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**Hospital Counsel vs. Medical Staff Counsel:
Conflicting Perspectives on Current Medical Staff Legal Issues**

I. OVERVIEW^{1/}

Most hospitals and medical staff physicians would probably agree, albeit begrudgingly, that their interests in rendering high quality patient care services while maintaining economic viability are essentially the same. They may view each other as a necessary evil but each is clearly dependent on the other in order to achieve these ends. Some other common interests and mutuality of needs would include the following:

- Both the hospital and medical staff physicians need to obtain and maintain licenses.
- Continued accreditation of the hospital and the Medicare/Medicaid eligibility of both the hospital and physicians are essential in order to maintain status as a provider.
- The hospital and medical staff must work together in order to meet these licensing and accreditation requirements as well as to comply with corporate negligence standards through adherence of the appointment, reappointment, credentialing, privileging and peer procedures as reflected in the medical staff bylaws, rules and regulations, department policies and the hospital's corporate bylaws.
- The hospital and physicians need to obtain and maintain adequate professional liability insurance.
- Physicians need a full service, financially stable hospital which can provide properly and adequately equipped in-patient and out-patient facilities, along with highly qualified personnel to support physicians in rendering quality patient care services.
- Hospitals need to attract qualified physicians with a balanced payor mix in order to remain competitive.

^{1/} This paper is intended to serve both as an expansion of the presentation made by the author and his co-presenter, Elizabeth A. "Libby" Snelson at the 8th Physician-Legal Issues Conference of the Health Law Section of the American Bar Association on June 22, 2007 as well as a response to the paper prepared by Libby Snelson. Therefore, the author would recommend that both papers be read together in order to achieve the full benefit of the respective views which are offered for the reader's consideration.

- The level of reimbursement which is paid to both hospitals and physicians is dependent on the ability of both to meet pay for performance and outcome standards being imposed by private and public payors.

Although these goals are mutual, the hospital and the organized medical staff are not always in agreement on how they are to be achieved. A hospital, for example, may feel compelled to enter into an exclusive arrangement for a hospital-based service, such as anesthesiology, in order to maintain quality, obtain 24/7 coverage and to have highly skilled anesthesiologists available to surgeons for the treatment of all patients, irrespective of ability to pay. Independent anesthesiologists, on the other hand, may not wish to organize as a group and might prefer to only work with surgeons with high end practices in which the reimbursement returns are greater as compared to Medicaid and indigent care patients. As a general matter, organized medical staffs do not like these contracts because they bar access to the hospital by independent physicians who are not part of the exclusive group. Medical staffs also are concerned about “contract creep” in which exclusive arrangements are extended to an ever increasing list of physician services.

Another area which recently has spawned some disagreement relates to the hospital’s need under the Emergency Medical Transfer and Active Labor Act, (“EMTALA”)^{2/} to provide emergency on-call treatment in all areas of in-patient care provided by the hospital. Although some physicians view the on-call schedule as an opportunity to generate additional patients and revenue, others see it as a significant burden, particularly if they serve on multiple medical staffs and are required to render all on-call services at each. The manner and method by which the ED coverage schedule is created and enforced has triggered physician resignations and has led to a demand for payment for agreeing to take call.

In addition, although hospitals and physicians generally work together, they also are competitors. A physician’s preferred relationship with a hospital is to remain as independent as possible and to use the hospital and its services only when needed. Employment and service agreements are generally shunned unless absolutely necessary and only if not otherwise available. Also, physicians are entering into joint venture or ownership arrangements with competing diagnostic centers, surgi-centers and other similar competing venues as a way to increase revenue and to become less reliant on hospitals. This competitive reality has raised complicated questions about whether hospitals should permit these physicians to obtain, much less maintain, their medical staff membership and clinical privileges. The resolution of this question places the hospital and the medical staff, or at least a number of its physicians, at odds with each other in terms of how this economic conflict of interest is to be resolved.

The purpose of this paper is to discuss the legal perspective of hospital counsel in these and other key areas where the means of achieving specific quality and economic goals may trigger a dispute with the organized medical staff. As a general matter, the paper attempts to track the same order set forth in Libby Snelson’s paper which provides the medical staff counsel’s perspective on these issues.

^{2/} 42 U.S.C. § 1595dd et seq.

II. WHO REPRESENTS THE MEDICAL STAFF – HOSPITAL COUNSEL OR SEPARATE MEDICAL STAFF COUNSEL?

There is little, if any, legal dispute over the proposition that medical staffs have the discretion to hire independent legal counsel for certain matters irrespective of whether the state law or the medical staff bylaws specifically authorize this decision.^{3/} Certainly, the American Medical Association (“AMA”) and other state medical societies strongly advise medical staffs to use independent counsel, particularly where a dispute between the hospital and the medical staff arises and hospital counsel is not in a position to represent both parties.^{4/} Although most hospital administrators may otherwise prefer that the medical staff work with its in-house or outside counsel, there is not much the hospital can do to interfere with the medical staff’s decision to retain separate counsel. Moreover, from a political perspective, it would probably make very little sense to do so. The biggest practical obstacle is whether the medical staff has sufficient funds to pay for outside counsel. Some medical staffs have generated quite a war chest from collected dues which they use for different purposes whereas other medical staffs may be required to impose a special assessment on their members in order to fund the services of an attorney.

While recognizing the right of the medical staff to hire legal counsel, experience shows that most medical staffs are generally willing to rely on hospital counsel and in fact, actively seek out their advice on matters affecting hospital and medical staff operations. As pointed out in the Overview section of this paper, the interests of the hospital and the organized medical staff are oftentimes the same. For example, if the hospital’s accreditation is at risk because it has failed to satisfy various requirements, including compliance with the medical staff standards, most hospitals and medical staffs will work together to address the identified problems. Similarly, if a physician’s clinical privileges are terminated based on quality of care issues and the practitioner turns around and sues the Department Chair, the Credentials Committee, the Medical Executive Committee and the Board of Directors, the defendant physicians have no hesitation over accepting hospital counsel’s advice and representation as well as the indemnification protection under the hospital’s insurance policies. This is particularly true given the fact that most courts have viewed physicians as agents of the hospital when participating in peer review decisions.^{5/}

There will be times, however, when conflicts do arise and the ability of hospital counsel to render advice to the organized medical staff is impaired if not prohibited based on the ABA Model Rules of Professional Conduct^{6/} and applicable state canons of ethics^{7/}. Some conflicts

^{3/} See e.g., California Business and Professions Code § 2282.5(a) where California law specifically allows the medical staff to retain and be represented by independent legal counsel at its own expense.

^{4/} See AMA Policy H-235.992 (Res. 59, I-83; Reaffirmed: CLRPD Rep.1, I-93; Modified: BOT Rep. 3, A-99).

^{5/} See, e.g., A. G., Pudlo v. Adamski 789 F. Supp. 247, affirmed 2 F.3d 1153 (7th Cir. 1993); Oksanen v. Page Memorial Hospital, 945 F.2d 696 (4th Cir. 1991). But see Bolt v. Halifax Hospital Medical Center, 851 F.2d 1273 (11th Cir. 1988).

^{6/} ABA Model Rules of Professional Conduct and Model Code of Professional Responsibility: Model Rule 1.13, Canon 5, EC5-14, 5-15.

may be waivable whereas others are not and therefore attorneys should be mindful of these governing standards in their respective jurisdictions.

III. ECONOMIC CREDENTIALING

The term “economic credentialing” means different things to different people. The AMA’s position, as well as those of certain state jurisdictions, is that a credentialing decision which is based on economic criteria that are unrelated to individual qualification through education, training and experience should be opposed or discouraged.^{8/} As a practical matter, however, the law allows for all kinds of economic credentialing, and with good reason.

It is important to keep in mind some of the fundamental principles which underlie this area of law. These include the following:

- There is no fundamental constitutional, common law or statutory right of a physician to obtain medical staff membership and clinical privileges at a private hospital.
- A physician can be terminated from the medical staff as long as the medical staff and the hospital comply with the medical staff bylaws, as well as applicable state and federal requirements especially if the parties are seeking immunity protection.
- Hospitals have a fiduciary responsibility under state statute and applicable case law to render those decisions which, in its business judgment, protect and maintain a hospital’s economic viability.
- Courts rarely interfere with the exercise of this business judgment.
- Although the Joint Commission recognizes the medical staff as a self-governing body, the Standards clearly vests in the hospital board the ultimate authority in operating the hospital, adopting the medical staff bylaws and in matters relating to patient care.^{9/}

^{7/} But see Illinois Supreme Court Rules - Article VIII - Rules of Professional Conduct, Rule 1.7, where Rule does not prohibit simultaneous representation if the lawyer reasonable believes that the representation will not adversely affect the relationship with the other client. See also Rule 1.13 which states that when dealing with organizations, directors, officers, employees, members, the attorney shall advise other constituents. The attorney is not prohibited from simultaneous representation but is required to notify the individuals involved that the interest of the hospital organization as a whole is a primary concern to the attorney.

^{8/} AMA Policy Compendium Section H.230.975. See also 210 ILCS § 85/2(b)(2).

^{9/} But see Illinois Supreme Court Rules - Article VIII - Rules of Professional Conduct, Rule 1.7, where Rule does not prohibit simultaneous representation if the lawyer reasonable believes that the representation will not adversely affect the relationship with the other client. See also Rule 1.13 which states that when dealing with organizations, directors, officers, employees, members, the attorney shall advise other constituents. The attorney is not prohibited from simultaneous representation but is required to notify the individuals involved that the interest of the hospital organization as a whole is a primary concern to the attorney.

- At the end of the day, it is the hospital’s accreditation, license, compliance with the Medicare Conditions of Participation, and liability exposure for corporate negligent claims which are on the line and not that the physician or the organized medical staff which has not been held to be a separate legal entity on which similar responsibilities are placed.

In Libby Snelson’s paper, she cites to two state statutes to support her contention that economic credentialing is prohibited.^{10/} This is a misleading statement at best. The Massachusetts statute provides, in pertinent part:

“Each application should be considered solely on the basis of the individual training, competence, experience, ability, personal care and judgment of the applicant.”^{11/}

There are other states which have similar language but these statutes have never acted as a bar for all decisions which may be characterized as “economic credentialing.” For example, courts across the country have universally upheld the use of exclusive contracts because of the well recognized quality of care and related benefits which flow from these arrangements.^{12/}

Illinois has identified a legislative intent against the inappropriate use of economic criteria in determining an individual’s qualifications for initial and continuing medical staff membership or privileges which “may deprive . . . citizens . . . access to a choice of . . . health care providers.”^{13/} On the other hand, the Illinois Hospital Licensing Act specifically authorizes the use of exclusive contracts and economic credentialing, in whatever form, is in no way prohibited under state law.^{14/}

As stated at the outset, economic credentialing means different things to different people. Decisions such as exclusive contracts, the use physician need studies to determine whether a medical staff should remain open in all categories based on hospital and community needs, denial of a medical staff application from a physician employed by a direct competitor, and decisions to deny access because of limited resources, staffing and similar decisions which are inherently based on an economic considerations. These actions will not be successfully challenged if the hospital can demonstrate reasonable grounds and documentation to support its business judgment. Ironically, many of these decisions are in fact advocated by the members of organized medical staff who are concerned about adding new physicians to the staff because it will have the effect of increasing competition in their market and diminishing

^{10/} See Mass. Gen. Laws § 51C; VA. Code Ann. § 32.1-134.1

^{11/} *Id.*

^{12/} See e.g. , Kochert v. Greater Lafayette Health Services, Inc., No. 05-1196 (7th Cir. Sept. 12, 2006)

^{13/} 210 ILCS § 85/2(b)(2)

^{14/} 210 ILCS 85/10.4(b)(2)(c)(ii)

their revenues. Not surprisingly, the battle cry against economic credentialing sometimes depends on whose economic ox is being gored.

Courts also have recognized that a hospital decision to exclude certain physician competitors is clearly an acceptable practice and well within a hospital's independent business judgment with which courts seldom interfere. For example, in Rosenblum v. Tallahassee Memorial Regional Medical, Inc.,^{15/} the hospital received an application from a cardiologist who was the chairman of a cardiology program at a competing hospital. Tallahassee Memorial was concerned that if Dr. Rosenblum was granted membership he would use its hospital as a means to funnel additional patients to the competing facility. The decision of the hospital to deny Dr. Rosenblum an application was upheld because the court determined state law allowed the hospital to take economic factors into consideration in deciding whether to allow a physician on the medical staff.

Similarly, in Mahan v. Adera St. Lukes,^{16/} a hospital had difficulty in recruiting a replacement neurosurgeon because of concerns about adequate patient volumes in order to support a new practice. The hospital successfully recruited a physician after it decided to close the medical staff to selected spine procedures and to orthopedic surgeons experienced in this specialty as a way guaranteeing certain patient volumes. A challenge was brought by an existing orthopedic group who wanted to bring on a new member who would have competed with the recruited neurosurgeon for these services. The Appellate Court affirmed the trial court's decision which held that judges should not interfere with a hospital's judgment where tied to its economic survival as well as its overall effort to improve health care services in the community.

As additional support to for the argument that economic credentialing is prohibited, Libby Snelson cites to the decision of Baptist Health v. Murphy.^{17/} This case involved a successful challenge to a hospital's conflict of interest policy which mandated the denial of an initial or a renewed membership on the staff for physicians who held a direct or indirect ownership in a competing hospital. The physician plaintiffs in this case held an ownership interest in a competing heart hospital and would have been denied reappointment based on the policy. Enforcement of the policy was enjoined the by trial court and the decision upheld by the appellate court on several grounds.

Although Baptist Health can be seen as prohibiting a form of economic credentialing through the use of certain economic conflict of interest policies, this would be a rather simplistic analysis. It certainly does not bar the use of all such credentialing decisions. Moreover, there were certain fatal flaws committed by the hospital in adopting the policy. For example, the policy, as applied to current staff members, did not allow for any hearings as a pre-condition to termination. These physicians simply would not be reappointed they agreed to divest themselves of their economic interest. Had a hearing been given as arguably provided

^{15/} Case No. 91-589 (Fla. Cir. Ct. 1992)

^{16/} 621 N.W.2d 150 (S.D. 2001)

^{17/} 189 S.W. 3d 438(Ark. S. Ct. 2005)

under the medical staff bylaws, the policy might have been viewed as enforceable. In addition, there were certain substantive and possibly dispositive arguments which the hospital failed to make at the trial level but were not addressed by the appellate court because these arguments were deemed to be waived.

Baptist Health is certainly instructive to all hospitals which are contemplating the development of a conflict of interest policy, but does not serve as a bar to such policies. See discussion at Section VI, infra.

Ms. Snelson also cites to Satilla Health Services, Inc. v. Bell^{18/} as a case which runs contrary to the otherwise universal position of the courts that hospitals have the legal right to enter into exclusive physician provider contracts. This case involved the decision of a hospital to initially terminate the medical staff privileges of a group of cardiologists whose exclusive arrangement with the hospital was not renewed. The hospital attempted to replace them with a new exclusive group but the decision to terminate their membership was successfully enjoined by the state court on based on a unique standard in Georgia. Although the courts in Georgia have upheld the use of exclusive contracts, they have done so based on a standard which requires that physicians individually agree to include a clean sweep provision in these contracts, i.e., physician agrees to waive all hearing and appeals rights upon termination of the contract.

The trial and appellate courts determined that no such individual waiver had been obtained. Moreover, the hospital's attempt to bar access to its supplies, equipment and personnel to plaintiffs through a board resolution was also rejected because it would seem as a back door way to effectuate termination. Furthermore, the Board policy would not have provided any hearing opportunity to these physicians. Rather than serving as precedence to bar the use of exclusive contracts, Satilla stands for the proposition that such arrangements are acceptable if the hospital adheres to clearly established standards.

In further support to the concept that a hospital has the discretion, if not an obligation, of taking economic considerations into account when making privileging and credentialing decisions, the Joint Commission adopted a new medical staff standard entitled "Determination of Organizational Resource Availability."^{19/} This new Standard requires that before granting any privileges, the hospital must determine whether "the resources necessary to support the requested privilege...are... currently available, or available within a specified time frame."^{20/} The stated rationale and the Elements of Performance for the Standard requires that information should be gathered and a process established that will determine "whether sufficient equipment, staffing and financial resources are in place or available"

^{18/} Satilla Health Services, Inc. v. Bell, 2006 WL 1719550.

^{19/} Joint Commission Standard M.S. 4.00

^{20/} Id.

before granting, renewing or revising clinical privileges “to support each requested privilege.”^{21/}

The clear impact of this Standard is that the hospital may deny an initial or renewed request of clinical privileges if it does not have sufficient or available equipment, space, financial support, staffing or other resources required to support the exercise of any clinical privilege. The Joint Commission also expects that the Standard will be taken into consideration by a hospital as applied to physicians seeking to obtain and exercise clinical privileges at off-site locations such as clinics, surgi-centers, diagnostic facilities and urgi-centers.

Examples to how this Standard could be applied include the following:

- Hospital declines to process the new application by a general surgeon because the surgical suites are overbooked and there is an insufficient number of qualified and trained personnel to assist.
- Request for cardiac cath privileges is denied because the cath lab is over subscribed.
- Off-site hospital surgicenter limits the growth of clinical privileges to a group of recruited physicians in order to maintain quality and 24/7 coverage.
- Hospital relies on a medical staff development plan to identify needs and available resources in order to establish how many physicians and in what specialties are required in its primary and secondary service areas.

The adoption of this new Standard also makes sense given the current environment in which private and public payors are basing reimbursement decisions on pay for performance standards and outcome determinations. Hospitals are now being requested, and in fact have implemented information systems, to “profile” a physician’s length of stay, cost per patient visit, number of kind of tests ordered, number of consultants used, and other similar factors in order to determine comparative costs and utilization in response to these reimbursement standards. These costs and efficiencies will invariably be a factor in deciding who can obtain and maintain privileges, even if a physician’s quality is acceptable.

Irrespective of the case law, statutory and accreditation standards which support a hospital’s decision to economically credential, it is also imperative that hospitals involve physicians in these key decisions. Hospitals do not and cannot remain financially self sufficient without physicians. They cannot expect to attract high quality and loyal practitioners if they make these judgments without the valuable business and quality of care insights of the medical staff. It is therefore important from a practical and legal standpoint that whatever committees or groups are gathered for the purpose of providing information or making recommendations to the Board regarding exclusive contracts, medical staff development plans, and similar institutional decisions specifically include physician representatives. Obviously, these decisions need to be Board driven and cannot be unilaterally made or vetoed by physicians. In addition, the more

^{21/} Id.

these decisions can be embraced and supported by the medical staff, the less likely they will be subject to internal challenges or protracted litigation.

In summary, hospitals have very broad rights and discretion in making and implementing decisions which further its statutory, accreditation and compliance obligations, particularly if supported by patient care objectives as well as decisions which have a direct and immediate impact on the hospital's financial viability. Hospital should avoid making these decisions unilaterally and should directly involve the organized medical staff and physicians in developing balanced policies which take into account patient care factors as well as the impact on existing physician practices. Looking to the spectrum of decisions which are viewed as "economic credentialing", at one end of the continuum are exclusive contracts which will be universally upheld. On the other end, any policies which limit or deny applications to physicians because their payor mix shows a high percentage indigent and Medicaid patients, or because they will not admit exclusively to the hospital or which terminate existing staff physicians based on a competing economic interest will most certainly be more thoroughly scrutinized and possibly challenged.

IV. DISRUPTIVE BEHAVIOR

As in any organization, there will be those employees and others whose behavior is considered disruptive and unprofessional. Given the kinds of stress imposed on hospital personnel and physicians due to the liability environment, regulatory obligations, dealing with cantankerous patients and family members, and being worried about short falls in revenue, proper coding procedures, compliance with bylaws, rules regulations and other hospital policies, it is not uncommon for physician to have a few bad days in which their frustration and consternation bubbles over in the form of unacceptable behavior.

In the past, this conduct often times was simply tolerated. For example, surgeons, as a group, are generally known as being difficult. I recall being involved in one matter in which a neurosurgeon, while performing a lumbar laminectomy, became incensed when the scalpel he requested was not in the surgical tray. He proceeded to yell and scream at the nurses and throw the instruments across the operating room. Such behavior was not uncommon and no disciplinary action was initiated. The next week, while performing another back procedure, a different scalpel which the surgeon requested also was not in the surgical tray. At this point, he not only yelled and screamed at the nurses and launched his instruments across the room, but continued to shout various insults while slapping the exposed rear-end of the patient. It was at this point the hospital drew the line and imposed corrective action, especially since they found out that he was the one who failed to list the requested instruments to be included in the surgical tray and not the nurses.

These days, hospitals and medical staffs are less willing to look the other way. Maintaining a safe and productive work environment for employees and patients has become much more important in maintaining good employee relations and acceptable patient satisfaction ratings. That being said, hospitals and medical staffs look for patterns of behavior. Rarely does a single incident give rise to some form of immediate remedial or corrective action.

Although this behavior is becoming less tolerated, at the same time, there is a growing realization that the disruptive physician may be impaired or, that with a little “counseling”, can be brought back into line before the problem gets so out of hand. In response to this changing perspectives, rules and regulations or policies, there are now three different courses of action that are reflected in most medical staff bylaws as a way of dealing with this problem.

A. CORRECTIVE ACTION

The more traditional but less utilized manner of confronting disruptive behavior is through the use of the disciplinary procedures set forth in the medical staff bylaws. Most bylaws require that physicians act in a “professional manner.” Although this reference is somewhat vague, this pathway typically requires that some form of complaint be issued by another physician or department or committee chair which specifies the nature of the disruptive behavior and cites to a violation of the bylaws, or rules or regulations to support further investigation. If the matter cannot be resolved through this initial phase, which usually involves a meeting with the physician, a recommendation which adversely affects the physician’s membership or clinical privileges could ensue. If remedial action in the form of monitoring or proctoring is recommended, they usually can be imposed immediately. If, on the other hand, a suspension, reduction or termination of privileges has been proposed, the physician is entitled to exercise the hearing and appellate review rights and procedures under the bylaws.

This course of action, while still available, it is now seen as a last option in the event that other means of addressing the problem discussed in more detail below have failed. Obviously, where a physician who is clearly impaired, presents an immediate and clear threat to the well being of patients or others, quick disciplinary action may be required.

B. PHYSICIAN WELFARE COMMITTEE

In recognition of the need to identify and work with physicians who are disruptive and may be impaired, most medical staffs have established a Physician Wellness Committee or Physician Assistance Committee. Rather than move along the corrective action path, when a serious incident or pattern of unacceptable behavior is identified, the bylaws typically empower a department chair or medical staff officer to request, if not require, that the physician seek to be evaluated by this physician committee. These proceedings are intended to be supportive and confidential with the purpose of evaluating the existence of any problem and designing a plan of action to address the cause of the behavior. The “loud mouth” or disruptive physician may in fact have an anger management problem, an emotional issue or could be suffering from some drug or alcohol impairment which he or she has been able to mask or hide from others. These committees typically include a cross-section of professionals as well as a psychiatrist or other appropriate health care professional experience in dealing with these issues. Evaluations are sometimes conducted internally or through agreed-to outside third parties. In addition, some state medical societies have comprehensive programs which will readily assist hospitals and medical staff in this evaluative effort.

If problems have been identified and part of the plan of action is for the physician to seek outside assistance or counseling, or participate in a rehab program with ongoing monitoring, the physician is expected to abide by the program, to make the results of any evaluation available to

the committee and ultimately, to avoid further unprofessional conduct. Under this approach, the physician's membership and clinical privileges are not adversely affected unless absolutely necessary. Physicians successfully participating in such programs need not be reported to the National Practitioner Data Bank.^{22/}

Under Joint Commission Standards, these committees cannot have the authority to directly impose disciplinary action but can make a report and recommendations to other committees that are so empowered.^{23/} Physicians usually are more willing to opt for the supportive committee route versus the corrective action pathway in order to avoid the prospect of disciplinary action knowing that a refusal to consent to an evaluation will force the hospital and medical staff to pursue such disciplinary measures.

C. CODE OF CONDUCT

A third option in dealing with disruptive behavior which has become more prevalent in recent years, is the development of a code of conduct for physicians and other hospital personnel. Compared to the more general references in the bylaws, these codes are much more precise in describing the kinds of disruptive and unprofessional behavior which are deemed unacceptable and prohibited under the code. In addition to identifying the general categories of unprofessional behavior, the codes typically give examples or definitions of what is considered verbal, physical and sexual harassment so that personnel can conduct themselves accordingly.

These codes also set up a defined method of reporting actual or suspected violations, including the use of incident and similar reports prepared by nurses, other physicians, hospital personnel as well as patients. Where such issues have been identified, codes call for required meetings in order to evaluate the incident, allow the physician to give his or her side of the story and to counsel them as necessary so that the problem is avoided in the future. These procedures are not viewed as a form of corrective action even though the respective investigation procedures are similar. Like the Physicians Wellness Committee approach, the code of conduct process is purposefully designated to constructively assist the hospital and the medical staff to try to get physicians to more willingly participate in the process. The ultimate goal is to reduce or eliminate the disruptive behavior in the future so that the physician can maintain membership and clinical privileges and be a productive member of the medical staff.

In the end, if the physician committee or code of conduct options fail, neither routes preclude the use of corrective action if the patterns of disruptive or unprofessional behavior persists. If the problem is not resolved where the physician is not a willing participant, it may eventually force the hospital and medical staff to consider formal corrective action.

In her paper, Libby Snelson sets forth the AMA policy and definition for disruptive behavior which is consistent with how hospitals and medical staffs are attempting to approach these

^{22/} Attorneys and hospitals are advised to consult with applicable state statutes to determine whether an identified impairment, although not reportable to the Data Bank, may have to be submitted to the state licensing authority.

^{23/} Joint Commission MS.4.80.

problems and as discussed above. She also identifies examples of where the label “disruptive behavior” is inappropriately applied both in the context of actions which clearly are more based on negligent conduct and should be addressed accordingly or where hospitals or staffs attempt to misuse these policies in instances where the physician is simply advocating on behalf of his patient. Clearly the improper use of these policies is to be avoided. As a general proposition, when hospitals are faced with a physician whose professional conduct does not adhere to standards identified by both the hospital and the medical staff and hospitals should err on the side of pursuing the physician wellness or the code of conduct tracks in lieu of more traditional discipline. The procedures under all options should be viewed as confidential and should be designed in a manner to maximize the confidentiality protections afforded under state law for peer review procedures.

It is also important to point out the Joint Commission has proposed a new leadership standard which would require the following:

“As a critical component of the culture of safety, leaders set expectations for behavior among those who work in the organization.”^{24/}

The Elements and Performance for the Standard include:

- The leaders develop a code of conduct that applies to everyone that works in the organization.
- The code of conduct defines desirable and disruptive behavior.^{25/}
- All the work in the organization are educated about both desirable and destructive behaviors.
- Leaders develop processes for managing destructive behavior.

Contrary to Libby Snelson’s remarks, this Standard was intended to apply to all employees but principally physicians. The “disruptive administrator”, who she suggests was part of the motivation behind the Standard, most likely will be reviewed in accordance with existing human resource policies applied to employees.

V. CONFLICT OF INTEREST POLICIES

Conflict of interest policies are designed to require the disclosure of financial, business or personal interests which affect or may affect a person’s objectivity when voting on certain matters while serving in a decision-making or leadership position because of some benefit gained if allowed to vote. For example, all hospital directors are obligated to have formally adopted an enforceable conflict of interest policy pursuant to IRS regulations^{26/}, Joint Commission

^{24/} Joint Commission LD 3.15.

^{25/} Id.

^{26/} See, e.g., IRS Form 1023 which requires adoption of board conflict of interest policy.

standards^{27/} as well as state corporate and/or licensing requirements.^{28/} Even the AMA has developed conflict of interest forms and guidelines for its members.^{29/}

There are three key questions and issues of controversy as to application of a hospital's conflict of interest policy to medical staff members.

- What scope of conflicts must be disclosed?
 - Employment by competing hospital or similar facility
 - Contract with supplier or vendor to hospital
 - Serves as a director, officer, department chair of a competing hospitals/surgicenters/diagnostic center
 - Existence of a the financial/investment/contract interest in competing facility
 - Physician has a spouse and/or family member who meets any of the above disclosure requirements.
- Who must disclose?
 - Board and Committee members
 - Medical Staff Officers
 - Department/Committee Chair
 - Employed physicians and physicians under contract with this hospital, i.e., medical director, lessee.
 - Joint venture participant.
 - Physicians receiving any kind of hospital contracted service.
 - All applicants and current members of the medical staff.
- What impact if conflict is identified?
 - Recusal from voting and/or participation in conflicted matter(s)

^{27/} Joint Commission RI. 1.20.

^{28/} See, e.g., 805 ILCS 105/108.60.

^{29/} Conflict of Interest Guidelines for Organized Medical Staffs Section, American Medical Association. The AMA also has promulgated conflict of interest guidelines including sample policies and interest disclosure forms for the organized medical staff.

- Ineligible to serve on Board or Board committees
- Cannot have contract of any kind with the hospital
- Cannot serve as a department/committee chair (or member?)
- Cannot serve as medical staff officer
- Cannot obtain or maintain membership or clinical privileges at hospital
- OR must invest ownership/financial interest or terminate contractual or related relationship with competing entity.

Other key questions would include:

- Do current corporate and/or medical staff bylaws address conflicts of interest and, if so, do they address all of these questions?
- Do state/federal/accreditation standards, along with applicable caselaw, address these questions?
- How have other peer hospitals/medical staffs approached these questions?
- Does hospital policy treat all board members, including physicians, uniformly?
- Are hearing rights triggered if a physician is denied membership or loses membership as a result of conflict of interest?
- Does policy conflict with AMA position?
 - Hospital conflict of interest policy should only apply to the physician employees and physician board members.
 - Remedial action should never result in a denial or revocation of medical staff membership and clinical privileges.^{30/}

From the hospital's perspective, and as discussed under the economic credentialing section of this paper, physician applicants to the medical have no legal or inherent right to membership and clinical privileges. Moreover, the hospital board has a fiduciary responsibility to maintain the institution's financial viability and to take all appropriate steps, economic or otherwise, to make sure that it has means to stay competitive, maintain accreditation and licensure, and to achieve the ability to render continuous high quality health care services. Physicians who have an ownership or financial interest in competing hospital or other health care facility have a direct and immediate conflict of interest of the hospital. Studies have shown, for example, that 70 percent of specialty hospitals have some form of physician ownership interest and that these

^{30/} See footnote number 29.

facilities treated lower percentage of severely ill patients compared to general acute care hospitals.^{31/} An additional and justifiable concern is that physicians will select to treat the better paying commercial and managed care patients leaving hospitals to care for the indigent and Medicaid patients. It is for these and other reasons that CMS chose temporarily not to approve additional specialty hospitals as eligible for Medicare and Medicaid reimbursement.

A. POLICY APPLIED TO PHYSICIAN APPLICANTS

Despite the AMA position that such conflict of interest policies should have both a limited scope and impact, it is not unreasonable for hospitals to require all new physician applicants to complete a conflict of interest questionnaire in order to determine the existence and degree of all conflicts, including financial. Asking the question and taking action on the information are two different things. Moreover, it is easier to exclude new applicants for justifiable cause because, as a practical matter, there are no reporting obligations nor hearing requirements for an initial applicant whose request for membership is been denied. As previously pointed out, courts have supported hospital decisions to exclude applicants who hold a competing economic interest or because the grant of membership would undermine certain strategic and economic decisions made by the hospital.^{32/}

As an additional example, lets assume that Dr. Smith has applied for medical staff privileges as a family practitioner at Community Hospital. Community has identified a need for such practitioners in its primary service area. As part of its application questionnaire, the hospital requires Dr. Smith to reveal whether he is employed by any other hospital, either as a direct employee or independent contractor, or has any other contractual, financial or other similar interest in any surrounding hospital or health care facility. In response to this questionnaire, Dr. Smith reveals the fact that he is a member of a multi-specialty physician group which recently was purchased by District Medical Center, a competing facility. Because of district's interest in making sure the physician group justifies the cost of its purchase, the expectation is that all primary physicians within the group will make all referrals to the multi-specialists in its group as well as to district where reasonable and appropriate and as long as patient care is not placed at risk.

Under this scenario why would Community ever consider placing Dr. Smith on the medical staff knowing full well that any patients seen would be directed to the controlled physician group and to District Medical Center where possible? Whether based on Joint Commission M.S. 4.00 or a court's deference to the hospital's ability to run its own business, it would entirely reasonable and legally defensible for Community to deny Dr. Smith an application for staff membership given the clear business and financial conflict of interest which exists between the two of them. Ideally, this decision should be made pursuant to some duly adopted policy citing the basis on which the application is being denied. Further, the policy should be uniformly applied to physicians and prospective lay board members alike.

B. POLICY APPLIED TO PHYSICIAN BOARD MEMBERS AND EMPLOYEES

^{31/} GAO-04-167 (Oct. 2003)

^{32/} See footnotes 15 and 16.

The next category of affected individuals would be physician board members and physician employees of the hospital. Even the AMA agrees the hospital conflict of interest policies should be applied to these physicians. The rationale is obvious. It would clearly be inappropriate for a physician to obtain and make decisions based on sensitive, confidential business information which could affect their objectivity and personal interests should they vote on particular matters such as strategic initiatives, approval of various contracts which may adversely affect their economic interest with the competing facility, or other similar conflict.

Most board policies under these circumstances would require the physician or other board member to recuse themselves from voting on the matter. Others would further preclude them from participating in the discussion given the sensitivity of the information being shared.

Although placement on the Board could be denied based on the identification of a significant business conflict, the more difficult question is whether it is appropriate for the hospital to also seek the resignation or removal of a current board member when such a conflict is revealed. To further complicate matters, what if the individual involved is the president of the medical staff who serves in this board position as an ex-officio member with vote?

I believe that most attorneys would support removal from the Board as an option, unless the member divests him- or herself of the identified financial conflict. Although an appropriate remedy, it should be applied uniformly across the board and should not simply target physician board members. Such uniform enforcement will make the policy more defensible should a legal challenge arise.

C. POLICY APPLIED TO INDEPENDENT PHYSICIANS UNDER CONTRACT

Another application of the conflict of interest policy relates to those physicians who do not serve on any board or leadership position, but have some form of contractual relationship with the hospital. This could take the form of an office lease, a medical director position, services through an independent contractor relationship and other arrangements where the physician receives fair market value in return for services rendered. It would certainly be within the hospital's independent judgment to refuse to enter into these arrangements at the outset if a conflict exists or to terminate the contract if a conflict is thereafter identified as long as the contract in question cites the existence of a conflict as a ground for termination. Under these circumstances, a physician's medical staff privileges and membership usually remain in tact but this, too, can be an issue open to negotiation.

D. POLICY APPLIED TO ELECTED MEDICAL STAFF OFFICERS AND DEPARTMENT CHAIRS

Perhaps the most difficult category to deal with is where an elected medical staff officer or department/committee chair member has disclosed a financial conflict of interest. Under these circumstances, it is not likely that physicians serving in this position will have access to sensitive business or other confidential information about the hospital because their role usually is limited to quality of care, peer review and other related department and administrative medical staff matters. Where such information might be discussed or made available, the physician certainly can be requested to recuse him- or herself depending on the nature of the conflict and/or could be

requested to not attend or participate during that portion of the meeting. For example, it would certainly be appropriate to request that a department chair not participate in the decision on whether to grant appointment to a new applicant of a competing group. Similarly, if the hospital is reviewing important strategic information with the Department of Surgery regarding its outpatient surgi-center initiative, the Department chair, who has an ownership interest in a competing surgi-center, should not participate in these discussions or any vote which transpires.

It would be quite a different matter, however, if the hospital chose not to recognize the department chair or medical staff officer or instead, seek their removal as a result of a financial conflict of interest. These individuals typically are elected by their medical staff peers and are not appointed by the hospital. In addition, it is not likely that the medical staff bylaws contain language that would authorize such removal or refusal to appoint these individuals. It is certainly possible that the corporate bylaws or policies could contain such language but under either instance, any attempt to remove or not recognize these individuals would be extremely controversial and could result in a legal challenge which would likely get the support of the state medical society and possibly the AMA. This scenario is distinguishable from the circumstance in which the hospital directly hires and pays the department chair who is not otherwise elected by the department or other medical staff members.

E. POLICY APPLIED TO INDEPENDENT PHYSICIANS WITH NO CONTRACTUAL OR LEADERSHIP POSITION

The last category of practitioner which was exemplified in the Baptist Health decision is the current staff member who holds no position of leadership but has an investment or financial interest in a competing hospital or other health care facility. The hospital in Baptist Health adopted its policy to bar the acceptance of new applicants or to require termination of existing staff physicians who hold a financial interest in a competing facility unless they divested such interest. The policy was adopted by the Board and not the medical staff. There was no language in the medical staff bylaws that would have supported this specific rationale as grounds for termination. In addition, the policy of the hospital did not afford the physician any rights to a hearing or appeal even though membership and clinical privileges were being terminated. The same held true in the Satilla case.

It is difficult to know whether other state courts would universally embrace the Baptist Health decision. Much of the court's rational decision was based on market and contract realities in the region. For example, the court in Baptist Health was certainly influenced by the fact that many insured patients who were treated by the plaintiff cardiologists were limited to using Baptist Health as their sole inpatient facility. Termination, therefore, by Baptist Health of these physicians would deny patients access to their long-standing practitioners if inpatient care was necessary. The court seemed convinced that Baptist Health was well aware of this impact. Also, as has been pointed out on a couple of occasions, these physicians were given absolutely no hearing rights or other opportunity to challenge this decision internally.

Not surprisingly, these cases often turn on the facts and circumstances involved. As was discussed in the Rosenblum and Mahan cases, and arguably supported by MS.4.00, hospitals may be experiencing significant financial exigencies which could adversely affect its ability to render quality patient care most certainly will be given broad discretion in making reasoned

business decisions which, at a minimum, can be used to deny new physician applicants. Hospitals may be left with little choice but to bar from membership or even to terminate existing physicians whose financial interests are significant enough and where they can demonstrate loss of patients and patient revenue as a result of the physician's continued access to the medical staff. Unlike the Baptist Health case, in larger markets it is not uncommon for the physician to have membership on multiple hospitals and staffs. Under these circumstances, it would not be difficult for a physician to shift his or her business to another facility and therefore loss of membership would have less financial impact on the physician. Documentation would be important in these cases should there be a challenge of such a policy. Hospitals which choose this rather controversial option most assuredly should offer some type of hearing, administrative or otherwise, to these affected individuals and should be prepared for a time-consuming, expensive litigation fight. They may ultimately win in the end, but the question will be at what political, legal and relationship costs.

VI. MEDICAL STAFF ON CALL

Under the provisions of EMTALA^{33/}, hospitals participating in the Medicare/Medicaid program must "maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition".^{34/} This obligation requires that the hospital make available sufficient numbers of physicians who are on call in order to make sure that patients have access to hospital and physician specialty services consistent with the scope of inpatient services provided by the hospital. Libby Snelson is correct that EMTALA does not impose a direct, specific obligation and all medical staff physicians to take ED call. On the other hand, most medical staff bylaws require that active staff and associate staff physicians to accept on-call obligations if determined by the department chair to be necessary in order to obtain adequate coverage.

In departments where there are numerous members, such as the department of medicine, it is not difficult to develop an on-call schedule which is not overly burdensome to physicians. In fact, depending on volumes and numbers of physicians available, the call might be completely voluntary because there are enough internist physicians in the department to take call. In other departments, it is conceivable that physicians over the age of 55 could be relieved of this obligation, again because of sufficient numbers available.

The plethora of available physicians, however, decreases dramatically when you start looking at rural hospitals and hospitals which offer specialty and sub-specialty services. Because there are fewer bodies, physicians are under a more significant burden, particularly if they serve on multiple medical staffs. Moreover, while some physicians view this obligation as a way to generate additional patients and revenue, others see this as an unreasonable burden which they would just as soon pass on to someone else.

^{33/} The Emergency Medical Transfer, and Active Labor Act, 42 U.S.C. § 1595dd et seq.

^{34/} 42 U.S.C. § 1395cc(a)(1)(I).

Unfortunately, it is not uncommon for physicians to refuse to take call or to fail to respond to an ED call. Such failures amount to a violation of EMTALA and could lead to the imposition of civil fines and termination from the Medicare/Medicaid programs for both the hospital and the physician. Loss of deemed compliance status regarding the Medicare Conditions of Participation and continued accreditation and licensure of the hospital also are placed at risk.

Some physicians have responded to the call obligations by either demanding to be paid for their time while taking call or, as a way to avoid these responsibilities, have either resigned from the medical staff or have claimed not to be qualified to handle emergency cases. They have gone as far as to request a reduction of certain key privileges which, if the request was granted, would conceivably place both the physician and the hospital at risk if asked to exercise a privilege which they no longer have or for which they are truly not qualified. Hospitals, of course, are skeptical of the true motives underlying these requests and view this effort by physicians to be simply a way to get out of their on-call obligations.

On June 13, 2002, a Department of Health and Human Services program memorandum and subsequent guidelines issued in 2004 made the following points:

- The guidelines state that where a hospital lacks capacity to treat a patient, a transfer consistent with EMTALA requirements is appropriate.
- Where there is limited physician availability and hospital resources, CMS “allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.” There is no requirement on how often physicians are required to be on call. Any limitations on coverage should be supported by documentation.
- Allowing the hospital medical staff the flexibility to exempt certain physicians based, for example, on the age or years of services, is acceptable as long as it “does not affect patient care adversely.”
- Although there are no set ratios relating to the number of physicians required to provide 24/7 coverage in any specialty, CMS will look to various factors such as the number of physicians, demands placed on these physicians and for emergency services, and alternative coverage or transfer arrangements when determining whether EMTALA coverage obligations have been met by the hospital.
- In response to a question as to whether hospitals in the same community can share on-call coverage so that there is a 100% coverage in one or more specialties, CMS essentially stated that this option was available, but emphasized the need to adopt appropriate policies, procedures and bylaws defining these responsibilities and options, particularly if circumstances do not permit either hospital to provide needed coverages on its own.
- CMS, while recognizing that a hospital may have particular problems with availability of on-call physicians, raised certain concerns over a policy which would permit an on-call physician to schedule an elective procedure at the same time.

- Physicians can be on call simultaneously in more than one hospital consistent with standards discussed above.

Although CMS has greatly assisted the problem by recognizing hospitals and medical staffs are not always able to provide 24/7 coverage in all specialty areas, any decision to provide limited coverages must be justified and documented. Moreover, backup and alternative plans involving plans for arrangements, shared coverage and other means must be developed, implemented and followed in order to adhere to EMTALA obligations.

From the hospital's perspective, the following principles regarding ED coverage are reasonable and defensible:

- As a general rule, a medical staff physician must be available to provide ED coverage as per the policy developed by the department.
- This coverage obligation should be set forth in the medical staff bylaws, rules and regulations as well as departmental policies.
- The scope of privileges which a physician is expected to exercise while on call is the same privileges listed on the privileged card or as included in the core privileges.
- If a physician is not qualified to render ED services, then he or she is not qualified to be a member of the medical staff.
- Physicians cannot seek to limit the scope of clinical privileges as a means of avoiding ED coverage obligations. Under the core privileging concept, physicians who have attended an accredited medical school and residency program and are board certified are presumed to be competent and qualified to perform the identified core privileges.
- If a physician is exercising the full range of privileges at another hospital, they must be available to exercise the same privileges within the Emergency Department.
- The burden is on the physician to establish if they are not qualified to render one or more clinical privileges that would otherwise be given to them.
- Physicians should not be allowed to meet a coverage burden by allowing him or her to obtain backup coverage for the gap privileges for which they state they are no longer qualified to perform.
- If a physician practices in a specialty or super-specialty area in which there are few practitioners and providing 24/7 coverage is impossible, impractical or imposes an unreasonable burden on the physician, they must attempt to coordinate with the hospital to come up with a reasonable coverage plan.
- Physicians must realize that all hospitals cannot afford to pay coverage in all specialty areas.

- The medical staff bylaws, rules and regulations should make clear that the failure to abide by established ED obligations can and will subject a physician to some form or remedial/corrective action.

In summary, there are more on which hospitals and medical staff can and do agree than disagree. Perfect synchronicity will never be achieved given the competitive nature of the market place but both sides need to strive for continued financial co-existence where possible. Hospitals may have economic and legal leverage at the end of day but also have more at stake. Pyrrhic victories do not fill beds or result and hospitals are not able to deliver high quality patient care services on their own. And while legal disputes may help generate significant revenues for attorneys, hospitals and physicians have better ways of utilizing limited resources.