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Health Law

Quality of Care Trumps Physicians' Property Rights

Termination of hospital privileges for physicians who show unprofessional and careless behavior can help improve overall patient care.

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For at least 5 years the anesthesiology department serving 2 nonprofit Memorial hospitals in Modesto and Ceres, California, was internally at war, a war which spilled out into the other departments of the 2 hospitals, and actually endangered the credentialing of the institutions. Eventually the hospital staff's Medical Executive Committee and the Board of Directors decided to solve the problem by closing the department and contracting with an anesthesiology service to provide exclusive services. A legal action was filed by 3 physicians who had previously been on staff but who were not rehired by the contractor under the new administration. The defendants included the hospital, the anesthesiology contractor, and various physicians affiliated with the hospitals and the contractor. The trial court found for the defendants, and the case summarized below (*Major v Memorial Hospital Association*) is the Court of Appeals review [1]. The case highlights the impact a physician and hospital can have on both quality of patient care and hospital stability.

The history of the turmoil behind the closing of the anesthesia department makes sad reading, but the case is also an object lesson in organizational dynamics. A brief chronicling of the highlights gives some flavor of the extent of the anesthesiology department's problems.

- Repeated scheduling conflicts leading to late or cancelled surgeries.
- A long history of problems with narcotics accountability and charges of drug and alcohol abuse against both physicians and nurses.
- Problems of security with regard to medication, equipment, and cleanliness on anesthesia carts.
- Misbehavior in the OR: street clothes, guitar playing, commodities trading, coffee-making, diet drinks, and telephoning.
- Personality conflicts leading physicians to refuse to talk to each other or cover each other's patients, physical altercations, and an argument in the presence of a patient awake on a gurney.
- Two anesthesiologists with higher than average complication rates, according to a consultant hired to review the situation.
- Allegations that crank calls were made and that a gasoline soaked rag was placed under the hood of one physician's car.

Notwithstanding the ongoing conflict, it is remarkable that it took the hospital administration at least 5 years to finally resolve the problems. The court noted critically, "The fact this problem existed is not as significant as the length of time it took to solve it, even though it jeopardized Memorial Hospitals' accreditation and posed a danger that narcotics would be diverted and misused. The lack of leadership also manifested itself in the department's failure to timely address and resolve quality of care issues involving anesthesiologists" [1].

Legal Analysis

The plaintiffs alleged violations of their civil rights, interference with the right to practice a profession, restraint of trade, breach of contract, defamation, and civil conspiracy. Also included in their complaint was an allegation of

tortious interference with their professional business relationships. The case effectively focused on the first 6 allegations and in the process provided an instructive primer on an issue of considerable importance to practicing physicians. It is these issues to which I will direct my comments. The tortious interference allegation, however, will provide grist for my final comments.

In brief, if a termination of hospital privileges constitutes an "adjudicatory act" there must be a showing of adequate cause arrived at through traditional due process, with courts assessing the adequacy of the hearings. On the other hand, if termination of privileges is a "legislative" or "quasi-legislative act," a judicial hearing is not required, and the courts will look only to determine whether the action was arbitrary, capricious, or entirely lacking in evidentiary support—a difficult case for an aggrieved party to make.

Because of this significant difference in a court's willingness to involve itself in an internal hospital dispute, defining the acts in question is important. "Adjudicatory" acts are defined as those actions directed at specific individuals, while "legislative" acts seek to address an administrative problem as a whole. "Generally speaking, a legislative action is the formulation of a rule to be applied to all future cases, while an adjudicatory act involves the actual application of such a rule to a specific set of existing facts" [2]. In considering quasi-legislative acts, courts are inclined to a "deferential standard of judicial review," seeking "only that there be some reasonable basis for a decision" [3].

The trial court rejected both of the plaintiffs' claims—that the hospital's decision to close the anesthesiology department was directed specifically at them and that it was arbitrary and capricious. The appellate court concurred with the trial court that the closure decision "was motivated by an honest, reasonable, and factually based concern about improving the overall functioning of the entire department and in improving employee morale…. In short, it was made to rid the Hospital of the undesirable effects of an open department and not directed specifically [at] excluding… the plaintiffs" [4]. The court found "ample evidence of systemic problems" in the department, citing its "failure to timely address and resolve the quality of care issues" [1]. It was found that "the overall problems associated with the operation of the department…motivated the closure rather than an intent to specifically exclude plaintiffs" [5]. The fact that the plaintiffs themselves created some of the difficulties did not mean that the decision was directed at them. The court stressed that hospital management was focusing not only on solving the existing problems, but also on "creating an organization capable of effectively dealing with similar issues in the future" [5].

Addressing the potential reflection on the plaintiffs' character, competency, or qualifications because of their exclusion from the newly closed anesthesiology department, the court supported the view that "elimination by reason of a departmental reorganization…does not reflect on the doctor's professional qualifications and should not affect his opportunities to obtain other employment" [6]. Recognizing the "public and patient interest in improving the quality of medical services," the court stated that the "vested rights" of a staff doctor to a hearing "take on a different quality and character when considered in light of a rational, justified policy decision" [6]. The court noted:

> There is, however, a definite distinction in the case law between the intentional actions of a hospital directed specifically toward the exclusion of a particular physician or groups of physicians, and the actions of a hospital which may, as a practical matter, result in the exclusion of individual practitioners but were undertaken for less personally directed reasons. Cases in the first category have protected physicians; cases in the latter category have often balanced the equities in favor of the hospitals. Thus, it may be seen that the "property right" of a physician in hospital staff privileges is subject to protection in some contexts but not in others... [7].

An extension of *Major?*

Major clearly stated that a physician does not have a "vested right" in retaining his or her staff privileges in a hospital, at least when the hospital is closing a department to resolve internal problems, especially "in these times when corporate change is so common" [8]. The *Major* court recognized that "an important public interest exists in preserving a hospital's ability to make managerial and policy determinations and to retain control over the general management of the hospital's business" [1]. However, it applied this interest in a case where there existed a rather egregious "situation which threatens or jeopardizes patient care" [6].

The *Major* court gives the plaintiff's argument of "tortious interference" short shrift. It recognizes that "a physician's hospital privileges constitute a property right": "[T]he essential nature of a qualified physician's right to use the facilities of a hospital is a property interest which directly relates to the pursuit of his livelihood" [9].

However, the court noted that "worthy objectives advancing important social interests," could be "sufficient to justify the interference with the plaintiff's ability to practice medicine resulting from the closed staff system" [10]. It explained that the physician's property right "is subject to protection in some contexts but not in others" [11].

One has to wonder what the courts will do with a new administrative issue that is looming on the horizon of American hospitals today—so-called "economic credentialing." Across the country insurers, employers, and hospitals are beginning to discourage physician-owned-and-operated health care facilities by eliminating them from networks and dismissing from hospital medical staffs those physicians who treat patients in such facilities. Will the courts find such exclusion from privileges to be addressed to specific individuals or at administrative problems as a whole? Will they find reflected in such decisions an "overriding concern for the quality of patient care" and support "a hospital's ability to make managerial and policy determinations and to retain control over the general management of the hospital's business?" Or, will they find that such actions are "directed at a specific physician or group of physicians" [6]? Will the courts see in such actions traditional "tortious interference with contracts" or an appropriate corporate response to changing economic models?

Many hospitals today feel that what they call "physician incentivized ambulatory clinics" are stripping them of their few remaining profitable lines of business while leaving them without the necessary support to maintain hugely expensive ERs, ORs, ICUs, and indigent care facilities. These clinics present a clear challenge to the economic viability of community-based hospitals, which the law in its current state may be unprepared to address. It will be interesting to see whether the courts extend the concepts set out in *Major* to address this new issue or are forced to develop new doctrines; whether the "adjudicatory" versus "legislative" distinction can be extended to this new medical business model.

The case of *Major v Memorial Hospitals Association* stands unequivocally for the concept that the quality of care provided to hospital patients must take precedence over competing property rights of physicians. As hospitals and physicians cope with rapidly changing economic models of care today, it will be interesting to see how far the courts are willing to go in impacting traditional business relationships between providers when quality of care is only incidental to the contested actions.

References

1. *Major v Memorial Hospitals Association* (1999), 71 Cal App 4th 1380, 84 Cal Rptr 2nd (Westlaw) 510:13. PubMed
2. *Strumsky v San Diego County Employees Retirement Assn*. 11 Cal 3d 28 (1974), at 35,fn.2, 112 Cal Rptr 805, 520 P2d 29.
3. *Major v Memorial Hospitals,* (Westlaw) 11. PubMed
4. *Major v Memorial Hospitals,* 12. PubMed
5. *Major v Memorial Hospitals,* 14. PubMed
6. *Mateo-Woodburn v Fresno Community Hospital & Medical Center*, 221 Cal App 3d at p. 1185, 270 Cal Rptr 894.
7. *Redding v St. Francis Medical Center,*208 Cal App 3d 103 105, 255 Cal Rptr 806.
8. *Major v Memorial Hospitals,*18. PubMed
9. *Anton v San Antonio Community Hosp.,*19 Cal 3d 802, 140 Cal Rptr 442, 567 P2d 1162.
10. *Lewin v St. Joseph Hospital of Orange,* 82 Cal App 3d at 394, 146 Cal Rptr 892.

11. *Redding v St. Francis Medical Center*, supra.

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