

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2 - A-06
(June 2006)

Subject: Fiduciary Credentialing
(Resolution 725, A-05)

Presented by: Joseph P. Annis, MD, Chair

Referred to: Reference Committee G
(C. Bruce Malone, MD, Chair)

1 At the 2005 Annual Meeting, the House of Delegates referred Resolution 725. Introduced by the
2 Ohio Delegation, the resolution calls for the American Medical Association to “adopt the term
3 fiduciary credentialing as a special case of economic credentialing and define it as a loss of hospital
4 privileges based on a physician’s economic competition with the hospital.” The resolution also
5 calls for the AMA to “adopt a position in opposition to fiduciary credentialing.” The Board of
6 Trustees referred this issue to the Council on Medical Service for a report back to the House at the
7 2006 Annual Meeting.

8
9 This report examines the merits of subdividing the comprehensive term “economic credentialing”
10 to recognize “fiduciary credentialing” as a special case; includes an overview of existing AMA
11 policy on economic credentialing; summarizes select legal cases explored by the Litigation Center
12 of the AMA and the State Medical Societies; and presents two recommendations.

13 14 BACKGROUND

15
16 The issue of economic credentialing has been monitored and addressed by the AMA for many
17 years. Current AMA policy defines economic credentialing as “the use of economic criteria
18 unrelated to the quality of care or professional competency in determining an individual’s
19 qualifications for initial or continuing hospital medical staff membership or privileges” (Policy
20 H-230.975, AMA Policy Database). At the time that this policy on economic credentialing was
21 written (Council on Medical Service Report B, A-91), physicians were concerned that hospitals
22 were placing unreasonable limitations on their medical staff privileges, or participation at a hospital
23 on the basis of a physician’s case-mix or utilization patterns. As physicians have become more
24 entrepreneurial, AMA policy has evolved to address the attempts to restrict the entrepreneurial
25 activities of physicians on the basis of their financial interest in another hospital/health system.

26
27 In July 2002, the Ohio State Medical Association (OSMA) sent a letter to the Board of Directors of
28 OhioHealth that objected to its use of economic credentialing to determine medical staff privileges
29 for OhioHealth hospitals. In response, OhioHealth developed a white paper that contends that the
30 AMA and OSMA definition of economic credentialing is too broad. OhioHealth believes that the
31 AMA and OSMA definition of economic credentialing conflicts with many state statutes which
32 permit the directors of nonprofit hospitals to make decisions to credential hospital staff on the basis
33 of their fiduciary duty to protect the interests of the hospitals. Consequently, OhioHealth urged the
34 OSMA to narrow the definition of economic credentialing so that there can be a meaningful debate
35 over the practice of withdrawing privileges from physicians who invest in competing health care
36 facilities.

1 In correspondence received by the Council, OSMA indicated that it was the intention of the author
2 of Resolution 725 (A-05) to have the AMA consider subdividing the term “economic
3 credentialing” and recognize “fiduciary credentialing” as special case of economic credentialing.
4 The reason that the author believed that this change was necessary was to “debate the merits of de-
5 credentialing a physician because a physician chooses to participate in a competing entity.” In
6 addition, the author of Resolution 725 (A-05) noted that the debate should “focus on the hospital
7 demonstrating some reasonable likelihood of economic damage prior to de-credentialing a
8 physician so this becomes a true fiduciary concern and not a punitive measure to restrict
9 entrepreneurial activity of physicians.”

10 11 RELEVANT AMA POLICY

12
13 The AMA has extensive policy in opposition to economic credentialing (H-230.975,
14 H-220.945, H-230.976, H-230.971, H-230.985, and H-230.965). In addition, existing policies
15 address the instance of a loss of hospital privileges in the case of economic competition. Policy
16 H-230.963[3] “opposes hospitals placing limitations on medical staff privileges or participation at a
17 hospital based in whole or in part on the physician (or a partner, associate or employee of the
18 physician) having a financial relationship with another hospital/health system.” Policy H-230.958
19 strongly opposes the implementation of economic loyalty criteria. In addition, it is the policy of
20 the AMA that if requested directly or by a constituent medical society, the AMA will provide
21 assistance to the medical staff in resolving a dispute over medical staff development plans or
22 economic credentialing controlled by the hospital, if appropriate (Policy H-225.963). The AMA
23 also has developed model medical staff bylaws, supported the physician’s role in developing
24 medical staff bylaws, and encouraged hospital medical staff to develop protective bylaw provisions
25 dealing with economic credentialing (Policy H-230.982, H-235.989, and H-235.991). Finally,
26 Policy H-215.968 supports and encourages competition between and among health facilities as a
27 means of promoting the delivery of high-quality, cost-effective health care.
28

29 STATE OF THE LAW REGARDING ECONOMIC CREDENTIALING

30
31 In developing this report, the Council sought the input of the legal staff within the AMA’s Division
32 of Health Law, which provided the following overview of the general state of the law regarding
33 economic credentialing.
34

35 Case Law

36
37 Absolute Right to Use Economic Criteria in Credentialing. In cases involving alleged breaches of
38 contract stemming from a hospital’s decision to withhold or revoke a physician’s medical staff
39 privileges based on economic criteria (“economic credentialing”), courts have generally sided in
40 favor of hospitals, granting them broad authority to make staffing decisions. In these cases,
41 hospitals have offered numerous rationales to support their right to make staffing decisions based
42 on economic criteria. The most common of these rationales include: the protection of health care
43 quality, the furtherance of the administrative goals, and the promotion of competition. *See, e.g.,*
44 *Knapp v. Palos Community Hospital*, 531 N.E.2d 989 (Ill. App. Ct. 1988); *Lister v. Methodist*
45 *Medical Center of Oak Ridge*, 1993 Tenn. App. LEXIS 717, *1 (Tenn. Ct. App. 1993); *Lewisburg*
46 *Com’ty Hosp., Inc. v. Alfredson*, 805 S.W.2d 756 (Tenn. 1991); *Rosenblum v. Tallahassee Mem’l*
47 *Reg. Med. Ctr., Inc.*, No. 91-589, slip op. at 4-5 (Fla. Cir. Ct. June 18, 1992); *Mahan v. Avera St.*
48 *Luke’s*, 621 N.W.2d 150 (S.D. 2001).

1 Furthermore, at least one court, *Miller v. St. Alphonsus Regional Med. Ctr., Inc.*, 87 P.3d 934 (Ida.
2 2004), has held that, to the extent they would limit a hospital's substantive criteria for medical staff
3 privileges, medical staff bylaws are not binding on a hospital and the hospital can change them at
4 will. According to this case, medical staff bylaws are enforceable only to the extent that they
5 establish procedural rights to a fair hearing.

6
7 Restrictions on Use of Economic Criteria in Credentialing. A few decisions have held against
8 hospitals in economic credentialing cases, mostly in cases where the hospital's actions were in
9 *clear* violation of the procedural requirements mandated by medical staff bylaws.

10
11 In *St. Mary's Hosp. of Athens, Inc. v. Radiology Prof. Corp.*, 421 S.E.2d 731 (Ga. Ct. App. 1992), a
12 hospital brought a declaratory judgment action against a specialty physician group seeking to
13 establish its right to terminate a contract for exclusive radiological services. In a counterclaim, the
14 physicians' group alleged that the hospital had breached its duties under the medical staff bylaws to
15 follow the procedures necessary to terminate its business relationship with the physicians. The
16 court held that the bylaws were enforceable under the state statute requiring hospitals to adopt
17 them. Thus, although hospitals generally have "broad power" to "control administrative,
18 operational, and managerial functions of the facility and its staff," they cannot "abridge or refuse to
19 follow...existing bylaws concerning staff privileges."

20
21 Where the bylaws are unclear as to the rights conferred to the medical staff, courts have generally
22 sided with the hospitals. For instance, in *Mahan*, a physician challenged a hospital's right to close
23 its staff to physicians performing particular types of spinal surgeries in order to ensure an adequate
24 number of patients for its newly recruited neurosurgeon. The physician alleged that the closure
25 violated the medical staff bylaws, which he believed required the hospital to consult with the
26 medical staff on such decisions. In ruling in favor of the hospital, the court held that members of
27 the medical staff have no rights with respect to staffing decisions unless specifically granted such
28 power by the bylaws. The bylaws in this case only required the hospital to consult the medical
29 staff with respect to decisions concerning physician competence. The decision to close its staff,
30 however, was not based on the competency of the barred physicians, so the hospital was entitled to
31 close the staff for any other purpose.

32
33 A few cases seem to have taken an intermediate approach. While they hold that hospitals can use
34 economic criteria in credentialing decisions, they also hold that those criteria, as applied, must be
35 "rationally related" to legitimate objectives and cannot be "arbitrary and capricious." For example,
36 in the companion cases *Desai v. St. Barnabas Med. Ctr.*, 510 A.2d 662 (N.J. 1986) and *Berman v.*
37 *Valley Hosp.*, 510 A.2d 673 (N.J. 1986), hospitals adopted a closed staff policy in response to bed
38 overcrowding and over-utilization of the hospitals' resources. Under the new policy, applications
39 for staff privileges would be denied unless the applicant satisfied one or more of six exceptions.
40 The most important exception was that the applicant had to be associated with another physician
41 who already had staff privileges at the hospital. While the court recognized the right of hospitals to
42 take "rational" steps to the perceived overcrowding, the court struck the hospitals' preference for
43 doctors who practiced with those already on the staff. The court held that the hospitals had not
44 sufficiently demonstrated that the preference genuinely served its stated objectives—that the staff
45 members would be able to help cover the patients of doctors with existing privileges and that the
46 new members were unlikely to require many new patient admissions to the hospitals. The court
47 struck the preference as discriminatory because the hospitals offered no data or other competent
48 evidence to support its rationale.

1 However, the overwhelming majority of cases while acknowledging that staffing decisions should
2 be “rationally related” to legitimate objectives and not “arbitrary and capricious,” ultimately regard
3 these requirements as mere verbiage. *Desai* and *Berman* are the only cases found in which the
4 court actually overturned a hospital decision on such grounds.

5
6 Medical staff bylaws, however, are not the only possible legal restrictions on the use of economic
7 criteria in credentialing. In *Baptist Health v. Murphy*, 2006 Ark. LEXIS 58, *1 (Ark. Feb. 2,
8 2006), a group of Arkansas physicians sued to retain their medical staff privileges, despite a
9 hospital policy that mandated a denial of privileges for any physician who had invested in a
10 competing hospital. The Arkansas Supreme Court held for the physicians, finding that the
11 hospital’s economic credentialing policy may have interfered with the relationship between
12 physician and patient and may also have violated the Arkansas Deceptive Trade Practices Act
13 (“ADTPA”), which makes illegal any trade practice that is “unconscionable” or “violative of public
14 policy or statute.”

15 16 Statutory Law

17
18 State Laws that Specifically Authorize Economic Credentialing. Most of the states that have
19 passed laws dealing with economic credentialing affirmatively sanction the practice. *See, e.g.*, Fla.
20 Stat. § 395.0191 (2005) (allowing hospitals to consider “such other elements” as determined by the
21 hospitals’ governing board); Ga. Code § 31-7-7(a) (2005) (allowing hospitals to consider
22 “appropriate utilization of hospital facilities”); Iowa Code § 135B.7 (2005) (recognizing “the
23 necessity to grant privileges to a practitioner” based on “cost-effective services”); N.Y. Publ.
24 Health Law § 2801-b(1) (2005) (allowing hospitals to deny privileges consistent with “the
25 objectives of the institution”); N.C. Gen. Stat. § 131E-85(a) (2005) (providing that privileges shall
26 be based upon the hospital’s “reasonable objectives”); Tenn. Code § 7-57-502(c) (2005) (allowing
27 hospitals to enter into exclusive contracts “regardless of the competitive consequences”).

28
29 State Laws that Restrict, Without Completely Barring, Economic Credentialing. Although some
30 states have adopted laws restricting a hospital’s ability to consider certain economic factors in
31 making credentialing decisions, such laws do not outright prohibit the use of economic criteria in
32 making staffing decisions.

33
34 The most common form of the laws which prohibit hospitals from engaging in economic
35 credentialing prohibits discrimination against physicians who maintain privileges at competing
36 hospitals. *See, e.g.*, Cal. Welf. & Inst. Code § 14087.28(a) (2005) (prohibits hospitals from
37 considering “the existence of a contract with the hospital or with others” in making credentialing
38 decisions); Colo. Rev. Stat. § 25-3-103.7 (2005) (hospital may not discriminate “on the basis of
39 whether a physician is an employee of, a physician with staff privileges at, or a contracting
40 physician with, the hospital”); R.I. Gen. Laws § 23-17-53 (2005) (hospital “may not refuse or fail
41 to grant or renew medical staff membership or staff privileges, or otherwise limit or restrict
42 medical staff membership or staff privileges, based in whole or in part on the fact that the physician
43 [provides] medical or healthcare services at a different hospital”); Tenn. Code § 68-11-205 (2005)
44 (limits ability of hospitals to restrict physicians’ referral decisions); Tex. Health & Safety Code §
45 241.1015 (2005 (hospital may not make credentialing decisions “based in whole or in part on the
46 fact that the physician [provides] medical or health care services at a different hospital”).

1 Some statutes contain prohibitive language that might be interpreted as forbidding any
2 consideration of economic criteria. *See, e.g.*, 210 Ill. Comp. Stat. § 85/2(b)(1) (2005) (prohibits
3 “inappropriate use of economic criteria in determining an individual’s qualifications for initial or
4 continuing medical staff membership,” but does not identify which uses are appropriate or
5 inappropriate); Mass Gen. Laws ch. 111 § 51C (2005) (requires hospitals to consider applications
6 for clinical privileges “solely on the basis of the individual training, current competence,
7 experience, ability, personal character and judgment of the applicant,” but does not define these
8 factors).

9
10 DISCUSSION

11
12 Today, physician investment in potentially competing hospitals, specifically specialty hospitals, has
13 emerged as a contentious issue among physicians and community hospitals. Advocates for
14 specialty hospitals contend that the focused mission and dedicated resources of specialty hospitals
15 improve quality and reduce costs. Critics contend that specialty hospitals and other physician-
16 owned ambulatory facilities erode the ability of general hospitals to cross-subsidize their less
17 profitable services.

18
19 As discussed in Board of Trustees Report 15 (I-04), “Specialty Hospitals and Impact on Health
20 Care,” hospitals have three core strategies to address competition (i.e. establish their own specialty
21 hospitals, form joint ventures with local physicians, or fight physicians that try to open a competing
22 facility). Of particular consequence to physicians is the strategy to establish barriers that would
23 aggressively restrict physician’ capabilities to open competing facilities (e.g., adopting
24 economic/exclusive credentialing policies).

25
26 In July 2004, a report by the Federal Trade Commission and the Department of Justice, “Improving
27 Health Care: A Dose of Competition,” noted that “general hospitals facing competition from single
28 specialty hospitals (SSHs) have removed the admitting privileges of physicians involved with the
29 SSH or otherwise acted to limit physician access to the general hospital.” The report also observed
30 that “hospital reactions to deter Ambulatory Surgery Centers (ASCs) entry and restrict competition
31 have been similar to those for single-specialty hospitals (SSH).”

32
33 As previously cited, AMA policy strongly opposes the practice of economic credentialing and
34 Policy 230.963[3] appears to directly address the intent of referred Resolution 725 (A-05). The
35 Council believes that to establish a definition of fiduciary credentialing, as Resolution 725
36 suggests, would not appear to solve the underlying problem – which is that hospital boards of
37 directors could still assert their authority to de-credential all physicians who have any type of
38 investment in any potentially competing entity. This view was generally shared by members of the
39 Governing Council of the Organized Medical Staff Section (OMSS) who provided input to the
40 Council regarding the need to further delineate the definition of economic credentialing. The
41 majority of comments received by the Council suggest that an additional term is probably
42 unnecessary, and that the AMA should continue to support existing AMA policy as it relates to
43 economic credentialing.

44
45 Based on the legal analysis undertaken by the AMA Health Law staff, it is clear that physicians
46 face many trade-offs when they seek a financial stake in a physician-owned facility, with the courts
47 generally siding in favor of hospitals. Community care hospitals view economic credentialing as a
48 way to prevent physicians from “cherry-picking” the potentially more lucrative cases for referral to

1 specialty hospitals, while leaving the more difficult, potentially less profitable cases for the
2 community hospital. However, when the hospital's actions are in clear violation of the procedural
3 requirements mandated by medical staff bylaws, as in the court cases *Desi* and *Breman*, a hospital
4 decision could be overturned. In egregious instances, the AMA may be able to provide assistance
5 to physicians through the efforts of the Litigation Center of the AMA and State Medical Societies.
6

7 RECOMMENDATIONS
8

9 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
10 725 (A-05), and the remainder of the report be filed:
11

- 12 1. That our American Medical Association reaffirm Policy H-230.963[3], which opposes
13 hospitals placing limitations on medical staff privileges or participation at a hospital based in
14 whole or in part on the physician (or a partner, associate or employee of the physician) having
15 a financial relationship with another hospital/health system. (Reaffirm HOD Policy).
16
- 17 2. That our AMA continue to encourage physicians who have experienced what they believe to be
18 inappropriate hospital de-credentialing to contact their state medical association and the
19 Litigation Center of the AMA and the State Medical Societies. (Directive to Take Action)

Fiscal Note: Encourage physicians who have experienced what they believe to be inappropriate
hospital decredentialing contact their state medical association and the Litigation Center at an
estimated total cost of less than \$500.