Medical Staff Issues: A Primer

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I. INTRODUCTION

In today's dynamic health care market, it is often easier to appreciate the massive changes occurring outside hospital walls. There is clearly a revolution occurring -- with health care entities entering into a wide array of “arrangements”: consolidating, forming networks, acquiring other health care entities and other providers, diversifying into other markets, other products, other types of providers. Nevertheless, the forces precipitating the “revolution without” are also effecting a no less dramatic “revolution within.” Changes are occurring within the hospital-Medical Staff relationship as well.

These materials and the accompanying presentation provide a “primer” on the anatomy of a hospital Medical Staff (including the Medical Staff Bylaws, the Medical Staff credentialing process, appointment and reappointment criteria, the awarding of special prerogatives and the intra-hospital hearing and appellate review process). They describe not only the traditional structure of a hospital's Medical Staff but also discuss some of the momentous new developments in the hospital-Medical Staff relationship.

II. MEDICAL STAFF BYLAWS

Medical Staff Bylaws, which are required by law and by accreditation standards, constitute the basic document governing the structure and conduct of the Medical Staff. See, e.g., JCAHO, 1997 Hospital Accreditation Standards, MS.2 et seq. (1996)' Medicare Conditions of Participation for Hospitals, 42 C.F.R. § 482.22(c).

Medical Staff Bylaws also reflect the integral “culture” of the institution - the relationship between the Hospital Board, Administration and Medical Staff.

A. Contractual Significance

In many States, Medical Staff Bylaws are considered to constitute a contract between the Hospital, the Medical Staff and the individual members of the Medical Staff. See, e.g., Berberian v Lancaster Osteopathic Hospital Ass'n, 395 Pa. 257, 149 A.2d 456 (1959),' Adler v Montefiore Hospital Ass'n, 453 Pa. 60, 311 A.2d 634 (1973), cert. den., 414 U.S. 1131, 94 S. Ct. 870' Joseph v Passaic Hospital Ass'n, 26 N.J. 557, 141 A.2d 18 (1958). Thus, any of these parties may assert a claim for breach of contract for breach of the Bylaws. Moreover, courts have granted injunctions in order to require a hospital to follow its Bylaws. See, e.g., Sandoval v. Maliver, 145 Pa. Commw. 439, 603 A.2d 695 (1992), appeal denied, 616 A.2d 987 (Pa. 1992). Nevertheless, not every failure to follow the Bylaws is actionable. Hospitals have only been required to maintain substantial compliance with their Bylaws. See, e.g., Lang v. The Allentown Hospital, No. 92-0427 (U.S. Dist. E.D.Pa. July 3, 1996).

B. Adoption by Medical Staff/Approval by Board of Directors

Although the Medical Staff Bylaws are developed and adopted by the Medical Staff, they must be approved by the Board. Many Bylaws contain a provision stating that the Board may not unreasonably withhold its approval. In recent years,
an increasingly important and yet still largely unresolved issue is whether the Board may exert its will over the Medical Staff and amend the Bylaws unilaterally without the approval of the Medical Staff. Although certainly the Board has overall responsibility for the operation of the institution and delegates power to the Medical Staff, some courts have held that unilateral amendment of the Bylaws is prohibited. See Austin v. Mercy Health System Corp., 197 Wisc. 2d 117, 541 N.W. 2d 838 (1995); St. John's Hospital Medical Staff v. St. John Regional Medical Center, Inc., 90 S.D. 674, 245 N.W. 2d 472 (1976). The JCAHO standards prohibit unilateral amendment of the Bylaws by the Medical Staff or Board. JCAHO, 1997 Hospital Accreditation Standards MS.2.1 (1996). Some Bylaws contain a provision stating that the Board may amend unilaterally but only if it provides the Medical Staff with adequate notice of its intention to act, an opportunity to act first, and submits any unresolved issue to a Committee with Medical Staff and Board members (usually the “Joint Conference Committee”).

C. Content of Medical Staff Bylaws

Medical Staff Bylaws contain a wide range of provisions. They often include detailed requirements regarding the following issues:

- Structure of Governance of Medical Staff (officers, committees, departments, divisions)
- Appointment/Reappointment of Medical Staff Members
  - What practitioners may be members of Medical Staff
  - Medical categories
  - Credentialing Process
  - Appointment/Reappointment qualifications and criteria
  - Requirements for Medical Staff membership (citizenship)
  - Granting of Clinical Privileges

Disciplinary Procedures and Procedural Rights

Responsibilities of Medical Staff Members (e.g., medical records, dues, meeting attendance, patient encounters, etc.)

Relationship with the Board (liaison procedure, conflict resolution, etc.)

Rights and Responsibilities of Non-Physician Health Care Providers and House Staff

Periodic review of Bylaws and Amendment Procedures

D. Importance of Bylaw Provisions


E. Trends

1. “Medical Staff Reengineering” - Commentators criticize the complexity and politicization of the Medical Staff and propose a simplification of Medical Staff structure and activities. In addition, some commentators suggest that the Medical Staff Bylaws have become too cumbersome and suggest that Medical Staffs and Hospitals reduce the size and detail in such documents.
2. **“Manual Development”** - Many hospitals have decided to eliminate much of the detail currently contained in Medical Staff Bylaws and to place the details into separate “manuals.” These manuals generally can be amended and updated without the same rigorous review and approval requirements of Medical Staff Bylaws. Hospitals often have credentialing manuals and manuals regarding the composition and responsibilities of Medical Staff committees.

3. **Removal of Issues from the Medical Staff Bylaws** - Hospitals are recognizing that the current Medical Staff processes are incapable of effectively addressing certain sensitive issues. Thus, some hospitals have adopted separate policies relating to such sensitive issues as sexual harassment and impaired physicians. By removing such issues from the Medical Staff Bylaws and specifically the disciplinary procedures, hospitals are able to handle these issues with greater speed, sensitivity, and privacy.

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**III. APPOINTMENT/REAPPOINTMENT PROCESS**

**A. Overview**

The Medical Staff credentialing process is the means by which a hospital selects physicians and other health care providers for its Medical Staff and defines the scope of services they will be permitted to provide within the Hospital walls. While there may be some variations among hospitals, Medical Staff credentialing is a multi-step process, with responsibilities divided among the Board, Administration and Medical Staff. Ultimately, the decision-making authority rests with the Board. Nevertheless, the Board is required (pursuant to various States' laws and JCAHO accreditation standards) to delegate to the Medical Staff the responsibility for reviewing practitioners' credentials and formulating an expert recommendation regarding appointment and clinical privileges. The Medical Staff credentialing process consists of three basic functions:

- Verification and Investigation of Information
- Evaluation of Credentials and Formulation of Recommendation
- The Final Decision

**B. The Verification/Investigation Phase**

The initial phase of the Medical Staff credentialing process, the verification and gathering of information on each applicant, preferably should be handled by a medico-administrative employee of the hospital such as a medical director.

**1. Pre-Application**

Many hospitals have instituted a pre-application stage at the beginning of the Medical Staff credentialing process. There are two reasons for adoption of a pre-application stage.

First, it is a cost-saving measure. The pre-application may identify practitioners who are objectively not qualified for Medical Staff membership and discourage those who are not seriously interested in joining the Staff. The cost of processing a single application for Medical Staff membership is approximately $355.00. Moreover it is an activity that takes much time - of administrators, physicians and Board members. In the current cost-conscious climate of the health care industry, hospitals simply cannot afford to waste their resources by processing numerous flawed applications for staff membership.
Estimated Costs of Verifying a Single Application for Medical Staff

<table>
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<tr>
<th>Appointment</th>
<th>$280.00 (5.5 hours @ $16.50/hr)</th>
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<td>$10.00</td>
</tr>
<tr>
<td>Total</td>
<td>$355.00</td>
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Source: The cost of processing a single application, MSB CREDENTIALING I (January 1994).

Second, in some hospitals, the role of the pre-application has been expanded to include the consideration of institutional criteria relating to the hospital's business needs. Pre-applications also may be an integral component of a Board-adopted Medical Staff Development Plan. If a hospital determines, based upon the information provided in the pre-application, that it does not have any need for additional physicians in the practice area of the pre-applicant, the hospital will deny the physician an application form.

The pre-application generally includes objective, as opposed to subjective, questions, inquiring into such areas as:

• Name'
• Professional and residential address'
• Educational background (pre-medical schools, graduate schools, professional schools, and residency, internship and fellowship programs)'
• License to practice medicine and Registration to prescribe controlled substances.

See JCAHO, 1997 Accreditation Manual for Hospitals, MS.2.4.1.3. In hospitals using the pre-application to ask questions relating to institutional concerns, a pre-application may request the pre-applicant to project his or her activity level at the hospital and identify the hospital resources needed. While the answers to such statements are not enforceable, a hospital may find this information useful in evaluating the adequacy of its facilities to meet the physician's needs and to determine whether appointing the physician to the Staff will further the institutional goals of the hospital. (CAVEAT: Regardless of the stage of the process, any consideration of institutional criteria should be performed by a Board Committee rather than by the Medical Staff).

2. Application

The Medical Staff application should require detailed information regarding the following issues:

• Education and Training
• Experience
• Professional Liability Insurance and Claims Experience
• Licensure and Registrations
• Hospital Affiliations (including any adverse actions)
• Clinical Privileges and Staff Category sought

The application should include the following provisions:

• A provision in which the applicant expressly authorizes hospital representatives to consult with others who may have information and to inspect any relevant records or documents'
• A provision in which the applicant expressly releases from liability all persons who provide information to the hospital and its representatives in good faith and without malice'
• A provision certifying that the applicant has read and understood the Bylaws and rules and regulations of the Hospital and its Medical Staff and agrees to abide by them.

3. Verification/Investigation of Information
The importance of fully and completely verifying and investigating the content of a completed application cannot be over-emphasized. The JCAHO standards require that action on an individual's application for appointment be withheld until such information is available and verified. JCAHO, 1997 Accreditation Manual for Hospitals, MS.5.4.3.1.1.

The investigation and verification of the contents of the application should include the following:

- **National Practitioner Data Bank**: The Health Care Quality Improvement Act of 1986 requires hospitals to request information from the data bank “at the time a physician or licensed health care practitioner applies to be on the Medical Staff of . . . the hospital.” 42 U.S.C. § 11135.

- **Other Data Banks**: Hospitals should also seek additional information from other sources, including the American Medical Association Masterfile and the Federation of State Medical Boards Physician Disciplinary Data Bank. See JCAHO, 1997 Accreditation Manual for Hospitals, MS.5.4.3.2.

- **Education, Training, Licensure**: Hospitals should verify information regarding an applicant's licensure, specific training, experience, and current competence from primary sources, where feasible. See JCAHO, 1997 Accreditation Manual for Hospitals, MS.5.4.3.1. Failure to verify a physician's credentials may subject a hospital to liability under the hospital corporate liability doctrine.

- **Letters of Reference**: The JCAHO standards require that peer recommendations constitute one basis for appointment and reappointment decisions. JCAHO, 1997 Accreditation Manual for Hospitals, MS.5.7. Hospitals should communicate in writing with those individuals identified as references in the applicant's application form. Many hospitals, facing increasing problems in obtaining references, have developed forms and/or checklists for persons providing references. Such forms should include space for general comments.

**REFERENCES: ISSUES AND ANSWERS**

1. **How specific must a letter of reference be?**
   A letter of reference should detail with specific examples at least the following matters:
   - The applicant's current clinical competence
   - The applicant's ability to interact in a professional fashion with fellow colleagues and support staff
   - The applicant's adherence to ethical mandates and,
   - The applicant's physical and emotional status.

2. **What can you do about an inadequate reference?**
   Although the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11111(a)(2), affords limited immunity from liability to individuals providing references, many individuals either refuse to provide a negative reference or, alternatively, overtly neglect to be entirely candid when rendering an appraisal. In the first instance, as previously stated, if no response is received to a requested letter of recommendation, the burden shifts to the applicant to ensure that the references are provided. If an inadequate or questionable letter of reference is received, there are a variety of approaches available:
   - Telephone Investigation (but this may have litigation consequences). Only
information provided in writing should be used to deny medical staff membership and clinical privileges. If the reference refuses to place a negative appraisal in writing, he or she should be asked to steer the hospital to records or other documents that would provide proof or documentation of the alleged deficiency.

- Obtain and review residency logs, residency evaluations and/or charts.
- Peer review medical charts.

Importantly, the applicant has the burden of producing adequate information for proper evaluation of his or her qualifications. If the application is either not returned or is returned in an incomplete fashion, the appropriate medico-administrative agent should correspond with the applicant with any follow-up questions. Hospitals may also consider implementing a policy of only accepting completed applications and returning all incomplete applications to the applicant. The Bylaws should provide notice to an applicant of the necessity and elements of a completed application. See, e.g., JCAHO, 1997 Accreditation Manual for Hospitals, MS.5.8.2. Depending upon the Medical Staff Bylaws, an applicant's failure to adequately complete the application form in a timely fashion may result in denial of the application. An applicant may also be precluded from reapplying for a specified period of time.

C. Evaluation of Credentials

1. Department Chair/Division Chief

Once the application has been deemed complete and fully verified and investigated, the application along with all supporting documentation is typically forwarded to the Department Chair and/or Division Chief for review.

The Chair/Chief review does present liability risks inasmuch as these physicians may be competitors of the applicant. For this reason, such physicians should confine their reports to an evaluation of the information available pertaining to whether the applicant is qualified for the clinical privileges sought. Any recommendation, personal opinion, or other attempt to dissuade the hospital from awarding Medical Staff membership may appear to be based upon anti-competitive motives. If the Chair/Chief is genuinely reluctant to evaluate an applicant or harbors some animosity against an applicant, the hospital should consider retaining an independent credentialing expert to fulfill these duties.

It is appropriate for the Chair/Chief to conduct an interview with the applicant. Based upon the interview as well as the entire application, the Chair/Chief should issue a written report articulating the pros and cons of the applicant's qualifications for the clinical privileges sought.

In some hospitals, applications are evaluated by the Division, Department or Medical Staff as a whole. This practice presents unnecessary legal risks. Some of the physicians voting on an application are likely to be competitors of the applicant or have an interest in excluding the physician. In addition, it is quite unlikely that all the physicians voting will have fully reviewed the application and other information necessary to make an informed decision. Thus, Hospitals are well-advised to limit the consideration of applicants to the Department Chair and/or Division Chief.

2. Credentials Committee

The completed application, supporting documentation, and the written report from
the Chair/Chief are generally forwarded to the Credentials Committee of the Medical Staff for its review and consideration. Hospitals may consider eliminating this step in the process if it is determined that the Credentials Committee merely constitutes an additional layer of review that is merely duplicative of the review by the Chair/Chief and/or the Medical Executive Committee.

Where a hospital has a Credentials Committee, the Committee should interview each applicant. Based upon the interview, as well as all applicable documentation, the Committee should prepare a formal recommendation regarding whether the applicant should be provisionally appointed, rejected, or that his or her application be deferred for future consideration. The Credential Committee's report should provide specific findings of fact and be based upon, among other things, the supporting documentation. In the case of an adverse recommendation, a mere record of a vote is insufficient and does not constitute a valid report.

Importantly, majority and minority findings and recommendations are required if applicable. Sealed votes by members of the Committee are inappropriate as they may suggest to a court or jury that the members of the Committee lacked confidence in their votes. In addition, because they fear liability, physicians may later not admit their true positions as reflected by their vote. The Credentials Committee's report, along with its recommendation, should be submitted to the Medical Executive Committee.

3. Medical Executive Committee

The Medical Executive Committee (“MEC”) receives and reviews the entire file submitted by the Credentials Committee. After reviewing the file, the MEC must make a recommendation to the Board regarding the appointment or reappointment of an applicant. The recommendation should be supported by information in the application and other documents. Where appropriate, all MEC reports should contain majority and minority views. Any member of the MEC who was previously involved in consideration of the applicant (e.g., as a Department Chair) should not vote.

If the recommendation of the MEC is adverse to the applicant regarding appointment or clinical privileges, the applicant should be notified and the applicant should then be afforded an opportunity to exercise or waive his or her rights to a hearing and appellate review. If the recommendation of the MEC is in favor of the applicant, the Committee's recommendation, along with all supporting documentation, is thereafter forwarded to the Board for final, unilateral determination.

D. Decision Making: The Board

The members of the Board of the hospital, or a designated Committee of the Board, should read the application and other documents and fully consider all information, as well as the reports and recommendations of the Medical Staff. It should not merely rubber stamp the MEC's recommendation. Members of the MEC should not exert any pressure or attempt to influence the Board. If the decision of the Board conflicts with the recommendation of the Medical Staff, the matter should be submitted to a joint committee (often called “Joint Conference Committee”). This joint committee may attempt to resolve the dispute. Despite the efforts of this committee, the Board retains final decision-making authority.

The final decision of the Board should be provided to the applicant along with an
explicit explanation of the reasons for the decision if it is adverse. If the decision is based upon specific criteria, the criteria should have previously been documented in the Bylaws or other hospital documents, formally approved, and reasonable. If the decision of the Board is adverse, the applicant should be provided with the procedural rights afforded by the Medical Staff Bylaws.

E. Reappointment Procedures

Physicians are required to apply for reappointment to the Medical Staff and for delineated clinical privileges every two years. The procedures for physicians seeking reappointment should be similar to those for initial appointment. Rather than an application, a physician should be required to timely submit an “interval information form” or “reappointment application,” requesting an update on the various issues contained within the pre-application and application (training, medical malpractice claims experience, insurance, licensure and the like) and documentation of continuing medical education.

In most hospitals, a request for reappointment moves through the same channels as an initial application (Department/Division Chair/Chief, Credentials Committee, Medical Executive Committee and the Board).

In general, reappointment of a Medical Staff member is based on the staff member’s demonstrated professional competence and clinical judgment. This competence will be judged by such factors as documented Hospital quality assurance activities, ethics and conduct, participation in continuing education activities relating to the current or requested clinical privileges, and cooperation with Hospital personnel and other practitioners.

F. Trends

1. “Medical Staff Reengineering”

Some hospitals are attempting to streamline their Medical Staff credentialing procedure to make it more efficient, simpler and less time-consuming. In these hospitals, after initial review, investigation and verification of information, Medical Staff applications are generally separated into three categories: (1) those applications that do not have any red flags (good credentials, affiliation with respected institutions, no bad recommendations, no significant malpractice claims, no gaps in training or experience)’ (2) applications raising questions‘ and (3) applications raising serious concerns. The Medical Staff credentialing procedures are modified for each group to provide the level of scrutiny and consideration required.

For example, the first group of applications (those without red flags) are processed in an expedited manner. They are not considered by the committees but are merely reviewed and approved by the Department Chair, Chairman of the Credentials Committee, the President of the Staff and the Chairman of the Board. By not requiring the meeting and consideration of committees, these hospitals are able to avoid the lengthy delays between meetings. Of course, this process requires an explicit delegation of authority documented in the Medical Staff Bylaws, credentialing policies and/or Corporate Bylaws. The second group of applications (those raising questions) are processed in a more traditional manner, with full discussion and interviews by the Department/Division Chair/Chief, Credentials Committee and Medical Executive Committee. The third group may be subject to even greater investigation and scrutiny.
2. Delegation of Credentialing Activities

Some hospitals have decided to “outsource” some of their credentialing functions. For example, in recent years, numerous credentialing organizations have been established - some affiliated with hospital associations or medical societies. There are essentially two types of credentials verification services: data banks and organizations.

Although the data banks may be quite helpful to hospitals, they are only as accurate and complete as the information they collect. Unless such data banks have the commitment of a large number of physicians and hospitals, they may be of only limited use.

In contrast, credentialing verification organizations (“CVOs”), which actually perform the verification and investigation of physician credentials are often able to perform these functions at lower cost and greater efficiency than Medical Staff office personnel. Nevertheless, hospitals must use caution in deciding which organization to employ and in monitoring the quality of the services provided. Hospitals, of course, remain ultimately responsible for assuring that these functions are accomplished with due care. For example, under the doctrine of hospital corporate liability, a hospital could be held liable for failing to use due care in its selection and supervision of a credentialing verification service. Under this doctrine, the hospital is ultimately responsible for using due care in its selection and retention of physicians on its Medical Staff.

In contracting with a specific CVO, hospitals should consider the following issues:

1. Does the CVO have written policies and procedures regarding the verification, frequency of reporting and management of data on credentials?
2. Does the CVO have a quality monitoring and improvement process to assure that credentials reports and files are accurate and complete and meet the needs of the hospital client?
3. Does the CVO obtain information and documentation from primary sources?
4. Does the CVO protect the confidentiality and integrity of credentials files?
   - Does it have a confidentiality policy?
   - Does it have a mechanism to prevent unauthorized access to and modification of credentials files?
5. Does the CVO have a mechanism for follow-up notification of the hospital if it later learns of any pertinent information regarding a practitioner's credentials?
6. Will the CVO assist the hospital in proving that it used due care in verifying the credentials of a physician as required by a claim brought by a practitioner, physician or patient.

Cf. NCQA, CVO Certification Program 1996–1997 (1996). The Hospital should address these issues in its contract with the CVO and adopt a mechanism to supervise the activities of the CVO.

Recently, the National Committee for Quality Assurance, which accredits managed care organizations, has commenced a program certifying credentials verification organizations that perform this function for managed care organizations. Some of these certified organizations also may perform similar services for hospitals. It should be borne in mind, however, that certification does not guarantee quality of service.
The JCAHO and the regulations of many States specifically require that hospital Boards make credentialing decisions based upon the recommendations of the Medical Staff. See, e.g., JCAHO, 1997 Hospital Accreditation Standards MS.5.1 (1996).

3. Credentialing Experts

Although the JCAHO requires that hospital Boards obtain the recommendation of the Medical Staff regarding Medical Staff appointment and clinical privileges, there are situations where a hospital should consider hiring a credentialing expert. This may be necessary in at least four situations:

1. Where there is a conflict between the department chair and a physician so extreme that the department chair cannot or will not objectively evaluate the credentials of the applicant or Medical Staff member.

2. Where the privileges requested include state-of-the-art services and the department chair and other Medical Staff members are simply not able to evaluate the credentials necessary to perform such procedures.

3. Where the hospital simply does not have the resources (including specialist physicians) necessary to perform the credentialing function.

4. Where the hospital believes that there is a significant risk of antitrust litigation. The full investigation and evaluation by an outside objective expert may assist the hospital in preventing or defending such litigation.

Once a hospital determines that an outside credentialing expert is necessary, it should consider taking the following steps to minimize its legal risks:

- The hospital's medico-administrative employee (e.g., Medical Director) should coordinate the retention of any such expert.
- The credentials and objectivity of any such expert should be beyond reproach.
- The expert should be afforded an indemnification agreement by the hospital or its insurance carrier for any good faith peer review actions undertaken.
- The outside expert should agree, up front, to issue a written report and to testify, as needed, at any intra-hospital hearing proceeding and/or subsequent civil deposition or trial.

Courts have validated the retention of independent experts to perform this function. See, e.g., Everett v. Franciscan Sisters Healthcare, Inc., 974 F.2d 77 (8th Cir. 1994), Soentgen v. Quain & Ramstad Clinic, 467 N.W. 2d 73 (N.D. 1991).

4. Medical Staff Strategic Planning

Some hospitals have engaged in Medical Staff strategic planning in order to achieve the best quality, specialty mix, and activity level of physicians to fulfill the hospital's mission and meet the current and future needs of its patients and the community. Medical Staff strategic planning can take many forms. The predominant forms of Medical Staff strategic planning consist of Medical Staff Development Plans, primary care plans, selective closure of departments, institutional criteria, and loyalty criteria.

At one end of the spectrum is the Medical Staff Development Plan. A hospital with a Medical Staff Development Plan must conduct a study of its Medical Staff and determine the optimal number of physicians for each clinical practice area. Only physicians of those specialties or subspecialties in which the hospital has
demonstrated need/space are permitted to apply. The hospital may recruit physicians or choose between applicants to determine the best candidate based upon institutional criteria.

A hospital may also find that it can achieve a benefit from closing, for example, select divisions to new applicants. Generally courts have upheld this form of Medical Staff strategic planning but require that there be a valid reason for closing the division supported by credible evidence. The selective closure of divisions should be driven by the Board and not the Medical Staff. It is impermissible for a hospital to close a division or other clinical area in order to insulate certain physicians from competition or to exclude a specific physician. See, e.g., Desai v. St. Barnabas Medical Center, 103 N.J. 79, 510 A.2d 662 (1985); Guerrero v. Burlington County Memorial Hospital, 70 N.J. 344, 360 A.2d 334 (1976).

Other forms of Medical Staff strategic planning include the adoption of institutional criteria (consideration of institutional concerns when appointing or reappointing physicians to the staff), and so-called “loyalty criteria” (the requirement that physicians maintain a certain minimum level of activity in order to “deserve” Medical Staff membership, membership in specific staff categories, political rights, admitting privileges, etc.). These criteria are discussed in greater detail in Part IV below.

5. Exclusive Contracts

Exclusive contracts endow a physician or group of physicians with the sole right to provide specific patient care services in a hospital. A hospital considering whether to enter into an exclusive contract must consider numerous factors, including: whether the hospital legally may enter into the exclusive contract, the appropriate structure of the exclusive arrangement, whether the exclusive contract may legally displace physicians with clinical privileges in the area, whether a hospital must provide such displaced physicians with procedural rights, whether a hospital may unilaterally terminate an exclusive contract and on what grounds, and whether procedural rights must be provided to such physicians who wish to challenge the termination decision.

Under appropriate circumstances, a hospital may legally enter into exclusive contracts with physicians. Exclusive contracts, however, may present, for example, antitrust and fraud and abuse legal risks. For example, hospitals should prospectively consider these legal risks in deciding whether to enter into an exclusive contract and in negotiating the terms of the exclusive contract.

Hospitals may take certain steps to reduce their risks of litigation and liability relating to exclusive contracts.

1. The Hospital Board should appoint a committee to study the propriety of an exclusive contract for the service in question.

2. The Board should determine the most appropriate structure for such an arrangement -- whether an exclusive contract providing one physician or physician group the right to provide all service, an exclusive contract only for specific services, or a non-exclusive contract containing a preference for the physician or group (e.g., assigning all patients to the contract-holder unless specifically referred to another practitioner).

3. The role of the Medical Staff and physicians in this process should be carefully circumscribed.
4. Affected practitioners should be allowed to comment on the proposed arrangement before the appropriate body (e.g., the Board Committee).

5. The Hospital Board should develop and adopt a policy of exclusivity detailing the hospital-specific reasons for entering into an exclusive contract. Such reasons could include promotion of team work, assurance of physician and staff competence, enhancement of education and teaching, reduction of potential scheduling conflicts and the use of equipment and facilities, enabling more accurate short and long-range budgeting, improved opportunity to recruit and retain highly qualified specialists, reduced liability exposure, promotion of economy and safety in patient care, direct physician accountability to the hospital, more effective quality management, improved administration, and provision of new services to meet community needs.

6. The Hospital generally should afford all physicians, currently providing services to be subsumed within the exclusive contract, an opportunity to compete for the exclusive contract.

7. The hospital should prepare a request for proposal (RFP) and advertise the contract nationally. The hospital may offer the contract to physicians inside or outside the hospital.

8. The Board needs to decide whether to provide a hearing and appellate review to incumbent physicians, whose Medical Staff membership and clinical privileges will be displaced by the exclusive contract. The majority of courts that have considered the issue have held that a hospital does not need to provide a hearing, even where bylaw provisions seem to indicate such a right, because the decision is based upon business reasons and not the clinical performance of the practitioners.

9. The Board should also review the Corporate and Medical Staff Bylaws to determine whether any Bylaw provisions will affect or be affected by the exclusive contract arrangement.

10. The contract should be drafted as clearly and comprehensively as possible. The Hospital should consider inserting a “clean sweep” provision in the contract and Bylaws. Under such a provision, a physician’s Medical Staff membership and clinical privileges will automatically terminate at the end of the exclusive contract without any procedural rights due to the physician.

6. Turf Wars

In response to competitive pressures, various specialists may seek to restrict, or oppose the expansion of, the privileges of other specialists (i.e., neonatologists, pediatricians). Physicians (e.g., anesthesiologists) may also attempt to circumscribe the scope of practice of limited health care practitioners (e.g., certified registered nurse anesthetists). Such actions may present antitrust risks. See, e.g., Todorov v. DCH Health Care Authority, 921 F.2d 1438 (11th Cir. 1991) (neurologist denied privileges to provide official interpretations of CT scans). Hospitals may reduce their legal risks from such actions if they comply with the following guidelines:

• The Board should appoint a committee to study the “turf war” issue, prepare a detailed report on the issue and advise the Board.
• The reasons for such recommendation/decision should be well-supported and documented.
• The influence of any competitors of the class of practitioner at issue (or others
with bias) should be minimized. Such competitors may be asked to provide information however.

- If necessary, the Board should adopt criteria or a written policy regarding the issue.
- The criteria or policy should be uniformly applied.

7. Managed Care Credentialing

Increasingly, managed care organizations (MCOs) are performing their own credentialing functions to ascertain the competence of the physicians who participate in their provider networks. Many MCOs are accredited -- either by the National Committee for Quality Assurance or the Joint Commission on Accreditation of Healthcare Organizations -- both of which require such organizations to perform ongoing investigations of practitioners on their panels.

MCOs are seeking an increasing amount of information from hospitals to assist them in performing their credentialing functions. Some of the information requests may be overbroad, invoke confidentiality concerns, and could expose hospitals to litigation and liability risks. For example, one insurer recently provoked a hospital's concern by requesting the hospital to provide a litany of information on all physicians on its Staff (not merely those physicians who participate with the insurer) on a quarterly basis. The insurer requested information regarding whether the physician was in good standing, whether there were any disciplinary actions taken against the physician and, if so, the nature of any disciplinary actions.

The National Committee on Quality Assurance ("NCQA"), an accreditation organization similar to the JCAHO for hospitals, requires subscriber managed care organizations to institute credentialing activities independent from hospitals' credentialing functions. The NCQA also requires managed care organizations to perform a due-diligence review of any credentialing activities delegated to other entities such as hospitals, physician networks, medical groups or credentialing verification organizations. See NCQA, Standards for Accreditation 1997, CR (1996).

The National Committee for Quality Assurance requires that all accredited managed care organizations comply with the following requirements:

1. The managed care organization documents the mechanisms for the credentialing and recredentialing of M.D. and D.O. physicians, dentists, podiatrists and chiropractors, including the scope of practitioners covered, the criteria and primary source verification of information used to meet these criteria, the process used to make decisions and the extent of any delegated credentialing or recredentialing arrangements.

2. The managed care organization has a process for receiving advice from participating practitioners to make recommendations or decisions regarding credentialing or recredentialing of practitioners.

3. At the time of credentialing, the managed care organization must verify at least the following information from primary sources: license to practice, clinical privileges in good standing at the primary admitting facility, DEA or CDS certificate, education and training, Board certification, work history, malpractice insurance, history of professional liability claims that resulted in settlements or judgments.

4. The applicant must complete an application for membership including reasons for any inability to perform the essential functions of the position with or without
accommodation, lack of present illegal drug use, history of loss of license or felony convictions, loss or limitation of privileges or disciplinary activity, and attestation of correctness and completion of the application.

5. The managed care organization receives information on the practitioner from the National Practitioner Data Bank, licensing agencies, Medicare and Medicaid.

6. The organization must conduct an initial site visit to each potential primary care practitioner's office and to offices of each OB/GYN to evaluate compliance (of medical recordkeeping and other practices) with the managed care organization's standards.

7. The managed care organization must recredential its practitioners at least every two years and must verify from primary sources: licensure, status of clinical privileges at primary admitting facility, valid DEA or CDS certificate, Board certification, current and adequate malpractice insurance, history of professional liability claims that resulted in settlements or judgments. The recredentialing process must include a current, signed attestation statement regarding reasons for any inability to perform the essential functions of the positions with or without accommodation, and lack of impairment due to a chemical dependency or substance abuse.

8. The managed care organization must obtain information during recredentialing on the practitioner from the National Practitioner Data Bank, licensing agencies, Medicare and Medicaid.

9. In recredentialing primary care practitioners, managed care organizations must incorporate data from member complaints, information from quality improvement activities, utilization management, member satisfaction surveys, medical records reviews and site visits.

10. At the time of recredentialing, the managed care organization must conduct a site visit to the offices of all primary care practitioners, all OB/GYNs and other high-volume specialists to document conformity with managed care organization's standards and medical recordkeeping practices.

11. Managed care organizations must have policies and procedures for altering the conditions of the practitioner's participation with the managed care organization based on issues of quality and service. Such policies and procedures must define the range of actions that the organization may take to improve performance prior to termination. The managed care organization must have procedures for reporting serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities. Managed care organizations must have an appeal process and inform practitioners of the appeal process.

12. The managed care organization must have written policies and procedures for the initial and ongoing assessment of organizational providers with which it intends to contract at least every three years. This assessment includes confirmation that the provider is in good standing with state and federal regulatory bodies and accreditation status.


The increasing importance of credentialing has resulted in a dramatic increase in the number and detail of requests for information regarding physician credentials. In the current health care environment, responses to these inquiries may present legal risks to institutions including such claims as antitrust, defamation, and
tortious interference with contracts and prospective contracts. Thus, hospitals should exercise caution in responding to such inquiries. Hospitals may manage these risks by following these guidelines:

- Request a statement signed by the physician authorizing such disclosures and releasing the institution and individuals from liability for providing information.
- Ascertain whether the requesting source is a peer review body, which will provide the hospital and individual with protection under State Peer Review Protection Acts and the Health Care Quality Improvement Act.
- Any inquiries should be directed to, and answered by, a specifically designated and authorized individual who is a medico-administrative employee of the institution (such as the Medical Director). Such inquiries should not be answered by the Department Director or a physician who is a competitor of the subject practitioner.
- All information provided should be truthful and factual in nature.
- The responding individual should not volunteer information not specifically requested in the inquiry.
- All information provided should be factually supported by documents in the subject practitioner's credential's file.

IV. APPOINTMENT/REAPPOINTMENT CRITERIA

At one time, the only Medical Staff criteria adopted by most hospitals were general requirements, usually appropriate licensure, competency, possibly Board certification or residency training, which were stated in the “Basic Qualifications” section of the Medical Staff Bylaws. In recent years, hospitals have identified Medical Staff criteria as a means of becoming more competitive in the marketplace and of gaining a modicum of quality and utilization control over their staff physicians. Medical Staff criteria may be used to improve the competency of physicians. For example, some hospitals now require physicians to perform a certain number of highly specialized procedures to assure physician proficiency and adequate data for credentialing. Criteria may be used to encourage physicians to concentrate their practices at the hospital (e.g., so-called “loyalty criteria”). Other criteria may be used to eliminate physicians who have economically inefficient practices (“economic credentialing”). Hospitals are well-advised to consider, prospectively, the legal validity of such criteria. Litigation may focus on three aspects of Medical Staff criteria. The process by which such criteria are adopted, the documentation of the criteria, and the substance of the criteria.

A. Process for Adoption of Criteria

The hospital, ultimately through its Board, has the legal duty to identify and articulate the criteria by which both Medical Staff membership and clinical privileges may be awarded, denied, suspended, or otherwise affected.

The Medical Staff should only propose criteria that relate to clinical competence or affect the quality of patient care - the criteria that physicians are best qualified to assess and recommend. Economic and institutional criteria affecting Medical Staff membership and clinical privileges should be the sole province of the Board.

B. Documentation of Criteria
Appointment and reappointment criteria should be formally articulated in Medical Staff Bylaws, rules and regulations or other hospital documents. Application of criteria that are not documented may expose the hospital to legal risks.

First, criteria applied by physicians without the approval of the Board are more likely to be challenged on grounds that they were adopted for anti-competitive reasons. Physicians, even when members of a hospital's Medical Staff, are considered to be independent economic actors with separate and distinct economic interests. See Weiss v. York Hosp., 745 F.2d 786, cert. denied, 459 U.S. 1060 (1985). In contrast, the Board of the hospital is responsible for ultimate management of the hospital, owes a fiduciary duty to the institution, and is not a separate actor from the hospital.

Second, criteria unilaterally adopted by the Medical Staff and/or its members may lack the type of clinical justification necessary to withstand judicial scrutiny. A professional criterion is more likely to withstand scrutiny if it can be established that the criterion enhances and promotes, for example, quality of care and is thus actually pro-competitive in nature. Physician-driven criteria sometime lack such a legally supportable justification because they were, in fact, adopted to stifle, rather than promote, competition.

Third, physicians applying for Medical Staff membership should be given notice of all requirements they must satisfy. See JCAHO, 1997 Accreditation Manual for Hospitals, MS.5.3.2 - 5.4* 42 CFR § 482.22 (1990).

Fourth, to the extent that Medical Staff Bylaws constitute a contract, a physician denied appointment/reappointment on undocumented criteria, for example, may have grounds to argue that the hospital breached its contract.

C. Substance of Criteria

Although most criteria have never been tested in court, a variety of sources provide guidance as to the legal propriety of specific Medical Staff criteria, including JCAHO, Medicare Conditions of Participation, and State and Federal statutes and regulations.

While competence is always a valid basis for criteria, and criteria discriminating on the basis of race, gender, national origin and the like are never valid, most criteria fall within these extremes. Examples include board certification, interpersonal relations, hospital needs and facilities, economic efficiency of physician's practice patterns, geographic proximity/response time, privileges and duties at other hospitals. The validity of such criteria may depend upon many factors, including the proximity of the hospital to others, the size and type of hospital, the specialty of the physician, and the reason for adoption of the criteria.

1. Standards of the Joint Commission on Accreditation of Healthcare Organizations

The JCAHO has adopted numerous standards relating to Medical Staff criteria in its accreditation manual.

MS.5.4 The mechanisms provide for professional criteria that are specified in the medical staff bylaws and uniformly applied to all applicants for medical staff membership, medical staff members, or applicants for delineated clinical privileges. These criteria constitute the basis for granting initial or continuing staff membership and for granting initial, renewed, or revised clinical privileges.
MS.5.4.1 Each clinical department makes recommendations to the medical staff regarding professional criteria for clinical privileges.

MS.5.4.2 The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care.

MS.5.4.3 The professional criteria at least pertain to evidence of current licensure, relevant training and/or experience, current competence, and ability to perform the privileges requested.

MS.5.6 Appointment or reappointment to the medical staff and the initial granting and renewal or revision of clinical privileges are also based on information regarding the applicant's competence.

MS.5.9 Gender, race, creed, or national origin are not used in making decisions regarding the granting or denying of medical staff membership or clinical privileges.

MS.5.12 Appraisal for reappointment to the medical staff or renewal or revision of clinical privileges is based on information concerning the individual's professional performance,

MS.5.12.2 judgment, and

MS.5.12.3 clinical and/or technical skills.

MS.5.15.2 Board certification is an excellent benchmark and is considered when delineating clinical privileges.


2. Medicare Conditions of Participation for Hospitals

(a) 42 CFR 482.12

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. However, if a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this Part that pertain to the governing body.

(a) Standard: Medical Staff. The governing body must:

(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff

***

(6) Ensure the criteria for selection are individual character, competence, training, experience and judgment and

(7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.

(emphasis added).

(b) 42 CFR 482.22

(c) Standard: Medical staff bylaws. The medical staff must adopt and enforce bylaws to carry out responsibilities. The bylaws must:

(1) Be approved by the governing body.

(4) Describe the qualifications to be met by a candidate in order the medical staff to recommend that the candidate be appointed by the governing body.
(6) Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.

(emphasis added).

3. Hospital Licensure Requirements

Many states have hospital licensure requirements that impact on the legality of specific criteria for Medical Staff membership and clinical privileges. For example, in Pennsylvania, the Department of Health adopted licensure regulations that provide:

No applicant shall be denied Medical Staff privileges on the basis of sex, race, creed, color, or national origin or on the basis of any other criterion lacking professional or ethical justification, including association with a prepaid group practice.

4. Federal and State Judicial Decisions

Judicial decisions, both federal and state, also may provide guidance regarding the legal propriety or impropriety of specific criteria. Unfortunately, there have been only a handful of cases that have addressed the validity of even the most common criteria and many of these cases are often quite fact-specific. Nevertheless, these cases may assist hospitals in determining what type of criteria are likely to be deemed legally valid and in determining how to support and document the adoption of these criteria. Some of the most common criteria (and a selection of the cases in which such criteria were discussed) are set forth below. This list of criteria and cases cited hereafter is illustrative only, and not necessarily comprehensive.

**INCOMPLETE APPLICATION**

*Completion of Application is Responsibility of Physician*


**DISHONESTY IN THE APPLICATION PROCESS**

*Valid Criterion*


**POOR REFERENCES**

*Valid Criterion For Denial of Staff Privileges*


**SPECIAL REQUIREMENT FOR SPECIFIC CLINICAL PRIVILEGES**

*Valid if Reasonable Basis*

Hay v. Scripps Memorial Hospital - LaJolla, 228 Cal.Rptr. 413 (Cal. App. 1986) (residency requirement upheld)


McMorris v. Williamsport Hospital, 597 F. Supp. 899 (M.D. Pa. 1987) (minimum number of procedures required to maintain competency)
POST-GRADUATE TRAINING REQUIREMENTS

AMA-approved Residency
Stern v. Tarrant County Hospital District, 778 F.2d 1052 (5th Cir. 1985) (valid)
Silverstein v. Gwinnett Hospital Authority, 861 F.2d 1560 (11th Cir. 1988) (valid)

Residency Requirement
Smith v. Vallejo General Hospital, 170 Cal.App.3d 450, 216 Cal. Rptr. 189 (1985) (residency requirement for specific clinical privileges upheld)

Valid but Inconclusive Reason for Denial of Staff Privileges
Ehrhardt v. Jane C. Stormant Hospital, 1982-1 Trade Cas. (CCH) ¶ 64, 703 (D. Kansas 1982)

DISCIPLINARY ACTION AGAINST LICENSE

Valid

BOARD CERTIFICATION

Compare: Medicare Conditions of Participation for Hospitals, 42 C.F.R. § 482.12(a)(7) (“Under no circumstances is the accordance of Medical Staff membership or professional privileges dependent solely upon certification, fellowship or membership in a specialty body or society.”)

with JCAHO, Accreditation Manual for Hospitals: 1995 Edition, MS.2.15.2 (1994) (“Board certification is an excellent benchmark and is considered when delineating clinical privileges.”)

Valid Requirement Even If Competence Shown By Performance
Khan v. Suburban Community Hospital, 45 Ohio St. 39, 340 N.E. 2d 398 (1976)

Valid Factor but Must Consider Other Evidence of Competence

Valid Where Does not Discriminate Against Osteopathic Physicians
Hull v. Bd. of Commissioners of Halifax Medical Ctr., 453 So.2d 519 (Fla. App. 1984)
Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), cert. denied, 470 U.S. 1060 (1985)

GEOGRAPHIC PROXIMITY

May be Valid Criterion if Reasonably Related to Hospital Objective or Concern
Kennedy v. St. Joseph Memorial Hospital, 482 N.E.2d 268 (Ind. App. 1985) (upheld)
Quinn v. Kent General Hospital, 617 F. Supp. 1226 (D.De. 1985) and 673 F. Supp. 1367 (D.Del. 1987) (may be valid)
UNSATISFACTORY INTERPERSONAL RELATIONSHIPS

Valid Criterion for Denial of Staff Privileges

Bryan v. James E. Holmes Regional Medical Center, F.3d 1318 (11th Cir. 1994) (physician's staff membership terminated for verbal abusive conduct).


Nanavati v. Burdette Tomlin Memorial Hospital, 107 N.J. 240, 526 A.2d 697 (1987)

Valid Criterion if Affects Patient Care

Leach v. Jefferson Parish Hospital District No.2, 870 F.2d 300 (5th Cir. 1989)

Mahmoodian v. United Hospital Center, 404 S.E.2d 750 (W. Va. 1991), cert. denied, 12 S.Ct. 185 (1991)

Not Valid if no Effect on Patient Care


See also Barr v. National Right to Life Committee, (1981–2 Trade Cas (CCH) ¶ 64,315 (M.D.Fla. 1981) (hospital could deny privileges because of physician's affiliation with abortion clinic based on perceived potential for disruption and impact on patient care from others)

MALPRACTICE INSURANCE COVERAGE

Valid Criterion


Renforth v. Fayette Memorial Hospital Ass'n, 178 Ind. App. 475, 383 N.E.2d 368 (1978)

Garrison v Bd of Trustees of Memorial Hosp., 795 P.2d 190 (Wyo. 1990)

MEMBERSHIP IN MEDICAL SOCIETY

Not Valid

Foster v. Mobile County Hospital, 398 F.2d 227 (5th Cir. 1968)

Falcone v. Middlesex County Medical Society, 34 N.J. 582 (1961)

See also Medicare Conditions of Participation for Hospitals, 42 CFR § 482.12(a) (7) (“Under no circumstances is the accordance of staff membership or professional privileges dependent solely upon certification, fellowship or membership in aspecialty body or society”)

VIOLATION OF MEDICAL STAFF BYLAWS AND RULES

Valid Criterion


Maxey v. Kadrovach, 890 F.2d 73 (8th Cir. 1989) (refusal to accept medical services patients)


Friedman v. Delaware County Memorial Hospital, 672 F. Supp. 171 (E.D. Pa. 1987), aff'd without opinion, 849 F.2d 600 (3d Cir. 1988) (rules regarding bronchoscopies)


**ETHICS VIOLATIONS AND CRIMINAL ACTIVITY**

*Valid Criteria*


**EFFECTIVE UTILIZATION OF EQUIPMENT AND FACILITIES**

*Valid*

Maltz v. New York University Medical Center, 121 A.D.2d 323, 503 N.Y.S. 2d 570 (1986)


**INEFFICIENT PRACTICE PATTERNS**


**PRIVILEGES AND DUTIES AT OTHER HOSPITALS**

May be Valid to Require Physician to Concentrate Practice at Hospital if Reasonably Related to Quality of Patient Care and Hospital is not a Monopoly


Forcina v. Hackensack Medical Center, No. C-1801-82 (N.J. Super. March 6, 1984) (physician's duties or privileges at other hospitals may impair development of proper case load and interfere with ability to fulfill teaching duties).

**ESTABLISHMENT OF OR PARTICIPATION IN A COMPETING INSTITUTION**

*Not Valid*


**MORATORIUMS AND CLOSED STAFFS OR CLINICAL DEPARTMENTS**

Mateo-Woodburn v. Fresno Community Hospital, 221 Cal.App. 3d 1169, 270 Cal. Rptr. 894 (5th Dist. 1990).
AHLA Seminar Materials


Court will not Examine Substantive Basis for Decision

Bloom v. Hennepin County, 783 F. Supp. 418 (D. Minn. 1992) (physician fired from employment with medical group with exclusive contract with hospital)

Valid only if Need to Close Staff is Documented and Viable

Claycomb v. HCA-Raleigh Community Hospital, 333 S.E. 2d 333 (NC App. 1985) (review of hospital decision to close staff to podiatrists finding that one practitioner on staff was sufficient)

REFUSAL TO APPOINT OSTEOPATHIC PHYSICIANS

Not Valid

Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), cert. denied, 470 U.S. 1060 (1985)

REFUSAL TO APPOINT OTHER HEALTH PRACTITIONERS

Valid Criterion

Kaczanowski v. Medical Center Hospital of Vermont, 612 F. Supp. 688 (D.Vt. 1985) (podiatrists)

Cooper v. Forsyth County Hospital Authority, 604 F. Supp. 685 (M.D.N.C. 1985) (podiatrists)

Wrable v. Community Memorial Hospital, 501 A.2d 787 (N.J. Super. 1985) (exclusion of psychiatric nurse)

Dooley v. Barberton Citizens Hospital, 465 N.E. 2d 58 (Ohio 1984) (restrictions on practice of podiatrists unreasonable and discriminatory)

Invalid Criterion

(Dooley v. Barberton Citizens Hospital, 465 N.E. 2d 58 (Ohio 1984) (restrictions on privileges accorded to podiatrists improper)

BEST INTEREST OF PATIENTS

Too Vague

Milford v. People's Community Hospital Authority, 380 Mich. 49 155 N.W. 2d 815 (1968)

Valid


OTHER

Bhogaonker v. Metropolitan Hospital, 164 Mich. App. 563, 417 N.W.2d 501 (1987) (discharge of employee physician for based upon the financial difficulties of the hospital was valid)

D. Trends

1. Numeric Requirements

Some hospitals have adopted specific numeric requirements for the granting and exercise of specific privileges. For example, a hospital may require a surgeon to
perform a specific number of procedures in a specified time period in order to grant privileges for that procedure.

2. Loyalty Criteria

Loyalty criteria relate, by way of one example, to physicians maintaining a certain level of activity at the hospital. Hospitals may consider adopting minimum patient encounter requirements in order to (1) encourage physicians to concentrate their practices at the hospital, (2) maximize patient admissions and other revenue-producing activities, (3) facilitate monitoring of physicians to determine competency necessary for reappointment decisions, (4) meet the hospital's needs for conducting professional education programs, i.e., residency programs, and (5) weed out physicians who do not contribute to the hospital.

Such criteria may be drafted in numerous ways. The definition of “patient encounter,” the scope of application of such criteria (e.g., whether physicians of certain specialties are exempt from the requirement), the specific numeric requirements, and the consequences of a physician's failure to satisfy such requirements (e.g., reduction of staff category, loss of political rights, loss of special privileges, exclusion from staff) must be individually tailored to each hospital.

3. Institutional Criteria

Hospitals are considering implementing institutional criteria in their efforts to survive in the competitive health care marketplace. Institutional criteria may relate to a wide range of issues, including, but not limited to, considerations of primary practice affiliation, office location, patient base, payor mix, participation in Physician-Hospital Organizations, and nature of professional practice.

The consideration of institutional needs and concerns in appointing physicians to the Medical Staff appears to be legally valid. For example, in Rosenblum v. Tallahassee Memorial Regional Medical Ctr., No. 91-589 (Fla. Cir. Ct. June 18, 1992), the court granted summary judgment to a hospital that denied Medical Staff membership to a physician who was the director of a competing hospital's clinical program.

4. Economic Credentialing

Some hospitals are considering the economic impact of a staff physician's practice on the finances of the institution. So-called “economic credentialing” occurs when a hospital considers economic, as opposed to clinical, factors in the decision of whether to appoint or reappoint a particular physician. Hospitals increasingly are considering such economic criteria as resource use, revenue generated, diagnosis-related groups, payor mix, reimbursement rates, admission rates, length of stay, referral patterns, economic efficiency of practice patterns, and effective utilization of hospital resources. The adoption of economic criteria, a subset of institutional criteria, also should be driven and applied by the Board rather than the Medical Staff.

Economic credentialing remains controversial. It has been opposed by numerous medical societies who assert that the best interest of the patient and the quality of care provided should be paramount to financial matters in Medical Staff decisions.

V. SPECIAL PREROGATIVES
Hospitals often have the ability to award physicians financially beneficial opportunities such as the ability to provide official interpretations for diagnostic tests (e.g., echocardiograms), or to provide patient care in specific units of the hospital (e.g., unassigned emergency room patients). In addition, hospitals may delegate to a physician the power to determine which other physicians may perform such services and how often. This “referral” or “scheduling” right may be very valuable to physicians. In the past, hospitals often used these special prerogatives to reward physicians for their commitment to the institution, their patient referrals and their Medical Staff service.

VI. INTRA-HOSPITAL FAIR HEARING AND APPELLATE REVIEW PROCESS

The fair hearing and appellate review process in hospitals has been transformed from a collegial forum to permit a physician to challenge an adverse peer review decision and vindicate his professional conduct to a adversarial proceeding that often is the precursor of litigation. This hospital function presents increasing concern and risk to hospitals, Board members, Medical Staffs, and Staff physicians.

Three factors have been responsible for this transformation. First, hospitals continue to be vulnerable to lawsuits from their decisions regarding Medical Staff appointment, reappointment and clinical privileges. Second, with the enactment of the Health Care Quality Improvement Act, physicians have a greater incentive to challenge adverse hospital decisions - avoidance of a report to the National Practitioner Data Bank. Third, the Health Care Quality Improvement Act sets forth explicit standards for assuring procedural fairness in intra-hospital proceedings. These criteria, modeled on court proceedings, require, for example, hospitals to permit physicians to be represented by lawyers.

In virtually all hospitals, the Medical Staff Bylaws or a separate Fair Hearing Plan set forth detailed procedures and requirements for the conduct of a hearing and appellate review.

A. When is a Hearing Required?

Generally, the Medical Staff Bylaws and/or Fair Hearing Plan set forth the types of actions that entitle a practitioner to a hearing and appellate review. Generally, this list includes most adverse actions that affect a physician's practice at the hospital, including denial, restriction and termination of Medical Staff membership or clinical privileges, mandated proctoring and suspensions. In many hospitals, however, a physician is not entitled to a hearing for administrative actions (e.g., suspension due to failure to complete medical records) or automatic actions (e.g., loss of license to practice medicine).

In recent years, there has been some controversy over whether physicians who are impeded from practicing at the hospital due to institutional decisions (e.g., the hospital's decision to enter into an exclusive contract displacing incumbent physicians) or class-based exclusions (e.g., a decision to amend the Bylaws to require Board certification or another criterion that the individual physician cannot meet) are entitled to a hearing. Courts have been divided over whether a hearing is required. Some courts have held that, although the Bylaws or contract may appear to entitle the practitioner to a hearing, none is required in such instances - either because there are no issues to be addressed in the hearing regarding an individual practitioner, because the issue is quasi-legislative rather than quasi-judicial, or
because the physician's Medical Staff membership and privileges were not significantly restricted. See, respectively, e.g., Anne Arundel General Hospital, Inc. v. O'Brien, 49 MD App. 362, 432 A.2d 483 (1981), cert. denied, (Oct. 23, 1981); Mateo-Woodburn v. Fresno Community Hospital, 221 Cal.App.3d, 270 Cal. Rptr. 894 (1990); Holt v. Good Samaritan Hospital, 69 Ohio App.3d 439, 590 N.E.2d 1318 (1990). Other courts disagree, finding the right to a hearing to be guaranteed in the Bylaws. Lewisburg v. Alfredson, 805 S.W. 2d 756 (Tenn. 1991); Hospital Corporation of Fort Worth v. Romaguera, 511 So. 2d 559 (Fla. Ct. App. 1986).

B. What Rights Does a Physician Have in the Hearing?

Generally, a physician has the rights set forth in the Bylaws. A hospital may be subject to liability if it fails to provide a hearing when required by the Bylaws or if the hearing provided does not conform to the procedures in the Bylaws or is tainted with bias, bad faith or malice.

The Health Care Quality Improvement Act provides limited immunity from some claims for the actions of professional review bodies provided that the professional review action is taken in the reasonable belief that the action was in furtherance of quality health care, after a reasonable effort to obtain the facts of the matter, after adequate notice and hearing procedures are afforded to the physician involved, or after such other procedures as are fair to the physician under the circumstances, and in the reasonable belief that the action was warranted by the facts.

A health care entity is deemed to have met the adequate notice and hearing requirement if the following conditions are met or voluntarily waived by the physician:

1. Notice of the Proposed Action, including:
   - Specific adverse action proposed
   - Reasons for the proposed action
   - The right to request a hearing
   - Time limit for such a request (30 days or more) and,
   - Summary of rights

2. Notice of Hearing, including:
   - Time, place and date of hearing (not less than 30 days after notice)
   - List of witnesses (if any) expected to testify hearing on behalf of the professional review body.

3. Conduct of Hearing
   - conducted before a mutually acceptable arbitrator, a hearing officer, or a panel of individuals who are not in “direct economic competition” with physician involved
   - Right to hearing forfeited if physician fails without good cause to appear
   - In the hearing, the physician has the right:
     - to representation by an attorney or other person of the physician's choice
     - to have a copy of the record of the proceedings upon payment of any reasonable charges
     - to call, examine and cross-examine witnesses
- to present relevant evidence regardless of its admissibility in a court of law, and
- to submit a written statement at the close of the hearing.

Upon completion of the hearing, the physician has the right:
- to receive the written recommendation of the arbitrator, officer or panel, including a statement of the basis for the recommendations,
- to receive a written decision of the health care entity, including a statement of the basis for the decision.

The HCQIA also specifically provides that the failure of a professional review body to satisfy the notice and hearing procedures does not, in itself, constitute failure to meet the standards of due process. 42 U.S.C. §11112. The affected practitioner, however, must be afforded a fair hearing and a true opportunity to defend the allegations and proposed adverse recommendation against him or her. Moreover, the HCQIA provides health care entities with an immunity from damages for their good faith peer review actions. It does not give physicians a cause of action for violation of its provisions. See Regualos v. Community Hospital Ass'n, 1991 U.S. Dist. LEXIS 11415 (Aug. 7, 1991).

C. Litigation/Liability Pitfalls

The intra-hospital due process and fair hearing proceedings present various litigation and liability pitfalls. Common general problem areas include the following:
- Lack of compliance with Medical Staff Bylaws'
- Inadequate notice of charges to affected practitioner
- Affected practitioner not provided with documentation sufficient to enable the practitioner to challenge the adverse recommendation at the hearing'
- Inadequate or incomplete findings of fact by Ad Hoc Hearing Committee necessary for subsequent appellate/judicial review.

D. Legal Representation Issues

In the past, some hospitals refused to permit applicants for Medical Staff appointment and reappointment to be represented by an attorney. This refusal was based upon the rationale that the proceedings were not legal but rather professional. Hospitals feared that the involvement of attorneys would create an adversarial environment and could intimidate the physicians. Now, due to the Health Care Quality Improvement Act and the heightened importance of intra-hospital proceedings to subsequent litigation, hospitals typically permit both the Medical Staff and the affected physician to be represented.

If the affected practitioner elects to retain counsel, the Medical Executive Committee should, in most cases, also retain counsel for case presentation. If the affected practitioner chooses, voluntarily and knowingly, to waive representation by counsel, the same should be documented and, in most cases, the Medical Executive Committee should likewise not be represented by counsel at the hearing. (NOTE: Even if the Committee is not represented by an attorney at the hearing, it should consult an attorney for advice prior to the hearing).

The attorney who represents the MEC in intra-hospital hearings arguably should not be involved in any subsequent litigation because of potential conflicts and
issues of loss of privilege.

E. Appointment of “Judge” and “Jury”

1. Composition of Hearing Panel

If permitted by the Bylaws, hospitals should consider appointing a hearing panel of three physicians. A larger panel may create difficulty with scheduling the hearing. The members of the hearing panel should usually be selected by Administration after consultation with the Medical Staff president (if the hearing is based upon the action or recommendation of the Medical Staff) or the Chairman of the Board (when the hearing is based upon an action of the Board). Caution should be exercised to prevent individuals from being appointed to the committee who are either economic competitors of the subject physician who have an “ax to grind,” or who previously participated in consideration of the adverse recommendation. NOTE: If it is impossible to select a representative group under these conditions due to the size of the Medical Staff or other factors, consideration must be given to appointing members from outside the institution. One of the members of this hearing panel should be designated presiding officer.

All members of the hearing panel must be present throughout the proceedings and hear all the evidence. If a member of the hearing panel is unavailable for any part of the proceedings, he or she should not be entitled to participate in the deliberations or vote.

2. Hearing Officer/Hearing Examiner

Some hospitals have chosen to use a hearing officer or hearing examiner in addition to, or in lieu of, a hearing panel.

A hearing officer is a person (often an attorney or retired judge) who serves as the presiding officer of a hearing. This individual is responsible for deciding procedural issues (including discovery and admissibility of evidence) and maintains order and decorum in the proceedings. The hearing is still held before a panel of physicians (usually members of the Medical Staff) and this panel decides the matter. The hearing officer does not participate in the deliberations or decision of the hearing panel.

In contrast, a hearing examiner is a person (often an attorney or retired judge) who serves in place of the hearing committee. The hearing examiner is responsible for deciding procedural matters, hearing evidence, and rendering a decision.

The use of a hearing officer or examiner provide several clear benefits:

1. Physicians generally lack the legal expertise required to decide procedural and evidentiary issues.

2. An attorney or judge may be in a better position to assure the orderly presentation of evidence, to mediate disputes between the attorneys for both sides and protect the committee from unjustified intimidation by attorneys for both sides.

3. The use of a hearing examiner rather than a panel of Medical Staff physicians may protect members of the Medical Staff from being drawn into protracted litigation.

4. The use of a hearing officer or examiner may assure that the physician receives a fair opportunity to vindicate his or her professional conduct and may provide a greater appearance of objectivity and fairness in the hearing proceedings and decision.
Hospitals may encounter two problems in deciding to use a hearing officer or examiner. First, the Fair Hearing Plan or Medical Staff Bylaws of many hospitals do not authorize the use of these individuals. These documents generally set forth a detailed procedure for the appointment of a hearing panel. Thus, hospitals would be well-advised to amend their Bylaws or Fair Hearing Plan to provide for the appointment of a hearing examiner or hearing officer if the Medical Staff, Board, or administration feels the same is necessary in an individual case. Otherwise, the hospital will need to obtain the stipulation of the physician in order to appoint a hearing officer or examiner.

Second, physicians may have grounds to object to the impartiality of a hearing officer or examiner. The hearing officer or examiner is generally selected by the hospital (administration, Board or Medical Staff), compensated by the hospital, and provided with an indemnification agreement whereby the hospital agrees to defend and indemnify the hearing officer or examiner in any lawsuit arising from his or her good faith involvement in the proceeding. Some of these problems may be alleviated if the physician is consulted in the selection of the hearing officer or examiner or is permitted to contribute to the compensation of the hearing officer or examiner.

F. Pre-Hearing Procedure

1. Notice of Hearing

The affected practitioner should receive a notice of hearing which should state, in concise language, the specific acts and/or omissions with which the practitioner is being charged, a list of specific charges being questioned, or other reasons or subject matters that were considered and relied upon in rendering the adverse recommendation. The affected practitioner should be informed of the reason for the proposed denial, and should be provided with fair opportunity to present a defense to the same. Requisite notice should be of the nature that actually notifies the affected practitioner of the charges, with specific references to testimony and/or documents and/or exhibits, where appropriate. Only then can the affected practitioner appear at the hearing and present an adequate defense.

2. Pre-Hearing Conference

The presiding officer, whether the physician chairman of a hearing panel or a hearing officer or examiner, should convene a pre-hearing conference with counsel for the Medical Staff or Board and the subject practitioner. The purpose of the conference is to prospectively address and resolve, for example, hearing procedural issues. For example, objections to the composition of the hearing panel or disputes relating to the sharing of evidence, which could impair the fairness of the hearing, can be effectively resolved prior to the hearing. In addition, the pre-hearing conference permits the parties and their counsel to agree in advance on the ground rules to be followed in the hearing. This conference should include, at a minimum, a discussion of the following issues:

- Objections, if any, to the composition of the hearing panel or the person selected as hearing officer or examiner
- Objections, if any, to the scheduling of the hearing
- Objections, if any, as to the scope of the hearing (time frame, incidents, issues, patient cases, etc.)
• List of witnesses’
• Document(s) exchange’
• Scheduling of hearings, including waivers of time limits established by Medical Staff Bylaws’
• Procedures to be followed at the hearing’
• Instructions to be given to the committee by the hearing officer’ and,
• Motions and Statements (e.g., those addressed to the adequacy of the charges and specifications, the admissibility of evidence, the discovery permitted, etc.).

3. Discovery Issues

The parties should exchange, well in advance of the hearing, all documents, charts, patient medical records, and other tangible items pertinent to the charges and recommendations. In addition, the parties may provide a list of witnesses, a synopsis of their testimony, and a list of exhibits that each side intends to present at the hearing. The liberal and timely discovery of evidence and information will promote the fairness of the hearing and permit each side to fully and adequately prepare for the hearing.

G. Hearing Procedure

1. Burden of Proof

Generally, pursuant to the Medical Staff Bylaws, the affected practitioner has the burden of establishing that he/she is eligible for admission to the Medical Staff, etc. Alternatively, when an affected practitioner's privileges are diminished, suspended, etc., the burden of proof falls upon the Medical Executive Committee. The standard of proof is generally set forth in the Bylaws or Fair Hearing Plan.

2. Admissibility of Evidence

An intra-hospital hearing is not a judicial proceeding and strict rules of evidence do not apply. Any relevant matters upon which reasonable persons customarily rely shall be considered, including, among other things, oral testimony, documentary evidence, case audits. However, evidence must be relevant and should satisfy minimum guarantees of trustworthiness.

The affected practitioner must have the right to call and examine witnesses, to cross-examine witnesses, to introduce written evidence and/or documents, and to challenge any witness and to rebut any evidence. If the affected practitioner does not testify in his/her behalf, he/she may nevertheless be called and examined as if under cross-examination.

3. Right to Submit Memorandum or Brief

The affected practitioner should be entitled to submit memoranda concerning any issue of procedure or of fact or of law and such memoranda should become a part of the hearing record.

4. Record of Hearing

An accurate record of the hearing should be made. Generally, the hearing should be transcribed by a court stenographer. Copies of any transcription of the testimony, with exhibits, if any, should be provided to all hearing participants and members of the hearing panel. All such persons should carefully review the transcript and note
any inaccuracies or corrections. They may not, however, substantively change any evidence or discussion that occurred during the hearing.

5. Report of the Hearing Panel or Hearing Examiner

The hearing panel or examiner shall prepare a written report and recommend confirmation, modification or rejection of the original adverse recommendation. This report should be detailed and contain specific written findings of fact upon which the recommendation is predicated. It should include all documents considered. The report may be needed to enable a subsequent appellate review panel and/or civil court to decide, amongst other things, whether there was sufficient evidence of record upon which a decision could be predicated. Importantly, any majority and/or minority opinions should be duly noted in the report of the hearing panel. Every physician voting member of the panel should have a vote ascribed to his or her name.

H. Post-Hearing Procedure: Appellate Review

While most state regulations and the JCAHO standards mandate that appellate review be available and set forth in the Medical Staff Bylaws, specific procedures for such appellate review are not mandated in federal (or, e.g., Pennsylvania) statutes and regulations nor provided in the JCAHO accreditation standards. JCAHO, 1997 Hospital Accreditation Standards, MS 5.4.4.1 (1996). In addition, although the HCQIA contains detailed requirements regarding a due process hearing from an adverse professional review action, the Act is silent on the procedures for appellate review. See 42 U.S.C. § 11112.

Generally, the physician should be entitled to present an oral or written statement to the Board. In addition, under certain circumstances and subject to the discretion of the Board, new or additional evidence may be submitted for consideration (although the Board may refer the matter back to the hearing panel for consideration of this evidence). Certainly, the appellate review procedure and final decision by the Board should be provided in a timely fashion, especially where the physician's practice at the hospital is suspended pending resolution of the matter at issue.

VII. CONCLUSION

In recent years, numerous changes have occurred and are occurring in the Hospital-Medical Staff relationship, corresponding to the seismic changes in the entire health care field. The Medical Staff has been a focus of concern and change as hospitals seek to assure their own economic survival. The hospital-Medical Staff relationship is currently on the front line of hospitals' efforts to battle the forces of change and forge their futures in the health care field.