

IN THE SUPREME COURT OF OHIO

LORETTA SCHELLING, : Case No. 07-2202
: :
Plaintiff-Appellee, : On Appeal from the Williams
: County Court of Appeals,
v. : Sixth Appellate District
: :
COMMUNITY HOSPITALS OF : Court of Appeals Case No: WM-07-001
WILLIAMS COUNTY, : :
: :
Defendant-Appellant. : :

**BRIEF OF *AMICI CURIAE*, THE OHIO HOSPITAL ASSOCIATION
AND THE OHIO OSTEOPATHIC HOSPITAL ASSOCIATION
IN SUPPORT OF APPELLANT COMMUNITY HOSPITALS
OF WILLIAMS COUNTY**

Catherine M. Ballard (0030731)
Anne Marie Sferra (0030855)
BRICKER & ECKLER LLP
100 South Third Street
Columbus, Ohio 43215
(614) 227-2300
(614) 227-2390 (facsimile)
Email: cballard@bricker.com
asferra@bricker.com
Counsel for Amicus Curiae,
Ohio Hospital Association and
Ohio Osteopathic Hospital Association

Jeanne M. Mullin (0071131)
Reminger & Reminger Co., L.P.A.
237 W. Washington Row
Second Floor
Sandusky, Ohio 44870
(419) 609-1311
(419) 626-4805 (facsimile)
Email: jmullin@reminger.com
Counsel for Defendant-Appellant,
Community Hospitals of Williams County

Peter O. DeClark (0064663)
Chad M. Tuschman (0074534)
Williams DeClark Tuschman Co., L.P.A.
416 N Erie Street
500 Toledo Legal Building
Toledo, OH 43604-6301
(419) 241-7700
(419) 245-3849
Counsel for Plaintiff-Appellee
Loretta Schelling

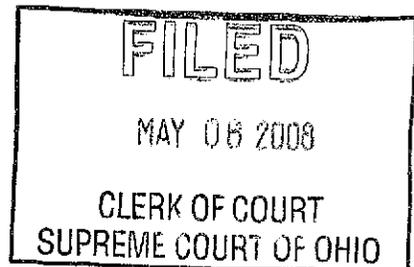


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STATEMENT OF INTEREST OF AMICI CURIAE

This case presents a critical issue of great importance to hospitals throughout the State of Ohio: whether a plaintiff should be permitted to pursue a negligent credentialing claim against a hospital in the absence of a prior finding that the medical negligence of the physician at issue caused harm to the plaintiff. Based on this Court’s decision in *Albain v. Flower Hospital* (1990), 50 Ohio St.3d. 251, 553 N.E.2d 1038—in which this Court first recognized what later became known as a negligent credentialing claim—the answer should be a resounding “no.” The reason for this is that *Albain* requires harm to a patient caused by a physician’s medical negligence before a negligent credentialing claim arises. See *Browning v. Burt* (1993), 66 Ohio St.3d 544, 566, 613 N.E.2d 993 (Moyer, C.J., dissenting) (explaining *Albain*). *Albain* is not unique in this regard; it is generally recognized that there can be no claim for negligent credentialing in the absence of medical negligence.¹

A few years after *Albain*, this Court addressed the issue of whether a one or two-year statute of limitations applies to a negligent credentialing claim in *Browning v. Burt* (1993), 66 Ohio St.3d 544, 613 N.E.2d 993. In reaching its conclusion that a two-year statute of limitations applies, this Court determined that a claim for negligent credentialing against a hospital is separate and distinct from a claim for medical negligence against a physician. *Id.* at 556. Even though these claims are distinct and have different limitations periods, this Court has never overruled *Albain* or held that underlying medical negligence is not required before a negligent credentialing claim arises.

¹ See 18 Schmit, Causes of Action 2d (2007) 329 (“In order to establish a prima facie case based on negligent credentialing * * * the plaintiff must prove: * * * 3. The physician caused harm to the patient. The underlying medical malpractice claim must be proved.”); 5 Peterson, ATLA’s Litigating Tort Cases (2007) Section 61.35 (“It is important to remember that one cannot simply prove that the hospital negligently granted privileges or retained an incompetent physician, but it must also be established that the physician was negligent” when treating the patient.”)

The Sixth District’s decision in the instant case strays from *Albain* and misconstrues *Browning* by allowing a negligent credentialing claim to proceed without a prior finding or determination that the plaintiff has been harmed by the medical negligence of the physician whose clinical privileges are at issue. If the decision of the Sixth District is permitted to stand, Ohio hospitals will be faced with additional litigation and forced to do what Ohio hospitals have never been required to do under Ohio law—defend against claims of medical negligence directed at medical staff physicians.² Simply put, Ohio hospitals are not in a position and should not be required to defend against claims of medical negligence directed at medical staff physicians. Although Ohio hospitals may be held liable for the negligent credentialing of a physician (or other licensed health care professional), a prerequisite to such liability is a prior finding that the staff physician’s medical negligence caused harm to the plaintiff at the hospital.

The Ohio Hospital Association (OHA) is a private nonprofit trade association established in 1915 as the first state-level hospital association in the United States. For decades, the OHA has provided a mechanism for Ohio's hospitals to come together and develop health care legislation and policy in the best interest of hospitals and their communities. The OHA is comprised of more than one hundred seventy (170) private, state and federal government hospitals and more than forty (40) health systems, all located within the state of Ohio; collectively they employ more than 240,000 employees. The OHA’s mission is to be a membership-driven organization that provides proactive leadership to create an environment in which Ohio hospitals are successful in serving their communities.

² The term “physician” is used herein as short-hand to describe medical practitioners who are required to be credentialed by a hospital, including allopathic and osteopathic physicians, podiatrists, dentists, and psychologists. As used herein, the term “physician,” “medical staff physician,” and “staff physician” refer to physicians who have clinical privileges at a hospital, but have no employment relationship with the hospital or one of its affiliates.

The OHA is a strong advocate of a comprehensive solution to the significant issues facing Ohio's health care system. In this regard, the OHA actively supports patient safety initiatives, insurance industry reform, and tort reform measures. The OHA was involved in the formation of the Ohio Patient Safety Institute³ which is dedicated to improving patient safety in the State of Ohio, and created OHA Insurance Solutions, Inc.⁴ which seeks to restore stability and predictability to Ohio's medical liability insurance market.

The Ohio Osteopathic Hospital Association (OOHA) was founded in 1939, and represents 21 healthcare facilities in Ohio that are accredited by the Health Care Facilities Accreditation Program of the American Osteopathic Association. Among other things, the OOHA strives to promote the influence and science of osteopathic medicine in Ohio by establishing, extending, and maintaining high standards of hospital service, and fosters high quality, patient-centered and cost-effective care at such healthcare facilities.

The OHA and the OOHA have a strong interest in Ohio's negligent credentialing laws because every Ohio hospital is responsible for credentialing its medical staff and, therefore, faces potential negligent credentialing claims. As amici curiae, the OHA and the OOHA urge the Court to reverse the judgment of the Sixth District Court of Appeals and hold that there is no claim against a hospital for the negligent credentialing of a physician in the absence of a prior finding that the physician's medical negligence, occurring in the hospital, caused harm to the plaintiff.

³ <http://www.ohiopatientsafety.org/>

⁴ <http://www.ohainsurance.com/>

STATEMENT OF THE CASE AND OF THE FACTS

Amici curiae defer to the Statement of the Case and the Statement of the Facts as presented by Appellant.

The facts and proceedings below most relevant to this appeal are: (1) Schelling voluntarily dismissed her claim for medical malpractice without procuring either an admission of liability or a finding of negligence against the physician that allegedly caused her harm, and (2) under the court of appeals' decision, Schelling is allowed to proceed to establish her claim for medical negligence in her negligent credentialing case in which only the hospital is a defendant, thereby requiring the hospital to defend the medical negligence claim even though it did not direct or control the medical treatment provided by the physician.

ARGUMENT

Proposition of Law: A plaintiff cannot proceed on a negligent credentialing claim against a hospital in the absence of a prior finding – by adjudication or stipulation – that the plaintiff's injury was caused by the negligence of the physician who is the subject of the negligent credentialing claim.

A. The Evolution of Negligent Credentialing Claims in Ohio

The relationship between a hospital and the medical staff physicians who provide medical care at the hospital is unique and complex. A physician is generally neither an employee nor an independent contractor in relation to the hospital. Despite this lack of employment or contractual relationship, a hospital cannot arbitrarily preclude a physician from practicing at the hospital.⁵ Rather, R.C. 3701.351 provides that a hospital must have objectively reasonable criteria for assessing competency and, if the physician meets such criteria, the hospital must grant the

⁵ There are some exceptions to this general rule. For example, a hospital is not required to grant privileges to a physician if the hospital is already a party to a contractual arrangement whereby a single physician or single physician's group has the exclusive right to provide certain services, such as anesthesia or pathology. Such exceptions are not applicable to the present case.

physician privileges. The hospital cannot take away those privileges on the basis of quality of care or professional behavior concerns unless the physician is first provided with procedural due process as set forth in the medical staff bylaws.⁶ See *Bouquett v. St. Elizabeth Corporation* (1989), 43 Ohio St.3d 50, 538 N.E.2d 113; *Khan v. Suburban Community Hospital* (1976), 45 Ohio St. 2d 39, 340 N.E.2d 398.

With this unique relationship as a backdrop, this Court first held that a hospital has an independent duty to appropriately credential physicians who seek to practice at the hospital⁷ in *Albain v. Flower Hospital* (1990), 50 Ohio St.3d 251, 553 N.E.2d 1038, reversed in part on other grounds *Clark v. Southview Hospital* (1994), 68 Ohio St.3d 435, 1994-Ohio-519. Specifically, the Court held: “In regard to staff privileges, a hospital has a direct duty to grant and continue such privileges only to competent physicians.” *Id.* at paragraph two of the syllabus (in part). The *Albain* Court made clear, however, that the mere act of granting privileges to a physician was insufficient to justify holding the hospital liable for a physician’s negligent acts under a theory of *respondeat superior*. *Id.* at paragraph one of the syllabus (in part).

With respect to proving this newly-recognized claim against a hospital (which later became known as a negligent credentialing claim), the *Albain* Court held:

In order to recover for a breach of this duty [to grant and continue privileges only to competent physicians], **a plaintiff injured by the negligence of a staff physician** must demonstrate that but for the lack of care in the selection or the retention of the physician, the physician would not have been granted staff privileges, and the plaintiff would not have been injured.

⁶ The medical staff bylaws are the documents generated by members of the medical staff and approved by the hospital’s board of directors that govern the relationship between the parties.

⁷ Hospitals are not the only health care entities that credential physicians. Other agencies that credential physicians include health maintenance organizations, preferred provider organizations, and insurance companies—to name a few.

Id. at paragraph two of the syllabus (in part). Thus, *Albain* plainly provided that a plaintiff first must be injured by the negligence of a physician with clinical privileges at the hospital to assert a negligent credentialing claim against the hospital.

In elaborating upon this independent duty, the Court understood that hospitals do not control a physician's medical treatment of patients. The Court made clear that a hospital's duty is limited to the exercise of due care in the granting and continuation of clinical privileges and does not extend to making medical decisions:

[A] hospital is not required to pass upon the efficacy of treatment; it may not decide for a doctor whether an option is necessary, or, if one be necessary, the nature thereof; but it owes to every patient whom it admits the duty of saving him from an illegal operation [or] false, fraudulent, or fictitious medical treatment. [Citations omitted.] In short, the hospital is not an *insurer* of the skills of physicians to whom it has granted staff privileges.

Id. at 259 (emphasis in original).

From *Albain*, two principles relevant to the issue before this Court emerged:

- (1) Before a hospital can be held liable for negligent credentialing, there must first be harm to the plaintiff caused by the medical negligence of the physician whose clinical privileges are at issue.
- (2) A hospital's independent duty to patients is limited to the granting and continuation of clinical privileges and does not extend to the efficacy of medical treatment.

As demonstrated below, subsequent decisions of this Court have not altered these principles. Additionally, Ohio's appellate and trial courts generally have acknowledged these principles. Indeed, even the Sixth District's decision in this case recognizes that for there to be a negligent credentialing claim, a plaintiff must be injured by the negligence of a medical staff physician. *Schelling v. Humphrey*, 6th Dist. No. WM-07-001, 2007-Ohio-5469, at ¶12, 2007 Ohio App. LEXIS 4804 ("The Supreme Court of Ohio has defined the tort of negligent

credentialing as when, ‘**a plaintiff injured by the negligence of a staff physician** must demonstrate that * * * ’”) (emphasis added).

Ohio courts consistently agree that a plaintiff cannot pursue a negligent credentialing claim in the absence of harm caused by the medical negligence of the physician whose privileges are at issue. But, there is some disagreement in the lower courts as to **when and against whom** a plaintiff pursuing a negligent credentialing claim must establish medical negligence. Pursuant to *Albain*, most lower courts have required a plaintiff to **first** (i.e., when) establish medical negligence against the physician **in an action against the physician** (i.e., against whom). Once such liability is established, the plaintiff can proceed to establish liability against the hospital for negligent credentialing. The underlying (and logical) rationale is that a negligent credentialing claim should not be adjudicated until medical negligence that caused harm to the plaintiff is found. See *Davis v. Immediate Medical Services, Inc.* (Dec. 12, 1995), 5th Dist. No. 94 CA 0253, 1995 Ohio App. LEXIS 6088 (reasoning that a negligent credentialing claim is not “ripe” until medical negligence is found), reversed in part on other grounds (1997), 80 Ohio St.3d 10, 1997-Ohio-363.

Consistent with this rationale, and in light of other legal and practical considerations, most trial courts bifurcate trial proceedings when a medical negligence claim against a medical staff physician is asserted in the same case as a negligent credentialing claim against the hospital. Among other reasons, bifurcation is appropriate to: prevent potential prejudice to the defendants, prevent jury confusion, and avoid costly, time-consuming and unnecessary litigation.

Evidence of prior lawsuits or acts of alleged malpractice is highly prejudicial to a defendant physician and can often lead to jury confusion in cases that are already complicated. As a result, such evidence is generally inadmissible in a medical malpractice action. See

Lumpkin v. Wayne Hospital, 2nd Dist. No. 1615, 2004-Ohio-264, 2004 Ohio App. LEXIS 251 (evidence of prior incident of medical negligence inadmissible because the prejudicial effect of the inference arising from the evidence outweighs any legitimate probative value it may have); *McGarry v. Horlacher*, 149 Ohio App. 3d 33, 43, 2002-Ohio-3161. Yet, that is precisely the type of evidence that a plaintiff would attempt to offer to establish negligent credentialing to show a pattern of incompetence of which the hospital knew or should have known. Bifurcation prevents this prejudice and avoids confusion between what evidence is admissible against the physician in the medical malpractice case and what evidence is admissible against the hospital in the negligent credentialing case (if both proceed simultaneously). See, e.g., *Lumpkin v. Wayne Hospital*, 2004-Ohio-264, at ¶6 (negligent credentialing claim bifurcated from medical negligence claim against physician to avoid prejudice). Additionally, bifurcation avoids costly, time-consuming and unnecessary litigation—if it is determined that the physician was not negligent, the negligent credentialing claim no longer exists.

Ohio law, public policy, and practical considerations support the conclusion that a negligent credentialing claim cannot proceed against the hospital in the absence of a prior finding of medical negligence, unless the physician whose privileges are at issue is also a party to the action.

B. This Court's Decision in *Browning* Left Intact the Requirement that a Negligent Credentialing Claim Cannot Proceed in the Absence of Medical Negligence that Caused Harm to the Plaintiff

1. The Majority Opinion in *Browning* Does Not Alter *Albain*

After *Albain*, this Court next addressed a negligent credentialing claim in *Browning v. Burt* (1993), 6 Ohio St.3d 544, 613 N.E.2d 993. The “narrow issue” in *Browning* was whether the negligent credentialing claims before the Court were timely filed pursuant to the applicable

statute of limitations. *Id.* at 553. *Browning* held that the two-year limitations period for bodily injury applies to a negligent credentialing claim, as opposed to the one-year period applicable to medical malpractice claims. In reaching this conclusion, the Court determined that negligent credentialing claims are separate and distinct from medical malpractice claims and, therefore, do not require the same limitations periods.

In distinguishing medical malpractice claims from negligent credentialing claims, the Court reaffirmed well-established Ohio law holding that hospitals do not engage in the practice of medicine and are not liable for the medical negligence of staff physicians:

A hospital does not practice medicine and is incapable of committing malpractice. See, generally, *Lombard v. Good Samaritan Med. Ctr.* (1982), 69 Ohio St.2d 471, 433 N.E.2d 162, and *Richardson v. Doe* (1964), 176 Ohio St. 370, 199 N.E.2d 878 (only physicians can commit “medical malpractice”) * * * [T]he negligent credentialing claims against [the hospital] are independent claims asserted directly against [the hospital] for the hospital’s own acts or omissions in granting and/or continuing the staff privileges of the doctor(s).

Id. at 556.

The Court further stated:

[W]e believe that claims asserted against a hospital for negligent credentialing do not arise out of the medical diagnosis, care, or treatment of a person. Negligent credentialing claims arise out of the hospital’s failure to satisfy its independent duty to grant and continue staff privileges only to competent physicians. This independent duty does not directly involve diagnosis or the medical care and treatment of a patient.

Id. at 557 (emphasis added). Thus, *Browning* underscored that which previously had been determined in *Albain*—that a hospital facing a negligent credentialing claim is not liable for the efficacy of a medical staff physician’s medical treatment of a patient.

Moreover, *Browning*, which relied on and quoted *Albain* with approval throughout its decision, did not address and, therefore, left intact the requirement that before a hospital can be

held liable for negligent credentialing, there must first be harm to the plaintiff caused by medical negligence of the physician whose privileges are at issue.

Lastly, *Browning* does not support the conclusion that a negligent credentialing claim can proceed against the hospital without either (1) a prior finding of liability for medical negligence that caused harm to the plaintiff, **or** (2) the physician as a party to the litigation. There are two physician defendants in *Browning* – Dr. Burt and Dr. Blue. Liability for malpractice against Dr. Burt was established by virtue of default judgments against him,⁸ and Dr. Blue was a defendant in the case defending the claims asserted against him. *Schelling* misses the mark in stating that *Browning* “established a clear precedent that a negligent credentialing claim can be made without the doctor being named a party.” *Schelling*, 2007-Ohio-5469, at ¶14. The plaintiff was able to proceed in the absence of Dr. Burt because **liability for medical malpractice had already been established against Dr. Burt**. In contrast, here, *Schelling* is attempting to proceed against the Hospital without either a prior finding of liability against the physician or the physician as a party. Proceeding in this manner requires the Hospital to do that which Ohio hospitals historically have never been required to do—defend against claims of medical negligence directed at members of the hospital’s medical staff. Ohio law does not hold Ohio hospitals liable for the efficacy of medical treatment of the physicians on their medical staffs and, therefore, hospitals should not be required to defend against such claims.

Thus, contrary to the Sixth District’s decision, *Browning* does not alter the rule that a plaintiff must first establish medical negligence to bring a negligent credentialing claim. Nor does it provide support for allowing a plaintiff to prove the medical negligence claim in the negligent credentialing case against only the hospital.

⁸ *Id.* at 554, fn.10.

2. The Dissenting Opinion in *Browning* Is Consistent with *Albain*

Despite the fact that *Browning* addressed only the statute of limitations applicable to a negligent credentialing claim and did not disturb the holding or criticize the analysis of *Albain*, some lower courts, including the Sixth District in this case, have misapplied *Browning* to negate the requirement that a plaintiff first must establish harm by a physician's medical negligence before there can be a negligent credentialing claim. Generally, lower courts that have done so have misinterpreted or misapplied Chief Justice Moyer's dissenting opinion in *Browning*.

Although the Chief Justice agreed with the *Browning* majority that medical negligence and negligent credentialing claims are separate claims, he opined that the majority, in determining which limitations period applies, "underemphasized" the "crucial point" that "under *Albain*, claims against a hospital for negligent retention or selection of a staff physician are dependent on an underlying medical malpractice claim against the staff physician." *Id.* at 566.

From this premise, Chief Justice Moyer explained this part of *Albain*:

In order to prevail in a cause of action for negligent credentialing against a hospital pursuant to *Albain*, the plaintiff must establish not only negligent selection and/or retention of a physician, but also that but for the hospital's negligence, the plaintiff would not have been injured. **That is, *Albain* requires that the underlying malpractice of the physician be proven before the plaintiff can recover damages against the hospital for its own negligence. Without an underlying harm to the hospital's patient through medical malpractice, an action against the hospital for negligent credentialing will never arise.** Although medical malpractice claims against the doctor and negligent credentialing claims against the hospital are separate causes of action, with separate and distinct duties owed to a singular class of individuals, both causes of action fail without proof that the physician's failure to abide by ordinary standards of care proximately caused the patient's harm.

Id. at 566 (emphasis added) (Moyer, C.J., dissenting).

The Chief Justice concluded that because “[t]he negligent credentialing claim against the hospital would not have arisen but for the underlying medical malpractice,” the negligent credentialing claim is a “medical claim” as defined in former R.C. 2305.11(D)(3) and is subject to the one-year statute of limitations for such claims. *Id.* at 567. In contrast, the majority, concluded that a negligent credentialing claim is not a medical claim subject to a one-year statute of limitations, but is a “bodily injury” claim subject to a two-year statute of limitations.

While Chief Justice Moyer is obviously in a position to explain or clarify his dissenting opinion, if necessary, his dissenting opinion is completely consistent with *Albain*. Moreover, and perhaps even more importantly, his dissenting opinion diverges from the *Browning* majority opinion on the narrow issue of whether a negligent credentialing claim is a “medical claim” (as defined by a former statute) for limitations purposes. That determination is not dispositive nor relevant to the issue at bar. What is relevant, however, is that both the majority and dissenting opinions in *Browning* rely on and quote paragraph two of the syllabus of *Albain* which provides that to recover for negligent credentialing a plaintiff first must be injured by the negligence of a medical staff physician. See *id.* at 555 and 566. Thus, the first principle that emerged from *Albain*—that a plaintiff first must establish harm caused by medical negligence to bring a negligent credentialing claim—was not overruled by and remained intact after *Browning*.

Although this Court has considered appeals involving negligent credentialing claims since *Browning*, none of those decisions have altered Ohio law as set forth in *Albain*. A plaintiff still must establish that he has suffered harm caused by a physician’s medical negligence at the hospital to proceed with a negligent credentialing claim, and a hospital’s duty to grant and continue clinical privileges still is limited and does not extend to the efficacy of medical treatment. The Sixth District’s decision herein disregards both of these rules. It allows Schelling

to proceed with a negligent credentialing claim in the absence of any finding that she is the victim of medical negligence **or** any claim for medical negligence against the physician. Schelling voluntarily dismissed her negligence claim against the physician without obtaining an admission of liability or a finding of negligence against him. If this case is permitted to proceed against the Hospital, the end result is that the Hospital will be required to defend against the medical negligence claim directed at the physician in order to protect itself from liability even though it did not make the medical decisions, perform the medical procedures, or direct or control them. Requiring hospitals to ensure and defend the actions of medical staff physicians is not only contrary to well-established Ohio law, but is bad public policy. See *infra* at 13-16.

C. **Public Policy and Practical Considerations Support The Conclusion That In the Absence Of a Prior Finding of Medical Negligence, A Plaintiff Should Not Be Allowed to Establish Medical Negligence in a Negligent Credentialing Case Against The Hospital**

There is nothing unusual about the requirement that there must first be medical negligence that caused harm to the plaintiff by a physician at the hospital before the plaintiff can proceed with a negligent credentialing claim against a hospital. See 18 Schmit, *Causes of Action* 2d (2007) 329. In fact, several other jurisdictions that have recognized the independent duty of a hospital to grant clinical privileges to only competent physicians also require medical negligence before a negligent credentialing cause of action arises. See *Winona Memorial Hospital v. Kuester* (Ind.App. 2004), 737 N.E.2d 824, 828, 2000 Ind. App. LEXIS 1712 (“[I]n order for Kuester to prove the tort of negligent credentialing, **she must first establish** that a negligent act of Dr. Crosby proximately caused her injury before she can proceed against Winona.”) (emphasis added); *Humana Medical Corporation of Alabama v. Traffanstedt* (Ala. 1992), 597 So. 2d 667, 669, 1992 Ala. LEXIS 188 (before the hospital could be held liable for extending staff privileges, a jury had to find that the physician was negligent when he operated on the

patient); *Hirons v. Scheffey* (Tex. App. 2002), 76 S.W.3d 486, 489, 2002 Tex. App. LEXIS 1318 (“If the physician is not negligent, there is no negligent credentialing claim against the hospital.”)

The Sixth District’s decision turns the law of negligent credentialing upside-down by allowing a plaintiff to pursue a negligent credentialing claim in the absence of first establishing medical malpractice liability. That is, under the court of appeals decision, a plaintiff may proceed with a negligent credentialing claim against a hospital even though he has not obtained an adjudication or admission of liability against the physician who is the subject of the negligent credentialing claim.

If allowed to stand, the court of appeals’ decision will directly impact hospitals by requiring them to defend negligent credentialing claims when there has been no prior determination that the plaintiff was harmed by the negligence of the physician who is the subject of the claim. As such, the court of appeals’ decision encourages additional negligent credentialing litigation—because it allows plaintiffs to proceed even though there may be no underlying medical negligence—and puts an unprecedented burden on hospitals to defend the acts or omissions of the physician. Hospitals do not practice medicine and are not in a position to defend a medical malpractice action against an independent physician.⁹ Requiring a hospital to defend in this manner is not only contrary to established Ohio law, but it completely defeats the policy considerations underlying the bifurcation process that lower courts have routinely applied when addressing negligent credentialing claims. See *supra* at 7-8.

Moreover, hospitals should not be required to expend significant resources to defend a physician’s conduct when they do not and cannot control it. But, that is what hospitals will be

⁹ See *Browning v. Burt*, 66 Ohio St.3d at 566 (“A hospital does not practice medicine and is incapable of committing malpractice.”) (citing *Lombard v. Good Samaritan Medical Center* (1982), 69 Ohio St.2d 471, 199 N.E.2d 878).

forced to do if a plaintiff is allowed to proceed with a negligent credentialing claim before establishing that negligence by the physician caused harm to the plaintiff. More specifically, if a plaintiff is allowed to establish medical negligence in a negligent credentialing case against the hospital without the physician as a defendant, the real party in interest to the medical negligence claim (i.e., the physician) will not be there to defend against it. Without the physician there to defend against the medical negligence claim, the hospital is given the Hobson's choice of attempting to defend against the medical negligence claim or allowing the case to proceed with undisputed evidence of medical negligence. To be clear, the physician does not need to be a party in every negligent credentialing case. But, if the physician is not a party **and** there is no prior determination that the plaintiff was harmed by the medical negligence of the physician, then the negligent credentialing case should not proceed to adjudication.

The issue before the Court not only has an impact on hospitals, it also impacts the communities served by hospitals. Because the court of appeals' decision expands litigation against hospitals in a way not previously allowed by Ohio courts, it will undoubtedly have an impact on the allocation of a hospital's limited financial resources. When hospitals are required to increase reserves for claims or pay additional insurance premiums to account for previously unanticipated litigation (as they would be to account for the increased risk emanating from the appellate court's decision), they need to reallocate resources. This often means cutting other programs and services offered to patients, employees, and the community at large, such as caring for the uninsured,¹⁰ community outreach and wellness programs, and medical research.

¹⁰ The Ohio Hospital Association's 2007 Community Benefit Report shows that in 2005 (the last year for which complete data is available), Ohio hospitals contributed a net community benefit of \$1.5 billion—to cover Medicaid shortfalls, to provide charity care to those who could not pay for medical care, and to provide community services (such as free or discounted health services). See <http://www.ohanet.org/benefit/>.

Data collected by the Department of Insurance (“ODI”) pursuant to R.C. 3929.302 shows that defense costs for medical malpractice cases in Ohio are substantial – even without any payment made to a plaintiff. A recent report prepared by ODI based on such data reveals that the average cost of simply investigating and defending a medical malpractice claim in Ohio was \$25,672 in 2006 – excluding the cost of any payment to the plaintiff/claimant. See Ohio Dept. of Ins., Ohio 2006 Medical Liability Closed Claim Report (January 2008).¹¹ In 2006, 4,004 medical malpractice claims in Ohio were “closed” and 3,210 of these closed claims resulted in no payment to the plaintiff/claimant. That means that approximately 80% of claims that were closed in 2006 were closed without medical negligence having been established, at a cost of roughly eighty-two million dollars (\$82,000,000).

If the Sixth District’s decision is allowed to stand, hospitals will be required to defend medical negligence claims asserted against medical staff physicians in the context of a negligent credentialing case. Undoubtedly, some (and perhaps even a high proportion) of those medical negligence claims will be meritless. Nonetheless, hospitals required to defend such claims will need to reallocate resources from other programs to account for this new risk. On the other hand, if medical negligence is required to be established first before a negligent credentialing claim is adjudicated, hospitals will not incur these completely avoidable and unnecessary costs.

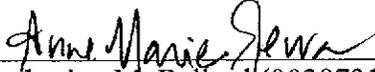
CONCLUSION

Consistent with this Court’s holding in *Albain*, this Court should make clear that Ohio law requires, as a legal prerequisite to a negligent credentialing claim, a prior determination of medical negligence resulting in harm to the plaintiff. The determination of medical negligence

¹¹ Relevant excerpts from this report are attached as Exhibit A. The report reflecting 2007 data has not yet been prepared.

can be by adjudication or stipulation, but cannot be established for the first time in an action against only the hospital.

Respectfully submitted,

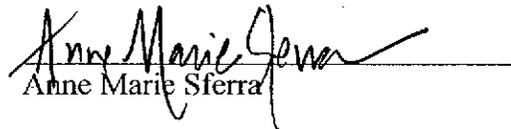

Catherine M. Ballard (0030731)
Anne Marie Sferra (0030855)
BRICKER & ECKLER LLP
100 South Third Street
Columbus, Ohio 43215
(614) 227-2300
(614) 227-2390 (facsimile)
Email: cballard@bricker.com
asferra@bricker.com
Counsel for Amicus Curiae,
Ohio Hospital Association and
Ohio Osteopathic Hospital
Association

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing BRIEF OF *AMICI CURIAE*, THE OHIO HOSPITAL ASSOCIATION AND OHIO OSTEOPATHIC HOSPITAL ASSOCIATION IN SUPPORT OF APPELLANT COMMUNITY HOSPITALS OF WILLIAMS COUNTY was sent via regular U.S. mail, postage prepaid this 6th day of May 2008, to the following:

Jeanne M. Mullin
Reminger & Reminger Co., L.P.A.
237 W. Washington Row
Second Floor
Sandusky, Ohio 44870

Peter O. DeClark
Chad M. Tuschman
Williams DeClark Tuschman Co., L.P.A.
416 N Erie Street
500 Toledo Legal Building
Toledo, OH 43604-6301


Anne Marie Sferra



Ohio Department of Insurance
2100 Stella Court, Columbus, OH 43215-1067
(614) 644-2658 www.ohioinsurance.gov

Ted Strickland, Governor
Mary Jo Hudson, Director

Ohio 2006 Medical Liability Closed Claim Report

January 2008



Ohio Medical Malpractice Closed Claim Report - 2006

I. Introduction

Pursuant to Ohio Revised Code ("ORC") §3929.302 and Ohio Administrative Code ("OAC") 3901-1-64, the Department of Insurance ("Department") hereby submits its second annual report to the General Assembly summarizing the Ohio medical liability closed claim data received by the Department for calendar year 2006. A copy of the first annual report is available on the Department's web site www.ohioinsurance.gov.

II. Overview

ORC §3929.302 requires all entities that provide medical malpractice insurance to health care providers located in Ohio, including authorized insurers, surplus lines insurers, risk retention groups and self-insurers, to report data to the Department regarding medical malpractice claims that close during the year. In addition, each entity must report the costs of defending medical liability claims and paying judgments and/or settlements on behalf of health care providers and health care facilities.

The Department is required to prepare an annual report to the General Assembly summarizing the closed claim data on a statewide basis. The data is summarized in this report in order to maintain the confidentiality of the specific data filed by each reporting entity.

Copies of ORC §3929.302 and OAC 3901-1-64 are attached to this report as Appendices A and B.

III. Data Collection

A secured application on the Department's web site has been set up in order to capture the data elements required by OAC 3901-1-64, Medical Liability Data Collection. Companies must submit data by May 1 for each medical, dental, optometric or chiropractic claim closed in the prior calendar year.

IV. Description of Analysis

For the purposes of this report, and based on general practice, when an insurer or other insuring entity opens a file and begins to investigate the circumstances of a demand for compensation due to alleged malpractice of a health care provider or facility, a claim has occurred, whether or not a lawsuit is ever filed. When the file is closed for one of the many reasons detailed in this report, even when the claimant receives no payment, the claim is considered closed. Multiple closed claim records can be generated from one incident, since a closed claim record must be entered for each health care provider and/or facility from which a demand for compensation is sought.

Ohio Medical Malpractice Closed Claim Report - 2006

In this report, two primary pieces of data are analyzed:

- **Paid Indemnity:** The amount of compensation paid on behalf of each defendant to a claimant.
- **Allocated Loss Adjustment Expense (ALAE):** The expenses incurred by a reporting entity, other than paid indemnity, which relate to a specific claim, such as the costs of investigation and defense counsel fees and expenses. As a business practice, some of the reporting entities do not allocate loss adjustment expenses to a specific claim.

This report organizes and summarizes the data to reflect the types of medical malpractice claims, the age and size of these claims, differences among regions of the state, differences among medical professionals, and several other categories.

V. Limitations of Analysis

The analysis is based entirely on historical closed claim data. That is, claims are reported to us and included in this analysis based on the year in which they reach a final outcome. Some arose from recent medical incidents, but most arose from incidents that occurred several years ago.

This report is not intended to be used to evaluate past or current medical liability insurance rates.

In addition, this data does not reflect plaintiffs' attorney fees, which are not separately collected and cannot be broken out from this data or from any data available to the Department.

VI. Key Findings

- **Total Claims:** For 2006, a total of 4,004 claims were reported by 93 entities. Authorized insurers¹ reported the majority of the claims, 2,495. Self-insured entities reported 1,283 claims; surplus lines insurers reported 169 claims; and risk retention groups reported 57 claims. For 2005, a total of 5,051 claims were reported by 91 entities. Total claims reported for 2006 were approximately 20% less than the number reported for 2005.

¹ Authorized (admitted) insurers are licensed to write business in the state; are subject to the Department's rate, policy form and solvency regulation; and are backed by the Ohio Insurance Guaranty Fund. Surplus lines insurers are not authorized and do not have guaranty fund backing, but are allowed to write policies for those doctors and hospitals that cannot obtain coverage from an authorized insurer. These companies must be on a list of accepted surplus lines insurers and are regulated for financial strength by their domiciliary state or country. Risk retention groups are permitted by federal law to cover the liability insurance risk of the group's members. These groups are not backed by the guaranty fund.

Ohio Medical Malpractice Closed Claim Report - 2006

- **Indemnity Payments:** A large majority of medical malpractice claims resulted in no payment to a claimant. Four-fifths of the claims, 3,210, had no indemnity payments, while one-fifth of the claims, 794, closed with an indemnity payment. The total amount paid to claimants was \$228,735,572, an average of \$288,080 per claim in which an indemnity payment was made. Similarly, in 2005, one-fifth of the claims closed with an indemnity payment, averaging \$269,374 per paid claim.
- **ALAE:** While most medical malpractice claims closed with no payments to claimants, almost all claims generated expenses for investigation and defense. The number of claims reported to have ALAE was 3,433. These expenses totaled \$88,131,139, an average of \$25,672 per claim. In 2005, the average ALAE was \$24,443.
- **Indemnity Payments and Age of Claim:** The amount paid to claimants increased with the age of the claim. Of the claims that closed with an indemnity payment, 168 closed within one year of being reported and had average paid indemnity of \$111,806. That figure rose to \$299,520 for 221 claims closing in their second year. Thirteen claims closed seven or more years after being reported, having average paid indemnity of \$595,067. Similar results were seen in 2005.
- **ALAE and Age of Claim:** Allocated loss adjustment expense also increased with the age of the claim, starting with an average of \$8,143 for claims that closed in the first year, and rising to \$16,878 for claims that closed in the second year. For claims closing seven or more years after being reported, average ALAE was \$74,419. Similar results were seen in 2005.
- **Regional Comparisons:** Nearly half of the claims, 1,896, came from Northeast Ohio. Of these, one-fifth or 377, resulted in indemnity payments totaling \$101,699,092. Almost half of the total dollar amount paid to claimants statewide in 2006 arose from Northeast Ohio claims. However, Northwest Ohio had the highest average paid indemnity of \$365,007. The breakdown of average paid indemnity for the remainder of the Ohio, in descending order, is: Southwest-\$288,988; Central-\$285,147; Northeast-\$269,759; and Southeast-\$256,266.
- **Specialty Comparisons:** When claims were broken down by medical specialty, Internal Medicine had the most claims at 245 with 19 resulting in paid indemnity averaging \$170,237. However, for those specialties that are broken out, Pathology had the highest average paid indemnity of \$663,000 for 5 claims with payments, out of 12 reported claims.
- **Treatment Comparisons:** Diagnosis-related incidents, such as failure to diagnose, delay in diagnosis, or misdiagnosis produced the highest number