



# The Virginia Health Lawyer

Bringing Healthcare and Law Together

Published by the Health Law Section of the Virginia State Bar

Vol. XVII, No. 2

Fall 2002

## Letter from the Chair

*Thomas C. Brown, Jr.  
McGuireWoods LLP*

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The Health Law Section begins the 2002-2003 State Bar year with 486 members and a Board of Governors consisting of 15 practicing lawyers plus 12 Ex Officio members.

The Section has enjoyed renewed vigor over the past several years.

In October of 2001, under the leadership of Bruce Stockburger, the Section sponsored the first Virginia CLE health law seminar in years.

During Jim Daniel's tenure as Chair, he established a Section list serve. The Section also amended and restated its Bylaws to, among other things, permit the Section to hold its annual meeting at the well-attended Annual Legislative Update held in Richmond in the Spring.

The Section's on-line newsletter has been renamed as The Virginia Health Lawyer and sports a new look.

So much for the recent past. What about the future? This year, the Board of Governors expects to do the following:

- Plan and present a CLE program on the morning of the Annual Legislative Update in lieu of a CLE program at the annual meeting of the Virginia State Bar in Virginia Beach.
- Review the State Bar's current inventory of brochures on legal topics of interest to the public and decide if a health law brochure is warranted.
- Review the current on-line publication method for The Virginia Health Lawyer and decide whether to renew hard copy distribution of the newsletter.
- Ask the Section's webmaster, Robyn Ellis, to update the Section's website and further develop the Section's list serve.
- Consider updating and publishing on-line a "Compendium of Health Trade Associations and Agencies" in Virginia prepared several years ago under the leadership of Pat Devine.
- Investigate the Section's participation in the Virginia State Bar's Speakers Bureau.
- Volunteer to sponsor the next-available "theme issue" of the Virginia Lawyer magazine.

*As you can see, the Health Law Section is alive and well and we welcome your active support in making it an even more useful and valuable resource for health lawyers in Virginia.*

# "Servants of the Servers": *The Division of Legislative Services*

*Norma E. Szakal*  
*Division of Legislative Services*

My name is Norma Szakal and I work for the Division of Legislative Services as senior attorney for education and health. When it was suggested that I write an article for the health bar newsletter on the Division's work and what I do within the Division, I was enthusiastic, but cautious. At the risk of sounding like Rodney Dangerfield, I suspect that many Virginia attorneys are unaware that the Division of Legislative Services exists and most attorneys, even lobbyists, don't have any idea what the Division's responsibilities are.

In confirmation of these suspicions, yesterday I received a phone call from an attorney who has practiced in Virginia for thirteen years. Her boss had advised her to call me about a school board question. Although she was grateful for the help, she frankly admitted that, until that morning, she had no idea that the Division of Legislative Services even existed and that she still had no clue what we did. At that point in the conversation, I went into my usual litany---a chant that I have repeated to many people, many times.

Established in Chapter 2.2 (§ 30-28.12 et seq.) of Title 30 of the Code of Virginia, the Division of Legislative Services is the research and legal arm of the General Assembly of Virginia. The Director is required to be an attorney and charged with carrying out the Division's statutory responsibilities and employing staff.

The Division's statutory duties include drafting "legislative bills or resolutions and amendments thereto"; advising the General Assembly, the Governor and the heads of legislative, judicial and independent agencies of the "constitutionality or probable legal effect of proposed legislation"; doing research and "examinations" of proposed legislation; and preparing "summaries of existing laws affected by proposed legislation, compilations of laws in other states or countries relating to the subject matter of

such legislation, and statements of the operation and effect of such laws."

The Division of Legislative Services is structured in four sections to cover certain broad topics and to subsume teams covering various subjects. Special Projects includes rules, privileges and elections and redistricting and the production of many publications. Human and Natural Resources includes conservation, natural resources, education, health, mental health, social services, and correctional institutions. Business and Jurisprudence includes insurance, banking, commerce, labor, and courts. Government and Finance includes taxation, local government, and general laws.

Although the majority of the Division's professionals are licensed attorneys with expertise in various subjects, the Division also employs some of the best researchers in the Commonwealth. The Division's resource center contains many historic and esoteric law books, documents, and materials, and a singular collection of past codes, and previous years' legislative indexes, calendars, bills, etc. Since Virginia has no written legislative history, Legislative Service's resource center and its attorneys and researchers are frequently the only sources of any historic information.

The attorneys and researchers in our office perform many functions for the General Assembly as an institution and the members as individuals. The most visible of our functions are the staffing of standing committees and the drafting of legislation. The Division provides legal counsel for every standing committee in the General Assembly, including the money committees. In addition, every introduced bill must pass through our hands.

We also provide legal counsel and general research and

*"The most visible of our functions are the staffing of standing committees and the drafting of legislation."*

policy analysis to study committees and commissions and various statutory legislative bodies, such as the Code Commission, the Water Commission, the Joint Commission on Science and Technology, and the Freedom of Information Council. Study staffing requires coordination with the Clerk's Offices, planning, diplomacy, and preparation of various legal memoranda, letters, memos, meeting summaries, and staff reports and final or interim reports. And, of course, we also draft any legislation needed to implement the study recommendations.

Statutory legislative bodies perform many exacting duties. For example, the Code Commission oversees and manages the Code of Virginia. Our work with the Code Commission includes, among other things, identification of archaic laws for repeal and recodification of laws. Recodifications are the reorganization, rewriting, revising, and fundamental recreating of entire titles of the Code. Each year, the Code Commission conducts two or three recodifications. As the attorney that wrote the health professions provisions in the recodification of Title 54.1, which passed in 1988, I can tell you that these projects are all consuming, very demanding, and highly challenging. However, recodifications are also the most rewarding tasks that attorneys in our office perform. No recodification bill has ever failed.

Our least visible responsibility is to review regulations for executive agencies within our subject areas and to approve the summaries as being reasonably descriptive of the contents---a responsibility that requires the reading of the regulations and frequently calls for large cups of coffee! We also approve federal exemptions of regulations---a responsibility that requires the reading of federal law and regulations (*a chore that is even more conducive to sleep!*).

The Division functions in some respects like a legal publishing organization. Immediately (within three to five days after sine die adjournment), the Summary is published, containing updated summaries of every introduced bill and most resolutions. This large paper-back document is used by many lawyers with their clients or for continuing legal education---without any knowledge of the tedious process of reviewing, searching for last minute

floor amendments, rewriting, editing, proofing, etc., that go into its production.

For the reconvened session, a summary of the Governor's proposed actions is prepared for the members. After final actions have been taken by the Governor, the Digest---a kind of advance sheet for changes in Virginia law---is published---for lawyers and others. During the interim, the Division produces Legislative Reports (a composite of legislative study committee meetings), various issue briefs, the Register of Regulations, and many other documents.

Some of these documents can be found on the Division's website.

In addition to the many public documents produced by the Division, we answer thousands of questions for the members, the public, and even attorneys about state programs, the Code of Virginia, introduced bills, studies, new enactments, and the legislative process.

This aspect of our job has been described by one of the Division's attorneys as "answering law school examination ques-

tions!" Indeed this is a very accurate description. A recent week brought questions about Stark II, insurance coverage for durable medical equipment, the Americans With Disabilities Act and handicapped access to public buildings, birth certificates for foreign-born adoptees, septic tank violations, malpractice, Medicaid reimbursement for nursing homes, regulation of food services, and other matters.

Most importantly, the Division is a law office with 140 plus clients that provides confidential legal advice on almost any issue. We research legal questions generated by local agencies, constituents, newspaper articles, and even casual comments. We write memos and letters on these matters---some of which do become public, but many of which remain confidential working papers. A former member of the General Assembly noted that the legislators are "the servants of the people" and summed up our role by dubbing us "the servants of the servers." And, indeed, that is what we are.

*"A former member of the General Assembly noted that the legislators are 'the servants of the people' and summed up our role by dubbing us 'the servants of the servers.' "*

# On Call Requirements for Medical Staff Members under EMTALA

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## INTRODUCTION

On August 28, 2002, the U.S. Court of Appeals for the Tenth Circuit rejected St. Anthony Hospital's appeal of a decision by an administrative law judge in which it was fined \$25,000 for violating the Emergency Medical Treatment and Labor Act ("EMTALA").<sup>1</sup> The imposition of the civil monetary penalty and the subsequent decision of the Tenth Circuit serves as a reality check for physicians and hospitals hoping for relief from the regulatory maze of EMTALA.

At first glance, the original EMTALA provisions appeared straight-forward, achieving the goal of ensuring that patients presenting to an emergency room were appropriately screened and treated, regardless of their financial resources or insurance coverage. It soon became apparent, however, that compliance with EMTALA was far from straight-forward.<sup>2</sup>

Among the many issues confronting hospitals was that of providing around-the-clock physician coverage, particularly in areas such as neurosurgery, cardiology, orthopedic surgery and pediatric subspecialties.<sup>3</sup>

The confusion surrounding coverage of emergency departments by on-call physicians often resulted in medical staff bylaw changes based on myth and rumor. A prime example was the widely circulated "fact" that continuous coverage of the emergency department was required by a given medical or surgical specialty if the medical staff consisted of three or more physicians with privileges in that specialty area. Baylor University Medical Center, in a newsletter, stated: "HCFA uses a rule of three. If there are three specialists on staff, the call list must include them daily."<sup>4</sup> Hospitals scrambled to ensure 24/7 coverage and engaged in time-consuming dialogues with medical staff over on-call requirements for part-time, courtesy and senior medical staff members.

As a result of increasing and vociferous requests from providers and professional associations, CMS issued guidelines and memoranda in an attempt to clarify EMTALA regulations. The end result was only partially successful. Some questions were answered, many more were left unanswered, and coverage requirements under EMTALA have remained essentially unchanged from those set forth in 1985.

## BACKGROUND

In 1985, Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act.<sup>5</sup> In part, EMTALA required hospitals to establish on-call schedules providing continuous physician coverage for the assessment and treatment or stabilization of any person presenting to a hospital emergency department.<sup>6</sup>

In 1998, CMS issued Interpretive Guidelines ("Guidelines") which stated that if a hospital offered a service to the public, that service must be available through on-call coverage of the emergency department. The on-call coverage requirement applied to all specialties and subspecialties providing care to hospital in-patients. The Guidelines further required that the medical staff bylaws or policies and procedures define the responsibility of on-call physicians, including procedures to be followed when a particular specialty was not available. The hospital was held accountable for ensuring that the on-call physician responded within a "reasonable period of time."<sup>7</sup> Speculation over the meaning of "reasonable" was rampant. The American Medical Association, in EMTALA Quick Reference Guide for Physicians, reported that CMS officials referred to 30 minutes as "reasonable." The on-call physician was required to come to the hospital to examine the patient and was thus prohibited from referring emergency patients to his/her office or from transferring the patient on the basis of verbal information provided by the emergency department staff.

The EMTALA on-call coverage requirements extended to any hospital that had an emergency department or which offered services for emergency medical conditions. The lack of a formal emergency department did not exempt a hospital. CMS opined, for example, that if a psychiatric hospital offered in-patient services for medical, psychiatric, or substance abuse emergency conditions, it was required to provide around-the-clock coverage for those medical or psychiatric emergency conditions for persons who presented to the hospital's ED.

In April 2000, the responsibility of the hospital and medical staff to provide 24/7 coverage was markedly expanded by CMS. Additional regulations were issued which applied EMTALA's screening and stabilization requirements to off-campus hospital-based departments. The regulations also defined a hospital campus as including an area within 250 yards of the main hospital buildings.<sup>8</sup>

The confusion created by the April 2000 regulations prompted CMS to issue revisions in May 2002. In part, the scope of EMTALA was restricted to the "dedicated" emergency department, defined as the specially equipped and staffed area of the hospital used to evaluate and treat outpatients for emergency medical conditions. Additionally, the 250-yard rule was clarified to include the parking lot, sidewalk and driveway, but excluding other areas that were not part of the hospital's main building or were non-medical facilities. Although the on-call coverage requirements outside the ED were limited, the original EMTALA on-call requirements for screening and treatment or stabilization remained unchanged. CMS did, however, set forth a general "rule of reason" for on-call obligations, denying any preset number threshold for coverage by specialists (the "rule of three"). No additional interpretive guidance was offered.

Confusion surrounding the EMTALA regulations was not limited to providers. At the annual meeting of the American Association of Neurological Surgeons in May 2002, the chief medical officer of CMS Region V told participants that hospitals could require physicians to take call 365

days of the year! Additionally, he suggested that simultaneous call at several hospitals was prohibited under EMTALA and elective surgery could only be scheduled if backup call coverage had been arranged in advance by the neurosurgeon.<sup>9</sup> This interpretation of EMTALA was received by the medical community with disbelief.

In June 2002, CMS reversed its stance. In a Program Memoranda sent to its Regional Administrators, CMS stated that "CMS is revising its policy to allow on-call physicians to provide coverage simultaneously at several hospitals to maximize patient access to care."<sup>10</sup> However, CMS reiterated that the medical staff bylaws or policies and procedures must define the responsibilities of on-call physicians and must contain policies and procedures to be followed when a particular specialty was not available or the on-call physician was unable to respond. Additionally, CMS required that if the on-call physician was simultaneously on-call at more than one hospital, all hospitals involved must be aware of the on-call schedule. Simultaneous call was not a defense to an alleged EMTALA violation. CMS also stated that while CMS did not prohibit a physician from performing elective surgery while on-call, a hospital may have such a policy. Regardless, if the on-call physician schedules elective surgery, that physician must have a planned backup and that backup must be identified in the on-call schedule.

*"The issue of compensating medical staff physicians for taking call has become increasingly pressing as physicians continue to provide emergency department coverage for patients with complex problems, often for little or no reimbursement."*

## CURRENT ISSUES

### A. *Payment for Call*

The issue of compensating medical staff physicians for taking call has become increasingly pressing as physicians continue to provide emergency department coverage for patients with complex problems, often for little or no reimbursement.

In August 2001, some orthopedic surgeons in Tacoma, Washington refused to take calls. When CMS threatened to terminate the hospital's Medicare certification for violations of EMTALA, the hospital offered to pay the surgeons for their call duties. An agreement was reached

in which the orthopedic surgeons were paid differing amounts for being on-call and for going to the hospital.

Potential problems arising from this alternative include the risk of AKB violations; a domino effect which results in payment to all physicians who agree to take call; and escalating costs to hospitals faced with decreasing reimbursement from government and private payors.

Several professional associations have issued position statements on contractual payments to physicians for on-call duties. The American Academy of Emergency Medicine (AAEM) has stated that "the solution to the on-call crisis requires reasonable compensation for all physicians engaged in the care of emergency department patients."<sup>11</sup> The AAEM statement reflects its concern over the unreasonableness of creating government regulations which force physicians to provide care for little or no compensation.

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons also have endorsed the provision by hospitals of a "reasonable stipend" for being on-call.<sup>12</sup>

In contrast, the American College of Emergency Physicians' Quality Advisory states that "on-call duties come with the privilege of practicing in a hospital. They are a covenant between physician and hospital as part of their mutual responsibility to all patients who come to the hospital door. Physicians who break that covenant call into question their medical staff privileges."<sup>13</sup>

Some hospitals are exploring means of providing funds to compensate physicians who take call, including the establishment of risk pools. Sources of monies include an annual assessment for each member of the medical staff, payment by physicians who wish to opt out of call, and assignment of collections by physicians for on-call duties to a risk pool.

Regardless of whether a hospital chooses to pay or stipend

or to require on-call coverage from all medical staff members, call responsibilities must be incorporated into medical staff bylaws and/or hospital policies and procedures. On-call lists must specify available and backup coverage by date, on-call coverage hours, individual name (not the name of the group practice) and specialty and should be posted in the ED, medical staff offices, hospital administration offices and department/section chair offices and in other areas where a patient could present with an emergency condition, such as L&D or pediatrics. On-call schedules must be retained by hospitals for 5 years.

*"If an on-call physician has privileges for a given procedure, but is legitimately not comfortable in performing that procedure, he/she must still evaluate and stabilize the patient and arrange for appropriate consultation and/or transfer."*

### B. Response Time

CMS regulations require the on-call physician to go to the hospital when a request is made by an ED staff member. The patient may not be sent off-site to a physician's office, unless the benefits of such a transfer clearly outweigh the risks. Physician convenience is not a factor.

Designation of a specific response time, such as 30 minutes, may be overly simplistic. Disagreements regarding minutia such as onset of the 30-minute countdown, timing of the on-call physician's appearance in the ED, etc. will invariably arise. Although the term "reasonable response time" is vague and may cause apprehension among medical staff members, the individual patient's status is materially relevant in determining what is "reasonable." The medical staff may prefer to identify a time limit for physician contact, either by telephone or in person, with the ED in response to the first page. The on-call physician and the ED physician should document in the medical record the time of each page and the time of the on-call physician response. Failure to respond within a given time period to the first page and/or to subsequent pages should result in corrective action in accordance with the medical staff bylaws.

### C. Scope of Practice

The issue of ED coverage by subspecialists continues to plague hospitals and medical staffs. Clearly, the care

which a physician provides in an ED is limited by the scope of his/her privileges. Thus, the on-call coverage schedule must accurately reflect the breadth of privileges granted to all medical staff members.<sup>14</sup>

If an on-call physician has privileges for a given procedure, but is legitimately not comfortable in performing that procedure, he/she must still evaluate and stabilize the patient and arrange for appropriate consultation and/or transfer. Hospitals may wish to arrange call schedules so that subspecialists are available for backup. If the ED physician asks the on-call physician to evaluate the patient, the on-call physician must do so. The on-call physician may not determine over the telephone that the patient will require treatment outside of the on-call physician's scope of practice.

The on-call physician should not engage in any debate with the ED physician regarding the appropriateness of the request for a consult. If the ED physician pages the orthopedist on-call and not the general surgeon, the orthopedist must respond. If the ED physician requests that the on-call orthopedist see the patient, the orthopedist must see the patient and evaluate, treat or stabilize. If this is a persistent problem, the hospital and medical staff may elect to establish protocols and guidelines for determination of appropriate specialty consults.

#### D. Coverage by Physician Assistants ("PA")

EMTALA requires a hospital to maintain a list of physicians who are on-call. However, the regulations are silent on the issue of first call or backup call for PA's. Clearly, PA's may take call in CAHs and may conduct MSE's, if deemed qualified by medical staff bylaws or policies and procedures.

The American Association of Physician Assistants has taken the position that EMTALA does not prohibit physicians from delegating call to PA's.<sup>15</sup> However, in Virginia, Section 54.1-2952(A) of the Code, states that

*the assistant shall transfer to the supervising physician the direction of care of a patient in an emergency department who has a life-threatening injury or illness. The supervising physician shall review, prior to the patient's discharge, the services rendered to each patient by a physician assistant in a hospitals' emergency department.*

*An assistant practicing in an emergency department shall be under the supervision of a physician present within the facility.*

Thus, while a PA may perform a MSE in a Virginia ED, the PA may not treat or stabilize a patient in the ED unless the supervising physician is present in the hospital.

#### E. Exemptions From On-Call Coverage

The Interpretive Guidelines issued by CMS permit each hospital to maintain an on-call list in the manner that best meets the needs of its patients.<sup>16</sup> There is no regulation or guideline that specifies on-call requirements for active, courtesy, senior or temporary medical staff members. The delineation of membership categories required to provide on-call coverage is discretionary. CMS does not require all specialties and subspecialties to be on-call at all times.<sup>17</sup> If the criteria for each category of medical staff membership is clearly defined, the inappropriate use of certain categories to escape on-call obligations should not be a problem. Relief from on-call obligations must be carefully reviewed by the medical staff, however. Under EMTALA, if a hospital offers a service to the public, that service must be available for coverage in the ED. A hospital with 2 cardiologists on active staff and 8 with courtesy staff membership status is going to risk intense scrutiny for EMTALA violations by CMS.

## CONCLUSION

The Tenth Circuit's decision in the St. Anthony case was based, in part, on the fact that the on-call physician refused to accept a transfer patient with an abdominal aorta injury.<sup>18</sup> The ED physician deferred to the on-call specialist. The court found that the refusal to accept the transfer was a failure by the Hospital to comply with EMTALA. The hospital was held responsible, under the principles of agency law, for the ED and the on-call physicians' refusal to accept the transfer, despite the hospital's argument that it should not be culpable for the independent decision of the on-call physician. St. Anthony's failure to ensure that its EMTALA-based policy was followed was sufficient.

The on-call physician must understand the requirements

imposed under EMTALA and must also clearly communicate with the hospital and the medical staff regarding each party's expectations and understanding of the responsibilities and duties imposed by EMTALA.

<sup>1</sup> The Omnibus Budget Reconciliation Act of 1989 deleted the word "active" from EMTALA.

<sup>2</sup> In June 2001, GAO issued a report which stated that there was widespread uncertainty among hospital officials and physicians about the extent of their responsibilities under EMTALA. More than 40 % of emergency department physicians and more than 60% of directors of emergency departments found EMTALA law and regulations unclear. *Report to Congressional Committees. Emergency Care: EMTALA Implementation and Enforcement Issues*. United States General Accounting Office. GAO-01-747.

<sup>3</sup> *The Emergency Medical Treatment and Labor Act. Survey of Hospital Emergency Departments*. Department of Health and Human Services, Office of the Inspector General. OEI-09-98-00220. January 2001.

<sup>4</sup> *Baylor University Medical Center Proceedings*. Volume 14, No.4, September 2001.

<sup>5</sup> P.L. 99-272; 42 U.S.C. 1395dd.

<sup>6</sup> The first EMTALA regulations, as well as the 2000 amendments, required a hospital to maintain a list of on-call physicians and to "provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examinations must be conducted by individuals determined qualified by hospital bylaws...." 42 CFR 489.20

<sup>7</sup> 42 CFR 489.20(r)(2).

<sup>8</sup> 42 CFR 489.24.

<sup>9</sup> See *Neurotrauma & Critical Care Newsletter*. "Chairman's Message." Fall 2002.

<sup>10</sup> CMS Ref: #S&C-02035. June 13, 2002.

<sup>11</sup> *On Call Crisis Position Statement*. American Academy of Emergency Medicine. May 18, 2002.

<sup>12</sup> See *Newsletter: Neurotrauma & Critical Care*. Fall 2002.

<sup>13</sup> *On-Call Responsibilities for Hospitals and Physicians*. American College of Emergency Physicians. December 13, 2001.

<sup>14</sup> CMS *Interpretive Guidelines* provide that the "capabilities of the staff of a facility means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses." 42 CFR 489.24(c)(l). *Interpretive Guidelines* Tag A407.

<sup>15</sup> "Physician assistants may take emergency room call, as long as it is allowed as a delegated task under state law and the individual PA has been granted privileges or other hospital authority to do so." EMTALA FAQ's. American Academy of Physician Assistants. September 6, 2002.

<sup>16</sup> Tag A404.

<sup>17</sup> Hospital policies should clearly define how patients are to be stabilized and transferred when a particular specialty is not covered. Transfer agreements should also be formalized with other hospitals.

<sup>18</sup> *St. Anthony Hospital v. United States Department of Health and Human Services*. No. 00-9529. August 28, 2002.

# YES, VIRGINIA, THERE IS SUCH A THING AS NEGLIGENT CREDENTIALING

## *But Not in This State*

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### INTRODUCTION

Consistent with its conservative approach to lawmaking, the Commonwealth of Virginia has been slow to adopt as a cause of action a hospital's negligence in granting privileges to its medical doctor staff. Negligent credentialing gained its toehold in Illinois almost 40 years ago,<sup>1</sup> and it now appears to be an accepted action in 25 to 30 states.<sup>2</sup>

Only a smattering of Virginia opinions exists on the matter. Neither the General Assembly nor the Supreme Court of Virginia has weighed in on the matter, yet, although each has given its own indication as to the directions they lean. Not surprisingly, those indications are at odds with each other.

This article briefly examines the bases used in Virginia's circuit courts to support a cause of action for negligent credentialing, concluding that none has yet been able to fashion a thoroughly convincing rationale. If negligent credentialing is to be widely adopted by Virginia courts, those courts will have to continue looking for support.

### *STOTTLEMYER v. GHRAMM*

Two published opinions<sup>3</sup> have recognized negligent credentialing as a cause of action, while two unpublished opinions<sup>4</sup> have held to the contrary. A third unpublished opinion, authored by the Honorable John J. McGrath, Jr. of the Circuit Court for the City of Winchester, explored the issue in depth. It sided with those recognizing negligent credentialing as a cause of action.

The issue in that case, styled *Stottlemeyer v. Ghramm*<sup>5</sup>, arose on the demurrer of co-defendant Winchester Medical Center, Inc. The plaintiff had alleged injuries

suffered at the hands of the defendant doctor. The plaintiff also alleged that, but for the hospital's negligence in granting hospital privileges to the physician, the plaintiff would not have been injured.<sup>6</sup>

In holding that there is a cause of action in Virginia for negligent credentialing,<sup>7</sup> Judge McGrath looked to the few Virginia circuit court opinions, as well as those from other jurisdictions. Two arguments persuaded him. First, he found convincing that the majority of other states had adopted a "corporate liability" theory supporting a cause of action for negligent credentialing.<sup>8</sup> Under this theory, a hospital has a "separate duty of care to allow only physicians with proper credentials to use its facilities."<sup>9</sup> Because that duty is independent of the relationship between the hospital and the physician, it differs from vicarious liability.

Judge McGrath found convincing the observation of a 1994 Ohio opinion that today's "hospital is a large, well-run business" whose patients "are unaware of and unconcerned with the technical complexities and nuances surrounding the contractual and employment arrangements between hospitals and various medical personnel operating therein."<sup>10</sup> In other words, those patients rely on the hospital to ensure that only qualified physicians grace their surgical suites, and it is that reliance that places upon the hospital the duty to ensure the physicians' competence.

In examining the existence of this duty, Judge McGrath also relied on the 1982 opinion of Judge Grenadier in *Carter v. Jefferson Memorial Hospital Corp.*<sup>11</sup> Judge Grenadier had grounded the existence of the duty on the "concept of foreseeability,"<sup>12</sup> observing that "[I]t is clearly foreseeable that if a hospital opens its facilities to demon-

strably incompetent professionals, including *independent contractors*, that injury to patients will occur."<sup>13</sup>

### INDEPENDENT CONTRACTORS?

As the foregoing quote makes clear, this duty grounded in foreseeability exists regardless whether the actor is an independent contractor or is employed directly by the hospital. A common defense theme for hospitals named in the conceded few cases involving negligent credentialing has relied on dicta from *Stuart Circle Hospital Corp. v. Curry*.<sup>14</sup> That case voiced the concept that a "physician is an independent contractor and alone is responsible for the exercise of professional skill and judgment, subject to no control by the hospital in the execution thereof."<sup>15</sup> Hospitals have relied on that dicta to support their premise that they cannot be held responsible for the negligence of the physicians using their facilities.

Judge McGrath suggests that the Supreme Court of Virginia recently has softened that view. He points to *McDonald v. Hampton Training School of Nurses* as an indication that the Supreme Court no longer views physicians as per se independent contractors. In that opinion, Justice Lacy used language reminiscent of *Clark v. Southview Hosp. & Family Health Ctr.*<sup>16</sup> to recognize the evolution of today's hospital from that of the *Stuart Circle* era. While *McDonald* did not involve negligent credentialing, it did consider the status of a physician employed by a hospital, holding that whether the physician was, in fact, an independent contractor depended on the jury's application of accepted independent contractor criteria to the specific facts of that case.

The reality is that the independence of the physician has no moment in negligent credentialing analysis. Credentialing is a threshold consideration. It concerns itself with a physician's competence before he is allowed access to the hospital's facilities. It does not concern itself with the physician's acts and omissions once he is permitted that access. The physician's status in this regard is a red herring, and an examination of that status gets us no closer to the answer.

### SHOW ME THE DUTY

The real issue is one of duty. For a hospital to be negligent in the credentialing of its physicians, and for its ensuing liability to a patient, the hospital must have a duty to that patient. Foreseeability alone does not define that

duty. As the Restatement (Second) of Torts makes clear, one generally has no duty to act for the protection of others.<sup>17</sup> There are exceptions and those exceptions are ably listed in the Restatement.<sup>18</sup> None of those exceptions include hospitals assuming the responsibility for the safety of its patients.

In addition to these exceptions, Virginia recognizes a duty where the actor has a special relationship with a third party. While none of the Virginia cases has analyzed negligent credentialing in this context, a superficial look at the relationship between a hospital and its patients suggests that such might constitute the special character required to impose a duty. That duty, however, is borne from and limited by the contractual relationship entered into by the parties. When a patient is admitted to a hospital, he contracts for specific care. That care may or may not include the care of a physician. If it does, then it can safely be said that the hospital owes a duty of care to the patient to allow only competent physicians to use its facilities.

On the other hand, if the patient's choice of hospital is predicated on her choice of doctor first, as in the common instance where the patient has a pre-existing relationship with her physician that is entirely independent of the hospital, the hospital cannot be said to owe a duty to the patient. The corporate liability ignores that contingency, holding a hospital liable for all credentialing decisions it makes. Judge McGrath recognized this anomaly and tempered the rule by adding the element of a patient's reliance on the hospital's credentialing process as a necessary prerequisite to a successful cause of action.<sup>19</sup>

The foregoing suggests that the existence of a cause of action for negligent credentialing depends on whether the physician is employed directly by the hospital. If the physician is so employed, then it can be presumed that the hospital owes a duty to its patient. If the physician is not so employed, and absent facts suggesting ostensible agency, then the hospital has no duty to the patient. In the former set of circumstances, however, the hospital would have vicarious liability for the physician's negligence. Since damages would be the same, a cause of action for negligent credentialing would serve no practical purpose while adding to the complexity of the plaintiff's burden of proof.

### GUIDANCE GOING FORWARD

Professor Keeton recognizes competing duties that suggest how Virginia courts may eventually decide this issue. On

the one hand, he finds a duty to exist "where a reasonable person would recognize the existence of an unreasonable risk of harm to others through the intervention of such negligence."<sup>20</sup> In this context, a hospital would owe a duty to a patient where it should recognize that allowing an incompetent physician to perform surgery would present an unreasonable risk of harm.

On the other hand, Professor Keeton finds that the putative plaintiff owes a reasonable duty of care to herself. "It is not due care to depend on upon the exercise of care by another when such reliance is accompanied by obvious danger."<sup>21</sup> In other words, a patient going under the knife has a duty to herself to make reasonable inquiry into the competence of the caregivers she intends to rely on. Failure to do so is contributory negligence.

Except for certain instances in which the General Assembly has seen fit for public policy reasons to abrogate the doctrine of contributory negligence, Virginia continues to support it. As long as the General Assembly continues to find medical malpractice awards burdensome to the containment of rising healthcare costs, it is reasonable to assume that the legislature will not act to abrogate contributory negligence in this context.

Further, the Supreme Court of Virginia has not been entirely silent on the matter. The defendant hospital in the case of *Mason v. Potomac Hospital Corporation of Prince William*<sup>22</sup> successfully demurred to Plaintiff's claim of negligent credentialing, and the plaintiff petitioned the Court for an appeal. The Court's writ panel denied the appeal, holding that the lower court had committed no reversible error.<sup>23</sup>

A review of the pleadings filed in that petition show that the Court was not persuaded by Plaintiff's argument that accreditation requirements countenanced by the Social Security Act created a duty on the part of the hospital to its patients. Those pleadings also demonstrate that the Court was unmoved by the same corporate liability argument Judge McGrath found compelling in *Stottlemeyer*.

## CONCLUSION

Until either the General Assembly or the Supreme Court of Virginia speaks out on this issue in definitive terms, circuit courts will continue to use their discretion in determining the viability of negligent credentialing as a cause of action. The set of facts that most likely will bring a plain-

tiff success include that plaintiff's overt reliance on the hospital's credentialing process combined with that plaintiff's documented due diligence of her inquiries into the hospital's credentialing of that doctor.

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- 1 *Darling v. Charleston Community Memorial Hospital*, 33 Ill. 2d 326, 211 N.E.2d 253 (Ill. 1965).
  - 2 *Stottlemeyer v. Ghramm*, Case Number 910-L-181, 3 (City of Winchester, July 13, 2001).
  - 3 *See Carter v. Jefferson Memorial Hosp.*, 9 Va. Cir. 489 (City of Alexandria 1982) and *Alderson v. Alexandria Hosp.*, 40 Va. Cir. 363 (City of Alexandria 1996).
  - 4 *See Kump v. Kotescu*, No. 95-374 (Arlington Cty. 1995) and *Mason v. Potomac Hosp. Corp.*, No. L-39762 (Prince William Cty. 1996).
  - 5 Opinion Order, Case Number 910-L-181 (City of Winchester, July 13, 2001).
  - 6 Plaintiff also alleged that the hospital was negligent in its supervision of Dr. Ghramm. Judge McGrath sustained the hospital's demurrer on this count on the grounds that Virginia does not recognize a cause of action for negligent supervision. *Stottlemeyer* at 11 (citing to *Chesapeake and Potomac Telephone Co. v. Dowdy*, 235 Va. 55,365 S.E.2d 751 (1988)).
  - 7 Although Judge McGrath held that a cause of action for negligent credentialing exists in Virginia, he sustained the hospital's demurrer on the basis that reliance is a necessary element and that the plaintiff had not so alleged.
  - 8 *Stottlemeyer* at 5.
  - 9 *Id.*
  - 10 *Id.* at 7-8 (quoting *Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46, 53 (Ohio 1994)).
  - 11 9 Va. Cir. 489 (City of Alexandria 1982).
  - 12 *Stottlemeyer* at 6 (quoting *Carter v. Jefferson Memorial Hospital Corp.*).
  - 13 *Stottlemeyer* at 6 (emphasis added).
  - 14 173 Va. 136, 3 S.E.2d 153 (1939).
  - 15 *Id.* at 149, 3 S.E.2d at 158.
  - 16 *See* n.10 and accompanying text, *supra*.
  - 17 Restatement (Second) of Torts § 314.
  - 18 *Id.* §§ 316-19.
  - 19 *Stottlemeyer* at 10.
  - 20 Prosser and Keeton on Torts § 33, W. Page Keeton et al. (5th Ed. 1984).
  - 21 *Id.*
  - 22 No. L-39762 (Prince William Cty. 1996).
  - 23 Order of the Supreme Court of Virginia, Record No. 962359, Feb. 21, 1997).