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**VITAL SURGERY OR UNNECESSARY PROCEDURE?
RETHINKING THE PROPRIETY OF HOSPITAL LIABILITY
FOR NEGLIGENT CREDENTIALING**

I. INTRODUCTION

Hospitals know best who is qualified to provide medical care.¹ For generations, this truth has been confirmed by the fact that doctors seeking use of hospital facilities to treat their patients must first gain deliberated approval from their peers in medicine to “practice [their] art” at hospitals.² Through detailed review of a private physician’s skills, education, and experiences, medical peer review, known as credentialing, serves as the mechanism whereby members of the medical community ensure that only competent practitioners may treat their patients in hospitals.³ However, in an era of tort law marked by increased instances and theories of medical malpractice liability, a number of states’ courts now allow patients to recover from hospitals for negligence in hospitals’ credentialing activities.⁴

Broadly, negligent credentialing is a theory in which the recipient of a harmful service recovers from a gatekeeping entity for allowing the provider of that service to engage in the activities that caused the recipient harm.⁵ Some states apply this concept to healthcare by allowing patients injured by their private physicians to sue the hospital for their injuries.⁶ In such cases, the hospital is liable for negligently deciding that the injurious physicians were qualified to perform the medical procedures that harmed the physicians’ patients.⁷ The prospect of such liability causes hospitals’ credentialing bodies to more closely scrutinize doctors seeking practice privileges and to predict the likelihood of a particular doctor engaging in (or being sued for) malpractice.⁸ Thus, the theoretical result of the availability of negligent credentialing liability is an increase in the quality of doctors permitted to treat patients in hospitals.

Although such an outcome is desirable, negligent credentialing liability causes hospitals to achieve that outcome through flawed means. By making a third-party physician’s medical competence and quality of care a question for juries, the focus of a hospital’s peer review committee moves from a substantive evaluation of competence to an educated guess at avoiding liability. The inquiry

1. See *Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989).

2. *Cobb County-Kennestone Hosp. Auth. v. Prince*, 249 S.E.2d 581, 584 (Ga. 1978).

3. See Craig W. Dallan, *Understanding Judicial Review of Hospitals’ Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 598–99 (2000).

4. See *Larson v. Wasemiller*, 738 N.W.2d 300, 306 (Minn. 2007).

5. Cf. *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 164 (Cal. Ct. App. 1982) (stating that hospitals are responsible for ensuring the competency of physicians who receive staff privileges).

6. See *Larson*, 738 N.W.2d at 306.

7. See *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1045 (Ohio 1990), *overruled on other grounds by Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46, 53 (Ohio 1994).

8. See Lu Ann Treviño, Note, *The Health Care Quality Improvement Act: Sword or Shield?*, 22 T. MARSHALL L. REV. 315, 342 (1997).

is no longer: “Is Dr. Jones truly qualified to treat his patients here?”; rather, the question is: “What is the likelihood that Dr. Jones will get us sued?” Any increase in the average caliber of private physicians at a particular hospital is thus incidental. Meanwhile, the cause of action can visit a number of problems upon a community’s healthcare system, including a shortage of physicians and surgeons, an increase in healthcare costs, a lowered availability of local medical services, and an overall decrease in the average quality of patient care. Additionally, once the claim applies to hospital peer review activity, it could spread to other licensed professions.⁹

Negligent credentialing has yet to become law in South Carolina.¹⁰ Neither appellate court has squarely decided whether someone can sue a hospital for negligently permitting a medical practitioner to admit and treat patients at its facilities.¹¹ It is likely that at least part of the reason negligent credentialing is not an available cause of action is because South Carolina has statutes privileging information obtained and produced in the credentialing process.¹² South Carolina’s courts have consistently protected this privilege in healthcare litigation because of its importance in facilitating quality medical services.¹³ However, a circuit court recently held that notwithstanding the privilege, a patient may sue a hospital for negligent credentialing in South Carolina.¹⁴ Because that case is now on appeal,¹⁵ it is likely that one or both of South Carolina’s appellate courts will soon have to decide whether patients can sue South Carolina hospitals for negligent credentialing.

This Comment argues that South Carolina should not recognize a cause of action for negligent credentialing against hospitals. Part II summarizes the credentialing, or privileging,¹⁶ process, the elements of a negligent credentialing cause of action, the common defenses to the claim, and treatment of the claim throughout the United States. Part III examines South Carolina laws pertaining to

9. This is not to say that the needs of the injured patient and the goals of the negligent credentialing theory should be ignored. Certainly, a person deserves compensation for injuries wrongfully received, and improved healthcare is a desirable goal. However, negligent credentialing’s greatest flaw is that it causes these harms unnecessarily, as injured patients may use other, already accepted tort theories against a hospital without eroding the integrity of peer review processes. *See infra* Part IV.E.

10. 18 S.C. JUR. *Hospitals* § 17 (2008).

11. *See, e.g., Strickland v. Madden*, 323 S.C. 63, 72, 448 S.E.2d 581, 586 (Ct. App. 1994) (per curiam) (declining to recognize a cause of action for negligent credentialing).

12. *See* S.C. CODE ANN. §§ 40-71-10 to -20 (2006 & Supp. 2008).

13. *See Durham v. Vinson*, 360 S.C. 639, 649, 602 S.E.2d 760, 765 (2004); *McGee v. Bruce Hosp. Sys.*, 312 S.C. 58, 62, 439 S.E.2d 257, 260 (1993); *Wieters v. Bon-Secours-St. Francis Xavier Hosp., Inc.*, 378 S.C. 160, 172, 662 S.E.2d 430, 436–37 (Ct. App. 2008), *vacated*, 381 S.C. 332, 332, 673 S.E.2d 417, 417–18 (2009).

14. *See Person v. Carolina Pines Reg’l Med. Ctr.*, No. 2004-CP-16-322, slip op. at 9 (Darlington County Ct. Com. Pl. Nov. 13, 2006) [hereinafter Summary Judgment Order].

15. *See* Notice of Appeal, *Person v. Carolina Pines Reg’l Med. Ctr.*, No. 2004-CP-16-322 (Ct. App. May 21, 2008). The South Carolina Court of Appeals’ case tracking number is 200891766.

16. This Comment treats these terms as synonymous and uses them interchangeably.

the privileging process and a circuit court's interpretation of these laws. Part IV explores the problems and benefits of allowing a negligent credentialing claim as well as alternative theories of recovery currently available in South Carolina. Finally, Part V suggests that should South Carolina appellate courts choose to allow negligent credentialing claims, they should refrain from doing so until presented with adequate facts for a landmark decision.

II. OVERVIEW OF THE CREDENTIALING PROCESS AND NEGLIGENT CREDENTIALING LAW

Negligent credentialing is a subset of the concept of corporate negligence.¹⁷ Corporate negligence entails holding a corporation directly liable for harmful acts or omissions proximately caused by persons working in conjunction with the corporation.¹⁸ In elemental form, a negligent credentialing claim is essentially a specialized claim for negligence.¹⁹

A. Overview of the Credentialing Process

The process of credentialing nonemployee physicians to practice in hospitals plays no small part in medicine. Doctors who wish to treat their patients at a particular hospital must have credentials to admit patients and conduct procedures using hospital facilities.²⁰ Hospital peer review committees determine whether to grant physicians staff privileges to treat and admit patients and whether the committees should later expand, limit, suspend, or revoke that physician's privileges.²¹ Many committees render decisions using the credentialing criteria established by the Joint Commission, a national healthcare accreditation organization.²² These criteria include current licensure; training and experience relevant to the type of privileges sought; physical and mental health;

17. See *Larson v. Wasemiller*, 738 N.W.2d 300, 307 & n.4 (Minn. 2007). Corporate negligence includes other tortious conduct, such as negligent hiring, see *Id.* at 308, and negligent supervision, see *Oehler v. Humana Inc.*, 775 P.2d 1271, 1272 (Nev. 1989) (per curiam).

18. *Simmons v. Tuomey Reg'l Med. Ctr. (Simmons I)*, 330 S.C. 115, 123, 498 S.E.2d 408, 412 (Ct. App. 1998), *aff'd as modified on other grounds*, 341 S.C. 32, 53, 533 S.E.2d 312, 323 (2000).

19. See, e.g., *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1045–46 (Ohio 1990) (describing negligent credentialing as a combination of a breach of duty of care and proximate causation of injuries), *overruled on other grounds by Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46, 53 (Ohio 1994).

20. Michelle M. Kwon, Comment, *Move over Marcus Welby, M.D. and Make Way for Managed Care: The Implications of Capitation, Gag Clauses, and Economic Credentialing*, 28 TEX. TECH L. REV. 829, 851 (1997).

21. Carol R. M. Moss, Note, *You Do Know What You're Doing? Right, Doc? Minnesota Supreme Court Contemplates Negligent Credentialing and Privileging*, 30 HAMLINE L. REV. 125, 140 (2007) (quoting MINN. STAT. § 145.61(5)(i) (1998)).

22. *Id.* (citing Joint Commission on Accreditation of Healthcare Organizations, <http://www.jointcommission.org> (last visited May 17, 2009)).

competence; currently pending challenges to licensure; previous successful challenges to licensure; involvement in a malpractice action; voluntary or involuntary withdrawal or reduction of privileges at another hospital; and peer recommendations.²³ As required for Joint Commission accreditation, peer review committees must periodically reevaluate the qualifications of a credentialed physician to ensure that the physician does not develop a pattern of incompetence.²⁴ This counterbalances another Joint Commission accreditation requirement that practitioners be able to obtain credentials to practice in the hospital without direction from hospital staff.²⁵

In addition to following Joint Commission criteria, or as an alternative to them, some hospitals use their own credentialing criteria that more closely reflect their specific needs, goals, and concerns regarding practitioner qualifications.²⁶ No matter what standards a hospital uses for its peer review decisions, federal regulations require that its peer review committee take certain actions during the committee's credentialing processes.²⁷ When a practitioner applies for hospital privileges, the peer review committee must request a report from the National Practitioner Data Bank; if the committee grants privileges, it must thereafter periodically request information from the Bank.²⁸

The credentialing process begins with the practitioner requesting an application from the peer review committee.²⁹ If the committee has interest in the applicant, it sends the applicant an application, a list of its privileging criteria, and copies of the hospital's bylaws.³⁰ The applicant then completes the application by providing copies of current state medical licenses and Drug Enforcement Agency registration numbers; copies of professional liability insurance and information on policy limits; information on education, training, and board certifications; letters of recommendation; and information on health status, location, and any past disciplinary action.³¹ The applicant also gives the

23. See JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK §§ MS.5.5–5.8 (1999).

24. See *Albain*, 553 N.E.2d at 1045.

25. See JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 23, at §§ MS.1.1.1.–1.1.2.

26. See, e.g., *Andrews v. Nw. Mem'l Hosp.*, 540 N.E.2d 447, 449 (Ill. App. Ct. 1989) (indicating that defendant hospital developed its own bylaws in addition to Joint Commission standards).

27. Moss, *supra* note 21.

28. *Id.* at 140–41. The Bank contains information on each licensed physician, as required by federal regulations. *Id.* at 141 (citing 45 C.F.R. §§ 60.7–9 (2007)). Doctors, hospitals, medical malpractice carriers, and governmental agencies (including state medical boards) must report investigations, adverse actions, malpractice verdicts or settlements and any other information that the Secretary of Health and Human Services deems necessary to report. *Id.* (citing 45 C.F.R. § 60.8 (2007)). This information is confidential and is not available to the public. *Id.* (citing 45 C.F.R. § 60.11 (2007)).

29. LEWIS M. LEVIN, MEDICAL STAFF PRIVILEGES: A PRACTICAL GUIDE TO OBTAINING AND KEEPING HOSPITAL STAFF PRIVILEGES 41 (1991).

30. *Id.* at 42.

31. *Id.*

committee permission to view all records of the applicant's past performance.³² When the committee receives the completed application, it verifies the documents and information for accuracy and may solicit the medical staff for opinions on the applicant.³³ The committee then forwards the application to the appropriate member of the department for which credentials are sought³⁴ for review and recommendation.³⁵ If the department member makes a favorable recommendation, the committee undertakes its own review and makes a recommendation.³⁶ The application then goes to the hospital's medical executive committee for a third review, and then the hospital's board makes the final approval.³⁷

B. Elements of the Cause of Action

Negligent credentialing is essentially a subset of the basic negligence claim.³⁸ The cause of action consists of the standard negligence elements: duty, breach, actual causation, proximate causation, and injury.³⁹ The specific types of facts a plaintiff must prove to make out a prima facie case are what characterize the tort.

1. Duty

Negligent credentialing rests on the assumption that a hospital owes the public a duty to allow only competent medical practitioners to work on its

32. *Id.*

33. *Id.* at 42–43.

34. For example, obstetrics or neurology.

35. LEVIN, *supra* note 29, at 43.

36. *Id.*

37. *Id.*

38. *See* Blanton v. Moses H. Cone Mem'l Hosp., Inc., 354 S.E.2d 455, 457 (N.C. 1987); St. Luke's Episcopal Hosp. v. Agbor, 952 S.W.2d 503, 513 (Tex. 1997) (Cornyn, J., dissenting) (quoting RESTATEMENT (SECOND) OF TORTS § 323 (1965)). At least one state has instead based recognition of the claim through analogy to negligent entrustment. *See* Mitchell County Hosp. Auth. v. Joiner, 189 S.E.2d 412, 414 (Ga. 1972).

39. *See* Pedroza v. Bryant, 677 P.2d 166, 168 (Wash. 1984) (en banc) (citing Hansen v. Wash. Natural Gas Co., 632 P.2d 504, 505 (Wash. 1981)). Courts and commentators present different formulations of a prima facie negligence case. *Compare* David G. Owen, *The Five Elements of Negligence*, 35 HOFSTRA L. REV. 1671, 1674 (2007) (explaining a five-element formulation), with Baggerly v. CSX Transp., Inc., 370 S.C. 362, 368–69, 635 S.E.2d 97, 101 (2006) (citing Bloom v. Ravoir, 339 S.C. 417, 422, 529 S.E.2d 710, 712 (2000)) (combining damages and both types of causation into one element), and Steinke v. S.C. Dep't of Labor, Licensing & Reg., 336 S.C. 373, 387, 520 S.E.2d 142, 149 (1999) (citing Bishop v. S.C. Dep't of Mental Health, 331 S.C. 79, 88, 502 S.E.2d 78, 82 (1998)) (treating actual and proximate causation as a single element). This Comment adopts the five-element model because it provides the clearest framework for discussion of negligent credentialing, both in its theory and in its application to cases.

premises.⁴⁰ This duty encompasses a variety of specific tasks, including creating adequate credentialing procedures;⁴¹ following these procedures in deciding whether to grant or renew privileges to a particular practitioner;⁴² and withdrawing these privileges when the hospital has notice of a practitioner's misconduct or incompetence.⁴³ These duties do not necessarily end at the hospital's door. For example, a Massachusetts court allowed a patient to sue a hospital for negligently credentialing a physician who sexually assaulted his patient in the patient's home.⁴⁴ Such a case is likely not anomalous. As the existence of the duty turns on whether the harm was foreseeable to the hospital, this example is in keeping with Justice Cardozo's famous "danger zone" from *Palsgraf v. Long Island Railroad Co.*⁴⁵ and illustrates just how broad that zone apparently can be.

The standard of care for any of these duties may come from several sources. A typical negligent credentialing state holds a hospital to a national standard of care and uses Joint Commission accreditation rules as the basis for that standard.⁴⁶ Meanwhile, a minority position defines the standard of care by behavior within a hospital's walls.⁴⁷ Some derive the standard of care from the hospital's own bylaws, regulations, and credentialing standards,⁴⁸ while others take such rules and practices as highly probative evidence of what the standard

40. See *Register v. Wilmington Med. Ctr., Inc.*, 377 A.2d 8, 10 (Del. 1977); *Candler Gen. Hosp., Inc. v. Persaud*, 442 S.E.2d 775, 777 (Ga. Ct. App. 1994) (citing *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 165 (Cal. Ct. App. 1982); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 164 (Wis. 1981)); *Pedroza*, 677 P.2d at 168.

41. See, e.g., *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991) (citing *Wood v. Samaritan Inst.*, 161 P.2d 556, 558 (Cal. Ct. App. 1945) (in bank)) (noting that hospitals have a "duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients").

42. See, e.g., *Frigo v. Silver Cross Hosp. & Med. Ctr.*, 876 N.E.2d 697, 723 (Ill. App. Ct. 2007) ("Hospitals are required to exercise reasonable care in the granting of medical staff privileges."). Conceivably, this task could be split into two instances of negligence: negligently reviewing a doctor's qualifications and negligently granting the doctor privileges. However, no reported case provides an example of a court actually treating these acts as separate instances of negligence.

43. See, e.g., *Copithorne v. Framingham Union Hosp.*, 520 N.E.2d 139, 141–43 (Mass. 1988) (holding that a reasonable jury could have found that a hospital violated its duty to a patient by "failing to take sufficient action in response to previous allegations" of a doctor's wrongdoing). Such a duty closely reflects that of negligent hiring and supervision. See *infra* Part IV.E.4.

44. *Copithorne*, 520 N.E.2d at 141–43.

45. 162 N.E. 99, 100 (N.Y. 1928).

46. See, e.g., *Frigo*, 876 N.E.2d at 723 (citing *Coleman v. Bessemer Carraway Methodist Med. Ctr.*, 589 So. 2d 703, 706 (Ala. 1991)) (noting that a hospital's compliance with Joint Commission requirements may be sufficient for summary judgment in its favor). If negligent credentialing becomes law in South Carolina, the courts would likely apply some national standard of care. See *McMillan v. Durant*, 312 S.C. 200, 207, 439 S.E.2d 829, 833 (1993) (extending a national standard of care for tort actions against healthcare professionals).

47. See, e.g., *Johnson v. St. Bernard Hosp.*, 399 N.E.2d 198, 205 (Ill. App. Ct. 1979) (stating that a hospital's bylaws imposed a duty to assist physicians in obtaining consultations from peers).

48. See, e.g., *id.* (finding that the bylaws created a direct duty).

should be.⁴⁹ Several states look to legislative acts for guidance in determining the proper standard of care.⁵⁰ For example, a Florida court held that because a state statute imposes upon hospitals a duty to select competent physicians, granting privileges to an incompetent doctor who injures a patient on the hospital's premises constitutes a breach of duty.⁵¹ Nebraska law provides that a hospital's violation of its own healthcare quality regulation supplies evidence of negligence but is not conclusive of a breach of duty.⁵² Lastly, federal law provides that a hospital has a duty to periodically request physician information from the National Practitioner Data Bank.⁵³

2. *Breach*

One defining characteristic of negligent credentialing is that a plaintiff must prove an underlying occurrence of medical malpractice by the treating physician in addition to the hospital's breach of duty.⁵⁴ This implies that courts view the claim as derivative in nature, in that the plaintiff cannot recover from the hospital without also showing other, independently actionable conduct by the practitioner. In such cases, the plaintiff must be able to prove professional negligence against the physician who directly caused the plaintiff's injury in addition to a breach of duty by the hospital.⁵⁵ Courts differ as to whether the plaintiff must satisfy this dual-breach requirement by either joining the doctor in the suit or showing recovery in a separate lawsuit, as opposed to merely

49. See, e.g., *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (stating that a hospital's bylaws, regulations, and standards aided the jury in determining the standard of care).

50. See, e.g., *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 165 (Cal. Ct. App. 1982) (noting the California legislature's efforts to ensure quality healthcare and protect patients); *Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989) (finding that Florida's legislature expressly codified the doctrine of negligent credentialing).

51. *Insinga*, 543 So. 2d at 214; see also *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 169 (Wis. 1981) (finding no conflict between health regulatory scheme and common law duty of care).

52. See *Foley v. Bishop Clarkson Mem'l Hosp.*, 173 N.W.2d 881, 884 (Neb. 1970).

53. See 42 U.S.C. § 11135(a)(2) (2000).

54. See, e.g., *Trichel v. Caire*, 427 So. 2d 1227, 1233 (La. Ct. App. 1983) (finding that because there was no negligence on the part of the physician, the hospital was not liable for its grant of privileges to the physician); *Hirons v. Scheffey*, 76 S.W.3d 486, 489 (Tex. App. 2002) (noting that if the doctor is not found negligent there can be no negligent credentialing claim against the hospital).

55. See, e.g., *Humana Med. Corp. of Ala. v. Traffanstedt*, 597 So. 2d 667, 669 (Ala. 1992) (stating the necessity of underlying physician liability); *Grobman v. Posey*, 863 So. 2d 1230, 1235–36 (Fla. Dist. Ct. App. 2003) (quoting William D. Underwood & Michael D. Morrison, *Apportioning Responsibility in Cases Involving Claims of Vicarious, Derivative, or Statutory Liability for Harm Directly Caused by the Conduct of Another*, 55 BAYLOR L. REV. 617, 619 (2003)) (same).

showing, as part of the negligent credentialing claim, that the plaintiff could prove the doctor's liability.⁵⁶

On the other hand, a small minority of states allow a patient to recover against a hospital for injuries received from a private physician, even if the physician did not negligently injure the patient.⁵⁷ The rationale is that because negligent credentialing is a direct theory of liability, the actions of a third party are irrelevant to proving a failure to uphold the duty of care.⁵⁸ Thus, hospitals in single-breach states may be liable for a doctor's nontortious conduct.

Regardless of a particular court's position on this issue, a plaintiff must at least prove the hospital's breach of duty. A hospital will have breached its duty if it has actual or constructive knowledge of conduct that should cause it to deny or withdraw privileges and it fails to do so.⁵⁹ A hospital fails to exercise reasonable care in performing its credentialing duties either by not obtaining information that is reasonably available to it or by not making a reasonable decision whether to grant, renew, or continue privileges based on the information before it.⁶⁰

3. Actual Causation

The minimum standard for actual causation is that the physician's conduct was, at the very least, a substantial factor in causing the plaintiff's injuries. If the state in question requires a doctor's negligence as part of the claim, that same negligent conduct must be the substantial factor.⁶¹ Other courts require a plaintiff to show that but for a hospital's lack of care in allowing a doctor to practice on its premises, the doctor would not have received credentials and would not have injured the plaintiff.⁶² In a state using the dual-breach rule, the plaintiff must

56. Compare *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 255 (Ill. 1965) (noting that plaintiff had settled negligence claim against doctor before proceeding to trial against hospital), with *Stottlmyer v. Ghramm*, 597 S.E.2d 191, 192 (Va. 2004) (noting that the trial court bifurcated the claims of the doctor and the hospital and made the plaintiff's ability to proceed against the hospital contingent upon the plaintiff first winning negligence action against the doctor).

57. See, e.g., *Moser v. Heistand*, 681 A.2d 1322, 1325 (Pa. 1996) (explaining that a patient need not prove a third party's negligence because a hospital's duty runs directly to the patient); cf. *Dicks v. U.S. Health Corp.*, No. 95 CA 2350, 1996 WL 263239, at *4 (Ohio Ct. App. May 10, 1996) (holding that a negligent credentialing claim against a hospital was severable from any related claims the patient sought to assert against a physician).

58. See *Moser*, 681 A.2d at 1325.

59. See *Fridena v. Evans*, 622 P.2d 463, 466 (Ariz. 1980). For example, failure to request information from the National Practitioner Data Bank results in a presumption that the hospital has knowledge of all the doctor's records on file at the bank. 42 U.S.C. § 11135(b) (2000).

60. See, e.g., *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991) (citing *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 174–75 (Wis. 1981)) (noting that hospitals have a "duty to select and retain only competent physicians").

61. See, e.g., *Johnson*, 301 N.W.2d at 158 (noting that a plaintiff must prove a doctor's negligence to provide the causal link between the hospital's grant of privileges and the plaintiff's injuries).

62. See, e.g., *Ferguson v. Gonyaw*, 236 N.W.2d 543, 550 (Mich. Ct. App. 1975) (explaining that a plaintiff must show "that even if the hospital had made the recommended and acknowledged

show two causal connections to the injury: one from the doctor and one from the hospital.⁶³

4. *Proximate Causation*

As for proximate causation, the normal negligence standards apply.⁶⁴ Basic tort theory teaches that defendants are liable for all injuries caused by their breach of duty until a supervening act destroys the nexus between the breach and an injury.⁶⁵ Accordingly, by negligently granting a doctor privileges, a hospital could proximately cause the injury of any patient whose injuries foreseeably stem from that doctor's connection to the hospital.⁶⁶ This includes patients admitted under a doctor's exercise of privilege⁶⁷ and conceivably includes patients who rely on their knowledge of the doctor's privileges as part of the decision to have that doctor treat them in the first place.

5. *Injury*

Lastly, the plaintiff must have suffered some physical harm at the hands of the credentialed practitioner.⁶⁸ This requirement does not differ from the injury requirement of the typical personal injury negligence claim.⁶⁹ Regardless of the

checks they would have denied staff privileges" in order to establish the hospital's liability); *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1045 (Ohio 1990) (citing *Johnson*, 301 N.W.2d at 164) ("[A] plaintiff must demonstrate that but for the hospital's lack of care in selecting the physician, the physician would not have been granted staff privileges and the plaintiff would not have been injured."), *overruled on other grounds by Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46, 53 (Ohio 1994).

63. *See, e.g., U.S. Fid. & Guar. Co. v. St. Elizabeth Med. Ctr.*, 716 N.E.2d 1201, 1206 (Ohio Ct. App. 1998) (stating that plaintiff suing for negligent credentialing must show a practitioner possessing negligently granted privileges negligently caused the injury).

64. *See Bickham v. Inphynet, Inc.*, 899 So. 2d 15, 18 (La. Ct. App. 2004).

65. *See Vinson v. Hartley*, 324 S.C. 389, 400–01, 477 S.E.2d 715, 721 (Ct. App. 1996) (citations omitted) ("Foreseeability is determined by looking to the natural and probable consequences of the act complained of. . . . A plaintiff therefore proves legal cause by establishing the injury in question occurred as a natural and probable consequence of the defendant's negligence.").

66. *See, e.g., Purcell v. Zimbelman*, 500 P.2d 335, 342 (Ariz. Ct. App. 1972) (deciding that a causal connection exists if, as a matter of ordinary experience, a particular act or omission might be expected to produce a particular result and that result occurs).

67. *See, e.g., Denton Reg'l Med. Ctr. v. LaCroix*, 947 S.W.2d 941, 942–43, 956 (Tex. App. 1997) (finding hospital's inadequate privileging procedures proximately caused brain damage from administration of anesthesia).

68. *See id.* at 950; *cf. Gay Parks Rainville, When a Biomedical Device Fails: Navigating the Regulatory and Legal Landscape*, INTELL. PROP. & TECH. L.J., Feb. 2007, at 12 (stating injury as part of the general test for corporate negligence liability).

69. *Compare Candler Gen. Hosp., Inc. v. Persaud*, 442 S.E.2d 775, 775–77 (Ga. Ct. App. 1994) (allowing negligent credentialing claim where patient died during surgery), *with Doe v. Marion*, 373 S.C. 390, 400, 645 S.E.2d 245, 250 (2007) (citing *Steinke v. S.C. Dep't of Labor*,

type of injury, a plaintiff could typically satisfy this element in proving actual or proximate causation.⁷⁰

C. Common Defenses

Hospitals may defend against a negligent credentialing claim in several ways. Although there is no common law affirmative defense unique to negligent credentialing, the standard affirmative negligence defenses—such as comparative or contributory negligence and assumption of risk⁷¹—apply as the facts allow.⁷² Additionally, a number of states have statutes that privilege information produced, obtained, and exchanged in the credentialing process.⁷³ These peer review statutes prevent litigants from discovering such information and are designed both to encourage candor among medical professionals and to allow a hospital's credentialing board greater autonomy in serving the hospital's needs.⁷⁴

Peer review statutes do not typically penalize hospitals for waiving the privilege,⁷⁵ and a hospital may invoke the privilege as a tactical defense.⁷⁶ A plaintiff asserting a deficiency in a hospital's credentialing activities may have difficulty proving the claim if the patient cannot access what may be the only source of proof.⁷⁷ For example, suppose a plaintiff alleges that a hospital

Licensing & Reg., 336 S.C. 373, 387, 520 S.E.2d 142, 149 (1999)) (noting plaintiff's burden to prove injury or damages in a negligence claim).

70. This could be the reason that some courts combine negligence causation and injury into a single element. *See, e.g.,* Bishop v. S.C. Dep't of Mental Health, 331 S.C. 79, 88, 502 S.E.2d 78, 82 (1998) (citing Rickborn v. Liberty Life Ins. Co., 321 S.C. 291, 300, 469 S.E.2d 292, 298 (1996)) (collapsing negligence causation and injury into "breach of [a] duty by a negligent act or omission").

71. Note, however, that assumption of risk is not always an available defense to negligence. *See, e.g.,* Davenport v. Cotton Hope Plantation Horizontal Prop. Regime, 333 S.C. 71, 87, 508 S.E.2d 565, 573–74 (1998) (finding that the doctrine of comparative negligence subsumes assumption of risk).

72. *See* Boles v. Urgent Care Pharmacy, Inc., No. COA05-540, 2006 WL 1984439, at *1 (N.C. Ct. App. July 18, 2006). Theoretically, a hospital could also defend against a negligent credentialing suit by using negative defenses, such as a lack of causation of the patient's injuries.

73. *See, e.g.,* FLA. STAT. § 395.0193(8) (2007) (providing that, with limited exceptions, peer review committee information is protected by privilege and not subject to compelled production); GA. CODE ANN. § 31-7-133 (2006) (same); MD. CODE ANN., HEALTH OCCUPATIONS § 1-401(d) (LexisNexis 2005) (same); N.C. GEN. STAT. § 122C-30(2) (2004) (same); TENN. CODE ANN. § 62-1-202(a) (1997) (same).

74. *See, e.g.,* McGee v. Bruce Hosp. Sys., 312 S.C. 58, 62, 439 S.E.2d 257, 260 (1993) ("[T]he public interest in candid professional peer review proceedings should prevail over the litigant's need for information from the most convenient source.").

75. *See, e.g.,* FLA. STAT. § 395.0193(8) (Florida's peer review privilege statute); N.C. GEN. STAT. § 122C-30(2) (North Carolina's peer review privilege statute).

76. *See, e.g.,* Sun Health Corp. v. Myers, 70 P.3d 444, 446 (Ariz. Ct. App. 2003) (explaining that a hospital was justified in refusing to make disclosures of information privileged by the peer review statutes).

77. *See* Larson v. Wasemiller, 738 N.W.2d 300, 310 (Minn. 2007).

negligently granted an incompetent surgeon operating privileges because the hospital did not properly follow its credentialing bylaws. In all likelihood, the most valuable evidence would be the surgeon's privileging file, which the peer review statute bars the plaintiff from viewing.⁷⁸

D. Development of the Claim

Negligent credentialing liability theory has existed for several decades. Illinois was the first state to recognize negligent credentialing as a theory of direct liability for hospitals,⁷⁹ but since then the theory has spread to other states.⁸⁰ Today approximately half of the states recognize negligent credentialing claims.⁸¹ Although courts vary in their reasoning for adopting the theory, many note a shift in public perception of hospitals from mere locations where

78. As discussed *infra* in Part IV.C., the opposite could be true; that is, producing the privileged information may be the hospital's only way to rebut the plaintiff's showing of negligence. A plaintiff could overcome lack of access to privileged information through use of medical qualification expert testimony. *See, e.g.*, Summary Judgment Order, *supra* note 14, at 3 (noting that the plaintiff's expert witnesses provided opinions that a doctor caused the plaintiff's injuries, that a proper credentialing process would have prevented the injuries, and that the hospital was grossly negligent in granting privileges to the doctor).

79. *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 164 (Cal. Ct. App. 1982) (citing *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 258 (Ill. 1965)). In *Darling*, a private doctor, on call in the hospital's emergency room, improperly applied a cast to a broken leg. *Darling*, 211 N.E.2d at 255. The doctor later discovered this error and the leg required amputation below the knee. *Id.* at 255–56. The Supreme Court of Illinois upheld a jury's verdict that the hospital was negligent in not reviewing the doctor's work or requiring him to consult with orthopedic surgeons on treating the leg, thereby imposing upon hospitals a duty of proper credentialing of private physicians that, if breached, could constitute the proximate cause of harm to the plaintiff. *See id.* at 258.

80. *See St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 509 (Tex. 1997) (Phillips, C.J., dissenting) (noting the recognition of negligent credentialing liability in twenty-seven states); *Stottlemeyer v. Ghramm*, No. 91-L-181, 2001 WL 34084307, at *3 (Va. Cir. Ct. July 13, 2001) (estimating twenty-five to thirty states); 18 CAUSES OF ACTION (SECOND) § 10 (2002) (listing twenty-eight states).

81. *See Humana Med. Corp. of Ala. v. Traffanstedt*, 597 So. 2d 667, 669 (Ala. 1992); *Purcell v. Zimbelman*, 500 P.2d 335, 341 (Ariz. Ct. App. 1972); *Elam*, 183 Cal. Rptr. at 165; *Insinga v. LaBella*, 543 So. 2d 209, 211 (Fla. 1989); *Mitchell County Hosp. Auth. v. Joiner*, 189 S.E.2d 412, 414 (Ga. 1972); *Darling*, 211 N.E.2d at 257; *Winona Mem'l Hosp., Ltd. P'ship v. Kuester*, 737 N.E.2d 824, 828–29 (Ind. Ct. App. 2000); *Ferguson v. Gonyaw*, 236 N.W.2d 543, 550 (Mich. Ct. App. 1975); *Gridley v. Johnson*, 476 S.W.2d 475, 485 (Mo. 1972); *Foley v. Bishop Clarkson Mem'l Hosp.*, 173 N.W.2d 881, 884–85 (Neb. 1970); *Moore v. Bd. of Trs. of Carson-Tahoe Hosp.*, 495 P.2d 605, 608 (Nev. 1972); *Corleto v. Shore Mem'l Hosp.*, 350 A.2d 534, 538–39 (N.J. Super. Ct. Law Div. 1975); *Felice v. St. Agnes Hosp.*, 411 N.Y.S.2d 901, 907 (N.Y. App. Div. 1978); *Bost v. Riley*, 262 S.E.2d 391, 396 (N.C. Ct. App. 1980); *Pedroza v. Bryant*, 677 P.2d 166, 170 (Wash. 1984) (en banc); *Utter v. United Hosp. Ctr., Inc.*, 236 S.E.2d 213, 216 (W. Va. 1977) (quoting *Duling v. Bluefield Sanitarium, Inc.*, 142 S.E.2d 754, 756 (W. Va. 1965)); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 164 (Wis. 1981); *Greenwood v. Wierdsma*, 741 P.2d 1079, 1088 (Wyo. 1987). *Cf. Storrs v. Lutheran Hosps. & Homes Soc'y of Am., Inc.*, 661 P.2d 632, 635 (Alaska 1983) (upholding a hospital's decision to revoke a doctor's privileges on grounds that not doing so could have constituted a breach of duty).

independent doctors treat patients to comprehensive medical care entities replete with diverse staff positions and technologies.⁸² A typical companion reason is that hospitals often hold themselves out to the public as institutions whose members collaborate in patient treatment.⁸³ Accordingly, courts have said that hospitals should have to uphold this perception.⁸⁴

Not all states presented with negligent credentialing have accepted it,⁸⁵ typically on grounds that a peer review statute immunizes hospitals from liability for negligent credentialing.⁸⁶ Colorado, for example, has held that its peer review privilege statute bars a negligent credentialing claim against hospitals as contrary to the public policies embodied in that statute.⁸⁷ Meanwhile, a limited hospital malpractice immunity statute bars negligent credentialing claims against hospitals in Kansas.⁸⁸ Arizona has officially recognized the claim but effectively nullified it by granting the peer review privilege a broad scope.⁸⁹

III. RELEVANT SOUTH CAROLINA LAW

At this time, no South Carolina statute or appellate decision recognizes a cause of action for negligent credentialing.⁹⁰ However, a recent circuit court's decision, if upheld, could change that.⁹¹ Regardless, any decision on the

82. See *Elam*, 183 Cal. Rptr. at 163 (quoting Arthur F. Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W. L. REV. 429, 429 (1973); *Ybarra v. Spangard*, 154 P.2d 687, 691 (Cal. 1944)).

83. See, e.g., *York v. Rush-Presbyterian-St. Luke's Med. Ctr.*, 854 N.E.2d 635, 651 (Ill. 2006) (noting that “hospitals advertise themselves as centers for complete medical care”).

84. See *Johnson*, 301 N.W.2d at 164.

85. See, e.g., *McVay v. Rich*, 874 P.2d 641, 645 (Kan. 1994) (explaining that a health care provider is not liable for claims arising out of the professional negligence of another health care provider).

86. *Stottlemeyer v. Ghramm*, No. 91-L-181, 2001 WL 34084307, at *4–5 (Va. Cir. Ct. July 13, 2001).

87. *Kauntz v. HCA—Healthone, LLC*, 174 P.3d 813, 820 (Colo. App. 2007), *cert. denied*, No. 075C793, 2008 WL 115540, at *1 (Colo. Jan. 14, 2008). Similarly, Delaware's peer review privilege law bars most negligent credentialing claims. See *Svindland v. A.I. DuPont Hosp. for Children of the Nemours Found.*, No. 05-0417, 2006 WL 3209953, at *3–4 (E.D. Pa. Nov. 3, 2006).

88. See *McVay*, 874 P.2d at 645–46 (quoting *McVay v. Rich*, 859 P.2d 399, 404 (Kan. Ct. App. 1994)).

89. See *Sun Health Corp. v. Myers*, 70 P.3d 444, 449 (Ariz. Ct. App. 2003). The remaining states, including South Carolina, have either avoided answering the question of whether to adopt the claim or have not yet had occasion for their appellate courts to decide the issue. See 18 CAUSES OF ACTION (SECOND) § 10 (2002) (listing Alaska, Arkansas, Connecticut, Hawaii, Idaho, Indiana, Iowa, Kentucky, Maine, Maryland, Minnesota, New Hampshire, New Mexico, Oregon, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, and West Virginia).

90. The *Strickland* court acknowledged the doctrine's adoption in other states but did not affirmatively join those states in recognition. *Strickland v. Madden*, 323 S.C. 63, 71, 448 S.E.2d 581, 586 (Ct. App. 1994) (per curiam). Moreover, the court did not make it clear what it meant by “corporate negligence.” *Id.*; see also *infra* text accompanying notes 109–112 (discussing *Strickland*).

91. See Summary Judgment Order, *supra* note 14.

propriety of negligent credentialing will likely take into consideration the following statutes and case law.

A. *The Peer Review Statutes*

South Carolina law provides hospitals and doctors with limited protections from liability and participation in discovery. First, a statutory privilege protects all information concerning medical peer review proceedings and all data, documents, and information acquired or created by parties to those proceedings.⁹² Known as the confidentiality statute,⁹³ it provides that such proceedings and documents are not subject to discovery, subpoena, or introduction into evidence in any civil action except on appeal from a peer review committee's action.⁹⁴ These protections are not absolute nor are they comprehensive.

As construed by South Carolina appellate courts, these provisions work in favor of hospitals. In *McGee v. Bruce Hospital System*, the South Carolina Supreme Court held that the statute protected applications for staff privileges and supporting documents.⁹⁵ In case of conflict over disclosure of the information during litigation, “the public interest in candid professional peer review proceedings should prevail over the litigant’s need for information from the most convenient source.”⁹⁶ The court noted that “[t]he underlying purpose behind the confidentiality statute is not to facilitate the prosecution of civil actions, but to promote complete candor and open discussion among participants in the peer review process,”⁹⁷ and that the “overriding public policy of the confidentiality statute is to encourage healthcare professionals to monitor the competency and professional conduct of their peers to safeguard and improve the quality of patient care.”⁹⁸

Likewise, in *Durham v. Vinson*,⁹⁹ the South Carolina Supreme Court held that under the statute, questioning a doctor about nonproduction of privileged information was improper. Although the court found that the attorney’s inquiry was harmless error, it emphasized the importance of safeguarding against such behavior in the future, stating:

92. S.C. CODE ANN. § 40-71-20(A) (2001 & Supp. 2008). Additionally, the South Carolina Supreme Court has held that the statutory privilege protects documents generated by the committee and “all information, documents, or records acquired by the committee as part of its decision-making process.” *McGee v. Bruce Hosp. Sys.*, 312 S.C. 58, 62, 439 S.E.2d 257, 260 (1993).

93. *McGee*, 312 S.C. at 62, 438 S.E.2d at 260.

94. See S.C. CODE ANN. § 40-71-20(A); *McGee*, 312 S.C. at 62, 439 S.E.2d at 260.

95. *McGee*, 312 S.C. at 63–64, 439 S.E.2d at 261. However, the statute does not prevent discovery of general policies and procedures for monitoring physicians. *Id.* at 64, 439 S.E.2d at 261.

96. *Id.* at 62, 439 S.E.2d at 260.

97. *Id.* at 61, 439 S.E.2d at 259 (citing *Cruger v. Love*, 599 So. 2d 111, 113–14 (Fla. 1992)).

98. *Id.*

99. 360 S.C. 639, 602 S.E.2d 760 (2004).

If physicians can be questioned before the jury about the refusal to produce this privileged information, the effect is to pressure them toward disclosure of the privileging file. As occurred here, the exercise of the statutory right not to disclose the information would be used against the physician as evidence the physician is hiding something. Allowing this to occur does not serve the policy goals of promoting candor and open discussion among participants in the peer review process.¹⁰⁰

More recently, in *Wieters v. Bon-Secours-St. Francis Xavier Hospital, Inc.*,¹⁰¹ the South Carolina Court of Appeals discussed a limited exception to the statute applicable only to doctors and other practitioners.¹⁰² “[O]nly in one narrow circumstance does a litigant have access to peer review information”: when that litigant is a physician appealing a peer review committee’s adverse credentialing decision.¹⁰³ The court emphasized the narrowness of the exception by noting what a broader exception would produce:

If peer review information is subject to compulsion beyond the narrow boundaries enacted by the legislature, the foundation of the peer review process would be severely compromised. Without the promise of confidentiality of the information, physicians would not fully and completely participate in the process or not participate at all. The lack of candor and openness would hinder and thwart hospitals in their efforts to effectively monitor physicians.¹⁰⁴

This exception was not the court’s creation; rather, the court merely restated an exception contained in the statute itself.¹⁰⁵ Thus, despite challenges to the statute to acquire information in suits against both doctors and hospitals, South Carolina’s courts have thus far upheld the confidentiality statute as inviolate in tort claims.

A second statute provides peer review committee members immunity from monetary liability for nonmalicious actions taken pursuant to hospital bylaws within the scope of the committee’s functions.¹⁰⁶ Whether this immunity applies to a hospital is not entirely clear, as there are no reported cases explaining the

100. *Id.* at 649, 602 S.E.2d at 765.

101. 378 S.C. 160, 662 S.E.2d 430 (Ct. App. 2008), *vacated*, 381 S.C. 332, 332, 673 S.E.2d 417, 417–18 (2009). The South Carolina Supreme Court’s order denied certiorari and vacated the South Carolina Court of Appeals’s opinion because the circuit court’s order was not immediately appealable. *Weiters*, 381 S.C. at 332, 673 S.E.2d at 418.

102. *See Weiters*, 378 S.C. at 171–73, 662 S.E.2d at 436–37.

103. *Id.* at 172, 662 S.E.2d at 436.

104. *Id.*, 662 S.E.2d at 436–37.

105. *See id.* at 171, 662 S.E.2d at 436 (quoting S.C. CODE ANN. § 40-71-20 (2001 & Supp. 2008)).

106. *See* S.C. CODE ANN. § 40-71-10 (2001 & Supp. 2008).

extent of the immunity.¹⁰⁷ In analyzing the statute, though, the fact that it protects these members only when they act within the scope of their duties as members of a peer review committee indicates that the legislature sought to provide immunity only for committee members acting in a professional capacity, rather than an individual capacity. Combined with the fact that those who grant privileges and conduct peer review will be acting as employees and board members of a hospital, applying the doctrine of respondeat superior leads to the conclusion that section 40-70-10 might protect a hospital. This reading has support from the South Carolina Supreme Court, which has noted that a hospital's executive committees—which consist of civilian board members and physicians—are “committees” for the purposes of the statute.¹⁰⁸

B. *Negligent Credentialing Case Law*

State court precedent addressing negligent credentialing is scant. In 1994, the South Carolina Court of Appeals avoided discussing the propriety of negligent credentialing when it declined to squarely recognize a cause of action for corporate negligence against a hospital.¹⁰⁹ In *Strickland v. Madden*, the plaintiff asserted that a hospital was negligent in not stripping an allegedly alcoholic doctor of his practice privileges.¹¹⁰ Noting that other jurisdictions allowed suits for “corporate negligence,” the court refused to find that a hospital owed patients a duty to review the competence of its staff physicians.¹¹¹ Additionally, the court stated that even if such a duty existed, there was no cognizable standard of care by which the court could determine whether the hospital had breached that duty.¹¹²

After *Strickland*, several commentators posited that because the South Carolina Court of Appeals seemed somewhat hesitant in its decision, South Carolina may eventually recognize some form of negligent credentialing.¹¹³ This

107. The *Person* court decided that the protection only applies to the committee members as individuals, see Summary Judgment Order, *supra* note 14, at 12, but because the *Person* appeal is in its infancy, it is unknown whether the court's reading of section 40-71-10 will be presented as an issue.

108. *McGee v. Bruce Hosp. Sys.*, 312 S.C. 58, 61, 439 S.E.2d 257, 259 (1993). Interestingly, the Supreme Court of Texas held that a similar statute that immunized medical peer review committees engaging in peer review from civil liability thereby provided a hospital with immunity against a negligent credentialing claim. *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 509 (Tex. 1997).

109. See *Strickland v. Madden*, 323 S.C. 63, 72, 448 S.E.2d 581, 586 (Ct. App. 1994) (per curiam).

110. *Id.* at 66, 71, 448 S.E.2d at 583, 586.

111. *Id.* at 71–72, 448 S.E.2d at 586. It is unclear whether the court used this phrase to refer to the corporate negligence doctrine or the negligent credentialing cause of action.

112. *Id.* at 72, 448 S.E.2d at 586.

113. See Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C. L. REV. 431, 472 (1996); Robin Sloan Cromer, Note,

prediction recently came one step closer to fulfillment in *Person v. Carolina Pines Medical Center*.¹¹⁴ In 2001, Ruth Person requested that her private surgeon, Dr. Thomas Mincheff, perform laparoscopic surgery to treat her severe acid reflux.¹¹⁵ Dr. Brooks Bannister assisted in the operation.¹¹⁶ The operation was unsuccessful and Person sued, alleging that Mincheff injured her colon, spleen, and pancreas during surgery.¹¹⁷ She also sued Carolina Pines, the hospital where she underwent the surgery, for negligently granting Mincheff surgical privileges.¹¹⁸

Carolina Pines eventually moved for summary judgment, arguing that because South Carolina does not recognize a legal duty of adequate credentialing, Carolina Pines owed Person no such duty.¹¹⁹ It added that South Carolina should not recognize a claim for inadequate credentialing in light of the confidentiality statute's strong protection of peer review and design to foster quality assurance.¹²⁰ The trial court denied Carolina Pines's motion, finding that South Carolina law does allow negligent credentialing lawsuits.¹²¹ The trial court went on to reject Carolina Pines's arguments that the confidentiality statute should bar the claim.¹²²

Carolina Pines petitioned the South Carolina Supreme Court for certiorari and mandamus, essentially reiterating its arguments from its motion for summary judgment.¹²³ The supreme court denied both petitions;¹²⁴ however, the hospital prevailed both at trial and on post-trial motions.¹²⁵ The case is currently before the South Carolina Court of Appeals.¹²⁶

Court Considers Limitations on Recovery for Emotional Distress, Adoption of Doctrine of Corporate Negligence, 47 S.C. L. REV. 160, 164 (1995).

114. See Summary Judgment Order, *supra* note 14.

115. *Id.* at 1.

116. See *id.* at 2.

117. *Id.*

118. *Id.* Eventually, both doctors settled with Person for \$1,000,000. *Id.* at 3.

119. See *id.*

120. *Id.*

121. *Id.* at 9, 15.

122. *Id.* at 11–12.

123. See generally *Petition for a Writ of Mandamus or for a Writ of Certiorari, Person v. Carolina Pines Reg'l Med. Ctr.*, No. 2004-CP-16-322 (Darlington County Ct. Com. Pl. Oct. 31, 2006) [hereinafter *Petition*] (arguing for the South Carolina Supreme Court to decide whether South Carolina recognizes negligent credentialing claims).

124. Letter from South Carolina Supreme Court Denying *Petition for Writ of Mandamus or for a Writ of Certiorari, Person v. Carolina Pines Reg'l Med. Ctr.*, No. 2004-CP-16-322 (Darlington County Ct. Com. Pl. Nov. 2, 2006).

125. See *Order Denying Plaintiff's Post-Trial Motions, Person v. Carolina Pines Reg'l Med. Ctr.*, No. 01-CP-16-0813 (Darlington County Ct. Com. Pl. April 7, 2008).

126. See *supra* note 15.

IV. ANALYSIS OF NEGLIGENT CREDENTIALING IN LIGHT OF SOUTH CAROLINA LAW AND POLICY CONSIDERATIONS

Recognizing a cause of action for negligent credentialing in South Carolina would be problematic because doing so runs contrary to established precedent upholding respect for a hospital's judgment of doctors' qualifications¹²⁷ and precedent that denounces reallocation of liability from doctors to hospitals.¹²⁸ Additionally, recognition would likely cause serious problems in the medical profession and, consequently, would cause problems for those who rely on medical professionals. While there are arguments in favor of recognition, none of them speaks to any overriding benefits—to plaintiffs or to society at large—of allowing the claim. To the extent recognition could improve healthcare through the threat of litigation and economic liability, South Carolina law already provides avenues to achieving that goal without producing the attendant detrimental effects that negligent credentialing would create for doctors, hospitals, and patients.¹²⁹

A. *Precedent Upholding Deference to the Hospital's Judgment*

Several South Carolina appellate court decisions indirectly reject negligent credentialing by holding that a hospital's privileging decisions are not subject to judicial review absent legislative or regulatory authority.¹³⁰ The supreme court recognized this principle in *Gowan v. St. Francis Community Hospital*, where a private physician sued a hospital for injunctive relief after the hospital denied him practice privileges.¹³¹ The South Carolina Supreme Court affirmed dismissal of the doctor's claim, stating that the freedom of a hospital to make credentialing decisions was a "longstanding principle" from which it would not depart.¹³² Six years later, in *Lee v. Chesterfield General Hospital, Inc.*,¹³³ the South Carolina Court of Appeals clarified this principle, stating that a court may review a private

127. See *Wood v. Hilton Head Hosp., Inc.*, 292 S.C. 403, 405, 356 S.E.2d 841, 842 (1987); *Gowan v. St. Francis Cmty. Hosp.*, 275 S.C. 203, 204, 268 S.E.2d 580, 581 (1980) (per curiam) (citing *Khan v. Suburban Cmty. Hosp.*, 340 N.E.2d 398, 402 (Ohio 1976); *Strauss v. Marlboro County Gen. Hosp.*, 185 S.C. 425, 426, 194 S.E. 65, 65 (1937); *Edson v. Griffin Hosp.*, 144 A.2d 341, 344 (Conn. Super. Ct. 1958)); *Lee v. Chesterfield Gen. Hosp., Inc.*, 289 S.C. 6, 9, 344 S.E.2d 379, 381 (Ct. App. 1986).

128. See *Newell v. Trident Med. Ctr.*, 359 S.C. 4, 14, 597 S.E.2d 776, 781 (2004) (per curiam); *Simmons v. Tuomey Reg'l Med. Ctr. (Simmons II)*, 341 S.C. 30, 52, 533 S.E.2d 312, 323 (2000).

129. See *infra* Part IV.E.

130. See *Wood*, 292 S.C. at 405, 356 S.E.2d at 842; *Gowan*, 275 S.C. at 204, 268 S.E.2d at 581 (citing *Khan*, 340 N.E.2d at 402; *Strauss*, 185 S.C. at 426, 194 S.E. at 65); *Edson*, 144 A.2d at 344; *Lee*, 289 S.C. at 9, 344 S.E.2d at 381.

131. *Gowan*, 275 S.C. at 204, 268 S.E.2d at 581.

132. *Id.* (citing *Khan*, 340 N.E.2d at 402; *Strauss*, 185 S.C. at 427, 194 S.E. at 66; *Edson*, 144 A.2d at 344).

133. 289 S.C. 6, 344 S.E.2d 379 (Ct. App. 1986).

hospital's privileging decisions when not prohibited by legislative or regulatory action.¹³⁴ The South Carolina Supreme Court affirmed this view in *Wood v. Hilton Head Hospital, Inc.*,¹³⁵ tracing the rule's existence in South Carolina law back to the 1930s.¹³⁶

None of these cases involved a patient's direct tort claim against a hospital. The cases that the *Gowan*, *Lee*, and *Wood* courts cite indicate that the courts recognized, especially in private hospitals, that evaluations of doctors' qualifications are best left to those with the most expertise. As the *Khan* court stated, "[a] court may not substitute its judgment for that of the hospital trustees' judgment."¹³⁷ Together with peer review statutes, this rule of independence indicates that South Carolina's courts and its legislature have a policy of protecting the medical community's ability to accurately judge the qualifications of its members. In negligent credentialing liability, though, a court substitutes its own judgment not only for that of the hospitals' trustees but also for those of the medical executive committee, the peer review committee, department chiefs, the physician, and the patient who selected the physician. Thus, allowing a claim for negligent credentialing would contradict both the letter and the purpose of South Carolina law.

B. Precedent Opposing Reallocation of Liability

Moreover, negligent credentialing conflicts with South Carolina law because it imposes a distribution of liability that the South Carolina Supreme Court has explicitly denounced. As discussed below,¹³⁸ the supreme court in *Simmons II* set boundaries on the circumstances in which a patient could hold a hospital vicariously liable for a private doctor's torts.¹³⁹ *Simmons II* provides that under the doctrines of apparent agency or nondelegable duty a hospital may be vicariously liable to a patient for a private physician's negligence because of the patient's perception that the hospital, and not a particular doctor, would treat him.¹⁴⁰ However, the hospital is not vicariously liable for injuries resulting from patients meeting their private doctors at the hospital for treatment.¹⁴¹ *Simmons II* thus implies a spectrum of liability progressing from direct liability, to vicarious liability, to none.¹⁴² Once outside the limits set by *Simmons II*, there is no

134. *Id.* at 9, 344 S.E.2d at 381.

135. 292 S.C. 403, 356 S.E.2d 841 (1987).

136. *Id.* at 405, 356 S.E.2d at 842 (citing *Strauss*, 185 S.C. at 427, 194 S.E. at 65).

137. *Khan*, 340 N.E.2d at 402; see also *Edson*, 144 A.2d at 344 (noting that the court has no authority to substitute its judgment for the decisions made by hospitals regarding policy and management).

138. See *infra* Part IV.E.1.

139. *Simmons II*, 341 S.C. 30, 52, 533 S.E.2d 312, 323 (2000).

140. *Id.*

141. *Id.*

142. This has support in the fact that vicarious liability is merely a fiction used to hold a party accountable for what the party did not do or, in the case of an organizational entity, physically could

cognizable causal nexus to the hospital left for the courts to make. At that point, the only legitimate recourse is for the patient to recover only from the doctor who negligently caused the harm.¹⁴³ However, negligent credentialing theory posits a different system of liability. By alleging an additional wrongful act in a malpractice suit, a plaintiff makes the spectrum of causation circular: once vicarious liability ends at *Simmons II*, direct liability begins anew.

Other precedent indicates that South Carolina rejects this concept. The South Carolina Supreme Court has dismissed a legal theory designed to produce changes in the medical community similar to those changes negligent credentialing liability would produce. In *Newell v. Trident Medical Center*,¹⁴⁴ the plaintiff argued that a doctor with hospital privileges was the hospital's agent for the purpose of getting his patients' informed consent on surgical procedures.¹⁴⁵ Noting that *Simmons II* limited the applicability of apparent agency and nondelegable duty in the context of malpractice cases, the court rejected the plaintiff's theory because of the results it would produce:

If [the plaintiff] is correct [that the doctor was the hospital's agent], then hospitals are potentially more responsible for the acts of admitting physicians than for the actions of physicians who are independent contractors as in . . . *Simmons*. We find *neither precedent nor public policy* support such a re-allocation of responsibility and liability between hospitals and physicians with staff privileges.¹⁴⁶

In other words, the South Carolina Supreme Court squarely rejected a proposal that would hold a hospital liable for granting privileges to a doctor who later harmed his patient during the course of treatment.¹⁴⁷ Instead, a plaintiff in a medical malpractice suit against a doctor should recover only from the person who most proximately caused the harm—the doctor.¹⁴⁸

In terms of shifting liability from doctors to hospitals, negligent credentialing and the failed theory from *Newell* could not be more similar. Each makes a hospital pay for the mistakes of a private physician with whom it has a

not have done itself. See *S.C. Ins. Co. v. James C. Greene & Co.*, 290 S.C. 171, 180–81, 348 S.E.2d 617, 622 (Ct. App. 1986) (describing respondeat superior as a fiction).

143. This point raises such challenges as: "What if the hospital's operating room nurse assisting Dr. Davis was negligent?", or "What if the only reason the plaintiff became Dr. Johnson's patient was because Dr. Johnson was admitted at Sacred Heart, where the plaintiff wanted her surgery?" Neither case implicates negligent credentialing. In the former, the patient could sue the hospital in respondeat superior negligence. In the latter, the circumstances have moved into the realm of apparent agency; the plaintiff ultimately sought treatment based on the hospital's reputation.

144. 359 S.C. 4, 597 S.E.2d 776 (2004) (per curiam).

145. *Id.* at 11, 597 S.E.2d at 779.

146. *Id.* at 14, 597 S.E.2d at 781 (emphasis added).

147. See *id.*

148. See *id.*

relationship more tenuous than it does independent contractors, and because of that, each theory produces an outcome South Carolina's highest court has found to be against public policy. South Carolina courts would also violate public policy by embracing a theory which results in a "re-allocation" of liability that the supreme court so recently rejected.¹⁴⁹ Therefore, recognizing negligent credentialing would be inconsistent with South Carolina precedent.

C. Problems of Recognition

Additionally, policy considerations warrant rejecting the theory. Although negligent credentialing could improve the quality of medical care by using the threat of liability as incentive for hospitals to increase oversight of private practitioners and limit credentials to only those most qualified to treat patients, there is great potential for the claim to worsen medicine in South Carolina. By shifting the primary purpose of peer review from quality care assurance to avoiding liability, negligent credentialing incentivizes hospitals and doctors to put litigation aversion ahead of patient care.¹⁵⁰ Hospitals could set unnecessarily high, or seriously low, peer review standards; hospitals could eviscerate peer review by waiving privilege to win otherwise unwinnable lawsuits; codefendant practitioners and hospitals could use waiver of the peer review privilege against one another; and practitioners could sue hospitals for denial of credentials. Additionally, allowing the claim against hospitals could lead to transforming peer review in other licensed professions into a calculus of avoiding litigation losses.

1. Undermining the Privileging Process

As South Carolina courts have indicated, candor and discretion are essential to ensuring quality healthcare in hospitals¹⁵¹ and preserving honest and open evaluation of candidates.¹⁵² Peer review committees rely on this independence in

149. *Cf. Wehle v. S.C. Ret. Sys.*, 363 S.C. 394, 402, 611 S.E.2d 240, 244 (2005) (quoting *Powers v. Powers*, 239 S.C. 423, 427, 123 S.E.2d 646, 647 (1962)) ("It is manifestly in the public interest that the law remain permanently settled.").

150. This Comment does not suggest that providing quality medical treatment and avoiding liability are mutually exclusive. Improving conduct to avoid negligence liability can result in better patient care; indeed, such an outcome is a prime goal of the theory of negligence liability. *See* David G. Owen, *Deterrence and Desert in Tort Law: A Comment*, 73 CAL. L. REV. 665, 666, 669 (1985). However, equally possible, and arguably more probable, is that the threat of monetary liability so predominates an actor's decision making that avoiding litigation and economic loss becomes more important than improving or even maintaining quality standards. The discussion that follows focuses on the latter possibility.

151. *See, e.g., McGee v. Bruce Hosp. Sys.*, 312 S.C. 58, 61–62, 439 S.E.2d 257, 259–60 (1993) (holding that a plaintiff's discovery request for staff privileged information at a hospital violated the public policy of the confidentiality statute).

152. *Id.*; LEVIN, *supra* note 29, at 126 (citing *Bredice v. Doctors Hosp., Inc.*, 51 F.R.D. 187, 188 (D.D.C. 1970)).

determining something as amorphous as a physician's competence.¹⁵³ In credentialing, the committee does not have a concrete definition of "competence" but rather it determines competence on a case-by-case basis according to the type of privileges the applicant desires.¹⁵⁴ After all, the purpose of the peer review inquiry is to determine whether the candidate can perform a procedure,¹⁵⁵ not whether a patient will ever sue the candidate for malpractice. That the Joint Commission leaves determination of competency standards to the limited discretion of the individual hospital's peer review committee¹⁵⁶ highlights the difficulty a hospital would have in predicting who is "competent" enough to avoid liability.¹⁵⁷ Because of this inherent difficulty, arguably the safest choice for a hospital is to effectively eliminate its discretion by making competence synonymous with perfection. Rather than risk negligent credentialing liability for the minutest flaw in a doctor's record, the litigation-averse hospital would substitute the judgment of the most plaintiff-friendly jury imaginable¹⁵⁸ for that of its board members and review committee members, regulatory agencies, and the patient who desired to select the private practitioner to perform the procedure in question.¹⁵⁹

Such a strategy would lead to the denial of credentials to genuinely qualified, albeit reasonably flawed, practitioners, thereby limiting their ability to treat their patients because they do not have access to the sophisticated equipment and staff resources that generally only a hospital can afford.¹⁶⁰

153. Recall that the overall purpose of credentialing is for hospitals to allow only competent practitioners to treat patients on their premises. See *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 170–71 (Wis. 1981).

154. See, e.g., 42 U.S.C. § 11151(9) (2000) (describing a peer review action as an evaluation of an individual physician's conduct).

155. Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1233 n.242 (2006).

156. Elizabeth A. Snelson, *Physician Employment and Alternative Practice Strategies: Avoiding "Company Doctor" Syndrome & Other Medical Staff Issues*, HEALTH LAW., Dec. 2008, at 14, 16–17.

157. See David H. Rutchik, Note, *The Emerging Trend of Corporate Liability: Courts' Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed*, 47 VAND. L. REV. 535, 562 (1994). This raises the issue of what criteria would be useful under such an analysis. Does a surgeon lack competence to perform a particular procedure because she has only performed it ten times before? Because she has only been out of residency for a year? Because she got a B+ in a first-year medical school course? Because she believes human life begins at conception?

158. See *id.* at 561.

159. Cf. Margo Schlanger, *Second Best Damage Action Deterrence*, 55 DEPAUL L. REV. 517, 527 (2006) (discussing the prevalence of substitutes—measures taken primarily to avoid liability, rather than correct a problem—in hospitals).

160. This strategy could severely impede the practice of medicine in South Carolina. Twenty-seven South Carolina counties have a single hospital system (Abbeville; Allendale; Anderson; Bamberg; Cherokee; Chester; Chesterfield; Clarendon; Colleton; Dillon; Edgefield; Fairfield; Georgetown; Greenwood; Hampton; Kershaw; Lancaster; Laurens; Lexington; Marion; Marlboro; Newberry; Oconee; Orangeburg; Sumter; Union; and Williamsburg) and four have none (Calhoun; Jasper; Lee; McCormick; and Saluda). See S.C. Hosp. Ass'n, *Participating Hospitals*,

Additionally, a hospital's overly sensitive credentialing standards could have a snowballing effect upon a doctor's ability to practice medicine.¹⁶¹ Given that many hospitals already inquire whether another hospital has denied credentials to an applicant¹⁶² and that the National Practitioner Data Bank requires notification whenever a hospital denies a doctor practice privileges,¹⁶³ a single denial could put so dark a stain on a doctor's record that no hospital would be willing to grant the doctor privileges. Combined with the likelihood of lawsuits¹⁶⁴ and ever-increasing malpractice insurance costs, such diminished chances of acquiring credentials may well deter people from pursuing careers in medicine in the first place.¹⁶⁵

The possibilities are no better where the breach in question is either the hospital's failure to develop peer review standards or its deviation from its own standards.¹⁶⁶ In this scenario, hospitals have the opportunity and incentive to

<http://www.myschospital.org/participatinghospitals.aspx> (last visited May 18, 2009). A hospital is currently under construction in Barnwell County. *Id.* Thus, even a single denial of credentials may mean that a doctor and his patient would have to travel many miles to find a hospital that will grant the doctor credentials. Alternatively, patients may not be willing or able to travel one or two counties over to have their doctor of choice perform a procedure. In that case, a qualified practitioner's practice could suffer or even cease to exist, further decreasing the availability of patient care. See LEVIN, *supra* note 29, at 2.

161. See LEVIN, *supra* note 29, at 2, 4.

162. *Id.* at 2.

163. See 42 U.S.C. § 11132(a) (2000).

164. A patient is up to seven times more likely to sue a faultless doctor than a negligent one. Ilene N. Moore et al., *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, 59 VAND. L. REV. 1175, 1195 (2006).

165. Such a scenario becomes all the more alarming—and realistic—in light of a recent report by the Physician's Foundation stating that 49% of primary care physicians consider leaving medicine because of these issues. Val Willingham, *Half of Primary-Care Doctors in Survey Would Leave Medicine*, CNN.COM, Nov. 17, 2008, <http://www.cnn.com/2008/HEALTH/11/17/primary.care.doctors.study/index.html>. The American Medical Association projects a shortage of 35,000–40,000 primary care doctors in the U.S. by 2025. *Id.*

One finer point is that allowance of the claim may additionally raise an acute danger for attorneys, especially those practicing healthcare law. Hospitals may develop unofficial policies of banning lawyers—particularly plaintiffs' lawyers—from receiving treatment in their facilities. Reasons would include retaliation for a lawyer's previous accomplishments, fear that an attorney will use treatment as basis for a future lawsuit, or a combination of both. It is no secret that physicians and surgeons routinely make personal choices not to treat lawyers for these very reasons. See Laura Parker, *Medical Malpractice Battle Gets Personal*, USA TODAY, June 14, 2004, at A2 (quoting a South Carolina surgeon who referred to the practice as "hardball," but emphasized that "it's ethical."). A surgeon who requested anonymity from the author stated that it is common practice for doctors on call to create an excuse not to treat an attorney admitted to the local emergency room. Interview with Anonymous Physician, in Charleston, S.C. (May 20, 2008). "I live in a plaintiff-friendly county, and I don't want my family to lose our house just because I put too many stitches in some guy's scalp after I stopped his brain from bleeding." *Id.* Worried about credentialing liability, peer review committees could adopt this as an unofficial criterion.

166. Note, though, that this could only occur in a jurisdiction that looked only to local custom. Because Joint Commission accreditation requires the development of *adequate* standards, as opposed to *any* standards, a court basing the duty of care on Joint Commission criteria may hold that peer review standards that fail the Joint Commission criteria fail breach of duty analysis. See,

lower their quality standards so that plaintiffs would have difficulty proving a breach of duty. This scenario not only contradicts a central premise of negligent credentialing—that the threat of monetary liability should be an incentive to improve the quality of peer review¹⁶⁷—but could also do great harm to patients. A duty of care that looks only to adherence to an existing standard, rather than the adequacy of the standard, could allow hospitals to circumvent liability by setting peer review standards low enough to avoid inquiry that might typically alert hospitals to problems with a practitioner's qualifications. Therefore, allowing claims for a hospital's failure to develop or adhere to some cognizable standard of peer review would be irresponsible because, rather than keeping good doctors out of hospitals, it could let poor ones in.

2. *Choosing Between Liability and Effective Peer Review*

In addition to problems resulting from a hospital's efforts to avoid litigation and liability in the first place, issues may also arise from actions a hospital takes during the course of a lawsuit. If a patient can produce sufficient nonprivileged evidence to support a finding of negligent credentialing, it is likely that the only way a hospital can challenge the plaintiff's case is by introducing peer review information, which requires surrendering the privilege.¹⁶⁸ Thus, a hospital facing a negligent credentialing claim will be faced with two unenviable options: keep the privilege and lose the case, or waive the privilege and harm an important medical process.

If the hospital elects the former choice, it will maintain the candor and confidence of the medical profession as the legislature and Congress intended all healthcare institutions to do.¹⁶⁹ However, a hospital would be upholding these ideals at the substantial monetary cost of litigating claims and paying settlements and adverse judgments, all of which will increase the hospital's insurance premiums and other operating expenses.¹⁷⁰ Rather than absorb these costs, a hospital would likely pass them on to patients or make reductions in the quantity and quality of its staff, services, equipment, and facilities (or both). The latter choice is no more attractive. In this situation, the hospital surrenders its privilege to win the case, but in the process it loses the confidence of practitioners who, now knowing that a plaintiff could use the slightest imperfection against them or

e.g., *Pedroza v. Bryant*, 677 P.2d 166, 170–71 (Wash. 1984) (en banc) (deciding that courts should hold the hospital's standard of care to the accreditation standards of the Joint Commission).

167. *See Moss, supra* note 21, at 150.

168. *See Summary Judgment Order, supra* note 14, at 11.

169. In addition to the peer review statutes and case law discussed above in Part III, Congress has concluded that peer review plays a fundamental role in the medical profession. *See* 42 U.S.C. § 11101(5) (2000). Thus, surrendering the privilege would be contrary to both federal and state policy.

170. *See* Nathan Hershey & Christine M. Jarzab, *Looking at Accountability 40 Years After Darling*, 14 ANNALS HEALTH L. 437, 439 (2005).

the hospital, will no longer be candid.¹⁷¹ Peer review thus becomes an adversarial process wherein applicants try to hide their weaknesses and hospitals try to expose them.¹⁷²

These scenarios are not mutually exclusive. Particularly in “plaintiff-friendly” areas, a hospital could surrender the privilege and disclose information to rebut a negligent credentialing claim but still lose the lawsuit. The medical community would forfeit the usefulness of peer review and the hospital would incur losses. Even if an appellate court decided that the record did not support the trial’s outcome and reversed in favor of the hospital,¹⁷³ the appellate court could not restore the trust and candor erased by an earlier waiver of privilege.

3. *Creating Litigation Adversity Between Practitioners and Hospitals*

In addition to the systemic impacts the claim would likely have upon patients and medical providers, it could also foster further breakdown of the medical community through competitive litigation strategy. Because the confidentiality statute does not prohibit a protected party from surrendering the privilege,¹⁷⁴ this creates opportunities for codefendant doctors and hospitals to prejudice each other by helping the plaintiff. A plaintiff could thus use an offer of a relatively inexpensive settlement to persuade a doctor or hospital into settling in exchange for waiving the privilege and producing credentialing information. The plaintiff would then obtain the information she needs to pursue a malpractice claim against the remaining defendant. Similarly, the doctor or the hospital may try to get out of the suit as soon as possible and offer to waive the privilege in exchange for settlement.

Regardless of the circumstances, the ability to waive the privilege would create a race between doctors and hospitals to be the first to settle, leading to distrust between doctors and hospitals. A hospital would be reluctant to grant privileges to a competent doctor based on worries that the doctor might turn on the hospital when a plaintiff eventually sued the doctor for malpractice.¹⁷⁵

171. See George E. Newton II, Comment, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 723–24 (2001) (citing Jeanne Darricades, Comment, *Medical Peer Review: How is it Protected by the Health Care Quality Improvement Act of 1986?*, 18 J. CONTEMP. L. 263, 263 (1992)).

172. Cf. Philip L. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals*, 38 U.S.F. L. REV. 301, 330 (2004) (criticizing credentialing for the animus it creates between hospitals and doctors appealing denial of credentials).

173. Note that a jury’s verdict can be set aside only if a party can show that no reasonable jury could have formed its decision under the evidence provided. See *Burns v. Universal Health Servs., Inc.*, 361 S.C. 221, 231–32, 603 S.E.2d 605, 611 (Ct. App. 2004) (citing *Horry County v. Laychur*, 315 S.C. 364, 367, 434 S.E.2d 259, 261 (1993); *Force v. Richland Mem’l Hosp.*, 322 S.C. 283, 284, 471 S.E.2d 714, 715 (Ct. App. 1996)).

174. See S.C. CODE ANN. § 40-71-20 (2001 & Supp. 2008).

175. Many doctors will be sued for malpractice at least once in their lives, even though there appears to be no clear causal correlation between a doctor’s medical qualifications and the

Because a hospital may do the same thing, a doctor may likewise be hesitant to practice medicine at a hospital. In either case, the end result would be an erosion of cooperation among practitioners and hospitals.

4. *Exposing Hospitals to Other Types of Liability*

A hospital that sets credentialing standards designed to avoid liability could still incur liability to private physicians. If a hospital denies, revokes, or restricts a doctor's privileges, that doctor may have grounds to contest the decision by suing the hospital.¹⁷⁶ A suit could include allegations of slander,¹⁷⁷ antitrust,¹⁷⁸ interference with contract,¹⁷⁹ or constitutional due process violations.¹⁸⁰ If a doctor succeeded in such a suit, the hospital would be punished for maintaining high standards, at least temporarily. Thus, exercising stringent credentialing standards could actually hold little financial appeal for the hospital.

5. *Affecting Other Licensed Professions*

Finally, allowing plaintiffs to sue hospitals for negligent peer review may open the door to expand the cause of action to other peer-reviewed professions. In addition to hospitals, the peer review statutes protect a number of other important professions, including "legal . . . osteopathic, optometric, chiropractic, psychological, dental, accounting, pharmaceutical, and engineering organizations."¹⁸¹ If South Carolina courts eviscerate the legislature's protections as applied to hospitals, there may be little reason to continue extending those protections to industries that provide important, but not vital, services. The claim could apply to virtually any entity that engages in licensure or other qualification

likelihood of being found liable for malpractice. *See* John W. Ely et al., *Malpractice Claims Against Family Physicians: Are the Best Doctors Sued More?*, 48 J. FAM. PRAC. 23, 25 (1999). Male physicians have a 56% chance of being sued over a ten-year practice period. *Id.* at 27.

176. *See, e.g.*, *Burdge v. Greenville Hosp. Sys.*, 318 S.C. 312, 314, 457 S.E.2d 610, 611 (1995) (stating that a physician filed suit against a hospital for suspending his staff privileges without a proper hearing).

177. *See, e.g.*, *Wieters v. Bon-Secours-St. Francis Xavier Hosp., Inc.*, 378 S.C. 160, 163, 662 S.E.2d 430, 432 (Ct. App. 2008), *vacated*, 381 S.C. 332, 332, 673 S.E.2d 417, 417–18 (2009) (involving a situation where a physician sued a hospital for slander after the hospital reported details of the suspension to a national data bank).

178. LEVIN, *supra* note 29, at 15–16. Antitrust situations include (1) when the hospital denies a physician's initial application for privileges; (2) when the hospital terminates, suspends, or reduces existing privileges; (3) when the hospital denies a non-physician practitioner (such as a midwife) clinical privileges; (4) when there is a physician boycott; and (5) when the hospital makes exclusive contractual arrangements for medical services. *Id.*

179. *See id.* at 101.

180. *Cf. Burdge*, 318 S.C. at 314, 457 S.E.2d at 611 (involving a physician who brought a claim for violation of due process rights after a hospital suspended his privileges).

181. *See* S.C. CODE ANN. § 40-71-10(A) (2001 & Supp. 2008).

review activities.¹⁸² Accordingly, negligent credentialing could transform peer review of many important, licensed service positions from a substantive inquiry of fitness for duty into an economics-based conjecture of a candidate's likelihood of attracting litigation in the future.

These possibilities may read like a parade of horrors. This does not change the fact that negligent credentialing could well negatively impact healthcare in South Carolina. Courts should not disregard the potential for patients, doctors, and hospitals alike to abuse a new liability-based regime of peer review.

D. Benefits of Recognition

There are of course arguments in favor of recognizing the claim. First, hospitals, as full-service institutions, have a duty to protect their patients from incompetent practitioners.¹⁸³ Imposing this duty upon hospitals via negligent credentialing allows plaintiffs greater recovery against hospitals by triggering additional insurance payouts¹⁸⁴ and improves medicine through the negative incentive of liability.¹⁸⁵ Each point has its merits and its problems.

1. Conformity with Patient Perception

The traditional view of healthcare is that only a properly educated and licensed individual doctor, and not a corporation, could practice medicine.¹⁸⁶ Under this view, a hospital is powerless under the law to control a physician or surgeon in the practice of his profession; correspondingly, the doctor bears all liability for harm caused by his conduct.¹⁸⁷ Hospitals are thus locations that provide doctors with a site and equipment to treat patients.

States that have adopted negligent credentialing have abandoned this view by instead considering a hospital as an active entity that appoints physicians and surgeons to its staff, employs a variety of medical practitioners on a salaried basis, and directly charges and bills patients for services rendered and for use of

182. One attorney has analogized the hospital negligent credentialing claim to a legal malpractice victim suing the state's bar or highest court for allowing his attorney to practice law. Memorandum in Support of Motion for Summary Judgment at 5, *Person v. Carolina Pines Reg'l Med. Ctr.*, No. 2004-CP-16-322 (Darlington County Ct. Com. Pl. Jan. 5, 2005).

183. See Moss, *supra* note 21, at 150.

184. See *Pedroza v. Bryant*, 677 P.2d 166, 170 (Wash. 1984) (en banc).

185. *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 165 (Cal. Ct. App. 1982); *Pedroza*, 677 P.2d at 170.

186. See, e.g., *McMillan v. Durant*, 312 S.C. 200, 203 n.2, 439 S.E.2d 829, 831 n.2 (1993) (citing 41 C.J.S. *Hospitals* § 21 (1991)) ("A hospital as an entity cannot practice medicine, diagnose an illness, or establish a course of treatment . . .").

187. Cf. *Newell v. Trident Med. Ctr.*, 359 S.C. 4, 12, 597 S.E.2d 776, 780 (2004) (per curiam) (finding there was no agency relationship between doctor and hospital and that informed consent is a matter between physician and patient).

its facilities.¹⁸⁸ These practices create a public perception and expectation that a hospital assembles practitioners to work together as a team to treat and cure a patient.¹⁸⁹ Accordingly, a hospital has a duty to protect patients from physical harm inflicted by private practitioners.¹⁹⁰ Thus, negligent credentialing liability reflects a duty corresponding to the scope and administration of services in the modern hospital.

The flaw in this argument, though, is that it summarily concludes that hospitals deserve liability without providing any substantive policy justifications in support.¹⁹¹ Moreover, the argument breaks down precisely where proponents of negligent credentialing claim it applies. Where a patient visits a hospital so that a doctor of his own choosing may treat him using the hospital's facilities, it can hardly be said that the patient has gone to the hospital with the reasonable expectation that the hospital—and not the private practitioner—will be providing the care and treatment.¹⁹² Thus, public perception is not a viable justification for recognizing negligent credentialing as a South Carolina cause of action.

2. *Increased Potential for Recovery*

Negligent credentialing is an attractive theory because it creates an opportunity to recover from multiple sources for a single injury. Recall that most courts hearing a negligent credentialing case require the plaintiff to prove two separate instances of negligence—one by the practitioner and one by the hospital.¹⁹³ For plaintiffs, the upshot of this is that they may trigger payouts from the malpractice policies of the hospital and the doctor. The typical medical liability insurance policy imposes recovery limits on a per-occurrence basis; that is, the insurer will only pay a certain amount of money for each incident of negligence.¹⁹⁴ Accordingly, there could be substantial payout increases if a court finds the hospital negligent in addition to finding the practitioner negligent.

188. See *Beeck v. Tuscon Gen. Hosp.*, 500 P.2d 1153, 1158 (Ariz. Ct. App. 1972); *Adamski v. Tacoma Gen. Hosp.*, 579 P.2d 970, 974–75 (Wash. Ct. App. 1978) (quoting *Bing v. Thunig*, 143 N.E.2d 3, 8 (N.Y. 1957)).

189. See, e.g., *Bing*, 143 N.E.2d at 8 (“Certainly, the person who avails himself of ‘hospital facilities’ expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.”).

190. Moss, *supra* note 21, at 150.

191. Rutchik, *supra* note 157, at 548.

192. Take the example of a pregnant woman: early in her pregnancy she develops a medical relationship with an OB-GYN, whom she visits periodically during gestation. When the child is due, she meets her doctor at the local hospital for delivery. It would be unreasonable for the woman to believe responsibility for a safe birth has somehow shifted to the hospital at the very moment her own doctor is physically delivering the child.

193. See *supra* Part II.B.2.

194. See, e.g., *Conn. Med. Ins. Co. v. Kulikowski*, 942 A.2d 334, 337 (Conn. 2008) (describing a malpractice policy's limits as \$1 million per occurrence with a \$4 million aggregate limit).

Patients get a greater chance to collect fully for actual damages and receive payment for their attorney's fees.

However, the mere possibility of reaching into two pockets instead of one cannot justify recognizing a substantive theory of liability.¹⁹⁵ Furthermore, this argument relies on the specious assumption that insurance payouts always fall short of what a plaintiff deserves to recover. Whatever the realities may be for the percentage of a judgment that a plaintiff actually recovers, damage awards are based on actual harm caused and, if applicable, the amount of punishment needed—not on how much insurance money is available.¹⁹⁶ If the award exceeds what the doctor's insurer has agreed to pay in the event of an occurrence, the doctor is certainly still obliged to pay the difference.¹⁹⁷ Negligent credentialing, then, effectively transforms a hospital into an excess insurance carrier for cases where doctors cannot make their injured patients whole. As discussed above, *Newell* rejects imposing such a role on hospitals.¹⁹⁸

3. *Improvements in the Credentialing Process*

A third pro-recognition argument is that holding hospitals liable for failing to properly screen and monitor private doctors serves punitive and deterrent functions; that is, hospitals will improve their credentialing practices for fear that not doing so will result in monetary loss from litigation costs and consequent increases in operating expenses.¹⁹⁹ If they do not, the courts will punish them through adverse judgments, and then the sting of having to pay such judgments will deter hospitals from repeating their conduct in the future. Either way, the system improves and thus unqualified doctors harm fewer patients.²⁰⁰ On its face, such an argument is compelling, as punishment and deterrence are indeed two fundamental functions of the whole system of tort liability²⁰¹ and would seem to apply in the context of negligent credentialing.

195. Cf. *In re Breast Implant Prod. Liab. Litig.*, 331 S.C. 540, 548, 503 S.E.2d 445, 449 (1998) (citing *Ayyash v. Henry Ford Health Sys.*, 533 N.W.2d 353, 355 (Mich. Ct. App. 1995)) (rejecting economics argument in refusing to extend strict liability to medical service providers).

196. In fact, evidence of whether a party does or does not have insurance for the incident in question is inadmissible in court. S.C. R. EVID. 411. Moreover, parties should not bring insurance coverage to the jury's attention. *Sarvis v. Register*, 288 S.C. 236, 238, 341 S.E.2d 791, 792 (1986) (citing *Bartell v. Willis Constr. Co.*, 259 S.C. 20, 24, 190 S.E.2d 461, 463 (1972)).

197. Cf. *Conn. Med. Ins. Co.*, 942 A.2d at 337 (finding that a nurse practitioner was not entitled to recovery of insurance proceeds because she was not a named insured and damages owed in malpractice suit exceeded the amount her employer, who was an insured, was entitled to).

198. See *supra* text accompanying notes 144–149.

199. See, e.g., *Pedroza v. Bryant*, 677 P.2d 166, 170 (Wash. 1984) (en banc) (“The most effective way to cut liability insurance costs is to avoid corporate negligence.”).

200. See, e.g., *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 165 (Cal. Ct. App. 1982) (stating that imposing corporate liability encourages hospitals to “oversee the competence of their medical staff” with the intent to further “the health care interest of the patient”).

201. See *Owen*, *supra* note 150, at 665.

This is not to conclude, though, that the improvements would play out as planned. A flaw exists in the dilemma hospitals would eventually encounter: either waiving privilege to win a suit or losing the suit and maintaining confidentiality. If the hospital elected the latter option, the punishment and deterrence functions would not legitimately apply because the hospital would pay for its rightful privilege—not for protecting the peer review process. At that point, the hospital would be “punished” for upholding the confidentiality it had established with its credentialed practitioners and for placing peer review above its own monetary interest. Although the sting of monetary loss may still cause the hospital to improve its credentialing practices, it would not be doing so because the loss indicates that the hospital conducted itself wrongfully, but because the cost of keeping the privilege and preserving peer review is too costly. Thus, an additional policy argument against recognizing the claim is that because negligent credentialing may punish acts that the law protects, it undermines foundational justifications for our system of civil liability.

E. Preferable Legal Theories

The above discussion notwithstanding, wrongfully injured patients deserve some recourse. However, a negligent credentialing claim is still inappropriate because South Carolina law already provides several theories of liability that allow patients recovery from hospitals, including apparent agency, nondelegable duty, respondeat superior, and negligent supervision.²⁰² These alternatives allow injured patients recourse against doctors and hospitals without causing the highly problematic scenarios discussed above. Taken together, these alternative theories subsume the applicability of negligent credentialing.

1. Apparent Agency

The broadest alternative to negligent credentialing is a negligence suit that uses the theory of apparent agency to hold a hospital responsible for harm caused by a doctor. Apparent agency allows a plaintiff to sue the hospital for the practitioner’s negligence, even if the practitioner is not an employee.²⁰³ To prove apparent agency, a patient must show that the hospital consciously or impliedly represented the doctor to be its agent, that the patient relied upon that representation, and that the patient detrimentally changed position in such

202. See, e.g., *Simmons II*, 341 S.C. 32, 47–48, 533 S.E.2d 312, 320 (2000) (applying apparent agency to hospital litigation); *Simmons I*, 330 S.C. 115, 123–24, 498 S.E.2d 408, 412 (Ct. App. 1998) (applying nondelegable duty doctrine in hospital litigation); *Doe v. Greenville Hosp. Sys.*, 323 S.C. 33, 38, 448 S.E.2d 564, 567 (Ct. App. 1994) (upholding verdict against hospital for negligent supervision); *Andrews v. Amisub of S.C., Inc.*, 302 S.C. 122, 124, 394 S.E.2d 22, 23 (Ct. App. 1990) (noting applicability of respondeat superior in action against hospital).

203. See LEVIN, *supra* note 29, at 14–15.

reliance.²⁰⁴ When a patient can show these elements and a resulting injury, the patient may directly recover from the hospital.²⁰⁵

Combined with a negligence claim, apparent agency directly responds to the public perception argument. Where a plaintiff's choice of the doctor is incidental to, or dependent upon, the choice of the hospital, the plaintiff may assert apparent agency as part of a negligence claim because of the plaintiff's expectations about the hospital. Moreover, the plaintiff need not implicate the peer review process as part of the claim by instead making the simpler allegation that the plaintiff selected a doctor in reliance upon the hospital's representation of agency.²⁰⁶ Consequently neither the hospital nor the doctor needs to surrender the privilege to defend themselves, and the patient does not need to compel waiver to get information for the case. Thus, where patients perceive themselves to be patients of the hospital or at least base their treatment decisions on the hospital, apparent agency is a preferable substitute to a negligent credentialing claim.

A leading example of apparent agency in hospitals comes from *Simmons II*, in which the South Carolina Supreme Court allowed a plaintiff to proceed on an apparent agency claim for the death of her father, an emergency room patient, even though upon admittance to the hospital the plaintiff signed a release and acknowledgment that the doctors on call were independent contractors.²⁰⁷ Despite signing the release, the plaintiff believed the doctors were hospital employees.²⁰⁸ The court concluded that the hospital's use of release forms could not overcome the plaintiff's expectation that the hospital was responsible for treating her father, and thus the hospital was liable under apparent agency.²⁰⁹

204. *Shuler v. Tuomey Reg'l Med. Ctr., Inc.*, 313 S.C. 225, 227, 437 S.E.2d 128, 129–30 (Ct. App. 1993) (citing *Graves v. Serbin Farms, Inc.*, 306 S.C. 60, 63, 409 S.E.2d 769, 771 (1991); *Watkins v. Mobil Oil Corp.*, 291 S.C. 62, 67, 352 S.E.2d 284, 287 (1986)).

205. *Cf. Graves*, 306 S.C. at 60, 409 S.E.2d at 771 (discussing elements for recovery using apparent agency).

206. *See Shuler*, 313 S.C. at 227, 437 S.E.2d at 130.

207. *Simmons II*, 341 S.C. at 36, 52, 533 S.E.2d at 314, 323.

208. *Id.* at 36, 533 S.E.2d at 314.

209. *Id.* at 47–48, 533 S.E.2d at 320 (citing *Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46, 54 n.1 (Ohio 1994)). Since *Simmons II*, the court has upheld the broad applicability of apparent agency to suits against hospitals involving private practitioners. For example, in *Osborne v. Adams*, 346 S.C. 4, 550 S.E.2d 319 (2001), a plaintiff successfully asserted a claim against a hospital whose marketing of its neonatal program induced her to have her prematurely-born son cared for there. *Id.* at 8, 550 S.E.2d at 321. Furthermore, the South Carolina Supreme Court has declared the primacy of apparent agency in hospitals: “hospital liability for non-employee physician negligence is limited to apparent agency situations.” *Newell v. Trident Med. Ctr.*, 359 S.C. 4, 14, 597 S.E.2d 776, 781 (2004) (per curiam) (citing *Osborne*, 346 S.C. at 8, 550 S.E.2d at 321; *Simmons II*, 341 S.C. at 52, 533 S.E.2d at 323).

2. *Nondelegable Duty*

As the *Simmons II* court noted, one limitation of apparent agency is that it requires a representation of an agency relationship by the hospital, even if only an implied one.²¹⁰ However, the courts in both *Simmons I* and *Simmons II* also found the hospital liable because it owed a nondelegable duty to the patient.²¹¹ When a duty is a nondelegable, a party may hire an independent contractor to perform the tasks that comprise the duty, but the party remains vicariously liable for the negligent acts of a nonemployee.²¹² Unlike negligent credentialing, a negligence claim operating on a nondelegable duty theory does not need to involve peer review. This is because the claim is not that the hospital negligently let the offending doctor work in the hospital but rather that, through the fiction of the duty, the hospital itself negligently injured the plaintiff.²¹³ Thus, plaintiffs essentially prove their case against the hospital as though they were suing only the doctor.²¹⁴ Therefore, a negligence suit enhanced with a nondelegable duty allegation provides a plaintiff a remedy against a hospital without involving peer review.

Although the current scope of the doctrine in healthcare lawsuits is not clear, it is likely fairly broad. The *Simmons II* court recognized that a hospital has a nondelegable duty to provide competent care to emergency room patients:

[An] . . . entity entrusted with important duties in certain circumstances may not assign those duties to someone else and then expect to walk away unscathed when things go wrong. . . . [This principle] applies to situations in which people must entrust that most personal of things, their physical well-being, to physicians at an emergency room intimately connected with and closely controlled by a hospital.²¹⁵

The supreme court in *Osborne* clarified that the nondelegable duty doctrine is not limited to emergency rooms.²¹⁶ To date, the only situation the supreme court has said the nondelegable duty does not cover is where a patient is admitted to the hospital “by a private, independent physician whose only connection to a

210. See *Simmons II*, 341 S.C. at 48, 533 S.E.2d at 320.

211. See *id.*; *Simmons I*, 330 S.C. 115, 124, 498 S.E.2d 408, 413 (Ct. App. 1998).

212. *Simmons I*, 330 S.C. at 123, 498 S.C. at 412 (quoting *McWilliams & Russell*, *supra* note 113, at 452).

213. *Id.* (quoting *McWilliams & Russell*, *supra* note 113, at 468).

214. See *id.* (quoting *McWilliams & Russell*, *supra* note 113, at 452). If, for example, a plaintiff were suing because a surgeon removed the wrong foot, the plaintiff would allege that the hospital had a duty to remove the correct foot and breached that duty.

215. *Simmons II*, 341 S.C. at 44, 533 S.E.2d at 318.

216. *Osborne v. Adams*, 346 S.C. 4, 8, 550 S.E.2d 319, 321 (2001) (“Although *Simmons II* involved emergency room physicians, we did not limit our decision to such physicians.”).

particular hospital is that he or she has staff privileges to admit patients to the hospital.”²¹⁷

3. *Respondeat Superior*

Respondeat superior, a common theory of vicarious liability, would apply in cases where the treating practitioner is an employee of the hospital—be it a staff doctor, medical resident, physician’s assistant, nurse, or other caregiver.²¹⁸ This method of recovery has proven to be enduringly effective and lucrative for victorious plaintiffs in tort actions against hospitals.²¹⁹ To show that a hospital is vicariously liable for injuries caused by a practitioner, a plaintiff must show that the practitioner acted within the scope of the practitioner’s relationship with the hospital.²²⁰ Conduct is within the scope of a practitioner’s employment when it is reasonably necessary to accomplish an employment goal and the practitioner undertakes the conduct in furtherance of the hospital’s business.²²¹ Where the employment or agency relationship to the hospital is clear, a patient may directly sue the hospital for negligence under respondeat superior²²² in addition to suing the doctor.²²³ Applying this doctrine would not require allegations of wrongdoing in peer review, as the plaintiff may instead impute the injurer’s negligence to the hospital.

4. *Negligent Supervision*

Lastly, a plaintiff may attack the conduct of the hospital by showing negligence in supervising the practitioner. Similar to negligent credentialing, negligent supervision allows a plaintiff to hold a party liable for failing to exercise reasonable care in supervising someone—typically an employee—who

217. *Simmons II*, 341 S.C. at 52, 533 S.E.2d at 323.

218. *See* *McMillan v. Durant*, 312 S.C. 200, 203 n.2, 439 S.E.2d 829, 831 n.2 (1993) (citing 41 C.J.S. *Hospitals* § 21 (1991)).

219. A recent example comes from a case in Anderson County in which a jury awarded a plaintiff \$2.2 million for complications arising during an extended hospital stay. *See* Brad Maxwell, *Woman Wins \$2.2M Case Against AnMed*, ANDERSON INDEP.-MAIL (Anderson, S.C.), June 21, 2008, at A8.

220. *See* *S.C. Ins. Co. v. James C. Greene & Co.*, 290 S.C. 171, 179, 348 S.E.2d 617, 621 (Ct. App. 1986) (requiring that servants act within the scope of employment for masters to be liable under respondeat superior).

221. *See* *Gathers v. Harris Teeter Supermarket, Inc.*, 282 S.C. 220, 227, 317 S.E.2d 748, 753 (Ct. App. 1984) (citing *Lane v. Modern Music, Inc.*, 244 S.C. 299, 305, 136 S.E.2d 713, 716 (1964)) (defining the test for scope of employment in the context of a false imprisonment action).

222. *See, e.g., McMillan*, 312 S.C. at 203 n.2, 439 S.E.2d at 831 n.2 (citing 41 C.J.S. *Hospitals* § 21 (1991)) (“[A] hospital may be held vicariously liable for the negligence of its employees.”).

223. *See* *S.C. Ins. Co.*, 290 S.C. at 183, 348 S.E.2d at 624 (“[U]nder the doctrine of *respondeat superior*, the principal is liable in addition to the agent, not by reason of his consent to be liable, but by operation of law.”).

causes harm to the plaintiff.²²⁴ This duty covers the “employee’s actions undertaken in his capacity as an agent for the employer.”²²⁵ Such a claim extends to hospitals that fail to adequately supervise private physicians because the physicians’ credentials act as licenses for them to enter onto hospital property and use hospital equipment.²²⁶ Because the hospital allows the doctor to admit patients and knows that the doctor is treating them using hospital facilities, the hospital has a duty to ensure that the doctor exercises reasonable care in the hospital.²²⁷ This additional occurrence of negligence would be particularly satisfying to a plaintiff trying to trigger a payout from the hospital’s insurance policy in addition to the physician’s.

Taken together, these theories obviate the need for negligent credentialing. This becomes clear when one asks: Why did the patient come to the hospital? If the patient came to be treated by the hospital, respondeat superior controls employee negligence, and either apparent agency or the nondelegable duty doctrine controls nonemployee negligence. Negligent supervision may apply in any of those scenarios. Where none of these avenues is open, it can only mean that there is an insufficient nexus to the hospital to establish liability.²²⁸ In such circumstances it would be improper to hold a hospital liable for an injury caused by a doctor’s independent relationship with his patient;²²⁹ after all, the patient, not the hospital, chose the doctor. The patient’s own doctor caused the injury, and it matters not whether the injury incidentally occurred within a hospital’s walls; it could just as easily have happened at the doctor’s office or the plaintiff’s home. Yet in such a case, the plaintiff still has a remedy by suing the doctor for malpractice. Therefore, South Carolina stands to gain nothing through allowing negligent credentialing claims.

224. *Degenhart v. Knights of Columbus*, 309 S.C. 114, 116–17, 420 S.E.2d 495, 496 (1992) (quoting RESTATEMENT (SECOND) OF TORTS § 317 (1965)).

225. *Charleston, S.C. Registry for Golf & Tourism, Inc. v. Young Clement Rivers & Tisdale, L.L.P.*, 359 S.C. 635, 645 n.2, 598 S.E.2d 717, 723 n.2 (Ct. App. 2004) (citing *Degenhart*, 309 S.C. at 117, 420 S.E.2d at 496–97).

226. *See Oehler v. Humana, Inc.*, 775 P.2d 1271, 1272 (Nev. 1989) (per curiam) (“[A] hospital may be liable for the negligent supervision of a nonemployee physician who has staff privileges”); *see also* RESTATEMENT (SECOND) OF TORTS § 318 (imposing a duty on possessors of land and chattels to ensure that others who the possessors allow to use the land or chattel and are not servants exercise reasonable care).

227. *See Oehler*, 775 P.2d at 1272.

228. The South Carolina Supreme Court has stated that “[s]uch patients could not reasonably believe his or her physician is a hospital employee.” *Simmons II*, 341 S.C. 32, 52, 533 S.E.2d 312, 323 (2000).

229. *See, e.g., Campbell v. Emma Laing Stevens Hosp.*, 499 N.Y.S.2d 993, 994 (N.Y. App. Div. 1986) (holding that a hospital was not liable for not intervening in the relationship between an independent physician and his patient).

V. PROPRIETY OF THE *PERSON* DECISION

If South Carolina courts nonetheless decide to recognize negligent credentialing claims, they should wait until the proper moment for recognizing the claim. *Person* is not an adequate landmark for such an expansion of tort liability because its facts do not conform to the cause of action. Moreover, *Person* does not provide a sound foundation for recognition of the claim because the trial court's reasoning for recognition is misguided. Using *Person* as the landmark for accepting negligent credentialing in South Carolina would set a faulty precedent.

A. *Factual Shortcomings of Person*

A justification for recognition of the negligent credentialing claim is that patients have no choice but to place "blind faith" in the qualifications of their doctors.²³⁰ Assuming that this assertion has merit in the context of private physicians with whom patients have formed independent professional relationships prior to visiting the hospital, it does not apply to *Person*. Rather than blindly trusting her surgeon, Ms. Person had a longstanding professional relationship with him,²³¹ during which time she could have formed an opinion as to his competence. Moreover, another reason why the facts do not conform to a case for negligent credentialing is that the plaintiff lost at trial.²³² Furthermore, after the court took the "unusual" step of permitting Ms. Person to conduct postverdict discovery, it concluded that, even with the newly-discovered evidence, her case lacked merit and upheld the verdict.²³³

Because of this shortcoming, future litigants will not be able to use *Person* for meaningful guidance as to what the claim entails in South Carolina. Instead, hospitals, doctors, courts, and attorneys will have an example of what does not qualify as a claim. This will create confusion as to what constitutes negligent credentialing, which could lead to inconsistent applications of the theory throughout trial courts. South Carolina's medical and legal communities will be better informed about the nature and scope of a negligent credentialing action if the appellate courts choose a more factually appropriate case as the landmark for expanding hospital liability.

230. See Moss, *supra* note 21, at 128 (citing Martell v. St. Charles Hosp., 523 N.Y.S.2d 342, 351 (N.Y. App. Div. 1987)).

231. See Memorandum in Support of Petition for Writ of Mandamus or for a Writ of Certiorari to the Circuit Court at 2, Person v. Carolina Pines Reg'l Med. Ctr., No. 2004-CP-16-322 (Darlington County Ct. Com. Pl. Oct. 31, 2006).

232. See Judgment in a Civil Case at 1, Person v. Carolina Pines Reg'l Med. Ctr., No. 2004-CP-16-322 (Darlington County Ct. Com. Pl. Nov. 14, 2006).

233. Order Denying Plaintiff's Post-Trial Motions at 1, Person v. Carolina Pines Reg'l Med. Ctr., No. 01-CP-16-0813 (Darlington County Ct. Com. Pl. Apr. 7, 2008).

B. *The Court's Misreading of Case Law*

Person additionally fails to be an adequate landmark because the circuit court's decision to allow a negligent credentialing claim results from its misreading of precedent and confusing the concepts of nondelegable duty and negligent credentialing. The trial court found it "beyond dispute" that *Simmons II* established patients' right to sue hospitals for "breaching a duty to properly staff and supervise emergency rooms."²³⁴ In no way, though, did the *Simmons* opinions set forth a hospital's specific liability under the umbrella concept of corporate negligence. Rather, *Simmons* specifically established that "hospitals have a *nondelegable duty to render competent service* to the patients of their emergency rooms."²³⁵ The *Simmons II* court was surely aware of *Strickland* and negligent credentialing, yet the court instead focused on the nondelegable duty theory. Furthermore, as the *Simmons I* court noted, "[t]he difference between direct liability and a nondelegable duty is subtle but important."²³⁶ With a nondelegable duty, the party may delegate the duty itself to another but may not delegate liability for performing that duty.²³⁷ The *Simmons I* court acknowledged this by distinguishing a nondelegable duty as a type of vicarious liability from direct liability.²³⁸ The *Person* court overlooked this distinction and contrarily concluded that *Simmons II* allows patients to bring negligent credentialing actions for emergency room malpractice.²³⁹ Finally, the *Person* court erred by believing that the *Simmons II* court cited an Alaska case in support of adopting corporate negligence in South Carolina.²⁴⁰ However, the *Simmons II* opinion cites *Jackson v. Power* for support in recognizing the nondelegable duty doctrine, not negligent credentialing.²⁴¹

Thus, the *Person* court essentially relied on *Simmons I* and *Simmons II* to expand the scope of a theory that South Carolina courts have never recognized. The *Simmons II* court made it clear that it was adopting the nondelegable duty doctrine, not corporate negligence.²⁴² In making that clarification, the *Simmons I* court noted how unfortunate it was that courts and commentators confuse and

234. Summary Judgment Order, *supra* note 14. The court then extended the duty into operating rooms. *See id.* at 9–10.

235. *Simmons I*, 330 S.C. 115, 124, 498 S.E.2d 408, 413 (Ct. App. 1998) (emphasis added).

236. *Id.* at 123, 498 S.C. at 412.

237. *Id.* (quoting McWilliams & Russell, *supra* note 113, at 452).

238. *Id.* (quoting McWilliams & Russell, *supra* note 113, at 468). Note, though, that the *Simmons II* court did not alter this distinction. *See Simmons II*, 341 S.C. 32, 42, 533 S.E.2d 312, 317 (2000) (citing *Simmons I*, 330 S.C. at 123, 498 S.E.2d at 412).

239. *See* Summary Judgment Order, *supra* note 14.

240. *See id.* (citing *Jackson v. Power*, 743 P.2d 1376, 1385 (Alaska 1987), *superseded by statute*, ALASKA STAT. § 09.65.096 (2008), *as recognized in Evans ex rel. Kutch v. State*, 56 P.3d 1046, 1067 (Alaska 2002)).

241. *See Simmons II*, 341 S.C. at 44, 533 S.E.2d at 318 (citing *Jackson*, 743 P.2d at 1385).

242. *See id.* at 48, 533 S.E.2d at 320.

misuse the terms “corporate negligence” and “nondelegable duty”;²⁴³ despite this warning, this appears to be precisely what the *Person* court did.²⁴⁴ It mistook nondelegable duty to mean corporate negligence, and then, recognizing that negligent credentialing falls under corporate negligence, it found a theory of liability between the lines of *Simmons II*.²⁴⁵ If anything, the only legal theory the *Person* court could have extended into South Carolina’s operating rooms is the theory of nondelegable duty.

The *Person* court also misread *Strickland* in support of its decision. In reviewing *Strickland*, the *Person* court thought that *Strickland* implied acceptance of negligent credentialing because that court cited a Washington case²⁴⁶ as an example of another state’s acceptance of corporate negligence.²⁴⁷ However, the *Strickland* court specifically cited *Pedroza v. Bryant* concerning the nondelegable duty doctrine, not negligent credentialing, and balked on the issue of allowing negligent credentialing claims.²⁴⁸ The *Simmons I* court acknowledged this reservation when it rejected Tuomey Hospital’s contention that *Strickland* squarely disallowed the claim.²⁴⁹ However, the *Person* court read this to mean that by implication, the *Simmons* courts adopted corporate negligence wholesale, including negligent credentialing.²⁵⁰ To be sure, the *Person* court accurately noted the *Simmons I* court’s conclusion that *Strickland* did not directly reject negligent credentialing or even the doctrine of corporate negligence.²⁵¹ However, it provided no further analysis to support its conclusion that *Simmons I* and *Simmons II* established negligent credentialing liability.²⁵² In short, not only did *Person* misread *Simmons II* and *Strickland*, but it also misread *Simmons II*’s reading of *Strickland*.

Thus, *Person* provides neither the factual basis nor sound reasoning for recognition of a cause of action for negligent credentialing. If the appellate courts wish to allow negligent credentialing claims, waiting for a more apt exemplar would better serve South Carolina’s attorneys, hospitals, physicians, and patients.

243. See *Simmons I*, 330 S.C. at 123, 498 S.E.2d at 412 (quoting McWilliams & Russell, *supra* note 113, at 468).

244. See Summary Judgment Order, *supra* note 14.

245. See *id.*

246. See *Strickland v. Madden*, 323 S.C. 63, 71–72, 448 S.E.2d 581, 586 (Ct. App. 1994) (per curiam) (citing *Pedroza v. Bryant*, 677 P.2d 166, 168–70 (Wash. 1984) (en banc)).

247. See Summary Judgment Order, *supra* note 14, at 7–8 (citing *Strickland*, 323 S.C. at 71–72, 448 S.E.2d at 586).

248. See *Strickland*, 323 S.C. at 71–72, 448 S.E.2d at 586 (citing *Pedroza*, 677 P.2d at 168–70).

249. *Simmons I*, 330 S.C. 115, 123, 498 S.E.2d 408, 412 (Ct. App. 1998) (citing *Strickland*, 323 S.C. at 72, 448 S.E.2d at 586).

250. See Summary Judgment Order, *supra* note 14.

251. See *id.* at 8–9 (quoting *Simmons I*, 330 S.C. at 124, 498 S.E.2d at 412).

252. See *id.* at 9.

VI. CONCLUSION

Put simply, negligent credentialing has no legitimate place or utility in South Carolina's jurisprudence. First, precedent indicates that the claim and its effects do not comport with South Carolina's statutes and court precedents. Second, recognizing the claim would exacerbate the problem of ensuring quality healthcare because peer review committees would base credentialing decisions on liability concerns rather than on merit and quality of care, and aversion to increases in malpractice insurance and litigation may drive hospitals to reject genuinely good doctors. This, in turn, may further discourage competent physicians from practicing medicine, and the claim could unnecessarily increase the cost of healthcare and unduly complicate South Carolina's hospital systems. Instead, a more sensible course for all involved is the continued use of the current legal system of tort remedies, which allows plaintiffs several avenues to full recovery without damaging the medical community and the people it serves.

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