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Medical Staff

The Shifting Balance of Power in Hospital-Medical Staff Relationships

BY KATHERINE BENESCH

Over the past 20 years, there have been dramatic changes in the health care system. None has been more pronounced than the change in the relationship between hospitals and the physicians who work on hospital medical staffs. The relationship of the hospital to its medical staff shifted gradually from that of two completely separate entities (the hospital as bricks and mortar, and physicians as independent care providers controlling the use of the facilities) to an uneasy symbiotic relationship in which hospitals and physicians relied upon each other from a somewhat antagonistic perspective.

Today, hospitals are increasingly employing physicians. Yet, the two groups are still competitors that must rely upon each other for patients, technology to produce quality care, and financial resources to enable necessary treatment.

New discoveries in biotechnology, the shift of emphasis from inpatient to ambulatory care, as well as the rise of consumerism and patients' rights have all led to circumstances where hospitals and physicians are required to compete for patients. Federal and state regulations dictate the types of interactions that are permissible between hospitals and physicians. As a result, hospital-physician integration has increased and the hospital and its medical staff often are joint managers of patient care.

This article will explore the changed relationship between hospitals and physicians, and some of the reasons these changes have taken place. The article also will explore the role of the Stark Law (42 U.S.C. § 1395nn), the anti-kickback statute (42 U.S.C. § 1320a-7b), EMTALA (42 U.S.C. § 1395dd) and the Joint Commission rules on disruptive practitioners in bringing about these changes.

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The Traditional Hospital-Physician Relationship

Years ago, the hospital was the facility within which surgeons operated and physicians performed diagnostic tests and treated patients. Medical care was focused in the hospital, and lengths of stay usually lasted more than a week. This began to change with the seminal case of *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965), *review denied* 383 U.S. 946 (1966), one of the first cases in which the court found that the hospital board of trustees had some legal responsibility under the theory of respondeat superior for oversight of the medical care and work of physicians within the institution.

The responsibility of the hospital and its board of trustees for the activity of the medical staff and for phy-

sicians who may not be on the hospital staff, but who come into the facility to treat patients, has evolved significantly. Under the theory of apparent authority, hospitals are legally responsible for the activities of physicians who may be held out to patients as working for the institution, even when this is not the case. *Cordero v. Christ Hospital*, 985 A.2d 101 (N.J. App. Div. 2008); *Basil v. Wolf*, 935 A.2d 1154 (N.J. 2007); *Kennedy v. Butler Memorial Hospital*, 901 A.2d 1042 (Pa. Super. Ct. 2006); *Kafri v. Greenwich Hospital Ass'n*, 2000 U.S. Dist. Lexis 22657 (D. Ct. 2004); *Guadagno v. Lifemark Hospitals of Florida Inc.*, 972 So. 2d 214 (Fl. Dist. Ct. App. 2007).

In most states, physicians' activities in hospitals were governed by medical staff bylaws (separate from the hospital corporate bylaws), which were legally determined to be a contract with the hospital. *See, e.g., Berberian v. Lancaster Osteopathic Hospital*, 395 Pa. 257, 149 A.2d 456 (1959). The medical staff was adjudicated to be a separate legal association in competition with its hospital partner. As competitors, both the hospital and its medical staff could be sued for restraint of trade. *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984), *review. denied*, 470 U.S. 1060 (1985). Most physicians were independent members of the medical staff governed by the medical staff bylaws. At the same time, most also were sole practitioners or members of their own independent medical practice groups. The exception were the so-called ''hospital-based physicians'': radiologists, pathologists and anesthesiologists. The ''hospital-based physicians'' were either employees of the hospital or worked in their own practice groups, which contracted with the hospital for services.

Physicians were accepted (or not) as members of the hospital medical staff after application, peer review and credentialing by the medical staff and its executive committee. Once a new physician was approved for membership on the staff, his/her application was sent to the hospital board of trustees with a recommendation from the medical staff that usually was ratified by the board. Reappointment of existing physician staff members was voted on in batches by the medical staff every two years, in accord with the requirements for hospital accreditation established by the Joint Commission.

Increasingly, hospitals began to enter into exclusive contracts with selected physician practice groups to staff certain hospital services. These exclusive contracts dictate that no physician can work at the hospital service staffed by the exclusive medical group, unless he or she is a member of that group. Needless to say, this arrangement has led to much litigation against the hospital and the exclusively selected group. Antitrust theories of restraint of trade, group boycott, conspiracy, and attempt to monopolize all have been asserted in these cases, *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984); *Gordon v. Lewistown Hospital*, 423 F.3d 184 (3d. Cir. 2005), *review denied*, 547 U.S. 1092 (2006).

Most exclusive contracts have been upheld in the courts under the rule of reason, as exclusive contracts have been found to reduce the cost of provision of care, and to increase quality and administrative efficiency of the services provided to the hospital's patients and community, *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991); *Nilavas v. Mercy Health System-Western Ohio, et al.*, 2007 U.S. App. Lexis 19127 (6th Cir. 2007).

This is not the case, however, for economic credentialing, which has been found to be contrary to public policy protecting competition and favoring specialty hospitals. The practice of ''economic credentialing,'' where hospitals attempt to exclude from the medical staff or from specific clinical privileges those physicians who compete with the hospital, refer most of their patients to other facilities, or hold ownership interests in competing hospitals, has been disfavored, *Murphy v. Baptist Health*, Ark. Cir. Ct., No. CV 2004-2002, 2/27/09. Recent data from three markets (Indianapolis, Phoenix, and Little Rock) show that specialty hospitals competing with general hospitals in the same community did not translate into actual financial challenges for the general hospitals in those communities. *See*, Joe Carlson, ''Specialty Facilities Don't Hurt General Hospitals: Study,'' *Modern Healthcare Daily Dose* (April 23, 2009). Thus, the gains that hospital medical staffs believe they will secure from economic credentialing are not universally confirmed by the data.

The Joint Venture Era

As noted above, hospitals have always relied financially upon physicians to admit patients to their facilities. Hospital emergency departments and specified clinics are the only portals of entry for patients without a physician admission. Specialty surgeons (for example, cardio-thoracic and neurosurgeons) have often had the upper hand, as they require the use of operating rooms and their patients necessitate longer hospital stays, thereby bringing greater reimbursement into hospital coffers. As physicians have been competing more openly with hospitals for patient revenues, hospitals searched for more ways to bring physician incentives in line with their own. This has led to an increased number of joint ventures between hospitals and physicians, as well as increased attempts by hospitals to employ and/or manage physician groups. Joint ventures have been more successful than hospital management of physician practices.

Concerned about the financial success of hospital/physician joint ventures, as well as the fees physicians were receiving from patient referrals (a long-standing practice in the medical profession), the federal government stepped up its prohibitions on payments for referrals and its regulation of joint ventures. In 1989, the Office of the Inspector General (OIG) began a new era in hospital-physician relationships by issuing its ''Special Fraud Alert on Joint Venture Arrangements,'' 59 Fed. Reg. 65372 (1994). In this alert, the OIG defined joint ventures as contractual arrangements between two or more parties to cooperate in providing services, or the creation of a new legal entity to provide such services.

The OIG expressed concern about these joint venture arrangements because they were typically entered into between physicians in a position to refer business and others providing items or services paid for by Medicare or Medicaid. While joint ventures might be formed for legitimate reasons, the OIG was concerned that these joint ventures might violate the Medicare/Medicaid anti-kickback statute (42 U.S.C. § 1320a-7b). The anti-kickback statute establishes criminal penalties where any person knowingly or willfully offers, pays, solicits, or receives remuneration in return for referring an individual to anyone for the furnishing, purchasing, leasing, ordering, or arranging for any item or service payable in whole or in part under a federal health care program.

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As noted by the OIG at 59 Fed. Reg. 65374, "Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary program expenditures."

In addition to the OIG's hostility to hospital/physician joint ventures, multiple changes in the Stark Law (42 U.S.C. § 1395nn) and its regulations increasingly have placed barriers in the path of physicians and hospitals seeking financial benefits from their work together as independent legal entities. Unlike the anti-kickback statute, the Stark Law is a strict liability statute that does not require improper intent for a violation. The Stark Law and its regulations have been amended and/or modified eight times between the original 1989 formulation and the 2009 final Medicare physician fee schedule released in November, 2008. The changes that took place in 2007 and 2008 created an atmosphere of uncertainty about the future of hospital/physician joint ventures.

The 2009 hospital inpatient prospective payment systems final rule published by the Centers for Medicare and Medicaid Services on Aug. 19, 2008, will likely cause hospitals and physicians to unwind many of these joint ventures. The most recent changes set forth by CMS will effectively prohibit the "under arrangement" structures that hospitals and physicians were using increasingly for joint investment in popular businesses such as diagnostic imaging centers and cardiac catheterization labs (42 C.F.R. § 411.351). In addition, the extension of the "anti-markup" rule contained in the 2008 Medicare physician fee schedule (72 Fed. Reg. 66306 (2007)) as well as new limitations on the use of percentage-based compensation and "per click" lease payments in the 2009 hospital inpatient prospective payment system rules (73 Fed. Reg. 48713 (2008)) make the continuation of joint ventures or the start of new ones much more difficult and less financially rewarding.

By contrast, the Stark Law exceptions for the bona fide employment (42 U.S.C. § 1395nn(e)(2); 42 C.F.R. § 411.357(c)) and personal services relationships (42 C.F.R. § 411.357(d)) and for fair market value (42 C.F.R. § 411.357(l)), as well as the anti-kickback employment and personal services safe harbors (42 U.S.C. § 1320a-7b(b)(3)(B); 42 C.F.R. § 1001.952(i) and (d)), encourage employment of physicians by hospitals in that they allow employment or contract-based relationships with physicians that may be financially advantageous as long requirements of the regulations are met.

The New Age of Physician Employment

For years, large health maintenance organizations and multi-state health plans, such as Kaiser, have employed physicians. Until recently, however, employing physicians to secure the majority of their services for hospitals was not a widespread practice. Physician employment has increased partly because of the increased commercialization of the practice of medicine. This, in turn, has weakened the rule promulgated by medical boards in many states that business corporations should not employ physicians (the "corporate practice of medicine doctrine"). Rather, organizations that employ physicians should be controlled by medical professionals to maintain quality of care for the public good.

In many states, hospitals have been an exception to the corporate practice of medicine rule for some time. *See, e.g., Berlin v. Sarah Bush Lincoln Health Center*, 688 N.E.2d 106 (Ill. 1997). Nonetheless, most physicians had been independent practitioners who provided hospital services to their patients through their relationships with the hospital medical staff or through hospital-physician joint venture arrangements that are now in question.

As noted above, certain Stark Law exceptions and anti-kickback safe harbors encourage the physician employment model and/or the rendering of physicians' services to hospitals through personal services agreements. There is more settled law related to aspects of these types of arrangements, and these relationships are easier to structure and define than more complex joint ventures. For physicians, employment by a hospital (either directly or by contract) may provide greater legal protection in some respects. For example, physicians working for a medical group that has an exclusive contract with the hospital must be credentialed by the medical staff to gain admitting privileges at the institution. Nonetheless, most exclusive contracts specifically deny the physicians in the exclusive group the due process and fair hearing rights afforded other physicians under the hospital medical staff bylaws. Thus, there may be a financial benefit to membership in an exclusive contracting group, but there is also more uncertainty and no due process in the event the physician breaches the employment agreement.

Instead of pursuing the medical staff bylaws process, physicians are increasingly filing suit for employment discrimination on the basis of age, race, sex, sexual orientation, and national origin under Title VII and state civil rights laws. A physician working under a professional services agreement was found to be an "employee" for purposes of state anti-discrimination law, *Johnson v. Riverside Healthcare System LP,* 103 F.E.P. (BNA) 1553 (9th Cir. July 28, 2008). A member of a hospital medical staff was able to prove to a jury that she was an "employee" of the hospital because the hospital used the peer review process to control the "manner and means" of her work, *Salamon v. Our Lady of Victory Hospital*, 514 F.3d 217 (2d Cir. 2008). Independent physicians allied with the hospital under the medical staff bylaws only could not have pursued these actions unless they were held to be hospital employees, a finding that has many broader ramifications.

Emergency department physicians are a special case. Hospital emergency departments often function as a provider of last resort or a "safety net" for patients who are unable to pay for medical care. Enacted in 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2008), requires hospitals to have physicians and appropriate specialists on call 24 hours per day to treat emergency patients. EMTALA does not require, however, that these physicians work in the emergency department.

For a number of reasons, finding physicians to take call has become increasingly difficult for hospitals. Specialists see more patients in sites outside the hospital, such as ambulatory surgery centers and specialty hospitals. Physicians who see patients in an emergency room may be required to continue to treat them without pay for services rendered, as many of these patients are uninsured or underinsured. In addition, patients seen in emergency departments may represent increased risk of malpractice liability, as they are often sicker or present with traumatic injuries.

In 2007, the OIG cautioned that, ''. . . improperly structured payments for on-call coverage could be used to disguise unlawful remuneration . . . problematic compensation structures . . . might disguise kickback payments. . .'' (OIG Advisory Opinion No. 70-10 (Sept. 27, 2007)). Under these circumstances, the employment of physicians to provide on-call coverage may solve many of the problems experienced by both the hospital and the physicians. As with other hospital services, the employment of physicians to provide services on-call to emergency patients solves many of the regulatory, Stark, or anti-kickback problems created by a hospital's development of a scheme to pay physicians to take call. Thus, the issue becomes how much the institution must pay to entice physician employees to cover the hospital's emergency service, not whether this is a good idea.

The Joint Commission Standards on Disruptive Behavior

Discipline for disruptive physicians traditionally has been handled by and through the hospital medical staff and its bylaws and fair hearing process. This is no longer the case. Two of the three trends that have changed this process are discussed above: 1) exclusive contracts, which deny physicians the due process protections of the medical staff bylaws fair hearing; and 2) the shift by physicians seeking protection under employment discrimination laws. The third significant change is found in the new Joint Commission requirement for hospital policies and procedures to control and minimize the risk to patients presented by disruptive physicians.

In the past several years, the Joint Commission (formerly the Joint Commission on Healthcare Organizations or JCAHO) has been working on major revisions of its Leadership Standards for hospitals that seek or desire to maintain accreditation from the Joint Commission. As of Jan. 1, 2009, the Joint Commission required all hospitals to implement a code of conduct defining acceptable and disruptive behaviors for members of the hospital's medical staff, and to create a process for managing disruptive and inappropriate behaviors. (L.D. 03.01.01). This new standard derives from the July 9, 2008, Joint Commission Sentinel Event Alert on ''behaviors that undermine a culture of safety.''

The Joint Commission's new standard requiring the management of inappropriate and disruptive behavior in the institution follows the Medical Staff Leadership's 2008 Hospital and Health System Medical Staff Survey, which found that out of 599 institutions, only 10 percent disciplined or counseled more than six members of the medical staff during the past two years. The same study found that 27 percent of the hospitals surveyed did not discipline or counsel any members of the medical staff during the two-year period (*Modern Healthcare*, Vol. 39, No. 12, p. 38, 3/23/09).

Disruptive behavior is behavior that interferes with the ability of everyone on the health care team to provide safe and effective care to the patients. The imposition of this standard by the Joint Commission effectuates another point of leverage for the institution in the control of its medical staff. If the hospital does not implement these standards, this could be a factor placing in jeopardy its accreditation and thereby its eligibility for participation in Medicare and Medicaid. Thus, the Joint Commission has taken a step to require that hospital standards and codes of conduct for disruptive physicians supplant policies, procedures, and processes that formerly were within the exclusive control of the medical staff.

As the relationship between the hospital and its medical staff changes, and the hospital assumes more control over the behavior and finances of its physicians, it will be more difficult to align the interests of the medical staff with those of the hospital, and to maintain the quality of care to patients seen in the institution. These are major challenges to both hospitals and physicians in an era when the U.S. health care system is in the process of undergoing significant change in its approach to services rendered, use of new technologies, and types of therapies and payment for services rendered.

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