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Economic Credentialing: Bottom-Line Medical Care

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INTRODUCTION

Norman Rockwell's paintings of the benevolent and trusted doctor offering his patients gentle ministrations defined the popular image of the physician-patient relationship of the 1940's and 1950's. In contrast, if Mr. Rockwell had had the opportunity to depict the physician-patient relationship of the 1990's, he probably would have shown the physician holding a stopwatch while he rushes one wary patient out of the office as he quickly ushers in the next. Perhaps, in his 1990's painting, Mr. Rockwell also would have included an insurance company representative whispering in the doctor's ear about the appropriateness of the procedure the physician had just performed on the exiting patient.

Recent advancements in information technology allow hospitals to measure precisely a physician's past economic and financial performance with respect to patient care, enabling them to create financial and economic profiles of physicians that are ultimately used by hospitals in credentialing,[1] contracting, or making staff appointments and/or reappointments.[2] The new focus of hospitals on economic and financial factors relating to patient care has significant future implications for the quality of medical care. Increasingly, physicians are evaluated on criteria such as: number of patients treated, time allotted to each patient, amount of

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1. VERGIL N. SLEE, M.D., HEALTH CARE TERMS 34 (1st ed. 1986). "Credentialing" describes the process of granting physicians hospital privileges in accordance with their medical credentials. *Id.* These credentials include: medical diplomas, state licenses, and specialty certifications. Supplemental credentials examined include: academic preparation, training, and performance at other hospitals. *Id.* Granting of privileges or an "appointment" to a hospital is the responsibility of the hospital's governing body. This group normally follows the recommendation of the medical staff organization that appoints the physician after the hospital's credentials committee has verified and investigated the physician's credentials. *Id.*

2. The American Medical Association ("AMA") defines "economic credentialing" as the "use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing medical staff membership or privileges." *See* AMA, *Economic Credentialing, Report of the Hospital Medical Staff Section Governing Council Report Q* (1993).

insurance reimbursement received, number of referrals and consultations, medication costs, liability claims, patient satisfaction surveys, and other similar economic factors.[3] The terms "economic efficiency" and "cost containment," frequently touted by hospitals, are merely euphemisms for economic credentialing. This new emphasis on financial and economic factors necessarily reduces the stature of traditional credentialing criteria, including: clinical skills, medical competence, experience in treating patients, and patient care results. As hospitals consolidate, they are forced to focus even more on financial considerations, rather than on patient outcome. Ultimately, financial interests of hospitals and insurance companies will take precedence over the more important societal interest of high-quality medical care.

BACKGROUND

Traditionally, physicians and hospitals provided services and were paid by the patient.[4] Direct payment limited the amount of money expended on health care, but it also limited the performance of unnecessary services.[5] Blue Cross developed what we now think of as the conventional health insurance system during the "Great Depression" of the 1930's.[6] Later, the federal government entered the health care field, through Congressional enactment of the Medicare and Medicaid programs under Title XVIII of the Social Security Act of 1965.[7] Health care costs

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3. John D. Blum, *Economic Credentialing Moves from the Hospital to Managed Care*, 22 J. HEALTH CARE FIN. 65 (1995).

4. ROBERT G. SHOULDICE & KATHERINE H. SHOULDICE, MEDICAL GROUP PRACTICE 1-11 (1978).

5. MARC A. RODWIN, J.D., Ph.D., MEDICINE, MONEY AND MORALS 13 (1993).

6. Jeff C. Goldsmith, Ph.D., *Managed Care Comes of Age*, HEALTHCARE FORUM J. 14-16 (Sep./Oct. 1995). *See also* SHOULDICE, *supra* note 4, at 4-12.

7. Pub. L. No. 89-97, 79 Stat. 290 (1965). Title XVIII established a two-part program of health insurance for the aged known as Medicare. Patients are eligible to participate in Medicare, Part A (the hospital insurance program), if they: (1) are 65 or older and are receiving retirement benefits under Title II of the Social Security Act or the Railroad Retirement Act, (2) qualify under a special program for persons with end-stage kidney disease, or (3) qualify under the special transitional program. Persons not qualifying, but who are over 65, may participate by paying premiums. Anyone aged 65 or older, who is a United States citizen or has been a permanent resident alien for 5 years may elect to enroll in Medicare, Part B (a supplementary medical insurance). *Id.*

Medicare covers services provided by a physician to a beneficiary. Claims must be presented to trigger reimbursement under Part A; reimbursement is a prospectively determined amount per discharge according to the patient's diagnosis and the facilities location. *See* Pub. L. No. 98-21, 97 Stat. 65 (1983) as amended by Pub. L. No. 98-369, 98 Stat. 1073 (1984); 42 C.F.R. Sections 405.470-405.477 (1988). Medicaid is a joint federal state program designed to provide medical assistance to individuals unable to afford health care.

increased significantly due to implementation of these programs, because government funding increased the number of persons eligible for care. The government's entry into the field of health care finance caused the cost of medical services to rise dramatically during the 1970's.

Institutional medicine has rapidly evolved in the twentieth century, experiencing both an organizational and a financial transformation.[8] This process was perhaps best described by Eli Ginzberg, who dubbed it, "the monetarization of medical care."[9] This emphasis on "the bottom line" has diminished medicine's reputation because society now perceives it as merely another expensive commodity in the stream of ordinary commerce.[10] The doctor of the early twentieth century entered practice after completing a lengthy apprenticeship and treated most patients with only the contents of his black bag.[11] Medical economics drastically changed as training grew more rigorous, hospitals became plentiful, and medical technology exploded. The cost of providing medical care burgeoned until it exceeded $400 billion per year in the late 1990's. According to estimates, by the year 2000, the health care industry will generate $2,000,000,000,000 annually; this figure represents 15% of the gross national product of the United States.[12]

From the 1930's through the 1950's, employment-based voluntary health insurance became widely available from third-party private insurers such as Blue Cross, Blue Shield, and others. These companies paid physicians for health services delivered to insured patients. In 1965, the federal government supplemented this private insurance network by creating Medicare and Medicaid, programs designed to fund medical care of the aged and indigent.[13] Medical privatization and the public insurance provided by Medicare and Medicaid allowed many patients to receive premium medical care for the first time. This care was the best in the world, but cost

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Id.

States are not required to have Medicaid programs (Title XIX of the Social Security Act). Medicaid is different from Medicare in that it provides medical assistance to persons in financial need, whereas Medicare only has an age limit of 65 or older without regard to financial need. *See* SANDY SANBAR, M.D., Ph.D., J.D., ET AL., LEGAL MED. 663-71 (3rd ed. 1995).

8. RODWIN, *supra* note 5, at 11.

9. *Id.*

10. *Id.*

11. *Id.*

12. National Center for Health Statistics, Health-United States, DHHS Pub. No. (PHS) 84-1232, U.S. G.P.O. (Dec. 1983).

13. RODWIN, *supra* note 5, at 13.

more than a middle-income wage earner could earn in a lifetime.[14]

Beginning in the 1970's, the consequences of the third-party payment system began to surface as the cost of medical care soared. Physicians worried little about budget constraints. Patients, similarly, had no incentive to monitor the cost of their medical care.[15] As a result, in the 1990's, managed care has become the dominant force in American health care. Managed care embraced the concept of the Health Maintenance Organization ("HMO"), which was designed to control spiraling costs. HMOs combine the risk assumption inherent in insurance with provider responsibility for cost control. By establishing HMOs, third-party insurers could provide physician and hospital services to all enrolled members at a reduced cost.[16] In addition, many traditional indemnity insurers could now offer managed care products.

"Health maintenance strategies," promulgated by HMOs, were designed to give participants comprehensive care in return for a fixed premium. HMOs rendered services through their own doctors and hospitals or "selected" doctors and hospitals. In an HMO, the insurer, hospital, and physician belong to a "network," bound by financial ties. These networks limit physician discretion as to the type of care delivered to the patient.[17]

The number of independent sole practitioners and practice group partnerships is rapidly declining, replaced by joint ventures formed between physicians and HMOs. Hospitals and HMOs are increasingly enrolling physicians in their networks or creating other arrangements that link physicians' financial well-being to the network. In return, the network asserts the right to control and review the clinical decisions made by physicians by rewarding those who utilize network facilities and economize in their use of network resources.[18] The more frugal a physician is, the more the system financially rewards him or her.[19]

To ensure the reduction of medical care costs, both the federal government and insurance carriers have targeted physicians as the principal point for cost containment.[20] Increasingly, hospitals face

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14. *Id.* at 13-14.

15. *Id.*

16. David O. Weber, *Second Thoughts: Can Managed Care Be Ethical?* 40 HEALTHCARE FORUM J. 17-24 (1997).

17. RODWIN, *supra* note 5, at 14.

18. *Id.*

19. *Id.* at 17.

20. Goldsmith, *supra* note 6, at 16-19.

compelling financial pressures, but because fees and reimbursements are fixed, they must continually search for alternate means of reducing costs.[21] For hospitals and HMOs, the primary methods for securing cost savings have been: reducing the number of patient visits, limiting or controlling the length of hospital stays, streamlining physician practices, and rationing of expensive treatment.[22] The only effective leverage that hospitals and HMOs can exercise over physicians is using economic credentialing to eliminate those physicians whose practices are not cost effective.

In the past, the credentialing procedure a physician underwent to obtain staff privileges in a health care organization was reviewed by the hospital or HMO medical staff credentialing committee. The committee investigated the physician's background, including his education, competence, ability, experience, and judgment. In addition, for staff reappointments, the committee subjected physicians with existing privileges to the same level of review to ensure that all physicians were competent and providing high quality care. Although the board of directors of a health care organization had the final word in any credentialing decision, it usually deferred to the decision of the medical staff credentialing committee.[23]

ECONOMIC CREDENTIALING

The evolution of managed care led directly to the proliferation of economic credentialing. No universal definition of "economic credentialing" exists, but it is commonly defined as the practice of applying economic data and efficiency criteria to hospital medical staff appointment and reappointment decisions.[24] The American Medical Association has adopted a somewhat more detailed definition. It defines "economic credentialing" as "the use of economic criteria unrelated to quality of care or professional competency in determining [a physician's] qualifications for initial or continuing hospital medical staff membership or privileges."[25]

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21. *Id.* at 18-20.

22. *Id.* at 18-23.

23. Brad Dallet, *Economic Credentialing: Your Money or Your Life!*, 4 HEALTH MATRIX 330 (1994).

24. Nathan Hershey, L.L.B., *Economic Credentialing: A Poor Title for a Legitimate Assessment Concept*, 9 AMERICAN COLLEGE OF MED. QUALITY 3 (1994).

25. Deborah S. Kolb, Randall L. Hughes, & C. Edward Young, *Economic Credentialing*, 19 TOP HEALTHCARE FIN. 59 (1993).

Hospitals employing economic credentialing typically apply the following criteria in evaluating physicians:

Length of stay by the diagnosis-related group ("DRG"),[26]
Charges by the DRG,
Charges or length of stay adjusted for severity of illness,
Utilization review denials,[27]
Bad debt expenses,
Timeliness of medical record completion, and
Incident reports.[28]

The AMA and other medical organizations are vehemently opposed to economic credentialing. For these groups, the rationale is obvious — credentialing of physicians should directly relate to professional competence — ensuring quality of care for patients. A physician's peers who are members of the organization's medical staff should conduct credentialing.[29] The real issue is whether economic credentialing is an appropriate tool for measuring a physician's entitlement to hospital privileges or participation in an HMO when the physician regularly meets objective medical quality standards, but because of factors wholly unrelated to the quality of medical care provided, causes an adverse economic drain on the hospital or HMO.[30]

Typically, these economic factors relate to cost per covered life

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26. PETER R. KONGSTVELDT, M.D., THE MANAGED HEALTH CARE HANDBOOK 563 (1996). A "DRG" is a statistical system of classifying by diagnosis any inpatient stay in an institution, such as a hospital, for purposes of payment. This form of reimbursement is used by the Health Care Financing Agency to pay hospitals for care of Medicare recipients. The DRG system has also been applied by a few states to all insurance payors. *Id.* It is also used by many private health plans (usually non-HMOs) for contracting purposes. *Id.*

27. DONALD SNOOK, JR. & KATHRYN M. RUCK, A GUIDE TO HOSPITAL WORDS, TERMS & PHRASES 46-47 (1988). A "utilization review committee" is comprised of physicians, nurses, and administrators. It reviews the medical records of current and discharged patients in order to determine the medical necessity for their treatment and hospital stay. "Utilization review denial" is defined as a denial of continued hospitalization and/or admission to the hospital based on the interdisciplinary review committee's determination that the patient's hospital admission, the services provided, the length of stay or the hospital's discharge practices created unnecessary costs. Utilization review is required by the Joint Commission for Accreditation of Hospital Organizations ("JCAHO"), Medicare, Medicaid, and other third-party payors and agencies. *Id.*

28. SLEE, *supra* note 1, at 66. An "incident" is an event occurring in the hospital in which a patient is injured, due to the alleged negligence of the hospital. Sometimes this event is called an "adverse patient occurrence," a broader term that includes unexpected results of a patient's treatment as well as accidents. *Id.*

29. Hershey, *supra* note 24, at 4.

30. Howard L. Lang, M.D., *Economic Credentialing - Why It Must Be Stopped*, 5 THE MED. STAFF COUNSELOR 19-20 (1991). *See also* Kolb, et al., *supra* note 25, at 59-61.

of the patient.[31] Costs of medical care are easily quantifiable and provide easy comparisons for measuring medical services. The proponents of economic credentialing conveniently overlook the fact that such factors do not readily risk-adjust for other than average patients.[32]

The question is: who is an average patient? No patient can be accurately classified as "average." Innumerable factors may reflect on patient care, as each individual patient is unique. A physician can scrupulously follow clinical practice guidelines. Nevertheless, patients may still develop unforeseen side effects from the therapy, fail to respond, or develop unpredictable complications. None of these occurrences relate to physician malpractice.

A physician's case mix or types of cases based on the severity of each patient's illness and "risk profile" may affect the physician's performance. As the number of diseases or the severity of a given patient's illness increases, the physician's care becomes more complicated. In all fairness, these factors should be considered in evaluating that physician.[33] In addition, each physician's medical practice will also exhibit age and sex differences in its patient population.[34] These factors should also be considered as relevant in computing the cost per covered life.[35]

Both the California and New York State Medical Societies are ahead of other states in developing economic criteria relevant to the quality of patient care. These criteria are used as additional secondary evaluation factors, after medical quality criteria, to credential or recredential a physician for privileges in health care organizations.[36] The California and New York models include: clinically unnecessary treatment, inappropriate/excessive testing of patients, and improper or improvident use of hospital resources that might have an adverse economic impact on the hospital.[37] These states reject irrelevant criteria that do not relate to quality of care, such as: revenue per physician, payor mix, and DRG profiling (comparing profitable DRG categories to non-profitable DRG categories).[38]

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31. *Id.*
32. David Palmer, *Clinical Practice Guidelines*, 99 PEDIATRICS 101-06 (1997).
33. KONGSTVELDT, *supra* note 26, at 440-49.
34. *Id.*
35. *Id.* at 448.
36. *Id.*
37. *Id.*
38. KONIGSVELDT, *supra* note 26, at 448. *See also supra* note 26. "DRG" is a prospective payment system for reimbursing hospitals that is based on a system of "Diagnostic Related

Hospitals and HMOs also utilize physician profiling in such areas as patient outcome and length of stay, comparing their findings to a norm. Further, they try to compare physician behavior with other practices.[39] The problem is that no universally accepted norms for care or physician behavior have been developed. Moreover, "quality of patient care" remains undefined.[40]

Many health care institutions have developed standard practice guidelines based on controlled clinical studies supplemented by data derived from patient outcomes.[41] Some institutions rely on these guidelines to regulate clinical decision-making and to produce cost savings.[42] At the very minimum, physicians who do not follow the "cookbook style" of medicine (those who fail to follow the practice guidelines) are required to justify any deviations from the practice guidelines. Failure to provide justification may result in denial of payments or sanctions.[43] Large-scale studies have never validated these practice guidelines because varied guidelines exist against which a particular medical intervention is judged. Serious doubts have been expressed as to whether these guidelines can properly identify the correct and appropriate medical intervention. As a result, many diagnostic tests that would normally be indicated are excluded because managed care deems them inappropriate.[44]

Medical practice and patient care is indeed a science, but the fact remains that the practice of medicine is an art, combining scientific knowledge with the clinical experience of the physician. Most of the practice guidelines, however, rely on a panel of experts

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Groups." *Id.* Under DRG, the hospital is reimbursed a fixed fee for each patient admitted. *Id.* Reimbursement is based on one diagnosis, even if the patient has multiple active medical problems requiring hospitalization. *Id.* Regardless of the expense of treatment or the length of stay, the hospital receives only a single DRG payment based on one diagnosis. *Id.* "DRG profiling" refers to choosing the proper diagnosis, thereby allowing the hospital to request reimbursement from Medicare. *Id.* "Profitable DRGs" are simple medical problems that are easily diagnosed, resulting in a short hospital stay for the patient. *Id.*

When the diagnosis is in doubt, the physician desires to perform procedures or tests to aid in proper diagnosis and treatment of the patient. This process is clearly opposed to the hospital's desire to keep expenses down by using minimal resources to diagnose and treat the patient. Hospitals and HMOs, therefore, have resorted to economic credentialing of individual physicians to lower the expense of health care and increase their profit margins. *Id.*

39. *Id.*

40. Jerome P. Kassirer, M.D., *The Quality of Care and the Quality of Measuring It*, 329 NEW ENG. J. MED. 1263-64 (1993).

41. *Id.* at 1263.

42. *Id.*

43. *Id.*

44. *Id.*

who merely extrapolate data from studies appearing in the medical literature. Typically, however, these experts are far removed from the actual physician-patient encounter.[45] Managed care organizations should not coerce physicians into using economic guidelines to decide medical issues. Rather, the guidelines should be voluntarily consulted to inform medical decision making.[46] To date, no proof exists that these guidelines improve quality of care. Furthermore, large variations in medical practice may cause physician error if he or she is forced to use these practice guidelines.[47] It is also doubtful that the full implementation of practice guidelines would produce cost savings.[48]

Because the data compiled by profiling patient outcomes and physician behavior has been inadequate to assess the quality of care, health care institutions, such as HMOs and third-party payors, have continued to focus on the economics of patient care. Reliance on economic credentialing forces physicians to implement guidelines designed to save money, without considering the impact on the quality of health care provided.[49] Economic credentialing has troublesome implications for physicians who are treating patients with acute or chronic illnesses that do not fit neatly within the parameters or guidelines attendant to the economic credentialing model.[50]

A study completed in 1987 conclusively demonstrates that financial incentives do influence the behavior of physicians toward their patients.[51] The study generally found that the use of financial incentives makes a statistically significant difference in the length of patient stays, illustrating a definite correlation between financial incentives and the number of patient visits; namely, the greater the financial risk to the physician, the fewer the visits by patients.[52] Studies have observed that the use of capitation[53] or salaries for

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45. Kassirer, *supra* note 40, at 1263.

46. *Id.* at 1263-64.

47. *Id.* at 1264.

48. *Id.*

49. Palmer, *supra* note 32, at 108-109.

50. *Id. See also* Lang, *supra* note 30, at 22-24.

51. Alan L. Hillman, M.D., Mark V. Pauly, Ph.D., & Joseph J. Kerstein, *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?* 321 NEW ENG. J. MED. 86 (1989).

52. *Id.* at 89-91.

53. KONGSTVELDT, *supra* note 26, at 989. "Capitation" refers to a set amount of money received or paid out based on membership in a managed care or insurance plan, not on the professional services rendered. It also refers to a fixed low monthly plan payment (usually ranging between $7 and $10 per patient) received by the physician whether or not the

HMO physicians (compared to physicians paid on a fee-for-service basis) resulted in physicians hospitalizing patients less often in for-profit networks.[54] Placing individual physicians at personal financial risk, combined with the imposition of penalties for deficits in HMO or hospital revenue, has resulted in significantly fewer outpatient visits ordered by physicians.[55] This reduced number of outpatient visits was associated with a lower rate of hospitalization, because more frequent visits lead to discovery of reasons to hospitalize the patient. Finally, it was found that for-profit HMOs had lower rates of hospitalization than non-profit HMOs.[56] Is it not evident that reliance on economic credentialing will undermine the quality of medical care?

ANALYSIS

Hospital Privileges

A physician may not admit a patient to a hospital unless the hospital grants the physician privileges.[57] A special peer review committee within the hospital reviews a physician's request for privileges. The committee reviews the individual physician's credentials, including medical education, residency training, board certification, and practical skills (i.e., the number of procedures the physician has performed), and determines whether the physician should be granted staff privileges. The extent of privileges granted to the physician depends on his level of training, expertise, and staff speciality. For instance, a physician trained in internal medicine would not be granted privileges in cardiovascular surgery because an internist does not generally possess this skill. The hospital would grant the internist privileges to practice medicine within the hospital only to the level of his training and expertise. The process by which the hospital determines which particular physicians may receive hospital privileges is commonly known as credentialing or peer review.[58]

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patient received services. This fee covers all of the patient's health care services. If a patient's care exceeds the capitation payment set by the managed health care plan, the physician becomes personally liable to the plan for the excess patient expenses.

54. *Id.*

55. *Id.*

56. *Id.*

57. Dallet, *supra* note 23, at 329.

58. *Id.* at 329-30. *See also Joint Comm'n on Accreditation of Healthcare Orgs.*, THE ACCREDITATION MANUAL FOR HOSPITALS 53 (1993).

Traditionally, the credentialing process focused on a number of criteria relating to a physician's medical and clinical competency.[59] Hospital credentialing decisions have commonly been based on such criteria as the physician's experience, ability, judgment and other related factors designed to ensure quality medical care for the hospital patient.[60] Prior to the recent emergence of economic credentialing criteria, all physicians seeking hospital privileges for the first time and those physicians seeking to maintain existing privileges were subject to the same examination by a peer review committee to ensure that physicians were competent and providing quality medical care.[61]

In recent years, the health care market has undergone a significant transformation, particularly due to increasing consolidation of hospitals and health care systems and the emerging importance of managed care.[62] The role of managed care providers, such as HMOs, and governmental payors in modern medical care, is pervasive. HMOs, insurance companies, and government medical programs have the tremendous power to deprive prospective users of the hospital's medical services.[63] Government advocates see the HMO as an attractive model because of its implicit incentive to maintain a low rate of hospital admissions. Third-party payors view medical services as a commodity and search for hospitals charging the lowest prices.[64] Due to the overwhelming leverage possessed by managed care corporations and government medical programs, hospitals are subject to strict pricing rules and, therefore, cannot bargain or negotiate the prices of medical services.[65] Accordingly, the strictures imposed by governmental HMOs and insurance company payors effectively transfer the financial burdens, risks of loss, and other economic risks to hospitals and physicians.[66] The hospitals respond by developing practices, programs, and incentives designed to alleviate the financial burden, ultimately shifting the cost to the patient by decreasing the care received. Physicians, and ultimately their patients, are thus penalized for increased utilization of

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59. *See generally* Elizabeth A. Snelson, J.D., *The Price of Profitability - Economic Credentialing Can Threaten Health Care Quality*, 76 MINN. MED. 37-39 (1993).

60. Dallet, *supra* note 23, at 330.

61. *Id.* at 330-31.

62. Hershey, *supra* note 24, at 4-5.

63. *Id.* at 4. *See also* RODWIN, *supra* note 5, at 4.

64. *Id* at 4-5.

65. *Id.* at 5.

66. *Id.*

medical services and hospitalization.

The financial pressures faced by hospitals have compelled them to evaluate medical service providers on a cost-benefit basis. Increasingly, hospitals are looking to economic credentialing to mitigate the financial pressures imposed by governmental and insurance company payors. For example, hospitals are using physician credentialing based on such factors as patient length of stay, hospital reimbursement, referrals, consultations, number of tests ordered, number of hospital admissions vis-à-vis outpatient services utilizations, excessive testing, DRG, and other bottom line considerations.[67]

Managed care corporations, such as HMOs and government payors, will soon displace the traditional fee-for-service practice with capitation as the primary method of reimbursement for medical services.[68] The capitation reimbursement system is generally the process of providing a fixed payment per patient per month.[69] Pursuant to the capitation system and other similar reimbursement schemes, hospitals assume the financial risk from insurance company and government payors.[70] In turn, hospitals are compelled to impose financial and economic pressure on doctors and other health care providers.[71] The most effective leverage available to the hospital is the physician credentialing process. By imposing economic criteria on the physician credentialing process, hospitals can create incentives for doctors to engage in more restrained and conservative medical care practices.[72]

Ethical and Legal Implications of Economic Credentialing

Economic credentialing by hospitals poses severe ethical and legal consequences that jeopardize the physician-patient relationship. Because a physician must be aware of the financial and economic consideration associated with a particular medical test, treatment, or care, it necessarily follows that the patient's welfare may not always be the physician's primary concern. Economic credentialing by hospitals creates inherent conflicting

67. Blum, *supra* note 3. *See also Snelson*, *supra* note 59, at 37-38.

68. John D. Blum, *The Evolution of Physician Credentialing into Managed Care Contracting*, 22 AM. J. LAW AND MED. 174-77 (1996).

69. *Id.* at 175.

70. Blum, *supra* note 3, at 66-67.

71. *Id.* at 66-68.

72. Blum, *supra* note 3, at 66-67.

loyalties for the physician in that he or she must make a choice between the patient's well being and the cost of diagnostic procedures and treatment options that will be reflected in his or her peer review. Such conflict poses significant ethical and legal ramifications for physicians and serious consequences for the patients in their care. By reducing expenditures, promoting efficiency, and decreasing hospitalization, managed care may, in some instances, provide better treatment for some patients. It will likely decrease the quality of life of other patients, however, because medical judgments will be based on the economic consequences of the service required.[73]

Ethical Issues

The basis of the physician-patient relationship is the patient's belief that a physician is wholly committed to serving his or her needs.[74] The Hippocratic oath states that physicians will do everything in their power to help their patients.[75] Society expects doctors to furnish a wide range of services, appropriate diagnostic testing, and the best treatment necessary to improve a patient's medical condition and quality of life.[76] Economic credentialing, however, creates two conflicting loyalties for the physician.

First, physicians must balance the interests of their patients with the interests of other patients.[77] Under the fiscal realities of economic credentialing, physicians have an obligation to keep expenses to a minimum by limiting the use of medical services, increasing efficiency, shortening the time spent with the patient, and using specialities very sparingly.[78] Therefore, the physician must decide whether to order a diagnostic test or procedure for a patient, reserve such tests or procedures for another patient, or choose not to order the test at all to comply with the fiscal profile established by the hospital.[79]

Second, the cost constraints inherent in economic credentialing compel physicians to choose between the best interests of their

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73. Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604-05 (1995).

74. Council Report of the AMA Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care*, 273 JAMA 331 (1995).

75. *Id.*

76. Jerome P. Kassirer, *Managed Care and the Morality of the Market Place*, 333 NEW ENG. J. MED. 50-51 (1995).

77. Council Report, *supra* note 74, at 331-32.

78. Kassirer, *supra* note 76, at 50.

79. Council Report, *supra* note 74, at 331.

patients and their own economic survival.[80] An unfortunate by-product of such conflict is a likely reduction in the quality of care. This is true because it is likely that doctors will increasingly limit the services and procedures they provide or fail in their role as a patient advocate by excluding or rationing care for acute patients.[81] Economic credentialing pushes physicians into excruciating quandaries as they deceive themselves into thinking that what they are doing is best for the patient when, in fact, they are deciding not to treat the patient based on their own economic survival.[82]

Legal Issues

Presently, no state or federal appellate decisions have specifically addressed the issue of economic credentialing. Accordingly, this Comment focuses on *potential* legal issues arising from economic credentialing. In *Rosenblum v. Tallahassee Memorial Regional Medical Center*,[83] a Florida trial court affirmed a hospital's decision to deny staff privileges to a reputable and skillful surgeon whose medical qualifications were beyond reproach, strictly because of economic factors.[84] In *Rosenblum*, the hospital denied the physician privileges in its cardiac department solely because he had a relationship with a competing hospital. The hospital did not base the denial on the physician's quality of care, but rather on the economic consequences of his professional behavior. The state court judge determined that economic credentialing was a valid basis for denying hospital privileges under Florida law.

Another potentially negative legal implication related to economic credentialing involves situations in which a class of patients or a medical specialty is a money-loser for the hospital and, therefore, does not meet the hospital's fiscal criteria. The hospital may consider discontinuing or limiting certain medical services, thereby reducing the utility of certain physicians' hospital privileges. Under these circumstances, however, the hospital may be vulnerable to allegations of antitrust or restraint of trade.[85] The Health Care Quality Improvement Act of 1986[86] provides limited

80. Kassirer, *supra* note 76, at 50-51.
81. *Id. See also* Council Report, *supra* note 74, at 331-333.
82. Kassirer, *supra* note 76, at 50-52.
83. No. 91-589 (Cir. Ct. Leon County, Fla., filed June 22, 1992) (unpublished decision).
84. *Rosenblum*, No. 91-589 (Cir. Ct. Leon County, Fla., filed June 22, 1992).
85. Kolb, et al., *supra* note 25, at 62-64; *See also* Dallet, *supra* note 23, at 353-62.
86. Health Care Quality Improvement Act of 1986, Sec. 402, 42 U.S.C. § 11101-52 (1988).

antitrust immunity for participants in medical staff peer reviews. This immunity, however, does not extend to a credentialing decision based solely upon economic considerations.[87]

Economic credentialing may implicate a new form of informed consent. Under the doctrine of medical malpractice, physicians may be held liable for inadequate disclosure in obtaining consent for medical procedure. Likewise, under economic credentialing, physicians also face potential liability for failing to disclose to the patient any direct or indirect financial or economic incentives they may have for limiting testing and treatment.[88] Such a scenario would raise an interesting conundrum for physicians: should they inform their patients of available diagnostic tests, alternative treatments, and clinical options to allow patients to elect the best course of medical action; or should they disclose the economic and financial constraints that managed care imposes upon them?[89] Failure to make either disclosure may expose the physician to liability.[90]

A legitimate objective of health care policy is to promote the improvement of the quality of patient care.[91] Because economic credentialing defines a physician's qualifications based on economic criteria unrelated to competency, it is an illegitimate public policy objective.[92] With economic credentialing, hospitals and HMOs place the interests of health care corporations before the interests of the public.[93]

CONCLUSION

In recent years, the rising cost of health care has resulted in a complete overhaul of the practice of medicine. Due to the increasing financial burden transferred by the government, HMOs, and insurance company payors, hospitals are seeking ways to impose financial discipline on physicians to further contain costs. Hospitals have already found effective means of controlling physician behavior through the traditional peer review process.

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87. Dallet, *supra* note 23, at 360-61.

88. Rodwin, *supra* note 73, at 605-06.

89. *Id.*

90. Marc A. Rodwin, *Physicians' Conflicts of Interest: The Limitations of Disclosure*, 321 NEW ENG. J. MED. (1989); *See also generally* Marcia Angell, *The Doctor as Double Agent*, 3 KENNEDY INST. OF ETHICS J. 279-286 (1993).

91. *See generally* Dallet, *supra* note 23, at 325-63.

92. *Id.* at 347.

93. *Id.*

Hospitals and HMOs are expanding the peer review process beyond traditional quality of care criteria such as competence, experience, and skill to include financial and economic factors. Under an economic credentialing policy, a physician may be excluded for treating too many poor people, having too many acutely ill patients, or simply for providing thorough and effective medical care.

Significantly, economic credentialing raises a host of potential ethical and legal issues. The failure of hospitals to recognize the potential legal and ethical consequences of economic credentialing may ultimately pose the greatest risk to patients. Although hospitals must continue to be cognizant of the inherent tension between quality medical care and bottom line business considerations, a meaningful effort must be made to prevent economic criteria from serving as the exclusive mechanism for defining medical care.

The AMA opposes economic credentialing. Nearly all physicians agree that economic credentialing is unprofessional and unethical. These physicians would like to use medical competence as the only standard for credentialing a physician.[94] California hospitals and physicians have drafted a mutual agreement on economic credentialing as an alternative to legislative changes. Their statement reads: "Termination or granting of medical staff privileges based solely on economic criteria unrelated to clinical qualifications, professional responsibilities or quality of care is inappropriate."[95] Because economic credentialing is still in its infancy, many states have not addressed this issue.

California was the first state to embrace managed care, and HMOs have been in business in California for many years. California Representative, Fortney Stark, Jr., is frustrated by the obstacles he had to overcome before his grandson could see a pediatrician. His solution, the "Managed Care Consumer Protection Act of 1997," H.R. 337, addresses the financial constraints placed on physicians by managed care.[96] Under his bill, no denial of medical services would be upheld unless it was issued by a physician reviewer who is clinically qualified within the same specialty as the recommending physician.[97]

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94. Daniel B. Moskowitz, *First, Do No Harm. Second, Turn A Profit*, 4 J. AM. HEALTH CARE 33 (1994).

95. *Id.*

96. *See generally* Weber, *supra* note 16.

97. *Id.*

In 1996, thirty-five states enacted legislation to protect health care consumers and physicians, aimed at tightening the reins of managed care corporations, such as HMOs. Economic credentialing of physicians should be added to the list of issues included in any list of necessary legislative reforms. The issues now under review include: gag clauses that prevent physicians from informing patients of more costly beneficial treatment options, deselection of physicians by HMOs without just cause, and reimbursement for emergency room visits if a lay person believes the visit is justified.[98] Physicians need to meet with legislators and lobby for their profession and patients. Most physicians believe that the goals of health care reform should include universal access and reasonable cost control. Policy makers, however, should not interfere with the integrity of the physician-patient relationship and turn this relationship into a market arrangement.

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98. *Id.*