

2015

# HEALTH LAW—BAND-AID JURISPRUDENCE: WHY THE RECOGNITION OF NEGLIGENT CREDENTIALING THREATENS PATIENT CARE IN MASSACHUSETTS

Kyle Deskus

*Western New England University School of Law*

Follow this and additional works at: <http://digitalcommons.law.wne.edu/lawreview>

---

### Recommended Citation

Kyle Deskus, *HEALTH LAW—BAND-AID JURISPRUDENCE: WHY THE RECOGNITION OF NEGLIGENT CREDENTIALING THREATENS PATIENT CARE IN MASSACHUSETTS*, 37 W. New Eng. L. Rev. 27 (2015), <http://digitalcommons.law.wne.edu/lawreview/vol37/iss1/2>

This Note is brought to you for free and open access by the Law Review & Student Publications at Digital Commons @ Western New England University School of Law. It has been accepted for inclusion in Western New England Law Review by an authorized administrator of Digital Commons @ Western New England University School of Law. For more information, please contact [pnewcombe@law.wne.edu](mailto:pnewcombe@law.wne.edu).

## NOTES

### HEALTH LAW—BAND-AID JURISPRUDENCE: WHY THE RECOGNITION OF NEGLIGENT CREDENTIALING THREATENS PATIENT CARE IN MASSACHUSETTS

#### INTRODUCTION

I swear by Apollo the physician . . . and all the gods and goddesses as my witnesses, that, . . . [i]n purity and according to divine law will I carry out my life and my art.<sup>1</sup>

For centuries, physicians have sworn to uphold the duties espoused by the Hippocratic Oath, pledging to follow a scheme of practice that ensures superior care for patients.<sup>2</sup> These duties have traditionally been the cornerstone of the medical field, providing guidelines for physicians to adhere to and ensuring the provision of adequate care to patients.<sup>3</sup> In modern times, standards such as those promulgated by the Oath are enforced through an extensive framework of hospital bylaws, regulations, and statutory law.<sup>4</sup> Medical peer review committees, comprised of staff physicians and nurses, play an integral role in maintaining these standards by reviewing health care decisions and making privileged and disciplinary recommendations at a health care facility.<sup>5</sup> Nearly every jurisdiction enforces laws that protect the participants of these peer review committees from civil liability to some degree.<sup>6</sup>

While simultaneously enforcing these protections, many states per-

---

1. *The Hippocratic Oath*, NAT'L LIB. OF MED., [http://www.nlm.nih.gov/hmd/greek/greek\\_oath.html](http://www.nlm.nih.gov/hmd/greek/greek_oath.html) (last updated Feb. 7, 2012).

2. *Id.*

3. See Rodney H. Lawson et al., *Credentialing and Peer Review of Health Care Providers: The Process and Protections*, A.L.I 1, 2 (2012) (discussing how peer review has been an ongoing part of medical care for hundreds of years).

4. See *infra* Part I.A-B.

5. Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 179 (1988).

6. See, e.g., Carr v. Howard, 689 N.E.2d 1304, 1307 (Mass. 1998) (citing Creech, *supra* note 5, at 179); Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 28-30 (1999) (comparing the strength of each state's peer review statutes to one another). Nearly every state has some form of a peer review statute on the books. Lawson, *supra* note 3, at 11 (stating that “at least 48 states have adopted peer review statutes, most of which grant immunity to peer review participants.”); Scheutzow, *supra*, at 28.

mit the tort of negligent credentialing, which allows for an injured patient to bring suit against a health care provider for negligently granting or renewing staff privileges to an incompetent physician.<sup>7</sup> The tort was first recognized as a plausible theory of recovery in Massachusetts in the Superior Court cases *Rabelo v. Nasif* and *DeJesus v. Milford Reg'l Med. Ctr., Inc.*<sup>8</sup> In both cases, however, the court only acknowledged the doctrine for the purposes of determining whether the bifurcation<sup>9</sup> of negligent credentialing claims from the overall medical malpractice action was proper.<sup>10</sup> Despite only a cursory examination into the plausibility of an independent action for negligent credentialing, these two decisions recognized that health care facilities could be found liable for granting staff privileges to incompetent physicians through negligent peer review.<sup>11</sup> Since these decisions, there has been an unsettling silence in Massachusetts concerning this tort and how it comports with the laws and procedures of the Commonwealth.

Consequently, legislative action is required to either properly incorporate the tort under Massachusetts law or bar it completely. The tort is subject to the many peculiarities of the medical field, such as a highly trained workforce and extensive regulatory and statutory guidelines.<sup>12</sup> In both *Rabelo* and *DeJesus*, the courts failed to consider these peculiarities in determining the appropriateness of the tort in Massachusetts.<sup>13</sup> A legislative solution would evaluate the various substantive considerations as well as the broader policy implications of negligent credentialing.<sup>14</sup> Until then, the recognition of the tort without further guidance will continue

---

7. See *Larson v. Wasemiller*, 738 N.W.2d 300, 302-03 (Minn. 2007) (hearing action for “negligent credentialing” where the plaintiffs alleged that the defendant health care facility was negligent in granting staff privileges to a malfeasant physician).

8. *Rabelo v. Nasif*, 30 Mass. L. Rptr. 547, 547 (Super. Ct. 2012); *DeJesus v. Milford Reg'l Med. Ctr., Inc.*, 30 Mass. L. Rptr. 653, 653 (Super. Ct. 2012).

9. Bifurcation is the procedure for the separation of a single action into multiple trials “in furtherance of convenience or to avoid prejudice, or when separate trials will be conducive to expedition and economy.” MASS. R. CIV. P. 42.

10. *Rabelo*, 30 Mass. L. Rptr. at 548-51; *DeJesus*, 30 Mass. L. Rptr. at 654.

11. *Rabelo*, 30 Mass. L. Rptr. at 548-51; *DeJesus*, 30 Mass. L. Rptr. at 654. This limited analysis can be attributed to both courts only discussing the merits of the tort under the extremely deferential test for bifurcation under Rule 42 of Massachusetts Civil Procedure. See MASS. R. CIV. P. 42. The rule allows bifurcation to be left entirely to the discretion of the trial judge, and is proper in the interests of economy, convenience, and avoiding prejudice. *Id.* Individual peer review participants are protected from civil liability as long as they act in good faith. MASS. GEN. LAWS ch. 231, § 85N (2012).

12. 243 MASS. CODE REGS. 3.01 (2012); Lawson, *supra* note 3, at 1-2.

13. See *Rabelo*, 30 Mass. L. Rptr. at 547-49; *DeJesus*, 30 Mass. L. Rptr. at 653-54.

14. See *infra* Part IV.

to confuse all parties involved in medical malpractice litigation.<sup>15</sup>

This Note argues that the rulings of the Massachusetts Superior Court were incorrect, and the ultimate decision to impose liability on health care facilities for negligent peer review should be left to the Massachusetts Legislature. Section I of this Note provides background of the peer review process, the doctrine of negligent credentialing, and its adoption in Massachusetts. Part I.A looks at the Health Care Quality Improvement Act and the history behind medical peer review. Part I.B discusses the basic organization of medical peer review committees. Part I.C explores the common pitfalls of medical peer review. Part I.D examines the basics of the tort of negligent credentialing as adopted in other jurisdictions. Part I.E analyzes the Massachusetts Superior Court cases of *Rabelo v. Nasif* and *DeJesus v. Milford Reg'l Med. Ctr. Inc.*

Section II of this Note illustrates that the Massachusetts Peer Review Statutes were intended to immunize hospital peer review committees from liability in medical malpractice actions. In particular, Part II.A shows how the Massachusetts Peer Review Statutes substantially burden the discovery process for both parties in a negligent credentialing action. Part II.B proves it was the intent of the Massachusetts Legislature to immunize medical peer review committees from malpractice litigation through the peer review statutes.

Section III demonstrates how the adoption of negligent credentialing would undermine the current regulatory scheme as well as existing hospital bylaws and procedures. Part III.A shows that the extensive regulatory scheme, promulgated by the Board of Registration in Medicine, would be compromised by the adoption of negligent credentialing. Part III.B argues that the current regulatory requirements for hospital risk assessment programs would be compromised by exposing the peer review process to litigation.

Finally, Section IV explores the negative effects of the adoption of negligent credentialing in Massachusetts. Part IV.A illustrates why the tort will reduce an already limited pool of healthcare professionals in Massachusetts. Part IV.B considers how the judicial system will be burdened by negligent credentialing actions that will be costly and likely unsuccessful.

---

15. See *Rabelo*, 30 Mass. L. Rptr. at 547-49; *DeJesus*, 30 Mass. L. Rptr. at 653-54 (failing to properly examine the procedural and policy ramifications of negligent credentialing).

## I. NEGLIGENT CREDENTIALING AND THE TORT'S ADOPTION IN MASSACHUSETTS

To understand negligent credentialing, it is necessary to examine the medical peer review process. Peer review has been a part of the medical community for hundreds of years and is an integral part of the health care system.<sup>16</sup> Understanding the basics of medical peer review is especially important because Massachusetts substantially regulates the peer review process and has enacted statutes protecting its participants.<sup>17</sup> This scheme furthers the Legislature's intent to ensure the highest quality of health care is administered to patients.<sup>18</sup> Once this framework is explained, it will become apparent that exposing the medical peer review process to the whims of the courtroom will only serve to undermine the fundamental purpose for the creation of the system.

### A. *The History and Organization of the Medical Peer Review Process*

The tradition of peer review has long been regarded as an effective approach to improve the overall quality of work performed in the medical field.<sup>19</sup> The process began to take hold in the United States as high demand for hospital care drastically increased the number of health care facilities in the late nineteenth and early twentieth centuries.<sup>20</sup> In an effort to bring standardization to the quality of care being rendered in the wake of this influx, the American College of Surgeons (ACS) was organized with the purpose of establishing minimum levels of safety and quality for the health care field.<sup>21</sup> The ACS created the Hospital Standardization Program, which encouraged health care facilities to enact by-laws and procedures to maintain adequate levels of care.<sup>22</sup> These pro-

---

16. Lawson, *supra* note 3, at 1.

17. MASS. GEN. LAWS ch. 111, § 203(c) (2012); MASS. GEN. LAWS ch. 111, § 204(a-e) (2012); *see* 243 MASS. CODE REGS. 3.02-3.14 (2012) (dictating the procedures for medical peer review and reporting requirements to the Board of Registration in Medicine).

18. The Massachusetts Supreme Judicial Court explained this purpose, stating that: Strong public policy mandates the highest quality of care in our health care facilities. That public policy finds voice in, among others, a strict regulatory scheme covering virtually all aspects of hospital operations. Integral to this regulatory scheme is an effective process for self-scrutiny, manifest most prominently in the medical peer review process.

Vranos v. Franklin Med. Ctr., 862 N.E.2d 11, 16 (Mass. 2007).

19. Murray G. Sagsveen & Jennifer L. Thompson, *The Evolution of Medical Peer Review in North Dakota*, 73 N.D.L. REV. 477, 477 (1997).

20. Craig W. Dallan, *Understanding Judicial Review of Hospital's Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 601 (2001).

21. *Id.*

22. *Id.* at 602.

grams imposed prerequisites to joining the medical staff at a hospital, such as being a licensed and competent physician.<sup>23</sup> Hospitals widely adopted these standards to benefit from having quality physicians working in their facilities.<sup>24</sup> The modern iteration of the ACS, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), provides further advantages to health care providers, including eligibility for state licensing and payments through Medicare.<sup>25</sup>

While voluntary adherence to the standards proffered by these health care groups was widely prevalent in the industry, the adoption of the Health Care Quality Improvement Act of 1986 (HCQIA) mandated professional peer review in order to quash a perceived medical malpractice epidemic in the country.<sup>26</sup> Although the statute requires the utilization of medical peer review, it only serves to impose basic immunities for peer review participants and requirements for the reporting of professional review actions by a health care facility.<sup>27</sup> Furthermore, it expressly states that:

Nothing in this chapter shall be construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal or State law to seek redress for any harm or injury suffered as a result of negligent treatment . . . by any . . . health care entity.<sup>28</sup>

Consequently, the HCQIA does not take a stance concerning negligent credentialing.<sup>29</sup> Even so, the statute and its related regulatory scheme required states to report information relevant to physician credentialing to the National Practitioner Database.<sup>30</sup> This database, run by the Federal Department of Health and Human Services, compiles this information and primarily disperses it upon request to health care facilities for review purposes.<sup>31</sup> Health care facilities must request information from the database anytime a physician seeks staff privileges at their fa-

---

23. *Id.* at 603.

24. *Id.*

25. *Id.*

26. 42 U.S.C. § 11101-11152 (2006); Sagsveen, *supra* note 19, at 479.

27. 42 U.S.C. §§ 11111(a)(1)(D), 11133(a)(1) (2006). The HCQIA uses the umbrella term “Board of Medical Examiners” to represent “a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians”. *Id.* § 11151(2). The information reported to the Board of Medical Examiners must also be reported to the appropriate state licensing boards that are ultimately responsible for the licensing of physicians. *Id.* §§ 11134(c)(2), 11151(14).

28. *Id.* at § 11115(d).

29. *Id.*

30. *Id.* § 11135(a); 45 C.F.R. §§ 60.01-60.16 (2013).

31. *About Us: Background*, NATIONAL PRACTITIONER DATA BANK, <http://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp> (last visited Mar. 11, 2015).

cility.<sup>32</sup>

Massachusetts has also imposed its own reporting requirements on health care facilities.<sup>33</sup> In particular, Massachusetts has enacted an extensive regulatory scheme governing the peer review and reporting process at health care facilities.<sup>34</sup> In order to maintain a level of quality care, the Massachusetts Board of Registration in Medicine requires that health care facilities establish Qualified Patient Care Assessment Programs that govern incident reporting and risk management.<sup>35</sup> These programs dictate “a health care facility’s rules, standards, and procedures, adopted pursuant to the facility’s bylaws” with the purposes of “establish[ing] effective programs in quality assurance, risk management, peer review, identification, and prevention of substandard practice, and maximization of patient care assessment and thus minimization of loss.”<sup>36</sup> Licensed practitioners “may not accept . . . privileges at a health care facility unless it has a Qualified Patient Care Assessment Program.”<sup>37</sup> Consequently, the privileging process cannot be effectuated without such a program in place.<sup>38</sup> The regulations require that health care facilities ensure that a physician seeking staff privileges is licensed and competent to provide satisfactory patient care.<sup>39</sup> Ideally, only after successfully surviving the vetting process will a peer review committee agree to credential a physician.<sup>40</sup>

#### B. *The Basics of Medical Peer Review*

Medical peer review committees are comprised of licensed providers who are part of a health care facility’s staff.<sup>41</sup> The committee may

---

32. 45 C.F.R. § 60.17 (2013).

33. MASS. GEN. LAWS ch. 112, § 2 (2012) (requiring that the Board of Registration in Medicine “shall participate in any national data reporting system which provides information on individual physicians.”); MASS. GEN. LAWS ch. 111, § 203(a) (2012) (requiring that medical facility by laws contain privileges for reporting).

34. See 243 MASS. CODE REGS. 3.02-3.14 (2012).

35. 243 MASS. CODE REGS. 3.03(1). The Board of Registration in Medicine is a government entity charged with overseeing medical reporting, information gathering, and disciplinary action in the health care industry. *Id.* at § 3.02.

36. Alan H. Einhorn & Lawrence B. Litwak, *Organization, Operation, and Governance of Hospitals*, 1 MASS. HEALTH AND HOSPITAL LAW MANUAL § 4.13(d) (2011).

37. 243 MASS. CODE REGS. 3.03(3).

38. *Id.*

39. 243 MASS. CODE REGS. 3.05(3)(a-d).

40. Lawson et al., *supra* note 3, at 9. But see Charles R. Koepke, *Physician Peer Review Immunity: Time to Euthanize A Fatally Flawed Policy*, 22 J.L. & HEALTH 1, 11 (2009) (stating that physicians participating in the peer review process may act in bad faith and abuse the system to forward their own ulterior motives).

41. 243 MASS. CODE REGS. 3.02 (defining medical peer review committees as “a com-

consist of a small group of designated individuals on staff depending on the hospital's bylaws.<sup>42</sup> Their protocol for conducting peer review is based on the health care facility's Qualified Patient Care Assessment Program.<sup>43</sup> The individuals who may comprise the committee include the hospital's chief of staff, various medical directors, and the heads of various departments.<sup>44</sup> Massachusetts also requires that at least one member of the facility's governing body sit on every medical peer review committee.<sup>45</sup> Credentialing is performed according to established hospital procedure that examines a physician's background, qualifications, and competency.<sup>46</sup> If a physician successfully satisfies the requirements of the credentialing process, the peer review committee will make the decision whether to grant staff privileges.<sup>47</sup> While the governing board of the hospital holds the authority for final approval, it bases its decision on the recommendations of the committee and "readily defer[s] to the medical staff's recommendations."<sup>48</sup> Once granted privileges, a physician is able to use hospital facilities to benefit their practice.<sup>49</sup>

Typically, medical peer review committees are afforded various statutory protections.<sup>50</sup> Nearly all states have some form of a peer re-

---

mittee of a state or local professional society of health care providers or of a medical staff of a licensed hospital, nursing home, or other health care facility."); BROOKE S. MURPHY ET AL., *Medical Staff Issues*, AMERICAN HEALTH LAWYERS ASSOCIATION SEMINAR MATERIALS at pt. 1 (1998).

42. Dallon, *supra* note 20, at 609; see QUALITY IMPROVEMENT AND PEER REVIEW POLICY OF THE MEDICAL STAFF OF REGIONS HOSPITAL, 2 (June 22, 2011) available at [http://www.regionshospital.com/ucm/groups/public/@hp/@public/documents/documents/cntr\\_b\\_028158.pdf](http://www.regionshospital.com/ucm/groups/public/@hp/@public/documents/documents/cntr_b_028158.pdf) (providing an example of how hospital bylaws establish a peer review committee).

43. 243 MASS. CODE REGS. 3.02; Einhorn, *supra* note 36, § 4.13(e) (describing Qualified Patient Care Assessment Programs as required in 243 MASS. CODE REGS. 3.03(1)(a-e)).

44. Dallon, *supra* note 20, at 608-09 (2001). See QUALITY IMPROVEMENT, *supra* note 42, at 2.

45. 243 MASS. CODE REGS. 3.06(1)(a) (2012).

46. 243 MASS. CODE REGS. 3.05(1-3); MURPHY ET AL., *supra* note 41, at pt. 1. See 243 MASS. CODE REGS. 3.02 (defining hospital peer review committees as a group of "professional health care providers or of a medical staff of a licensed hospital . . . provided the medical staff operates pursuant to written by-laws").

47. MURPHY ET AL., *supra* note 41, at pt. 1; Dallon, *supra* note 20, at 610. Possessing staff privileges does not create an employment relationship with a health care facility. Dallon, *supra* note 20, at 604. Instead, privileges permit physicians to use and admit patients to hospital facilities and have a voice in the administration of care at the hospital. Dallon *supra* note 20 at 604-09. In exchange, a hospital is able to organize a staff of qualified medical practitioners to provide adequate care to patients. *Id.* at 601.

48. Dallon, *supra* note 20, at 610.

49. See generally *id.* at 604-09.

50. Scheutzwow, *supra* note 6, at 28-29.

view statute on the books, although they vary in detail and strength.<sup>51</sup> These protections offer some form of immunity to individuals and entities participating in the peer review process, such as protection from civil liability or being compelled to testify.<sup>52</sup> The intention of the statutes is to strengthen the peer review process and encourage participation by hospital staff, since peer review is viewed by many as an effective tool for improving patient care.<sup>53</sup>

### C. *The Pitfalls of Medical Peer Review*

While medical peer review is often promoted as a noble process that improves the quality of health care, it is not without problems. Physicians are often reluctant to participate in the peer review process for a variety of reasons.<sup>54</sup> One reason for such unwillingness is fear of becoming involved in litigation.<sup>55</sup> Participation on the committee means that a physician will be making critical decisions concerning the privileging of fellow colleagues.<sup>56</sup> The looming risk of defamation suits, discrimination actions, and malpractice actions is of great concern to peer review participants.<sup>57</sup> This is exacerbated by the possibility that a health care facility may attempt to disclose peer review materials and their intimate contents during litigation.<sup>58</sup> A member of a peer review committee would then be forced to bring an action to protect those documents from discovery in the litigation against the hospital.<sup>59</sup>

Another issue prevalent in the peer review process is the occurrence

---

51. *See id.* at 28-30.

52. *Id.* at 8.

53. *Id.* at 7-9. “[P]olicy-makers have widely accepted peer review of physicians as essential to encouraging high quality medical practice.” However, data “suggests that peer review protection statutes do not encourage peer review.” *Id.*

54. *See* Jeanne Darricades, *Medical Peer Review: How Is It Protected by the Health Care Quality Improvement Act of 1986?*, 18 J. CONTEMP. L. 263, 271 (1992) (stating that physicians possess trepidation about participating in peer review due to “the possibility of being named in a suit for illegal discrimination or an antitrust action because they have participated in an adverse peer review determination”).

55. *Id.*

56. 243 MASS. CODE REGS. 3.05(3) (2013) (stating the criteria under which peer review committees credential physicians); *see* Darricades, *supra* note 54, at 271 (stating that “[t]he consequences of an adverse finding in the medical peer review process may be very significant to the physician who is censured”).

57. Darricades, *supra* note 54, at 271.

58. *See* Ayash v. Dana-Farber Cancer Inst., 822 N.E.2d 667, 692 (Mass. 2005) (describing how a health care facility voluntarily provided privileged peer review materials to the defendant in litigation). *But see infra* Part II.A.

59. *See* Swatch v. Treat, 671 N.E.2d 1004, 1008 (Mass. App. Ct. 1996) (allowing a peer review organization to interfere in litigation for the purpose of protecting peer review materials).

of partiality.<sup>60</sup> Oftentimes physicians are granted staff privileges at a health care facility based not on their qualifications but through a political game of who they know.<sup>61</sup> When a physician on staff becomes incompetent, their privileges may be maintained purely because of their status at the hospital.<sup>62</sup> Oftentimes, physicians not privy to these social circles of power are inclined to keep silent about glaring issues at the hospital in order to stay on good terms.<sup>63</sup> Should a staff member speak out against the hospital's ruling circle, they may find themselves brought before the peer review committee to be disciplined without cause.<sup>64</sup> These examples of substandard peer review illustrate how the peer review process, often lauded as a noble calling, is rife with problems.

#### D. *The Tort of Negligent Credentialing*

With the increasing use of peer review in hospitals, negligent credentialing became a theory of recovery in some jurisdictions upon which patients could recover damages from a hospital for wrongfully granting or renewing staff privileges to an unfit physician.<sup>65</sup> Over thirty states have recognized negligent credentialing as an independent cause of action.<sup>66</sup> To prove negligent credentialing, “a plaintiff injured by the negligence of a staff doctor must show that but for the lack of care in the selection or retention of the doctor, the doctor would not have been granted staff privileges and the plaintiff would not have been injured.”<sup>67</sup> In order for a negligent credentialing claim to be brought, the plaintiff must suffer an actual injury in order to then allege that the hospital negligently gave staff privileges to the malfeasant physician.<sup>68</sup>

If no injury is proven, then any negligent credentialing allegation against the hospital lacks a causal connection to the plaintiff, even

---

60. Koepke, *supra* note 40, at 10. (stating that “physicians may manipulate the [peer review] process to achieve ulterior motives”).

61. *Id.*

62. *Id.*

63. Gail Garfinkel Weiss, *Is Peer Review Worth Saving?*, MED. ECON., Feb. 18, 2005, at 2 (2005), available at [http://www.peerreview.org/acrobat\\_files/ispeerreviewworthsaving.pdf](http://www.peerreview.org/acrobat_files/ispeerreviewworthsaving.pdf).

64. *Id.*

65. *Schelling v. Humphrey*, 916 N.E.2d 1029, 1033 (Ohio 2009). *Schelling* is the Ohio Supreme Judicial Court decision that the court in *DeJesus* used to set the standards of negligent credentialing in Massachusetts, although they referred to the case as “*Schilling v. Humphrey*.” *DeJesus v. Milford Reg’l Med. Ctr.*, 30 Mass. L. Rptr. 653, 654 (Super. Ct. Jan. 18, 2012).

66. *Rabelo v. Nasif*, 30 Mass. L. Rptr. 547 (Super. Ct. Feb. 18 2013).

67. *Schelling*, 916 N.E.2d at 1030.

68. *Id.*

though the plaintiff may have been provided health care by a poorly qualified physician.<sup>69</sup> Absent a negligent act, it cannot be said that the physician inflicted a harm upon the patient directly stemming from incompetence.<sup>70</sup> Because an initial case of medical malpractice must first be successfully litigated, separating negligent credentialing allegations from a malpractice action through bifurcation is often necessary to prevent prejudice and unnecessary litigation.<sup>71</sup> This promotes judicial economy by limiting litigation should the initial malpractice action be dismissed.<sup>72</sup> Furthermore, it ensures that the physician defending against claims of malpractice receives a fair trial and will not have to defend himself in the malpractice action for his past misdeeds.<sup>73</sup>

E. *The Recognition of Negligent Credentialing in Massachusetts*

The first of two Massachusetts Superior Court cases that recognized the tort of negligent credentialing was *DeJesus v. Milford Regional Medical Center*, in which the court concluded that the doctrine had merit under Massachusetts law.<sup>74</sup> In *DeJesus*, the plaintiff, Sidney DeJesus, was injured by Dr. Ronald Nasif during an alleged negligently-performed surgery.<sup>75</sup> DeJesus brought claims of medical malpractice against the physician and a claim of negligent credentialing against the Milford Regional Medical Center, alleging that the hospital's "credentialing committee was negligent in granting Nasif privileges to perform surgery."<sup>76</sup> Milford moved to bifurcate the negligent credentialing allegation and stay discovery until the underlying claims of medical malpractice were decided.<sup>77</sup>

---

69. See, e.g., *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 509 (Tex. 1997) (requiring proof of malice in the peer review process as a threshold standard to hold a hospital liable); *Kinney v. Barton*, 816 N.E.2d 1255 (Mass. App. Ct. 2004) (finding that an individual participant in a medical peer review committee held no duty for the malpractice committed by credentialed physician).

70. *DeJesus*, 30 Mass. L. Rptr. at 654 (requiring an actual injury be proven before litigating a claim for negligent credentialing).

71. *Schelling*, 916 N.E.2d at 1035-36. In *Schelling*, the Ohio Supreme Court explained that bifurcation would be beneficial because it "avoids the problems of jury confusion or prejudice . . . [and] also allows a negligent-credentialing claim against a hospital to be dismissed if the plaintiff does not prevail" in the initial malpractice action. *Id.* at 1037.

72. See *id.*

73. See *id.*

74. *DeJesus*, 30 Mass. L. Rptr. at 653.

75. *Id.* Dr. Nasif was also the allegedly negligent physician involved in *Rabelo v. Nasif*, the other Massachusetts case that also recognized negligent credentialing. 30 Mass. L. Rptr. 547, 547 (Super. Ct. Feb. 18, 2013).

76. *DeJesus*, 30 Mass. L. Rptr. at 653.

77. *Id.*

In *DeJesus*, negligent credentialing was an issue of first impression, so the court looked to the Ohio Supreme Court case of *Schelling v. Humphrey* for guidance.<sup>78</sup> The court followed the premise put forth in *Schelling* that separating allegations of negligent credentialing from the underlying medical malpractice action is proper because it “avoids the problems of jury confusion or prejudice that may result from admitting evidence of prior acts of malpractice in a combined trial on both claims.”<sup>79</sup> An actual negligent injury by Dr. Nasif was required in order to establish the chain of causation between the harm done and the granting of staff privileges by Milford’s peer review committee.<sup>80</sup> Consequently, the court ruled that bifurcation of the two claims was proper in order to prevent the problems of prejudice and lack of economy associated with litigating both at the same time.<sup>81</sup>

Furthermore, the court grappled with the issue of staying discovery until the medical malpractice claim had been adjudicated.<sup>82</sup> There is an established practice of staying discovery in claims “pending the outcome of . . . underlying tort or contract claim[s].”<sup>83</sup> Here, the court was concerned that “[a]llowing *DeJesus* to conduct discovery . . . against Milford for negligent credentialing prior to the adjudication of his medical malpractice claim would be complicated and wholly unnecessary if a jury were to find no negligence occurred.”<sup>84</sup> Accordingly, the court stayed discovery of the bifurcated negligent credentialing action until the underlying medical malpractice action had been decided.<sup>85</sup>

In contrast, the court in *Rabelo* went a different route in recognizing negligent credentialing as a plausible theory of recovery in Massachusetts.<sup>86</sup> The case focused on a separate medical malpractice action against the same physician as in *DeJesus*, Dr. Nasif.<sup>87</sup> The plaintiffs al-

---

78. *Id.* at 654. The court referred to *Schelling* as “Schilling.” *Id.*

79. *Id.* (quoting *Schelling v. Humphrey*, 916 N.E.2d 1029, 1036 (Ohio 2009)). *Schelling* required the medical malpractice first be established against the physician for the purposes of causation. 916 N.E.2d at 1035-36.

80. *Schelling*, 916 N.E.2d at 1035-36

81. *Id.* (allowing bifurcation under MASS. R. CIV. P. 42(b), which grants “[t]rial judges . . . discretion to separate parties, claims, and issues in order to avoid prejudice or in the interest of expedition and economy”).

82. *Id.*

83. *Id.* This approach was developed from handling unfair settlement claims, where the courts first required adjudication of the underlying claims that materially affected the ruling of the case before the court. *See generally* *Kay Constr. Co. v. Control Point Assoc.*, 15 Mass. L. Rptr. 203 (Super. Ct. Aug. 16, 2002).

84. *Kay Constr. Co.*, 15 Mass. L. Rptr. 203.

85. *Id.*

86. *See Rabelo v. Nasif*, 30 Mass. L. Rptr. 547, 547 (Super. Ct. Feb. 18, 2013); *DeJesus v. Milford Reg’l Med. Ctr.*, 30 Mass. L. Rptr. 653, 654 (Super. Ct. Jan. 18, 2012).

87. *Rabelo*, 30 Mass. L. Rptr. at 547.

leged that Milford negligently granted staff privileges to Dr. Nasif, causing the hospital to respond by moving once again to bifurcate the trial into two separate actions.<sup>88</sup> Consequently, the Massachusetts Superior Court had to determine whether the tort of negligent credentialing was valid under Massachusetts law in order to approve the petition for bifurcation.<sup>89</sup>

The court deviated from the approach of *DeJesus* in analyzing the plausibility of negligent credentialing.<sup>90</sup> Rather than looking to the interpretations of other jurisdictions, the court attempted to find a justification for the adoption of the doctrine under Massachusetts law.<sup>91</sup> The judge derived the doctrine from the already established tort of negligent hiring, which imposes a duty on employers “to exercise reasonable care in the selection and retention of employees.”<sup>92</sup> The court recognized, however, that physicians are not typically employees of hospitals.<sup>93</sup> Even with this glaring distinction, the court believed the doctrines were related enough to warrant employing the four-pronged test of the negligent hiring doctrine to determine if Milford had a duty of care owed to Rabelo arising out of the medical peer review process.<sup>94</sup> Using the

---

88. *Id.*

89. *Id.* (recognizing that “the tort of ‘negligent credentialing’ has not been explicitly recognized . . . [but] it has not been found invalid either”).

90. *See id.* (relating negligent credentialing to the tort of negligent hiring); *DeJesus*, 30 Mass. L. Rptr. at 653-54 (adopting the tort of negligent credentialing through the Ohio Supreme Court Case of *Schelling*, 916 N.E.2d 1029 (Ohio 2009)).

91. *Rabelo*, 30 Mass. L. Rptr. at 547.

92. *Id.*; *Foster v. Loft*, 526 N.E.2d 1309, 1310 (Mass. App. Ct. 1988) (holding that an employer has the duty to use reasonable care in the selection and retention of its employees).

93. *Rabelo*, 30 Mass. L. Rptr. at 547. While physicians may be deemed hospital employees under concepts of negligent hiring, physicians and other medical practitioners are highly educated professionals that merit different treatment under the law. *See Harju v. Knutson*, 10 Mass. L. Rptr. 646, 648 (Super. Ct. Nov. 3, 1999) (finding a hospital liable for negligent hiring a private surgeon whose negligence resulted in a patient’s death); *Lawson*, *supra* note 3, at 9-10 (stating that medical profession is “composed of individuals with extensive specialized education, training, and knowledge”).

94. *Rabelo*, 30 Mass. L. Rptr. at 547. The negligent hiring doctrine requires that a plaintiff prove:

- (1) [T]hat the persons whose actions form the basis of the claim were . . . employees of the defendant employer;
- (2) that the . . . employees came into contact with members of the public in the course of their employer’s business;
- (3) that the employer failed to use reasonable care in the selection, supervision, and retention of the . . . employees; and
- (4) that the failure to use such reasonable care was the proximate cause of harm to the plaintiffs.

*Id.* While it may be argued that the court erroneously used the negligent hiring doctrine to serve as a foundation for the recognition of the doctrine of negligent credentialing as a result of the specialized, professional nature of the medical industry, that discussion is outside of the scope of this note. *See Lawson*, *supra* note 3, at 1 (stating that medical profession is “composed of individuals with extensive specialized education, training, and knowledge”).

standards of negligent hiring as a foundation, the court determined that negligent credentialing was “cognizable under Massachusetts law.”<sup>95</sup> However, they denied bifurcation due to a lack of evidence by either party that continuing litigation as a single trial would result in prejudice.<sup>96</sup>

As in *DeJesus*, the court addressed the issues of discovery that accompany a claim of negligent credentialing for the purposes of determining whether bifurcation would be proper.<sup>97</sup> The court recognized that caution would be necessary in handling the discovery of such cases because evidence of a physician’s involvement in past malpractice litigation could be brought forth in a credentialing action.<sup>98</sup> Such an admission could instill in a jury the presumption that the physician was also negligent in the current malpractice action, causing undue prejudice.<sup>99</sup> However, Milford Regional Hospital failed to show any prejudice that would justify the bifurcation of the trial into two actions, so the motion was quashed.<sup>100</sup> Though the court recognized the plausibility of an action for negligent credentialing in Massachusetts, they openly admitted that “the ‘applicability’ of the peer review statute[s] meant discovery . . . would be complicated.”<sup>101</sup> While the complex procedural aspects of the tort were clearly recognized, the court failed to offer even a meaningful discussion of whether negligent credentialing should be adopted under Massachusetts law in light of the protections given to peer review committees by statutes.<sup>102</sup>

## II. THE RECOGNITION OF NEGLIGENT CREDENTIALING IS IMPROPER UNDER MASSACHUSETTS LAW

The lower courts in *Rabelo* and *DeJesus* failed to take into account the extensive statutory scheme that protects medical peer review committees in Massachusetts.<sup>103</sup> This scheme immunizes the work product

---

95. *Rabelo*, 30 Mass. L. Rptr. at 548.

96. *Id.* at 548-49.

97. *Id.* (discussing the admissibility of the evidence needed to successfully prove a negligent credentialing claim).

98. *Id.* at 549 (stating that the judge must examine the “danger[s] of unfairness, confusion, and undue expenditure of time in the trial of collateral issues”).

99. *Id.*

100. *Id.*

101. *Id.* (agreeing with the court in *DeJesus v. Milford Reg’l Med. Ctr.*, 30 Mass. L. Rptr. 653 (Super. Ct. 2012)).

102. *Id.* at 547.

103. *See id.* at 547, 549 (relating negligent credentialing to the tort of negligent hiring in only a few sentences without exploring the relation further and recognizing that the peer review statutes could pose complications in litigation); *DeJesus*, 30 Mass. L. Rptr at 654 (adopting the tort of negligent credentialing through the Ohio Supreme Court Case of *Schelling v.*

of the committees and burdens plaintiffs with immense roadblocks to the material required to prove their cases.<sup>104</sup> The framework also imposes significant hurdles for a defendant health care facility when faced with a prima facie case of negligent credentialing.<sup>105</sup> The recognition of the claim also contradicts the intent that the Massachusetts Legislature and the Board of Registration in Medicine had in creating these protections that medical peer review committees enjoy.<sup>106</sup> Accordingly, negligent credentialing does not have a place under Massachusetts law.

A. *The Massachusetts Peer Review and Medical Malpractice Statutes Unduly Burden Both Parties in a Negligent Credentialing Action*

The statutory scheme in Massachusetts offers extensive privileges to medical credentialing committees to foster effective peer review.<sup>107</sup> State law specifically defines medical peer review committees as “professional societ[ies] of healthcare providers . . . provided the[ir] medical staff operates pursuant to written bylaws . . . which . . . has as [their] function the evaluation or improvement of the quality of health care.”<sup>108</sup> These committees perform their credentialing duties by examining cases where a practitioner may not have followed the applicable standards of care, instances where a practitioner may not be fit to perform their duties, and cases involving substance abuse.<sup>109</sup> Actively engaging in the open criticism of their peers’ work performance allows honest discussion about remedying problems and educating staff.<sup>110</sup> These protections fur-

---

*Humphrey*, 916 N.E.2d 1029 (Ohio 2009) without considering the tort’s application to Massachusetts law).

104. See MASS. GEN. LAWS ch. 111, § 204(a) (2012) (protecting the work product of medical peer review committees); MASS. GEN. LAWS ch. 231, § 85N (2012) (granting immunities to individual participants of peer review committees).

105. James W. Gustafson Jr. & Thomas D. Masterson, *Challenging Hospitals That Tolerate Incompetent Doctors*, 39 TRIAL 18, 23 (May 2003).

106. 243 MASS. CODE REGS. 3.01(1) (2012) (stating that the goal of the legislature was to “provid[e] extensive safeguards of confidentiality, immunity and privilege for . . . internal reviews”); *Vranos v. Franklin Med. Ctr.*, 862 N.E.2d 11, 17-18 (Mass. 2007) (“That [sic] public policy finds voice in, among others, a strict regulatory scheme covering virtually all aspects of hospital operations. Integral to this regulatory scheme is an effective process for self-scrutiny, manifest most prominently in the medical peer review process.”).

107. See MASS. GEN. LAWS ch. 111, § 204(a) (protecting the work product of medical peer review committees); MASS. GEN. LAWS ch. 231, § 85N (granting immunities to individual participants of peer review committees).

108. MASS. GEN. LAWS ch. 111, § 1 (2012).

109. *Id.*

110. *Bd. of Registration in Med. v. Hallmark Health Corp.*, 910 N.E.2d 898, 904 (Mass. 2009) (quoting *Vranos*, 862 N.E.2d at 18 (stating that the purpose of medical peer review is “[t]o ‘promote candor’ and ‘foster aggressive critiquing of medical care by the provider’s peers’”)); *Francis v. U.S.*, No. 09 Civ. 4004(GBD)(KNF), 2011 WL 2224509, at \*5 (S.D.N.Y. May 31, 2011) (illustrating that failure to promote open and honest discussions in the peer

ther the public interest of improving the quality of health care in Massachusetts.<sup>111</sup> Accordingly, recognition of negligent credentialing in Massachusetts is not in the public interest and undermines the statutory scheme intended to ensure quality medical peer review.<sup>112</sup>

The medical peer review privilege in Massachusetts is considered to be one of the more protective in the country.<sup>113</sup> Chapter 111, section 204(a) of the Massachusetts General Laws specifically exempts “the proceedings, reports and records” of medical peer review committees from discovery.<sup>114</sup> These documents are not admissible in any formal court proceeding, including medical malpractice actions.<sup>115</sup> Yet, any documents or reports arising out of bad faith participation in the peer review process are admissible as evidence.<sup>116</sup> However, the Legislature only intended this exception for licensed professionals who were treated unfairly in the peer review process itself and provided the recourse for when the proceedings of the committee were tainted.<sup>117</sup>

The decisions in *Rabelo* and *DeJesus*<sup>118</sup> should have discussed the medical peer review statutes and how the adoption of negligent credentialing would fit within the legislative scheme. The express, unambiguous language of the statute makes any such action a daunting challenge to both parties as a result of the drastic protections medical peer review committees enjoy from the discovery process.<sup>119</sup> The work product of

---

review process “significantly impair[s]” that ability of a hospital to correct problems, educate practitioners, and take disciplinary action).

111. *Francis*, 2011 WL 2224509, at \*5 (stating the general purpose of medical peer review committees).

112. See *Ayash v. Dana-Farber Cancer Inst.*, 822 N.E.2d 667, 692 n. 28 (Mass. 2005) (finding that exposing the peer review process to litigation “would significantly undermine the effectiveness of the statute. Physicians could hardly be expected to volunteer information, or express honest opinions, if the confidentiality of their comments could be waived after the peer review process were completed and . . . used as evidence in a lawsuit . . .”).

113. *Scheutzow*, supra note 6, at 60 (ranking the Massachusetts peer review privilege as “medium-high”).

114. MASS. GEN. LAWS ch. 111, § 204(a) (2012).

115. *Id.*; see also 42 U.S.C. § 11111(a)(2) (2006).

116. MASS. GEN. LAWS ch. 111, § 204; MASS. GEN. LAWS ch. 231, § 85N (2012).

117. *Vranos v. Franklin Med. Ctr.*, 862 N.E.2d, 18-19 (Mass. 2007) (finding that “[t]he Legislature has permitted the subject of a medical peer review to pierce the statutory privilege to establish a cause of action against the member of a peer review committee for the member’s failure to act in good faith pursuant to G.L. c. 231, § 85N (1993) . . . [However], failure to act in good faith must be construed narrowly to preserve the purposes of the peer review privilege to promote good health care”).

118. See generally *Rabelo v. Nasif*, 30 Mass. L. Rptr. 547 (Super. Ct. Dec. 27, 2012); *DeJesus v. Milford Reg’l Med. Ctr.*, 30 Mass. L. Rptr. 653 (Super. Ct. Jan. 18, 2012) (omitting any analysis of how negligent credentialing would fit under the legislative scheme of Massachusetts).

119. See MASS. GEN. LAWS ch. 111, § 204 (protecting the work product of medical peer review committees); MASS. GEN. LAWS ch. 112, § 5(e) (2013) (requiring that the Board col-

peer review committee is off limits to any party in an action for negligent credentialing in Massachusetts.<sup>120</sup> For plaintiffs, this poses an intimidating challenge. They must establish “that but for the lack of care in the selection or retention of the doctor, the doctor would not have been granted staff privileges, and the plaintiff would not have been injured.”<sup>121</sup> This is burdensome considering that medical malpractice must first be proven before attempting to litigate negligent credentialing.<sup>122</sup>

In particular, establishing a “lack of care” poses a problem because only the statutorily protected work product of a peer review committee will conclusively indicate the rationale behind the ultimate decisions to grant staff privileges.<sup>123</sup> A plaintiff will be forced to establish, by using sources other than peer review materials, that a physician was so unqualified that he could only be granted staff privileges through a lack of care.<sup>124</sup> This can be proven through the publically available “original source” materials within the Board of Registration in Medicine’s database.<sup>125</sup> These materials are used by medical peer review committees to illustrate the practice history and credentials of a physician for the purposes of granting staff privileges.<sup>126</sup> This database collects information concerning a physician’s involvement in past malpractice cases, educa-

---

lect pertinent information regarding a physician’s competence “that shall be available for dissemination to the public”); Gustafson, *supra* note 105, at 23-24 (discussing that if a plaintiff can establish a physician’s poor credentials, “the hospital will be unable to defend itself as it watches the plaintiff present his or her case”); Lawson, *supra* note 3, at 124 (stating that “[i]ronically, if a plaintiff is able to make a *prima facie* claim of negligent credentialing without the physician’s credential file, the defendant hospital may be put in the position of having to waive the privilege to defend itself”).

120. MASS. GEN. LAWS ch. 111, § 204 (2012); MASS. GEN. LAWS ch. 231, § 85N (2012). The only material that is not privileged is information from original sources that happens to be presented to the peer review committee and the testimony of peer review participants to matters unrelated to the peer review process. § 204(b). If a person is a participant of the medical peer review committee of a charitable organization, they enjoy total immunity, regardless of whether they acted in good faith in carrying out their duties. § 85N.

121. Schelling v. Humphrey, 916 N.E.2d. 1029, 1033 (Ohio 2009).

122. *See id.*

123. *See generally* Swatch v. Treat, 671 N.E.2d. 1004, 1006 (Mass. App. Ct. 1996) (protecting the report and materials of a peer review committee that were critical of the actions of a clinical social worker).

124. Gustafson, *supra* note 105, at 23-24.

125. Larson v. Wasemiller, 738 N.W.2d 300, 310 (Minn. 2007) (finding that a plaintiff submit “original source” materials to prove negligent credentialing); *see* Vranos v. Franklin Med. Ctr., 662 N.E.2d 11, 19 (Mass. 2007); MASS. GEN. LAWS ch. 112, § 5(e) (2013) (requiring that the Board collect pertinent information regarding a physician’s competence “that shall be available for dissemination to the public”); *see* Gustafson, *supra* note 105, at 23-24 (discussing that if a plaintiff can establish a physician’s poor credentials, “the hospital will be unable to defend itself as it watches the plaintiff present his or her case”).

126. *See* Gustafson, *supra* note 105, at 23-24.

tion, any past criminal activity, and any known substance abuse.<sup>127</sup> A plaintiff can utilize this and other information if it suggests that a physician had deficient credentials when granted staff privileges.<sup>128</sup> However, the nature of these materials is likely sufficient only when the physician in question has a substantial history of actions undermining any presumption of competence.<sup>129</sup> Consequently, murkier negligent credentialing cases will arise where this information is insufficient or nonexistent and parties will be greatly burdened by the statutory bar on access to peer review materials.<sup>130</sup>

While the Massachusetts peer review privilege imposes a significant burden on a plaintiff in successfully proving their case for negligent credentialing, defendants face equally serious challenges. As stated, plaintiffs may establish a *prima facie* case of negligent credentialing through the materials available to the public on the Board of Registration in Medicine's database.<sup>131</sup> Oftentimes, this forces a defendant hospital to waive the peer review privilege to counteract this evidence or simply watch helplessly as the plaintiff proves their case.<sup>132</sup> The health care facility's hand is effectively forced because the rationale behind granting the malfeasant physician staff privileges lies within the protected work product of the peer review committee.<sup>133</sup> It is only within these materials that a defendant can hope to show that they were not negligent in granting staff privileges to a physician with a dubious track record.<sup>134</sup>

However, Massachusetts does not allow a health care facility to waive the peer review evidentiary privilege.<sup>135</sup> In *Swatch v. Treat*, a medical review committee was permitted to intervene in litigation to

---

127. MASS. GEN. LAWS ch. 112, § 5(e) (2013).

128. *See id.*; Gustafson, *supra* note 105, at 23-24; Lawson, *supra* note 3, at 124. Other information includes past court documents, insurance records, the Joint Commission's credentialing standards, newspaper articles, advertising geared towards the quality of care provided at the hospital, and state licensure records. Gustafson, *supra* note 105, at 24.

129. *See* Gustafson, *supra* note 105, at 24 (listing various sources where evidence of a physician's qualifications may be found).

130. *See id.*

131. MASS. GEN. LAWS ch. 112, § 5(e) (2013) (requiring that the Board collect pertinent information regarding a physician's competence "that shall be available for dissemination to the public"); Gustafson, *supra* note 105, at 23-24 (discussing that if a plaintiff can establish a physician's poor credentials, "the hospital will be unable to defend itself as it watches the plaintiff present his or her case"); Lawson, *supra* note 3, at 124 (stating that "[i]ronically, if a plaintiff is able to make a *prima facie* claim of negligent credentialing without the physician's credential file, the defendant hospital may be put in the position of having to waive the privilege to defend itself.>").

132. Gustafson, *supra* note 105, at 23-24.

133. *Id.*

134. *See id.*

135. *See Ayash v. Dana-Farber Cancer Inst.*, 822 N.E.2d 667, 692 n. 28 (Mass. 2005).

prevent the disclosure of privileged materials.<sup>136</sup> The action revolved around the alleged negligence of Treat, a licensed clinical social worker.<sup>137</sup> Prior to the initiation of litigation, both the plaintiff and defendant appeared before the National Association of Social Workers (NASW), a professional organization that conducted a hearing and subsequently produced a report critical of the defendant's actions.<sup>138</sup> When Swatch submitted as evidence the report and hearing materials during the medical malpractice tribunal, the NASW moved to intervene into the litigation to prevent the disclosure of the materials under the Massachusetts peer review privilege.<sup>139</sup>

The NASW was granted appellate review after the trial judge believed that the medical peer review privilege had been waived because both parties had participated in the hearing.<sup>140</sup> The Massachusetts Court of Appeals reversed this decision, finding that the peer review privilege was one that could not be waived.<sup>141</sup> This was justified because “[t]he ability of committee members to speak with candor and the willingness of persons called before them to be equally forthright would be seriously hampered by public release of proceedings or reports of the peer review body.”<sup>142</sup> Furthermore, if privileged materials make their way into litigation, a peer review committee has the right to intervene to protect the information.<sup>143</sup>

The Massachusetts Supreme Judicial Court effectively agreed with the holding in *Swatch* when they decided *Ayash v. Dana-Farber Cancer Institute*.<sup>144</sup> In dicta, the court indicated that the defendant's sharing of peer review materials was incorrect and could not constitute a waiver of the privilege.<sup>145</sup> The privilege itself is unrelated to maintaining confidentiality between the parties of a suit but is meant to protect and facilitate medical peer review.<sup>146</sup> The court believed that applying waiver principles to the privilege “would significantly undermine the effectiveness of the statute . . . [and that] [p]hysicians could hardly be expected to volunteer information, or express honest opinions, if the confidentiality of their comments could be waived after the peer review process were

---

136. *Swatch v. Treat*, 671 N.E.2d 1004, 1007-08 (Mass. App. Ct. 1996).

137. *Id.* at 1005-06.

138. *Id.*

139. *Id.* at 1006.

140. *Id.*

141. *Id.* at 1007.

142. *Id.*

143. *Id.* at 1008.

144. *Ayash v. Dana-Farber Cancer Inst.*, 822 N.E.2d 667, 692 (Mass. 2005).

145. *Id.* at 692 n.28.

146. *Id.*

completed and . . . used as evidence in a lawsuit.”<sup>147</sup> Essentially, the guarantees of confidentiality encourage physicians to effectively critique their peers without fear of reprisal or liability.<sup>148</sup>

As indicated in *Ayash* and *Swatch*, the medical peer review privilege cannot be waived by a defendant in a negligent credentialing action because the peer review process is viewed by the higher Massachusetts courts as a sacred process deserving of protection.<sup>149</sup> Allowing a defendant to waive the privilege in a negligent credentialing action would expose these materials, undercutting the statutory protections put in place to mitigate the fears of licensed hospital staff who participate in peer review.<sup>150</sup> The consequence of this bar on waiving the privilege is that non-negligent health care facilities may be found liable for credentialing a physician with a negative past.<sup>151</sup> It is possible that such a facility’s peer review committee had rational justifications for granting staff privileges to a physician even in the face of a questionable resume.<sup>152</sup>

The fact that current Massachusetts law would permit a circumstance where a non-negligent hospital would be held liable for a tort that it did not commit based solely on an inference derived from a physician’s past credentials is excessively unjust. Negligent credentialing contradicts the extreme deference that Massachusetts has shown for medical peer review;<sup>153</sup> one that is so substantial that it permits peer review committees to intervene in litigation for the sole purpose of protecting their work product.<sup>154</sup> The undue burdens placed on the parties involved in a negligent credentialing action only further support the notion that it was wrong to recognize the doctrine without further analysis.<sup>155</sup>

---

147. *Id.*

148. *See id.*

149. *See id.*; *Swatch*, 671 N.E.2d at 1008.

150. *See* 243 MASS. CODE REGS. § 3.01 (2012) (stating that the purpose of the peer review statutes is to “provide[] extensive safeguards of confidentiality, immunity and privilege for both internal reviews and reports to the Board” in order “[t]o assure free self-examination by physicians and institutions”).

151. *See supra* pp. 28-29.

152. *See* MASS. GEN. LAWS ch. 112, § 5(e) (2013). The information required to be collected by statute is not necessarily indicative of a physician’s current competency. People pay their debts to society for past crimes and become upstanding citizens, they may overcome past issues with drug addiction, and they may make efforts to improve their skills to become competent in their trade. *See* MASS. GEN. LAWS ch. 112, § 5(a-e) (giving the Board of Registration the ability to organize remediation programs to retrain or rehabilitate physicians in lieu of disciplining them for wrongful acts).

153. *See Ayash v. Dana-Farber Cancer Inst.*, 822 N.E.2d 667, 692 n.28 (Mass. 2005); *Swatch*, 671 N.E. 2d at 1007-08.

154. *Swatch*, 671 N.E.2d at 1007.

155. *See Rabelo*, 30 Mass. L. Rptr. at 547-49; *DeJesus*, 30 Mass. L. Rptr. at 653-54 (failing to substantially examine the effects of adopting).

Any decision altering the state of medical peer review should be left to the Legislature and not to the rationale of the judiciary, which may not consider the depth of the issue.

B. *Recognition of the Tort of Negligent Credentialing Undermines the Legislative Intent of the Peer Review Statutes*

The entire purpose of the peer review statutes is to immunize the process from potential litigation, which would undermine open discussion and criticism.<sup>156</sup> A physician will be less likely to participate in the peer review process if his work product is exposed through litigation.<sup>157</sup> Medical peer review committees exist and enjoy statutory protections because they “identify problems in practice before they occur and . . . put in place preventive measures designed to minimize . . . substandard practice.”<sup>158</sup> These protections ensure that medical malpractice will be reduced and “an atmosphere of mutual trust between physicians and their patients” will be fostered.<sup>159</sup>

The intent of the Massachusetts Legislature in enacting the peer review statutes is explained in the Supreme Judicial Court case *Vranos v. Franklin Medical Center*.<sup>160</sup> In *Vranos*, the Plaintiff physician moved to compel discovery of peer review materials to support his allegations of malicious peer review.<sup>161</sup> His staff privileges had been suspended after various occurrences of violent and disruptive behavior with his peers.<sup>162</sup> Vranos applied for appellate review of whether the communications of a medical peer review committee were discoverable under chapter 111, section 204(a) of the Massachusetts General Laws.<sup>163</sup>

In determining whether such documents should be discoverable in instances of alleged bad faith peer review, the Supreme Judicial Court reviewed the legislative purpose behind the peer review protections.<sup>164</sup> The Court explained that the protections were created due to strong public desire for the provision of the highest quality of health care to patients in Massachusetts.<sup>165</sup> This is accomplished through “a strict regulatory scheme covering virtually all aspects of hospital operations,”

---

156. 243 MASS. CODE REGS. 3.01(1).

157. *Ayash*, 822 N.E.2d at 692 n.28; *Swatch*, 671 N.E.2d at 1007; Creech, *supra* note 4, at 179.

158. 243 MASS. CODE REGS. 3.01(1).

159. *Id.*

160. *Vranos v. Franklin Med. Ctr.*, 862 N.E.2d 11 (2007).

161. *Id.* at 16-17.

162. *Id.* at 14-15.

163. *Id.* at 17.

164. *Id.* at 17-18.

165. *Vranos v. Franklin Med. Ctr.*, 862 N.E.2d 11, 17 (2007).

including “an effective process for self-scrutiny, manifest[ed] most prominently in the medical peer review process.”<sup>166</sup> The immunities granted “foster aggressive critiquing of medical care by the provider’s peers.”<sup>167</sup> In essence, the Massachusetts Legislature deferred to the judgment of the medical field, protecting them from liability so that they could perform the important task of peer review.<sup>168</sup>

In regards to the allowance for disclosure when an individual has failed to perform his peer review duties in good faith, the Supreme Judicial Court narrowly construed the exception.<sup>169</sup> Limitation on the exception is due to the importance of ensuring high quality medical care, which would be undermined by exposing hospitals to liability for their credentialing actions.<sup>170</sup> A plaintiff must show that the individual acted in bad faith in order to obtain the disclosure of pertinent credentialing materials.<sup>171</sup> An example of a bad faith peer review would be where a participant intentionally misled the committee, undermining the integrity of the process.<sup>172</sup> Any straying from the well-established statutory and regulatory guidelines would “severely undermine the Legislature’s carefully constructed scheme to promote system wide good health care.”<sup>173</sup> The Legislature clearly believed that the greater good was best served by protecting peer review committees from discovery.<sup>174</sup>

Effective medical peer review affects every recipient of health care in Massachusetts,<sup>175</sup> while the allowances of any holes in the statutory scheme would only serve to satisfy the needs of the few at the expense of the many.<sup>176</sup> The peer review protections are so extensive that the Legislature should ultimately decide whether health care facilities should be held liable for negligent peer review as they are in the best position to

---

166. *Id.*

167. *Id.* at 18 (quoting *Pardo v. General Hosp. Corp.*, 841 N.E.2d 692, 700 (Mass. 2006)).

168. See *Vranos*, 862 N.E.2d at 18; *Carr v. Howard*, 689 N.E.2d 1304, 1315 (Mass. 1998) (stating that “the peer review privilege imposes some hardship on litigants seeking to discover information from hospital records, but the Legislature has clearly chosen to impose that burden . . . in order to improve the medical peer review process”).

169. *Vranos v. Franklin Med. Ctr.*, 862 N.E.2d 11, 20 (2007).

170. *Id.* at 19.

171. *Id.*; MASS. GEN. LAWS ch. 231, § 85N (2012).

172. *Vranos*, 862 N.E.2d at 18.

173. *Id.* at 19.

174. *Id.* at 18. (holding that “the interests of the general public in quality health care are elevated over the interest of individual health care professionals in unfettered access to information about peer review of their actions”).

175. MASS. GEN. LAWS ch. 111, § 203(d) (2012) (requiring that “[e]very licensed hospital, as a condition of licensure, and every public hospital shall be required to participate in risk management programs established by the board of registration in medicine”).

176. *Vranos*, 862 N.E.2d at 18.

ensure the doctrine comports with existing law. As the law currently stands however, the tort undermines the pre-existing statutory scheme.<sup>177</sup>

### III. THE EXTENSIVE REGULATORY STANDARDS CURRENTLY ENFORCED WOULD BE UNDERMINED BY THE ADOPTION OF NEGLIGENT CREDENTIALING

The purpose of the extensive protections afforded to peer review committees in Massachusetts arises out of the concern that exposure to liability will undermine the peer review process.<sup>178</sup> As stated in *Vranos*:

Strong public policy mandates the highest quality of care in our health care facilities. That public policy finds voice in, among others, a strict regulatory scheme covering virtually all aspects of hospital operations. Integral to this regulatory scheme is an effective process for self-scrutiny, manifest most prominently in the medical peer review process.<sup>179</sup>

The regulatory scheme that protects peer review committees displays the clear intent of the Legislature to maintain the highest possible standards of medical care in the Commonwealth.<sup>180</sup> Imposing a new incarnation of hospital liability through the tort of negligent credentialing only serves to undermine these well-established regulations and hospital policies that seek to improve patient care.

The deference that medical peer review committees receive is a direct result of their specialized knowledge.<sup>181</sup> Medical practitioners have specialized understanding about topics that a layman legislator unfamiliar with the field could not hope to effectively grasp.<sup>182</sup> Complementary to this extensive pool of unique knowledge is also the fact that the medical field is constantly changing as a result of technological and procedural advancements.<sup>183</sup> The Legislature cannot be expected to maintain a current and extensive knowledge of these advancements, so as a result, the field has been provided the means to self-regulate.<sup>184</sup> In order to effectively self-regulate, an extensive scheme of mandating risk management policies and peer review has been created by the Board of Registra-

---

177. See MASS. GEN. LAWS ch. 111, § 204; MASS. GEN. LAWS ch. 231, § 85N.

178. *Vranos*, 862 N.E.2d at 17-18.

179. *Id.* at 17-18.

180. *Id.* at 18. See 243 MASS. CODE REGS. 3.01(1) (2012).

181. CHARLES JOSEF BLANCHARD ET AL., *Credentialing and Peer Review of Health Care Providers: The Process and Protections*, THE AMERICAN LAW INSTITUTE 7, 8 (2012); Lawson, *supra* note 3, at 8-9.

182. BLANCHARD ET AL., *supra* note 181, at 8-9.

183. *Id.* at 9; Lawson, *supra* note 3, at 2.

184. BLANCHARD ET AL., *supra* note 181, at 8-9; Lawson, *supra* note 3, at 2.

tion in Medicine, The Joint Commission, and the self-imposed staff policies and procedures at hospitals.<sup>185</sup> This regulatory framework is threatened by the adoption of the tort of negligent credentialing because exposure to liability undermines the candor of the privileging process.<sup>186</sup>

A. *Regulations Promulgated by the Board of Registration in Medicine Will Be Crippled by the Recognition of Negligent Credentialing*

The regulatory scheme that governs hospital peer review in Massachusetts by the Board of Registration in Medicine enumerates protocols that foster higher standards of care and reduce occurrences of medical malpractice.<sup>187</sup> Such regulations are only effective when hospital peer review occurs cohesively and honestly.<sup>188</sup> The regulations require that every medical facility have established Qualified Patient Care Assessment Programs<sup>189</sup> that designate the procedure for risk management programs such as incident reporting and peer review.<sup>190</sup>

Furthermore, the regulations impose standards for peer review committees to follow during the credentialing process.<sup>191</sup> These regulations require that “[n]o health care facility in the Commonwealth shall . . . grant privileges to a licensee, unless the health care facility first completes” the necessary licensing procedure.<sup>192</sup> The credentialing procedure itself is extremely intensive and looks at all aspects concerning a physician’s ability to practice medicine.<sup>193</sup> It requires that the hospital verify that a practitioner seeking staff privileges is actually licensed to

---

185. See 243 MASS. CODE REGS. 3.01; *Specifications Manual for Joint Commission National Quality Core Measures*, JOINT COMMISSION, [http://manual.jointcommission.org/releases/TJC2013B/rsrc/Manual/TableOfContentsTJC/HBIPS\\_v2013B.pdf](http://manual.jointcommission.org/releases/TJC2013B/rsrc/Manual/TableOfContentsTJC/HBIPS_v2013B.pdf) (last visited Oct. 30, 2013).

186. *Ayash v. Dana-Farber Cancer Inst.*, 822 N.E.2d 667, 692 n.28 (Mass. 2005).

187. See 243 MASS. CODE REGS. 3.01.

188. Scheutzow, *supra* note 6, at 8; see 243 MASS. CODE REGS. 3.04.

189. “A Qualified Patient Care Assessment Program is a ‘risk management program’ established by the Board of Registration in Medicine pursuant to” MASS. GEN. LAWS ch. 111, § 203(d). 243 MASS. CODE REGS. 3.02. This program consists of:

A health care facility’s rules, standards and procedures, adopted pursuant to the facility’s bylaws (unless otherwise required by statute), designed to establish effective programs in quality assurance, risk management, peer review, identification and prevention of substandard practice, and maximization of patient care assessment and thus minimization of loss, and which meet or exceed the rules, procedures and standards set forth in 243 CMR 3.00.

243 MASS. CODE REGS. 3.02.

190. 243 MASS. CODE REGS. 3.03, 3.05.

191. *Id.* at 3.05(1).

192. *Id.*

193. See generally 243 MASS. CODE REGS. 3.05.

practice medicine.<sup>194</sup> Also, the physician seeking privileges must provide a copy of their most recent application for registration to practice medicine and report any malpractice claims within the previous ten years.<sup>195</sup> The information provided to the hospital is then analyzed under an extensive set of criteria that determine if a physician is fit to practice.<sup>196</sup>

The regulations also have extensive requirements placed on hospitals in their continued evaluation of already privileged physicians.<sup>197</sup> Hospitals are required to have an established Qualified Patient Care Assessment Program<sup>198</sup> in which every practitioner given staff privileges must participate.<sup>199</sup> These programs are instituted to ensure compliance with hospital and general patient care procedures, which ensure the highest possible standards of care are maintained.<sup>200</sup> A licensee shall not participate or associate with a health care facility that does not have a Qualified Patient Care Assessment Plan in place, signifying that the Massachusetts government intends hospital procedure, including peer review, to be strictly followed and enforced.<sup>201</sup>

High standards of care in the hospital setting rely on honesty and candor.<sup>202</sup> The information that is considered during the credentialing process is of a professionally sensitive nature.<sup>203</sup> Participants in the peer review process are privy to possibly the most damning and embarrassing information concerning a licensee's professional career.<sup>204</sup> From a simple perspective, this information is not easily discussed. There is an inherent fear that exists in the credentialing process; participants may disclose thoughts in apparent confidence one day only to hear it the next

---

194. 243 MASS. CODE REGS. 3.05(3)(a). The Health Care Quality Improvement act requires that health care facilities obtain information concerning the physician when they apply for staff privileges. 42 U.S.C. § 11135 (2006).

195. 243 MASS. CODE REGS. 3.05(3)(c).

196. 243 MASS. CODE REGS. 3.05(3)(d). These criteria include:

[P]rofessional performance, judgment and clinical skills; . . . mental- and physical status; . . . compliance with continuing education requirements; . . . data dealing with utilization; . . . adherence to health care facility and medical staff by-laws, policies and procedures; . . . malpractice claims filed against the licensee; and . . . information regarding any criminal proceedings.

197. *See generally* 243 MASS. CODE REGS. 3.03-3.11.

198. *Supra* note 175.

199. *See generally* 243 MASS. CODE REGS. 3.03.

200. 243 MASS. CODE REGS. 3.03(1).

201. *See* 243 MASS. CODE REGS. 3.03(3).

202. Scheutzow, *supra* note 6, at 7-8.

203. *See* 243 MASS. CODE REGS. 3.05(3).

204. *See id.*

day at the water cooler.<sup>205</sup> This is one reason why licensed medical professionals are afforded staunch protections in Massachusetts that insulate hospital policies and procedures.<sup>206</sup> The judicial analysis under *Rabelo* and *DeJesus* lacked these important considerations in adopting the tort of negligent credentialing.<sup>207</sup> As the current law stands, the tort is in direct conflict with the medical peer review statutory scheme and the Legislature's desire to extinguish peer review participants' fears of liability.<sup>208</sup> To solve this legal quandary, the Legislature should determine whether the negligent credentialing has any place under Massachusetts law, and if so, how it will comport with the existing statutory scheme.

Allowing negligent credentialing as recognized in *Rabelo* and *DeJesus* would undermine the peer review system in Massachusetts.<sup>209</sup> Even if the Massachusetts Peer Review Statutes continue to strictly protect the work product of medical peer review committees, making any allegation of negligent credentialing a questionable endeavor,<sup>210</sup> the lay peer reviewer may not realize this. The fact that members of peer review committees are highly educated individuals does not denote a sufficient knowledge of law.<sup>211</sup> The mere recognition of negligent credentialing will adversely influence medical practitioners in hospitals across Massachusetts.<sup>212</sup> The fear of litigation is a very real anxiety that physicians face in their profession.<sup>213</sup> A failure to take a decisive stand to denounce the findings of *Rabelo* and *DeJesus* will likely chill the peer review process.

---

205. BLANCHARD ET. AL., *supra* note 181, at 3 (alluding to a physician's "reluctan[ce] to participate in peer evaluation because of the . . . personal and professional consequences"); Steve Twedt, *The Cost of Courage: How the Tables Turn on Doctors*, PITTSBURG POST-GAZETTE, Oct. 26, 2003, available at <http://old.post-gazette.com/pg/03299/234499.stm> (discussing how physicians may face ramifications for their willingness to openly speak of unsafe practices or conditions).

206. See 243 MASS. CODE. REGS. 3.01 (stating that the legislative purpose of the peer review protections is "[t]o assure free self-examination by physicians and institutions").

207. See *DeJesus v. Milford Reg'l Med. Ctr.*, 30 Mass. L. Rptr. 653, 654 (Super. Ct. Jan. 18, 2012); *Rabelo v. Nasif*, 30 Mass.L.Rptr. 547, 547 (Super. Ct. 2012).

208. See MASS. GEN. LAWS ch. 111, § 204 (2012); *Schelling v. Humphrey*, 916 N.E.2d 1029, 1030 (2009) (defining negligent credentialing); 243 MASS. CODE. REGS. 3.01.

209. See *DeJesus* 30 Mass. L. Rptr. at 653-54; *Rabelo*, 30 Mass.L.Rptr. at 547.

210. See *supra* pp. 27-28.

211. Lawson, *supra* note 3, at 8-9 (stating that "[p]rofessions, by their nature, are composed of individuals with extensive specialized education, training, and knowledge. . . . This knowledge disparity is especially prevalent in the medical profession.").

212. *Ayash*, 822 N.E.2d 667 at 692 n. 28.

213. Scheutzow, *supra* note 6, at 16; Kenneth R. Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 MASS. L. REV. 157 (2002).

B. *The Existence of Hospital Bylaws and Policies Coupled With Qualified Patient Care Programs Already Ensure High Standards of Medical Care*

One of the primary justifications for expanding the liability of health care facilities through the tort of negligent credentialing is that it acts as a safeguard to ensure competent peer review.<sup>214</sup> However, when the extensive framework of hospital policies and procedures are taken into account, it is clear that extending liability to health care facilities for negligent credentialing is not necessary to protect patients.<sup>215</sup> Hospital bylaws, when considered in conjunction with medical peer review, are an effective way to maintain high standards of care.<sup>216</sup> These bylaws are extensive, and credentialed physicians are obligated to follow them, even though they are not hospital employees.<sup>217</sup> Furthermore, effective peer review allows hospital procedures to be changed to remedy problems that arise in practice, something that would be diminished with the adoption of negligent credentialing.<sup>218</sup>

As part of the requirements for establishing a Qualified Patient Care Assessment Program under the Board of Registration in Medicine's regulatory requirements, a health care facility must establish procedures that include "risk identification and analysis . . . loss prevention and risk reduction activities"<sup>219</sup> . . . [and] patient communications and documentation activities."<sup>220</sup> These programs reduce economic loss from medical malpractice litigation by maintaining high standards in order to reduce

---

214. See generally David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893 (2005) (discussing how allowing malpractice liability is the most effective means to facilitate the improvement of medical care rather than the use of a purportedly flawed credentialing and educational system).

215. See generally MASS GEN. LAWS ch. 111, § 204 (2012); MASS GEN. LAWS ch. 231, § 85N (2012); 243 MASS. CODE REGS. 3.01 (2012).

216. See generally MURPHY ET AL., *supra* note 41 (providing various examples of sample hospital bylaws, and how they may be altered in order to address various circumstances).

217. 243 MASS. CODE REGS. 3.05(1)(b-d) (2012).

218. 243 MASS. CODE REGS. 3.02 (stating that peer review, as part of a greater risk assessment program, promotes "quality assurance, risk management . . . identification and prevention of substandard practice, and maximization of patient care assessment and thus minimization of loss").

219. Loss prevention and risk reduction refers to reducing or mitigating a health care facility's economic losses from medical malpractice litigation. See Leonard J. Nelson, III et al., *Medical Liability and Health Care Reform*, 21 HEALTH MATRIX 443, 449 (2011) (discussing how the problem of under-claiming in medical malpractice may reduce a health care facility's interest in engaging in loss prevention to reduce malpractice liability).

220. 243 MASS. CODE REGS. 3.03(1)(a-d) (2012).

the occurrence of negligence.<sup>221</sup> The bylaws promulgate practices that ensure a safe, professional, and effective work environment.<sup>222</sup> For example, bylaws will likely contain provisions regarding sexual harassment and degrading treatment of hospital staff.<sup>223</sup> The level of a physician's adherence to these bylaws plays a substantial role in the determination of staff privileging.<sup>224</sup>

The double layered protection that bylaws and peer review bring should not be intruded upon by the adoption of a new tort without meaningful consideration. As stated, exposing health care facilities to liability for allegedly wrongful peer review will undermine the credentialing process.<sup>225</sup> Peer review acts as an enforcement mechanism for hospital bylaws, discerning when discipline and discussion are appropriate.<sup>226</sup> Instead of seeking a solution through litigation, a more prudent answer to prevent inadequate peer review should be designed by the Massachusetts Legislature. A judicial solution, as seen in *Rabelo* and *DeJesus*, may not contemplate the substantial legislative and regulatory framework that facilitates effective medical peer review.<sup>227</sup> In contrast, the Legislature has the power to institute meaningful changes to the system to improve the credentialing process that will coincide with existing policies.

#### IV. THE ADOPTION OF NEGLIGENT CREDENTIALING AS A VIABLE FORM OF RECOVERY THREATENS TO UNDERMINE HEALTH CARE IN MASSACHUSETTS

In conjunction with the statutory and regulatory justifications for not recognizing negligent credentialing as a form of possible recovery in Massachusetts, there are also multiple underlying public and judicial policy concerns surrounding it.<sup>228</sup> Recognizing the tort will potentially reduce the already limited number of medical practitioners in the state be-

---

221. *Vranos*, 862 N.E.2d at 17; see 243 MASS. CODE REGS. 3.03(1) (2012).

222. See generally MURPHY ET AL., *supra* note 41 (providing various examples of sample hospital bylaws, and how they may be altered in order to address various circumstances).

223. *Id.* at pt. 4.

224. See 243 MASS. CODE REGS. 3.05(3) (2012).

225. See *supra* Parts II.B, III.

226. See 243 MASS. CODE REGS. 3.05(3) (2012).

227. See *DeJesus v. Milford Reg'l Med. Ctr.*, 30 Mass. L. Rptr. 653, 654 (Super. Ct. Jan. 18, 2012); *Rabelo v. Nasif*, 30 Mass. L. Rptr. 547, 547 (Super. Ct. 2012).

228. See Dallon, *supra* note 20, at 624 (stating that the high "concern for public safety has resulted in a high level of deference to hospital staffing decisions"). The entire legislative scheme surrounding medical peer review, both federal and state, derive this public interest and "the need for widespread availability of quality health care services and [a patient's] opportunity to choose a physician." *Id.*

cause health care facilities will be reluctant to grant staff privileges to practitioners without pristine credentials.<sup>229</sup> Moreover, an action for negligent credentialing has little likelihood of success under Massachusetts and would only waste judicial resources.<sup>230</sup>

A. *The Adoption of Negligent Credentialing Threatens To Restrict The Already Limited Pool of Physicians in Massachusetts*

The adoption of negligent credentialing will burden the privileging practices of healthcare providers at a time of a growing physician shortage.<sup>231</sup> Currently, the country has been facing a growing shortage of medical practitioners since 2005.<sup>232</sup> The United States will face an estimated shortage of 90,000 physicians by 2020.<sup>233</sup> The growth in demand is so great that the supply of physicians will likely be unable to keep up with demand.<sup>234</sup>

Demand itself is also drastically increasing, even with this current shortage of adequate health care providers.<sup>235</sup> Part of the reason for this increase has been a result of the Baby Boomer generation requiring greater amounts of health care.<sup>236</sup> It is undisputed that a growing population of elderly will exponentially increase demand as time goes on.<sup>237</sup> Also, the enactment of the Affordable Care Act (ACA) will add to the demand for health care nationally, with “some projections estimat[ing] that over 32 million Americans may become insured under the law.”<sup>238</sup> Even though Massachusetts already enacted health care reform in 2006,<sup>239</sup> the ACA will result in a substantial increase of newly insured

---

229. See *infra* Part III.A.

230. See *supra* Part. II.A.

231. 2013 MMS Physician Workforce Study, MASS. MED. SOC’Y 3 (Sep. 2013), [http://www.massmed.org/News-and-Publications/Research-and-Studies/2013-MMS-Physician-Workforce-Study-\(pdf\)/](http://www.massmed.org/News-and-Publications/Research-and-Studies/2013-MMS-Physician-Workforce-Study-(pdf)/).

232. *Id.* at 4.

233. *Id.*

234. *Id.* The adoption of the ACA has contributed to increasing the demand for health care across the country. Richard S. Foster, Chief Actuary, U.S. Dep’t of Health & Human Servs., *Estimated Financial Effects of the “Patient Protection and Affordable Care Act,”* 15-16 (2010), available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/S\\_PPACA\\_2010-01-08.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/S_PPACA_2010-01-08.pdf).

235. See Foster, *supra* note 234, at 15-16 (forecasting the number of newly insured individuals seeking healthcare after the adoption of the ACA).

236. *Physician Workforce Study*, *supra* note 232, at 4.

237. *Id.*

238. *Id.* at 6, (citing *2012 Review of Physician Recruiting Incentives. An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians.* (2012), <http://www.merrithawkins.com/uploadedfiles/merrithawkins/pdf/mha2012survpreview.pdf>).

239. See *generally* MASS. GEN. LAWS ch. 111M, § 2 (2012).

individuals in the state.<sup>240</sup> Demand for health care will rise drastically across the country while individuals in Massachusetts have already been experiencing market limitations in the wake of their own universal health care law.<sup>241</sup> As of 2012, Massachusetts has already seen increases in health care costs after the adoption of 2006 health care reform law, paying fifteen percent more than the national average.<sup>242</sup>

As a result of this demand, the recognition of negligent credentialing will burden the process of granting staff privileges to physicians.<sup>243</sup> Hospital credentialing committees will be reluctant to provide privileges to newly minted physicians.<sup>244</sup> A new physician lacks the credentialing background of experienced practitioners.<sup>245</sup> A health care facility would be taking a risk in credentialing an unproven physician when the threat of a negligent credentialing action potentially looms in the future.<sup>246</sup> Since the tort will make peer review committees consider the likelihood of litigation resulting from the future acts of their potential colleagues, they will be reluctant to grant staff privileges, particularly to junior physicians, as a form of self-preservation.<sup>247</sup> Negligent credentialing could effectively prevent some qualified physicians from obtaining staff privileges at a time when the demand for health care is extremely high.<sup>248</sup>

B. *Recognition of Negligent Credentialing Will Increase the Number of Frivolous Medical Malpractice Actions in Massachusetts*

A claim of negligent credentialing is extremely unlikely to succeed

---

240. *Id.* at 5-6; Associated Press, *How the Affordable Care Act will Affect Mass.*, 90.9 WBUR, Sept. 30, 2013, available at <http://www.wbur.org/2013/09/30/obamacare-massachusetts-changes> (stating that 45,000 previously uninsured individuals will become eligible for MassHealth with the adoption of the Affordable Care Act); see Foster, *supra* note 234, at 15-16.

241. Sharon K. Long, *What is the Evidence of Health Reform in Massachusetts and How Might the Lessons Learned from Massachusetts Apply to National Health Reform?*, URBAN INST., 2 (June 2010), available at <http://www.urban.org/uploadedpdf/412118-massachusetts-national-health-reform.pdf>; see Foster, *supra* note 234, at 15-16.

242. *Massachusetts Health Care Reform: Six Years Later*, The Kaiser Found, 1 (May 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf>.

243. *Physician Workforce Study*, *supra* note 231, at 8-9 (discussing how state health care reform may shorten the pool of available physicians).

244. See generally MASS. GEN. LAWS ch. 112, § 5(e) (2012).

245. See *id.* (requiring information concerning a physician's practice history be reported to the Board of Registration in Medicine). A new physician will lack this history, making it a gamble, in light of expanded liability, for a health care facility to grant staff privileges to an untested practitioner. See *id.*

246. See *id.*

247. See Nelson, III et al., *supra* note 219, at 449 (discussing how a health care facility's motivations to run loss prevention programs, such as medical peer review, can be influenced by economic factors like expanded civil liability).

248. See Associated Press, *supra* note 240.

under current Massachusetts law. Any action for medical malpractice against a provider of healthcare must go through a medical malpractice tribunal.<sup>249</sup> Since the tort of negligent credentialing is attached to medical malpractice claims, it will also be scrutinized by the tribunal if it is present in the initial complaint.<sup>250</sup> A medical malpractice tribunal will approve an action to proceed if the plaintiff produces “[s]ubstantial evidence,” which the Legislature defines as “such evidence as a reasonable person might accept as adequate to support a conclusion.”<sup>251</sup>

But the Massachusetts Peer Review Statutes protect the information necessary to establish a successful cause of action for negligent credentialing.<sup>252</sup> A plaintiff would have to present some sort of evidence to even suggest the possibility that a peer review committee wrongfully granted staff privileges to an undeserving physician.<sup>253</sup> They would be forced to utilize the Board of Registration in Medicine’s public database that contains records of a physician’s qualifications, education, past criminal history, past malpractice history, and occurrences of substance abuse.<sup>254</sup> Furthermore, knowing that medical peer review committees are focused on improving patient care through education and awareness of errors, mere evidence of a physician’s past medical malpractice history may not be sufficient to establish negligence to a jury without knowing the actual rationale the committee relied on when granting privileges.<sup>255</sup>

Bringing claims that are borderline frivolous when it is clear that the peer review statutes have made them impracticable<sup>256</sup> puts an undue strain on the judicial system. Zealous attorneys will allege negligent

---

249. MASS. GEN. LAWS ch. 231 § 60B (2012).

250. See *Rabelo v. Nasif*, 30 Mass. L. Rptr. 547, 547 (Super. Ct. 2012) (leaving the decision to bifurcate a negligent credentialing claim attached to a medical malpractice claim to the discretion of the trial judge); *DeJesus v. Milford Reg’l Med. Ctr.*, 30 Mass. L. Rptr. 653, 653 (Super. Ct. 2012) (allowing the bifurcation of a medical malpractice claim from a negligent credentialing claim brought in the same action).

251. MASS. GEN. LAWS ch. 231, § 60B.

252. See MASS. GEN. LAWS ch. 111, § 204 (2012); MASS. GEN. LAWS ch. 231, § 85N (2012).

253. *Supra* Part II.A.

254. MASS. GEN. LAWS ch. 112, § 5(e) (2013); Lawson, *supra* note 3, at 11; Gustafson, *supra* note 105, at 24.

255. See Creech, *supra* note 5, at 183 n. 14 (citing Hall, Hospital Committee Proceedings and Reports: Their Legal Status, 1 AM. J.L. & MED. 245, 248 (1975) (discussing that the purposes of medical peer review committees includes providing continued education)). The Board of Registration in Medicine provides a general set of guidelines for peer review committees to follow when credentialing a physician. 243 MASS. CODE REGS. 3.05(3)(d)(1) (2013). However, these standards are very subjective and, within themselves, can only provide cursory guidance to a plaintiff in determining what to look for in order to prove negligent credentialing. See *id.*

256. See *supra* Part II.A.

credentialing against hospitals in order to increase the possible sources of compensation for their clients, not to mention the likelihood of settlement.<sup>257</sup> However, the low likelihood of success for these claims imposes unnecessary litigation costs on the plaintiff.<sup>258</sup> The courts are also forced to hear these allegations, and the hospitals must pay money to defend against them. In the case that a plaintiff establishes a prima facie case for negligent credentialing, a defendant hospital may be forced to pay for damages regardless of their actual negligence because they will be unable to mount a defense.<sup>259</sup> Considering that plaintiffs wrongfully injured during medical procedures will be fully compensated by the negligent physician's malpractice insurance, claims of negligent credentialing against a health care facility only serve to burden the system.<sup>260</sup>

#### CONCLUSION

The recognition of negligent credentialing as a viable theory of recovery by the Massachusetts Superior Court was shortsighted. The extensive statutory, regulatory, and public policy concerns that contradict its adoption clearly show that the tort has no place under Massachusetts law. If courts continue to permit these claims, it will disregard these overriding considerations and would pose a substantial threat to the status of health care in the state. Since *Rabelo* and *DeJesus*, there have not been subsequent cases in Massachusetts addressing the doctrine. This may be a result of the numerous unreasonable difficulties litigating this tort poses.

Massachusetts's courts should recognize these difficulties in any further decisions concerning negligent credentialing and should unequivocally defer to the judgment of the Legislature. The lack of any subsequent case law is indicative of the difficulty of successfully establishing an action for negligent credentialing. The Legislature is best equipped to remedy negligent peer review without harming the overall credentialing process. They instituted the protections that medical peer review committees enjoy out of concern for the public interest.<sup>261</sup> For example, section 85N already protects individual peer review participants "provided that [they] act[] in good faith and in the reasonable belief that based on all of the facts the action or inaction on [their] part was

---

257. See Gustafson, *supra* note 105, at 22 (stating that "a negligent-credentialing claim can be devastating to both the physician and the hospital" and should be brought when a physician's questionable practice history can be demonstrated).

258. See *id.*

259. *Id.*

260. *Id.*

261. 243 MASS. CODE REGS. 3.01(1) (2012).

warranted.”<sup>262</sup> The Legislature can create such an exception to pertain to health care facilities and the actions of their peer review committees as a whole.<sup>263</sup> This would serve to protect the integrity of the peer review process while simultaneously providing a safeguard in instances of “bad faith” peer review.<sup>264</sup>

As the law currently stands, the holdings in *Rabelo* and *DeJesus* provide an insufficient basis to justify future claims of negligent credentialing in Massachusetts.<sup>265</sup> The adoption of an entirely novel avenue of liability requires greater analysis than what was performed by the superior courts. Furthermore, it encroaches upon the powers of the Legislative branch, which ideally, represents the best interests of the public. The Legislature has the opportunity to create an effective answer to the quandary created by the adoption of negligent credentialing. Until they take such action, the decisions in *Rabelo* and *DeJesus* recognize a potential problem, but only act as an ineffective Band-Aid to a greater issue deserving substantial analysis and action.

*Kyle Deskus\**

---

262. MASS. GEN. LAWS ch. 231, § 85N (2012).

263. For example, Utah has expressly stated in statute that “[i]t is the policy of this state that the question of negligent credentialing, as applied to health care providers in malpractice suits, is not recognized as a cause of action.” UTAH CODE ANN. § 78B-3-425 (LexisNexis 2011).

264. See *supra* Part II.B.

265. See *generally* *Rabelo v. Nasif*, 30 Mass.L.Rptr. 547 (Super. Ct. 2012); *DeJesus v. Milford Reg’l Med. Ctr.*, 30 Mass.L.Rptr 653 (Super. Ct. 2012).

\* J.D., Western New England University School of Law, 2015. I would like to thank Professor Barbara Noah for providing invaluable feedback on every draft of my Note and guiding me in the field of health law. I am also indebted to the Western New England Law Review for their hard work and diligence during the editorial process. Finally, this Note would not have been possible without my parents, William and Joanne, who taught me the value of education and hard work.