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THE PARADOX OF THE THREE WISE MONKEYS: DISCOVERY AND DISCLOSURE OF INFORMATION REGARDING DANGEROUS HEALTH CARE PROVIDERS

ABSTRACT: Mistakes, misconduct or ethical transgressions by doctors, nurses, and other healthcare professionals can have staggering and catastrophic consequences for patients and their families. Recent dramatized and documentary accounts on television of the 2003-2004 discovery of the activities of Charles Cullen over the preceding 15 years underscored the critical importance of background and reference checks as safeguards to ensure the safe, competent, and ethical practice of medicine. Working as a nurse in New Jersey and Pennsylvania, Cullen was responsible for the deaths of between 40 and 400 patients and he came to be known as the "Angel of Death." Through a coalescence of limited pre-employment vetting, lack of thorough investigation of suspicious occurrences, and a failure to provide candid and complete information to prospective subsequent employers, he was able to move from one position to another without detection. The long-standing response to requests by prospective employers for information concerning the job performance of an individual was often limited to confirmation of employment and its duration with little or no detail. This defensive "see no evil, hear no evil, speak no evil" posture to avoid becoming embroiled in defamation or employment-related litigation has ominous ramifications. In healthcare, it presents substantial moral and ethical challenges. The New Jersey Legislature responded to the reluctance to disclose medical errors with enactments to develop warning systems for patient safety and an enhanced reporting obligation imposed on healthcare entities and professionals. The so-called Cullen Law is an attempt to reduce patient safety risks but with inherent limitations and unintended consequences.

***104** Originating in Buddhist teaching, the proverb of the Three Wise Monkeys presents the refrain of "see no evil, hear no evil, speak no evil," intended to provide a path for avoiding evil thoughts and, hence, the pursuit of a righteous life.[3] However, over time, the proverb has been perverted to refer to turning a blind eye and a deaf ear to a problem or wrongdoing and keeping silent about it. Such actions lead to a less-than-righteous path.

The late October 2022 release of the Netflix movie "The Good Nurse,"[4] as well as the contemporaneous release of a documentary entitled "Capturing the Killer Nurse,"[5] prompts reflection on the Three Monkeys. From differing vantage points, these programs present a retelling of the horrific story of Charles Cullen, a nurse who killed multiple patients with the administration of medications through intravenous bags attached to their arms and avoided discovery or revelation of his misdeeds for years.

I. Brief Summary of the Cullen Case

Charles Cullen was born in West Orange, New Jersey in 1960.[6] He became a nurse in 1986. His personal history included growing up in a dysfunctional family, having marital difficulties, and experiencing mental health problems, including suicide attempts.[7]

His first acknowledged murder was in June 1988 at St. Barnabas Medical Center.[8] Four years later, after killing an estimated dozen more patients, Cullen left St. Barnabas when the hospital began investigating contaminated IV bags.[9] He began working at a different hospital. While at Warren Hospital, Cullen killed three older women with overdoses of the heart medication, Digoxin. After a patient's death, the hospital investigated, but cleared Cullen.[10] He continued to work there. Cullen eventually moved on again. He worked for ten different health care facilities in New Jersey and Eastern Pennsylvania during his career.[11] Cullen was arrested in New Jersey ***105** on December 12, 2003.[12] His last nursing position had been at Somerset Medical Center. Cullen was terminated, but the stated reason for his termination at Somerset Medical Center was not his suspected involvement in the series of patient deaths. Rather, it was based on inaccuracies in his job application concerning the dates of his previous employment.[13]

During his career as a nurse, Cullen was fired from five health care facilities, questioned about patient deaths four times, and accused twice of improperly administering medications.[14] Primarily working night shifts, Cullen's employment at the various hospitals or nursing home facilities ranged between just over two weeks to as long as five years.[15]

The Netflix movie looks at an overburdened hospital system, a shortage of available qualified nurses, and conflicting interests intertwined in providing health care. These factors enabled Cullen to be continually employed as a nurse for fifteen years, despite multiple suspicious incidents that were either inadequately investigated or ignored. To some extent, the shortness of his time in some of these settings explains his ability to avoid detection as he moved from facility to facility. In essence, Cullen was able to move from hospital to hospital in New Jersey and Pennsylvania without detection, limited scrutiny, and no adverse commentary from former employers. Unsurprisingly, the intersection of providing quality care for patients with the business demands and priorities of the organization can be ugly.

Following Cullen's 2003 arrest, he was convicted in both New Jersey and Pennsylvania. News accounts referred to Cullen as New Jersey's Angel of Death, responsible for approximately 400 patient deaths, making him the "most prolific serial killer in history."[16] In addition, multiple civil lawsuits were filed in New Jersey[17] and Pennsylvania[18] against the various hospitals ***106** that had employed Cullen, forcing some hospitals to also file their own claims against insurance seeking coverage for the Cullen-related events.[19]

After the pattern of Cullen's reprehensible actions was exposed, in 2004, the New Jersey Legislature took steps to change the paradigm regarding monitoring of medical errors and the process of employment recommendations and performance evaluations. The first step was to establish a non-punitive environment and stimulate a culture of safety that ***107** would allow for the early identification of medical errors and encourage corrective action.[20] On January 13, 2004, a bill was introduced that led to the enactment of the Patient Safety Act[21] with a system of mandatory reporting to the Department of Health of medical errors and incidents meeting the criteria of the Act.[22] In March 2004, the Senate unanimously passed the bill. It received the vote of all members of the Assembly with one abstention.[23] New Jersey's Patient Safety Act was enacted before the somewhat comparable Patient Safety and Quality Improvement Act of 2005 became part of federal law.[24]

Additional legislation followed the Patient Safety Act. On September 27, 2004, a bill was introduced that would lead to the enactment of the Health Care Professional Responsibility and Enhanced Reporting Act (HCPRERA).[25] Passed unanimously by both houses of the New Jersey Legislature, HCPRERA has come to be known as the "Cullen Law."[26] While this article briefly reviews the Patient Safety Act, its principal focus is the Cullen Law. The foundation for guarding against a recurrence of a Cullen-type disaster can be seen in these two laws. The Patient Safety Act provides a mechanism for identifying and reporting errors and near-misses to develop data to formulate corrective or preventive steps. The Cullen Law safeguards against inappropriate individuals being placed or kept in positions of trust and identifies the problematic history of such individuals when they seek new places of employment.

II. The Long-Standing Fear Factor in the Exchange of Health Care Employee Information

Caring and competent individuals are essential for the delivery of health care. Evaluating and monitoring competence and conduct can be challenging. Furthermore, evaluating physician competence and credentials is critical to maintaining a hospital's accreditation.[27] Moreover, quality of ***108** care and patient safety are closely linked to the credentialing process.[28] It is generally

accepted that past performance is the best predictor of future performance, and past employers are significant resources for this information concerning past performance.[29]

Human resource decision-makers confront a quagmire of contradictory objectives. They seek to obtain as much information as possible about a potential new staff member to formulate a reasoned hiring decision. Later, however, they strive to provide as little information as possible on a current or former employee because of the possibility of a lawsuit premised on the disclosure of negative information. The moral questions presented with the withholding of information about negative experiences or encounters that may impact the prospective employer's decision are often pushed aside. Legal advice has played a role in bringing this swamp into existence. The potential crisis of conscience is particularly acute in the setting of health care, where patients can be truly endangered by incompetence or negligence.[30]

Employment lawyers have routinely advised that only “name, rank, and serial number” information be given in response to requests for employment references.[31] This guidance is based on the manifest wisdom that although winning a lawsuit is good, avoiding being sued is better. This type of recommendation attempts to avoid becoming embroiled in prolonged and expensive litigation involving claims of defamation, wrongful termination, or discrimination. It has been estimated that one-third of all ***109** defamation lawsuits originate from the workplace, with the employer as a defendant.[32] The literature examining the consequences of providing references, as well as the failure to give them, is extensive.[33]

The plaintiff's defamation claim, however, will often fail for several reasons. The statements in the allegedly libelous reference may, in fact, not even meet the legal standards to be defamatory.[34] There may be defenses ***110** based on legal concepts of truth[35] and conditional or qualified privilege.[36] Furthermore, even when a case is lost, the occasional jury awards are not ***111** necessarily devastating. However, achieving a favorable outcome incurs legal expenses and requires the expenditure of time and resources away from the primary focus of the business, not to mention the risk of adverse publicity.

A nationwide study of hospital executives, which included some New Jersey hospitals, demonstrated a resistance to sharing employee information based on a fear of being sued.[37] The short-term perspective of claim avoidance, however, minimizes the more significant consequence of an avoidable devastating injury to another human being. It sets up a Hobson's Choice that comes about with an awareness that employees for whom no substantive or meaningful reference was provided will engage in conduct that is harmful to some third person in the new work setting. Such harm, if foreseeable, is based on past behavior that provides a basis for tort liability.[38] The claim can be in the form of a negligent hiring lawsuit against ***112** the current employer for failing to investigate the prospective employee adequately.[39] It may also be a lawsuit against the former employer for failing to disclose critical information, whether based on an affirmative misrepresentation or some form of negligent misrepresentation resulting from the omission of material information.[40] In most circumstances, the ***113** latter type of claim against the former employer would not be likely to succeed because, generally, there is no legal duty or obligation to provide a reference.[41] This approach, however, changed with the Cullen Law. Indeed, an administrator at the last hospital where Cullen worked commented, “[i]f anything good comes from this it would be to reform the system where we are prevented from telling what we know out of fear of being sued.”[42]

III. Review of the Scope of The Cullen Law

As the principal sponsor of the bill for what would become known as the Cullen Law, as well as the Patient Safety Act, Senator Joseph Vitale released a statement indicating the expectation that “[t]he culture of secrecy and the ‘Hear no evil, See no evil’ attitude” would end in New Jersey.[43] The ***114** Cullen Law has imposed an obligation on health care entities to report to a regulatory authority broad categories of inappropriate behavior by health care professionals, as well as imposing a duty on the part of a health care entity to provide information regarding any report submitted about the health care professional, together with information concerning the health care professional's performance to any other health care entity seeking information for purposes of evaluating the health care professional as a member of its workforce or medical staff.[44] The Cullen Law provides qualified immunity against tort liability for good faith reporting and disclosure of information.[45] It also provides for penalties on health care entities for the failure of a health care entity to comply.[46] The Patient Safety Act sets up a system for mandatory but confidential reporting of certain medical errors.[47] Patient safety is enhanced through analysis of the data to minimize recurrences. Implementing regulations calls for applying the root cause analysis process with a collection of tools and techniques to identify direct and underlying causes of a preventable adverse event and thereby develop corrective actions.[48]

Statutory and regulatory requirements concerning health care-related background checks and reporting have evolved over the years. In 1983, a licensed health care facility was required to notify the State Board of Medical Examiners of any disciplinary action or proceeding taken by the governing body against a physician or surgeon that resulted in the reduction or suspension of privileges or removal or resignation from the staff.[49] However, the reporting was limited to disciplinary action taken by "the governing body" and not at a lower level within the health care facility.[50] Furthermore, the only health care professionals covered were physicians and surgeons.[51] There was a related requirement to report any settlement, judgment, or arbitration award in a medical malpractice matter to which the health care facility was a party as a presumptive sign of potential competence concerns.[52]

These reporting requirements were amended and supplemented with the enactment of the Professional Medical Conduct Reform Act of 1989.[53] In addition to licensed health care facilities, this amendment now included ***115** health maintenance organizations.[54] The Legislature established the Medical Practitioner Review Panel to review medical malpractice and health care facility or health maintenance organization privilege cases.[55] The Panel was to investigate the information received regarding medical malpractice claims and facility or HMO privilege actions before making recommendations to the State Board of Medical Examiners.[56] Dispositions by the Panel might include recommendations to investigate a matter further, close a matter, initiate a disciplinary action, defer a recommendation pending the outcome of litigation or a disciplinary action at a health care facility or HMO, or refer the practitioner to a focused education or treatment program.[57] Although "practitioner" was still defined only as a person licensed to practice medicine and surgery, the 1989 legislation expanded the circumstances that would trigger a reporting requirement.[58] The eventual enactment of the Cullen Law would further expand the scope of triggers.

Since 1997, New Jersey has required that facilities offering health care or health-related services for the institutionalized elderly obtain a criminal background check concerning any unlicensed person who would have regular contact with a patient, resident, or client.[59] In 2002, this was expanded to require a criminal background check concerning all health care professionals applying for initial licensure.[60] The Cullen Law expanded the scope of the criminal background check beyond those applying for initial licensure as of 2002. It required a background check in connection with license renewals so that, eventually, all licensees would have undergone a criminal background check.[61]

The Cullen Law covers both "health care entities" (HCE) and "health care professionals" (HCP) and thus involves the authority of both the Department of Health (DOH) and the State Board of Medical Examiners (BME).[62] It has a broad definition of "health care entity" that goes beyond hospitals.[63] The definition includes HMOs and carriers regulated by the New Jersey Department of Banking and Insurance, state or county psychiatric hospitals, state developmental centers, staffing registries, and home care service agencies.[64] The scope of a "health care professional" is similarly extensive and encompasses individuals licensed or authorized to practice by ***116** Boards within the Division of Consumer Affairs.[65] These include the following:

- Acupuncture
- Audiology & Speech-Language Pathology
- Chiropractic Examiners
- Dentistry
- Marriage & Family Therapy

- Medical Examiners
- Nursing
- Occupational Therapy
- Ophthalmic Dispensers and Technicians
- Optometrists
- Orthotics & Prosthetics
- Pharmacy
- Physical Therapy
- Psychoanalysts.
- Psychological Examiners
- Respiratory Care
- Social Work Examiners
- Veterinary Medical Examiners

The statutory definition also includes a nurse's aide and a personal care assistant certified by the Department of Health.[66]

The relationship between an HCE and the HCP giving rise to the reporting is multi-faceted. It includes where an HCP is employed by, under contract with, has privileges granted at, or provides services through an agreement with a health care services firm or staffing agency at an HCE.[67]

The Cullen Law focuses on professional impairment, incompetency, or misconduct that relates adversely to patient care or safety. Because of that focus, it excludes forms of personal conduct from the concepts of incompetence, professional misconduct, or unprofessional conduct, such as tardiness, insubordination, or other similar behaviors that do not relate to patient care or safety.[68]

The Cullen Law specifically requires an HCE to provide written notification to the Division of Consumer Affairs concerning an HCP when there are manifestations of impairment, incompetence, or misconduct involving patient care or safety that involve:[69]

***117** a) Full or partial revocation or suspension of privileges, whether done summarily, temporarily, or permanently;

b) Removal from a list of eligible employees of a health services firm or staffing registry;

c) Discharge from the staff;

d) Termination or rescission of a contract to render professional services;

e) Placement of conditions or limitations on the exercise of clinical privileges or practice, including but not limited to second opinion requirements, non-routine concurrent or retrospective review of admissions or care, non-routine supervision by one or more members of the staff, or the completion of remedial education or training;

f) Voluntary resignation from the staff if (1) the HCE is reviewing or investigating the HCP's patient care for reasons of impairment, incompetence, or unprofessionalism or (2) the HCE has expressed the intention to do such a review;

g) Voluntary relinquishment of any partial privilege or authorization to perform a specific procedure if (1) the HCE is reviewing or investigating the HCP's patient care for reasons of impairment, incompetence, or unprofessionalism or (2) the HCE has expressed the intention to do such a review;

h) Granting the HCP a leave of absence during or after a review by the HCE relating to impairment of the ability to practice with reasonable skill and safety due to a physical, mental, or emotional condition or drug or alcohol use, except that no report is required for pregnancy-related leaves of absence or if the HCP has sought assistance from an approved professional assistance or intervention program and is complying with the treatment or monitoring regimen; and

i) Involvement in a medical malpractice liability suit to which the HCE is also a party, which has resulted in a settlement, judgment, or arbitration award.

The events triggering reporting under the Cullen Law were built on the closing of loopholes that had begun with the 1989 Professional Medical Conduct Act's modification of the 1983 legislation that excluded any ***118** disciplinary action taken below the level of the governing body and for anything less than reduction or suspension of privileges or removal or resignation from the medical staff.[70] That version had no mention of leave of absence as a reportable action.[71] Notably, the triggering events of the Cullen Law are broader, and the time within which the reporting must be done is shorter than required by the National Practitioner Data Bank.[72]

***119** The written notification to the Division of Consumer Affairs is to be done within seven days of the triggering action or event, using a form approved by the Department of Health in the promulgated regulations.[73] A copy of the form is to be provided to the HCP who is the subject of an investigation except in the circumstance of a voluntary resignation while the HCP's care is under review.[74] If a health care service firm or staffing registry was involved in placing the HCP, it too, is to be provided with a copy of the form by the reporting HCE.[75] Failure to provide the required notice subjects the HCE to penalties imposed by the DOH of $500 per day.[76] While the Cullen Law imposes a duty to disclose the designated information, it also provides an HCE with immunity. If the report has been made "in good faith and without malice," an HCE or any employee is not liable for civil damages arising out of the reporting of this information.[77]

The Cullen Law also imposed reporting obligations on HCPs to report colleagues. The trigger for this reporting obligation is having information that reasonably indicates that the HCP-colleague has demonstrated an impairment, gross incompetence, or unprofessional conduct that would present "an imminent danger to an individual patient or to the public health, safety or welfare."[78] An implementing regulation defines the contours of "imminent danger" as an unmistakable demonstration that harmful actions or outcomes may occur during the licensee's continued unrestricted practice.[79] There is no requirement to report if the knowledge of impairment or incompetence was acquired as a result of rendering treatment to that HCP.[80] The statute provides for penalties in the event of a failure to report but explicitly precludes a private right of action for failure to comply with the notification requirements.[81] Moreover, like reporting by HCEs, it provides immunity from civil damages to the HCP who provides the notification in good faith and without malice.[82] A separate provision within the Cullen Law requires an HCP with information regarding impairment, ***120** incompetence, or unprofessional conduct to promptly inform the person at the HCE designated to receive this information.[83]

In addition to establishing a duty for an HCE to report manifestations of impairment, incompetence, or professional misconduct to licensing authorities, providing immunity from civil damages for the reporting, and imposing penalties for the failure to report, the Cullen Law goes further. It requires the retention of records of documented complaints concerning events related to patient care and disciplinary proceedings involving an HCP for seven years.[84] Failure to maintain such records is another penalty-provoking circumstance.[85]

The HCE receiving an inquiry from another HCE concerning an HCP must "truthfully" disclose whether it had provided any notice pursuant to the Cullen Law "within the seven years preceding the inquiry."[86] In addition, the inquiring entity must provide a certification that the inquiry is to evaluate an HCP for hiring, continued employment, or continued privileges.[87] It is unclear what enforcement actions have been undertaken by ***121** DOH for the failure of entities to comply with the Cullen Law. For at least the last seven years, the DOH does not have annual reports or summaries of enforcement actions for failure to comply with N.J.S.A. 26:2H-12.2c that are available through the New Jersey Open Public Records Act (OPRA).[88]

The HCE must provide a copy of the notice submitted to the regulatory authorities along with supporting documentation to the inquiring HCE.[89] The statute also requires that the HCE provide information concerning a current or former employee's job performance as it relates to patient care and, in the case of a former employee, the reason for the employee's separation.[90] The inquiry is to be made using a form promulgated by the DOH that has come to be known as CN-9.[91] The regulation requires that the response be provided within eight business days of receipt of the CN-9 form.[92] As previously noted, the statute and implementing regulations provide immunity from civil damages for providing information in accordance with the Cullen Law.[93] In addition, HCEs are exposed to penalties for failure to provide information to the inquiring entity.[94]

However, one significant limitation of the Cullen Law is that the duty to provide information to an inquiring entity does not encompass out-of-state facilities or hospitals. This is a result of the statutory definition of "health care entity," which is limited to health care facilities and entities licensed in New Jersey.[95]

IV. Case Law Applying the Cullen Law

The Cullen Law, together with the Patient Safety Act, have done much to change the "See No Evil, Hear No Evil, Speak No Evil" paradigm. It has proven to be a substantial and meaningful defense to claims of ***122** defamation and tortious interference made on behalf of former employees for employers who provided a negative employment reference.

The 2011 decision in *Senisch v. Carlino*[96] concerned a physician assistant employed in the cardiology department of Deborah Heart & Lung Center who had received favorable performance reviews in his early years at the facility. But in 1999, he received an unfavorable review with his grievance appeal rejected.[97] He was terminated early the following year.[98] In 2004, he applied for a position with Memorial Hospital of Salem.[99] The prospective employer requested a reference from his former employer.[100] Deborah Center did not respond to specific questions but only provided his dates of employment and his position title.[101] The Cullen Law was not yet in effect.

The plaintiff had some other employment changes but without the necessity of references.[102] In 2007, he obtained a position with a surgical orthopedic practice, which required him to get credentials at Underwood Memorial Hospital.[103] The hospital contacted Deborah Center, which replied with statements concerning "performance deficiencies" and an indication that he was not eligible for re-employment there.[104] When the plaintiff's application for privileges at Underwood was not immediately approved, the orthopedic group told him that he would be terminated if he did not receive credentials from the hospital.[105] He withdrew his application and resigned his employment.[106]

The court accepted that the Deborah Center reference prevented the plaintiff from securing credentials at Underwood.[107] However, it concluded that because the statements accurately presented information from the plaintiff's personnel file, there was no evidence of malice to sustain the claims of defamation or tortious interference.[108] The court also referred to the HCPRERA as "prohibit[ing] health care entities from withholding certain information about current or former employees from other health care entities that request the information."[109] It also emphasized the immunity under the ***123** Cullen Act for disclosure of reference information in accordance with the Act.[110] Accordingly, the plaintiff could not prevail on these tort claims.

In *Weisman v. New Jersey Dept. of Human Services*,[111] a nurse's employment at the Ancora Psychiatric Hospital was terminated with a report to the Board of Nursing.[112] The plaintiff's union appealed the termination, and the matter was submitted to arbitration with an eventual settlement.[113] She subsequently obtained a position as a part-time nurse at Kennedy Memorial Hospital. But that position was rescinded because of Kennedy's receipt of unsatisfactory job references.[114] The suit was dismissed at the trial level. The Third Circuit Court of Appeals affirmed, commenting in connection with the arbitration settlement that Ancora could not "bargain away" its statutory obligation to provide information regarding the report to the Board of Nursing.[115]

The Appellate Division addressed another provision of the Cullen Act in the context of discovery for a medical malpractice lawsuit. In *Blum v. Morristown Medical Center*,[116] the court noted that information provided to the Board of Medical Examiners was to be treated as confidential until the final disposition of any inquiry or investigation by the licensing board. Furthermore, if the result of the inquiry or investigation was that there was no basis for disciplinary action, "the information shall remain confidential."[117]

The circumstance of an individual HCP making a report to the Board of Medical Examiners has also been litigated. In *Hanna v. Shnaidman,*[118] the plaintiff was a physician involved in a custody dispute. The defendant performed a psychiatric evaluation.[119] Based on her evaluation, she had concerns regarding the plaintiff's ability to practice medicine safely and contacted the Board.[120] The Board then commenced an investigation.[121] The plaintiff's lawsuit for defamation, malicious prosecution, and other torts was dismissed based on the statutory requirement that an HCP "promptly notify the [Board] if that health care professional is in possession of information which reasonably indicates that another health care professional has demonstrated an impairment, gross incompetence or unprofessional conduct ***124** which would present an imminent danger to an individual patient or to the public health, safety or welfare."[122]

In *Gasperetti v. Deborah Heart & Lung Center*,[123] the plaintiff, a cardiologist, sought to preclude the Division of Consumer Affairs from modifying her public profile to include a notation that she resigned from her position while her clinical practices were under review at Deborah Center.[124] The clinical review was triggered when two of her colleagues complained to an administration official regarding the plaintiff.[125] Specifically, they reported that the plaintiff provided her patients with medically unnecessary catheterizations.[126] The hospital commenced its focused professional practice evaluation process, including an external review.[127] The external reviewer found numerous issues related to the standard of care. Before the hospital could analyze this report, the plaintiff resigned her privileges and obtained new employment.[128] Counsel for the hospital submitted a report to the Board of Medical Examiners that the plaintiff resigned from her position while the hospital was reviewing her patient care.[129] The court rejected the plaintiff's contention that she was not under review when she resigned, finding that the focused professional practice evaluation fell within the statute's ambit.[130] It further found that the plaintiff's lack of awareness of the review did not preclude the resignation from being a triggering event for the reporting, because of the mandatory nature of the reporting to the Board and the duty to provide information to other requesting facilities of any report to the Board.[131] Like other courts, the Appellate Division relied on the statutory immunity provision in the Cullen Act and the lack of evidence of malice or lack of good faith. It concluded that "the policy behind the enactment of the Cullen Act" protected defendants from all the related tort claims predicated upon the same conduct of reporting information.[132] Plaintiff's requests for further review were denied by the Supreme Court of New Jersey[133] and the United States Supreme Court.[134]

***125** In *Jefferson v. Community Hospital Group*,[135] the former employer provided information regarding an applicant for a nursing position at a Veteran's Affairs ("VA") hospital, indicating that she had been involuntarily terminated for failing to comply with occupational health requirements regarding a flu shot.[136] This involuntary termination was not disclosed by the plaintiff as part of her application.[137] After receiving the information, the VA hospital withdrew a conditional job offer.[138] The information from the former employer, however, was inaccurate and incomplete in that the nurse eventually complied with the policy and received the vaccination.[139] The former employer attempted to correct the misinformation, but the plaintiff did not get the job offer reinstated.[140] In dismissing the complaint against the former employer and its human resources manager, the court noted that the disclosure was made pursuant to the Cullen Law and expressed its regret at the harsh resolution of the case, considering the manifest mistakes made by the former employer. Nonetheless, it concluded: "The greater public good of encouraging employers to report negative information about employees to future employers, especially in the critical health care industry, must take precedence."[141]

V. Consequences - Intended and Unintended

The Cullen case involved deliberate criminal activity that resulted in multiple patient deaths.[142] The moral imperative to discover and disclose to prevent further occurrences in that context is quite indisputable. But this is neither the sole nor even the primary conduct encompassed by the Cullen Law requirements. It includes incompetence, professional misconduct, and impairment related to patient safety.[143] What should be the threshold to trigger a report for one of these categories? There is no bright-line answer. ***126** Two knowledgeable New Jersey nurse-attorneys have commented on the potential for a fundamental unfairness in the invocation of the Cullen Law.[144] They observe that nurses are reported "for conduct seen as incompetent but that is really the result of inexperience" with unfortunate long-term consequences given the minimum seven years for which records of the reported information must be maintained.[145] The Cullen Law does not define "competence," and that term has been understood differently in several contexts.

For example, in 1999 the Accreditation Council for Graduate Medical Education established the following six "Core Competencies": (1) Patient Care and Procedural Skills; (2) Medical Knowledge; (3) Practice-Based Learning and Improvement; (4) Interpersonal and Communication Skills;(5) Professionalism; (6) Systems-Based Practice.[146] In contrast, in its 2003 report *Bridge to Quality*, the Institute of Medicine described five core competencies of all health care professionals as: (1) patient-centered care, (2) teamwork and collaboration, (3) evidence-based practice, (4) quality improvement, and (5) informatics.[147] More complex approaches identifying "attributes and generic competencies" that are not specifically clinical but are ***127** applied in a clinical setting have recently been advocated.[148] But more succinctly, the Joint Commission describes competency as a combination of observable and measurable knowledge, skills, abilities, and personal attributes that constitute an individual's performance. The ultimate goal is to demonstrate that the individual has the required attributes to deliver safe, quality care.[149]

Indeed, lack of competence, otherwise referred to as incompetence, is different from negligence, though the two are intertwined in encompassing deviations from accepted standards by which someone may be held liable for injury to another person. Incompetence presents as a lack of knowledge, ability, or fitness to do something. In contrast, negligence is the failure to behave

with the level of care that someone would reasonably have exercised under the same circumstances.[150] Negligence is situational and involves failing to abide by the standard of care that a competent practitioner would employ in similar circumstances. Malpractice claims thus become a proxy of sorts for incompetence. The validity of this supposition is debatable, if not doubtful, especially in connection with the settlement of malpractice claims.[151] The settlement of a malpractice claim with payment of money is a reportable event to the National Practitioner Data Bank[152] and the New Jersey Medical Practitioner Review Panel for inclusion in a practitioner's Health Care Profile.[153] However, both sets of data have similar disclaimers. The New Jersey version is quite explicit:

> Settlement of a [malpractice] claim and, in particular, the dollar amount of the settlement may occur for a variety of reasons, which do not necessarily reflect negatively on ***128** the professional competence or conduct of the practitioner.[154]

The unfortunate reality is that death and injury occur to patients, even without deliberate criminal intent, through unintended medical mistakes and misadventures. In *To Err Is Human: Building a Safer Health System,* the Institute of Medicine reported that preventable adverse medical events were one of the leading causes of death in the country and estimated that "as many as 98,000 persons died in hospitals each year as a result of medical error."[155] It further concluded that most of these medical errors could be prevented by improved systems. It made the important point that not all errors resulted in patient harm, and such "near-misses" presented an opportunity to learn how to avoid not only injury but the error itself.[156] However, the opportunity to implement safer systems and policies may not be found unless physicians and hospitals acknowledge and disclose these errors.[157] The reflexive response of secrecy and denial of medical error has a corrosive effect.

It has long been recognized that the purpose of medical malpractice law and other tort claims is to compensate victims, provide deterrence to reduce the likelihood of negligent behavior, and improve the quality of care. ***129** Except for the compensation factor, professional discipline through action by a regulatory agency or hospital has similar objectives. However, the premise of both approaches is that a single critical event that made the difference between injury and non-injury can be identified, and that the recognition of such occurrences is predictive of future events. Experience and the mounting literature have shown that this premise rarely has a sound basis.[158]

While significant literature demonstrates that the most consistent and powerful predictor of future violence is past violent behavior, the same is not true of negligent error.[159] Physician negligence in providing care that is below the accepted standard of care is related to competence, but it is not equivalent. It is a truism that they are human beings, physicians are fallible. Part of the standard New Jersey instruction in a malpractice trial informs the jury that "[t]he law recognizes that the practice of medicine is not an exact science. Therefore, the practice of medicine, according to accepted medical standards, may not prevent a poor or unanticipated result."[160]

There are some treatment modalities that are particularly vulnerable to the risk of a poor outcome. At least one commentator has contended that "it is unreasonable to infer a propensity for error or for negligence on the basis of the association of two apparently related events when both the antecedent and the subsequent event are highly likely to happen." This inference has been termed "overforeseeability."[161] In assessing a physician for possible Cullen Law reporting, one must take care to recognize that a physician who has a large number of complications may not be a substandard physician. Instead, the incidents may result from a practitioner caring for many patients with an exceptionally high risk for adverse events. Nonetheless, while the risk and occurrence of complications are accepted because of the perceived benefit from the successful treatment, the expanding Patient Safety Act-movement requires more analysis to distinguish "known complications" from safety events resulting from substandard care. A methodology referred to as "The Known Complication Test" poses a series of four questions to reach a pertinent conclusion.[162]

> ***130** 1. Was the procedure, treatment, or test appropriate or warranted for the patient based on nationally recognized standards of care?

> 2. Was the complication a known risk, and was the standard of care employed to mitigate risk?

3. Was the complication identified in a timely manner?

4. Was the complication treated according to the standard of care and done in a timely manner?

If it were determined that the procedure, treatment, or test was not warranted, the decision to provide the episode of care should be considered a deviation from expected procedures or standards of care. The event should then be classified as a safety event for further evaluation, including root cause analysis.

The scope of the Cullen Law goes beyond health care entities and includes a duty imposed upon individual health care professionals. The obligation to disclose colleague errors - whether to the patient or the institution - has long been recognized as a matter of professional ethics. This is clearly outlined in the American Medical Association's Code of Medical Ethics[163] and various editions of the American College of Physicians Ethics Manual.[164] The Cullen Law fortifies the ethical obligation into a legal duty. The first item included on the BME website regarding licensee reporting obligations is "Colleague Reporting."[165] The Board of Nursing has had a regulation since 1985 requiring licensees to report in a timely manner incidents, which leads to the good faith belief that the conduct violates the Nurse Practice Act or its implementing regulations.[166]

While the ethical and legal duty to report is clear, compliance has been negatively impacted by several factors. To begin with, there is a lack of clarity as to what kinds of misconduct should be reported. The Cullen case itself does not provide a reliable guide since rarely does the misconduct involve the intentional killing of a patient. There is the confounding factor that the incident may be only an isolated occurrence that is not likely to recur. There may be a lack of certainty regarding the actual facts resulting in silence or a "there-but-for-the-grace-of-God-go-I" response. The use of peer review can prevent overreaction to isolated occurrences that may be mistakes but not ***131** substandard practice. However, critics have identified the potential abuse of "sham peer review."[167]

A 2010 report[168] by researchers from the Massachusetts General Hospital concerning a survey of physicians in several medical specialties practicing around the country found that there was overall support for a professional obligation to report impaired or incompetent colleagues to a relevant authority. They concluded, "however, when faced with these situations many do not report."[169] The most commonly expressed reason for the inaction was the belief that someone else was taking care of the problem.[170] A significant number of respondents to the survey question indicated that they did not report a colleague because "it could easily happen to you."[171] A greater percentage failed to report because of a fear of retribution. This was more common among physicians whose practices were dependent on referrals.[172] Similar information was developed during a 2017 summit conference conducted by the Federation of State Medical Boards, discussing barriers and challenges to effective reporting and information-sharing with a focus on the two levels of individual behavior and system issues.[173] Significant factors at the individual behavior level were summarized:

> Summit participants agreed that cultural attitudes - in both the workplace and society, in general - are a key factor to be addressed. Because the reporting of adverse events or issues in health care is usually perceived as an action that leads to punitive results, cultures of fear - rather than openness - have emerged that may encourage suppression of information rather than transparency and a willingness to share. Strongly hierarchical workplaces can exacerbate the problem, impeding the willingness of individuals to come forward to report problems in the ***132** behavior or performance of those in more senior positions. "Power differentials" are often perceived in health care teams, in which some participants are viewed as having sway and influence over others - making those in subservient roles less likely to speak up about problems or issues. In an office setting, individuals may fear retribution - including loss of employment - if they report the behavior of a person in authority.

> Peers working in health care may be reluctant to report issues of competence or ethics in their colleagues for fear that they will be identified and ostracized by others. For physicians or other professionals who rely on referrals, such ostracization can have economic impacts. Participants noted that in health care workplaces, where physicians, nurses, pharmacists, and others have a high degree of interdependence in a pressure-filled environment, their reliance upon each other may serve as an impediment to "rocking the boat."[174]

The reporting of colleagues has many similarities to whistleblowing. Despite Ralph Nader's effort to put a positive gloss on this term, a whistleblower is frequently seen in a negative light. More commonly appearing in connection with health care fraud or corruption,[175] the whistleblower designation carries a certain stigma. Moreover, the expression "snitches get stitches and end up in ditches" can potentially turn someone away from making a report relating to a safety concern. However, the medical ethicist Arthur Caplan has rejected the use of the term "snitch" or "ratting out" a colleague when dealing with the reporting of incompetence or impairment.[176]

Proponents of safety culture have nonetheless observed that "[h]ealth care does not report well" with a propensity for "shooting the messenger" carrying the report with bad news.[177] Applying safety culture principles to health care involves developing high-reliability organizations and drawing on the experience gained with such entities in other high-risk industries. This requires the protection of individuals making reports in good faith. It moves away from an approach that focuses on the errors of individuals, blaming ***133** them for forgetfulness, inattention, or moral weakness, and instead places an emphasis on the conditions under which individuals work, trying to build defenses to avoid errors or mitigate their effects.[178]

In New Jersey, the DOH has established a program for the anonymous reporting of safety risks or complaints through online reporting and a telephone hotline.[179] The BME also has an online complaint process but without the assurance of anonymity.[180] Many health care institutions have their own anonymous hotlines for employee reporting of safety concerns.[181] Although a report may initially be made confidentially, it does not mean that the reporting individual's identity may not later become known. The Cullen Law does not provide any protection against retribution in the workplace. Such protection and relief may, however, be available through invocation of laws such as the Conscientious Employee Protection Act[182] or the New Jersey Law Against Discrimination.[183]

VI. Conclusion

The Cullen Law has merged ethical and legal responsibilities. While not perfect in and of itself, it has provided a model that has been emulated widely in more than 35 other states.[184] The Cullen Law has provided a comprehensive response and resolution of the problem of health care incompetence, impairment, or misconduct. The paradigm of the three monkeys has again been altered so that turning a blind eye or burying one's head in the sand is no longer the usual and expected response. It has never been an acceptable response. The intended impact of the three wise monkeys known as Mizaru, Kikarazu, and Iwazaru is enhanced if one includes the often omitted fourth monkey, Shizaru.[185] The aphorism associated with this fourth monkey is "do no evil." This phrase brings to mind the "expression of a primary obligation of the physician, *primum non nocere*."[186] The more ***134** commonly used phrasing of this fundamental precept of medicine is: First, do no harm.

Footnotes

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[3] *See* A.W. Smith, *On the Ambiguity of the Three Wise Monkeys*, 104 Folklore 144, 146 (1993), https://www.jstor.org/stable/1260803.

[4] The Good Nurse (NETFLIX 2022).

[5] *Id.*

[6] Charles Graeber, The Good Nurse: A True Story of Medicine, Madness, and Murder (Twelve, Hachette Book Group 2022); *See also* George Mair, Angel of Death (Chamberlin Bros. 2004).

[7] Charles Graeber, The Good Nurse: A True Story of Medicine, Madness, and Murder (Twelve, Hachette Book Group 2022); *See also* George Mair, Angel of Death (Chamberlin Bros. 2004).

[8] Graeber, *supra* note 6, at 235. This book incorrectly listed the date of death as November 6, 1988. The obituary in *The New York Times* of the victim, John W. Yego, Sr., however, gave the date as June 11, 1988. https://www.nytimes.com/1988/06/15/obituaries/john-w-yengo-sr-72-ex-judge-in-jersey-city.html.

[9] Graber, *supra* note 6 at 22-23.

[10] *Id.* at 48-51.

[11] Mair, *supra* at 3-4.

[12] *Id.* at 15.

[13] Graeber, *supra* note 6, at 170.

[14] *Id.*

[15] *Id.*

[16] Amy Kuperinsky, *Meet 'The Good Nurse' Hero Who Helped Put N.J. Serial Killer Charles Cullen Behind Bars*, NJ.com (Oct. 28, 2022), https://www.nj.com/entertainment/2022/10/meet-the-good-nurse-hero-who-helped-put-nj-serial-killer-charles-cullen-behind-bars.html.

[17] Graeber, *supra* note 6, at 271.

[18] *Id.* note 1, at 295. The Pennsylvania litigation arising out of Cullen's time at St. Luke's Hospital had a more tortuous course than in New Jersey. Lawsuits were filed against both Cullen and St. Luke's Hospital. In eight of them, the medical expert for plaintiffs was unable to connect Cullen to the deaths. Accordingly, the claims against St. Luke's were dismissed for lack of expert evidence. These were matters in which Cullen had not confessed or acknowledged his role. A default judgment on the liability issue was entered against Charles Cullen for failure to respond to the

complaints filed against him. A jury heard a damages-only trial and returned a verdict on March 10, 2010, with awards that totaled $95 million. However, Cullen was without assets and judgment proof. The Pennsylvania appellate court and then the Pennsylvania Supreme Court upheld the dismissal as to St. Luke's. Fish v. Saint Luke's Hosp., 47 A.3d 1243 (Pa. Super. Ct. 2012), *aff'd*, 617 Pa. 631 (2012). In five other cases in which Cullen acknowledged the killings, the trial court denied a motion to dismiss based on the expiration of the two-year statute of limitations for wrongful death claims. The families had received death certificates indicating causes of death consistent with the progression of diseases for which the decedent patients were being treated. The trial court concluded from the record before it that there were questions of facts as to a fraudulent concealment of the cause of death that tolled the running of the statute of limitations. The denial of dismissal was upheld on appeal with the court concluding that the claim of fraudulent concealment was sustained by a theory of constructive notice even in the absence of actual knowledge on the part of St. Luke's as to the cause of death being the actions of its employee nurse. Krapf v, St. Luke's Hosp., 4 A.3d 642, 648, 653-54 (Pa. Super. Ct. 2010). The Pennsylvania Supreme Court declined to review the case. 34 A.3d 831 (Pa. 2011). These cases settled in the next year with the record sealed by the trial court.

The saga of the Pennsylvania Cullen cases continued with institution of an abuse of process lawsuit by St. Luke's Hospital against the families of two patients and their lawyers who had filed wrongful death claims arising out of care at St. Luke's Hospital. Pursuant to a Pennsylvania statute, the hospital contended that these lawsuits were "frivolous" because the patients were in severely compromised health when they entered the hospital, Cullen denied killing them, and several investigations had concluded that neither patient was harmed by Cullen. The patient lawsuits were dismissed for lack of expert testimony. Based on the families' assertion of an advice of counsel defense, the hospital dismissed them from the lawsuit and continued against only the lawyers. The trial court entered an order overruling the hospital's assertion of attorney-client privilege during discovery, denying the hospital's request for a protective order, and imposing sanctions for obstreperous behavior by the hospital during discovery. St. Luke's Hosp. of Bethlehem v. Vivian, No. 2011-C-1182, 2012 WL 11891519, at *1 (Pa.Comm.Pl. June 15, 2012). This was upheld on appeal to the Superior Court. St. Luke's Hosp. of Bethlehem v. Vivian, 99 A.3d 534, 545 (Pa. Super. Ct. 2014). The Pennsylvania Supreme Court denied the further appeal. St. Luke's Hosp. of Bethlehem v. Vivian, 114 A.3d 417 (Pa. 2015). The hospital's case was subsequently dismissed. The executors of the deceased patients then instituted their own countersuit against St. Luke's Hospital and its attorneys for wrongful use of civil proceedings. At trial, the jury found there was probable cause for the assertion of the families' claim about Cullen and that the hospital had instituted its lawsuit for an improper purpose. The jury, however, awarded no damages. This case too was affirmed on appellate review. Miller v. St. Luke's Univ. Health Network, 164 A.3d 479 (Pa. 2016). The Pennsylvania Supreme Court denied any further appellate review. *Id.*

19 Within the context of the consolidated New Jersey cases, some hospitals initiated declaratory judgment actions against insurers for defense and indemnification of the underlying lawsuits pursuant to Directors, Officers and Trustees Liability policies. *See* Somerset Med. Ctr. v. Exec. Risk Indem., Inc., No. A-6214-08T2, 2010 WL 4057151, at *1 (N.J. App. Div. March 22, 2010). In rejecting the insurer's attempt to avoid coverage, the Appellate Division remarked: "[T]he underlying claims against the hospital and its principals arose from negligence in hiring and supervising Cullen, not in Cullen's actions in harming patients .... The fundamental defect of this entire argument is that the underlying claims result from and involve acts and omissions by Somerset's officers, not actions by Cullen." *Id.* at *6-7.

20 N.J. Stat. Ann. § 26:2H-24(e) (West 2012).

21 N.J. Stat. Ann. § 26:2H-12.23 (West 2004). *See generally* Adam Blander, Codifying Common Law: The Self-Critical Analysis Privilege and the New Jersey Patient Safety Act, 21 J. L. & Pol'y (2013).

22 In *C.A. ex rel. Applegrad v. Bentolia*, 99 A.3d 317, 324 n.8 (N.J. 2014), the New Jersey Supreme Court noted that the Legislature enacted the Patient Safety Act as a response "in part" to the revelation of the multiple patients that had been killed while Charles Cullen was a nurse on staff at several New Jersey hospitals.

23 N.J. OLS, *Bill S557 ScsAca (SCS/1R)*, N.J. Leg., https://www.njleg.state.nj.us/bill-search/2004/S557 (last visited April 8, 2024).

24 42 U.S.C. § 299b-21.

25 N.J. Stat. Ann. § 45:1-33 (West 2005); N.J. Stat. Ann. § 26:2H-12.2b (West 2012).

26 *Bill S1804 Sca (1R)*, n.j. legis. (2004) https://www.njleg.state.nj.us/bill-search/2004/S1804.

27 *See generally* Mark R. Chassin, *The Oliver C, Schroeder, Jr. Scholar-in-Residence Lecture: Improving the Quality of Health Care: Where Law, Accreditation, and Professionalism Collide*, 23 Health Matrix 395

28 Cynthia E. Boyd, *How Compliance Intersects with Medical Staff Issues: Credentialing*, 10 J. Healthcare Compliance 11, 13 (2008).

29 Donna Malvey, Myron D. Fottler & Jennifer Sumner, *The Fear Factor in Healthcare: Employee Information Sharing*, 58 J. Healthcare Mgmt. 225, 234 (2013).

30 The Pennsylvania intermediate appellate court in *Krapf v. St. Luke's Hosp.,* 4 A3d 642, 654 (Pa. Super. Ct. 2010), quoted comments by the trial court that provide an eloquent perspective on this issue:
In light of those factors set forth in *R.W. v. Manzek*, 888 A.2d 740 (Pa. 2005), it would be shocking to contemplate a state of affairs where society would condone a hospital keeping silent while knowing, or being aware that it is highly probable, that a member of its staff killed a patient. Accordingly, the duty to disclose such information surely flows not merely as a concomitant of the express duties set forth in *Thompson [v. Nason Hospital,* 591 A2d 703 (Pa. 1991)], but is also understood more profoundly as one of the collection of duties that civilized people have come to, expect of each other and their institutions. Therefore, while the court in this situation may be perceived as "imposing" a duty, it is in truth only recognizing an obligation that, it may fairly be said, persons would widely expect ought to apply, even in the absence of a more formal judicial pronouncement. It is, after all, the extent to which our principles of jurisprudence resonate with our collective convictions and shared notions of right and wrong that ultimately lend vitality to, and command respect for, our system of laws. To fail to recognize such an obvious duty on the part of a hospital in these circumstances would, by contrast, render the common law not only effete but a legitimate object of derision.

31 *See, e.g.,* Cathy A. Schainblatt, *The New Missouri Employer Immunity Statute: Are Missouri Employers Still Damned if They Do and Damned if They Don't?*, 44 St. Louis U. L.J. 693 (2000).

32 Ann M. Barry, *Defamation in the Workplace: The Impact of Increasing Employer Liability*, 72 Marq. L. Rev. 264, 265 (1989).

33 *See, e.g.,* Deborah A. Ballam, *Employment References - Speak No Evil, Hear No Evil: A Proposal for Meaningful Reform*, 39 Am. Bus. L.J. 446-47 n.5 (2002). Over twenty-five law review articles spanning the time period of 1977 to 1998 are referenced in this article's footnote 5. The literature on this topic has continued to expand and evolve.

34 "Defamation" is the all-encompassing and overarching term for the spoken or written publication of a false assertion of fact to a third-party, which subsequently results in injury or damage to another party's reputation. In *DeAngelis v. Hill*, 847 A. 2d 1261 (N.J. 2004), the Supreme Court stated:
[T]he elements of a defamation claim are: (1) the assertion of a false and defamatory statement concerning another; (2) the unprivileged publication of that statement to a third party; and (3) fault amounting at least to negligence by the publisher. [*Id.* at 1267-68.]
The law of defamation is divided into two branches: slander which involves verbal false assertions and libel which involves written false assertions. Slander and libel can be further refined into the categories of slander *per se* and libel *per se.* These terms are not synonymous. The slander *per se* doctrine is limited to defamatory statements which impute to another person (1) a criminal offense; (2) a loathsome disease; (3) conduct, characteristics or a condition that is

incompatible with his business, trade or office; or (4) serious sexual misconduct. *See, e.g.,* Biondi v. Nassimos, 692 A.2d 103, 107 (N.J. Super. Ct. App. Div. 1997). The primary impact of the characterization of a defamatory statement as libel or slander *per se* is with regard to recoverable damages. The recoverable damages for defamation are: (1) compensatory or actual, which may be either (a) general or (b) special; (2) punitive or exemplary; and (3) nominal. *See generally* W.J.A. v. D.A., 43 A.3d 1148, 1154 (N.J. 2012).

The predicate for a defamation action is a false statement. The court must determine whether the statement is one of fact or opinion. A factual statement can be proved or disproved objectively while an opinion statement generally cannot. A statement of opinion is not actionable. DeAngelis v. Hill, 847 A. 2d 1261, 1267-68 (N.J. 2004). Not every false statement of fact is defamatory. Whether the alleged statement is susceptible of a defamatory meaning is "a question of law for the court." *Id.* Defamation has been further defined as a statement that is false and injurious to the reputation of another or exposes another person to hatred, contempt, or ridicule or subjects another person to a loss of the good will and confidence in which he or she is held by others. Romaine v. Kallinger, 537 A.2d 284, 287 (N.J. 1988). The court must consider three factors in making this determination: (1) the content, (2) the verifiability, and (3) the context of the challenged statement. DeAngelis v. Hill*, supra*, 47 A.2d at 1268.

35 Erickson v. Marsh & McLennan Co., 569 A.2d 793, 806 (N.J. 1990). Truth is a recognized common law defense that can invoke protection under the First Amendment. G.D. v. Kenny*,* 15 A.3d 300, 310 (N.J. 2011); Ward v. Zelikovsky, 643 A.2d 972, 979 (N.J. 1994). Truth may be asserted as a defense even when a statement is not perfectly accurate as the focus is on "substantial truth" and minor inaccuracies do not make a statement false as long as "'the substance, the gist, the sting, of the libelous charge can be justified.'" G.D. v. Kenny, *supra*, 15 A.3d at 310.

36 There is substantial case law recognizing that in certain situations public interest considerations outweigh the interest in the protection of an individual's reputation. Accordingly, a person is allowed to communicate without fear of being sued or at least with some otherwise defamatory statements not imposing liability on the speaker. *See generally* Feggans v. Billington, 677 A.2d 771, 775-76 (N.J. Super. Ct. App. Div. 1996). This privilege may be absolute or qualified. An absolute privilege is applicable only in the narrowest of instances where the public interest demands unfettered communication. A qualified privilege is intended to advance an important public interest while retaining a measure of protection for the plaintiff who is defamed. *Id.* This is sometimes referred to as a conditional privilege or conditional-occasional privilege or conditional special-interest privilege.

The leading case dealing with privilege in the context of a physician defamation claim is *Bainhauer v. Manoukian*, 520 A.2d 1154, 1159 (N.J. Super. App. Div. 1987). The plaintiff anesthesiologist claimed the defendant general surgeon defamed him when the surgeon told the Chief of Anesthesia that he did not want plaintiff to administer anesthesia to any of his patients anymore "because he just killed my patient." The Appellate Division viewed the conditional privilege as "well-defined" in New Jersey case law for communications on any subject matter in which the party communicating has an interest or to which the party has a duty to communicate that is made to a person having a corresponding interest or duty. These communications may protect the speaker's interest, that of the recipient, or other third person, or an interest in common to the speaker and recipient. The test to validate the appropriateness of recognizing the privilege include (1) the legitimacy of the interest being protected or promoted and (2) the pertinence of the receipt of that information by the recipient. [*Id.* at 1170.] The opinion has a powerful summary of interests bringing the surgeon's statements within the ambit of the privilege:

Each physician within a hospital community has a significant and obvious interest in the professional qualification, skill and competence of every other health-care professional rendering services within that community and particularly those with whom he or she works directly. The welfare of patients, the reputation of the hospital, the physician's own ability properly to treat and protect patients, and the physician's own professional reputation are all implicated. Moreover, the public relies on the professional judgments of the hospital community to assure it of the professional skill, qualification, and competence of the medical staff it provides and to take whatever steps are appropriate to that end. This is singularly so when hospital staff personnel are beyond the patient's choice. Although a patient may choose his surgeon, he does not typically choose his anesthesiologist any more than he chooses his nurse or lab technician. It is therefore not only the physician's self-interest but also the public's interest which demands that hospital staff physicians be free to express themselves openly and without fear of reprisal when matters directly affecting the quality of health care are involved. Indeed, we regard such expression as, at the least, a moral duty of each physician. In any event, we have no doubt that an individual physician's significant interest in his own reputation produces a lesser weight

on the balance scale than the aggregate of the public and private interests served by encouraging physicians to speak out when, in their professional judgment, a colleague's skill and qualification are questionable.

37 *See also* Jennifer L. Sumner, *Healthcare Communication Networks: The Dissemination of Employee Information For Hospital Security*, Univ. Cent. Fla. (2008), https://stars.library.ucf.edu/etd/3782.

38 A major component in the lawsuits brought by the families of Cullen's victims were allegations against the hospitals and their officers for negligent hiring, negligent supervision and entrustment, negligent reporting, and negligent continuation of employment. *See supra* note 5. On August 21, 2007, Superior Court Judge Bryan D. Garutto denied a motion by St. Luke's Hospital seeking dismissal of claims by the families of victims who were killed at Somerset Medical Center after Cullen's employment at St. Luke's had ended. He rejected the contention that St. Luke's was both unaware of and not responsible for informing Somerset Medical Center about the danger posed by Cullen as a prospective employee. In his Memorandum of Decision, he wrote: "The record reflects that St. Luke's did not affirmatively misrepresent Mr. Cullen as a 'model employee.' However, because St. Luke's chose to omit information about Mr. Cullen's rehiring status to an inquiry by Somerset Medical Center when at the same time St. Luke's officials were calling other local area hospitals to inform them of Cullen's 'do not rehire' status, it is not immune from liability." While denying the motion to dismiss, Judge Garutto granted a motion by Somerset Medical Center to amend its pleadings to name St. Luke's Hospital as a third-party defendant. Graber, *supra* note 6, at 287 n.3. While noting that no published New Jersey decision had decided whether a former employer had a duty to disclose negative information about a former employee, he found a California precedent describing circumstances in which a court might impose liability on an employer who failed to disclose material information to a prospective employer. Kelly M. Pyrek, Healthcare Crime: Investigating Abuse, Fraud, And Homicide By Caregivers 207-08 (2011). In *Randi W. v. Muroc Joint Unified School District*, 929 P.2d 582, 582 (Cal. 1997), the California Supreme Court reviewed the trial court's dismissal of claims on behalf of a middle school student who was sexually molested by the vice principal of her school. The complaint alleged that several prior employers knew or had reason to know that the vice principal had engaged in wrongful sexual contact with students and not only failed to report but affirmatively recommended him for positions at subsequent educational institutions. The court concluded that the letters of recommendation without reservation or qualification constituted affirmative representations as to fitness for working with female students and that the representations were false and misleading with half-truths that could invoke an exception to the general rule excluding liability for mere nondisclosure or failure to act. *Id.* at 593.
On January 29, 2008, the Appellate Division heard oral argument on the trial court ruling that the claims of the families could proceed. However, before it rendered a decision, the Appellate Division dismissed the appeal after being informed that the cases were settled. In re Cullen Litigation, 2008 WL 1991694 at *1 (N.J. App. Div. May 9, 2008).

39 The seminal case recognizing a cause of action for negligent credentialing is the Illinois decision of *Darling v. Charleston Cmty. Mem. Hosp.*, 211 N.E.2d 253, 261 (Ill. 1965), holding that a hospital could be liable for negligence in allowing a doctor to practice at a hospital and that the hospital had a duty to supervise the competence of its staff members. The cause of action has been accepted in most but not all states. Larson v. Wasemiller, 738 N.W.2d 300, 306-07 n.3-5 (Minn. 2007) (collecting cases). *See generally* Lindsey Stout, *Negligent Credentialing as a Cause of Action in Indiana Medical Malpractice Litigation*, 10 Indiana L. Rev. 249, 250 (2013). This cause of action is a claim of direct negligence, not vicarious liability. New Jersey moved toward acceptance of this cause of action in *Corelto v. Shore Mem'l Hosp.*, 350 A.2d 534, 538 (N.J. Super. Ct. Law Div. 1975). The Supreme Court endorsed the claim in *Jarrell v. Kaul*, 123 A.3d 1022, 1040 (N.J. 2015), in holding that liability could be imposed where an independent physician was "incompetent" to provide the care through a cause of action for "negligent hiring" that could be asserted against a healthcare facility that grants privileges to a physician, and that the facility has a continuing duty to ensure that any physician granted privileges was maintaining compliance with necessary conditions for licensure. In *Jarrell*, an ambulatory surgery center allowed a physician to practice without ascertaining that he had the malpractice liability insurance required for licensure of a physician providing direct patient care.

40 In *Estate of Fazaldin v. Englewood Hosp. & Med. Ctr.*, No. A-4948-04-T34948-04T3, 2007 WL 2126832, at *1 (N.J. Super. Ct. App. Div. July 26, 2007), a claim was brought on behalf of a deceased patient against the attending surgeon and the hospital where the treatment was provided with a claim of administrative negligence against the hospital in

granting privileges. In addition, plaintiff also sued another hospital and its chief of obstetrics and gynecology where the surgeon had had privileges. Plaintiff alleged that the former hospital improperly failed to disclose the surgeon's poor performance there before he ended his relationship and joined the staff of Englewood Hospital. The Appellate Division reviewed reporting requirements of HCQIA and of the New York Department of Health. In the circumstances of the surgeon having had his employment terminated but not his clinical privileges, the court described "[t]he obligation to make a report to the NPDB in this setting is fairly debatable." *Id.* at *8. At the trial, a jury had found that there had been negligent misrepresentation by the former hospital but did not find that to be a proximate cause. The Appellate Division concluded that the trial court had inappropriately precluded consideration of obligations under the New York statute. Since the surgeon resigned from the hospital staff rather than undergo further scrutiny of his care, the Appellate Division determined that the hospital had a duty to report to the New York Department of Health "as a matter of law." *Id.* at *11. It further concluded that the limitation on the use of the New York statute may have caused the jury's determination of proximate causation to be tainted by the error. *Id.* at *15. It remanded the case for an evidentiary hearing as to whether the information that should have been reported to the New York Department of Health would have been forwarded to the NPDB and a determination as to the need for a new trial. *Id.* at *15-16. After remand the trial court concluded that the New York Department of Health would not have passed on an unfavorable report of the surgeon to the NPDB. On review, the Appellate Division held that the trial court had complied with the mandate of the remand and affirmed the dismissal. Estate of Fazaldin v. Englewood Hosp. & Med. Ctr., No. A-2165-08T32165-08T3, 2009 WL 4547063, at *5 (N.J. Super. Ct. App. Div. Dec. 2, 2009).

41 In the New Jersey Cullen litigation, not only did the families of victims sue St. Luke's Medical Center, but Somerset Medical Center was permitted to amend its pleadings to assert a third-party complaint against St. Luke's for failure to provide information to it as a subsequent employer. The validity of this employer against former employer claim was not fully litigated in the Cullen case. However, such a claim was recognized and upheld in *Kadlec Med. Ctr. v. Lakeview Anesthesia Assoc.*, 527 F.3d 412, 412 (5th Cir. 2008). The Kadlec Medical Center is located in the State of Washington. In 2001, a Dr. Berry applied for privileges to administer anesthesia at Kadlec. He had been employed in Louisiana by Lakeview Anesthesia Associates and was privileged to administer anesthesia at Lakeview Regional Medical Center. On receiving Dr. Barry's application for privileges, Kadlec did a background check including contacting his former employers and place of work. The referral letters did not disclose that Dr. Berry had been found using narcotics while on duty and was fired and his privileges were terminated. Dr. Berry was granted privileges and began administering anesthesia to patients at Kadlec. Several months after his start, he provided anesthesia for a patient undergoing a tubal ligation. The patient stopped breathing and Dr. Berry was unable to resuscitate her, leading to the patient's permanent vegetative state. The family sued Kadlec on the basis of *respondeat superior.* It settled the case for $7.5 million. It then instituted an independent action for intentional and negligent misrepresentation against Lakeview Anesthesia Associates, Lakeview Regional Medical Center, and the respective physician representatives who had provided letters of reference. The claims were tried to a jury resulting in a verdict in favor of Kadlec. On appeal, the Fifth Circuit upheld the verdict against the Lakeview Anesthesia defendants but reversed the judgment against the Lakeview Regional Medical Center defendants. It summarized its ruling in the following passage: "We begin our analysis below by holding that after choosing to write referral letters, the defendants assumed a duty not to make affirmative misrepresentations in the letters. We next analyze whether the letters were misleading, and we conclude that the LAA defendants' letters were misleading, but the letter from Lakeview Medical was not. We also examine whether the defendants had an affirmative duty to disclose negative information about Dr. Berry in their referral letters, and we conclude that there was not an affirmative duty to disclose." *Id.* at 418. For a critical assessment of the decision, *see* Sallie Thieme Sanford, *Candor After Kadlec: Why, Despite the Fifth Circuit's Decision, Hospitals Should Anticipate an Expanded Obligation to Disclose Risky Physician Behavior*, 1 Drexel L. Rev. 383 (2009).

42 Donna Malvey, Myron Fottler & Jennifer Summer, *The Fear Factor in Healthcare: Employee Information Sharing*, 58 J. Healthcare Mgmt. 225, 228 (2013).

43 *Vitale Bill Requiring Greater Medical Error Reporting Signed Into Law*, N.J. S. Democrats (2005), https://www.njsendems.org/vitale-bill-requiring-greater-medical-error-reporting-signed-into-law/.

44 N.J. Stat. Ann. § 26:2H-12.2b (West 2012).

45 N.J. Stat. Ann. § 26:2H-12.2b(g); N.J. Stat. Ann. § 45:1-35; N.J. Stat. Ann. § 45:1-37; N.J. Stat. Ann. § 26:2H-12.2c(d) (West 2012).

46 N.J. Stat. Ann. § 26:2H-12.2a(c); N.J. Stat. Ann. § 26:2H-12.2b(b); N.J. Stat. Ann. § 26:2H-12.2c(d)

47 N.J. Stat. Ann. § 26:2H-12.24 (West 2004).

48 *See also* Patient Safety Network, *Root Cause Analysis*, Agency for Healthcare Rsch. and Quantity (Sept. 7, 2019), https://psnet.ahrq.gov/primers/primer/10/root-cause-analysis.

49 N.J. Stat. Ann. § 26:2H-12.2 (West 2005) (repealed 2006).

50 *Id.* § 1(a)

51 *Id.*

52 N.J. Stat. Ann. § 17:30D-17 (West 1983) (amended 2006).

53 N.J. Stat. Ann. § 45:9-19.4 (West 1990).

54 N.J. Stat. Ann. § 45:9-19.4 (West 1989).

55 *Id.* § 8 (codified at N.J. STAT. ANN. § 45:9-19.8).

56 *Id.* § 9

57 *Id.* § 9(d).

58 *Id.* § 1(f).

59 N.J. Stat. Ann. § 26:2H-82 (West 1997) *et seq*,

60 N.J. STAT. ANN. §§ 45:1-28 (West 2005).

61 N.J. Stat. Ann. § 45:1-28 (West 2005).

62 N.J. Stat. ANN. §§ 45:1-33 (West 2005).

63 N.J. Stat. Ann. § 26:2H-12.2(b)(i) (West 2005).

64 *Id.*

65 *Id.*

66 *Id.*

67 N.J. Stat. Ann. §26:2H-12.2b(a) (West 2012).

68 *Id.*

69 N.J. Stat. Ann. §26:2H-12.2b(a) (West 2012).

70 N.J. Stat. Ann. § 26:2H-12.2 (West 1983) (repealed 2005).

71 *Id.*

72 The National Practitioner Data Bank (NPDB) was the result of Congress enacting the Health Quality Improvement Act (HCQIA), 42 U.S.C. § 11101, in 1986. The purpose of HCQIA was to improve the quality of health care nationwide through an interstate reporting system that collected and disseminated adverse data on practitioner conduct and competence whether the issues arose through malpractice litigation, adverse action concerning hospital privileges, or licensure. It was intended to restrict practitioners from moving state to state without disclosure of their previous unprofessional conduct or incompetence. HCQIA requires state licensing board and health care entities to report to the United States Department of Health and Human Services (HHS) all adverse actions that affect a physician's clinical privileges but only if it is for longer than 30 days or a physician's license is affected. 42 U.S.C. § 11132; 42 U.S.C. § 11133. HCQIA also requires that medical malpractice payers report all payments made on behalf of a physician. 42 U.S.C. § 11131. HHS subsequently promulgated regulations at 45 C.F.R. § 60.1 (2013) to create the NPDB. The NPDB became operational in 1990.

HCQIA requires that a hospital access the NPDB as part of the process of credentialing physicians for privileges at a hospital to assure that hospitals are apprised of the applicant's corrective action and malpractice history, prior to deciding whether to grant privileges. The query to the NPDB is to be made in connection with an initial application for privileges and every two years thereafter. 42 U.S.C. § 11135(a). If a hospital does not request information from the NPDB, it is presumed to have knowledge of any information reported regarding the physician or practitioner. 42 U.S.C. § 11135(b). This could potentially impact a claim for injuries resulting from a hospital's negligence in the credentialing process.

While most of the HCQIA mandates are directed at physicians, some provisions are broader in scope covering "licensed health care practitioners" and "practitioners" with these terms meaning "an individual (other than a physician) who is licensed or authorized by the State to provide health care services." 42 U.S.C. § 11151(6). Malpractice payments are to be reported whether made for the benefit of a "physician or licensed health care practitioner." 42 U.S.C. § 11131(b). In contrast, the reporting of adverse privileging actions concerning licensed health care practitioners is permissive. 42 U.S.C. § 11133(b).

Emphasizing that Charles Cullen is not alone among "nurses who harm or kill the patients to whom they provide care," expansion of the requirements for reporting to and accessing of the NPDB along with other reforms was advocated in Lisa L. Dahm, *Regulation of Nurses: Should the NPDB Be Expanded?,* 11 Mich. St. U. J. Med. & L., 33, 36-42, 69 (2007). Indeed, it is not only nurses who harm or kill patients. *See generally* James M. Thunder, *Quiet Killings in Medical Facilities: Detection & Prevention,* 18 Issues L. & Med. 211 (2003). There have been graphic examples of this occurring with physicians. A particularly notorious example is Dr. Michael Swango who is estimated to have been involved in killing at least 60 patients with poisons or overdoses of their medication. Swango is the subject of a detailed book-length examination and pointed criticism of the NPDB. *See* James B. Stewart, Blind Eye: How the Medical Establishment Let a Doctor Get Away with Murder (Simon & Schuster 2000).

In January 2022, legislation was enacted requiring all New Jersey professional licensing boards regulating the practice of a health care professional to not issue a license unless the board first determined that no information existed on file with the NPDB that might disqualify an applicant and to use the NPDB's continuing query function to determine whether a license should be renewed or revoked if the licensing board determined that there was cause for such action based on information obtained from the NPDB. N.J. Stat Ann. § 45.1-32.1 (West 2022).

73 N.J. Admin. Code § 8:30-1.3 (West 2024).

74 N.J. Stat. Ann. § 26:12b(h) (West 2024).

75 N.J. Stat. Ann. § 26:12b(d) (West 2024).

76 N.J. Admin. Code § 8:30-1.6 (2024).

77 N.J. Stat. Ann. § 45:1-37 (LexisNexis through L. 2023, c. 130, J.R. No. 12) (2005).

78 *Id.*

79 N.J. Admin. Code § 13:45E-5.1 (West 2023).

80 N.J. Admin. Code § 13:45E-3.1 (2024).

81 N.J. Stat. Ann. § 45:1-37(c).

82 N.J. Stat. Ann. § 26:2H-12.2d (LexisNexis through L. 2023, c. 130, J.R. No. 12) (2005).

83 N.J. Stat. Ann. § 26:2H-12.2d (LexisNexis through L. 2023, c. 130, J.R. No. 12) (2005).

84 N.J. Admin. Code. § 13:45E-8.1 (LexisNexis through N.J. Reg., Vol. 55 No. 24) (2023).

85 N.J. Stat. Ann. § 26:2H-12.2a(c).

86 N.J. Stat. Ann. § 26:2H-12.2c (Westlaw through L. 2023, c. 130, J.R. No.12) (2005).

87 N.J. Admin. Code §13:45E-6.1(a-b) (LexisNexis through N.J. Reg., Vol. 55 No. 24) (2023). Delayed recognition of problematic behavior and a failure to report it to appropriate authorities as well as permitting or facilitating the quiet relocation of the perpetrator to another setting is not a phenomenon unique to health care. "'Passing the trash,' as it is commonly referred to in the field of education, is an unfortunately ubiquitous practice." Amos Guiroa, *Sea of Destruction: Legal and Social Forces Enabling Sexual Abuse of Children*, 55 Tex. Tech. L. Rev. 99, 121-22 (2022). This has been seen in various settings typically involving relationships built on some degree of trust. Its occurrence in the context of sexual abuse or harassment in secondary and higher education has drawn attention and corrective action. *See generally*, Susan Fortney & Theresa Morris, *Eyes Wide Shut: Using Accreditation Regulation to Address the "Pass-the-Harasser" Problem in Higher Education*, 12 Calif. L. Rev. 43, 44 (2021). In *Child M. v. Fennes*, No. A-0873-15T2, 2016 WL 447253, at *1-5 (N.J. Super. Ct. App. Div. Aug. 25, 2016), the Appellate Division considered "troubling" facts arising out of the sexual abuse of a child by her male teacher who had engaged in similar conduct with a prior employer school district. The court reversed a determination that the prior school district was not negligent and held that there was a duty to report the teacher to the then Division of Youth and Family Services and to the State Board of Examiners in the Department of Education, and that a jury could conclude that such reporting would have deterred or prevented Fennes from obtaining employment at another elementary school. However, it did not find that there was a duty to report Fennes' conduct to potential employers or that there had been any misrepresentation to the prospective employer. In 2018, New Jersey took legislative action that remedied some of the flaws in this opinion. Public Law 2018, Chapter 5, codified at N.J. Stat. Ann. § 18A:6-7.6 (West through L.2023, c. 228 and J.R. No. 15) (2018) imposed stricter background checks regarding child abuse and sexual misconduct on any "school district, charter school,

nonpublic school, or contracted service provider holding a contract" with such schools. It requires a prospective employer to contact prior employers for relevant information regarding child abuse or sexual misconduct unless the allegations were false or not substantiated. N.J. Stat. Ann. § 18A:6-7.7(b)(2) (a-b) (West through L.2023, c. 228 and J.R. No. 15) (2018). The Act further requires that an employer of the applicant within the prior 20 years "shall disclose the information requested." N.J. Stat. Ann. § 18A:6-9 (West through L.2023, c. 228 and J.R. No. 15) (2018). There is immunity from civil liability unless the information provided is knowingly false. N.J. Stat. Ann. § 18A:6-7.11(b) (West through L.2023, c. 228 and J.R. No. 15) (2018). The Act also prohibits any contract or settlement agreement that would have the effect of suppressing information or impairing the ability of a school to provide information of suspected child abuse or sexual misconduct. N.J. Stat. Ann. § 18A:6-7.12(a)(1-2) (West through L.2023, c. 228 and J.R. No. 15) (2018).

88 Request for Information (W192697) dated November 18, 2022, and Response from Office of the Commissioner, New Jersey Department of Health on file with the authors.

89 N.J. Stat. Ann. § 26:2H-12.2c(a)(1) (West through L.2023, c. 228 and J.R. No. 15) (2012).

90 N.J. Stat. Ann. § 26:2H-12.2c(a)(2).

91 N.J. Admin. Code §8:30-1.4(a)(1) (LexisNexis through N.J. Reg., Vol. 55 No. 24) (2023).

92 *Id.*

93 *See*, N.J. Stat. Ann. § 45:1-37 (Westlaw through L. 2023, c. 130, J.R. No. 12); N.J. Stat. Ann. § 26:2H-12.2d (Westlaw through L. 2023, c. 130, J.R. No. 12).

94 N.J. Stat. Ann. § 26:2H-12.2c(d) (2012).

95 N.J. Stat. Ann. §26:2H-12.2(b)(i) (West 2005).

96 Sensisch v. Carlino, 32 A.3d 217 (N.J. Super. App. Div. 2011), *certif. denied*, 50 A.3d 41 (N.J. 2012).

97 *Id.* at 220.

98 *Id.* at 219-20.

99 *Id.* at 220.

100 *Id.*

101 *Id.*

102 *Id.*

103 *Id.*

104 *Id.* at 220-21.

105 *Id.* at 221.

106 *Id.*

107 *Id.* at 222.

108 *Id.*

109 *Id.* at 223.

110 *Id.* at 224.

111 Weisman v. N.J. Dep't Hum. Res., 593 Fed.Appx. 147 (3rd Cir. 2014).

112 *Id.* at 149.

113 *Id.*

114 *Id.*

115 *Id.* at 150.

116 Blum v. Morristown Med. Ctr., No. L-1534-12, 2015 WL 6559004, at *4 (N.J. Super. App. Div. Oct. 30, 2015).

117 *Id.* at *4-5.

118 Hanna v. Shnaidman, No. L-1268-10, 2015 WL 6629766, at *1, (N.J. Super. App. Div. Nov. 2, 2015).

119 *Id.* at *1.

120 *Id.*

121 *Id.* at *1.

122 *Id.* at *2 & n.2.

123 Gasperetti v. Deborah Heart & Lung Ctr., No. A-0244-13T2, 2017 WL 5619212, at * 1 (N.J. Super. App. Div. Nov. 22. 2017), *certif. denied*, 183 A.3d.100 (N.J. 2018), *cert. denied*, 139 S. Ct. 198 (2018).

124 Gasperetti v. Deborah Heart & Lung Ctr., No. A-0244-13T2, 2017 WL 5619212, at * 5 (N.J. Super. App. Div. Nov. 22. 2017).

125 *Id.* at *1.

126 During this time, the plaintiff had reported that she was subjected to a hostile work environment and bullying by physicians, including the two physicians that reported deficiencies in the plaintiff's clinical care of her patients. *Id.* at *1-2.

127 *Id.*

128 *Id.* at *2-3.

129 *Id.* at *3.

130 *Id.* at *4.

131 Gasperetti, 2017 WL 5619212 at *5.

132 *Id.* at *9-10.

133 183 A.3d.100 (N.J. 2018).

134 139 S. Ct. 198 (2018).

135 Jefferson v. Cmty. Hosp. Grp., No. A-2608-18T4, 2020 WL 773083, at *1, (N.J. Super. App. Div. Feb. 18, 2020).

136 *Id.* at *1.

137 *Id.*

138 *Id.* at *2.

139 *Id.*

140 Jefferson v. Cmty. Hosp. Grp., No. A-2608-18T4, 2020 WL 773083, at *1, (N.J. Super. App. Div. Feb. 18, 2020).

141 *Id.* at *4.

142 *See supra* note 8-13.

143 Incompetence, professional misconduct, and impairment can merge with criminal activity. This was seen in the circumstances of Texas neurosurgeon Dr. Christopher Duntsch known as “Dr. Death.” He had substance abuse issues and was identified as lacking surgical skills despite his training at a leading institution. Regardless of multiple bad outcomes and fatalities, Dr. Duntsch was able to obtain staff privileges at hospital after hospital and continued to operate on patients. There was nothing of record in his residency or credentials files to this effect. Complaints from colleagues were largely ignored. Wendy Keegan et al., *Where Does It Begin and How to Stop It: Opportunities to Prevent “Bad”*

Physicians, 118 Mo. Med. 3, 3-4 (2021). Duntsch was eventually arrested and convicted of aggravated assault. David A. Hyman, *Are We Driven By Data? The Problem of Bad Doctors*, 96 Denv. L. Rev. 761, 765 (2018). While other physicians have on occasion been criminally prosecuted for intentional killing or wrong-doing, Duntsch seems to be the first physician found to have committed a criminal act in the way that he had performed the surgery.
Duntsch had been able to evade reporting by a combination of bullying of hospital administration with potential loss of revenue and threats of litigation and gaming the system of the National Practitioner Data Bank and Texas law mandating reporting to the Texas Medical Board. After being suspended at a major Dallas hospital, he was not fired but was allowed to resign and apply elsewhere. Because the suspension was for a period under the 30-day threshold for reporting, the hospital was under no obligation to report him to the NPDB. Laura Beil, *A Surgeon So Bad It Was Criminal*, ProPublica (Oct. 2, 2018), https://www.propublica.org/article/dr-death-christopher-duntsch-a-surgeon-so-bad-it-was-criminal.
The pertinent provisions of Texas law were revised with an amendment enacted on June 13, 2023. Among other enhancements to strengthen the power of the Medical Board to monitor and discipline physicians, the amendments to the Texas Occupations Code shortened the time within which the results and circumstances of a medical peer review proceeding is to be reported to the Medical Board from 30 days to 14 days. H.R. 1998, 88th Leg., Reg. Sess. (Tex. 2023). The effective date is September 1, 2023.

144 Natalie Vaughn, *This Could Be You: Cullen Law Under Scrutiny*, Nurse.com (Mar. 10, 2023) https://www.nurse.com/blog/this-could-be-you-cullen-law-under-scrutiny.

145 *Id.*

146 *See, e.g.,* Joseph LaManita, *The ACGME Core Competencies: Getting Ahead of the Curve,* 9 Acad. Emerg. Med. 1216, 1216 (2002). The ACGME core competencies were endorsed by the American Board of Medical Specialties and have undergone updating since 1999. *See, e.g.,* Laura Edgar et al., *Milestones 2.0: A Step Forward*, 10 J. Grad. Med. Educ. 367, 367 (2018).

147 Inst. of Med., Health Professions Education: A Bridge to Quality 4 (Ann C. Greiner & Elisa Knebel eds., Nat'l Acad. Press 2003).

148 Kathryn Ogden, Sue Kilpatrick, Shandell Elmer & Kim Rooney, *Attributes and generic competencies required of doctors: findings from a participatory concept mapping study*, 7 BMC Health Serv. 560, 560 (2021).

149 Brenda G. Summers & WendySue Woods, Competency Assessment: A Practical Guide to the Joint Commission Standards at 3 (HCPro, Inc. 3rd ed. 2008).

150 *Compare incompetence*, Black's Law Dictionary (11th ed. 2019)("the quality, state, or condition of being unable or unqualified to do something") *with negligence*, Black's Law Dictionary (11th ed. 2019) ("the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation"). In a legal setting, these concept merge and overlap. "The failure to exercise reasonable care constitutes legal fault, a conclusion that can be quite different from the colloquial attribution of fault. No one can be blamed for not being perfect. We all make mistakes, but any misstep, whether the result of professional incompetence or a simple lapse of attention, can be sufficient to establish negligence liability." Mark A. Geistfeld, *Commentary - Malpractice: Problems and Solutions*, 471 Clin. Orthop. Relat. Res. 715, 719 (2013).

151 John Zen Jackson, *Physician Profiling: Posting Physician Malpractice Data on the Internet*, 101 N.J. Med. 17, 17 (2004).

152 42 U.S.C. § 11131(a).

153 N.J. Stat. Ann. § 26:2H-12.2b(a)(6) (West 1971) (Amended 1978) (Amended 1993); N.J. Stat. Ann. § 45:9-22.23(a)(10) (West 2003).

154 N.J. Stat. Ann. §45:9-22.23(a)(10)(d) (West 2005). For the Federal version related to NPDB reporting, see 42 U.S.C. § 11137(d).; 45 C.F.R. § 60.7(d) (2024)("payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred").

155 Inst. of Med., To Err Is Human: Building A Safer Health System 26 (Linda T. Kohn et al. eds., Nat'l Academies Press 2000).

156 *Id.* at 87.

157 Disclosure of medical error to the patient or family is a matter of controversy. There is a long-standing strategy in the presence of a potential medical malpractice claim to "deny and defend" that has been advanced by risk professionals and defense counsel. A markedly different approach can be found in the apology and disclosure movement that began to develop following the publication of the Institute of Medicine publication *To Err Is Human: Building a Safer Health System*. *See generally* John Zen Jackson, *Defending What Went Wrong by Doing What's Right: An Evidential Assessment of Apologies*, 200 N.J.L.J. 758 (2010). The mindset underlying the deny and defend strategy is in tension with the aspirational guidance found, for example, in the AMA Principles of Medical Ethics. The first of these principles is that "[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights." The immediately following second principle states that "[a] physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities." Am. Med. Ass'n*, AMA Principles of Medical Ethics*, https://code-medical-ethics.ama-assn.org/principles (June 2001).
Two early pioneers in what came to be known as the disclosure, apology, and offer (DA&O) model were the Veterans' Medical Center in Lexington, Kentucky in 1987 and the University of Michigan Health System in late 2001 and early 2002. Joseph S. Kass & Rachel V. Rose, *Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs*, 18 Am. Med. Assoc. J. of Ethics 299, 303-304 (2016). The process is tailored to individual cases, but the basic paradigm is that patients and family are to be contacted and informed regarding complications, with full disclosure, an apology, and an offer of compensation when appropriate after the hospital's investigation.

158 *See, e.g.*, David W. Bates & Atul Gawande, *Error in Medicine: What Have We Learned?* 132 Annals of Internal Med. 763, 766 (2000); Douglas A. Wiegmann et al., *Understanding the "Swiss Cheese Model" and Its Application to Patient Safety*, 18 J. Patient Safety 119, 120 (2022).

159 *See generally* Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 New Eng. J. Med. 629, 635 (2011).

160 *Model Civil Jury Charges 5.50A*, New Jersey Courts (March 2, 2024), https://www.njcourts.gov/courts/civil/model-civil-jury-charges.

161 *See generally* Allan J. Jacobs, *Duty to Third Parties in Employment References: A Possible Poisonous Potion for the Healthcare Industry?*, 24 J. of Contemp. Health L. & Pol'y 312, 342 (2008).

162 Cheri Throop & Carole Stockmeier, *SEC & SSER Patient Safety Measurement System for Healthcare*, Healthcare Performance Improvement, LLC (May 2011), https://dl.icdst.org/pdfs/files4/870b0f29a989bc0aadb758876423f054.pdf.

163 Virtual Mentor, *The AMA Code of Medical Ethics' Opinions on Patient Safety,* 13 Am. Med. Assoc. J. of Ethics 626, 627 (2011).

164 Lois Snyder Sulmasy et al., *American College of Physicians Ethics Manual (7th Edition)*, 170 Annals Of Internal Med. S1, S6 (2019).

165 N.J. Div. of Consumer Aff., *Licensee Reporting Obligations*, (Feb. 10, 2016, 7:20 AM), https://www.njconsumeraffairs.gov/bme/Pages/Reporting-Obligations.aspx.

166 17 N.J.R. 2909 (Dec. 2, 1985). N.J. Admin. Code § 13:37-5.8 (2000).

167 *See generally* Lawrence R. Huntoon, *Tactics Characteristic of Sham Peer Review,* 14 J. Am. Physicians and Surgeons 64 (2009). *see also,* Ronald Chalifoux, Jr, *So What Is a Sham Peer Review?*, 7(4) Medscape Gen. Med. 47 (2005); Leigh Ann Lauth, Note, *The Patient Safety and Quality Improvement Act of 2005: An Invitation for Sham Peer Review in the Health Care Setting*, 4 Ind. Health L. Rev. 151, 166 (2007).

168 Catherine M. DesRoches et al., *Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues*, 304 JAMA 187 (2010).

169 *Id.* at 187. *See also* Thomas H. Gallagher et al., *Talking with Patients about Other Clinicians' Errors*, 369 New Eng. J. Med. 1752, 1753 (2013).

170 *Id.* at 192.

171 *Id.*

172 *Id.*

173 *Duty to Report: Protecting Patients by Improving the Reporting and Sharing of Information about Health Care Practitioners*, Fed'n St. Med. Bds. 1 (Feb.. 7, 2017), https://www.fsmb.org/siteassets/advocacy/publications/duty-to-reportsummary.pdf.

174 *Id.* at 3.

175 John Blenkinsopp, et al., *Whistleblowing Over Patient Safety and Care Quality: A Review of the Literature*, 33 J. Health Org. & Mgmt. 737, 743-44 (2019) [https://nrl.northumbria.ac.uk/id/eprint/40695/].

176 Arthur Caplan, *Should You Report a Colleague Who Makes a Medical Error?*, MedScape (Dec. 9, 2013), https://www.medscape.com/viewarticle/817473.

177 P Hudson, *Applying the Lessons of High-Risk Industries to Health Care*, 12 Quality & Safety in Health Care i7, i11-i12 (2003).

178 James Reason, *Human error: models and management*, 320 BMJ 768, 769-70 (2000).

179 N.J. Admin. Code § 8:43E-10.8 (Lexis Advance through the New Jersey Register, Vol. 56 No. 7, April 1, 2024).

180 *State Board of Medical Examiners Frequently Asked Questions*, New Jersey Division of Consumer Affairs (Apr. 14, 2023), https://www.njconsumeraffairs.gov/bme/Pages/FAQ.aspx.

181 *See, e.g.*, Sabrina Rodak, *Creating a Just Culture With a Hospital Safety Hotline*, Becker's Healthcare (July 26, 2013), https://www.beckersasc.com/asc-quality-infection-control/creating-a-just-culture-with-a-hospital-safety-hotline.html.

182 N.J. Stat. Ann. § 34:19-1 *et seq* (LexisNexis, Lexis Advance through New Jersey 220th Second Annual Session, L. 2023, c. 228 and J.R. 15).

183 N.J. Stat. Ann. § 10:5-1 *et seq.* (LexisNexis, Lexis Advance through New Jersey 220th Second Annual Session, L. 2023, c. 228 and J.R. 15).

184 Graeber, *supra* note 6, at 271.

185 J.D. Barker, The Fourth Monkey 199-200 (Houghton-Mifflin 2017).

186 In re Quinlan, 355 A.2d 647, 669 (N.J. 1976).

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