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Hospital Counsel/Medical Staff Counsel: Conflicting Perspectives on Current Medical Staff Legal Issues

Elizabeth A. “Libby” Snelson

Legal Counsel for the Medical Staff
121 Virginia Street
St. Paul, Minnesota 55102
Telephone: 651.293-0321
Fax: 651.293-1003
easesq@snelsonlaw.com

Michael R. Callahan

Katten Muchin Rosenman LLP
525 W. Monroe Street
Chicago, Illinois 60661
Telephone: 312.902.5634
Fax: 312.577.8945
michael.callahan@kattenlaw.com

Overview – Hospital and Physician Interests Aligned

- As a general proposition, the economic and quality of patient care interests of the hospital and the Medical Staff are aligned and consistent.
 - Hospital and physicians need to obtain and maintain licenses.
 - Continued accreditation of the hospital and Medicare/Medicaid eligibility of the hospital and the physicians is essential in order to maintain status as a provider and for economic viability.

Overview (cont'd)

- Hospital and Medical Staff must work together to meet licensing, accreditation and corporate negligence standards through the appointment, reappointment, credentialing, privileging and peer review procedures as reflected in the medical staff bylaws, rules and regulations, department policies and the hospital's corporate bylaws.
- Hospital and physicians need to obtain and maintain adequate professional liability insurance.

Overview (cont'd)

- Physicians need a strong viable hospital which can provide properly and adequately equipped inpatient and outpatient facilities along with highly qualified professional hospital personnel to support physicians in rendering quality patient care services.
- Hospitals need to attract qualified physicians to obtain and maintain membership and clinical privileges, with a balanced payor mix, in order to remain viable and competitive.

Overview – Interests at Odds

- Although hospital outside and in-house counsel can and do effectively advise and legally represent the interests of the hospital and the Organized Medical Staff (“OMS”) on most legal and regulatory matters which affect all parties, there are certain areas and issues for which the OMS should or does seek independent legal counsel with an expertise in medical staff matters. These areas include, but are not limited to, the following:

Overview (cont'd)

- Medical Staff Bylaws.
- Development and implementation of conflict of interest policies which could result in removal or limitation in role of physicians as members of the board of directors, medical staff officers, department/committee chair or even medical staff membership.
- Development and implementation of economic credentialing policies which condition appointment/reappointment decisions on criteria other than a physician's professional training, education, experience and conduct.

Overview (cont'd)

- Hospital response and possible opposition to competing facilities in which physician or family member holds a business or financial interest.
- Emergency Department call schedules:
 - Who is eligible and who is not
 - Who wants it and who does not
 - What ED services must a physician provide – all or only some a his or her “core privileges”

Overview (cont'd)

- Can a physician seek to limit his or her privileges so as to limit or avoid serving on the call schedule.
- Hospital/Physician Joint Ventures
- Fair Hearings
- Who appoints and/or approves medical staff officers and department chairs
- Who sets limits on professional liability coverage limits
- Scope and implementation of disruptive Behavior/ “Code of Conduct” policies

Conflict of Interest Policy

- A conflict of interest policy is designed to require the disclosure of a financial, business or personal interest which will or may effect a person's objectivity when voting on certain matters while serving in a decision making leadership position.
- For example, all hospital boards of directors are obligated to have a formally adopted and enforceable conflict of interest policy pursuant to IRS, Sarbanes Oxley, AHA policy and Joint Commission Standards as well as state corporate and/or licensing requirements.

Conflict of Interest Policy (cont'd)

- The AMA also has developed Conflict of Interest Guidelines, including sample policy and interest disclosure forms, for the OMS.
- There are three key questions and issues of controversy as to the application of a **hospital's** conflict of interest policy.
 - What scope of conflicts must be disclosed?

Conflict of Interest Policy (cont'd)

- Employment by competing hospital or similar facility
- Contract with supplier or vendor to hospital
- Service as a director, officer, department chair of competing hospital/surgicenter/ diagnostic center
- Existence of a financial/investment/contract interest in competing facility
- Physician has a spouse and/or family member who meet any of the above-disclosure requirements

Conflict of Interest Policy (cont'd)

- Who must disclose?
 - Board and board committee members
 - Medical staff officers
 - Department/Committee chairs
 - Employed physicians and physicians under contract with the hospital, i.e., medical director, office lease
 - Joint venture participants
 - Physicians receiving any kind of hospital service support, i.e., medical staff office services, IT

Conflict of Interest Policy (cont'd)

- All applicants and current members of the Medical Staff
- What impact if conflict is identified?
 - Recusal from voting and/or participation in the conflicted matter(s)
 - Ineligible to serve on Board or Board Committee
 - What about Medical Staff President who typically serves as an ex officio, voting member of the Board?

Conflict of Interest Policy (cont'd)

- 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 and clinical privileges at hospital
- OR must divest ownership/financial interest or terminate contractual or related relationship in competing entity

Conflict of Interest Policy (cont'd)

- Other Key Questions
 - 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?

Conflict of Interest Policy (cont'd)

- 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 the conflict of interest?
- Does policy conflict with AMA position?
 - Remedial action should never result in the denial or revocation of Medical Staff membership and clinical privileges

Hospital Position on Conflict of Interests

- Physician applicants to Medical Staff have no legal or inherent right to membership and clinical privileges.
- Hospital Board has a fiduciary responsibility to maintain the institution's financial viability and to take all appropriate steps, economic and otherwise, to make sure that it has the means to stay competitive, maintain accreditation and licensure, and to achieve the ability to render high quality health care services.

Hospital Position on Conflict of Interests (cont'd)

- Physicians who have are ownership/financial interest in a competing hospital or other health care facility have a direct and immediate conflict of interest with the hospital.
 - Studies have shown that 70% of specialty hospitals have some form of physician ownership interest and that these facilities treat a lower percentage of severely ill patients compared to general acute care hospitals (See GAO-04-167 (Oct. 2003))
 - Additional concern is that physicians will select to treat the better paying commercial and managed care patients leaving the hospital to care for the indigent and Medicaid patients

Hospital Position on Conflict of Interests (cont'd)

- It is reasonable for the hospital to require all new physician applicants to complete a conflict of interest questionnaire to determine existence and degree of all conflicts of interest, including financial.
- If a physician, or spouse, has an ownership or financial interest, including a significant contractual arrangement, with a competing health facility, hospital is within its legal authority to deny pre-application or application for membership.

Hospital Position on Conflict of Interests (cont'd)

- See, e.g., Rosenblum v. Tallahassee Memorial Regional Medical Center, Inc. (Case No. 91-589 (Fla. Cir. Ct. 1992) (Court upheld denial of application from cardiologist who was program chair and developed a cardiology program at a competing hospital based on board policy which took economic factors into consideration).

Hospital Position on Conflict of Interests (cont'd)

- See also Mahan v. Avera St. Lukes, 621 N.W.2d 150 (S.D. 2001) (Court upheld decision of hospital to close medical staff to selected spine procedures and closed applications for orthopedic services after having recruited a replacement neurosurgeon who also performed back procedures. Challenge brought by existing orthopedic group who wanted to bring on a new member was rejected by appellate court which upheld trial court's decision that judges should not interfere with hospital's judgment which was tied to hospital's economic survival and overall benefit to the community).

Hospital Position on Conflict of Interests (cont'd)

- Hospital needs to identify reasons for denying application. Decision is not reportable and unless otherwise provided in medical staff bylaws, physician is not entitled to a hearing.
- To enhance enforceability and protect against a challenge, hospital needs to create appropriate policies and justification for excluding prospective applicants and needs to apply uniformly.
- Policy also should be applied to prospective lay Board members.

Hospital Position on Conflict of Interests (cont'd)

- Hospital is within its legal authority to deny placement on Board or seek resignation or removal from Board and its committees and competing physicians and lay persons unless they agree to divest ownership/financial/contract interests.
 - Can be applied to President of Medical Staff

Hospital Position on Conflict of Interests (cont'd)

- Hospital can also seek to terminate any leases, medical director arrangements and other contracts with physicians where conflict is disclosed or identified and confirmed.
 - Contract must include appropriate language to support termination on these grounds.
 - Medical Staff privileges and membership usually remain in tact but this is an issue open to negotiation.

Impact of Conflicts Policy on Existing Physicians

- Hospital choosing to adversely affect an existing staff members elected position as an officer, department/committee chair and/or medical staff membership and clinical privileges will likely face a more difficult, if not a successful, challenge for the following reasons:
 - Conflict of interest policies would need to be very specific as to nature and extent of any adverse effect.
 - Officers and department/committee chairs typically are elected by voting medical staff members or are appointed by the President of the Medical Staff as per the bylaws.

Impact of Conflicts Policy on Existing Physicians (Cont'd)

- Interference with these duly elected positions will give rise to significant political and legal issues, particularly in jurisdictions which hold that bylaws are binding on hospital and medical staff.
- Corporate bylaws are likely silent on this issue. Under Joint Commission Standard MS 1.20, Element of Performance 5, corporate and medical staff bylaws cannot conflict (proposed revisions to MS.1.20 would eliminate this restriction); Joint Commission Standard MS 1.30 also states: "Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaw or rules and regulations."

Impact of Conflicts Policy on Existing Physicians (Cont'd)

- But see February 6, 2003 letter to OIG from AMA re: Solicitation of New Safe Harbors and Special Fraud Alerts where AMA states that physicians with “competing personal financial interest or similar positions at competing hospitals should not serve in positions that are privy to sensitive business or strategic planning information....”
 - Any such action is contrary to AMA position and likely will attract opposition from AMA and state medical society
 - Medical staff bylaws will not include any language to support removal

Impact of Conflicts Policy on Existing Physicians (Cont'd)

- Documentation of adverse economical and/or quality reasons to support removal would need to be detailed
- Hospitals which choose to terminate membership and/clinical privilege should consider providing a hearing as per the bylaws or some similar fair forum in anticipation of the argument that privileges and membership cannot be terminated without the right to a hearing and appeal.

Impact of Conflicts Policy on Existing Physicians (Cont'd)

- See Baptist Health v. Murphy - 189 S.W.3d 438 (Ark.S.Ct.2005) (Existing staff physicians successfully challenged hospital conflict of interest policy which mandated the denial of initial or renewed membership on the staff for physicians who held a direct or indirect ownership or investment in a competing hospital. Trial court granted physicians request for injunctive relief to enjoin enforcement of the policy on the basis of a finding of intentional interference in the doctor-patient relationship and a violation of the Arkansas Deceptive Trade Practices Act which was affirmed on appeal. Policy did not allow for any hearing rights.)

Medical Staff Position on Conflict of Interests

- Hospital Conflict of Interest Policies do not apply to medical staff members
 - Unless Board Member
 - Unless Hospital Employee

Medical Staff Position on Conflict of Interests (Cont'd)

Medical Staff Should Address *Medical Staff* Conflicts of Interest in Medical Staff Bylaws, e.g.

- Peer Review Conflicts
 - Credentialing/Privileging Bias
 - Corrective Action Bias
- Leadership Conflicts
 - Hospital Employment
 - Hospital Contract
- Research/Equipment Conflicts
 - IRB Participation
 - Instrument/Equipment Recommendations

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”?

- MS.4.00 - “Determination of Organizational Resource Availability”
 - New Standard requires that before granting any privileges, a hospital must determine whether “the resources necessary to support the requested privilege are . . . currently available, or available within a specified time frame.”
 - Stated rationale and the Elements of Performance for the Standard is that information should be gathered and a process established that will determine “whether sufficient space, equipment, staffing, and financial resources are in place or available” when granting, renewing or revising clinical privileges “to support each requested privilege.”

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”? **(Cont’d)**

- Although reliance on these factors might not be viewed as “pure” economic credentialing, such as the conflicts policy in Baptist Health, the AMA defines “economic credentialing” as “the use of economic criteria unrelated to quality of care or professional competence in determining a physician’s qualifications for initial or continuing hospital Medical Staff membership or privileges (AMA Policy 2-230.975) See also 210 ILCS 85/10.4(a)(4).

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”? **(Cont’d)**

- Clear impact of the Standard is that the hospital may deny an initial or renewed request for clinical privileges if it does not have sufficient or available equipment, or space or financial support or staffing or any other resources required to support the exercise of any clinical privilege.
- Statements made by the Joint Commission also expect that the Standard will be taken into consideration by a hospital when physicians seek to obtain and exercise privileges at off-site locations such as clinics, surgicenters, diagnostic facilities, urgicenters, etc.

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”? (Cont'd)

- Examples of how Standard could be applied:
 - Hospital declines to process a new application by a general surgeon because surgical suites are overbooked and there is an insufficient number of qualified and trained personnel to assist.
 - Request for cardiac cath privileges denied because cath lab is oversubscribed.
 - Hospital’s surgicenter is limited to a solicited off-site ambulatory group of physicians and site can only accommodate a finite number of practitioners.

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”? (Cont’d)

- Hospital relies on Medical Staff Development Plan, which looks to identified needs but also available resources, to define how many physicians, and in what specialties, are required in primary and secondary service areas and what services it can afford to provide.
- Is this a new or old question?
 - Pure economic credentialing and the requirement that physicians be required to admit exclusively to the hospital in order to obtain and maintain membership is still a sensitive legal and political issue.

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”? **(Cont’d)**

- Hospitals are now being requested to “profile” a physician’s length of stay, cost per patient visit, number and kind of tests ordered, number of consultants used, etc., in order to determine levels of cost and utilization as part of pay for performance expectations.
- Cost and efficiencies will be a factor in deciding who can obtain and maintain privileges even if quality is good.
- MS.4.00 is a Standard which hospitals will be able to rely on in making these decisions as long as it is part of a defined process.

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”? **(Cont’d)**

- How does hospital plan to involve physicians in this process?
- Needs to be Board driven with the Board making final decisions but with significant medical staff involvement in the form of gathering information and making recommendations.
- Where is process located? Bylaws? Policy? Board or Medical Staff?

Joint Commission Standard MS.4.00 – A Revised Form of “Economic Credentialing”? **(Cont’d)**

- Although these market questions and decisions are not new, MS.4.00 provides Joint Commission support for the use of criteria which could trigger some opposition from the OMS depending on how the criteria are adopted and implemented.
- In order to provide additional legal support for the ability to rely on resource availability in making credentialing decisions, hospitals may be requesting that this Standard be reflected in medical staff and corporate bylaws.

Emergency Department Call Coverage

- An area in which there has been considerable discussion is the requirement that under EMTALA, a hospital has to provide Emergency Department services and to make sure that there are a sufficient number 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.
- Most hospitals require that as a condition of obtaining and maintaining membership and privileges, a physician has to agree to participate on the ED call roster.

Emergency Department Call Coverage

(Cont'd)

- Sometimes only associate and active staff members are permitted to take call because of the need to make sure physicians are experienced and qualified to care for emergency patients.
- Call schedule is usually established by the department chair based on numbers in the department, their experience, availability, age, and department needs based on expected volume of calls.

Emergency Department Call Coverage

(Cont'd)

- Some physicians view ED call as a duty and some treat as a privilege.
- Almost all hospitals treat ED as a duty and therefore, removal from the call roster typically does not trigger a fair hearing.
- Failure to respond to an ED call when on the roster can result in corrective action, but such action is rarely imposed unless there is a bad result.

Emergency Department Call Coverage

(Cont'd)

- Such a failure is a violation of EMTALA and can lead to the imposition of civil fines and termination from the Medicare/Medicaid programs for both the hospital and the physician, and loss of deemed status regarding compliance with the Medicare Condition of Participation. Continued accreditation and licensure also are placed at risk.
- Until recently, CMS expected hospitals and medical staffs to provide 24/7 coverage in the ED including a dedicated staff, usually through an exclusive contract and on call physicians in each specialty area based on a rotating schedule.

Emergency Department Call Coverage

(Cont'd)

- These coverage requirements become increasingly more difficult to meet particularly in specialty areas such as neurosurgery, OB, and plastic surgery, where there were few available specialists who were being forced to cover at all hospitals where they had medical staff privileges – is especially problematic in rural and some suburban areas.
- Physicians are beginning to refuse to take call or have started dropping off of medical staffs in order to reduce ED call obligations.

Emergency Department Call Coverage

(Cont'd)

- Some physicians have refused to take call unless they are paid for their time.
- More recently, some physicians are claiming that they are not qualified to take call or are requesting fewer privileges as a way to argue that they are not properly credentialed to handle all ED cases and requiring that they stay on the call roster will expose both them and the hospital to liability claims and damages.

Emergency Department Call Coverage

(Cont'd)

- June 13, 2002 DHHS Program Memorandum and the 2004 Guidelines regarding EMTALA on-call requirements made the following points:
 - The Guidelines state that where hospital lacks capacity to treat a patient, 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 set requirement on how often physicians are required to be on-call. Key is to document.

Emergency Department Call Coverage

(Cont'd)

- Allowing the hospital and medical staff the flexibility to exempt certain physicians based, for example on age or years of service, 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 numbers of physicians, demands on these physicians and for emergency services and alternative coverage or transfer arrangements when determining whether EMTALA coverage obligations have been met made by the hospital

Emergency Department Call Coverage

(Cont'd)

- In response to a question as to whether hospitals in the same community can share on-call coverage so that there is 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
- Call schedules must list physician by their individual names. Naming a specific physician group is not permitted

Emergency Department Call Coverage

(Cont'd)

- CMS, while recognizing that hospital may have particular problems with availability of on-call physicians, raised 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 at more than one hospital consistent with standards discussed above.

Emergency Department Call Coverage

(Cont'd)

- Hospital Position on ED Coverage
 - As a general rule, if you are on the medical staff, you must be available to provide ED coverage as per the policy developed by the Department.
 - The scope of privileges which physician is expected to exercise while on call is the same privileges listed on privilege card .
 - If physician not qualified to render ED services then not qualified to be a member of the medical staff.

Emergency Department Call Coverage

(Cont'd)

- Physician cannot seek to limit scope of clinical privileges as a means of avoiding ED coverage obligation. Under 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 identified “core” privileges.
- If physician is exercising full range of privileges at another hospital, must be available to exercise privilege in ED.
- Burden is on the physicians to establish if they are not qualified to render one or more clinical privileges that would otherwise be given to them.

Emergency Department Call Coverage

(Cont'd)

- Physician should not be allowed to meet this burden by allowing him/her to obtain back up coverage for the gap privileges he/she says he/she is not qualified to perform.
- If physician practices in a specialty or super specialty area in which there are few practitioners and providing 24/7 coverage is impossible or impractical and poses an unreasonable burden on the physician, must attempt to coordinate with the hospital to come up with a reasonable coverage plan.

Emergency Department Call Coverage

(Cont'd)

- Not all hospitals can afford to pay for coverage.
- Failure to abide by established ED call obligations should subject physician to some form of remedial/corrective action.

Emergency Department Call Coverage

(Cont'd)

- Medical Staff Position on ED Coverage
 - EMTALA does not require a physician to serve on call.
 - Call is voluntary.
 - Medical staff departments determine call rotations.
 - “Core” privileges should not be used to manipulate emergency coverage.
 - Where voluntary call does not adequately supply the hospital’s EMTALA obligations, the hospital should arrange contracts for compensated call and transfer agreements.

Disruptive Behavior/ “Code of Conduct” Scope & Implementation

- **PENDING** Joint Commission Standard LD.3.15: “As a critical component of the culture of safety, leaders set expectations for behavior among those who work in the organization.”
- Elements of Performance for LD. 3.15
 - The leaders develop a code of conduct that applies to everyone who works in the organization
 - The code of conduct defines desirable and disruptive behavior.
 - All who work in the organization are educated about both desirable and disruptive behaviors.
 - The leaders develop processes for managing disruptive behavior.

Disruptive Behavior/ “Code of Conduct” Scope & Implementation (cont’d)

- Leaders identify the roles of individual leadership groups in managing disruptive behavior.
- The organized medical staff manages disruptive behavior exhibited by physicians or individuals who are granted clinical privileges.
- Leaders establish a fair hearing process for those who exhibit disruptive behavior.

Medical Staff Position on Disruptive Behavior

- Pursuant to Medical Staff Bylaws
- Disruptive Behavior Defined:
 - Personal Conduct, not Substandard Care
 - Includes Harassment
 - On Hospital Property/ In Professional Context
- Referral to Medical Staff Impairment Committee
- Discipline Within Medical Staff Peer Review Process