

Hospital-Medical Staff Relations in the Face of Shifting Institutional Business Strategies: A Legal Analysis*

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I. BACKGROUND

Recent changes in healthcare, particularly in the financial arena, have had a profound impact on hospitals. Empirical studies and innumerable anecdotal accounts lead commentators to conclude that the American hospital is a troubled institution.¹ Between 1980 and 1989, low profit margins and competition for patients, physicians, and managed care contracts largely contributed to the closure of 698 hospitals.²

Deciphering the reasons for the current status of the American hospital industry is a challenging task. Clearly, multiple factors have affected, and continue to affect, acute care institutions. Elements contributing to the downturn of hospitals include the following: rising labor costs; the shifting focus from medical treatment to ambulatory care; the uncontrolled diffusion of new, high cost technology; and changes in reimbursement policies by both government and the private sector.³ Significant differences among hospitals by type and location further complicate the analysis of a hospital's economic posi-

* This Article will explore, from a legal perspective, the dynamics of the changing relationships between hospitals and their medical staffs. Specifically, the Article will discuss hospital strategies for maximizing the efficiency of their medical staff operations. In this regard, the discussion will encompass two general areas: (1) the use of agreements and policies that restrict access to medical staff membership; and, (2) the development of economic criteria to assess physicians for appointment and reappointment to medical staffs. Both of these general areas of discussion entail significant legal issues that have never been extensively explored and hold the potential to reshape the balance of hospital operations.

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1. Solovy, *Healthcare in the 1990s: Forecasts by Top Analysts*, HOSPITALS, July 20, 1989, at 34-36; Goldsmith, *Competition's Impact: A Report from the Front*, 7 HEALTH AFF. 162-73 (no. 43, 1988).

2. AHA HOSP. DATA CENTER, AM. HOSP. ASS'N, HOSP. CLOSURES 1980-89, A STATISTICAL PROFILE 6 (1990).

3. See *supra* note 1.

tion. These differences affect both the cause and the nature of the specific problems institutions face.

Their failure to serve a single constituency is an additional factor complicating the analysis of hospitals. Granted, a hospital's overriding mission is to provide patient care services. But, to successfully accomplish that goal and still remain fiscally viable, other parties must be considered. For example, hospitals compete for physician referrals. Thus, it is essential for institutions to attract and retain doctors on their staffs who will favorably impact the bottom line.⁴ In addition, hospitals serve government regulators, third-party payors, managed care plans, investors, donors, unions, community organizations, and others.⁵ The attempt to serve multiple constituencies has complicated hospital operations and has created uncertainty over what the primary objectives of an acute care facility should be.

As this environment within which hospitals function has changed, there also has been a related change in the manner in which acute care facilities are managed. The past twenty years have witnessed a growing professionalization of hospital management.⁶ Today's hospital executives are students of modern management. As a result, external and internal hospital operations reflect a growing level of business sophistication. One author has convincingly argued, that, in spite of severe economic pressures, hospitals in the 1990s are far more efficient than they have been in the past.⁷

While hospitals have undergone their own changes, signifi-

4. Millenson, *Hospitals Woo Doctors to Win Patients*, Chicago Tribune, Feb. 12, 1989, at 1, col. 1.

5. Stravic, *Market and Market Segment Portfolio Assessment for Hospitals*, HEALTHCARE MANAGEMENT REV. 25-32 (Summer 1989).

6. Longest, *The Contemporary Hospital Chief Executive Officer*, HEALTHCARE MANAGEMENT REV. 43-53 (Spring 1978).

7. Kaner, *Really Managing: The Work of Effective CEOs in Large Health Care Organizations*, HEALTH ADMIN. PRESS 1988. Clearly, management practices have had to change in response to regulation, accreditation, and more importantly, marketplace pressures. For instance, the dawn of hospital marketing is a direct reflection of the growth of competition. Additionally, implementation of more sophisticated management information systems is, in fact, a reaction to the DRB reimbursement system. For information on hospital marketing, see Clarke, ch. 13 to L. WOLPER & J. PINA, HEALTH CARE ADMINISTRATION (1987); see also Toplansky, *Physicians and Their Hospitals: A Marketing Partnership*, HEALTHCARE MANAGEMENT REV. 58-63 (Fall 1987). For information on the impact of DRGs, see Crawford & Fotter, *The Impact of Diagnosis Related Groups and Prospective Pricing Systems on Health Care Management*, HEALTHCARE REV. (1985). For information on hospital management information systems, see Brightbill, *Systems Departments Get in Shape for the Quality Weigh-In*, Healthweek Dec. 17, 1990, at 15, 18-19.

cant changes have also occurred in the organization of service delivery. Reorganization has resulted in the development of new and revised services, particularly in ambulatory and surgical care.⁸ Few of the changes in hospital operations have been either original or successful. But compared to the past, we have witnessed a high level of creativity and innovation as administrators struggle to meet the demands of multiple constituencies.

Interestingly however, in spite of the changes in hospital operations, the basic structure of the American hospital has not changed. The so-called "three-legged stool" of hospital organization, namely, the administration, the board, and the medical staff, still provides the primary, if not the only, model that underlies the core structure of acute care facilities.⁹ This structure, blessed by tradition and sanctioned by law, is rarely questioned. While the three-part structure may serve the interests of physicians, and to a some extent trustees, it is questionable whether, in the current economic climate, it always serves the best interests of the hospital corporation. From a management standpoint, the tripartite arrangement in practical terms means that administrators must always work through the medical staff and through the board to effectuate institutional changes.

Perhaps historically, the split among administration, board, and medical staff served to create a workable balance in which business issues could be separated from medical ones. However, in the current hospital milieu where facilities have become direct providers of service, it is more difficult to draw sharp lines between managerial and medical functions. As hospital management seeks to expand institutional health care roles and enter into new service areas, both individual physicians and the medical staff as a whole see their positions as being directly threatened.¹⁰

Despite their lack of control over society and governmental pressures, physicians have considerable power over hospitals by virtue of hospitals' dependence on them for economic

8. House, *A Forward Move in Medicine-Ambulatory Care*, NURSE MANAGEMENT 88, July 1989; see also Durant, *Ambulatory Surgery Centers: Surviving, Thriving into the 1990s*, J. OF MED. GROUP MANAGEMENT, 14-20 Mar.-Apr. 1989.

9. Johnson, *Revisiting the Wobbly Three-Legged Stool*, HEALTHCARE MANAGEMENT REV. 15-22 (1979).

10. McDermott, *The New Challenge: Organizing and Managing Physician Organizations*, 3 HEALTHCARE MANAGEMENT REV. 57-61 (1988).

survival.¹¹ Physicians have never seen hospitals as having control over their medical practices. Instead, they have viewed themselves as customers who are willing to take their business elsewhere if they aren't satisfied with conditions in a particular institution.¹² From a legal standpoint, common law, statutory law, and the Joint Commission on Accreditation of Health Organizations ("JCAHO") accreditation standards, buttress the medical staff as a self-governing entity, and give physicians collectively even more leverage against the hospital.¹³

Governing boards also have tended to side with physicians, viewing them as "surrogate customers" of the institution. Consequently, they are cautious in adopting policies that alienate medical staffs.¹⁴ Generally, when hospital administrators and the medical staff disagree, the board tends to side with the latter group. Historically, hospital trustees have been relatively uninvolved in the details of either administration or medical affairs.¹⁵ Thus, although there has been some shift in trustees' roles as the enterprises they oversee have become increasingly complex, it seems unlikely that greater involvement will move boards toward a closer allegiance with administrators. While skillful executives may be able to "manage" their boards, it would be rare for a hospital CEO to have the same influence over a hospital corporation as his counterpart in industry.

The optimal situation is one in which the hospital and its medical staff are able to work in sync by reaching a consensus about future directions. The pressures of the current environment make it difficult for hospital management and medical staff to develop an agenda that simultaneously promotes institutional interests and protects physician autonomy and medical staff status quo. All too often, it appears that management and medical staff are working at cross purposes, and may in fact be pursuing courses that conflict. The challenge faced by hospital managers is to make and implement sound business strategies within the constraints of the hospital's corporate structure. By and large, the key challenge of hospital administration is to

11. Shortell, *Economic Regulation and Hospital Behavior: The Effects on Medical Staff Organization and Hospital-Physician Relationships*, HEALTH SERVICES RESEARCH Vol. 20, No. 6, Dec. 1985.

12. See Johnson, *supra* note 9, at 18-19.

13. *Id.*

14. *Id.* at 16-17.

15. Meighan, *Hospital-Physician Relationships: Some Factors Beneath the Surface*, MED. STAFF COUNSELOR 48, 50-51, Summer 1987.

work with the medical staff in a constructive manner and to pursue options that will insure institutional survival.

Hospitals have implemented a number of strategies to create unity with their medical staffs.¹⁶ For example, some have attempted to facilitate better working relationships by expanding hospital boards to include more physician representatives. Similarly, many institutions have created positions for corporate medical directors to act as liaisons between management and doctors.¹⁷ A more complex way of fostering unity is through the myriad of joint venture arrangements between hospitals and medical staffs which act to align the economic interests of the parties.¹⁸ Still other institutions utilize hospital recruitment and staff development to attract and retain physicians who will benefit an institution financially.¹⁹

Beyond joint efforts with medical staffs, hospital managers are exploring arrangements that are mutually beneficial with one or more physician staff members. Hospitals commonly enter into exclusive contracts for certain core hospital services such as radiology or pathology, or for specialized surgical services that require considerable capital investment.²⁰ The exclusive contract is a way for a hospital to establish greater control over the service in question, to enhance efficiency and quality, and to restrict the provision of services to those physicians whose practices are cost effective.

Related to exclusive contracting, some hospitals simply decide to close membership in one or all departments.²¹ Another practice, often divisive to medical staffs, that is motivated strongly by economics, involves appointment and reappointment processes that utilize economic efficiency measures. Finally, peer review programs which focus increasingly on

16. Smith, Reid, & Piland, *Managing Hospital-Physician Relations: A Strategy Scorecard*, 15 HEALTHCARE MANAGEMENT REV. 23-33, No. 4 (1990).

17. Betsen, *Physician Managers: A Description of Their Job in Hospitals & Health Services Administration*, J. OF AM. COLLEGE OF HEALTH EXECUTIVES 353-69, Fall 1989.

18. Gleason & Sullivan, *Physician-Hospital Joint Ventures Addresses Mutual Needs*, 67 HEALTH PROGRESS at 55-67, Dec. 1986.

19. Wedig, *Physician Bending: Nice or Necessary*, HOSPITAL STRATEGY Report 1, 5-7, Feb. 1989; see also Dismike, *Maximizing Physician Recruitment Efforts in Today's Competitive Environment*, MEDICAL STAFF COUNSELOR 43-49, Summer 1989.

20. Holthaus, *Enter Exclusive Contracts for Right Reasons*, HOSPITALS 63, Apr. 20, 1989; see also Scott, Chenin, *Exclusive Contracts and Hospital Privileges*, THE MED. STAFF COUNSELOR 1-7, Winter 1989.

21. *Closed Medical Staffs* 38 TRUSTEE 58, Sept. 1985.

practice efficiency measures can be a threat to physicians.²²

Clearly, avenues followed by hospital management that threaten medical staffs' independence, even if they are economically compelling, are subjects of considerable controversy. Individual medical staffs and organized medicine traditionally have pursued various strategies geared toward optimizing the financial position of physicians and, more importantly, protecting autonomy.²³ Medical staffs threatened by aggressive hospital management have sought outside legal representation and, when they felt it necessary, have mounted legal challenges. Some medical staffs have formed independent associations and conduct themselves akin to bargaining units.²⁴ With the expansion of hospital efforts to increase the economic efficiency of physicians, there has been a notable strain placed on institutional-medical staff relations.²⁵

While it is beyond the scope of this Article to present a detailed exploration of the legal status of a hospital medical staff, some explanation is in order. A medical staff is a type of unincorporated association whose legal framework has been shaped primarily by state law.²⁶ By and large, state laws require that hospital medical staffs be self-governing entities within a hospital corporation.²⁷ According to the JCAHO, a medical staff is the entity which has overall responsibility for the quality of professional services, and as such, controls physician staff appointments, reappointments, delineation of privileges and a variety of peer review processes (i.e., surgical review, drug use evaluation, clinical record review).²⁸

Medical staffs have become powerful and unique entities as a result of several factors in the development of hospitals.

22. Hershey, *Medical Staff and Hosp. Accountability*, MED. STAFF COUNSELOR 1-7, Winter 1989.

23. *Id.*

24. Pearlman, *Carlisle Hospital Medical Staff Incorporates*, PENNSYLVANIA MED., May 1984; see also Chenin, *The Incorporated Medical Staff—An Old Solution to a New Problem*, MED. STAFF COUNSELOR, 42-47, Summer 1987.

25. Johnson, *CEO's Support Tougher Physician Screening Criteria*, HOSPITALS 60, June 5, 1990; see generally MEDICAL STAFF SECTION, JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS 1991 [hereinafter JCAHO ACCREDITATION CRITERIA].

26. Nodzanski, *A Critical Analysis of the Self-Governing Medical Staff* (to be published) — OKLA. L. REV., —, 1991 (in press).

27. See JCAHO ACCREDITATION CRITERIA, *supra* note 25, at 99; see also JOINT TASK FORCE REPORT ON HOSPITAL MEDICAL STAFF RELATIONSHIPS OF THE AMA AND AHA (1985).

28. See JCAHO ACCREDITATION CRITERIA, *supra* note 25.

Historically, hospitals were viewed as custodial facilities, shells in which medicine was practiced, and hospital administration only had authority to manage the business side of the operation.²⁹ Reinforcing this separation was a doctrine banning the corporate practice of medicine which created a legal barrier against a hospital directly providing medical care.³⁰ Against this legal background of constriction in the hospital role, the organized medical staff developed, and its role was incorporated into law and accreditation standards. While the legal realities that existed when the medical staff structure evolved have dramatically changed, the core structure of a hospital, as mentioned, has not been fundamentally altered. But as also noted, there are significant, current pressures on the medical staff structure that call into question its long-term viability.

II. RESTRICTING ACCESS TO THE MEDICAL STAFF

Statistics on medical staffs are not particularly good. Consequently, it is difficult to gauge how many hospitals have developed policies which allow for closed departments, or have entered into exclusive contracts for specialty services. Anecdotal evidence leads one to conclude that such policies are not uncommon. There are various reasons for limiting access to a medical staff through closure of a department or through exclusive arrangement. The primary factors motivating such limitations revolve around economics and quality of care. More specifically, the reason usually given for limiting medical staff membership is the increased profit from having the best physicians available to perform certain services. In addition, restrictions on staff membership are buttressed by the need to run a more efficient operation in that open staffing often makes scheduling and coordination of patient care difficult. Also, physical restrictions in a given facility may make it difficult to accommodate more staff.

While a hospital may benefit from limiting staff in a particular area, and physicians generally recognize the need to do so, such arrangements can be divisive. Those physicians who are parties to exclusive agreements or who are members of closed departments clearly stand to gain financial advantages

29. A. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* 346 (1978).

30. Wiorek, *The Corporate Practice of Medicine: An Outmoded Theory in Need of Modification*, 8 *J. OF LEGAL MED.* 465 (1987).

at the expense of other practitioners. Hospital-imposed limitations on staff membership are often viewed as arrangements that circumvent medical staff credentialing authority in that such restrictions shift staffing decisions to hospital management.³¹ Where an exclusive contract results in a limitation on staffing in a specialty area, the arrangement will make staff privileges moot for those specialists not included in the respective contract.

Limitations on staffing, whether in the form of exclusive contracts or closed department arrangements, are clearly inter-related strategies. However, from a legal standpoint, the nature of the challenges against medical staff restrictions are virtually identical, regardless of the arrangement in question. Physicians injured by exclusive contracts or closed department staff policies have argued that such arrangements violate due process rights, constitute a breach of contract, or constitute a tortious interference with practice. In addition, restrictions on access to medical staff membership raise the specter of anti-competitive behavior, and as such, are subjects of antitrust challenge. Several cases, discussed below, have dealt specifically in these various ways with the problems of medical staff restrictions.

Of the recent cases challenging closed medical staff department policies, one of the most noteworthy is the New Jersey Supreme Court decision in *Desai v. St. Barnabas Medical Center*.³² *Desai* is important not only because it is one of the few state supreme court opinions in this subject area, but it comes from a court that has established a tradition of leadership in the area of hospital law.

The *Desai* case arose out of a hospital's response to a problem of overcrowding and overutilization. In 1969, St. Barnabas Medical Center, a 705-bed hospital, adopted a closed staff policy restricting the admission of new physicians onto its staff.³³ The St. Barnabas policy was not an absolute ban, as new staff could be admitted if one or more of six criteria were met. The specific criteria included the following: a need for the specialty, available hospital space, a special expertise, the specialty in question not currently represented, lack of privileges elsewhere, and the fact that the applicant was joining the practice

31. See *supra* note 20.

32. 103 N.J. 79, 510 A.2d 662 (1986).

33. *Id.* at 84 n.1, 510 A.2d at 664.

group of a physician on staff.³⁴ The trial court found that association with a current staff member was the key factor in determining a new applicant's success.³⁵

In July of 1978, Dr. Mahesh Desai, a board certified internist and gastroenterologist, applied for staff privileges at St. Barnabas. The hospital rejected Desai's application. The hospital stated that the facility lacked sufficient beds, and that the applicant did not add any new skills to the hospital staff. The plaintiff resubmitted his application on three occasions, and was turned down each time for the same reasons. Eventually, Desai sued, alleging that the hospital's criteria which limited access to staff membership were arbitrary and capricious and thus illegal.

In analyzing the plaintiffs' claim, the New Jersey Supreme Court found extensive state judicial and legislative authority supporting a wide range of hospital discretion in managing its affairs, including medical staff appointments. The court found that institutional discretion is checked by a hospital's obligation to act as a public fiduciary.³⁶ As such, the *Desai* court held that if hospital management decisions reasonably serve public health purposes, they should not be overturned.

The state supreme court analyzed the St. Barnabas staffing limitations under the litmus test of reasonableness. The court concluded that in spite of legitimate disagreement over whether there was overcrowding at the hospital, the institution's decision to limit medical staff membership was appropriate.³⁷ The court did not agree, however, that the exception to the staff closure policy based on association with a current staff member was a reasonable way to foster the public's health.³⁸ Rather, the *Desai* court saw the association exception as a form of discrimination that the hospital was not able to justify with any competent evidence, and thus, it failed to meet the standard of reasonableness.

As noted, the decision in *Desai* comes from a court that is among the most active in the nation in the area of hospital law. While the public fiduciary analysis of the New Jersey courts is unique, *Desai* is a significant case in establishing rather broad

34. *Id.*

35. *Id.* at 95, 510 A.2d at 670.

36. *Id.* at 88, 510 A.2d at 668.

37. *Id.* at 94, 510 A.2d at 669, 670.

38. *Id.* at 95-97, 510 A.2d at 670-71.

parameters within which hospitals can make decisions to limit staff membership. The New Jersey Supreme Court's reluctance to meddle in a hospital's internal affairs is a common judicial reaction. As long as a legitimate rationale can be identified for policies that restrict medical staff membership, courts will hesitate to intervene even if individual physicians are hurt by such policies.

Clearly in *Desai*, St. Barnabas crossed the line of reasonableness by allowing a loophole in its staff restriction policies that only served to foster the economic interests of its current staff members and not the public policy interests that underlie hospital operations in New Jersey. Interestingly, while the other exceptions developed by St. Barnabas appeared to be acceptable on public policy grounds, each of those exceptions, individually and collectively, could mask underlying economic motivations. As a result, they could actually have nothing to do with fostering the public good. For example, the exception allowing physicians with privileges in no other facilities to be granted appointment can be seen not only as a publicly motivated gesture, but also as a way to selectively foster an exclusive alliance with physicians whose loyalty may yield financial benefit to the institution.

In California, the other state court system that has developed an extensive body of hospital law, medical staff challenges against hospitals have been a frequent subject of litigation. The position of the California courts towards closed medical staff policies was articulated in the 1978 appellate court opinion of *Lewin v. St. Joseph's Hospital of Orange*.³⁹ Plaintiff, Dr. Lewin, had sought privileges in St. Joseph's chronic hemodialysis facilities. Dr. Lewin was rejected, not because he lacked qualifications, but rather because the hospital ran the unit as a "closed staff" operation. Lewin sued, arguing that the institution's policy interfered with his ability to practice medicine, and further, that the hospital had acted in an arbitrary manner not supported by evidence.⁴⁰ The trial court agreed with Lewin's contentions, but the opposite conclusion was reached at the appellate level. The appellate court was impressed by the fact that the hospital's executive committee had carefully considered the question of an open versus a

39. 82 Cal. App. 3d 368, 146 Cal. Rptr. 892 (1978).

40. *Id.* at 380, 381, 146 Cal. Rptr. at 899.

closed staff in a hemodialysis unit.⁴¹ There was adequate evidence demonstrating that a closed staff was the preferred option from both an administrative and a quality of care standpoint. The court found particularly persuasive the fact that the closed staff policy was allowed for services to be provided at lower costs.⁴² Moreover, plaintiff Lewin did not question the efficiency and quality of the hemodialysis unit; in fact, he was attracted to it because of its reputation and felt that it should have been an open staff unit.

The appellate court in *Lewin* resolved the legal controversy by assessing whether the institution's governing body had the authority to adopt a closed departmental policy. Based on precedent, the court concluded that hospital boards could limit access to a medical staff.⁴³ The *Lewin* court's assessment of the hospital's decision to close the hemodialysis unit as a socially responsible decision tipped the balance in favor of the hospital.⁴⁴ In addition, the injury to Dr. Lewin's practice was very minimal because he held multiple hemodialysis privileges elsewhere.

If Lewin had no other practice options and if the hospital had intentionally hindered his practice, the plaintiff doctor may have had a viable case. However, the court indicated that as long as the hospital acted lawfully, with adequate justification, the institution's right to maintain a closed staff policy would be protected, even if the adverse effect on Lewin had been more severe.⁴⁵ In effect, the *Lewin* court's position requiring proof of institutional policy justifications is quite similar to that articulated in *Desai*. Although *Desai* rests on a concept of public policy, the California court's acceptance of a hospital policy that is reasonable from a business standpoint fits within a similar analysis of fiduciary obligations.

While exclusive contracts are very closely related to closed staff policies, there are differences. A closed staff policy is typically motivated by an oversupply of physicians which occurs as a result of physical limitations in a particular facility. As a management tool, closing an entire department or staff may be a rather harsh measure, although it may appeal to medical staff as a way to stem competition. It is possible to reach the

41. *Id.* at 389, 146 Cal. Rptr. at 905.

42. *Id.*

43. *Id.* at 391, 392, 146 Cal. Rptr. at 907.

44. *Id.* at 390, 146 Cal. Rptr. at 906.

45. *Id.* at 391, 392, 146 Cal. Rptr. at 906, 907.

same outcome in a more selective fashion by restricting the granting of new privileges in a particular area. Thus, exclusive contracting is a more targeted way to reduce the size of a medical staff. While the primary motivation behind exclusive contracting is quality, it also insures that only cost-effective specialists in certain areas (i.e., radiology, pathology, anesthesiology, surgery) practice in a particular facility. Additionally, from a business standpoint, it affords management with an additional level of control, beyond credentialing.

In the area of exclusive contracts, the New Jersey Supreme Court decision of *Belmar v. Cipolla*,⁴⁶ which predated *Desai*, provides an instructive example of how the courts have viewed such arrangements. In *Belmar*, two anesthesiologists challenged an exclusive contract between an anesthesia group and a hospital parent corporation, Community Hospital Group Inc. of J.F.K. Community Hospital. The plaintiff physicians argued that the exclusive contract entered into between the defendants and the Community Hospital Group was illegal in that it violated New Jersey public policy and also violated the state's antitrust laws.⁴⁷

The facts underlying the challenge in *Belmar* unfolded over the course of several years. For the sake of administrative efficiency, the Community Hospital board decided to operate the department of anesthesiology under an exclusive contract. The contract was awarded to a partnership of three physicians who employed Dr. Belmar as an anesthesiologist for ten years. The arrangement with the plaintiff ended as he and two other physicians formed a second partnership. The hospital trustees intervened, voting to continue the contract with the original group, thus excluding the plaintiffs from performing anesthesia services at the hospital.

Analyzing whether or not exclusive contracts violated public policy, the New Jersey Supreme Court followed a line of reasoning identical to that it would later adopt in *Desai*, namely, that hospitals are institutions that will be judged on whether they act in the public's interest.⁴⁸ Following prior cases and New Jersey statutory law, the *Belmar* court concluded that an institution could not arbitrarily exclude quali-

46. 96 N.J. 199, 475 A.2d 533 (1984).

47. *Id.* at 212, 475 A.2d at 540.

48. *Id.* at 208, 475 A.2d at 538.

fied physicians from hospital medical staffs.⁴⁹ On the other hand, the court recognized, as have other New Jersey courts, the need to give the hospital administration wide discretion in managing the internal affairs of the institution, including staffing. In reconciling public interest concerns with managerial discretion, the court stated that hospital actions in entering into an exclusive contract were reasonable and motivated by a desire to insure quality medical care.⁵⁰ The court rejected the argument that exclusive contracts violated public policy and saw the limitation on staff access for other anesthesiologists as an appropriate management decision.

The plaintiff physicians argued that the exclusive contract constituted an illegal tying arrangement resulting in a *per se* violation of New Jersey antitrust law.⁵¹ Their allegations posited that the Community Hospital Group had unlawfully tied the sale of other hospital services, particularly surgery, to the sale of anesthesiological services. The New Jersey court relied heavily on the U.S. Supreme Court opinion of *Jefferson Parish Hospital District No. 2. v. Hyde*⁵² in analyzing the plaintiff's claim. According to the Supreme Court, the key factor underpinning illegality in alleged hospital tying arrangements in a *per se analysis* is proof that the hospital employed its market power to force patients to use an unwanted anesthesiologist in order to obtain needed hospital services.⁵³ Arguing that the *per se analysis* should be abandoned in favor of weighing the issues of economic impact and potential benefits of the tie-in, Justice O'Connor in *Hyde*, questioned whether the relationship between surgery and anesthesiology was a tie-in.⁵⁴ Justice O'Connor correctly pointed out that surgical patients rarely request specific anesthesiologists.⁵⁵ Further, she argued that even if such a relationship was a tie-in, there is no evidence that it has adverse effects on patients.⁵⁶

The *Belmar* court concluded that the antitrust claim was not a *per se* violation, but rather that under a rule of reason, the competitive and anticompetitive impacts had to be assessed.

49. *Id.*

50. *Id.* at 211, 475 A.2d at 539.

51. *Id.* at 212, 475 A.2d at 540.

52. 466 U.S. 2 (1984).

53. *Id.* at 9-18.

54. *Id.* at 43-44 (O'Connor, J., concurring).

55. *Id.* at 44 (O'Connor, J., concurring).

56. *Id.* at 43-44 (O'Connor, J., concurring).

The plaintiff had not produced conclusive evidence defining the market area for anesthesiological services, nor was there evidence about how the exclusive contract affected consumers' demand for specific anesthesiologists. Even if JFK Hospital had increased the number of anesthesiologists, the court noted that it wasn't clear whether patients would actually be able to exercise a wider range of choice.⁵⁷ The evidence of anticompetitiveness flowing from a tie-in at JFK was not strong enough to warrant a violation of antitrust law under a rule of reason test, and consequently, the plaintiff physicians' claim was rejected.

Recently, the California courts have been confronted with legal challenges against physician contracts that severely limited non-party physicians' ability to practice in a particular facility. In the most noteworthy of the recent exclusive contracting cases, *Redding v. St. Francis Medical Center*,⁵⁸ the plaintiffs, two cardiac surgeons, challenged a hospital's decision to enter into an exclusive contract for heart bypass surgery with one surgeon, who was responsible for directing and staffing the program. The plaintiffs' complaint alleged breach of contract, breach of good faith and fair dealing, negligence, negligent interference with prospective economic advantage, interference with present and future contractual rights and professional relationships, and unfair competition.⁵⁹

Both plaintiff physicians in *Redding* had been active staff members at St. Francis for a number of years and had performed the majority of coronary bypass surgeries in the hospital. In 1986, the hospital's executive committee became concerned about the unacceptably high mortality rates in bypass surgery. Quality problems were identified in the unit, and after studying the problem, the hospital concluded that the open staffing policy in the bypass area was the cause. The hospital did not question the clinical performance of either plaintiff. However, each physician did refuse to direct a closed bypass program because both surgeons wanted to maintain multiple hospital privileges.

Following the reasoning of the *Lewin* court, and of other courts deciding related California hospital cases, the *Redding* Court recognized that a physician's relationship with a hospital could only be interfered with for a legitimate reason (i.e. qual-

57. *Belmar v. Cipolla*, 96 N.J. 199, 218-19, 475 A.2d 533, 543 (1984).

58. 208 Cal. App. 3d 98, 255 Cal. Rptr. 806 (1989).

59. *Id.* at 100, 255 Cal. Rptr. at 807.

ity, managerial efficiency).⁶⁰ In fact, the California courts have elevated medical staff privileges to the level of a protectable property right.⁶¹ Still, the California courts have allowed hospitals to enter into exclusive contractual arrangements. And, as noted in *Redding*, such arrangements would only be set aside if they are found to be irrational, unlawful, contrary to public policy, or procedurally unfair.⁶²

While the *Redding* court agreed with the plaintiffs that their privileges were property rights, it did not endorse the argument that years of staff membership gave the plaintiff surgeons a vested, permanent right to practice at St. Francis. On the contrary, the court concluded that it would be detrimental to patients and to society to prevent hospitals from making reasonable management decisions by giving physicians a vested or permanent interest in indefinite continuation of hospital staff privileges.⁶³ The court reasoned that a better approach would rest on a traditional balancing of conflicting interests.⁶⁴ Balancing the interests of the parties, the *Redding* appellate court, as the trial court, concluded that the hospital's desire to improve quality, particularly to reduce mortality rates, outweighed any potential adverse economic impact on physicians.⁶⁵ The court ruled in favor of St. Francis and indicated that the record demonstrating a need for change in the bypass area was strong enough to support the institution's decision. The court also indicated that failure to allow the hospital to enter into an exclusive contract would amount to a violation of public policy.⁶⁶

The issue of the legality of a hospital's exclusive contract was again reviewed by a California court in the case of *Mateo-Woodburn v. Fresno Community Hospital (FCH)*.⁶⁷ Up until 1985, the FCH department of anesthesiology was run on an open staff basis, allowing anesthesiologists to have their pick of cases on a rotating basis. The hospital was concerned about the inefficiencies of such a system and its adverse impact on quality. Consequently, subsequent to a medical staff recommenda-

60. *Id.* at 103, 104, 255 Cal. Rptr. at 809.

61. *Id.* at 105, 255 Cal. Rptr. at 810.

62. *Id.* at 104, 255 Cal. Rptr. at 809.

63. *Id.* at 106, 255 Cal. Rptr. at 810.

64. *Id.*

65. *Id.*

66. *Id.* at 108, 255 Cal. Rptr. at 812.

67. 221 Cal. App. 3d 1169, 270 Cal. Rptr. 894 (1990).

tion the hospital created a task force to study the possible closure of the anesthesia department. A series of meetings were held in which the pros and cons of closing the anesthesia department were publicly considered, after which the hospital's board adopted a proposal endorsing departmental closure. In June of 1985, FCH entered into an agreement with anesthesiologist Haas that allowed his professional corporation to have exclusive control over the department. This agreement enabled him to subcontract with other medical staff anesthesiologists who belong to the medical staff. Five anesthesiologists, all highly qualified members of the FCH staff, refused to sign a contract with Haas and challenged the legality of the hospital arrangement.

The plaintiffs in *Mateo-Woodburn* complained that the exclusive contract for anesthesiology deprived them of their fundamental and vested right to practice.⁶⁸ Drawing on California precedent, the appellate court concluded that a hospital board can make a legislative or administrative decision to close membership in a department, as long as such conduct is the result of a rational policy and isn't an attempt merely to exclude a particular type of physician. The *Mateo-Woodburn* court viewed reorganizing services, in this case, anesthesiology, as a reasonable management decision, particularly in view of evidence demonstrating serious problems in the department.

The plaintiffs raised several arguments, one of which asserted that the hospital could not reorganize a department without having the medical staff amend its bylaws. In addition, plaintiffs argued that enabling the exclusive contractor, Haas, to subcontract with other anesthesiologists was an illegal delegation of medical staff authority to make appointments.⁶⁹ The court rejected both contentions, pointing out that Haas did not involve himself in issuing credentials but limited his contractual agreements to anesthesiologists who had staff appointments.⁷⁰ Secondly, the court reiterated a fundamental principle of hospital law that while a medical staff has the power to make appointment-reappointment recommendations, the actual appointment decision is made by the institution's board of trustees.⁷¹ Further, the *Mateo-Woodburn* court

68. *Id.* at 1182, 270 Cal. Rptr. at 900-01.

69. *Id.* at 1188, 270 Cal. Rptr. at 905.

70. *Id.*

71. *Id.*

strongly endorsed the right of hospital management to eliminate organizational deficiencies by making changes in the interests of safety, efficiency and quality care.⁷²

In balance, review of case law dealing with exclusive contracts shows that decisions to close departments and medical staffs have been upheld by the courts. It appears that as long as there are legitimate business or quality of care reasons to limit access to medical staffs, those decisions by hospital management will be upheld. Clearly, scenarios could be constructed in which exclusive arrangements breach contracts, constitute tortious interference or violate antitrust law, but such situations would be unusual. One issue not dealt with here concerns the relationship between exclusive contracts and the ability of physicians to retain medical staff privileges once their hospital agreements are terminated; this area ought to be dealt with in the language of the respective contract, but on occasion is not.⁷³

III. THE REVERSE KICKBACK

An emerging and still novel issue in exclusive contracts concerns the impact of the Medicare Fraud and Abuse law⁷⁴ on such arrangements with hospital based specialists. Under the Medicare-Medicaid Anti-Kickback Law,⁷⁵ Congress created a very broad proscription against knowingly and willfully offering, paying, or soliciting any remuneration for patient referrals. The law is fairly expansive, and judicial interpretation has made it clear that violations do not need to be intentional, nor can the alleged violations be justified by arguing that other legitimate factors are present.⁷⁶ To help providers navigate the shoals of this rather nebulous law, the Department of Health and Human Services ("DHHS") is creating so called "safe harbors" that will give some guidance as to what practices are acceptable, at least in a general sense.⁷⁷ But until the safe

72. *Id.*

73. See *Alfredson v. Lewisburg Community Hospital*, No. 01-S-019002CV00022 (Tenn. March 4, 1991) (WESTLAW, Tenn. library).

74. 41 U.S.C. §§ 51-58 (1988).

75. *Id.*

76. For a detailed discussion of the judicial interpretations of the Medicare Anti-Kickback Law, see Department of Health & Human Services, Departmental Appeals Board, Civil Remedies Division, In the Case of *Inspector General v. Hanlester Network*, No. C-186 through C-192, No. C-208, and C-213, 6-11, (May 8, 1990).

77. 54 Fed. Reg. 3088 (to be codified at 42 C.F.R. § 1001) (proposing regulations dealing with safe harbors to implement section 14 of PL100-93).

harbors are issued there remains great ambiguity in the area.

In reviewing the anti-kickback law, and the controversies and concerns over its application, it seems clear that the primary pattern of violation that the law anticipates falls into the physician "gatekeeper" model.⁷⁸ The government is concerned about checking those arrangements that reward physicians for referring Medicare-Medicaid patients to a particular institution. Exclusive contracting raises a reverse scenario in which a hospital based specialist receives referrals from the institution, and in turn, is required to remunerate the hospital in some fashion for obtaining business. While the reverse kickback situation is not a primary focus of the law, it nevertheless appears to fall within the ambit of the statute.⁷⁹

Review of the literature dealing with exclusive contracts indicates a common practice among hospitals to require certain payments by hospital-based practitioners (anesthesiologists, radiologists, pathologists) as a condition of the exclusive arrangement.⁸⁰ The payment requirements could entail charges for rent, depreciation of equipment, maintenance fees, housekeeping, franchise fees, administrative services, charitable payments or payments for specific services. The key issue in determining whether or not there is a statutory violation concerns assessing the fair market value of the charge.⁸¹ It is possible that a particular payment may be quite reasonable, in keeping with the hospital's need to recover costs and to obtain a return on investment. On the other hand, if the hospital's charges exceed the value of their service there may be a violation of the Medicare law. Additional questions concerning whether the services are needed, and whether such payments are required of other physicians would also have to be addressed. Those situations in which a percentage of profit or billing over a certain level must be paid by the exclusive contracting specialist raise the most likely scenarios for government challenge.

78. Tarine, *Hospital-MD Contracts: Fair Deals or Kickbacks?*, AMERICAN MEDICAL NEWS, March 16, 1990.

79. *Opinion Letter of the Office of Inspector General DHHS*, Sept. 26, 1989.

80. For example, see Tarine, *supra* at n.78; see also Freudenheim, *Hospitals Battling Specialists Over Revenues Testing*, New York Times, at A1, col. 1., July 6, 1990.

81. See *supra* note 76.

A. Pending Cases

There are currently two cases pending in which violations of the Medicare Anti-Kickback Law have been raised in the context of exclusive contracts. In the case of *Virginia Radiology Associates v. Culpeper Memorial Hospital*,⁸² a group of radiologists recently brought suit against a hospital for ending their ten year exclusive arrangement with the institution. The complaint alleges a breach of contract and a violation of Virginia antitrust law.⁸³ While the suit is not a private attempt to enforce the Medicare Anti-Kickback Law, the radiologists' contention that they were required to purchase unnecessary and illusory services to retain their contract raises the question of improper kickbacks. In fact, Culpeper Memorial Hospital has been the subject of a federal investigation of the radiologists' contractual arrangements.⁸⁴

If the Virginia court agrees with the radiologists' contention that the contractual requirement to pay Culpeper 50% of the group's billings over a set dollar amount violates the Medicare law, it would go a long way to bolstering the physician's case. The hospital, in turn, does not deny that it has established financial requirements that must be met by the contracting party. Rather, it argues that such requirements are legitimate management charges.⁸⁵ The outcome of the Virginia Radiology Associates's challenge probably will significantly affect future cases. The requirements that Culpeper incorporated into its exclusive contract are not uncommon, and so the court's reading of them will help other institutions in crafting such arrangements.

In the case of *U.S. v. Kensington Hospital*,⁸⁶ recently filed by the U.S. Justice Department, the government claimed that the hospital and others associated with it had engaged in a number of illegal activities violating the Anti-Kickback Law. Among the series of alleged violations are four allegations that a pathologist, radiologist, dentist, and a group of anesthesiolo-

82. *Virginia Radiology Associates v. Culpeper*, No. 90-L-172 (Circuit Court of Culpeper County, Va., filed Aug. 8, 1990). See also Perry, *Overpriced Billing Services May Break Anti-Kickback Laws*, MODERN HEALTHCARE, July 30, 1990.

83. *Culpeper*, No. 90-L-172.

84. Perry, *Virginia Legal Battle Highlights Unrest Between Hospitals, Physicians*, MODERN HEALTHCARE, Sept. 17, 1990, at 34-36.

85. *Id.*

86. *U.S. v. Kensington Hosp.*, No. 90-5430, (E. Dist. Pa., filed March 13, 1991). See also McCormick, *Kickback Law Used in Hospital Probe*, AM. MED., Jan. 28, 1991, at 5.

gists were required to pay kickbacks to the hospital as a condition of their exclusive contracts with Kensington.⁸⁷ On the basis of the information presented in the Justice Department's complaint, the required kickbacks were only a part of a much larger pattern of illegal conduct by the hospital. From the facts presented by the government it appears that the kickback requirements, in the form of required donations, were far more questionable than the management fees under dispute in *Culpeper*. In *Kensington*, it seems rather clear that the payments demanded of the hospital based specialists were clearly a quid pro quo for the privilege of having an exclusive franchise at Kensington. As noted, a pivotal issue in determining the outcome of these reverse kickback cases will be the guidelines laid out by DHHS in the safe harbor regulations.

IV. REFOCUSING QUALITY ASSURANCE/UTILIZATION REVIEW

With the exception of an entirely closed medical staff, most arrangements that limit access to staff membership do not impact on a large number of physicians. For a hospital to realize efficiencies in medical practice, it must develop medical staff-wide policies that go beyond exclusive arrangements for certain practitioners. There are currently several areas in which hospitals are making efforts at developing and implementing policies that result in greater cost efficiencies by medical staffs. Such efforts range from widely accepted, and universally pursued quality assurance/utilization review ("QA/UR") strategies, to less accepted physician incentive programs, to proposals that alter the credentialing processes to incorporate an economic evaluation. Like exclusive contracting and closed departments, any alteration in the status quo between hospitals and medical staffs must undergo careful legal scrutiny. This scrutiny is necessary because of the delicate nature of the relationship between medical staff and hospital, and the potential disruption to the facility when the relationship is altered.

Perhaps the most general means in which a hospital engenders efficient performance from its medical staff is through quality assurance and utilization review.⁸⁸ The majority of medical staffs have rather involved QA and UR pro-

87. Complaint at 14-15, *Kensington Hosp.*, No. 90-5430.

88. Horwitz, *Measuring Quality of Care*, THE MED. STAFF COUNSELOR, Fall 1988, at 31-39.

grams, in part, because of JCAHO (Joint Commission on Accreditation of Health Organizations) and state/federal law mandates.⁸⁹ But aside from meeting specific mandates, there is a long-standing consensus that peer review activities focusing on clinical performance evaluations, which in turn educate physicians, are a way to enhance not only individual performance, but also overall institutional efficiency.

Of late, the evaluation of physician performance whether through quality assurance or utilization review has undergone significant changes. Hospitals are spending considerably more time in assessing quality by creating more comprehensive quality assurance teams and by expanding evaluation considerations to include such factors as patient satisfaction.⁹⁰ In addition, various hospital programs have been designed to sensitize physicians to the economic ramifications of clinical decision-making.⁹¹ Certain types of routine reviews such as blood and drug usage have very strong economic implications in addition to their quality components.

A growing practice since the advent of Diagnostic Related Groups (DRGs) has been the development of physician profiling.⁹² Using data from more sophisticated hospital information systems, institutions are able to assemble individual physician profiles that detail admissions by type, length of stay, diagnosis, charges, and hospital reimbursement.⁹³ Individual physician practice profiles can, in turn, be compared with aggregate profile data either from one hospital or from an entire region. Clearly, physician profiles present a powerful tool for evaluating both clinical and economic performance in that they assemble a unified data set that allows analysis of a physician's entire practice in a particular facility for a given time period. While use of profiles has been restricted to QA and UR activities, it is not unreasonable to see such data extended into the credentialing area.

Increasing cost pressures on hospitals have spawned the

89. National Health Lawyers Association, *Utilization Management, PROs and Quality Assurance Seminar Materials* (April 6-7, 1989).

90. Thompson, *Exploring 12 Myths About Quality Assurance and Peer Review*, THE MED. STAFF COUNSELOR, Fall 1988, at 39-49.

91. See AMA COST EFFECTIVENESS EVALUATION NETWORK: ECONOMIC GRAND ROUNDS (1984).

92. Koska, *Physician Practices Go Under the Microscope*, HOSPITALS, Feb. 20, 1990, at 32-37.

93. *Id.*

growth of analytical capabilities in the physician performance area. In addition, the dramatic increase in information technology has played a vital role in the ability to assemble physician practice data that yields insightful portraits of economic and clinical performance.⁹⁴ Hospitals are able to purchase or develop software packages that allow them to accurately track and measure physician performance and merge clinical and financial data.⁹⁵ In at least one state, Pennsylvania, acute care facilities have a legal mandate to report physician clinical data to a governmental agency and, as part of the program, all hospitals in the state are required to use the same software package.⁹⁶ As physician-hospital data systems develop and improve, it is clear that the barriers between hospital management and medical staff will erode further. It is also clear that these developments and improvements have given management a set of new and powerful tools to enhance organizational efficiency and to increase its ability to individually and collectively monitor a medical staff.

The other side of the quality arena affecting hospitals concerns the widespread efforts at developing clinical practice guidelines, which are being conducted on national, regional, and local levels by government, organized medicine, and individual institutions.⁹⁷ The likely result of all this activity will be that hospitals and medical staffs will be confronted with multiple sets of guidelines in almost all areas of practice. Clearly, those who develop guidelines want them used. As a result, these developers will pressure provider institutions to adopt their new measures. For example, one specialty society, the American College of Physicians, is encouraging hospitals to use its clinical practice guidelines in credentialing.⁹⁸

Not only are different sponsors drafting guidelines, but the guidelines themselves, even in the same clinical areas, may be quite different depending on what methodology was used in

94. *Id.*

95. Mohlanbroek, *Quality and Cost Efficiency Data to Support Physician's Clinical Decisions*, 5 QRC ADVISOR 4 (1989).

96. 40 PA. STAT. ANN. LIT. § 6125 (Purdon's Supp. 1990).

97. G. Young, *Medical Practice Guidelines & Hospital Staff Privilege Decisions: An Antitrust Perspective*, (Unpublished manuscript) (available in Agency for Health Policy & Research, Rockville, Md) (1990); see also Billings, *The Emergence of Quality as a Major Health Policy Issue* in ROSCOE POUND FOUND., MED. QUALITY AND THE LAW (1990), O'Leary, *Beyond Generic Occurrence Screening*, 265 J. A.M.A. 1993 (1991).

98. HOSP. CLINICAL PRIVILEGES: GUIDELINES FOR PROCEDURES IN GASTRO-ENTEROLOGY AND NEPHROLOGY (American College of Physicians 1988).

their development. Guidelines can be based on physician opinions, on study of clinical evidence, on analysis of patient outcomes, or on patient preferences.⁹⁹ Regardless of the type of guideline, the issue of cost appropriateness and cost effectiveness can be incorporated into recommendations of how physicians should proceed.¹⁰⁰ A hospital confronted with multiple guidelines likely would be inclined to select the evaluation sets that articulate the standards of practice reflecting appropriate quality and would pay due deference to cost effectiveness issues. Thus, a hospital can, by selecting appropriate evaluation criteria, set the stage for QA and UR activities that promote medical staff cost efficient practices, and possibly carry over such criteria into credentialing.

V. PHYSICIAN ECONOMIC EFFICIENCY: A NEW ANALYSIS IN CREDENTIALING

The notion of evaluating physicians from an economic vantage point is one that is receiving increasing attention in the context of medical staff credentialing.¹⁰¹ Analyzing a physician's economic performance in the medical staff appointment and reappointment processes has been referred to as economic credentialing.¹⁰² Significantly, the lack of a consensus on just what economic credentialing is or how it should be conducted has created difficulty in studying this evolving area of analysis.

There are currently two major ways to define economic credentialing.¹⁰³ First, it is an extension of QA/UR processes that focus on individual physician efficiency measures which have economic ramifications. Such a process of economic credentialing is clearly linked to ongoing quality reviews; when extended into the appointment/reappointment area, it has not been overly controversial. Data from both QA/UR have been routinely used in credentialing either directly by the relevant committees or by department chairs who make key recommen-

99. See generally Havighurst, *Practice Guidelines for Med. Care: The Policy Rationale*, 34 ST. LOUIS U.L.J. 777, 819 (1990).

100. *Id.*; Burda, *Changing Physician Practice Patterns*, MODERN HEALTHCARE, Feb. 17, 1989, at 18-25.

101. McCormick, *HMSS Assails Use of Economic Criteria in Credentialing*, AM. MED. NEWS, Dec. 14, 1990; see also Eller & Teplitsky, *Considering Economic Factors in Hospital Privilege Decisions*, 3 HEALTH SPAN 11-18, Aug.-Sept. 1986.

102. *Id.*

103. Blum, *Economic Analysis of Physician Practices*, THE MED. STAFF COUNSELOR 25-30 (1991).

dations in the process.¹⁰⁴

Second, the California Medical Association ("CMA") has identified economic credentialing as a way to evaluate physicians based strictly on bottom line measures that have no direct relationship to quality.¹⁰⁵ According to the CMA, factors such as concurrent DRG review, revenue per physician, admission rates, payor mix, and community need for service have no bearing on quality. Consequently, the CMA considers these inappropriate grounds for evaluating and making staffing decisions.¹⁰⁶ Other economic measures, however, including varia-

104. J. Blum, *Introducing Economic Factors into Credentialing*, GOVERNANCE 100 LEADERSHIP PAPER SERIES 1991.

105. J. Rotenberg, *Report to Council from the Taskforce on Exclusive Contracting and Economic Credentialing* (July 1990) (on file with the California Medical Association).

106. *Id.*

The following are examples of economic criteria that do not apply to quality:

- Concurrent DRG Review
- Reimbursement Based on IDC-9 Code
- Comparison to "Alternative" DRGs
- Physician Profit by Reimbursement
- Physician Profit By Cost
- Revenue Per Physician
- Medi-CAL Participation Status
- MediCare Participation Status
- HMO/PPO/IPA Contracting Status
- Malpractice Risk Exposure
- Physician DRG Profiling Comparing Profitable DRG Categories to Nonprofitable DEG Categories
- Market Need For Particular Type of Physician
- Allocation of Hospital Resources
- Admission Rates
- Number of Hospital-Owned Outpatient Services Utilized
- Staff Development Plans
- Resource Utilization In Dollars
- Payor Mix
- Commercial Payor Profiles
- Personal Referral Patterns
- Operating Room Underutilization
- Low Census
- Hospital-Owned Ambulatory Facility Under Utilization
- Age As A Development Rather Than Health Status Criterion
- Patient Demographics
- Use of Facilities In Order To Maximize Current, Projected or Desired Hospital Market Share
- Community Need For Service
- Hospital Fiscal Viability
- Facilitate Equipment Maintenance
- Charges Comparison
- Comparative Utilization of Hospitals
- Promised Utilization of Inpatient Services

tion studies (comparisons of resources used), number of tests ordered, use of consultants/referrals, and DRG outliers do have a quality nexus and, according to CMA, can be used in credentialing.¹⁰⁷ The CMA position, endorsed by the AMA's Hospital Medical Staff Section, makes clear that the decision of the economic-quality data used in appointment-reappointment is within the purview of the medical staff, and not the hospital corporation.¹⁰⁸

Economic credentialing raises two levels of legal inquiry. The first analysis focuses on whether a hospital can mandate assessments of physician economic practice factors in either appointment or reappointment. The second analysis, assuming that economic credentialing is permissible, focuses on assessment of specific legal problems it may create.

In determining the legal viability of economic credentialing, this proposed process must be placed within the broad context of credentialing generally. The mandate that hospitals possess in the appointment and reappointment area flows from the institutional quality duty. Even prior to the seminal hospital case of *Darling v. Charleston Community Hospital*,¹⁰⁹ hospitals have had a recognized legal duty to appoint and

Promised Utilization of Hospital Outpatient Services

107. *Id.*

The following are examples of economic data that may have quality ramifications:

Comparison of Numbers of Resources Used To (Variation Studies)

Number of Tests Ordered

Number of Hospital Admissions Vis a Vis Outpatient Services

Utilization

Comparative Profiles of Physician Outcomes and Resource

Utilization Within Same DRG Category

Number of Consultants/Referrals

DRG Outliers

108. See McCormick, *supra* note 101.

The following are examples of criteria which have validity for quality assurance purposes:

Length of Stay

Disruption of Hospital Operations, As Pertains to Patient Care

Improper Use of Hospital Resources, As Pertains to Patient Care

Fraud and Abuse

Sanctions by any Government Authority, As Pertains to Patient Care

Health Status

Office Proximity

ICU Days

Excessive and Redundant Testing

Clinically Unnecessary Treatment

High Length of Stay

Excessive Number of Denial Letters

109. 33 Ill.2d 326, 211 N.E.2d 253, *cert. denied*, 383 U.S. 946 (1966).

reappoint competent medical staff members.¹¹⁰ This credentialing responsibility is firmly established in both common and statutory law, as well as in the accreditation standards of JCAHO.¹¹¹ For example, in 1989, the Supreme Court of Florida ruled that a hospital possessed a corporate obligation to grant and continue providing medical staff privileges for qualified individuals. The court held that failure to do so would result in corporate liability.¹¹² In turn, Florida statutes impose a legal responsibility on hospital boards to engage in credentialing activities. In addition, these statutes create a limited immunity for hospital boards while engaged in this process.¹¹³ Under the JCAHO accreditation standards, credentialing is a shared process between the medical staff and the hospital board that must be detailed in the medical staff's bylaws.¹¹⁴

While JCAHO and state law recognize the self-governing medical staff model, credentialing is ultimately the legal responsibility of the hospital trustees. Under a system of delegation endorsed by JCAHO, standards and processes of appointment and reappointment fall within the medical staff ambit.¹¹⁵ The hospital board generally does not become overly involved in the details of credentialing, but merely passes on the results of the medical staff review. From a legal standpoint, however, a hospital board could choose to manage, even control, credentialing of physicians. Outside of accreditation considerations, the barriers to having trustees "take over" credentialing are raised more by institutional politics than by law.

110. HAYT, HAYT, & GROESCHEL, *LAW OF HOSPITAL, PHYSICIAN AND PATIENT* 133 (1972). In a certain sense, economic credentialing is a paradox in that it is both a reverse trend, and an extension of hospital law emanating from *Darling v. Charleston Community Hospital*. With *Darling*, and the law that flowed from it, hospitals broke down the distinctions between management and medical practice, and as such experienced an expanded legal duty for monitoring of medical care. With economic credentialing, hospitals are reaching further into what organized medicine portrays as a legally protected medical function, credentialing, thus expanding *Darling* on the one hand. On the other hand, a physician economic analysis program, resting on corporate legal power, is an attempt to make the credentialing process a function of hospital administration, bringing it back into the management area.

111. C. HAVIGHURST, *HEALTH CARE LAW AND POLICY* 620-686 (1989); see also JCAHO ACCREDITATION CRITERIA, *supra* note 25.

112. See *Insinga v. Labella*, 543 So. 2d 209 (Fla. 1989).

113. See generally FLA. STAT. ANN. §§ 395.011(1)-(11), 395.0115(1) (1986); for immunity, see FLA. STAT. ANN. § 395.011(8) (1986).

114. See JCAHO ACCREDITATION CRITERIA, *supra* note 25 (note with particularity chapters entitled *Governing Body* and *Medical Staff*).

115. *Id.*

California appears to be the only state in which there is a legitimate debate about the scope of a hospital board's authority vis-a-vis the medical staff. Under California law, the medical staff is given clear legal authority over professional work performed in the hospital.¹¹⁶ The line of demarcation between board and medical staff has been further deepened with the passage of the state Peer Review Law which establishes a series of special safeguards for physicians adversely affected by credentialing decisions.¹¹⁷ The California law limits the ability of the governing board to take action in credentialing independent of the hospital medical staff's peer review committee.¹¹⁸

Even in California, however, the final authority in credentialing rests with the board. While one could argue that a California hospital board may not be able to independently deny a physician appointment or reappointment, clearly the trustees bear ultimate legal liability for these decisions. In *Mateo-Woodburn v. Fresno Community Hospital*,¹¹⁹ the appellate court recognized the medical staff's credentialing role, but clearly indicated that the staff only has power to make recommendations and that final membership decisions are those of the board.¹²⁰

In view of the final authority of the board in credentialing, an interesting question arises about whether a hospital board could implement a physician economic credentialing program independent of the medical staff. The answer is contingent to a significant degree on how one defines economic credentialing. If one views economic credentialing as an extension of quality assurance/utilization review into the appointment and reappointment area, it may not be feasible for the board to usurp this function. As noted, the board has final say in credentialing, but the tradition of delegating the actual review process is strongly buttressed by JCAHO, state law, and the policies of organized medicine. A board applying economic criteria to evaluate physicians independent of the medical staff could be viewed, at least, as an inappropriate interference. Indeed, under California law, it may even be classified as illegal.

116. CAL. ADMIN. CODE § 70701(e)(1)(F) (1991).

117. CAL. BUS. & PROF. CODE § 809-809.9 (West 1989).

118. *Id.* at § 809.05.

119. 221 Cal. App. 3d 1169, 270 Cal. Rptr. 894 (1990).

120. *Id.* at 1188-89, 270 Cal. Rptr. at 905.

The legal analysis changes, however, with a different definition. If economic credentialing is seen, not as an extension of a traditional medical staff quality or utilization review process, but as a separate, unique analysis, different from medical staff credentialing review, it may be defended more easily. In fact, to distance such analysis from medical staff credentialing, a board may choose to refer to such review in non-credentialing terminology. Politically, establishing a second tier of review for staff membership may be difficult. However, as the final decision makers in staffing matters, the board has the power to amend hospital bylaws to allow for such a review. Buttressing this position is the economic reality of the hospital business with which the board, as a fiscal fiduciary, must deal. It seems appropriate for trustees, as fiscal fiduciaries, to review the economic performance of individual physicians who exert control over the hospital's business performance. In fact, one could argue that the failure of a board to consider economic issues in appointing and reappointing physicians to a medical staff violates a legal mandate to engage in necessary fiscal oversight.¹²¹

By viewing economic analysis of individual physician practices as being distinct from medical staff credentialing processes, a couple of interesting issues arise. First, on a parochial level, the California law which so strongly supports the independent medical staff as the situs for credentialing may be circumvented.¹²² By separating economic analysis from traditional credentialing, the board is implementing a process that has never been performed by a medical staff, and falls outside the staff's quality monitoring function. If the board can make distinctions between business and quality measures, then it need not exclude bottom line factors in an alternative analysis of physician efficiency.

A second issue raised by recasting economic credentialing as a review different from traditional medical staff review is the question of immunity under federal law. Under the Health Care Quality Improvement Act of 1986,¹²³ hospital peer review has provided a limited immunity from federal antitrust liability. The immunity, however, is applicable to situations dealing with the various reviews that are oriented to insuring quality medical care as provided in the hospital. If economic creden-

121. See discussion *supra* note 110.

122. See *supra* note 115 and accompanying text.

123. 42 U.S.C. §§ 11101-11152 (Supp. 1988).

tialing focuses only on bottom line measures, it would not be classified as a type of quality review and would thus, not qualify for the federal immunity.¹²⁴ Such activity may, however, receive protection under state law. For example, Illinois law creates an absolute immunity for peer review activities that appear to be broad enough to include economic analysis of physician practices, even if it is a process separate from traditional credentialing review.¹²⁵ Thus, however economic credentialing is defined, it appears that the process is legally justified in that the weight of hospital law rests more with the board than with the medical staff in the credentialing area.

VI. ANTITRUST IMPLICATIONS OF ECONOMIC CREDENTIALING

Assuming that economic credentialing is legally appropriate, certain antitrust implications arise. Typically, medical staff antitrust challenges fall within Section 1 of the Sherman Act.¹²⁶ Section 1 violations involve illegal restraints of trade of some form, such as conspiracy, group boycott, or concerted refusal to deal. Within the context of economic credentialing, one could easily foresee a scenario in which a medical staff or hospital used economic criteria as a way to inappropriately exclude a physician from staff membership for competitive reasons.

However, constructing an antitrust case in the medical staff context is not easily done. Section 1 violations are either classified as a per se violation or as a rule of reason violation, depending on the conduct in question. The majority of medical staff antitrust challenges fall under the so-called rule of reason analysis.¹²⁷ It is the rare case in which a per se or automatic violation of antitrust law is found in medical staff cases because the requisite elements are generally not present. In fact, courts are becoming increasingly reluctant to apply the per se rule, particularly where the alleged anticompetitive conduct can be justified on the basis of quality care.¹²⁸ In one of the more noteworthy exceptions, *Weiss v. York Hospital*,¹²⁹

124. Blum, *Economic Credentialing: A New Twist in Hospital Appraisal Processes*, — J. LEGAL MED. — (in press) (1991).

125. ILL. ANN. STAT. Ch. 111 1/2 ¶ 151.2 (Smith-Hurd 1988).

126. 15 U.S.C. § 1 (1991).

127. See Blumstein & Sloan, *Antitrust & Hospital Peer Review*, 51 LAW CONTEMP. PROBS. 7 (Spring 1988).

128. *Id.* at 53-56.

129. 745 F.2d 786 (3rd Cir. 1984).

the Third Circuit found that a medical staff's refusal to deal with the plaintiff, an osteopathic physician, was a group boycott and thus, a per se violation of the Sherman Act.¹³⁰

Under the more typical rule of reason analysis, several factors must be demonstrated. These include the existence of a conspiracy, the impact of the conspiracy on the relevant market, and the lack of an appropriate rationale for discriminating against the plaintiff.¹³¹ The issue of conspiracy is complicated by the uncertainties of whether a court will recognize a hospital and its medical staff as economically distinct entities. In the alternative, the medical staff itself has been viewed as a combination of individuals with disparate interests, and thus, capable of conspiring among itself.¹³² Proof of conspiracy raises interesting evidentiary challenges. In *Bolt v. Halifax*,¹³³ the Eleventh Circuit noted that few medical staff conspiracies can be proven with direct evidence. Relying on circumstantial evidence, a conspiracy would have to be proven as inuring economic benefit to the defendants, and excluding possibilities that co-conspirators acted independently in a manner consistent with business objectives.¹³⁴

If an economic credentialing challenge is analyzed under a rule of reason analysis, defendants would more than likely argue that use of such criteria is justified by operation efficiency requirements; such an argument is difficult for a plaintiff to overcome. Legitimate business reasons are valid grounds for defense of practices that may result in economic injury to certain individuals.¹³⁵ Institutions adopting economic criteria for analyzing physician appointment and reappointment could make a convincing case for doing so on business grounds. As such, without strong and somewhat unique factors underlying a conspiracy, an antitrust challenge would be frustrated.

While the very process of peer evaluation using economic criteria may raise concerns about antitrust, those concerns don't easily materialize into an illegal action. Economic credentialing does not inherently create antitrust problems.

130. *Id.* at 820.

131. See Blumstein & Stone, *supra* note 128, at 52.

132. *Id.* at 59-65.

133. 851 F.2d 1273 (11th Cir. 1989).

134. See Blumstein & Stone, *supra* note 125, at 52.

135. See *Hassan v. Independent Practice Associates*, 698 F. Supp. 6679 (E.D. Mich. 1988).

And, when misused, it is really no different than misapplication of any other type of evaluation criteria that stymies competition. Economic efficiency measures could fall outside defensible bounds if targeted at a particular individual, but such a possibility is not highly probable. If economic guidelines used in credentialing do not meet legitimate institutional objectives they could be viewed as suspect, and a possible subterfuge for anticompetitive behavior.

A hospital could generate antitrust problems if the economic criteria it uses are not based on verifiable evidence, but only on arbitrary standards. In *Friedman v. Delaware Memorial Hospital*,¹³⁶ the United States District Court for the Eastern District of Pennsylvania confronted an antitrust challenge regarding the scientific merits of medical criteria for a certain procedure. While the court found the criteria valid, commentators have suggested that a finding of invalidity would raise questions about inappropriate use and would clearly diminish a defense that use of the criteria was justified even if it led to economic injury.¹³⁷ Proof that a particular economic standard was not formally or routinely applied, but rather, was used on an ad hoc basis, could raise legitimate concerns about inappropriate motives and would support a viable antitrust challenge.

Any of the factors noted that might lead to questioning a hospital's motives in the adoption and implementation of economic criteria merely open the door of inquiry into the antitrust context. Without the necessary findings to establish a rule of reason violation, ad hoc use of institutionally incompatible economic criteria or arbitrary guidelines do not, in and of themselves, lead to a violation of law. In addition, as previously noted, any antitrust challenge in the medical staff area should be reviewed in reference to possible immunity protections under state and federal law.

VII. NEW STANDARDS FOR ECONOMIC CREDENTIALING

Whenever new legal standards are utilized as a vehicle to evaluate performance, legal problems can be anticipated. In the case of economic credentialing, hospitals will need to either develop or adopt new sets of criteria for evaluating physician financial performance. A physician whose staff privileges have been adversely affected by new economic criteria likely will

136. 672 F. Supp. 171 (E.D. Pa. 1987).

137. See G. Young, *supra* note 97.

challenge those baselines as being inappropriate on one or more grounds.

Much of the discussion about new health care criteria has focused on the adoption of clinical practice standards at medical malpractice trials.¹³⁸ The prime consideration in judicial use of new practice criteria deals with a range of procedural issues impacting admissibility of evidence.¹³⁹ Provided it is directly relevant, courts likely will admit new economic criteria into evidence at trial.

The attitude that courts adopt regarding the propriety of judging physician performance on economic grounds generally will color the fate of economic criteria at trial. If a court views economic credentialing as a legitimate business inquiry, economic criteria probably will not fare any differently than other new sets of criteria. On the other hand, if a court adopts the position that a physician's privileges should only be evaluated by use of traditional quality standards, the newly adopted economic criteria may be subjected to a higher degree of scrutiny. While the advocates in a given case, as well as state hospital law precedent, will color a court's attitude, it seems safe to predict that the judicial reaction to economic criteria will not be universally favorable. Regardless of judicial attitude, hospitals must be prepared to justify economic criteria with proof of how they were developed and applied.

As economic credentialing develops, hospitals, as in the QA and UR areas, likely will be able to utilize regionally or nationally developed criteria as a basis for their evaluations. It is difficult to determine whether such criteria will be viewed more favorably by a court than will economic guidelines for physician practices that are institution-specific and locally developed. In the abstract, a case could be made that national/regional criteria ought to be more valid in that they are based on a larger statistical sample. But hospital economics are reflective of a local area market and, as such, may be more accurately represented by individually tailored criteria.

The critical issue involving criteria will not be local versus national, but rather the specific content and manner of applica-

138. See Kinney & Wilder, *Medical Standard Setting in the Current Malpractice Environment: Problems and Possibilities*, 22 U.C. DAVIS L. REV. 421 (1989).

139. Schockemoehl, *Admissibility of Written Criteria As Evidence of the Standard of Care in Medical and Hospital Negligence Actions in Virginia*, 18 U. RICH. L. REV. 725 (1984).

tion given to the standards.¹⁴⁰ The validity of the methodology underlying the criteria, the legitimacy of the economic baselines, and the appropriateness of application in a given case are all grounds on which economic criteria could be challenged. As economic credentialing becomes an established process, the legal challenges more likely will focus on application of specific criteria in that questions of methodological appropriateness would be answered in the initial cases that deal with economic criteria.

Another possible area of challenge, depending upon the specific criteria, is vagueness. If particular criteria establish only broad guidelines, a physician might argue that such criteria are too general to serve as a basis for an adverse decision, or don't provide adequate notice of expected performance. In balance, it appears that economic criteria, if fundamentally sound, would be able to sustain legal challenges.

VIII. ECONOMIC CREDENTIALING: A MODEL

Beyond a theoretical analysis of the legal impact of physician practice economic criteria, there are almost no working models from which to draw. To date, only one hospital program has been documented in the literature.¹⁴¹ The physician economic efficiency program used by Harford Hospital in Havre de Grace, Maryland has been in place since 1987. Harford has developed a four part economic efficiency criteria screen in areas that the hospital felt were most significant to institutional viability.¹⁴² The evaluation criteria include days above standard, charges above standard, denials for inappropriate utilization, and medical malpractice.¹⁴³ Each of the respective criteria screens rests on objective measures. For example, the basis for determining days above standard is derived from the Maryland Health Services Cost Review Commission data that lays out case mix adjusted average lengths of stay for the state.¹⁴⁴

Under the Harford system, if a practitioner is found deficient in two or more of the criteria screens, a second set of cri-

140. See *supra* notes 136-37 and accompanying text.

141. Cantrell & Flick, *Physician Efficiency and Reimbursement: A Case Study*, HOSP. AND HEALTH SERVICES ADMIN. 43-50, (1986); Hartford Memorial Hospital Summary of Economic Efficiency Criteria, 1989.

142. See Cantrell & Flick, *supra* note 141, at 44-45.

143. *Id.* at 45-46.

144. *Id.* at 45.

teria are applied. The supplemental criteria include analysis of outpatient ancillary service charges, and medical record documentation.¹⁴⁵ In conjunction with the economic efficiency analysis, the hospital has developed a counseling protocol that affords staff members opportunities to improve their individual economic efficiency. A physician who deviates from the screens is provided with several opportunities to remedy his or her behavior prior to being subjected to reduction or removal of staff privileges. Interestingly, the final economic review and action taken is within the discretion of hospital management, not the medical staff, and the program itself has been written into Harford's corporate bylaws.¹⁴⁶

While it is difficult to generalize on the basis of one model, the Harford physician economic efficiency program does provide some guidance as to how economic criteria can be incorporated into a formal evaluation program. Economic criteria, as quality criteria, probably will not be applied in a cookbook format. Rather, economic analysis will mirror quality review methodology with a use of screens that will evaluate performance and will trigger further review and analysis if problems are uncovered. Such a process will entail ongoing contact between reviewers and physicians. Also, economic analysis programs will need to develop remedial processes prior to sanction. A more rigid approach to economic credentialing would engender significant resistance by medical staff, JCAHO, and perhaps even the courts.

IX. LESSONS FROM CASE LAW

A review of case law does not as yet uncover any reported decisions dealing explicitly with economic credentialing. As this very new concept evolves, it likely will be the subject of judicial challenge. For the present, however, there is a small body of case law involving physician loss or reduction of staff privileges that may prove helpful. In this group of cases, the hospital's conduct rested, at least in part, on the physician's exceeding utilization review guidelines that have strong financial implications, and, as such, have relevance to economic credentialing.

In *Knapp v. Palos Community Hospital*,¹⁴⁷ which is repre-

145. *Id.* at 47.

146. *Id.* at 45.

147. 125 Ill. App. 3d 244, 465 N.E. 2d 554 (1984).

sentative of legal actions where physicians' practices are called into question through quality review, a group of physicians challenged the curtailment of their medical staff privileges on multiple grounds.¹⁴⁸ The hospital based its conduct against the doctors on quality assurance reviews that revealed serious utilization problems. Specifically, reviews uncovered a pattern of both inappropriate utilization and overutilization of lung scans and medications, excessive use of diagnoses, and improper testing and treatment.¹⁴⁹ While the areas noted raised major quality problems, the hospital was also concerned because the disciplined physicians' costs were 31% higher than those of other staff members.¹⁵⁰ The cost problems clearly mirrored quality of care difficulties, but if cost was not affected by poor practices the hospital may not have been as motivated to take negative credentialing actions against the plaintiff doctors.

In the case of *Rao v. St. Elizabeth's Hospital*,¹⁵¹ a physician challenged his summary suspension from the medical staff, seeking to enjoin the hospital's conduct. The hospital executive committee took action against the plaintiff because an extensive review of the physician's charts demonstrated serious utilization problems.¹⁵² The executive committee presented evidence indicating a pattern of inappropriate use of laboratory procedures, particularly EKGs and glucose tolerance tests. Cost was not an issue in *Rao*, but clearly, since such behavior is not cost effective and can also result in payment denials, the physician's practice demonstrated a pattern of abuse having a negative financial impact on the hospital.

In *Friedman v. Delaware County Memorial Hospital*,¹⁵³ the previously noted antitrust case, the plaintiff was excluded from the staff for overutilizing bronchoscopes, and for refusing to adhere to the recommendations of the hospital's utilization review committee. In a very exhaustive discussion of facts, the federal district court never directly mentioned the cost implications of the plaintiff physician's behavior. Cost, however, was a very real factor in the hospital's revocation of Dr. Friedman's privileges. The hospital formed a special medical staff endoscopy committee for the purpose of reviewing the plain-

148. *Id.* at 257, 465 N.E.2d at 564.

149. *Id.* at 252, 465 N.E.2d at 560.

150. *Id.* at 251, 465 N.E.2d at 560.

151. 140 Ill. App. 3d 442, 488 N.E.2d 685 (1986).

152. *Id.* at 444-45, 488 N.E.2d at 687.

153. 672 F. Supp. 171 (E.D. Pa. 1987).

tiff.¹⁵⁴ In doing so, the hospital was responding, in part, to audit deficiencies raised by Blue Cross of Greater Philadelphia.¹⁵⁵ Blue Cross auditors felt that Dr. Friedman, and another physician at Delaware County, were performing an unnecessarily high number of unjustified bronchoscopes. Clearly, the conclusions of Blue Cross have direct economic implications: third party payors do not reimburse for unnecessary procedures. One could reasonably conclude, therefore, that the entire scenario involving Dr. Friedman's unorthodox use of bronchoscopes, while reflecting quality problems, had very strong financial repercussions attached to it.

The only action in which a court has explicitly upheld economic credentialing is the New Jersey lower court case of *Edelman v. JFK Hospital*.¹⁵⁶ In *Edelman*, the hospital's utilization review program found that the plaintiff physician's lengths of stay exceeded acceptable norms, even when the ages of his patients were taken into account. In addition, the plaintiff demonstrated a pattern of excessive and unnecessary use of diagnostic tests. The hospital based its decision to deny Dr. Edelman's reappointment to the medical staff on his utilization problems, which as a result of payment denials, cost the facility over a quarter of a million dollars.¹⁵⁷

Dr. Edelman challenged JFK's conduct on the grounds that it violated his due process rights.¹⁵⁸ The New Jersey Superior Court rejected the plaintiff's challenge and ruled that the credentialing action taken by the board was appropriate.¹⁵⁹ The court held that it was the board's duty to see that the institution was run in an orderly and efficient manner. Significantly, the court did not reject the notion that a physician be judged on economic grounds.¹⁶⁰ While *Edelman* may be closer to an economic credentialing decision than the other cases, previously noted, it still is a situation where quality and cost are tightly intertwined. In fact, the case is not really a classic example of economic credentialing, but rather of utilization review applied in the credentialing context.

154. *Id.* at 183.

155. *Id.*

156. N.J. Sup. Ct., No. C-2104-80 (1982); *cert. denied*, 96 N.J. 289, 475 A.2d 585 (1984). See also *Economic Credentialing is Fine for Tightrope Walkers*, 15 HOSP. PEER REVIEW 4, 1990.

157. *Edelman*, No. C-2104-80.

158. *Id.*

159. *Id.*

160. *Id.*

There are a number of cases in which hospitals have made adverse credentialing decisions based on economic or business factors. For example, in the case of *Maltz v. New York University Medical Center*,¹⁶¹ the Medical Center rejected a staff application on the basis that the institution lacked the physical capacity. A New York appellate court upheld the hospital's decision, finding that the hospital was entitled to broad discretion.¹⁶² In other cases, courts have upheld hospital policies allowing removal of physicians from the medical staff for failure to admit a requisite number of patients annually.¹⁶³ Such decisions, however, constitute enforcement of hospital policies that have fiscal ramifications, but are not the result of a review of individual physician practices using financial guidelines.

While related, the cases discussed herein do not deal specifically with economic credentialing. Nevertheless, courts will likely support hospital credentialing decisions that stem from quality problems having very clear cost implications. The cost issues may have driven the hospital's action but as long as the action has a quality rationale, it will be accepted by the courts. Thus, if economic credentialing is seen merely as an extension of QA/UR, the courts probably will uphold such a process. The real question is whether the courts will allow exclusion or expulsion of physicians based on an institutional judgment that costs of beneficial care are excessive. This question assumes, as does the California Medical Association, that a distinction can be made between quality of care and bottom line factors. One could argue that a strict bottom line measure, such as revenue per physician, ultimately impacts on institutional efficiency and, as such, affects quality.

Two competing bodies of law must be balanced when addressing the legal viability of economic credentialing. First is law drawn from state common and statutory sources, coupled with JCAHO accreditation criteria. This line buttresses the self-governing medical staff's power in credentialing. Second are legal principles, also from state common and statutory sources, which bolster the hospital's corporate legal power in credentialing and business policy decision-making. Apparently, greater legal authority rests with hospitals than with medical

161. 121 A.D.2d 323, 503 N.Y.S.2d 570 (1986).

162. *Id.* at 571.

163. *Jackaway v. Northern Dutchess Hosp.*, 139 A.D.2d 599, 526 N.Y.S. 599 (1988).

staffs. Thus, economic credentialing generated by the hospital is legally defensible.

Five factors make the argument for economic credentialing compelling. First, hospitals, even in California, have the final authority to make credentialing decisions, and the law has never specified what criteria be used in so doing. Second, the hospital corporation bears the legal liability for inappropriate credentialing decisions, not the medical staff. Third, hospital boards have a legal duty to act as fiscal fiduciaries. That duty, stemming from the first two factors, creates a mandate to make decisions in the best financial interests of the institution. If a physician practices medicine in a way that hurts the hospital economically, the board, particularly in a highly competitive market, has a responsibility to take action.

Fourth, a review of hospital case law clearly shows that the courts have upheld and supported the right of management to make decisions either that are in the public interest, or that reflect sound business policies. Finally, economic analysis of physicians is arguably a necessary activity in competitive situations, and that protecting the viability of a hospital's operation is in the public interest. While these five factors collectively support the legal underpinnings of economic credentialing and are persuasive, they do not make the political and logistical task of implementing such a program an easy one to accomplish.

X. CONCLUSION

In the future, there likely will be considerable debate over any strategy a hospital pursues that attempts to alter the medical staff status quo. In particular, strategies that infringe on traditional staff functions, such as credentialing, will undoubtedly lead to controversy and litigation. The notion of measuring physician practices in a hospital setting is not a foreign one. However, allowing the measures to be economic and the evaluators to be administrators and trustees is a clear departure from tradition.

Market realities for the hospital industry will require dramatic operational changes and, in the context of the two hospital strategies reviewed here, limiting access to staff membership and economic credentialing, the law is supportive. In the case of exclusive contracts and closed departments, legal precedent provides that schemes buttressed by sound rationale

will be difficult to alter without identifying major legal flaws. In the case of economic credentialing, there are more potential legal issues that must be confronted. But here too, the weight of the law creates a persuasive case in defense of such reviewing practices.

Hospitals can not realize progress in achieving physician efficiencies if such attempts become focal points of struggles between medical staff and management. As long as the structure of a hospital corporation is not altered or the system of health delivery itself is not changed, the key parties in the hospital will need to cooperate in order for effective changes to occur. Hospital administration must recognize the need for medical staff agreement in exclusive contracting and in economic credentialing and must only proceed independently in these areas with great caution.