant and the Respondents by depositing a copy of same in the United States Mail, postage prepaid, on **3rd of August, 2015**, addressed to its attorneys of record as follows:

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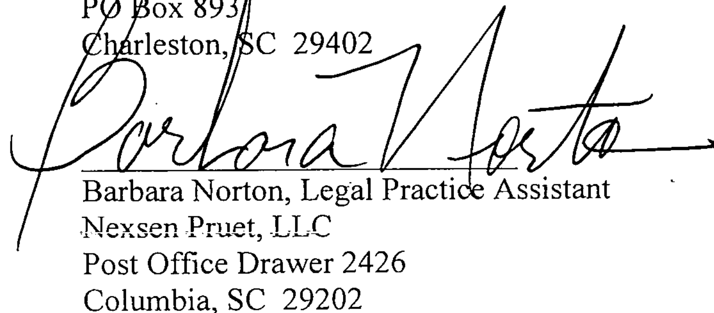

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