ORAL ARGUMENT – 11/05/03
02-0902 & 02-1101
GARLAND V. ROSE

JUNG: This court has said many times the language of a statute is the starting place for its interpretation. And often the ending place as well. We believe that the language of this statute affords the court many different opportunities to conclude that a cause of action for improper credentialing is a health care liability claim. We also believe that conclusion is reinforced by the traditional tests employed by Texas courts for healthcare liability claim, and by the policy of the statute.

First, we believe that such a claim is a cause of action against a healthcare provider for treatment. Now it is not disputed the hospital did not actually treat Ms. Rose. But it is also undisputed that Dr. Fowler did treat her. And so the question becomes, is the cause of action against the hospital a cause of action for Dr. Fowler's treatment?

The court's considering improper credentialing claims have analogized such claims to negligent entrustment or to negligent hiring. In the case of both of those causes of action, the misconduct, the acts or omissions of being trustee are part and parcel of the cause of action against the entrustor. And so a cause of action for improper credentialing is a cause of action for the hospital's credentialing, but it is also a cause of action for the improper treatment to which that credentialing allegedly led.

A cause of action encompasses duty, breach and causation. And so the _____ acts or omissions of which the hospital is accused are not themselves treatment, does not mean that the cause of action against the hospital is not a cause of action for treatment. And there's nothing in the statute that requires that the cause of action be for treatment by the same healthcare provider as is the defendant in that cause of action.

Second, we believe that this was a cause of action against a healthcare provider for a claimed departure from accepted standards of healthcare during the patient's medical care, treatment or confinement. Again, Dr. Fowler unquestionably treated Ms. Rose during her medical care treatment for confinement. And his negligence, his departure from accepted standards is part and parcel of the improper credentialing cause of action. The courts have held if the physician was not negligent, then there is no improper credentialing claim.

The only case that we have found from a jurisdiction whose statute includes this during the patient's care, treatment or hospitalization language comports with this analysis. And that's the Wynonna Memorial Hospital v. Kesler case, out of Indiana. There the court said a claim for negligent credentialing is a claim for two sets of negligence. For negligence on the part of the hospital in credentialing the physician and for the physician's negligence. And those cannot be separated. And so a cause of action for negligent credentialing is a cause of action for malpractice

occurring during the patients care, treatment or hospitalization.

Thirdly, we believe this is a cause of action against a healthcare provider for a claim to departure from healthcare standards by the hospital itself during the patient's care, treatment or hospitalization. We know that from looking at Rose's own allegations. Contrary to her brief in this court, in her petition she alleged not a series of discrete, prehospitalization events at which the hospital acted improperly. But a continuous process through which it acted improperly continuing up to the moment of surgery. We were accused of entrusting the operating room to an incompetent physician, of failing to prevent him from performing the surgery, acts and omissions that may have begun earlier but continued right up through treatment. Whether that's alleged by the plaintiff or not in a given case that is of the essence of the credentialing process. The credentialing process does not take place at discrete times. It is a continuous process involving supervision by department heads, involving mortality, morbidity conferences. That is a continuous process from the moment a physician is credentialed to the moment that he treats a patient.

JEFFERSON: Apart from the Indiana case, how many cases have been decided that hold, as you contend here , that this is a healthcare liability claim?

JUNG: There are six part from Indiana cases.

JEFFERSON: How many are Texas?

JUNG: None one way or the other. There are a couple of cases holding that pre-admission acts or omissions by hospitals give rise to a healthcare liability claim. There is a negligent hiring of a nurse case and one other.

We believe that the continuous nature of this process is analogous to the blood banking case out of a lower court in Virginia, Jappel v. Arlington Health Foundation. There the court realized that blood banking is a continuous process beginning with the collection of blood from a donor and ending with the transfusion of that blood into a patient. That the purpose of those earlier acts is to affect the later act. Here the temporal linkage under the statute is not to the acts or omissions of the healthcare provider, that's the way the CA analyzed this case, but rather to the departure from accepted standards. A departure from accepted standards is a concept of duty and breach of that duty. The hospital's duty to Ms. Rose arose when she was admitted and a hospital/patient relationship was formed.

The fulfillment of that duty may have depended on preadmission acts or omissions. Just as a manufacturer has a duty not to distribute a defective product, but to fulfill that duty needs to properly design the product and properly manufacture the product before it distributes. Nevertheless the duty triggering event is the distribution. The duty triggering event in this case is the hospital admission.

WAINWRIGHT: Does it concern you that the Texas Medical Practice Act precludes a hospital

from practicing medicine, and if so, how do you address that?

JUNG: I recognize that fact. I address it by saying that the statute has dual standards: one for medical care, which requires that it be done by a licensed physician; and one for healthcare. Hospitals do not provide medical care, but they very much do provide healthcare. To go further, they provide treatment. The nurses and technicians may actually treat a patient, but more broadly the hospital provides healthcare, not only in its treatment of the patient, but in its provision of a facility and staff in which the physicians can do their work.

The cases on direct hospital liability acknowledge a duty to have proper procedures, to have proper equipment, to provide a proper atmosphere where medical care by physicians can occur. And so when a hospital credentials a medical staff and then when it later provides that properly credentialed medical staff to a patient, it is providing healthcare to that patient even though it does not actually render the medical services.

Finally, we believe that the cause of action fits as a cause of action against a healthcare provider for claims of departures from accepted standards of safety. This court in Diversicare v. Rubio will be exploring exactly what that term "safety" means; whether it is limited to standards of safety within the healthcare industry standards of safety to require expert proof. But in any event that term includes no durational language similar to the other two terms. Now what the CA did was transplant the durational language from the statutorily defined terms into the undefined terms. And in doing that it violated the statutory mandate, which this court acknowledged in Verizon v. Ald, that undefined terms in art. 4590i are to be construed according to the common law, and by implication not according to the definitions of others terms. So safety, whatever its scope may be, does not include a durational element. We believe the CA erred in including one.

Let me touch on the standard traditional tests employed by Texas courts for a healthcare liability claim. And there are essentially three. They overlap and are not completely distinguishable. Does it involve a healthcare standard of care? It's undisputed in this case that improper credentialing does involve such a standard of care. Does it require expert testimony? It's undisputed in this case that the cause of action will require expert testimony. Is it an inseparable part of the rendition of healthcare services? The fact of the matter is, physicians cannot practice in a hospital setting without being credentialed. Conversely, hospitals cannot function without credentialed physicians. So if healthcare, medical care is to occur in a hospital setting, there must be credentialing. And not only is credentialing a but for prerequisite to the provision of healthcare, there is an essential linkage between the two. The purpose of credentialing, its entire function, its essence is to ensure quality patient care by ensuring that only competent physicians provide that care.

The patient care provided by the physician is where the rubber meets the road of the credentialing that took place earlier. And so we believe that the two are inseparably linked. That indeed is the rationale of many of the 7 cases from other states cited in our reply brief, which reasoned that the provision of healthcare by licensed physicians, credentialed physicians, simply cannot be decoupled from the hospital's decision to credential those physicians in the first place.

And so for those reasons, as well as the policy reasons of the statute with which the court is well familiar to reduce the frequency and severity of healthcare liability claims, we believe that this claims fell squarely within the statute and that the CA erred in holding otherwise.

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RESPONDENT

ENGLISH: J. Phillips in his dissent in Agbor, I believe first articulated a request that with regard to negligent credentialing claims there be some clarification from the Texas legislature. Because it was very clear that the way that Medical Liability Insurance Improvement Act (MLIIA) was written, that it was supposed to be limited only to healthcare liability claims. And so there's this inherent question over whether what we would think of as mixed questions of medicine and risk analysis, or medicine and business aspects - running a hospital, like credentialing can properly be held to be under the ambit of the Medical Liability Insurance Improvement Act.

PHILLIPS: But on this one instance, the legislature hasn't clarified.

ENGLISH: They have not clarified it as you requested. Now 8 years later. However, as you all are familiar, there have been a thing called H.B. 4. The hospital is very proud of HB 4 I think when the language was introduced, and in fact they filed a supplement petition for review based upon the language of HB 4. Because I believe that the hospital thought that by amending the definitions of what was covered by HB 4 to include the words "professional" or "administrative services", I believe that the hospital thought that HB 4 would be clarified to legislate around the Rose v. Garland Hospital case. To finally clarify that what they considered to be professional or administrative services ie credentialing services would indisputably and finally be covered by the medical practice act.

However, if this court is to give credence to the legislative intent of this bill, I would like to point to the conference committee report on HB 4 adopted, which was published on June 1, 2003 in the Senate Journal. I believe this will be an exhibit to an amicus brief. In the joint committee report, Senator Hinojosa was making a request of Senator Ratliff, the proponent of HB 4, and asked him: on page 46, at lines 8-13, there is a definition of professional or administrative services. Are claims involving those services automatically made healthcare liability claims? What about hiring convicted felon or extending privileges to a drug addicted physician, or having a hazardous condition on your premises? And Senator Ratliff replied. No. Those aren't made healthcare liability claims. Because if you look at the definition of healthcare, and healthcare liability claims, the services must relate directly to the treatment of a particular patient. And none of the examples it gives would qualify.

I believe that what this means is that HB 4 has been clarified to comport with definitions that did not change from the surviving 4590i statute, particularly the definition of healthcare liability claim. And I believe that what Sen. Ratliff presumably, a senator who would be the most knowledgeable about how all encompassing this statute was intended to be, was specifically

made in the legislative intent, published in the Senate Journal, to not include nonmedical decision making such as negligent credentialing, or extending privileges to. In this case drug addicted physician. And in the case of our doctor, a physician who had 17 claims against him over a period of 4-5 years, who was an ear, nose and throat specialist, performing what he called cosmetic surgery, but what was really plastic surgery, which he should never have been allowed to perform in a hospital setting.

PHILLIPS: Under the misguided decision in Agbor you're still going to have to show malice against this hospital to recover.

ENGLISH: And those are the sort of facts I'm telling you about that I think we can show with.

PHILLIPS: Aren't you going to - even if not as a legal matter, as a practical matter of proof need an expert witness to say 17 claims in 5 years is way over - you know from reading some of the press you might think the doctors got a malpractice claim against him every week or something. Don't you need somebody with expert knowledge to put this in context anyway before you're ever going to have any chance of making this case?

ENGLISH: Yes. And I think Mills tells us we have to.

PHILLIPS: So what's the problem with lining that up and just complying with 4590i at the outset?

ENGLISH: First of all, I would note that we did that. We had an expert who ultimately, I believe, rendered an opinion that comports with the good faith requirement outlined by this court in Palacios.(?) But also ultimately the question then becomes, I believe, can an expert at all within the first 90 or 180 days of a lawsuit with presumably very, very little discovery done at that point, ever reach a professional opinion that there is - I mean would this then mean that the expert report must outline that the conduct of the hospital was malicious in order to comply with both 4590i and the Texas Medical Practice Act? And is that ever going to be as a practical purpose possible from a litigant standpoint when he's got a lawsuit that is 90 or even 180 days old when presumably the depositions have not been taken, full discovery has not even been engaged in. The Texas Medical Practice Act is already out there to establish the bar that a negligent credentialing claim needs to get over. If we add the 4590i requirements, which are now the ch. 74 requirements, I think that a practical result will be that courts will find that these reports must include an expert opinion about malice and that that will practically do primarily to practical and procedural hurdle right this cause of action out because it will never be able to be made. And I don't think that that's what the courts have intended. And I don't think that that's what the legislature has intended.

WAINWRIGHT: You acknowledge that expert testimony is required for a negligent credentialing claim.

ENGLISH: Mills tells us we have to have an expert.

WAINWRIGHT: Is that expert opinion a medical opinion or some other expert opinion?

ENGLISH: I think that that's the key to the difference between what is truly I believe should be governed by the MLIIA, which is true medical decision making, and what is governed by something else. Because I would in this case not choose a doctor, but rather choose a hospital administrator, a hospital risk manager, or even perhaps even an insurance expert. Because the kind of decision that will be made in that credentialing committee, and in the ombudsman process that Mr. Jung has alluded to, is not a medical decision. It is, is the doctor exercising good judgment? is the doctor a drunk? does the doctor have claim's history? And those are not medical decisions.

WAINWRIGHT: What if there are claims pending against say a physician who seeks to be credentialed at a hospital and there's been no resolution of those claims. They are just claims of medical negligence. Let's say there are 17 for example. No resolution. No determination. No settlement. No admissions either way. And the hospital is considering credentialing that physician. Is medical judgment required or not?

ENGLISH: I would still in that position put up as my expert a risk manager. Because I would say what did the hospital do to ensure that this doctor was exercising proper medical judgment. But I think that there would have to be investigation that is risk management oriented rather than medical oriented, because I think that we would want to know are there other factors about this doctor that makes him a risk.

O'NEILL: So you're focusing on the quality of the review itself: what the credentialing committee is reviewing. And in doing that are you rejecting this temporal element that the CA put forth, because you would have to admit that's problematic?

ENGLISH: The CA I think was - and I disagree with the petitioner in that that was the sole focus of their analysis. I merely think that they were trying to articulate or articulating the fact that these decisions are made and they said at a different time. And I would say at a different time, and in a different place, and using a different decision making criteria.

O'NEILL: But time and place don't matter so much based on the argument that you're making. In other words, the dividing line should be the quality or what is being accessed as opposed to when or where it's being accessed.

ENGLISH: And temporal analysis is part of that. I guess the point that I'm trying to make is these are decisions that are made in boardrooms and in insurance offices and in administrator's offices, and on ombudsman committees, and not at the bedside in the emergency room and the operating room.

O'NEILL: Now why would that matter? Let's say it's a conference to approve of doctors or hospital administrators watching over to look at an x-ray and make a joint determination. Now where that takes place or when temporally it takes place doesn't matter so much as the essence of what they are doing.

ENGLISH: And I agree with you. I think it's the essence of what they are doing which is that they are making a risk analysis based upon the kind of issues that risk management folks...

O'NEILL: And isn't that risk analysis different depending upon the nature of the injury. So for example if you have a serial rapist who is given credentials at a hospital, who then rapes a patient, that would be a more clear demarcation of what would not be perhaps healthcare liability. Whereas if they are assessing the doctor's medical abilities, that would tend more towards the healthcare.

ENGLISH: I agree. There are going to be a spectrum of decisions that some will as you know weigh more in on the medical decision making process. I would urge more often and certainly in Dr. Fowler's case, more often these decisions are on the other end of the spectrum in that the doctor is using bad judgment in failing to obtain medical liability insurance, failing to file his reports on time, failing to do the sorts of things that are different from medical decisions.

O'NEILL: But to the extent credentialing depends upon assessment of the quality of care provided, you would agree that it is a more of a healthcare liability claim?

ENGLISH: I agree in that it requires more analysis of medical decision making. However, again, it is a review process, an administrative process. It is one doctor saying is the other doctor exercising sound medical decision making for the patient? It's not the doctor rendering treatment to the patient. It's a review process, an administrative process, and even though the criteria and the judgment used are more in that case akin to medical decision making for the original patient, I would assert to you that it's still one step back and therefore is an administrative process, an analysis process that's different from rendering treatment and care to the patient.

OWEN: But again our confines seems to me is the language of the statute. And I'm looking at what you allege. You said at least 5 different times that the hospital was grossly negligent because the doctor was reckless and careless and constituted a threat to the safety of his patients and the hospital knew it or should have known it. And then you go and look at the definition of expert report, and it seems to me that that definition captures what you're alleging essentially. But you're going to have to have an expert report within that definition of expert report to prove the allegations you've made.

ENGLISH: I think that Mills tells us we have to have expert testimony to get to the jury. And I know that we would have to have expert testimony. Whether or not it has to be in a report 90 days from the filing of the lawsuit is the core issue. Ultimately after discovery and when we get ready to go to trial, we're going to have to disclose that there is an expert opinion, and we're going to have

to disclose that there is evidence of that, and the bases of it.

OWEN: Again, going back to the statute. It seems to me like you're claiming that there was a departure from accepted standards of healthcare.

ENGLISH: It depends on whether or not you're talking about - No. Yes and no. To me a standard of healthcare involves medical decision making. Was the procedure done correctly? Did the personnel perform the procedure correctly? Were the proper...

OWEN: What about safety? I mean isn't an aspect of accepted standards of safety if a physician was reckless and careless and constituted a threat to the safety of his patients, which is alleged.

ENGLISH: Again, to me the safety that we're talking about in this particular language - I mean it could be interpreted extremely broadly. If the court wanted to consider that the safety of doctors driving in the parking lot was an element of safety, then the court could conclude a car accident that happened in the hospital parking lot is a violation of the MLIIA, that required an expert report declaring that the doctor violated a rule of safety. I would urge a more restricted definition that focuses the kind of safety we're talking about on safety related medical decision making: were the bed rails up?

OWEN: That's what I thought you were saying that he's not safe because he's careless and he constitutes a threat to the medical decision making. Isn't that what you're alleging?

ENGLISH: That and so much more with regard to this particular physician. And again with regard to lots of positions that you could think of. There are the physicians whose safety record is indeed part and parcel and intimately intertwined with their medical decision making. But then there are also the physicians that you don't want in the operating room because they are serial rapist, or because they have an _____lepsy. Or because they are alcoholics. For any other number of reasons that perhaps don't deal with the physician's medical decision making. And I think that this physician in particular is just such an example whose medical decision making will be called into question, but also whose judgment in general will be called into question, and the hospital's knowledge of that will be part and parcel with our negligent credentialing claim.

O'NEILL: But in order to be able to practice medicine at a hospital a doctor has got to go through this process to prove that they are qualified to treat. And why it's not the decision whether a doctor is qualified to treat an inseparable part of that analysis?

ENGLISH: I would urge that particularly the pre-credentialing claims, but also with - in order to get credentials the first time, you do have to show that your licensed and that you are qualified. I agree that that is part of the application process. But it's not all. You also have to show that in most hospitals that you carry medical liability insurance, that you have a relatively free claim's history, that in order to do the procedures that you are attempting to do in the hospital, that

you have obtained the proper education, and that you have the proper continuing medical education credentials. For example, Dr. Fowler an ear, nose and throat specialist performing plastic surgery when our expert says that it's malice to even allow a person who is an ear, nose and throat surgeon to hold themselves out as a cosmetic surgeon.

I think that your analysis is right on that part of it has to do with a question or a judgment about the ___ medical decision making. But so much more of it has to do with risk assessment, and types of issues which don't have anything to do with treatment rendered to a particular patient, whether it's Debi Rose or any other patient.

WAINWRIGHT: Where would you draw the line in 4590i cases? You started out by saying that this case involves a mixed question of administrative and medical judgment. Where along that continuum do you draw the line such that it can be replicated with predictability in Texas consistent with the language of the statute of course?

ENGLISH: I think that an aspect of the CA's temporal analysis ought properly be a part of it, although not all of it. I think if you just ask the examiner what type of decision is being made? Is it a decision being made on behalf of the patient, or is it an administrative decision that's being made in review secondary based on other factors.

WAINWRIGHT: You've acknowledged that these decisions involve some of both. How much medical judgment is required before it's subject to 4590i, or how little medical judgment is required before it does not involve 4590i? Where would you draw that line?

ENGLISH: I would think that some direct interaction with the patient has to be a part or an element of the criteria.

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REBUTTAL

JUNG: They call it peer review for a reason. The reason is the credentialing decision for a doctor is made by that doctor's peers. It is not made in the boardroom of the hospital, or by the parent corporation, or by an administrator. It is made by doctors. Those doctors make that decision by evaluating the physician's credentials and determining whether in their medical judgment he poses an unacceptable risk to the welfare of the future patients that he will treat.

PHILLIPS: So you reject that there is any kind of continuum, and hiring a serial murder would be the type of decision that would not require an expert affidavit?

JUNG: Because the decision is a medical decision made by doctors under a healthcare standard of care, I would say that's right. I think that's a pretty easy medical decision to make under those circumstances.

WAINWRIGHT: What if they credentialed a doctor or someone who purported to be a doctor who had never been to medical school? Would you still disagree with the chief and say that that's still a medical judgment?

JUNG: It is still a medical judgment just as it's a medical judgment to take out the wrong kidney. But just as there are classes of medical malpractice cases that do not require expert testimony because they are within the can of a lay jury, this might well be a situation that a lay juror could say there was improper credentialing going on here, because I know enough as a lay person to know that.

WAINWRIGHT: So all credentialing decisions right, wrong, neutral are medical judgments under 4590i?

JUNG: They are still medical judgments. They may not require expert testimony to prove them in the most obvious cases.

WAINWRIGHT: But an expert report would be required in your opinion.

JUNG: Under the terms of the statute that's right. I don't think this court has faced a 4590i case against a physician for let's say taking out the wrong kidney where expert testimony was not going to be required at trial and addressed whether nevertheless under 13.01 an expert report is required. I think it would be a reasonable construction to say if you're not going to need expert testimony at trial, then you don't need an expert report pre-trial. But this court has never addressed that question.

PHILLIPS: So in this case if you think we could say as a matter of law that the hiring of the physician was malicious, then we could dispense with the expert?

JUNG: I can see that possibility. I'm not sure how the court ought to come out on whether 13.01 requires a report, whether or not expert testimony is going to be required at trial. Here I think we know both by the respondent's concession and by the facts of the case, that the judgment to credential Dr. Fowler was a medical judgment. The question was, did he have the skills that he needed to do the kind of things that he was doing? Did his track record show in the judgment of physicians that he was likely to commit improper acts in the future? All of those were clearly, even if you want to say that there is a spectrum, those were clearly on the medical part of the spectrum and not the taking out of a wrong kidney part of the spectrum. So that decision was indeed a healthcare decision made by the physician.

There is no requirement that treatment or healthcare require a direct interaction with the patient. If there were no radiologist would ever be liable.

O'NEILL: Did the CA did not address the _____ of the affidavit under 4590i, because it held that it wasn't a healthcare liability claim. And the plaintiff has alleged that their affidavit is

sufficient to stay the case under 4590i if that's what the court's decision is. Do you claim that the affidavit is defective because the failure to address malice is that the reason you say it's defective? Does it in fact address malice?

JUNG: It does not address malice.

O'NEILL: Is that why you claim it's defective?

O'NEILL: Yes. In part. And it does not reflect a deviation from the standard of care by the hospital. It's devoted to the proposition that Dr. Fowler is an incompetent physician. That is not the standard of care for a credentialing committee. The credentialing committee is supposed to do whatever investigation of the standard of care requires to determine whether someone is an incompetent physician. There is no expression of an expert opinion about whether they did or didn't do the things the credentialing committee is supposed to do.