WHITTIER LAW REVIEW

THE HOSPITAL MEDICAL STAFF: WHAT IS ITS FUTURE?

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I. INTRODUCTION

What the future is for the medical staff is an important rhetorical question. After the earlier presentation on "Integrated Delivery Systems," this question either has become much more significant or much more irrelevant, depending on one's perspective.

In the past years our discussions have focused on medical staff and physician relations issues, and principally on statutory, regulatory and accreditation requirements as they impact on the medical staff. These discussions have centered around the following four topic areas: first, requirements created by federal law and changes in the Healthcare Quality Improvement Act,[1] including National Practitioner Data Bank reporting; second, state law changes required by Senate Bill 1211, codified as California Business and Professions Code Section 809,[2]

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1. 42 U.S.C. § 11101 (1986).
2. CAL. BUS. & PROF. CODE § 809 (West 1990 & Supp. 1995).

governing fair hearings in the medical staff area; third, accreditation and other standards regarding credentialing practitioners; and fourth, the impact of national clinical practice guidelines on risk management and performance improvement.

The discussions on these subjects have in large part concentrated on the hospital medical staff and its activities, because that is where the most significant impact has been seen. All these topics were premised, therefore, on the continued existence and viability of the medical staff. Examination of this important premise will show how it underlies all of these discussions.

II. History of the Hospital Medical Staff

A brief thumbnail sketch of the important history of the organized hospital medical staff will suffice. What began as a simple idea to better coordinate the delivery of quality care in an institutional setting has now turned into a complicated structure. This structure is comprised of multiple substructures which have numerous functions that are governed by lengthy and oftentimes unwieldy policies, procedures, protocols, bylaws, rules and regulations.

Organization of the medical staff started simply in 1919 when the American College of Surgeons decided to issue a document entitled a "Minimum Standard for a Definite Medical Staff." This minimum standard provided that the physicians and surgeons privileged to practice in the hospital be comprised of licensed medical school graduates, competent and worthy in character and in matters of professional ethics; prohibited fee division; organized the staff in terms of rules, regulations, and policy; governed professional work; required the basis for the reviews to be conducted of the patients' medical records; and required that accurate and complete medical records were to be written by all those present.

In 1919, the purpose of the minimum standard was quite singular in that it was concerned with quality. In that respect, it is important to understand that legal issues, particularly accountability for the quality process that the medical staff was performing, were not addressed by the American College of Surgeons. The legal accountability existing at that point and still in existence today was viewed to lie with the institution, i.e., the hospital.

The credentialing, the quality improvement work, the peer review, and the determination of who did or who did not meet the standards

These individuals devoted their time to the thankless and uncompensated task of improving the quality of care in the institution. On the other hand, it was understood that, should the medical staff fail to undertake those functions, the institution suffered the loss of accreditation and/or licensure, and ultimately would suffer liability for corporate negligence in connection with negligent credentialing theories.

Nonetheless, it is important to understand that the voluntary organized hospital medical staff came from a promulgation by the American College of Surgeons earlier in this century. In 1951, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) was formed and it adopted these principles, incorporating them into what is now known as the Medical Staff Chapter, which is the medical staff portion of the accreditation manual.[3] Medicare, when it promulgated its Conditions of Participation in 1965, also adopted many of these principles.[4] Moreover, the federal Hill-Burton Act, which provided funds for hospital development and growth in construction in the 1950's, also incorporated these functions into the state licensure requirements under federal law.[5] For the most part, the minimum standard that was established in 1919 has found its way to be codified into the requirements and rules of various accrediting and licensing bodies, as well as the payment process of the Medicare program.

One of the current concerns is that there has been a major shift in the locus of authority in the healthcare delivery system. This move which is shaped by familiar forces and pressures will cause drastic changes in the organizational and operational structure of the organized hospital medical staff. When the call is for less committee meetings and for more meaningful discussions at every step along the line in the healthcare delivery system, it is likely that form will follow function, and the structures we have come to know will change to accommodate the new functions assigned to them in the new healthcare environment.

III. The New Issues on the Horizon

The Health Care industry is going through dramatic change. The first change concerns the disruption of the traditional patient/physician

3. Joint Commission on the Accreditation of Health Care Organizations, Accreditation Manual for Hospitals (1995).

4. 42 C.F.R. § 482 (1993).

relationship where the focus is being placed on HMO providers. There is also a change in both the attitude toward physicians and the manner in which physicians are governed. Physicians are now seen as a commodity and there is a different, more centralized authority structure that is emerging on the scene.

Also, there are physicians who are servicing patients in distant and far removed settings. As a consequence, standards control will be a significant issue. Indeed, the standards issue needs to be faced in all of these integrated structures. There is an emerging social concern that the Health Care industry will end up with something that it does not want.

In 1991, Sandra Kretz in an AAPPO article identified four significant elements for "quality focused contracting" for specialized managed care.[6] These four elements are basic in putting together an effective managed care network: (1) providers at an appropriate level of training; (2) large data bases which would help monitor the performance of providers, physicians and hospitals; (3) a system of *active* network management, in which one could control and influence quality; and, (4) systems of provider profiling, so that one could identify those physicians and institutions that are effective as well as meeting the needs of the network.

In large measure these elements do not exist, even in the most sophisticated integrated organizations, although there are pieces of them. Nevertheless, there are forces that are producing changes in the organized medical staff of the hospital, in the relationships of physicians both in and out of the hospital, with each other, and with the hospital itself.

It is important to note some of the forces in hospital medical staff relations that are driving the change. First of all, there is a market need to develop cross-disciplinary lines of service. For the most part, patients do not come to the hospital for an X-ray, a shot of penicillin, or the services of an internist. They come for a package of services that is related to a given clinical outcome. Because of that, there is a need to think differently in terms of how the relationships work.

There has been a problem for a number of years regarding a narrow definition of quality. This has limited the ability of managers, within the institution, to get beyond a definition and look at inefficient or disruptive patterns of care. However, since 1992 the industry has been obligated to shift to performance improvement rather than to

traditional quality assurance. This performance improvement is interdisciplinary, dealing not only with cross-specialty, but with cross-profession as well, and it is a deliberate effort to bring managers and clinicians into a collaborative model which can address specific functions.

Along with these changes in the medical staff is the emergence of medical administrative leaders with real authority. The traditional medical director has now changed to a medical administrator who has training, not only on the clinical side, but in the management of quality and resource use, and has been imbued with even greater authority.

At the present time, there is a certain discordance between those structures in place, mandated in medical staff organization by the Joint Commission,[7] by the Medicare Conditions of Participation,[8] and by California Code of Regulations, Title 22 Licensure.[9] Yet, even in those areas, the language is being interpreted to accommodate these new changes. Although the language in Title 22 has not changed in twenty years, if one is currently surveyed with respect to Title 22, it is expected that transition from quality assurance to performance improvement has been made and that there has been an acceptance of a structure which is consistent with Joint Commission's requirements.

There is also another economic factor that is driving change in the organized medical staff, and that is the recognition that the hospital can no longer operate as a collection of independent clinical entities. When the hospital has to provide a bundled price in order to contract for a service, that hospital has to have a strategy for integrating the services of physicians who actually participate in that bundled price. This has led to the creation of internal service groups which will more than likely expand to include those physicians who provide critical care services and, at least, emergency invasive services. The end result will be an integrated response team to those patients who will account for most of the business of the hospital.

The hospital will be largely an entity that responds to critical illness. It will need to work out the systems among various groups such as radiologists and pathologists, who, before now, have not talked to each other. Coupled with this change, and in an effort to make this operation more efficient, there will emerge a two-tiered system, not unlike the British system, in which there will be large numbers of phy-

7. JOINT COMMISSION ON THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS, MANUAL FOR HOSPITALS (1995).

sicians practicing in the community who will not have much to do with the active management of patients. In order to conserve scarce specialty time, there will be mid-level practitioners trained to support specialty operation.

As a consequence of the growing sophistication of networks, integrated delivery systems, vertically and horizontally, there will be a change in the locus of the peer review process in the credentialing process. The locus will be shifted to one in which the practice values of integrated delivery system will control the credentialing policies, the peer review polices, the performance evaluation technology, and very likely, the corrective action mechanisms. A more difficult task for hospitals, as they approach the need to contract for business in the most efficient mode, is to recognize that they have carried on their books a number of unproductive physicians for a long time.

There is also a serious concern about the need for the courtesy staff altogether. The courtesy staff member, by and large, is a cost to the institution, not a benefit. Further, where there is the possibility of groups of physicians providing the same service, the hospital will want to field its best team when it is the contracting entity, and therefore control the patient flow. The hospital will want that group to be a well-honed functioning team to provide service.

With that concept, economically driven as it is, the demise of the egalitarian medical staff will be on the horizon when anybody who comes to an industry meeting is allowed to have an opinion which drives medical staff policy. Indeed, they can, in the current model, through the bylaws, demand their fair share at least of political voice. Ultimately, what will be seen is the emergence of a strong central authority.

In the 1980's, Steven Shortell at the Kellogg School of Management at Northwestern conducted a review of for profit healthcare corporations.[10] The conclusion reached was that those corporations that would do best, and which were doing best from the point of view of economics and the measure of patient care available at that time, were those that had the greatest degree of "systemness." They had, in fact, identified those elements that pulled their institutions together beyond the need to financially report what they were doing and pay a central management fee to the corporation. Rather there were systems that related to the information flow, the development of risk management,

and quality assessment strategies. What has been seen in the industry is the shift from a corporate control to a system control, with developing sophistication of the tools of "systemness."

The Joint Commission, it seems, has recognized this point. The proposed Joint Commission medical staff standards for 1996 became available recently and, although the language is not final, much of it will survive.[11] This language is the key to the discussion. It states that "[m]embers of the medical staff in providing patient care and carrying out other professional responsibilities, are in increasingly complex organizations."[12] This language was proposed to position the Joint Commission's accreditation process to look beyond the individual hospital to the hospital's position in the continuum of care, incorporating both pre-hospitalization and post-hospitalization care. In the Joint Commission standards, the hospital and the physicians have an obligation for this pre and post-hospital care, but they also have a significant economic interest as well.

There is a directive that the medical staff participate and exercise professional leadership. The medical staff is one of the four leadership entities in the institution. When the Joint Commission uses the term "leadership," 25 percent of that word in their code jargon means medical staff. The medical staff must participate in what is now the mantra of accreditation: measure, assess, and improve performance. One must be able to demonstrate this participation by the medical staff not only in terms of clinical activities, but in terms of nonclinical activities. As a result, the interaction between the medical staff members and patients becomes present once again.

How hospitals relate as clinical entities is the traditional area of concern. The term "department" means the service entities within the hospital. The term "overall organization" concerns increasingly complex organizations that go beyond the walls of the hospital. The efforts made as the operator of an institution to show how it productively relates to outside entities with which it may integrate will be used as a measure of one's leadership skills.

The preamble also incorporates a description of what the expected contribution to quality healthcare services will be by the medical staff. The Joint Commission's language articulates those points previously stated, namely, that the medical staff participates actively in all aspects

11. JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDI-

of the hospital operation because there is nothing that is not relevant to clinical care.

One unique medical staff change in the 1996 standards is that in evaluating performance, the medical staff has the obligation to evaluate the efficiency of performance. The term "efficiency" is not found in the 1994 CMA model bylaws.[13] More and more it is being seen that the medical staff has the obligation to evaluate and improve the efficiency of physician performance because, presently, efficiency is seen as a subset of quality.

In the Joint Commission standards for 1996 there are other items that herald substantial medical staff change. One such change relates to privileges. The statement used to read, "[e]ach clinical department develops its own criteria for recommending privileges."[14] However, the new construction of the language states, "[e]ach clinical department makes recommendations to the medical staff regarding professional clinical privileges."[15] This is a substantial shift in the locus of authority within the medical staff. The medical executive committee used to function like the council of barons at Runnymede at the signing of the Magna Carta. A group of independent fiefdom holders got together and said to the central authority, "King Baby, you do it this way or off with your head." Now medical staff administrative leaders are able to identify this point to say that the departments make a contribution to the medical staff as a whole, regarding professional criteria and professional standards.

The second two standards follow from the first, but continue in a radical direction. The second standard states that when criteria are not directly related to the quality of care, the impact of the decision on the quality of care is considered. Such criteria include, for example, the economic impact of practice patterns or business arrangements that are used in making decisions on appointment or reappointment, or on granting revocation or renewal of clinicians' privileges.

The Joint Commission has, in effect, stated that as a medical staff there is an obligation to measure, assess, and improve economic performance. The hospital may relate that economic performance to appointment, reappointment, allocation of credentials, allocation of privileges,

13. CALIFORNIA MEDICAL ASSOCIATION MODEL BYLAWS (1994).

14. JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS (1995).

corrective action, and can use its fair hearing process for that. An easier way to address this is not to use the fair hearing process, but as a medical staff, come together and talk in the abstract, without dealing with specific physicians or specific cases.

The next standard is concerned with setting administrative standards. The one that is commonly seen is the administrative standard which states, "[i]n order to get OB privileges, you must be board certified at the time of application or within four years of being accepted to the medical staff." If the physician is not board certified at the end of that time, the process is over. This appears to be a growing tendency, driven by the fact that the managed care entities are demanding that physicians are board certified. These entities are attempting to bolster their quality issue by that tool. The result is that if an institution wishes to develop an integrated relationship with the managed care entities that has that standard, it must figure out what to do with that portion of its medical staff that is not board certified.

The California Association of Hospitals and Healthcare Systems has come out with its model by-laws.[16] For the first time, they create an alternative track for those hospitals that wish to integrate their core medical staff systems into a systems approach, and they accomplish it in a simple fashion. If the hospital is part of an affiliated system, the medical staff may enter into arrangements that deal with credentialing, peer review, corrective actions, joint hearings, and appeals.

It should be recognized that the hospital medical staff section of the CMA is not the most forward looking group as it relates to integration and especially these issues that have been discussed. The language from the 1995 CMA model by-laws presents a much more restrictive kind of position.[17] The language states that as a medical staff operator, hospital operator or hospital attorney, one cannot support a standard confining medical staff privileges to those eligible for, or a member of, a given integrated group.

Rick Norling, formally the CEO of California Hospital, in a workshop on integration, identified this integration continuum.[18] It is the shift in the change of the organized medical staff to the integrated system, and it is useful for a couple of reasons. First, it provides direc-

16. CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH CARE SYSTEMS MODEL BYLAWS (1995).

17. CALIFORNIA MEDICAL ASSOCIATION MODEL BYLAWS (1995).

tion. It also provides a tool for evaluating one's own institution regarding the question of how far along is the institution with respect to integration. It starts from total independence to one in which information is shared. As it progresses, the credentialing process is shared, as well as the control of the credentialing process and the control of the evaluation process. The end result is more centralized management.

What is found in an integrated system? Currently, the easiest aspect is the initial appointment of an individual to membership in one of the entities of the system. There are centralized credentialing bodies. What this centralized processing mechanism for credentialing does, is to pull together the information for the institution to make a decision. However, there is, at this point, little centralization of the appointment process itself. When one is appointed, he or she is appointed to a succession of entities which may be related to each other, each of which appoints him or her as a member of a unique medical staff controlled by a unique board.

There is evolving a process of centralized performance evaluation. For example, in the Uni-Health Organization there are centralized programs for the evaluation of care. They include support, which permits hospitals to use sophisticated tools to improve care, to measure those improvements, to share the data, and to rank and compare, so that hospital aid can be compared with the rest in the system. Those are very effective centralized programs.

There are also emerging centralized programs for case management. Usually corporate resources come to the assistance of an institution or the institution may be sophisticated enough to have individuals who can look specifically at the management of an individual case. There are tools that have corporate support to permit the management of patients through clinical pathways. The concept of the clinical pathway is probably best explained by an analogy to forces invading a beachhead. First the beach is shelled. Then the troops are landed. That kind of simple technology is now applied.

In addition, because of the need for integrated delivery systems to be able to market their superiority over competing integrated delivery systems, there is an emerging concept of disease management. The effect is that there are fewer people on total disability to account for. The concept of responsibility for a population of patients has emerged as a consequence of legislation in California for the acute care hospital. It has not been extended to the integrated delivery system yet, but that is not far away where tax exemption is an issue.

tion is the mechanisms that are in place for privilege allocation, including privilege withdrawal and, ultimately, deselection. At present, managers who work in integrated delivery systems are concerned about *managing* physicians and not about a process which is based in medical staff bylaws or fair process. This is analogous to managing a baseball player, which becomes a much more businesslike deselection process. The frequency of that deselection in a given system may vary, but under some circumstances it may occur on a quarterly or an annual basis.

The final issue to consider is the potential impact on the organized medical staff of the hospital by these currents in the marketplace. First, there needs to be some strategy worked out to limit the number of the physicians on the medical staff to the number actually needed in order to service contracts and carry out the mission of the hospital. In the current system this is difficult.

There is a need to breakdown traditional specialty-based departmental barriers and develop multi-disciplinary models of care. There is a need as well to shift the physician from the mindset of "I go in, make rounds, and write orders. Good-bye, I have to get to my office," to a posture which says, "I am a member of, or may be the player coach of, an integrated delivery team, and that what I do must have close relevance to what all of the other people who have to work with me to achieve this given outcome. I have to work closely with that group."

There needs to be a recognition on the part of administration and the physical staff that volunteer medical participation in the peer review standards setting disciplinary process does not work with the changes in today's delivery system. No one has the time or the stomach to sit through fair hearings that might go two months in order to create an appellate record, and then go through the endless depositions and time away from practice as a volunteer participant in the fair hearing process. This is unrealistic and does not work. This leads to a "chilling effect" on future fair hearings.

There is a need to recognize that as a consequence of the Joint Commission requirements and the economics of selling a product that one can account for the continuum of care. This means that there must be responsibility for the patient before and after.

There is a need to get the attention of the medical staff on performance. In a typical medical executive committee meeting they discuss parking, the dinner dance, and the occasional physician who has gotten

ceives a data stream of performance measures which are then integrated with the information that is provided to the administration and to the board and to nursing management. The result of which will be everyone reading that same collection of data and making management judgments based on the movement of data streams.

There will be a need to decrease the role of the typical medical staff department from the academic model. The simplest way to address those two issues of standards and privileges in this context is to have the department set standards and determine the criteria for which, in general, privileges will be allocated. These are professional issues. The enforcement of standards and the enforcement of privileges are not a collaborative consensus and democratically based process. It has to be the work of a strong executive that has been trained and entrusted to do this.

There needs to be a way of aligning the physician and the medical staff incentives. Who does the medical staff really work for? It has authority delegated by the board to keep the board's house in order, and yet it is the political representative of the medical staff, vis-a-vis the board and everybody else. In aligning interests, the medical staff has to be seen as the protector of the physicians' access to those functions which it shares collaboratively with the hospital, namely to make sure that the hospital is able to participate effectively in the activities of the system. Then the physicians' incentives are linked to the system's incentives as well. This is seen to some degree in the Kaiser system and the in the Cigna system where physicians have begun to accept their role as part of a larger structure and the medical staffs' role as protecting their interests within that aligned system.

IV. The Health Care Lawyer's Perspective

The focus of this discussion thus far has been that integrated delivery systems have to do with market forces and that the medical staff has been relegated to secondary significance. It is evident that people think that it is just not going to be around any longer.

This part of the discussion will focus on the legal underpinnings of the medical staff and some of the public policies reasons for the existence of a medical staff. In California there are statutes which recognize that integral to the existence of hospitals are medical staffs. For example, Health and Safety Code Section 1250, states that private general acute hospitals, meaning a health facility with a governing

vide twenty-four hour inpatient care.[19] California law requires and recognizes that the staff must be self-governing. There is a public policy recognition that the public will be best protected when the physicians are organized to maintain quality of care. The public policy underlying this legislation is that physicians and medical staffs, which are essentially associations of physicians, are supposed to protect the quality of care. For example, in the California Code of Administrative Regulations at Title 22, section 70701, it is required that governing bodies adopt bylaws and provide for a formal organization of a medical staff.[20] The medical staff must be self-governing with respect to the professional work that is performed in the hospital. It is significant that California Business and Professions Code section 2282 prohibits physicians from practicing in private hospitals unless there are medical staff bylaws and a formal self-governing medical staff because the public policy that physicians are there to guard quality of care.[21]

Another consideration that should be taken into account in light of economic and operational concerns is the constitutional rights with respect to the medical staff's privileges. The California courts have held that physicians have a property right in staff privileges. This is important because if a physician is hospital based and does not have medical staff privileges, he or she cannot practice.

The California Supreme Court and the cases in California, such as *Miller v. Eisenhower Medical Center*,[22] provide that privileges cannot be denied to physicians for arbitrary reasons. There must be good cause related to patient care and operations of the hospital. Physicians are entitled to fair procedure before they can be deprived of staff privileges, and this has been true as a matter of case law in California.

Physicians are entitled to notice and a hearing, and are entitled to examine, cross-examine and confront accusers. This is a matter of statutory law in California under Business and Professions Code section 809.[23] The medical staff model will survive, but there will be changes. There will be integration between hospital medical staff functions and credentialing in outpatient settings. If it is inevitable that there will be integration of one form or another, the medical staff will then have to assume a credentialing role with respect to outpatient functions. For

19. Cal. Health & Safety Code § 1250 (West 1990 & Supp. 1995).
20. Cal. Code Regs. tit. 22, § 70701 (West 1995).
21. Cal. Bus. & Prof. Code § 2282 (West 1990 & Supp. 1995).

example, the medical staff should take on an expanded role with respect to the right of insurance companies and HMOs to decredential physicians.

Currently, there is movement toward managed care. In this regard, the medical staff has an opportunity to guard the quality of care for the public and to protect the interest of the individual physicians who are being arbitrarily treated.

These rights of the individual physicians are extremely important concerns that need to be addressed. Also, there has to be an expansion of the medical staff model where the primary purpose of the medical staff is to protect the public interest, so that the end result is good quality of care. Physicians and hospital medical staffs will need economic power to balance the enormous economic power of integrating insurance companies and hospitals.

V. What Does The Future Hold?

How are the changes discussed above going to be achieved? The answer lies in the physician organizations, which are going to have to reorganize and operate more as unions in some respects. These organizations will have to focus on the issues of power and will have to become involved in other arenas, such as the medical staff.

As integration becomes more common, there is going to be a push toward credentialing across regional lines, so that a medical staff in a local hospital will operate more like a local union. This could include having a district counsel organization or some configuration of a medical staff organization on a regional level. This would have the tendency to superintend the individual hospital medical staff organizations.

To expect physicians to provide these kinds of services without remuneration is inconsistent with the economic pressures they face. Perhaps, the CMA will have to pay elected, staff officers on a full-time basis to perform these quality care functions.

In the near future, physician associations should try to fall within the antitrust labor exemptions. Presently, these associations are not exempt from antitrust laws and if they attempt to organize and effect changes collectively, that is considered a conspiracy, or a restraint of trade. There needs to be a concerted effort to extend the antitrust labor exemptions, even if the exemptions are not absolute, so that associations and physicians can effect some of the needed changes.

Unionized organization will most likely occur on a geographical

local medical staffs and local physician organizations. However, this will not be limited on a hospital basis. It is foreseeable that there will be district counsels, state organizations and national organizations. Individual physicians will continue to be involved in an ongoing basis in peer review, but credentialing and decredentialing with respect to hospitals and manage care organizations will change. There will continue to be protection for the right to practice fair standards and due process. The issue in this respect is: Who is going to be carrying out the hearings? Presently, the system is imperfect in that it allows peers, who could be competitors, to conduct these hearings. With integration, however, trained arbitrators would conduct the hearings in places other than their own hospitals and would have immunity, because quality of care decisions would have to be made on an ongoing basis. This, in turn, could very well lead to binding arbitration of credentialing disputes based upon a development of a common law of collective bargaining agreements between physician associations and managed care providers analogous to the labor sector. Although a system of binding arbitration may still be too far in the future, a more realistic view of an arbitration system would include a body of arbitrators able to reconcile the economic issues, able to take into account quality issues, and able to deal fairly with issues relating to the credentialing and disciplinary procedures.

In lieu of an arbitration system as described above, another possible alternative would be to have state-employed, administrative law judges decide these issues and to carry out decredentialing and disciplinary decisions because of the constitutional issues involved, such as the right of physicians to practice medicine.

VI. Conclusion

From the preceding discussion, it can fairly be determined that the hospital medical staff will survive in the future, albeit perhaps with a different focus, with a different structure, and with a different mission. Also, it may well survive in the future with some interesting concepts that have been resisted by the medical staffs of the past, i.e., economic credentialing and a focus on efficiency. In the past those involved in every area, other than the medical staff, have known that efficiency and quality do have an important connection.

Finally, there is need to be cognizant of the history of the medical staff in looking towards its future. It has evolved from a voluntary

institutions have become unwieldy, the medical staff functions have become broad, diverse and complicated. Perhaps it is time for the medical staff to return to its roots.

VII. Questions and Answers

QUESTION: Are the existing state laws which provide for protections from discovery[24] and for immunities from liability,[25] as well as many of the federal law immunities that exist under the Healthcare Quality Improvement Act,[26] going to provide protection for the various sharing of information on practitioners that may go back and forth between these various components of integrated delivery systems, such as credentialing information, privileging information, the fair hearing decision processes, as well as quality improvement information?

ANSWER: This is a troublesome area, and it is unclear if the laws as currently written will provide much protection, if any, for some of the novel ways physicians are being pressured to share information. There is a major concern associated with information that has previously been protected by existing state law. For example, under California Evidence Code Section 1157,[27] when information is shared with small medical groups or gets shared with PPOs or insurance carriers, this information is subject to discovery.

Another institutional liability that exists is the sharing of information vertically within an integrated delivery system by giving it to the parent from hospital A, hospital B, and hospital C, which have their own protections. This is different from the horizontal sharing of information that is also problematic, and the sharing of information with an HMO, which has its own special protections under section 1370 of the Health and Safety Code.[28] There are increasing demands for the sharing of information with the corporate parent and others who want to have, as a network, some type of ongoing quality improvement process.

As part of integration there is a need for the creation of a system-wide peer review structure. That system-wide structure might then fall within the general framework of Evidence Code Section 1157, which

24. Cal. Evid. Code § 1157 (West 1995).

25. Cal. Civil Code § 43.7 (West 1982 & Supp. 1995); Cal. Civil Code § 43.8 (West 1982 & Supp. 1995); Cal. Civil Code §47 (West 1982 & Supp. 1995).

26. 42 U.S.C. § 11101 (1986).

provides protections of peer review organizations with greater than twenty-five members.[29] There will have to be some creativity to address that issue, and create an integrated structure for collecting very sensitive information and keeping it from getting caught in liability issues.

QUESTION: In light of *Miller* and those cases that followed, what is the present status of economic credentialing?

ANSWER: The key language has to appear in the medical staff bylaws. If the medical staff bylaws include in its performance standards, economic performance as measured and evaluated in the same way that the medical staff measures and evaluates quality, then it is appropriate for the medical staff to use its corrective action mechanisms to deal with those economic issues. One of the things that will propel that movement is the language in the 1996 Joint Commission's standards,[30] which recognize that efficiency is one of the elements of performance. Indeed, the performance elements that the Joint Commission promulgated in 1994,[31] and which essentially underpin all of its performance evaluation, incorporates a number of measures of performance, including things which are not normally related to quality, such as the measurement of efficiency, access and safety.

In California, there was legislation proposed by the CMA that would have prohibited economic credentialing. That legislation was ultimately withdrawn and instead there has not been a joint protocol or an agreement between the Hospital Association and the CMA that sets up a dispute resolution process for individuals who feel aggrieved by the economic credentialing. Currently, Illinois is the only state that has legislatively addressed economic credentialing by passing a law which prohibits it and requires fair hearing rights where exclusive contracts are terminated.[32]

QUESTION: Would the concept of a closed medical staff, i.e., closing the staff to particular medical group foundation or IPA, be the way to integrate the outpatient and the inpatient decision making and perhaps avoid the economic credentialing problem on the hospital and

29. Cal. Evid. Code § 1157 (West 1995).

30. Joint Commission on Accreditation for Health Care Organizations, Accreditation Manual for Hospitals (1996).

31. Joint Commission on Accreditation for Health Care Organizations, Accreditation Manual for Hospitals (1994).

32. Ill. Ann. Stat. Ch. 210, § 85/2 (Smith-Hurd 1995). *See also* Mark A. Kadzielski,

medical staff by terminating the appointment relationship on the physician side?

ANSWER: Clearly that is the model that exists in a single organization as illustrated when Cigna had its own hospitals. To that extent, the closing of the medical staff is one approach. However, attempting to close the medical staff of a community hospital would be a more difficult avenue, unless some other mechanism were brought into bear. The important case on closure of medical staffs is *Desai v. St. Barnabas Medical Center*,[33] in which the New Jersey Supreme Court found that there were serious problems with closing an entire medical staff because of the difficulties in replacing retiring physicians or physicians with needed specialties. There is always the problem of exceptions when there are physicians joining a group practice out of a residency program or when limiting and closing certain departments or specialty areas occurs. In California, the findings made by the California appellate court in *Redding v. Saint Francis Medical Center*[34] is a good example of this type of approach.