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Beyond the Bylaws: Hospital—Physician Relationships, Economics, and Conflicting Agendas

JOHN D. BLUM†

People should think things out fresh and not just accept conventional terms and the conventional way of way of doing things.

R. Buckminster Fuller¹

In 2003 the Seattle based retailer, Nordstrom, opened a new store on Chicago's trendy North Michigan Avenue. Unlike the department stores of old that carried a vast array of consumer goods, the new Nordstrom is a large shoe store, accompanied by a number of small cosmetic and clothing departments.² The Michigan Avenue Nordstrom is one small example of how the retail industry has been, and continues to be, shaped by various external forces in the consumer marketplace. While hospitals, with their unique blend of human resources, technologies, services and products, are far more complex organizations than department stores, they share a commonality in as much as they too have been profoundly impacted by market forces, which have shaped their structures and operations. Even a cursory examination of hospitals in the last twenty-five years demonstrates that the acute care facility of the early twenty-first century, like a department store, is contained

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1. R. BUCKMINSTER FULLER, SYNERGETICS (1975).

2. See James L. Swanson, *As Nordstrom Carves Its Niche, What's In It For You*, CHI. TRIB., Sept. 20, 2000, at C6.

in a far different structure than the hospital model which emerged post-World War II. Not only have hospitals undergone dramatic internal changes, but since the 1970s they have been moving services out of inpatient settings and have developed a wide array of affiliated, focused, outpatient service delivery programs. Unlike retail establishments, however, the structural evolution of hospitals driven by external markets is complicated by the presence of regulation, which paradoxically both sparks and impedes change. Unquestionably market forces, and in some cases regulations, have been catalysts for reshaping the structure of the American hospital. But to a large extent the regulatory system has been a major factor in protecting the structures of hospitals, retaining structural elements in the face of market forces, which, unchecked, may have even further eroded core features of the hospital.

From a legal standpoint, the corporate structure of hospitals, best typified by its tripartite arrangement of board, medical staff, and administration, has remained a constant in the midst of the evolving complexities in acute care facilities. It is the contention of this article that the permanence in the corporate structure of hospitals, reflected in the tripartite arrangement is only a veneer under which profound changes are occurring, demonstrating that even the core features of general hospitals are being altered by market forces. In particular, the manner in which physicians relate to hospitals is changing, and even amid current battles to solidify the power of the medical staff, the structure in which that entity exists is eroding. The purpose of this article is to explore the evolution of the hospital-physician relationship in the context of community hospitals. The article will briefly examine the changing marketplace within which hospitals and doctors function, demonstrating that competitive pressures are both altering and complicating the relationship of these two parties. A significant portion of the discussion will focus on the changing nature of credentialing disputes as an area that mirrors the external pressures in the health delivery environment. The article will point out that current credentialing disputes, that combine quality and cost considerations, are often just a pretext for airing larger issues over the respective roles of the involved parties, and frequently touch on broader matters of autonomy and governance. The article will

conclude with some suggestions as to how the relationships between community hospitals and medical staff members can be recalibrated to better reflect current marketplace realities.

BACKGROUND

In recent years the landscape of the American hospital has been profoundly altered by two primary factors, regulation, and more recently, marketplace competition.³ On the regulatory side, hospitals have been the ongoing subjects of a vast array of local, state, and federal mandates, which touch on virtually all aspects of operations. Historically, hospital regulation is rooted in state licensure laws, and it is these laws that contain the key structural components that must be present in hospital corporations.⁴ The basic tripartite structure of hospitals, board, medical staff, and administration has been universally incorporated into state licensure laws, as well as a detailed delineation of the scope of departments and services which must be present in the acute care facility. Licensure laws act as an ongoing vehicle to alter and/or expand hospital obligations, and tend to be the first forum in which legal changes are made to address such problems as emergency care or patient safety. On the federal side, Medicare, in particular, has become a key element in shaping hospital operations. The Medicare Conditions of Participation, which act as an entree vehicle into the program, parallel hospital licensure requirements, requiring similar elements such as the basic tripartite structure.⁵ The most significant impact of Medicare on hospitals is felt in reimbursement policies that have acted both to promote, alter and end operational practices, touching on all matters of the institution's business. A key example of the impact of Medicare reimbursement policy can be seen in the adoption of a prospective payment system via Diagnostic Related Groupings (DRGs) in the 1980s which had a profound effect not only on direct

3. See REGINA E. HERZLINGER, *MARKET DRIVEN HEALTH CARE* 221-28 (1997).

4. A good example of the nature and scope of hospital licensure laws can be found in the following three state statutes, DEL. CODE ANN. tit. 16, § 1005 (2004), HAW. REV. STAT. § 321-14.5 (2004), 210 ILL. COMP. STAT. 85/6 (2004).

5. 42 C.F.R. § 482.1 (2005).

reimbursement, but on patient care utilization generally.⁶ Also in the Medicare context, the area of fraud and abuse enforcement, and the related institutional efforts in corporate compliance, have become major areas of focus in the ongoing efforts by institutions to devise a whole range of internal and external business strategies.⁷ Beyond Medicare there are numerous examples of how federal law has shaped hospitals either through application and enforcement of federal schemes such as antitrust law or via an ongoing proliferation of new legislative initiatives such as the Emergency Medical Treatment and Active Labor Act or more recently the medical information regulations devised under the Health Insurance Portability and Accountability Act.⁸ Tax law has always been a core concern for the hospital industry, and the current debate about the community benefit requirements of nonprofit hospitals has caused considerable refocusing on the obligations of 501(c)(3) acute care corporations.⁹ Not only does government regulation impact the structure and operations of hospitals, but also in this sector, private regulation, particularly that spawned by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), plays a very significant role.¹⁰ For many years JCAHO (formerly JCAH) has had an active hospital accreditation program, which, like licensure and the Medicare Conditions of Participation, mandates a series of structural and operational policies which hospitals must comply with. JCAHO standards have been altered significantly over time, but the core structure of the hospital (board, administration, and medical staff) around which the standards are centered, continues to be the model in use.¹¹

6. 42 U.S.C. § 1395ww (1988).

7. While there are several federal laws that concern Medicare and Medicaid fraud and abuse enforcement, three laws stand out as being of primary note, the Federal Anti-Kickback Statute, 42 U.S.C. §§ 1320a-7b(b)(1)-(2) (2000), the so-called Stark Laws, 42 U.S.C. § 1395nn(a)(1)(A) (2000), 42 U.S.C. § 1395nn(h)(6), and the Federal False Claims Act, 31 U.S.C. §§ 3729-33 (2000).

8. Emergency Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2000), Health Insurance Portability and Accountability Act, 18 U.S.C. § 1347 (1996).

9. 26 U.S.C. § 501(c)(3) (2000).

10. See HOSP. ACCREDITATION STANDARDS (Joint Commission on Accreditation of Healthcare Organizations 2000).

11. See *id.*

The JCAHO standards are particularly important because compliance with them allows a hospital to participate in Medicare under the principle of “deemed status,” thus avoiding an independent government survey process required for program participation.¹²

The context within which hospital regulations are applied has changed dramatically since the 1970s. Hospitals in the early part of the twenty-first century have evolved from community service entities that were quasi-public in nature to health care delivery businesses, competing in increasingly competitive markets. Starting in the 1980s the hospital world experienced dramatic changes ushered in by the convergence of a number of regulatory and related business realities. As noted, a significant catalyst for change was the adoption of a Prospective Payment System (PPS) via Diagnostic Related Grouping (DRG) categories that resulted in a major alteration in the financing and delivery of medical care.¹³ After years of expansion and high occupancy rates, hospitals, as a result of PPS, were motivated to introduce operational efficiencies that reduced lengths of stay, cut down on diagnostic tests, limited treatment to uninsured and underinsured patients, and forced institutions to be more aggressive in billing and collection practices. The system also favored admission of patients with high DRG payments such as surgery and endoscopy. In turn, as inpatient occupancy rates fell, hospitals were forced to engage in marketing and look for new ways to attract patients that frequently involved opening various types of ambulatory treatment centers (i.e., ambulatory surgical treatment centers, urgent care centers, renal dialysis centers, birthing centers), which became popular with managed care payers.¹⁴ The changes in the acute care sector sparked increased competition, which pushed nonprofit hospitals into capital markets to finance technology, supplies, and human resources needed to be competitive.¹⁵ In addition, the growing costs of regulatory

12. 42 U.S.C. § 1395bb (Supp. V 1993); 42 C.F.R. §§ 482.12, 482.22 (2005).

13. 42 U.S.C. § 1395ww (2000).

14. See Melvin Horwitz, *Corporate Reorganization: The Last Gasp or Last Clear Chance for the Tax-Exempt, Nonprofit Hospital?*, 13 AM. J.L. & MED. 527, 539 (1988).

15. See *id.* at 540.

compliance, aggressive external peer review, unionization, increased consumer demand, and stricter scrutiny over costs and operations by purchasers were other factors that combined to change the nature of the hospital enterprise in the 1980s. Currently hospitals face major workforce shortage pressures, increased medical liability costs, heightened public accountability on both the public and private sides, as well as increased legal scrutiny.¹⁶

To cope with the realities of financing and regulation, many nonprofit hospitals reorganized their corporate structures in the hope that organizational flexibility would result in opportunities to pursue new ventures, garner additional income, and attract patients and physicians alike. While a variety of corporate models were used, the most typical reorganization entailed the adoption of the nonprofit parent holding company that would oversee both nonprofit and for-profit subsidiaries, including the hospital corporation.¹⁷ The parent and subsidiaries may be involved in activities that would normally be regulated if pursued through the traditional single hospital corporate model. In tandem with internal reorganization, a variety of external corporate arrangements evolved including affiliations, alliances, mergers, and even the creation of hospital systems. A number of hospitals entered into joint ventures with members of their medical staffs to create Physician Hospital Organizations (PHOs) that were used as vehicles to attract managed care plans to enter into agreements with institutions for the provision of physician services. The most ambitious external hospital model entailed the creation of integrated delivery systems, which attempted to link together a spectrum of acute care services with other types of institutional providers and health programs, as well as physician groups.¹⁸ While over time the internal organizations and external alignments of individual hospitals often changed due to regulatory and market pressures, the structural templates spawned in the 1980s still characterize the present acute care sector.

16. See American Hospital Association, *The State of Hospitals' Financial Health*, available at <http://www.aha.org/aha/advocacy-grassroots/advocacy/advocacy/content/Wp2002HospFinances.doc> (last visited May 18, 2005).

17. See HORWITZ, *supra* note 14, at 545-47.

18. See Jeffrey M. Teske, *Second-generation legal issues in integrated delivery systems*, 49 HEALTHCARE FIN. MGMT. 54 (Jan. 1995).

EXPLORING THE CORPORATE STRUCTURE

It is a curious anomaly that in the midst of so much fundamental change in the internal and external environments of hospital operations, the core corporate legal structure of hospitals, board, medical staff, and administration, has remained intact. The fact is, however, that although the tripartite structure has been retained, the dynamics of how the three parts of the hospital structure relate to each other has been altered by many of the changes noted in the background discussion. In practical terms, the tripartite arrangement can be best thought of as a bifurcated structure with the medical staff being a distinct entity and board-administration viewed as unified pieces. More recently, focus has been placed on the role of the board as a distinct, independent entity within the hospital, sparked by concerns over trustee responsibilities in the for-profit sector triggered by the passage of the Sarbanes-Oxley legislation, as well as by a growing need of board members to be more engaged in business matters in competitive marketplaces.¹⁹

Within the hospital tripartite, the medical staff is clearly the most unique part as its status is that of a self-governing, independent, unincorporated association contained within the overall corporate structure. There does not appear to be any one distinct event which triggered the concept of the independent medical staff, but rather three related factors can be identified that have converged to spark this unique arrangement. One factor that has influenced the independent medical staff is the long-standing doctrine of the corporate practice of medicine. The corporate practice of medicine doctrine prohibits a lay corporation from providing medical services.²⁰ The logic underpinning the corporate practice of medicine doctrine is that only those trained and licensed as physicians should be

19. 15 U.S.C. § 7211 (2003). While Sarbanes-Oxley does not apply to nonprofit boards, more and more legal commentators in the health law area are arguing that boards in the hospital world should act in accordance with the governing principles delineated in this law. For example, see Ashby Jones, *Pre-emptive Actions Seen at Non-Profits*, 26 NAT'L L.J. 8 (2005).

20. See Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Healthcare Industry*, 40 VAND. L. REV. 445 (1987).

able to oversee the delivery of medical care. While the importance of the corporate practice of medicine doctrine has waned over time, the rationale supporting the doctrine parallels the logic that requires an independent medical staff to exert control over matters touching on the provision of medical care within the institution. The second factor which supports the independent, self-governing medical staff, is common law case precedent, starting in 1965 with the Illinois Supreme Court decision of *Darling v. Charleston Community Hospital*.²¹ Under *Darling* and its progeny, hospitals have been required to assume legal responsibility for the quality of the medical care provided in the institution, a mandate that requires physician engagement as lay administrators and board members lack expertise in this area. The quality function extends beyond monitoring into areas touching on institutional/medical practice policies and procedures that must be crafted by physicians in the hospital, thus providing a broad and distinct institutional role that, in a sense, removes the medical staff from general corporate control. Thirdly, the medical staff has traditionally been composed of independent contractors, who, not being employees of the hospital, safeguarded their autonomy through a structure that provides them with a collective voice, carves out unique professional and institutional roles, and safeguards physicians collectively from being treated as members of a corporate department. The self-governing medical staff has been recognized as a type of unincorporated association, and as part of its self-governance structure, staffs have developed their own bylaws, separate from the overall institutional bylaws, which detail structures and functions of this entity.²² This rather unusual arrangement that makes the medical staff separate, but a part of the hospital corporate structure, has been recognized in law as well as in the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).²³ While there is a mutual

21. 211 N.E.2d 253 (Ill. 1965).

22. See The California Medical Association, Legal Counsel, *Document # 1280, Medical Staff Self-Governance: Policy and Law*, (Jan. 2004) at http://www.healthlawyers.org/pg/cpr/docs/lunch_oncall.pdf (last visited April 11, 2005). See also, Howard Lang, *Why Self Government*, at <http://www.medspectrum.com/selfgovernance.pdf> (last visited April 13, 2005).

23. See HOSP. ACCREDITATION STANDARDS, *supra* note 10 at M.S.1.10.

dependency binding the three elements of the hospital tripartite structure together, the distinctiveness of the medical staff structure has created strains within the hospital, and has resulted in a very strong sense of independence on the part of physicians that often exceeds the legal support for this model.

CREDENTIALING AS A BACKDROP TO PHYSICIAN-HOSPITAL RELATIONS

One window into the dynamics of the relationships between hospital administration/boards and medical staffs can be found in the credentialing process. Credentialing, the appointment, reappointment and delineation of clinical privileges, is a long-standing legal responsibility of hospitals that fits within the general ambit of quality, and is perhaps the most visible manifestation of the broader quality mandate.²⁴ Credentialing, as noted recently by the Supreme Court of Texas, is a continuing hospital obligation that is not just a discrete series of processes, but rather constitutes an ongoing mandate to monitor and assess physician competence within the institution.²⁵ While the credentialing process entails collection and verification of routine background information, the evaluation component of credentialing involves an assessment of a physician's practice that necessitates professional input. Legally, credentialing decisions are ones made by the hospital board, but in practice the credentialing function has been delegated to the medical staff, who through its committee structure conducts necessary evaluations and makes recommendations in the area. The law has recognized credentialing as a delegated function, and the process is so ingrained in the medical staff world that rarely would a hospital board differ from the staff recommendations, for to do so is to spark an inevitable controversy, and possible lawsuit.²⁶

24. See *Garland Cmty. Hosp. v. Rose*, 156 S.W.3d 541 (Tex. 2004).

25. See *id.*

26. See J. STUART SHOWALTER, *SOUTHWICK'S THE LAW OF HEALTHCARE ADMINISTRATION* 439-40 (4th ed. 2004); see also Phillip L. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals*, 38 U.S.F. L. REV. 301 (2003-2004).

Traditional credentialing controversies entail situations in which individual physicians who have been adversely affected by a particular decision challenge that decision as being in violation of law. Typically, physicians who are denied medical staff membership, removed from the staff, or have practice privileges restricted, face such consequences because of concerns by credentialing committees over quality of care matters. The types of quality matters at issue in adverse credentialing can range from administrative violations such as failure to complete medical records in a timely fashion and patient abandonment, to concerns over patterns of substandard care, serious lapses in patient care, conduct endangering patient safety, or concerns over chemical dependency.²⁷ Physicians who challenge credentialing decisions are locked into an administrative process delineated in hospital and medical staff bylaws in which the complainant must proceed through a lengthy and complex web of procedures. Those who persist with credentialing claims can pursue their remedies in courts where over time a number of theories have been argued from breach of contract, to violation of due process, to allegations of statutory violations.²⁸ Interestingly enough, the most typical challenge in physician credentialing tends to be a breach of contract action, rooted in allegations of a hospital's failure to follow established policies, and many courts have recognized hospital and medical staff bylaws as having contractual import, thus being the foundation for claims of breach.²⁹

Physician credentialing disputes are a constant in the world of hospital law as the individual doctor who is affected by an adverse credentialing decision may suffer considerable professional damage. From a legal standpoint, the credentialing area is layered with federal and state law which mandates reporting of adverse decisions, safeguards

27. See Merkel, *supra* note 26.

28. See *id.*

29. For example, see *Barrows v. Northwestern Mem'l*, 123 Ill.2d 49, 525 N.E.2d 50 (1988), a well known Illinois hospital case which is an excellent example of the use of a contract theory as the basis for a physician credentialing dispute. While many state courts have recognized the hospital (and in some cases medical staff) bylaws as having contractual import, not all do. See *Mason v. Cent. Suffolk Hosp.*, 3 N.Y.3d 343, 819 N.E.2d 1029 (2004).

credentialing committee information from discovery, and provides conditional immunity for credentialing committee members.³⁰ Like most other aspects of hospital operations, the credentialing area is one that has not been insulated from change as the internal and external forces affecting hospitals in recent years have also had an impact on this process. One very visible change can be found in the nature of the information upon which credentialing decisions, particularly privileging decisions, are made.³¹ In the 1980s with the movement to prospective payment systems, analyses of medical practice shifted, with a greater focus on individual physician performance, accompanied by data capabilities, which allowed for examination of practitioner performance in the aggregate over a discrete period of time. Portraits of physician performance could be compiled in profiles that would allow a doctor's performance in dealing with a given patient diagnosis or in delivering a particular service to be evaluated. Accompanying changes in evaluation was the growing national movement in health services research, which led to the development of clinical guidelines and protocols as vehicles against which individual performance could be measured.³² There is no data to verify how many credentialing committees used either physician profiles and/or clinical guidelines as a basis of their evaluations, but what seems clear, is that the capability for a more rigorous analysis of physician practices developed and questions of performance were no longer strictly based on anecdotal observations.

A thread that has always underlain the physician credentialing process is economics. Even in the period before the overt discussions about credentialing and economics, when presumably quality of care was the only recognized focal point of medical staff considerations in this process, financial elements were never totally off the table. The obvious fact found in the physician credentialing challenges, noted above, is that while a given case may

30. See Merkel, *supra* note 26; SHOWALTER, *supra* note 26; see also Daniel M. Mulholland, III & Phil Zarone, *Waiver of the Peer Review Privilege: A Survey of the Law*, 49 S.D. L. REV. 424 (2003-2004).

31. See Jennifer Daley, *Physician Clinical Performance Assessment: The State of the Art*, INST. FOR HEALTH POLICY, MASS. GEN. HOSP. (2002).

32. See Stefan Timmermans & Aaron Mauck, *The Promises and Pitfalls of Evidence-Based Medicine*, HEALTH AFF., Jan.-Feb. 2005, at 18.

have been sparked by a controversy over quality, the motivation for such suits stemmed from the physician plaintiff's desire to protect his/her ability to earn a living. In California, medical staff disputes have been brought using the fairness doctrine, which in common law parallels a due process claim.³³ The fairness doctrine is rooted in employment law, and is one which provides the right to a fair hearing in cases of termination, recognizing that such a safeguard is needed in the face of serious economic injury. The use of the fairness doctrine in the medical staff credentialing context is a recognition that what is really at issue in such disputes is a potential, underlying financial injury. A more direct attestation to the fact that medical staff credentialing has never been far a field from economic considerations are cases where aggrieved doctors mount claims based on state and federal antitrust theories, arguing that the adverse credentialing actions arose from restraints of trade, conspiracies or illegal monopolies.³⁴ While antitrust is not easily applied in the medical staff context, its application in this area demonstrates the business realities which underpin the medical staff credentialing processes.

ECONOMICS ENTERS CREDENTIALING

With changes in the hospital markets and the increase in competition, which were noted earlier in this article, the relationship between the hospital and the medical staff changed. Doctors, individually and collectively, took on a very clear economic importance to the hospital. While unquestionably hospitals could never exist without physicians, the interests of the institution in a competitive arena go beyond having a medical staff composed of individuals who perform at acceptable levels of quality, to having a medical staff that is able to strike the necessary balance between quality and cost effectiveness. Internally, acute care facilities were pressed to find, and retain, clinicians to staff key profit centers, as well as to recruit physicians whose performance was compatible with the fiscal goals of the institution. Externally, hospitals needed

33. See Merkel, *supra* note 26, at 311.

34. See Kurt Erskine, Comment, *Square Pegs and Roundholes: Antitrust Law and the Privileging Decision*, 44 U. KAN. L. REV. 399 (1995-96).

to have a medical staff composed of physicians with practice profiles, which would be attractive to insurers and managed care plans. In some instances, the purchasers' decisions on which hospitals to contract with have been totally cost driven. It was, thus, inevitable that credentialing and economics were destined to mix in a much more direct way than what had occurred prior to the dramatic market changes noted.³⁵

Starting in the late 1980s, the concept of economic credentialing emerged on the hospital scene. While never uniformly defined, economic credentialing referred to the application of fiscal measurements to assess the appointment, reappointment and grant of clinical privileges.³⁶ Unlike traditional credentialing that was largely rooted in a clinical/quality evaluation of a physician's background and performance, economic credentialing was an assessment, which focused on "bottom line measures" as the arbiter of medical staff membership. The very fact that economic credentialing emerged as a concept is reflective of the competitive environment within which hospitals were operating, and underscores a shift in attitudes by hospital management and boards as physicians individually and collectively were seen as akin to economic units. The "did you, or will you make money for the hospital" analysis underpinning economic credentialing sparked considerable controversy in the ranks of organized medicine.³⁷ The process was viewed as both an inappropriate application of financial standards into an area that should be rooted only in clinical quality considerations, as well as an illegal usurpation of the credentialing function by the lay board. A strong campaign was waged by organized medicine against economic credentialing that succeeded in the enactment of legislation in a number of states, which severely curtailed the

35. See Cindy Reisz, *Whatever Happened to Credentialing for Quality*, HEALTH LAW NEWS, Sept. 2003, at 5.

36. See Beverly Cohen, *An Examination of the Right of Hospitals to Engage in Economic Credentialing*, 77 TEMP. L. REV. 705, 706 (2004).

37. See American Medical Association, *Economic Credentialing - Issues and Answers* (last updated Mar. 14, 2005), available at <http://www.ama-assn.org/ama/pub/category/10919.html>; *Economic and Exclusive Credentialing; Exclusive Contracting*, LEGAL BRIEF (Ohio State Medical Association, Hilliard, OH), July 2001 [hereinafter OMA LEGAL BRIEF].

process.³⁸ In addition, questions arose about whether economic credentialing was a type of illegal kickback requirement in violation of federal law.³⁹

By and large the economic credentialing controversy was one that was more political than legal as there is a dearth of cases specifically litigated on economic credentialing issues. Perhaps the best known case concerning economic credentialing was the Florida lower court opinion of *Rosenblum v. Tallahassee Regional Hospital*.⁴⁰ The court in *Rosenblum*, a case centering on a perceived economic conflict of interest, upheld a hospital board's right not to extend cardiac thoracic surgical privileges to the plaintiff, despite a recommendation from the medical staff that such privileges be granted. There was no question that the plaintiff, Dr. Rosenblum, was a qualified thoracic surgeon, but the board was concerned that the plaintiff's position in a competing heart program could be economically injurious to Tallahassee Regional.⁴¹ The *Rosenblum* case is noteworthy because the board decision not to grant privileges was overtly economic, as there was no underlying, intertwined cost and quality consideration at issue, as is common in credentialing disputes. It is also worth noting that the *Rosenblum* dispute involved an initial appointment and grant of privileges, for had the plaintiff been a member of the staff, the board likely would have been reluctant to reduce privileges without some nexus to quality, and would also would have to be concerned about a challenge based on infringement of a property right.

From a legal standpoint, economic credentialing can be supported on the grounds that the hospital board has final control over credentialing, has the ultimate legal responsibility for appointing and monitoring medical staff,

38. See Paul Danello, *Economic Credentialing: Where Is It Going?* (2003), available at <http://articles.corporate.findlaw.com/articles/file/00989/009358>. Interestingly enough, as noted by Danello, a number of states have actually passed legislation which allows economic credentialing in some forms to take place.

39. See *id.*

40. Final Summary Judgment in favor of the Defendant, *Rosenblum v. Tallahassee Reg'l Hosp.*, No. 91-589 (Fla. Cir. Ct. June 18, 1992) (on file with author).

41. *Id.*

and has a duty to act as the institutional fiscal fiduciary. No doubt, counterarguments can be raised that state law and accreditation supports credentialing as a medical staff function that cannot be arbitrarily interfered with by a board, and as a quality process, it should not be corrupted by use of standards that are not matters fundamentally rooted in clinical performance. The practical difficulty in this regard is that quality and cost factors are intertwined, and quality problems, more often than not, spark financial considerations. In considering the parameters of the credentialing function, it is worth turning to state law to ascertain whether specific guidance can be identified about what grounds must exist for a board to take actions against a physician affecting his or her privileges. Under New York law, four areas can be identified that serve as the basis for curtailing, diminishing or terminating hospital privileges. They include factors related to standards of patient care, patient welfare, character or competency and objectives of the institution.⁴² It can be argued in the context of the four identified grounds for affecting hospital privileges that institutional objectives might encompass an imperative to consider economic ramifications, but the other elements noted are ones rooted in the traditional quality evaluation, giving pause about how far a board should venture in taking negative, independent credentialing actions outside the quality area. In light of the lack of court decisions in the area, it would appear that hospitals have been very cautious in pursuing credentialing that did not fit within the framework of the medical staff's quality analysis. A recently decided New York case, *Mason v. Central Suffolk Hospital*, buttressed the power of the hospital board to make legitimate credentialing decisions, presumably on all the grounds noted above, including decisions that meet institutional objectives.⁴³ *Mason* is particularly noteworthy because the New York Court of Appeals rejected the ability of a physician to use the hospital bylaws as the basis for a breach of contract action against the hospital, ruling that such an action must be based on an explicit agreement between the plaintiff physician and the hospital.⁴⁴

42. See N.Y. PUB. HEALTH LAW § 2801-b (McKinney 2005).

43. 3 N.Y.3d 343, 819 N.E.2d 1029 (2004).

44. *Id.*

To an extent, the notion of using fiscal measures to evaluate physicians for purposes of determining hospital staff membership and privileges was an issue supplanted by other developments, but the economic considerations that sparked the concept are largely still present, giving the concept continued relevance. In particular, if the current movement toward pay-for-performance evolves, hospital administration and medical leadership will be more directly confronted with the linkage between those physicians whose practices fall below quality and patient satisfaction standards and reimbursement.⁴⁵ In pay-for-performance, quality and its implications on cost are directly tied, so it would seem difficult to keep the awareness of this relationship from being considered in the credentialing process. In addition, recent opinions issued by the Department of Health and Human Services Office of the Inspector General indicate that hospital programs which reduce costs through medical care practice standardization represent efficiencies that do not violate the federal anti-kickback statute, and so represent another type of behavior that credentialing might consider.⁴⁶

BEYOND ECONOMIC CREDENTIALING

From an analytical standpoint, credentialing continues to be a valuable window into the relationship of physicians and hospitals, but controversies over the influence of economics in that relationship are no longer rooted only in traditional quality performance credentialing controversies. While the term economic credentialing continues to be used,

45. See Deborah Gesensway, *ACP's Response to the Pay-For-Performance Movement*, ACP OBSERVER (Jan./Feb. 2004), available at <http://www.acponline.org/journals/news/jan-feb04/herald.htm>; see also Susan Carhart, *Stakeholders Confront Host of Issues Attendant on Pay for Performance Systems*, 14 BNA HEALTH LAW. REP. 321, 322 (March 10, 2005).

46. The development of joint projects between hospitals and physicians to improve efficiencies and reduce costs falls into the general area of gainsharing. On its face gainsharing which rewards physician behaviors may be in violation of the Federal Anti-Kickback legislation, and has been an area of controversy in as much as some joint efforts that have legitimate ends may require some type of reward scheme to succeed. The Department of Health and Human Services has issued several directives on gainsharing in the form of advisory opinions. U.S. Dep't of Health and Human Servs., Off. Inspector Gen. 05-01 to 05-06 (2005), 01-01 (2001), available at <http://oig.hhs.gov/fraud/advisoryopinions/opinions.html>.

the fact is that the concept does not apply to just the use of fiscal measurements in the appointment and privilege delineation area. Economic credentialing has become a catchall concept that represents hospital board decision-making, based on business considerations, which affects medical staff autonomy and governance generally.⁴⁷ In the expanded world of economic credentialing, controversies arise that pit hospital management/boards against medical staffs where acute care business strategies are at odds with individual medical practice considerations. While the credentialing process is often the platform for economic disputes between the medical staff and hospital, the details of such disputes are largely ones that fall outside the bounds of more typical quality evaluation. During the period in which economic credentialing emerged, the use by hospitals of physician specialty exclusive contracts, a practice by which institutions developed exclusive arrangements for certain services with a particular medical group, was growing.⁴⁸ Typically, exclusive contracts cover hospital-based specialties, such as anesthesiology, radiology and pathology, but are often used in other areas such as surgery or emergency room care. The majority of hospitals have engaged in some type of exclusive contract arrangement, driven by a desire for greater efficiencies in core service areas as well as by cost and quality considerations.⁴⁹ Exclusive contracts do not negate the need for involved physicians to be credentialed, but in a sense add another dimension to the issue of medical staff evaluation, which falls outside the purview of the medical staff. It is common for a physician who enters into an exclusive contract to have his/her privileges on the staff linked to the continuation of the contractual agreement. As such, physician hospital practices in the exclusive contracting context are not bounded only by quality related credentialing. Exclusive contracts raise considerations revolving around operational and financial issues, and such matters are very much in play in making determinations about whether to enter into and continue a given

47. See Reisz, *supra* note 35, at 7.

48. See OMA LEGAL BRIEF, *supra* note 37.

49. See *id.*; see also John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 181-82 (1996).

contractual arrangement with a group of credentialed doctors.⁵⁰ Physician group members in exclusive contract arrangements reap the economic benefits of such deals, but the quid pro quo is a change in their relationship to the contracting hospital, as their livelihoods are tied to both clinical and financial performance.

The exclusive contracting issue has spilled over into a number of judicial disputes in which the exclusive contract in question did not link continuation of the respective contract with privileges but led to the odd result of a physician retaining specialty privileges without access to needed technologies.⁵¹ In litigated exclusive contract cases, physician plaintiffs have argued that issues concerning their hospital privileges needed to be evaluated under the medical staff bylaws. While the courts have generally agreed with the need to invoke fair hearing rights when continuation of contracts and privileges are not linked, there is also a general recognition in these cases of a hospital board's authority to enter into exclusive contractual arrangements, as part of its mandate to improve institution efficiencies.⁵² Unquestionably, physician exclusive contracts alter traditional credentialing in that they add another element to the hospital based practice of medicine, outside considerations expressed in the medical staff bylaws. Joining privilege retention with contract continuation may not inherently alter the quality related criteria of credentialing, but its impact is to add a distinct business component to staffing issues, removing the exclusivity of medical staff decision-making in the physician assessment area.

Another strategy pursued by administration and boards to enhance institutional efficiency, and to retain physicians on staff, is to close medical staff membership, in whole or in part. As medical staff membership, outside of some public

50. See Blum, *supra* note 49, at 181-82.

51. See, e.g., *Lewisburg Cmty. Hosp. Inc. v. Alfredson*, 805 S.W.2d 756 (Tenn. 1991).

52. See *Mahan v. Avera St. Luke's*, 621 N.W.2d 150 (S.D. 2001); see also Client Memorandum from Thomas Campbell and John J. D'Attomo, Gardner, Carton, & Douglas, *South Dakota Case Will Be Significant Precedent for Hospital Governing Boards to Take Economic Factors Into Consideration When Granting Medical Staff Privileges* (Jan. 2001), available at <http://www.gcd.com/db30/cgi-bin/pubs/SouthDakota.pdf>.

hospitals, is a privilege and not a right, authority to close staff membership falls within the authority of hospital trustees.⁵³ Boards that decide to close medical staff membership in given medical and surgical areas do so in recognition of the fact that there is an identifiable need for a set number of practitioners in given practice areas, and exceeding a requisite number may result in inefficiencies, as well as force affected physicians to seek privileges in several institutions. It is also common to close medical staffs in certain areas to retain specialists whose practice viability is eroded by a lack of patient demand stemming from excess capacity in a particular hospital.⁵⁴ Medical staffs often draft staff development plans, which delineate strategies for meeting future needs in given practice areas.⁵⁵ While hospital boards may rely on medical staff plans in making decisions about staff closure, they are under no legal obligation to do so, and thus the development plans play only an advisory function. Just as is the case with exclusive contracting, a board's decision to close membership in a medical staff on a limited or general basis erodes medical staff control of such matters, impacts credentialing, and is another manifestation of the growing inroads of business considerations in areas once primarily focused on quality considerations.

Perhaps the best known "economic credentialing" case in recent years is the decision of the South Dakota Supreme Court in *Mahan v. Avera St. Luke's*, which concerns a decision by a hospital board to close medical staff membership in orthopedic surgery and restrict surgical privileges in three related areas.⁵⁶ The board decision in *Mahan* was made to protect the viability of neurosurgical practice in the hospital, as well as to enhance the institution's ability to recruit and retain orthopedic surgeons.⁵⁷ An orthopedic surgeon, Dr. Mahan, who had previously joined the staff of a competing day surgicenter,

53. See *Mahan*, 621 N.W.2d at 160.

54. See *id.*

55. See American Medical Association, *Medical Staff Development Plans – An Impetus for Young Physician Involvement*, available at <http://www.ama-assn.org/ama/pub/category/2388.html> (last visited Apr. 7, 2005).

56. *Mahan*, 621 N.W.2d at 150.

57. *Id.* at 152-53.

sought membership on the staff of Avera St. Luke's, but was turned down as a result of the hospital policy, and in turn challenged the board's closure decision. Plaintiff Mahan argued that the board's decision to close staff membership in orthopedic surgery violated the medical staff bylaws, as it was a decision that could only be made by the medical staff. The South Dakota Supreme Court noted that the medical staff's authority for monitoring quality and ensuring the ethical and professional practice of its members was based on derivative powers granted via the hospital corporate bylaws and buttressed by state law.⁵⁸ As such, the court characterized the medical staff as an entity with a very limited range of delegated authority, and the decision at issue, to close membership in the medical staff, was seen as a business matter over which the board, and not the medical staff, had authority. The *Mahan* decision painted a very thorough picture of the role of the hospital board and underscores both the freedom and obligation hospital trustees have to make good faith decisions to maintain the economic integrity of the institution.⁵⁹ Expanding the role of the medical staff into business-making decisions would require changes in both hospital corporate bylaws, as well as in state laws and accreditation policies, and such changes would directly call into question the established tripartite structure of the hospital.

STRUCTURAL CHANGES

While economic credentialing, exclusive contracting, and decisions to close membership in medical staffs have all tested the bounds of the relationship of physicians and hospitals, each of these areas is reflective of institutional strategies to use its physician component to enhance fiscal viability in increasingly competitive markets. While the friction between the medical staff and the hospital concerning credentialing persists, another arena sparking tensions has spawned with the ongoing growth of hospital sponsored ambulatory care programs.⁶⁰ In the struggle to

58. *Id.* at 155-56.

59. *Id.* at 160.

60. Greg Piche, *Economic Credentialing: Now It Comes To Distances*, at http://www.hollandhart.com/healthcare/2004_02_01_archive.htm; see also, Robert J. Milligan, *Plata o Plomo: Hospital Medical Staff Relations in the Era of*

be competitive, maximize reimbursement dollars, and meet regulatory pressures, hospitals for some time have developed outpatient services that may alter their relationships with involved physicians. While hospital sponsored ambulatory centers are staffed by institutionally credentialed physicians, such arrangements can spark disputes over physician selection and can pose direct competition with certain physician staff members. In a larger sense, the movement to ambulatory treatment centers has altered the nature of the hospital business, and for those affected doctors, changes the nature of their relationship to the hospital corporation beyond credentialing to a contractual one, in a manner akin to exclusive contracts.

Another example of how hospital structures that evolved as a result of competitive marketplaces alter the physician relationship to the institution, outside of traditional credentialing, can be seen in the case of physician hospital organizations (PHOs).⁶¹ The PHO is a type of joint venture between the hospital and members of its medical staff that is used as a shell to provide a variety of medical services, and which is created to attract contracts from insurers and managed care plans based on the offered services and panel of physicians. Typically physicians, usually all members of the same medical staff, invest in PHOs, and in turn form separate medical groups, Independent Practice Associations (IPAs), which engage in credentialing of their members, often using different criteria from that used in the hospital. As a business oriented entity, PHO membership is open to physicians whose practices fit into the respective scheme, and thus not every credentialed physician in the hospital sponsor may be attractive to a PHO. While the existence of a PHO entity does not directly change hospital credentialing, it is an organization which alters the relationship of its physician member investors to their hospital partner, binding them economically to the hospital in a way that medical staff membership seldom does. Only direct employment or practice acquisition situations may create a tighter economic relationship to the hospital than would be the

Conflicts Credentialing, HEALTH LAW. WKLY (Sept. 2004).

61. See Frederick B. Abbey & K. Michael Treash Jr., *Reasons Providers Form PHOs*, 49 HEALTHCARE FIN. MGMT. 38 (1995).

case with the PHO, and in such situations the contractual arrangements with the hospital add another dimension in practitioner-institutional relationships. Although PHOs and various other ambulatory service programs complicate the professional relationships of doctor and hospital, they are competitive strategies in which physicians voluntarily participate, induced by economic and professional opportunities. PHOs tend to be the most visible external vehicles for bringing together hospitals and a diverse range of medical staff members, but other partnering vehicles are developing: for example, the creation by hospitals of practice institutes in areas such as cardiovascular services which also entail separate contractual arrangements outside traditional bylaws.⁶²

A related set of strategies pursued by hospitals to be more competitive entails a constant internal alteration of institutional organizational arrangements, which reflects longstanding management practices designed to optimize the effectiveness of an institution through structural changes. While any reorganization may spark controversies, a strategy of moving traditional hospital based departments into outpatient settings for purposes of competition and reimbursement, as noted, has direct implications for physician-hospital relationships, and like exclusive contracts, can result in an excluded medical staff member being disenfranchised from the institution. The decision to dismantle long-established elements in the internal structure of a hospital places the board in an area of governance that may be necessary in the current economic climate, but can be seen by staff as an inappropriate foray into clinical matters. In the Alabama Supreme Court case of *Radiation Therapy Oncology v. Providence Hospital*, a small group of radiation oncologists challenged a hospital board's decision to transfer radiation oncology out of the hospital setting in order to consolidate services in this area.⁶³ The three radiation oncologists employed by RTO were all members of the Providence medical staff and had had a contractual relationship with the hospital to provide services in their specialty area since

62. See Daniel K. Zisner, *What Happens Next With Cardiovascular Services Strategies?*, DISCOVERY, July/Aug. 2004, at http://www.dorseyhealthstrategies.com/grouppubs/2004/discovery_200407-08.asp.

63. No. 1022099, 2005 Ala. LEXIS 10 (Jan.14, 2005).

the mid 1980s. In the late 1990s, Providence Hospital, with the assistance of an outside consulting group, reviewed the institution's oncology program and felt that for quality and business reasons these services were better provided in an ambulatory office setting. Specifically, the hospital and its consultants concluded that the relationship between medical and radiation oncology was dysfunctional and that radiation oncology services were complicated by the fact that RTO operated competing centers, had multiple employers, failed to use standard treatment protocols, and had problems with staffing, scheduling, and space usage.⁶⁴ In addition, the Providence board decision to consolidate radiation oncology out of the hospital was motivated by a change in Medicare reimbursement that favored office-based services over traditional inpatient settings in this area.⁶⁵ As the medical staff privileges of the RTO physicians were affected by the relocation of services, the three physicians were allowed a fair hearing under the dictates of the medical staff bylaws. The fair hearing panel, composed of members of the medical staff, concluded from testimony that the physicians' privileges were improperly infringed upon. The panel position was based on their interpretation of the medical staff bylaws which required that adverse credentialing determinations needed to be based on quality considerations only. The Providence board, however, relying on the same hearing testimony, felt that the decision to consolidate oncology outside the institution was appropriate, and thus rejected the conclusion of the fair hearing panel. The RTO physicians sued the hospital, arguing that the board improperly reduced their privileges by denying them access to medical equipment and that their decision failed to be based on the requisite quality component required in the medical staff bylaws. Similar to the *Mahan* decision, the Alabama Supreme Court characterized the authority of the medical staff as derivative, and in the credentialing and discipline area, advisory in nature.⁶⁶ The court found from the hearing record that there was substantial support for the decision to transfer radiation oncology outside the hospital, and that

64. *Id.* at *6.

65. *Id.* at *8.

66. *Id.* at *14.

the decision was supported by adequate quality considerations. The RTO court also found that the hospital board had the power to make business decisions, including transferring medical services under the institution's corporate bylaws.⁶⁷ In fact, it is arguable from the Alabama Supreme Court decision that the hospital board has the necessary power to make operating decisions without having to ensure that the medical staff fair hearing measures were invoked.⁶⁸ It also seems reasonable to conclude that most board business decisions which impact medical services likely will have a strong nexus to either clinical quality, or to operational efficiency, and thus, can generally be supported on quality grounds.

PHYSICIAN ENTREPRENEURIAL BEHAVIOR, CATALYST FOR CONTROVERSY

While most of the current disputes between physicians and hospitals that are waged in the credentialing and governance area concern medical staff reactions against hospital strategies that are seen as negatively impacting individual physicians or challenging staff autonomy, the pendulum in the area is beginning to shift. Considerable focus has now been directed to a new series of disputes in which hospitals are reacting to the entrepreneurial activities of staff physicians. In particular, attention has been directed to the reaction of hospitals against staff physicians who are engaged in the formation and delivery of services in niche provider programs, which may be competing with a given hospital, siphoning off patients in lucrative practice areas.⁶⁹ Niche provider programs are not a new phenomenon, but their ongoing, visible proliferation and the commensurate threat they pose to community

67. *Id.*

68. *See id.* at *21-29 (Harwood, J., concurring) (raising the issue of the board's power to make business decisions without providing a due process hearing to affected medical staff members).

69. *See Business Update: Hospital Study Finds Doctor-Owned Services Draw From Profits*, PHYSICIAN BUSINESS WEEK, March 15, 2005, at 2.; *see also* John K. Igelhart, *The Emergence of Physician-Owned Specialty Hospitals*, 352 NEW ENG. J. MED. 78 (2005); GENERAL ACCOUNTING OFFICE, GAO-04-167, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE (Oct. 2003).

hospitals has increased. From a governmental perspective, niche providers are classified as entities in which the diagnosis of two thirds of their Medicare patients fall into no more than two major diagnostic related grouping categories.⁷⁰ Typically, niche providers include heart, orthopedic, and cancer hospitals/clinics, ambulatory surgery centers, dialysis clinics, and pain, imaging, and mammography centers; and often such entities are owned in part by physician specialists who refer to them. Physician investors are joined by business partners who provide both capital and management expertise to run these specialized institutions, with results that have led to higher profit margins than most general hospitals running similar services. Beyond profitability, physicians are attracted to such ventures for several reasons, including ease of governance through a decrease in bureaucracy, enhancement of quality in a more controlled setting, and practice efficiencies. In turn, such niche services meet consumer demands for convenience and ease of access, together with optimal outcomes. From the community hospital perspective, niche providers roil institution-physician relationships in that specialists involved in the niche entities generally retain their admitting privileges at the general hospital, but have an option to channel patients to the specialty hospitals.⁷¹ The community hospitals see niche providers as “cream skimmers” that reduce their patient volume in profitable areas and leave the institution with the inability to subsidize care in less profitable areas, as only some state licensure laws place service demands on specialty hospitals, such as requirements to provide complete emergency care.⁷²

In some instances the possibility of a niche provider opening in a particular market has prompted general hospitals to counter such a possibility by developing a hospital sponsored niche entity, together with its physician specialists.⁷³ But in some cases, it has been the refusal of

70. See GENERAL ACCOUNTING OFFICE, *supra* note 69.

71. See Igelhart, *supra* note 69, at 81.

72. See *id.*; see also American Hospital Association, *The Trend Toward Niche Providers*, available at http://www.hospitalconnect.com/aha/annual_meeting/content/03mtgpaper_Niche.pdf (last visited Apr. 23, 2005).

73. See Kelly J. Devers et al., *Center for Studying Health System Change*,

general hospitals to partner with specialists that was the catalyst for a group of physicians to enter into a joint venture to create a niche entity with an outside party. The area of specialty hospitals has sparked controversies which have spilled over into the credentialing area, as hospital boards have adopted policies which restrict the privileges of physicians who are investors in competing niche entities. As the area is evolving, the legal disputes that have arisen are still winding their way through the courts but have been matters which have been well-publicized by organized medicine.⁷⁴ A widely reported situation occurred in Columbus, Ohio, where an eight-hospital system, Ohio Health, terminated the privileges of seventeen physicians who had admitted to being investors in a forty-two bed orthopedic specialty hospital, the New Albany Surgical Hospital.⁷⁵ The system board decided to terminate the investor physicians' privileges because of their fear that these specialist investors would "cherry pick" the most profitable cases, and refer the most costly and least profitable patients to one of the non-profit system hospitals. The Ohio Health board was concerned that the loss of revenue, which they projected at twenty-eight million dollars per year, would adversely hurt the hospitals' abilities to provide uncompensated care.⁷⁶ Interestingly, it was the action of the Ohio Health board in converting one of its hospitals to an outpatient center that had displaced eighteen surgeons, which provided an incentive for many of the involved physicians to become investors in the specialty niche operation. Similar situations have occurred in other places around the country, where physicians who have become investors, or active practitioners, in competing specialty entities have had their privileges removed by general hospitals who had been, or could be, adversely affected by the niche provider, based upon a perceived,

Specialty Hospitals: Focused Factories or Cream Skimmers?, Issue Brief No. 62 (April 2003), available at <http://www.hschange.com/CONTENT/552/552.pdf>.

74. See Cohen, *supra* note 36, at 735-39.

75. See generally Mark Taylor, *Doc Investors in For-Profit Hospitals Denied Staff Privileges; Ohio Not-For-profit System Fear Loss of Market Share to Specialty Hospitals Owned By Physicians*, 32 MOD. HEALTHCARE 12 (July 15, 2002); Mark Taylor, *Striking Back at Doc Investors*, 34 MOD. HEALTHCARE 10 (Jan. 26, 2004).

76. Taylor, *supra* note 75.

measurable economic injury. There has even been consideration of the antitrust implications of community hospital behavior when institutions have attempted to restrict referrals to medical staff members who invest in niche providers, or use institutional leverage to convince insurers to refuse to contract with specialty hospitals.

A multiple issue controversy between a hospital board and medical staff at Community Memorial Hospital of San Buena Ventura, California, was triggered when the hospital trustees refused to recognize the election of the medical staff president because the individual in question, an orthopedic surgeon, had a financial interest in a competing niche provider.⁷⁷ The Community Memorial board action was taken on the basis of a code of conduct and conflict of interest policy that required that physicians on staff acknowledge competing interests, and prevented those individuals with such interests from holding medical staff leadership positions which then gave access to confidential hospital plans.⁷⁸ The rejection of the president-elect of the medical staff due to an economic conflict, while not a credentialing matter, was seen as an inappropriate, unilateral decision that challenged the autonomy of the medical staff, and became the basis for a suit by the staff against the hospital administration, trustees, and management company that ran the hospital. The medical staff lawsuit contained a number of claims beyond the refusal to accept the election of officers, including challenges to the unilateral amendment of medical staff bylaws through adoption of a code of conduct and conflict of interest policy, as well as failure to consult with the staff concerning the development of new specialized programs, or entering into exclusive contracts. Medical staff plaintiffs argued that the hospital actions constituted unfair business practices, as well as a breach of the board's fiduciary duty,

77. See Tanya Albert, *California Deal Reaffirms Medical Staff Autonomy*, AM. MED. NEWS, Sept. 6, 2004, at <http://www.ama-assn.org/amednews/2004/09/06/prl20906.htm>.

78. See Second Amended Complaint, *Medical Staff of Community Hospital of San Buenaventura v. Community Memorial Hospital of San Buenaventura*, No. Civ 219107 (Cal. Super. Ct. Ventura Cty. Sept. 8, 2003). See also James W. Marks & Jayme R. Matchinski, *Conflicts Credentialing: Hospitals and the Use of Financial Considerations to Make Medical Staffing Decisions*, 31 WM. MITCHELL L. REV. 1009, 1014 (2005).

in violation of the medical staff bylaws and state hospital law.⁷⁹ The California court dismissed most of the medical staff allegations ruling that the claims had to be pursued by individual physicians, but the court did acknowledge that the medical staff could sue the hospital and its trustees as an unincorporated entity. The *Community Memorial Hospital* case resulted in a settlement between the hospital and medical staff that guaranteed that the medical staff bylaws would not be unilaterally changed, and that conflict/conduct policies be incorporated into the medical staff bylaws, that board approval of staff officers would not be unreasonably withheld, that the staff would be allowed to retain independent counsel and file lawsuits in its own behalf, that medical staff input be provided on exclusive contracts, and that the addition of new hospital services be independently evaluated to determine medical appropriateness.⁸⁰ The settlement has been seen as a powerful confirmation of the status of the self-governing medical staff, and in fact, triggered a political response that will be noted below. In terms of the struggle between hospitals and medical staffs over specialty hospitals the *Community Hospital* case has had more of a practical than legal implication, for the settlement places certain constraints on the hospital-medical staff relationship in the case of a single institution. But more broadly, the *Community Memorial* settlement reflects the broad tensions surrounding the matter of niche providers, demonstrates the growing challenges administration/boards face with medical staffs over conflicting business strategies, and demonstrates that a hospital, which enters into a dispute with a medical staff, may jeopardize the overall viability of the institution.

LEGISLATIVE/ADMINISTRATIVE RELIEF

In credentialing disputes and the more recent controversies concerning economic evaluation of medical practices, hospitals have tended to rely on corporate bylaws and state law to support their respective positions.

79. See *Medical Staff of Community Memorial Hospital of San Buenaventura v. Community Memorial Hospital of San Buenaventura*, *supra* note 78.

80. See *Albert*, *supra* note 77.

Physicians, on the other hand, have argued their cases based on medical staff bylaws and JCAHO accreditation standards, and have frequently resorted to the courts to seek redress from what they perceive as illegal hospital decisions. Additionally, both medical staffs and hospitals have sought to use the legislative and administrative processes to protect their respective interests. Starting with traditional credentialing, organized medicine has been successful in lobbying for the incorporation of a series of protections for medical staff members which have been supported by state (and to a lesser extent federal) law, as well as accreditation criteria.⁸¹ When economic credentialing burst onto the scene of hospital-medical staff affairs in the early 1990s, organized medicine launched a vigorous campaign opposing the practice, which resulted in several states enacting legislation restricting the practice. In addition, the arguments against economic credentialing raised concerns about whether the practice constituted a form of an illegal kickback in violation of federal law.⁸² Interestingly enough, the related practice of exclusive contracting did not engender as strong an opposition as economic credentialing from organized medicine in that it is a practice which splits the ranks of physicians, in that it rewards certain doctors at the expense of their competitors.

Perhaps the best recent example of the power of the medical lobby to influence the legislative process to protect its current position vis-à-vis the hospital can be seen in California in the reaction to the *Community Memorial* case noted above.⁸³ The California Medical Association was able

81. Harty, *supra* note 26.

82. See Cohen, *supra* note 36, at 748-53; see also Solicitation of Safe Harbor and Special Fraud Alerts, 67 Fed. Reg. 72,894 (Dec. 9, 2002); see also OIG Draft Supplemental Compliance Program Guidance for Hospital, 69 Fed. Reg. 32,012, 32,023 (June 8, 2004). In the December 9, 2002, Federal Register the OIG raised several questions about the link between competitive credentialing practices and the anti-kickback law at the urging of the AMA. See Solicitation of Safe Harbor and Special Fraud Alerts, 67 Fed. Reg. 72,894 (Dec. 9, 2002). In the June 8, 2004, Federal Register the OIG advised hospitals to examine credentialing practices to insure that they don't run afoul of the anti-kickback statute, cautioning about the adoption of practices which link privileges to a particular number of referrals or procedures. See OIG Draft Supplemental Compliance Program Guidance for Hospitals, 69 Fed. Reg. 32,012.

83. Tom Gilroy & Susan Webster, *California Governor Signs Bill Spelling Out Medical Staff Self-Governance Rights*, 13 BNA HEALTH L. REP. 1 (Sept. 30,

to secure passage of SB 1325, which creates a statutory recognition that the medical staff is an independent identity, separate from the hospital, and this independent entity has a right of self-governance, including the right to sue.⁸⁴ While the governing boards in California hospitals still retain final authority over the institution, the board must respect the independence of the medical staff to craft its own bylaws, and largely relinquish control over developing standards for credentialing, privileging, and matters dealing with quality assurance. Although the board still has the power to approve medical staff bylaws, rules, and regulations, it cannot unreasonably withhold such approval, and failings in this area can result in court intervention in the form of an injunction or writ of mandate directed against the hospital. While the new California law is a firm articulation of how medical staffs and boards should relate to one another, making the medical staff a legally recognized independent entity with a right to sue is hardly an artful clarification of this relationship, as it raises several new issues.⁸⁵ For example, if the medical staff can sue a hospital as an independent entity, in turn the staff could be sued by the hospital, as well as by outside parties. In reference to the economic relationships between physicians and hospitals, it clearly confounds the ability of institutions to enter into exclusive contracts without significant input from the medical staff, and calls into question whether economics can ever be grounds for exclusion from a medical staff, constraints that may not be helpful in competitive markets. While much of what is present in SB 1325 comes from the *Community Memorial* dispute, the settlement in that case, as discussed, constitutes far less burdensome requirements, particularly the resort to litigation permitted, if not invited, by the California law. The passage of SB 1325 has been touted by the California Medical Association as a history-making recognition of medical staff self-governance and has been promoted by the American Medical Association around the country as a model to be followed by other states, but

2004).

84. CAL. BUS. & PROF. CODE § 2282.5 (Supp. 2005).

85. See Albert, *supra* note 77. See also *New California Law Permits Medical Staffs to Sue Hospitals*, HEALTH CARE UPDATE (Fulbright & Jaworski, L.L.P., Houston, TX), Oct. 7, 2004.

whether it can roll back the clock, and alter the market-driven changes in hospital-physician relationships remains to be seen.

Hospital boards, as noted, have resorted to using arguments that reinforce their economic fiduciary duty in disputes with physicians over business-related decisions impacting medical practice. Recently, however, the hospital lobby has been very actively engaged in fighting the growth of niche providers sponsored, in whole or part, by physician investors who retain privileges in general hospitals. As noted, the general hospital lobby sees the growth of niche providers generally as a form of “cherry picking” that will result in leaving traditional hospitals with unprofitable patients and services, further straining a troubled industry. Although it can be argued that such entities spark healthy competition and may be catalysts to spark improvements in community hospitals, such a view is far a field from that of the community hospital lobby. The acute care industry has proceeded on three fronts to combat the growth of competing niche entities, and like the medical lobby’s strategies, these efforts are highly protectionist in nature.

At the federal level the industry has succeeded in influencing the enactment of legislation in the Medicare Modernization Act, which places an 18-month moratorium on the use of the whole hospital exception.⁸⁶ The whole hospital exception is one that applies to the ban on self-referrals under the Stark II law, allowing physicians to make patient referrals to institutions in which they have an investment interest, a practice that is on its face illegal under the Stark II law. The federal advisory agency, Medpac, has recommended that the 18-month moratorium be extended, and the hospital industry is lobbying to make the ban on referrals to specialty hospitals by investor physicians permanent.⁸⁷ The moratorium, however, fails to touch physicians who are indirect investors in specialty hospitals, but even here, hospitals have sought to restrict privileges as demonstrated by a current lawsuit in

86. Medicare Program; Physicians’ Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II); 69 Fed. Reg. 16,053 (Mar. 26, 2004) (interim final rule).

87. MEDPAC, *Report to Congress: Physician-Owned Specialty Hospitals*, Executive Summary 4 (Mar. 2005)

Arkansas.⁸⁸ The second strategy being pursued to restrict niche providers deals with recalibrating reimbursement formulas and reducing payments for outpatient services, such as ambulatory surgery centers and other niche providers, making them less attractive as investment vehicles.⁸⁹ Thirdly, in some jurisdictions state certificate of need laws (CON) have been expanded to specialty hospitals and niche providers, and in one state currently debating the future of CON, it appears that the primary justification for retaining such a law is to protect the interests of community hospitals against the encroachment of specialty providers.⁹⁰

TOWARD A NEW RELATIONSHIP

At best the winners in the ongoing economic disputes between physicians and hospitals achieve pyrrhic victories. Hospitals that merely approach medical staff issues from a strict economic vantage point, or go so far as to actually take punitive measures against staff members whose practices compete with the institution, risk alienation of their medical staffs, and chart courses that could be counterproductive over the long term. Physicians, on the other hand, who invest in competing niche providers to which they channel well-reimbursed patients, may seriously jeopardize the fiscal health of the community

88. Michael Romano, *Round 3: Doc Privileges Fight Heating Up; Lawsuit in Arkansas*, MODERN HEALTHCARE 10 (Feb. 16, 2004).

89. MEDPAC, *supra* note 87 at Executive Summary 4, in which Medpac argues for changing reimbursement formulas in the context of niche providers. For a general discussion of how the federal government regulates the area of ambulatory surgery as a case in point of the extent of leverage the federal regulators have over this area see Scott Becker & Amber McGraw Walsh, *An Overview Of Federal Laws And Regulations Governing Ownership in and Reimbursement For Ambulatory Surgical Centers*, HEALTH CARE L. MONTHLY, Feb. 2005, at 3. Related to reimbursement are changes in the scope of procedures authorized by the feds which clearly have a dramatic impact on specialty providers as well; see David Glendinning, *Physicians Blast Medicare Plan to Curb Surgery Center Procedures*, AM. MED. NEWS (Feb. 14, 2005), at <http://www.ama-assn.org/amednews/2005/01/14/gvsa0214.htm>.

90. C. Lynn Fitzgerald, *Certificate of Need Reinstatement*, PHYSICIAN'S NEWS DIGEST (Dec. 2004), at <http://www.physiciansnews.com/cover/1204.html>; see also Illinois Hospital Association, *Report of the 2004 IHA Blue Ribbon Panel on Certificate of Need— The Problem: Access to Essential Health Care in Jeopardy* (Jan. 2005), at http://www.ihatoday.org/issues/cert_of_need/blueribbonrep.pdf.

hospitals where they are on staff. From a fundamental standpoint a hospital in which the medical staff is out of sync with the two other core parts, board and administration, is an organization whose effectiveness is compromised. Large current challenges, such as ongoing regulatory compliance, marketplace competition, and patient safety, cannot be dealt with efficiently in hospital environments in which the board/administration and the medical staff are working at cross purposes. In light of the profound internal and external changes and fiscal pressures faced by hospitals, and the straining relationships with physicians, it seems reasonable to argue that the traditional structure tripartite of the general hospital should be reshaped, in particular as it involves the hospital-medical staff relationship.

OBSERVATIONS

Before positing a model for reshaping the internal relationships of the hospital tripartite structure, three observations need to be made that flow from the prior discussion in this article. First, it seems clear that health care delivery will continue to be based on a free market system, and as such, competition with all its idiosyncrasies, is not likely to abate.⁹¹ Both hospitals and doctors will be forced to cope with increased financial pressures that will test mutual loyalties and cause further restructuring of the delivery system. Such restructuring will, in fact, be a sort of constant reality as competitive forces in the health care marketplace will be such that not all new ventures will succeed, causing further reconfiguration, as already seen in the world of niche provider entities.⁹²

Secondly, technology will continue to evolve in ways that will allow more hospital-based services to be either relocated outside of the inpatient setting, or to be configured in new and novel ways. While a certain degree of programmatic centralization will be present in the traditional hospital setting, what is considered the core compliment of inpatient services is likely to undergo frequent change with technological innovations. It seems

91. See generally HERZLINGER, *supra* note 3.

92. *Id.*

reasonable to predict that more and more inpatient care will be delivered in physician office settings, and that the development of such services will outpace regulatory control. Hospitals, in turn, will not only be the providers of inpatient and expanding out patient services, but may enter into the medical equipment business, leasing various technologies and space to medical staff members. It is possible to envision a scenario in which hospitals are structured as a type of medical mall, combining a series of core services with a range of specialty offerings, each of which may have a different ownership model.⁹³ At the extreme, it is possible to conceptualize the hospital as a condominium arrangement in which groups of physicians have ownership interests in respective departments and in turn, are contractually bound to the acute care facility.

Thirdly, perhaps the most apparent observation that can be made in the context of the evolving economic struggles between doctors and hospitals is that the two parties cannot easily function without the other. Clearly this mutual dependency is under stress from the reality noted, namely that more and more physicians can practice successfully out of hospital settings due to technological innovations. Still, a significant number of physicians require hospital affiliations, regardless of the viability of ambulatory medical practice, and some doctors, in fact, are highly supportive of the broader roles of community hospitals generally. Additionally not all physicians are entrepreneurial, and even those who are, are generally dependent on the management skills of laypersons to oversee their respective ventures. Hospitals, for their part, are clearly dependent on physicians for provision of services and referrals, but as this article demonstrates, the need for doctors exists in certain specialty areas only.⁹⁴ Also simultaneous to the growth of outpatient medicine, there is a growing trend on the inpatient side for hospitals to be staffed by full time attending physicians, hospitalists whose practices are focused on the most acutely ill individuals and

93. Kelly M. Pyrek, *Empowering Physicians One Center at a Time*, SURGICENTERONLINE (2005), at <http://www.surgicenteronline.com/articles/361feat1.html>

94. See PricewaterhouseCoopers, *Hospital/Physician Partnerships Are Key to Growth of Market Share*, available at <http://www.healthcare.pwc.com/st200305.html> (last visited Jun. 2, 2005).

are totally based in the institution.⁹⁵ While various dependencies exist between physicians and hospitals, the nature of these dependencies appears to be anecdotal, fluid, and hardly one-sided.

CONFRONTING TENSIONS: ARE THERE SOLUTIONS?

Recognition of the evolution and escalation of tensions in the relationships between medical staffs, their individual members and hospitals, and of the points noted in the three observations above, needs to be followed with a vision of how physician-hospital relations may be improved. Any solution must recognize that the respective actors are both pursuing strategies to allow them to be competitive, maximize income and hopefully enhance quality, and these goals will ignite a range of conflicts where matters of autonomy and economic viability are at issue. To diffuse tensions between doctors and hospitals compatible strategies and incentives must be aligned in a way that both parties stand to benefit from any given arrangement. Of course, it is unrealistic to assume in highly competitive delivery markets that the relations between physicians and hospitals can always be bettered, as competition may ultimately present insurmountable barriers to long term cooperation.

It can be argued that the market is such a powerful reality in American health care that ultimately, together with technology, it will continue to force a restructuring of hospitals that will further change relationships with medical staffs, foiled only temporarily by regulatory interventions. To a large extent, changes in the hospital world have occurred naturally via the unpredictable intersection of the many variables that make up American health delivery, and the continuing challenge of the regulators and accreditors is to keep pace with such changes, and craft new mandates that do not frustrate such market developments unnecessarily. On the other hand, it can be argued that health delivery is too important an area to be left to the vicissitudes of uncertain market forces, and

95. See e.g., Robert M. Wachter, *The Hospitalist Movement: Ten Issues to Consider*, 34 HOSPITAL PRAC. 95 (Jan. 15, 1999), at <http://www.hosppract.com/issues/1999/02/wachter.htm>.

legal/regulatory intervention are warranted to diffuse the escalating tensions between physician and hospital.

BLUE SKY, NOTHING BUT BLUE SKIES

Within the confines of an academic article there is a temptation to throw caution to the wind and recommend a more radical restructuring of the hospital and its three parts in order to strike a more workable balance between administration/board and medical staff.⁹⁶ For example, an idea could be posited to abolish the medical staff, making it a department, and thus pursue a hospital corporate model that would give management and board full control of the entity. A very different approach would be to empower the medical staff by abolishing the lay board system, and in essence place full control over the institution in the hands of the medical staff, making it the governing authority with full oversight over the business and quality aspects of the institution. Still another possibility would be to reorganize a community hospital as a joint venture arrangement, much like a specialty hospital, in which physicians and a management group would control the facility, and in structuring such a deal, decipher the respective roles and responsibilities of medical and administrative parties. Another idea, as noted previously, would be to convert hospitals into a collective arrangement of various core and specialty services, each with separate hospital – physician arrangements and possibility with distinct ownership akin to a type of condominium. Any of these proposed ideas would certainly require major alterations in state and federal law, as well as changes in accreditation standards that would pose challenges for public and private regulators who, to date, have not been overly creative in ways in which they have approached regulation of this sector. But, perhaps, the most difficult aspect of effectuating dramatic changes in hospital structures is to overcoming the strong opposition of entrenched lobby organizations in both the hospital and medical worlds who generally seek to promote their respective interests, usually by maintaining the status quo.

96. John D. Blum, *Feng Shui and the Restructuring of the Hospital Corporation: A Call for Change in the Face of the Medical Error Epidemic*, 14 HEALTH MATRIX 5 (2004).

THREE MODEST CHANGES

In approaching the challenges of facilitating a more cooperative relationship between doctors and hospitals, three possible changes come to mind, two of which are relatively modest, and seemingly ought not incur dramatic opposition and require massive regulatory revisions. First, the medical staff officers should automatically be given slots on the hospital board to formally bring these two parts of the institution together. The physician medical staff officers on the board would serve as any other trustees, and as such, assume the full responsibilities of this role, but could do so in a way that reflects the concerns of the physicians on staff. If nothing else, this relatively simple alteration of the board would help to diffuse some of the communication barriers that separate board/administration and medical staff. Secondly, hospitals should be required to have a business development committee (if such an entity does not currently exist) that can be used to devise short, and long-term institutional business strategies. The business development committee should be staffed jointly by members of both the medical staff and administration. One of the charges of such a committee would be to draft a hospital/medical staff development plan that details both inpatient and outpatient strategies for the institution, with a strong focus on the physician component on both the inpatient and outpatient side. Undoubtedly such transparency may come at a risk, and will not necessarily deter physician staff entrepreneurial behavior, but such transparency will, at the least, allow potential problems with business strategies to be openly discussed. Those states which retain health planning should require agencies involved to review the hospital/medical staff development plans as part of their CON review processes.

Third, the current relationship of hospital and medical staff member which is captured in the credentialing process may no longer be an adequate mechanism in which to join doctor and institution, and should be modified in favor of express contracts. Credentialing, at least indirectly, has gone beyond a pure quality review process, and in some cases has become a mechanism for the institution to apply fiscal measures to physician assessment, in a world where the lines between cost and quality are increasingly fuzzy. Perhaps the most significant change affecting credentialing

is that an increasing number of physicians, in addition to being credentialed via the medical staff bylaw process, now have some type of contractual arrangement with the acute care institution. The proliferation of exclusive contracts in specialty areas, together with practice acquisitions, the growth in the numbers of hospital employed specialists and now the expanding array of hospital-physician specialty programs have all contributed to a second tier of relationships beyond credentialing which bind doctor and hospital in a different, more business like fashion than traditional membership in a medical staff. It thus seems appropriate for all physicians on a medical staff to have an explicit contract with the hospitals in which they practice to detail the expectations of both parties in the quality and business sides of their relationship. Physicians will still need to go through the medical staff credentialing process, but that process would be folded into a given contractual agreement binding hospital and doctor. Protections for physicians could be built into contracts such as termination with cause provisions, and requirements for a hearing if agreements were not renewed, necessitating explicit delineation of the termination criteria. From the hospital standpoint conflict of interest policies could be spelled out, as well as reasonable, limited non-compete clauses for specialists in whose practices the hospital invests. Unlike the current ambiguity surrounding questions of whether hospital corporate and medical staff bylaws constitute contractual agreements, explicit contracts would avoid such uncertainties by setting out the terms of the doctor-hospital relationship, and such agreements could be tailored to fit individual situations. The presence of explicit contracts between physicians and hospitals should neither minimize the need for a medical staff organization as a collective voice for physician interests, nor, as pointed out, obviate the role of the medical staff in credentialing and quality matters, nor alter the fiduciary obligation of the board. It can be argued that explicit contracts are not only a more realistic way for hospital and physician to relate to each other, but can be a catalyst to raise a necessary awareness of all the variables that impact the viability of the parties. In a sense moving to individual contracts can be seen as part of the evolution of the hospital-physician relationship, and is a recognition that such relationships have reached a point of development where not all of the necessary issues (including quality and economic factors) that must be

addressed are reflected in either the hospital or medical staff bylaws. Undoubtedly the use of explicit contracts for all medical staff members will be resisted by both institutions and medical staffs as an erosion of the traditional tripartite structure, and will necessitate regulatory changes in areas such as licensure, accreditation and fraud and abuse requirements. It is unrealistic to expect that the existence of a specific hospital-physician contract will ameliorate all disputes (in fact contracts may spark new disputes), but the current system has only spawned increasing ambiguities and conflicts and is no longer workable in the business world of health care delivery.

CONCLUDING THOUGHTS

To return to the Nordstrom analogy presented in the introduction, there undoubtedly will be some who will take offense to comparing department stores and hospitals, arguing such a comparison fails to take into account the complexities and essential needs met by acute care institutions. Hospitals and the physicians who staff them provide highly complex and necessary professional services, and as such, there is a societal need to protect them against the forces of marketplace that are pushing this sector to become yet another commercially dominated enterprise. It can further be argued that a key role of law in this area is to assist in the preservation and enhancement of medical professionalism, and one way in which that can be done is through the protection of the self-governing medical staff. Medical staffs can be characterized as a vehicle to ensure that hospitals do not degenerate into collective units of health services, driven only by business forces such as competition and related consumer demands, devoid of any true overall vision or social responsibility. There is, of course, some merit in the sentiment just expressed, but the fact is that our society has chosen to provide health care services in a market setting, and in some fashion, it will be the behavior of the market that will continue to shape these services. Government may try on its own initiative, as a concerned payer, to stem the tide of certain market forces, or may intervene to alter given market developments in response to powerful political pressures. Still, with no clear vision as to how our health system should be structured,

the primary focus of government policy makers will continue to be rooted in managing and manipulating health care financing as a tool to control the delivery system, with the private market being the forum within which these policies are being effectuated. It may be overly harsh to conclude that health care delivery is just a matter of crass commercialism, but it is also short sighted to argue that the world in which the hospital structure evolved, with its internal tripartite arrangement, is still a current reality. Technology, regulation, and competition have all brought about changes in medical practice and in hospital operations that will only continue to evolve in new and unpredictable ways, and will move physicians and hospitals in different directions. The current controversies spawned in this new healthcare marketplace, pitting doctors against hospitals, will not be solved by buttressing traditional medical staff structures, but can best be addressed by realigning professional and business interests where possible through endorsement of more liberalized hospital structures, and if necessary the eventual dismantling of traditional arrangements.