Nos. A05-1698 and A05-1701

STATE OF MINNESOTA

IN COURT OF APPEALS

MARY LARSON AND MICHAEL LARSON,

Respondents,

v.

JAMES PRESTON WASEMILLER, M.D.,

Appellant, (A05-1698)
Defendant (A05-1701),

PAUL SCOT WASEMILLER, M.D., and DAKOTA CLINIC, LTD.,

(Defendants (A05-1698),

ST. FRANCIS MEDICAL CENTER,

Appellant (A05-1701).

JOINT BRIEF AND ADDENDUM OF AMICI MINNESOTA HOSPITAL ASSOCIATION, MINNESOTA MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION

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INTRODUCTION AND INTEREST OF AMICI

The three Amici Curiae submitting this brief have both public and private interests in this appeal.[1] All three Amici are directly involved in developing legislative policy to assist society in providing the highest quality healthcare. The Minnesota Medical Association ["MMA"] and the Minnesota Hospital Association ["MHA"] have been particularly involved in the unique and positive developments in the law and policy of Minnesota that have directly resulted in significant improvements in the quality of healthcare within this State. Both the MHA and the MMA have worked to distinguish Minnesota from every other state in the country by supporting legislative development of the strongest peer review and reporting systems in the nation, including most recently the Minnesota Adverse Health Event legislation, a unique statute designed to require reporting and self-analysis of unexpected adverse health events.[2] Minnesota's Adverse Health Event legislation--the first of its kind in the country--draws heavily upon the strength of Minnesota's peer review laws that are under attack in this case.[3] The

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[1] Pursuant to Rule 129.03, the undersigned counsel certifies that no counsel for a party to this case authored this brief in whole or in part and no one made a monetary contribution to the preparation or submission of this brief other than the Minnesota Hospital Association, the Minnesota Medical Association and the American Medical Association.

[2] Peer review statutes or common law protections exist in all 50 states. However, Minnesota's law is unique in that it is the only state that imposes criminal penalties for releasing peer review material. *See* Minn. Stat. § 145.66.

[3] The *Wall Street Journal* described the legislation as a "path-breaking move" designed to prevent medical error. (Addendum at 1) The *Journal* described Minnesota and its employers as having "long been incubators of ideas for improving and containing health care costs."

Minnesota Hospital Association, Minnesota Medical Association and American Medical Association ["AMA"] greatly fear that if a claim for "negligent credentialing" were recognized in this case, it would set back important quality advances within this State that separate Minnesota from the rest of the country.

Minnesota Hospital Association

MHA is a statewide organization comprised of almost all hospitals in the State of Minnesota, including 136 acute care hospitals and 22 health systems. MHA's objective is to provide leadership toward the advancement of sound healthcare policy. MHA's efforts focus on access to healthcare, consumer value, and improving the quality of care in the state. MHA serves its members as the State's most influential, trusted and respected leader in healthcare policy and advocacy and is a valued resource for healthcare information. In 2003, MHA worked closely with the Minnesota Department of Health to develop and implement Minnesota's Adverse Health Event legislation. This unique cooperative effort resulted in the creation of the first state legislation in the nation to mandate the reporting of adverse health events.

The Minnesota Medical Association

MMA is a professional association representing approximately 9,500 physicians, residents, and medical students in the State of Minnesota. MMA seeks to promote excellence in healthcare, to insure a healthy practice environment, and to preserve the professionalism of medicine through advocacy, education, information and leadership. For more than 150 years MMA and its members have worked together to safeguard the quality of medical care in Minnesota and the future of the medical profession.

The American Medical Association

The AMA is an Illinois non-profit corporation, comprised of approximately 250,000 physicians, residents, and medical students. The AMA is the largest medical society in the United States. Its objects are to promote the science and art of medicine and the betterment of public health. Its members practice in every state, including Minnesota, and in every field of medical specialization.[4]

* * *

The interests of the MMA, MHA and AMA in this case are primarily public in nature. These Amici have no interest whatsoever in the particular dispute between these litigants. Rather, our interests primarily focus on our concern that recognizing a claim of negligent credentialing would drastically erode Minnesota's legislatively-created peer review systems and other advances in healthcare legislation unique to this state.[5] From a public perspective, we believe that recognizing negligent credentialing as a cause of action under Minnesota law would significantly decrease the willingness of physicians to participate in peer review, as physicians involved in making credentialing decisions would increasingly become targets in credentialing lawsuits. Moreover, we fear that

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[4] The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition of the AMA and private, voluntary, non-profit state medical societies, including the MMA, formed to represent the views of organized medicine and the courts.

[5] At times, the parties and the trial court have referred to the potential claims as either negligent credentialing or negligent privileging. Our concerns would arise if the court were to recognize either claim. For the sake of uniformity, we refer to the claim as "negligent credentialing" throughout our brief.

recognizing negligent credentialing claims would result in physicians becoming less willing to speak openly and honestly about their concerns regarding a credentialing candidate, for fear that those concerns may later become the focus of a lawsuit.

Since the members of the MMA, MHA and AMA include hospitals and healthcare professionals who themselves may be sued for malpractice, a decision by this Court could implicate Amici's private interests as well. We believe that recognizing "negligent credentialing" claims would dramatically and improperly change the focus of medical malpractice lawsuits from whether a physician complied with the applicable standard of care in the community in treating a particular patient to events entirely irrelevant to that patient's care. From a hospital perspective, we are equally concerned that hospitals would effectively become excess insurers for underinsured physicians and be held liable for negligent hiring or retention even when the hospital did not employ the physician.

Nonetheless, our greatest concern remains that recognizing the cause of action will set aside 30 years of significant legislative advances in Minnesota's peer review laws and this state's nationally-acclaimed healthcare legislation.

Amici believe this Court ought to have a broader perspective of the legal policy issues raised by this case than what may be presented by the parties. The parties will naturally focus on the particular facts of the case as those facts bear on the ruling below. Amici do not intend to reargue or restate Appellants' arguments. Instead, Amici seek to provide some broader perspective on the issues of law and policy that should guide this Court's decision in analyzing what the law on the issue of negligent credentialing *should* be.

ARGUMENT

Amici submit that this Court should not recognize negligent credentialing as a new cause of action under Minnesota law for four separate, critical reasons. First, creating such a cause of action would drastically erode successful legislatively-created peer review systems in Minnesota and would undermine unique healthcare legislation that has developed in Minnesota over the last 30 years. Second, as a practical matter, allowing such claims would impose liability upon hospitals for legislatively-imposed tasks performed by the Minnesota Board of Medical Practice, since hospitals would be exposed to civil damages simply for relying upon the investigation performed by the Medical Board. Perversely, hospitals would become liable for credentialing decisions where the State's Board of Medical Practice would not, despite the fact that the Legislature has directed that the Board of Medical Practice alone shall decide whether a physician should be allowed to practice medicine.

We also urge the Court not to recognize negligent credentialing as a viable cause of action because it would change the focus of medical malpractice law in this State away from whether the particular physician or nurse complied with the standard of care and instead direct that focus toward entirely irrelevant, prejudicial events that have nothing to do with whether the medical care complied with the applicable standard of care in the community. Finally, hospitals would become *de facto* excess insurers for physicians as hospitals become liable for the acts of an independent contractor whom they never employed.

I. RECOGNIZING NEGLIGENT CREDENTIALING WOULD ERODE MINNESOTA'S PEER REVIEW LAWS.

Since the enactment of the state's first peer review statute in 1971, the Minnesota Legislature has repeatedly taken steps to create unique confidentiality protections for information assembled by a hospital review organization (a/k/a peer review information):

> [Peer review information] shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery.

Minn. Stat. § 145.64, subd. 1(a). The Minnesota peer review statute sets forth 23 recognized purposes of a review organization that are covered by the confidentiality protections of Minn. Stat. § 145.64. Significantly, the Legislature identified credentialing decisions as deserving of the statute's confidentiality provisions by recognizing those decisions as a legitimate purpose of a review organization, directing that statutory confidentiality shall extend to information used in:

> Determining whether a professional shall be granted staff privileges in a medical institution . . . . or whether a professional's staff privileges, membership, or participation status should be limited, suspended or revoked.

Minn. Stat. § 145.61, subd. 5(i). Moreover, in addition to specifically establishing credentialing decisions as a legitimate function of a review organization, the Legislature believed it was so important for those discussions to be kept private that it imposed *criminal* penalties upon any organization or individual who discloses the events that occurred within a review organization, an element to peer review that does not exist elsewhere in the country. Minn. Stat. § 145.66.

In their briefing to the trial court, the parties spent considerable time arguing about the holdings and analysis of courts in other jurisdictions on the question of negligent credentialing. We strongly believe this is not the appropriate focus for this Court. Rather, we urge the Court to realize that this case presents a uniquely Minnesotan issue, and to focus on the specific statutory language established by the Minnesota Legislature, the plain statutory intent to protect the integrity of the Minnesota peer review process, and the nationally-recognized advances in Minnesota healthcare legislation. Importantly, the Court should not focus on whether the common law of *other states* recognizes negligent credentialing but rather on whether establishing such a cause of action in Minnesota is appropriate given the overriding and broad scope of Minnesota's health care legislation.

Obviously, different states have created different mechanisms to assure that hospitals credential physicians appropriately. While some states police those activities through common law civil actions, the Minnesota Legislature has elected to allow hospitals to police those activities internally through its peer review programs. *Campbell v. St. Mary's Hospital*, 252 N.W.2d 581, 587 (Minn. 1977) (peer review is intended to "encourage the medical profession to police its own activities with a minimum of judicial interference"); *In re: Parkway Manor*, 448 N.W.2d 116, 119 (Minn. App. 1990) (same). No party has pointed to a statutory peer review program as well developed and unique as Minnesota's.

Amici are extremely concerned that recognizing negligent credentialing as a new cause of action would dissuade physicians and other professionals from participating in

the credentialing (or other review organization) processes. The Minnesota Supreme Court has repeatedly recognized similar concerns. *See Amaral v. St. Cloud Hospital*, 598 N.W.2d 379, 387 (Minn. 1999) (absent confidentiality, professionals will be reluctant to "participate freely" in peer review); *Campbell v. St. Mary's Hospital*, 252 N.W.2d 581, 587 (Minn. 1977) (import of peer review is to encourage the medical profession to "police its own activities with a minimum of judicial interference"). *See also Konrady v. Oesterling*, 149 F.R.D. 592, 597 (D. Minn. 1993) (confidentiality in peer review is necessary "to protect the unimpeded flow of ideas and advice"). Until the trial court's recognition of negligent credentialing in this case, there has been little question that Minnesota's peer review laws protect the integrity of the peer review process by maintaining confidentiality. *Id.*; *In re: Fairview University Medical Center*, 590 N.W.2d 150, 153 (Minn. App. 1999) (peer review is designed to improve patient care "despite threats of malpractice and defamation actions"); *In re: Parkway Manor*, 448 N.W.2d 116, 120 (Minn. App. 1989) (same).

The statute-based peer review confidentiality provisions allow physicians to speak openly, honestly and frankly about all review organization functions, including credentialing. If this cause of action were recognized, however, physicians would quite naturally fear that their candor may ultimately be punished in a later civil lawsuit alleging negligent credentialing. In particular, if one physician voices concerns about an applicant's qualifications, but is over-ridden by the balance of the committee, then that physician will unintentionally become the subject of (if not the plaintiff's expert in) a subsequent negligent credentialing claim. This confidentiality concern arises because

hospitals and physicians would be forced to make the impossible choice of either not defending the negligent credentialing claim to escape criminal prosecution or else sharing the entire analysis of the credentialing committee, with the risk of criminal punishment and erosion of their peer review program. *See* Minn. Stat. § 145.66. Should a hospital find it necessary to defend the lawsuit (a reasonable decision with millions of dollars at stake), it will be forced to erode the integrity of its peer review program and share peer-review protected information, thereby subjecting itself to criminal prosecution.

The Minnesota Supreme Court has expressed grave concerns about the "chilling effect" the erosion of peer review confidentiality will have on a physician's willingness to participate or to speak openly. *Amaral*, 598 N.W.2d at 388. Consequently, the Supreme Court has even rejected efforts by a physician to access a hospital's credentialing records about that physician's own credentialing application, recognizing that the statute favors the public interest of maintaining confidentiality over the physician's interest in accessing his files. *Id.* Moreover, the Court recognized the critical importance of encouraging the most open candor possible:

> In pursuit of their goal of improving the quality of health care through the use of the peer review system, state legislatures have recognized that professionals will be reluctant to participate freely in peer review proceedings if full participation includes: (1) the possibility of being compelled to testify against a colleague in a medical malpractice action, and (2) the possibility of being subjected to a defamation suit by another professional.

Id. at 387. The *Amaral* Court noted that medical professionals rely on collegiality with, and referrals from, their peers and that "the quality of patient care could be compromised if fellow professionals are reluctant to participate fully in peer review activities by

coming forward with candid and honest reports about a colleague." *Id.* at 388. *See also* Owens, *Peer Review: Is Testifying Worth the Hassle?*, Med. Econ., Aug. 20, 1984, at 168 (noting that 21% of physicians had lost referrals or had antagonized colleagues because of their participation in peer review procedures); P. Scibetta, Note, *Restructuring Hospital – Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. Pitt. L. Rev. 1025, 1034-35 (1990).

Consistent with Minnesota's legislative construct and the interpretations by the Minnesota Supreme Court, it has been well-recognized in other venues that medical peer review is blunted when physicians engage in review activities with the fear that their identities, comments, records, and recommendations will be disclosed. As one commentator noted, "curtailing the candid deliberations of these committees because of a fear of the discovery process could eventually lead to the destruction of the benefits of committee review." Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 Am. J. L. & Med. 245, 267 (1975); *See also* K. Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures,* 86 Mass. L. Rev. 157, 162 (2002) ("the erosion of the medical peer review privilege leaves physicians without adequate assurance of the confidentiality of their participation in peer review activities, thereby undermining the effectiveness of peer review. . . Ultimately, physicians cannot be expected to participate candidly in peer review or error reporting activities if their identities, comments, records and recommendations are not afforded strict protection.").

Consistent with the Supreme Court's directive in *Amaral*, maintaining confidentiality of review organization functions is imperative to the success of the

process. Otherwise, physicians will either refuse to participate in the process or will be reluctant to speak honestly about the merits of credentialing a physician. Credentialing committee members would bite their tongue out of fear that their comments would be used against the hospital in a subsequent negligent credentialing claim or against the physician in a malpractice case.

Recognizing negligent credentialing would erode the legislatively-created confidentiality provisions and set aside significant legislative advances unique to Minnesota. For example, in August 2003 Governor Pawlenty signed the Minnesota Adverse Health Event Legislation that created mandatory reporting of adverse health events. *See* Minn. Stat. §§ 144.706-144.7069.[6] In addition to requiring mandatory reporting, the Adverse Health Event legislation also required hospitals to create and implement their own corrective action plans as part of their peer review programs. Minn. Stat. § 144.7065, subd. 8.[7] Under the new law, peer review information is voluntarily (and confidentially) provided to the Minnesota Department of Health, which makes recommendations for improving health care on a state-wide basis. In creating the Adverse Health Event legislation, the Legislature further strengthened Minnesota's peer

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[6] Governor Pawlenty called the legislation "an important step in improving patient safety." (Addendum 3) At a bill-signing ceremony, Governor Pawlenty described Minnesota as a national leader in creating the legislation to track and monitor events to improve patient safety. (Addendum 6) Likewise, the President of the National Quality Forum, a national leader in healthcare reform, identified Minnesota's model legislation as the "vanguard" of reporting error and improving patient care. *Id.*

[7] With the support of the National Quality Forum on Healthcare, Minnesota was the first to pass Adverse Health Event Legislation. New Jersey and Connecticut have already followed suit.

review statute by making the hospital's corrective action plan subject to the same confidentiality protections as the hospital's credentialing program. *See* Minn. Stat. § 145.61, subd. 5(q). But the success of the Adverse Health Event legislation hinges on a hospital's willingness to self-report an event, perform corrective action in the peer review system, and report process improvements to the Minnesota Department of Health.

The lessons learned from the Legislature's establishment of the Adverse Health Event legislation affect this case in two ways. First, the Adverse Health Event legislation is further evidence of Minnesota's progressive, legislative desire to improve the quality of healthcare. Second, and perhaps most important with respect to the issue of negligent credentialing, the success of the Adverse Health Event legislation hinges on the ability of the hospital to perform its own evaluation of a patient care situation without the fear that an honest evaluation will then become the subject of future litigation. By eroding the integrity of the peer review process in credentialing, claims of negligent credentialing will also erode the success of the Adverse Health Event legislation as well as 30 years of similar innovative legislative action including the joint efforts of Amici and the Minnesota Department of Health.[8] It would be the first step in destroying the Legislature's plain intention to protect peer review and the peer review system.

Finally, these peer review issues have obviously been directed and shaped by repeated Legislative action. Thus, unlike the *Lake v. Wal-Mart* case relied on so heavily

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[8] Appellants also address the immunity provisions of the peer review statute. A finding of immunity would obviously address many of Amici's primary concerns. Appellants' Briefs have fully addressed this issue and we have nothing to add on this point.

by the trial court, the creation of a new cause of action here would not just simply be a matter of evolving *judicial* law, but would in a very real sense be a direct usurpation of authority committed to, and already affirmatively exercised by, the Legislature. There is to that extent a serious separation of powers problem lurking here, a problem the trial court never really came to grips with. The states that have rejected negligent credentialing claims have largely based their analysis on statutory constructs similar to Minnesota's, recognizing the court should not impede constitutionally-appropriate legislative action. *See Gafner v. Down East Community Hosp.,* 735 A.2d 969, 979 (Me. 1999): "Before the expansion of tort liability into an area that has been significantly controlled by the Legislature, we should allow the Legislature to address the policy considerations and determine whether imposing such a duty constitutes wise public policy."; *St. Luke's Episcopal Hosp. v. Agbor,* 952 S.W.2d 503, 509 (Tex. 1997) ("The legislature is free to set a course for Texas jurisprudence different from other states. Once the legislature announces its decision on policy matters, we are bound to follow it within constitutional bounds.").

The Minnesota Legislature has spoken, loudly and clearly – the confidentiality of peer review information is critical to Minnesota's healthcare system. A decision to recognize negligent credentialing would drastically undermine the Legislature's mandate on this issue and the Supreme Court's repeated recognition of the need to maintain the confidentiality of that information.

II. RECOGNIZING NEGLIGENT CREDENTIALING WOULD IMPOSE LIABILITY ON HOSPITALS FOR LICENSING DECISIONS MADE BY THE MINNESOTA BOARD OF MEDICAL PRACTICE.

If negligent credentialing were to be recognized as a viable cause of action, it would unfairly impose liability on a hospital for tasks the Legislature declared to be the function of the State government. In creating the Minnesota Board of Medical Practice, the Legislature specifically stated that it is the Board's "primary responsibility" to protect the public from the "unprofessional, improper, incompetent and unlawful practice of medicine." Minn. Stat. § 147.001.

In fulfilling its purposes, the Minnesota Board of Medical Practice regularly evaluates precisely the same issues that would be the subject of a negligent credentialing claim. Those issues include a physician's malpractice history (Minn. Stat. § 147.035), qualifications, improper licensure, criminal history, actions against the physician in other jurisdictions, unethical conduct, mental impairments or chemical abuse, unprofessional behavior, or even failing to repay a student loan. *See* Minn. Stat. § 147.091, subd. 1.[9] In making credentialing decisions, hospitals throughout this state regularly rely in part on the Board's ability to evaluate a physician's ability to practice medicine safely before credentialing that physician.

Certainly, the Minnesota Board of Medical Practice takes its role very seriously. In performing its duties, the Board regularly assembles and evaluates the same types of

[9] In the current fiscal year (July 1, 2005 – June 30, 2006), the Legislature allocated $3,729,000 to the Board of Medical Practice to perform the responsibilities and obligations set forth in Minn. Stat. §§ 147.001-147.36. H.F. 139 1st Engrossment, 2005; 1st Spec. Sess. §§ 440.12-440.34 (Minn. 2005).

information that would form the basis of Plaintiffs' proposed negligent credentialing case here (i.e. malpractice claims history, prior disciplinary actions, etc.). Because some of a hospital's credentialing analysis relies heavily on the Board's expertise, a negligent credentialing cause of action would ultimately impose legal liability on hospitals for licensing decisions by the Board of Medical Practice (whom the Legislature directed to evaluate these issues). Of course, the law does not allow patients to sue the Minnesota Board of Medical Practice for its decision to license a physician. Nonetheless, that is precisely the type of action the Plaintiffs now seek to pursue against hospitals. If allowed to go forward, hospitals would be forced to accept liability risks for having relied, in part, upon the Board of Medical Practice in evaluating a physician's ability to practice medicine.

If recognized, negligent credentialing claims would impose an elevated threshold upon hospitals beyond that imposed upon the Board of Medical Practice. Hospitals would be forced to do more than the very agency whose "primary responsibility and obligation" is to protect the public in connection with the granting and subsequent use of a medical license. *See* Minn. Stat. § 147.001. Certainly, such an obligation would impose undue and, frankly, unfair obligations on hospitals and prevent them from relying at all upon the expertise of the Board of Medical Practice. It also would demand unlimited resource allocations for the hospital to complete that task because the Medical Board's analysis simply would not be deemed sufficient.

In sum, it is entirely appropriate for hospitals to be able to rely upon the expertise of the Medical Board as the Board works to maintain the public health, safety and

welfare and to protect the public from the unprofessional, improper, incompetent and unlawful practice of medicine.

III. RECOGNIZING NEGLIGENT CREDENTIALING WOULD DRASTICALLY AND UNFAIRLY PREJUDICE HOSPITALS AND PHYSICIANS.

It is black-letter law that a plaintiff can prevail in a claim of medical malpractice only by establishing duty; breach of the standard of care; causation; and damage. *Plutshack v. University of Minnesota Hospital*, 316 N.W.2d 1, 5 (Minn. 1982). Thus, the liability aspects of a medical malpractice case focus on defining the standard of care, articulating whether the standard of care was breached by a particular physician or nurse, and whether that breach caused injury.

Because medical malpractice cases focus on the care of the patient at issue, tangential, irrelevant issues such as care provided to other patients is routinely held inadmissible, as events involving other patients are not probative on the question about whether the physician complied with the standard of care *in the case at issue.* Indeed, evidence of other lawsuits is generally not even discoverable, much less admissible. *Wood v. McCullough*, 45 F.R.D. 41 (S.D.N.Y. 1968).

Maryland's highest court correctly explained the significant prejudice that occurs when a jury in a medical malpractice case is tainted by information regarding other lawsuits. In *Lai v. Sagle*, 818 A.2d 237 (Md. App. 2003), the court reversed a jury verdict for the plaintiff, holding it was reversible, prejudicial error for the trial court to allow plaintiff's counsel to refer to prior suits against the defendant physician. *Id.* at 249. The court reached a similar conclusion with respect to the physician previously having

failed to become board certified. *Id.* at 246. The court held the prior suits had "little, if any, relevance to whether [the physician] violated the applicable standard of care in the immediate case," finding that evidence of prior suits does not aid the jury but "tends to excite its prejudice and mislead." *Id.* at 247.[10] The court acknowledged that it could not "conceive of a more damaging event in a medical malpractice trial" than disclosing prior suits. *Id.*

If negligent credentialing claims were recognized, the focus of medical malpractice litigation would drastically shift away from the relevant issues (whether the care of this patient complied with the standard of care) to the tangential and irrelevant. Here, for example, Plaintiffs focused primarily on a number of prior malpractice cases involving Dr. James Wasemiller (see Plaintiff's Memorandum in Support of Motions to Amend Complaint and Compel Discovery at pp. 7-8). Then, due to the prior claims, Plaintiffs turned their focus to Dr. Wasemiller's insurance history and discipline imposed by the Minnesota Board of Medical Practice. *Id.* at 9-11.

Plaintiffs even went so far as to try to support their negligent credentialing claim by offering evidence that the physician was behind in child support obligations and unpaid taxes. *Id.* at 11. Paying child support or taxes has nothing to do with whether the

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[10] The *Lai* Court cited at least six jurisdictions that recognized the fundamental principle that prior malpractice actions are neither relevant nor admissible. *See* 818 A.2d at 248. Additional courts from across the country have reached the same conclusion. *See Stottlemyer v. Ghram*, 597 S.E.2d 191, 194 (Virg. 2004); *McGarry v. Horlacher*, 775 N.E.2d 865, 872 (Ohio App. 2002); *Lund v. McEnerney*, 495 N.W.2d 730, 734 (Iowa 1993); *Delgaudio v. Rodriguera,* 654 A.2d 1007, 1010 (N.J. App. 1995); *McKee v. McNeir*, 151 S.W.2d 268, 270 (Tex. App. 2004); *Weil v. Seltzer*, 873 F.2d 1453, 1461 (D.C. Cir. 1989).

physician complied with the standard of care. Certainly, the evidence of Dr. Wasemiller's debts, other malpractice history or insurance has absolutely nothing to do with whether Mary Larson received medical services consistent with the standard of care.

Recognizing a negligent credentialing claim would drastically change medical malpractice litigation in this State because the focus would shift entirely from whether the physician complied with the standard of care, to collateral, wholly unrelated cases and irrelevant evidence. No longer would the jury limit its analysis on the standard of care to whether medical care was appropriate; but it also would need to consider whether the entirely unrelated lawsuits involving the physician were valid claims. The end result is obvious -- the plaintiff will have successfully smeared the physician in the eyes of the jury with evidence that is entirely irrelevant to whether the physician complied with the standard of care in connection with this particular patient.

In Dr. Wasemiller's case, the parties would need to turn the focus of the litigation away from the care provided to Ms. Larson; defendants would, in essence, be forced to retry ten other cases involving separate plaintiffs and separate procedures to determine whether it was appropriate for the hospital to have credentialed the physician in the first place.[11] The plainly inadmissible would suddenly and unfairly become the centerpiece to the litigation.

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[11] This would raise a plethora of additional issues: How would those ten other cases be retried without the consent of the patients involved in the original claims? How many experts would be necessary? Would the patients from the prior cases be forced to testify? Would malpractice insurance adjusters be forced to testify about why a case was settled?

The prejudice to hospitals would be at least as egregious, as plaintiffs would rely on public information from outside the peer review process (e.g. prior suits or tax liens), yet the hospital defending that case would be completely unable to defend its analysis about why the decision to credential the physician was proper. In other words, the hospital would be completely prejudiced and unable to fairly defend the claim because state law categorically prohibits the hospital from telling a jury *what it actually did in evaluating the public information in its private meetings about the physician's credentials.* *See* Minn. Stat. §§ 145.64, 145.66. With all due respect, the trial court's comment about a hospital defending the claim "with one hand tied behind its back" is a rank understatement. The hospital would be *unable to defend the claim at all* since it could not legally provide the jury with any of the information supporting its decision to credential the physician.

Simply stated, recognizing a negligent credentialing claim under Minnesota law would drastically, unfairly and prejudicially change the face of medical malpractice litigation in this state. The entirely irrelevant and highly prejudicial evidence about prior claims or a physician's personal life will unfairly become more important than the events regarding the actual care provided to a particular patient. Hospitals would be equally prejudiced because they are prohibited from responding to, or explaining why, they credentialed a physician despite information otherwise available in the public arena.

IV. CORPORATIONS ARE NOT LIABLE FOR THE ACTS OF INDEPENDENT CONTRACTORS.

Allowing a negligent credentialing claim also would drastically change the law in the state with respect to a corporation's responsibilities for individuals who are not employed by the organization. Of course, it is black-letter Minnesota law that under the doctrine of *respondeat superior*, an employer is vicariously liable for the torts of its employees committed in the course and scope of the employee's employment. *Fahrendorff v. North Home, Inc.*, 597 N.W.2d 905, 910 (Minn. 1999). As the Supreme Court has recognized, imposition of liability on an employer due to the acts of its employees is a matter of public policy, for the courts have determined that "liability for acts committed within the scope of employment should be allocated to the employer as a cost of engaging in that business." *Id. See also Schneider v. Buckman*, 433 N.W.2d 98, 101 (Minn. 1988). Lacking an employment relationship, one entity is not responsible for the acts or omissions of an unrelated entity. *See Pacific Fire Insurance v. Kenny Boiler & Manufacturing Co.*, 277 N.W. 226, 228 (Minn. 1937).

But Amici greatly fear that recognizing a negligent credentialing claim will impose liability on hospitals for the acts of physicians who are *not* employed by the hospital. This would drastically change the law in this state. Credentialed physicians are generally not employees of the hospital, but are independent contractors. Thus, hospitals would become *de facto* employers or excess insurers for physicians who lack sufficient malpractice insurance coverage. In virtually every situation involving a potentially