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Recommended Citation
David J. Behinfar, Exclusive Contracting Between Hospitals and Physicians and the Use of Economic Credentialing, 1 DePaul J. Health Care L. 71 (1996)
Available at: https://via.library.depaul.edu/jhcl/vol1/iss1/4
EXCLUSIVE CONTRACTING BETWEEN HOSPITALS AND PHYSICIANS AND THE USE OF ECONOMIC CREDENTIALING

David J. Behinfar *

INTRODUCTION

The transformation of health care delivery systems over the past several decades has placed increasing economic demands on hospitals that have responsively altered the way they conduct business, especially in the area of medical staffing decisions.1 The economic pressures fostering these changes include rising cost of health care, changing patient population, reduced government reimbursement for Medicare and Medicaid patients and pay or reform.2 Liability exposure has also played an important role in redefining how hospitals operate.3

Many hospitals enter into exclusive contracts with a physician or group of physicians in response to these economic challenges.4 In such agreements, the physician or physician group is designated as the exclusive provider of a specified service within the hospital, such as radiology or anaesthesia with the result that other physicians are precluded from

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2 Id.

3 Bing v. Thunig, 2 N.Y.S.2d 656 (1957) (eliminating hospital immunity and applying the principle of respondeat superior to physician-employees of hospital); Jackson v. Power, 743 P.2d 1376 (Alaska 1987) (hospital has nondelegable duty to provide non-negligent physician care in its emergency room and hospital may be liable for breach of this duty); Gilbert v. Sycamore Mun. Hosp., 622 N.E.2d 788 (Ill. 1993) (hospital may be liable for negligent act of a physician even if physician is an independent contractor so long as an apparent agency relationship exists).

A hospital may also be liable for the negligent hiring of a physician who commits negligent acts while an employee of the hospital. See Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253 (Ill. 1965), cert. denied, 383 U.S. 946 (1966) (hospital has a duty to exercise reasonable care in the selection of its employee physicians). This duty was expanded in Johnson v. Minocqua Community Hosp., 301 N.W.2d 156 (Wis. 1981) and Elam v. College Park Hosp., 183 Cal. Rptr. 156 (1982) (where both cases held a hospital has a duty to carefully review a physician's qualifications upon application). See also Gilbert v. Sycamore Mun. Hosp., 622 N.E.2d 788 (Ill. 1983)

performing those services at the same hospital.\(^5\) The impact of these hospital-physician exclusive contracts is potentially devastating to staff-physicians who are not included within the agreement. Unless the contracted group chooses to employ a particular staff-physician, once an exclusive contract goes into effect, the staff physician is no longer able to perform similar services at the hospital and his or her staff privileges become meaningless. As a result, staff-physicians who do not enjoy exclusive contracts have, with increasing frequency, sought judicial relief for their exclusion\(^6\) basing a cause of action on violations of hospital bylaw provisions\(^7\) that require notice and a hearing for actions affecting the staff privileges of physicians.\(^8\)

This article will review the courts' posture towards physician-hospital contractual relationships, and develop a rationale for avoiding such disputes and clarifying parties' contractual rights and obligations. The first section analyzes the legal issues surrounding exclusive contracts and the termination of staff privileges. The next section provides advice on drafting individual contracts and hospital bylaws. Finally, this article delineates strategies for avoiding problems associated with hospitals' attempts to enter into exclusive contracts, and provide an example of how physicians and hospitals have worked together to solve the problems associated with exclusive contracting.

**LEGAL ISSUES SURROUNDING EXCLUSIVE CONTRACTS AND THE TERMINATION OF STAFF PRIVILEGES FOR ECONOMIC REASONS**


Increasingly, physicians are forced to seek legal remedies when a hospital adversely affects their staff privileges through the use of exclusive contracts. However, courts are not always receptive toward the complaining physician with the overwhelming majority of courts finding that a private hospital has a right to deny staff privileges to a physician. Hence, courts will not normally review a private hospital's decision regarding the denial of a physician's initial application for staff privileges.

The general rule of refusing to provide judicial review is based on the premise that it is inappropriate for a court to substitute its own judgment for the professional judgement of hospital officials who have superior qualifications in making medical staffing decisions. Therefore, courts will only inquire as to whether a hospital's denial of an applicant's staff privileges followed proper procedure. To adhere to proper procedure, a hospital need follow only its own governing documents when denying staff privileges to physicians. Consequently, courts involve themselves only when there is evidence of a conspiracy between the hospital's board and other physicians who have staff privileges, or if there is a departure from standards set by hospital bylaws.

While the staffing decisions of hospitals can be free from judicial review when they deny applicants admittance to the medical staff, courts take a different view when hospitals seek to reduce the existing staff.

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9 Shulman v. Washington Hosp. Ctr., 222 F. Supp. 59 (D.D.C. 1963) (stating private hospital has right to exclude any physician from practicing at that hospital). The Illinois Supreme Court in Barrows v. Northwestern Memorial Hosp., 123 Ill. 2d 49 (1988) noted that public policy supported the nonreviewability of staff privilege decisions by private hospitals in denying initial staff applications. The court stated that the large majority of states do not provide for review of a hospital's decisions on medical staffing. Only Arizona, California, Hawaii, New Hampshire, Vermont and New Mexico employ a broader scope of review. Consequently, physicians do not enjoy a right to practice at a private hospital.


12 Knapp v. Palos Community Hosp., 176 Ill. App. 3d 1012, 1018 (1988) (private hospital must follow its own bylaws when revoking a physician's staff privileges or the decision is subject to judicial review); see also Yarnell v. Sisters of St. Francis Health Servs., Inc., 446 N.E.2d 359 (Ind. App. 1983); Lapidot v. Memorial Medical Ctr., 144 Ill. App. 3d 141, 147 (1986).

13 Knapp, 176 Ill. App. 3d at 1018.
privileges of a physician.\textsuperscript{14} When a hospital reduces staff privileges previously granted to a physician, courts allow full judicial review to determine whether the action was proper.\textsuperscript{15}

Courts not only review actions that expressly reduce a physician's staff privileges, they also provide for review when staff privileges are constructively terminated.\textsuperscript{16} Constructive termination occurs when a physician has privileges at a hospital and the hospital enters into an exclusive contract with a physician group. If the individual physician who formerly held staff privileges is not employed by the new physician group, his or her staff privileges are useless due to the fact that he or she can no longer use the hospital's facilities. This is considered a "constructive termination" because the hospital did not directly terminate or reduce the physician's staff privileges.\textsuperscript{17}

In summary, legal relief is not available for a physician seeking appointment to a hospital staff whose application is denied, unless the hospital failed to conform to its own procedural requirements in denying the application. However, when a hospital reduces, terminates or constructively terminates the existing staff privileges of a physician, full judicial review is available to the physician.

The Contractual Relationship Between Physician and Hospital

Once a physician demonstrates termination or constructive termination of his existing staff privileges, he has overcome the first hurdle and will be allowed to have a court determine the propriety of the hospital's actions. The next step is predicated upon determining the legal relationship between the parties; this inquiry is directed toward determining the contractual relationship between hospital and physician. Therefore, the first

\textsuperscript{14} Id.
\textsuperscript{15} Id.
\textsuperscript{16} Id.
substantive issue a court will address is whether the hospital bylaws created any contractual rights.\textsuperscript{18}

When a hospital agrees to grant staff privileges to a physician, it enters into an individual contract with that physician.\textsuperscript{19} This contract defines the rights of the parties with respect to the physician's use of hospital facilities.\textsuperscript{20} For example, a physician might be restricted from providing services at other hospitals, or be obligated to perform a specified number of services at the contracting hospital.\textsuperscript{21} This individual contract clearly binds both the physician and the hospital.

In addition, courts have found that hospital bylaws also constitute part of the contractual agreement between physician and hospital.\textsuperscript{22} Thus, in most states, the individual contract and the hospital bylaws act together to


define the contractual relationship between the parties. Hospitals must act in accordance with their bylaws to remain free from judicial review.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards require certain hospital bylaw provisions to provide for notice and a hearing for a member-physician when the hospital acts to suspend or terminate the physician's staff privileges. As a result, numerous suits have been predicated on a hospital's denial of notice or a hearing before staff privileges are "constructively terminated." However, it is notable that some courts have held hospital bylaws to be ineffectual in contractually binding a hospital and physician. In St. Mary's Hospital v. Radiology Professional Corp., and Szczerbaniuk v. Memorial Hospital for McHenry County, the hospitals both successfully argued that bylaws do not create an enforceable contract between the


25 Standards MS._MS_, 1995 JCAHO ACCREDITATION MANUAL.


27 See Manczur v. Southside Hosp., 183 N.Y.S.2d 960 (1959) (bylaws and hospital constitution did not suffice as requirements of mutuality of obligations and consideration so breach of contract action was not proper); see also e.g., Leider v. Beth Israel Hosp. Assoc., 182 N.E.2d 393 (N.Y. App 1962); Medical/Dental Staff of St. John's Episcopal Hosp. v. Board of Managers, No. 81-3793 (N.Y. Sup. Ct., June 22, 1981).


physician and hospital. In Szczerbaniuk, the court's decision was based on the existence of a detailed individual contract between the physician and the hospital that conflicted with the hospital's bylaws. In St. Mary's, the court determined that since the hospital had the authority to revise the rules and regulations governing physicians, the bylaws did not create any contractual rights.

While St. Mary's and Szczerbaniuk support the proposition that bylaws may not bind physicians and hospitals, a consistent trend is emerging as courts find that parties are contractually bound by bylaw terms.

Staff Privileges vs. Clinical Privileges: When are they terminated?

Because bylaws often act to contractually bind parties, the notice and hearing provisions of bylaws must be adhered to in any actions reducing, adversely affecting, or terminating a physician's staff privileges. Therefore, the question courts now face is whether physicians, who are not part of the physician group exclusively contracted with by the hospital, have had their staff privileges reduced, adversely affected or terminated by that exclusive contract.

The fact pattern routinely seen in these cases consists of a situation where a hospital grants staff privileges to a physician to provide a designated service at the hospital. Later, the hospital enters into an exclusive contract with a physician group whereby members of that group are to be the sole providers of the designated service at that hospital. Meanwhile, the hospital often fails to give the staff physician notice or a

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31 Szczerbaniuk, 180 Ill. App. 3d at 714.
32 St. Mary's, 421 S.E.2d at 736.
hearing on the matter. Finally, the individual physician may file suit against the hospital claiming the notice and hearing procedures were not followed as required by the hospital bylaws for actions reducing, adversely affecting or terminating a physician's staff or clinical privileges.

In Garibaldi v. Applebaum, a recent case decided by the Illinois Court of Appeals, the court addressed the above scenario and held that by entering into an exclusive contract, the hospital adversely affected the clinical privileges previously granted to plaintiff physician, and therefore had violated bylaw provisions requiring notice and a hearing.

In several cases, including Garibaldi, the determining factor concerning whether a hospital rightfully or wrongfully failed to provide a staff physician with notice or a hearing, rested upon whether the hospital had granted staff privileges or clinical privileges. Various courts have recognized a distinction between staff privileges and clinical privileges, which are also referred to as "the right to use the staff privileges."

Staff privileges have been interpreted by courts as a minimum standard; however, they are insufficient alone to permit the physician to actually provide services at the hospital. Clinical privileges, on the other hand, actually give the physician the right to perform services at the hospital when used in conjunction with staff privileges.

This distinction between clinical privileges and staff privileges has allowed courts to find that exclusive contracting affects the clinical privileges of a physician, by restricting his or her ability to practice at a hospital, but not the physician's staff privileges. Thus, a hospital avoids the

37 Garibaldi, 653 N.E.2d 42.
38 Id., at 45.
39 Id. at 44.
40 See cases cited supra note 6.
42 Engelstad, 718 F.2d at 262, 267-268; Lewisbury, 805 S.W.2d at 760.
necessity of providing a physician with notice or a hearing.  The result of this distinction is that a physician may have staff privileges at a hospital, but is unable to perform any services at that hospital.

Nevertheless, this difference can serve the interests of either party, depending upon the inclination of the reviewing court. For example, in *Garibaldi*, the court found the plaintiff's staff privileges were unaffected by the exclusive contract, but that the plaintiff's clinical privileges had been constructively terminated as a result of the hospital's exclusive contract with the physician group. In determining whether the plaintiff was entitled to notice or a hearing, the court relied on provisions in the hospital bylaws that specifically distinguished between staff privileges and clinical privileges. The court also relied on provisions in the hospital bylaws that provided:

Actions that limit, reduce, suspend or revoke membership or clinical privileges of a practitioner of the staff of the Hospital or revoke staff membership shall be deemed to be adverse to the practitioner and shall entitle the practitioner to notice and the hearing and appeal procedures as provided in Article VIII. These actions include:

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(2) Reduction, suspension or revocation of clinical privileges and/or admitting privileges;

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(4) Suspension or revocation of specific clinical privileges or staff membership...

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Thus, in *Garibaldi* the court found the plaintiff was entitled to notice and hearing protections found in the bylaws. Based on this conclusion, the

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43 *See, e.g., Engelstad*, 718 F.2d at 266.
45 *Id.* at 45.
46 *Id.* at 43.
court reversed the lower court's summary judgment ruling for the hospital and remanded the case to the trial court. 47

Similarly, in Bartley v. Eastern Maine Medical Center, 48 the Supreme Court of Maine also recognized the distinction between the granting of staff privileges and clinical privileges. However, the court came to a conclusion opposite that of the Garibaldi court. In Bartley, the hospital did not provide the physicians with notice or a hearing and maintained that the bylaws only required notice and a hearing when remedial or corrective action affected the staff privileges of a physician. 49 The Bartley court also found the notice and hearing provisions in the bylaws to be applicable only to "major corrective actions," defined in the bylaws as occurring when a recommendation is made to reduce a physician's privileges. 50 Because the decision to contract exclusively with a group of physicians was based on economic factors, the court concluded the hospital's decision was not tantamount to a major corrective action. 51 Accordingly, the court found the provision inapplicable to the hospital's decision to enter into an exclusive contract which constructively terminated the physician's privileges. 52

The Bartley court also distinguished between the granting of privileges and the right to use privileges. 53 The court found the physician's staff privileges were not reduced, because the grant of privileges did not include the right to use those privileges. 54 Here, the distinction between staff privileges and clinical privileges was not as explicit as in Garibaldi. 55 The hospital bylaws did not provide for any distinction between the two types of privileges; therefore, the court pinpointed the distinction itself and the differing protections for the two types of privileges. The court defined staff privileges to mean the physicians were qualified to practice at the

47 Id. at 45.
49 Id. at 1023.
50 Id.
51 Id.
52 Id.
53 Id.
55 Id.
However, the court's definition of staff privileges did not extend to the right to use those privileges. Therefore, the court found the exclusive contract with the physician group only affected the physicians' right to use the staff privileges, and the bylaws did not require notice or a hearing for actions that only affected the right to use those privileges.57

Finally, the court in Bartley did not identify a contractual basis for its distinction, nor did the court cite a provision in either the physician's contract or the bylaws supporting the distinction between granting staff privileges and the right to use such privileges. The court however did cite two cases, Engelstad v. Virginia Mun. Hosp. & Va. Hosp. Comm.65 and Holt v. Good Samaritan Hosp. & Health Ctr,59 which both support a distinction between the granting of staff privileges and the actual right to use those privileges.60

In both Engelstad and Holt, the legal analysis focused on the premise that the grant of staff privileges did not include the right to use those privileges.61 This reasoning permitted the court in both cases to conclude that a physician who has staff privileges at a hospital would not necessarily have the right to exercise those privileges.62 The court in Bartley applied this same analysis as the foundation for determining that the exclusive contract did not affect the physician's staff privileges, but only restricted the right to use privileges not protected in the bylaws.63

Finally, in Dutta v. St. Francis Regional Medical Center,64 an opinion rendered by the Supreme Court of Kansas prior to Garibaldi, the court rejected the notion that notice and a hearing must be provided even when a physician's clinical privileges are affected. As in Garibaldi, the hospital

56 Id. at 1022-1023.
57 Id. at 1023.
61 Engelstad, 718 F.2d at 268; Holt, 590 N.E.2d at 1323.
62 Engelstad, 718 F.2d at 268; Holt, 590 N.E.2d at 1323.
63 Bartley, 617 A.2d at 1023.
byslaw provisions granted a hearing when a decision by the hospital adversely affected the physician's status as a member of the medical staff or the physician's clinical privileges. This is the same type of provision the court in Garibaldi used to support its finding that the physician the has a right to a hearing. Nevertheless, in Dutta, the court rendered a decision in favor of defendant hospital.

In Dutta, plaintiff physician argued that her clinical privileges were adversely affected by the hospital's decision to revoke her right to use the hospital facilities and enter into an exclusive contract with another radiologist. Plaintiff also argued the bylaws required a hearing, because the agreement had an adverse affect on plaintiff's clinical privileges. In response, the hospital maintained that the grant of privileges did not include the right to use those privileges, and referred to provisions in the bylaws distinguishing between medical staff membership and clinical privileges, the latter being merely a privilege and not a "right." The hospital further argued it could deny plaintiff access to the hospital's equipment without adversely affecting her staff privileges.

The Dutta court sided with the hospital holding that because the hospital's decision to refuse plaintiff access to the hospital's equipment was a business decision, plaintiff was not entitled to a hearing for the adverse effect of the decision on her staff privileges. The court remained unpersuaded by the plaintiff's attempts to argue that her clinical privileges had been reduced.

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65 Dutta, 867 P.2d at 1061. The bylaws also included that hearings are provided for the purpose of deciding matters concerning the resolution of professional competency and conduct matters.
66 Id.
68 Dutta, 867 P.2d at 1062.
70 Id. at 1061.
71 Id. at 1060.
72 Id. at 1062.
Economic Credentialing

To understand why courts have rendered such diverse opinions on similar fact scenarios, and developed a transparent distinction between the protection of staff privileges and clinical privileges, it is important to understand the economic rationale behind staffing decisions. The legal battle between a hospital and a physician is often the result of a hospital's decision, based on economics and pure business motives, to exclusively contract with a physician group.

Typically, hospitals enter into exclusive contracts with physician groups for purely economic reasons. The term used to describe this phenomenon is "economic credentialing". Economic credentialing refers to the use of economic criteria, unrelated to quality of care or professional competency, used by a hospital for determining a physician's qualifications for initial or continuing medical staff privileges. For example, a hospital might consider factors such as a physician's ability to use the hospital facilities and equipment in an efficient manner. Moreover, the hospital may consider the physician's DRG profiles, patient services, admissions, and levels of reimbursement. Exclusive contracting has become a means for hospitals to engage in economic credentialing, thereby maximizing revenues while reducing costs.

According to a 1989 survey conducted by the American Hospital Association (AHA), 73.4 percent of the hospitals responding stated they

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73 See generally, Brian McCormick, Suing over Exclusivity: Courts Grappling with Economic Credentialing; Physician-Hospital Contracts Based on Economic Criteria, AMERICAN MEDICAL NEWS, Jan. 13, 1992 at 3; see also, Anita J. Slomski, Hospitals Wield A Heavy Club Against High-Cost Doctors; Economic Credentialing, MEDICAL ECONOMICS, Oct. 7, 1991 at 57.
75 Id.
76 Id.
77 Id.
held exclusive contracts with their hospital departments.\footnote{Id.} The departments that were most frequently exclusively contracted with were radiology, pathology, emergency medicine and anesthesiology.\footnote{Id.} A hospital will generally offer quality of care reasons in support of their decision to enter into exclusive contracts. However, physicians see the use of exclusive contracting as a means of economic credentialing where the hospital is making medical staffing decisions based on economic criteria unrelated to the quality of patient care.\footnote{Id.}

Several opinions have expressly recognized the hospital's use of exclusive contracting for economic reasons as a viable proprietary interest unhindered by hospital bylaws. For example, in Bartley, the hospital argued the decision to exclusively contract with a group of physicians was an economic decision, unrelated to quality of care. The hospital further argued that these types of medical staffing decisions should not be subject to the notice and hearing requirements found in the bylaws.\footnote{Bartley v. Eastern Maine Medical Ctr., 617 A.2d 1020, 1021 (Me. 1992).} The court agreed holding the hospital board of trustees had the authority to act irrespective of the bylaws in order to enter into new contracts and manage the hospital.\footnote{Id. at 1022.} The court gave priority to the hospital's board of trustees, and favored the hospital board's interest in the power to conduct business, rather than the interests of physicians in notice and hearing provisions found in the bylaws.\footnote{Id.}

In Dutta, the court embraced similar arguments by the hospital and found the hospital's right to make business decisions regarding the medical staffing of its departments took priority over a physician's rights as expressed in the bylaws.\footnote{Dutta v. St. Francis Regional Medical Ctr., 867 P.2d 1057, 1062 (Kan. 1994).} In Garibaldi, however, the court either ignored the economic stakes at hand, or was unaware of the economic indicia behind the hospital's actions. In either event, the court simply looked to
the hospital's bylaws and found the notice and hearing protections reserved for the physician had not been followed.\textsuperscript{85}

Garibaldi, Bartley and Dutta illustrate the difficulties courts face when interpreting the contractual relationship between a physician and hospital. The inconsistency of the decisions result from the courts' struggle to weigh the physicians' interest in continued employment, against the interests of the hospital in making medical staffing decisions. These inconsistent holdings may also be explained by the lack of individual contract provisions between hospitals and physicians regarding termination.

\textbf{DRAFTING CONTRACTUAL CLAUSES TO AVOID UNCERTAINTY}

Consistency and clarity are both necessary in order to effectively draft reliable bylaws and physician contracts. This section addresses some points on drafting contracts that will help avoid potential dilemmas, and also allow parties to better understand their legal rights and obligations should the hospital enter into an exclusive contract with another physician or physician group.

There are several steps both hospitals and physicians can take to reduce the possibility of suits over termination provisions in hospital bylaws and the applicability of those provisions to decisions based on economic motives. There are two specific approaches toward drafting such agreements. The first gives the physician more rights in an action adversely affecting his or her privileges. The second gives the hospital greater leeway to make medical staffing decisions without giving notice or a hearing to the physician.\textsuperscript{86} Drafting agreements that favor either side are possible as well. However, as one commentator has noted, hospitals and hospital-based physicians are inexorably intertwined in a relationship that has common goals and objectives.\textsuperscript{87} The importance of the two parties

\textsuperscript{85} Garibaldi v. Applebaum, 653 N.E.2d 42, 44 (Ill. 1995)
\textsuperscript{86} Mary T. Koska, \textit{Exclusive Physician Contracts can be a Win/Win Situation}, \textit{HOSPITALS, Oct. 20, 1990}, at 84.
\textsuperscript{87} \textit{Id.}
finding a common ground on which to base future relations is necessary if the two parties wish to remain allies rather than adversaries.  

To clarify the agreement between the hospital and physician, parties must draft the contract with greater specificity. If there are straightforward and specific provisions governing the rights of the parties upon termination, the parties will be able to act within these rights.

Because courts have increasingly held hospital bylaws to contractually bind parties to its provisions, the bylaws must also contain the relevant revisions of clarity and specificity. There are several clauses the parties might include in either the bylaws or the individual physician contract to clarify their agreement.

**Drafting With Specificity**

One provision that can clarify the parties' rights is the clean sweep provision. A clean sweep provision in the physician's individual contract with the hospital typically provides that in the event of the termination or expiration of the agreement, the physician's privileges at the hospital will also be terminated. As part of the agreement, the physician is required to waive his or her right to a hearing and must sign a written waiver in order for the provision to be effective. This provision allows the hospital to terminate the contract without prolonging the process with a hearing.

A California appellate court has found the clean sweep provision valid holding that a physician may waive his or her rights to a hearing.

While the hospital may benefit from this arrangement, the physician does not appear to receive any additional benefits. Nevertheless, in return for the hearing waiver, the physician might receive a higher salary or a six

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88 Id.
89 Id.
90 Hospital Consolidation, Integration Provides Challenge for Bylaws Drafting, 4 HLR 25 (1995).
91 Id.
92 Id.
93 Id.
month to one year extended notification of termination provision in the contract.  

Another way of incorporating the efficiency of the clean sweep provision into the contract is simply to define the parties' rights upon termination of the individual contract. This termination provision should distinguish between termination for cause and termination for economic reasons.

If a physician is accused of doing an inadequate job, then the hospital should have the right to terminate his or her contract and his or her staff privileges. The physician should also have the right to defend himself or herself from the accusations; therefore, the physician should be entitled to notice and a hearing. However, when a hospital wishes to reduce or terminate the staff and clinical privileges of a physician for economic reasons, a hearing could be waived by the physician in a separate provision. The contract should also specify what economic reasons are appropriate for termination. This will enable the physician to better protect his or her position by monitoring these areas before they become problematic.

The actions triggering a right to a hearing must also be clearly defined. If hearings are proper only when considering a physician's professional competency or conduct, then the parties must recognize that economically motivated actions are not subject to a hearing. If a physician wishes to have a hearing when a hospital adversely affects his or her staff or clinical privileges for economic reasons, the physician must request the provision to be included in their individual contract.

Individual contracts and/or bylaws must also contain specific definitions of clinical privileges and staff privileges. The definition of

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97 Id. at 85.
98 Id.
99 See supra note 74.
100 Id.
101 See Zellers and Poulin, supra note 96, at 84.
staff privileges should specifically include language on whether staff privileges include the right to use those privileges. In addition, the definition will restrict courts from redefining the agreement of the parties in accordance with prior case law. Inclusion of such terms will also force courts to define the contractual relationship of the hospital and physician based on the actual terms of the contract.

Finally, the hospital and physician must ensure that the bylaws are consistent with the individual physician's contract. Conflicting provisions will lead to inconsistent results and must be identified before problems occur. The most apparent difficulties arise when the contract language differs from or is contradictory to the language contained in the bylaws. For example, in Hospital Corp. of Lake Worth v. Romaguera, a hospital and physician entered into a contract which included specific language regarding the physician's rights upon termination. Later, the hospital modified its bylaws to state the opposite of what was contained in the physician's contract. The court held the modification was valid only because it expanded, rather than reduced, the physician's rights.

The Romaguera case illustrates the hospital's need to draft and modify its bylaws and individual physician contracts with respect to each other. Therefore, it is important for both parties to review and compare the hospital's bylaws with the individual physician contract so any potential differences can be identified. Thus, when individual physician contracts are drafted, the parties might want to draft a clause into the contract preempting the application of the bylaws with regard to any conflicting provisions. This will help eliminate problems arising from the differing provisions. Drafting agreements and bylaws with clear and concise provisions that account for the problem areas discussed above will allow the parties to have greater confidence in their actions because their rights and obligations are clearly defined in the contract.

Working Together and Good Faith Actions

102 See Zellers and Poulin, supra note 96, at 68 n.7.
103 Hospital Corp. of Lake Worth v. Romaguera, 511 So. 2d 559, 560 (Fla. 1987).
104 Id.
105 Id.
106 Id.
Once the hospital has decided to terminate a physician's or group of physicians' staff or clinical privileges, there are good faith actions that the hospital can take to support the transition to help avoid a legal battle. First, notice by the hospital to the affected physicians of the hospital's intentions is a step towards a more peaceful transition.\textsuperscript{107} Although any time a hospital moves from a nonexclusive contract to an exclusive contract with the previous credentialed physicians not included, tension will exist regardless of whether the hospital gives notice to the physicians.\textsuperscript{108} The hospital should also have evidence indicating improvements in departments that operate under exclusive groups supporting their decision to enter into an exclusive contract,\textsuperscript{109} and encourage both written and oral comments from those affected by the change.\textsuperscript{110} Finally, a hearing would help finalize any concerns of those interested.\textsuperscript{111}

Even though providing notice and a hearing does help eliminate many problems, the hospital must realize the most difficult aspect of the process for the hospital is telling the physician that although he or she may be doing a fine job, the hospital has decided to terminate their staff privileges due to economic reasons. Ultimately, physicians will seek to limit the economic reasons that hospitals may use to terminate or reduce staff privileges.\textsuperscript{112} Physicians view decisions based on economic criteria alone as improper, because these decisions do not necessarily take into account the quality of patient care.\textsuperscript{113}

The debate over the appropriateness of hospitals using economic criteria for medical staffing decisions has not escaped the attention of legislatures. Illinois has begun studying the situation by requiring hospitals to report every adverse medical staff membership and clinical privilege decision based substantially on economic factors to the Illinois Hospital

\textsuperscript{107} See Zellers and Poulin, supra note 96, at 84.
\textsuperscript{108} Id.
\textsuperscript{109} Id.
\textsuperscript{110} Id.
\textsuperscript{111} Id.
\textsuperscript{112} Howard Larkin and Brian McCormick, The Many Faces of Economic Credentialing, AMERICAN MEDICAL NEWS, July 20, 1992 at 3.
\textsuperscript{113} Id.
The Hospital Licensing Board submitted an initial study to the Illinois Hospital Licensing Board on January 1, 1996. Potentially, the study may support the adoption of legislation that limits the economic reasons a hospital may use for making medical staffing decisions.

To avoid having the legislature decide the issue and further divide physicians and hospitals, in 1992 the California Association of Hospitals and Health Systems (CAHHS) and the California Medical Association (CMA) signed a joint policy statement on exclusive contracting and economic credentialing. Both organizations agreed not to sponsor or support any legislation on credentialing or economic contracting. Furthermore, the organizations agreed that the termination or granting of medical staff privileges based solely on economic criteria unrelated to clinical qualifications, professional responsibilities, or quality of care was inappropriate.

In addition, the two groups initiated a voluntary dispute resolution panel for addressing disagreements between the hospital and its medical staffs. Both the joint statement and the dispute resolution panel are evidence that the groups' have acknowledged the seriousness of curtailing medical staff privileges by exclusive contracting.

While the CAHHS and CMA agreement represents a good faith attempt to avoid the ramifications of having a court or legislature decide the issue for them, their attempts will likely result in merely delaying a decision by both. However, the joint agreement illustrates how hospitals and physicians can work together to avoid lengthy and costly legal battles, and how they can build a commitment toward working together rather than against each other.

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114 210 ILCS 85/10.4(H)(3) (West 1994) "Illinois Hospital Licensing Act"
115 Id.
116 Id.
118 Id.
119 Id.
120 Id.
CONCLUSION

The current atmosphere surrounding medicine, and the economic pressures faced by hospitals, will undoubtedly result in further utilization of exclusive contracting by hospitals to alleviate economic pressures. The decision in Garibaldi indicates that courts will continue to rule inconsistently while addressing the termination and reduction of privileges of staff members when hospitals attempt to enter into exclusive contracts. However, a carefully drafted contract with equally supportive hospital bylaws can give parties greater confidence in knowing their rights and obligations, thus avoiding costly and speculative litigation. Both the physician and the hospital can protect their interests by cautiously drafting agreements and bylaws.