Placing Profits Above Hippocrates: The Hypocrisy of General Service Hospitals

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PLACING PROFITS ABOVE HIPPOCRATES: THE
HYPOCRISY OF GENERAL SERVICE HOSPITALS

Robert Steinbuch*

I. INTRODUCTION

Specialty hospitals focus on a specific medical field—often high dollar fields, such as orthopedics or cardiology.1 These hospitals are often physician owned.2 "The GAO (Government Accountability Office) classified hospitals that met these criteria into five types of specialty hospitals: cardiac, orthopedic, surgical, women's, and other."3 General service hospitals (GSHs), in contrast, are full service entities and are generally non-profit institutions.4 For GSHs, "cases requiring cardiac, orthopedic, or general surgical services are among their most profitable."5 As a consequence of their desire to hold onto their most profitable cases, GSHs—through "[t]he American Hospital Association (AHA) and the Federation of American Hospitals (FAH)[—

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2. Id.


4. Id. at 79.

The GAO also reported that more than ninety percent of the specialty hospitals that have opened since 1990 are for-profit entities, as compared with twenty percent of all general hospitals. Specialty hospitals are much less likely than general hospitals to have emergency departments (forty-five percent vs. ninety-two percent) or to treat Medicaid or uninsured patients. In 2001, specialty hospitals accounted for an estimated $871 million, or one percent, of Medicare’s spending on inpatient services, nearly two-thirds of which went to facilities that treat patients with cardiac disorders

5. Id. at 78.
have begun an aggressive [political] effort to thwart the development of more specialty hospitals” through the use of “economic credentialing” and loyalty oaths. GSHs typically critique specialty hospitals by arguing that (1) the specialty hospitals threaten the viability of GSHs by skimming off revenue-generating cases that finance unprofitable basic services such as emergency room services and (2) specialty hospitals create conflicts of interest when physicians refer patients to their own hospitals for financial reasons. This article considers these arguments and concludes that the anti-competitive tactics utilized by GSHs are against societal interests and medical regulations.

II. THE EFFORTS TO THWART THE GROWTH OF SPECIALTY HOSPITALS

In Little Rock, Arkansas, there are several GSHs; the three most notable are University of Arkansas for Medical Science Hospital, Saint Vincent Health System, and Baptist Medical Center. There are also two outstanding specialty hospitals—the Arkansas Heart Hospital and the Arkansas Surgical Hospital. These specialty hospitals actively compete on the basis that they generally provide better care than that provided at GSHs.

One method that GSHs have adopted to combat the encroachment of specialty hospitals is the concept of “economic credentialing.”

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6. Id. at 83.
7. AAMC REPORTER, supra note 1. (“'The AAMC is concerned that specialty hospitals treat disproportionately low shares of very sick and uninsured and underinsured patients, create conflicts of interest, and negatively impact the revenue centers of teaching hospitals,' said Richard Knapp, executive vice president of the AAMC and head of the office of government relations.”); Sujit Choudhry, Niteesh K. Choudhry & Troyen A. Brennan, Specialty Versus Community Hospitals: What Role For The Law?: A paradox exists in the mixed market/regulatory posture of U.S. health care, HEALTH AFFAIRS:THE POLICY JOURNAL OF THE HEALTH SPHERE, Aug. 9, 2005, available at http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.361/DC1 [hereinafter Choudhry, Specialty Versus Community Hospitals]. “General hospitals warn that specialty hospitals threaten their financial viability and quality of care by reducing the volume of procedures performed in full-service settings.” Id.
8. I have no affiliation with these hospitals. I have served as a Board of Trustees Member on the Society of Chest Pain Centers, which accredited both Saint Vincent's Chest Pain Center and the Arkansas Heart Hospital. If I thought that I was having a heart attack or if I needed orthopedic surgery, I would prefer to go to the Arkansas Heart Hospital or the Arkansas Surgical Hospital, respectively.
9. See, e.g., AAMC REPORTER, supra note 1. (Officials at Houston’s Texas Orthopedic Hospital said specialty hospitals can perform routine orthopedic procedures three times faster than the average general hospital, with an infection rate of less than one percent and high patient satisfaction.)
Although there is no single definition for economic credentialing, the American Medical Association (AMA) has defined it as "the use of economic criteria unrelated to quality of care or professional competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges." The method for credentialing doctors employed by hospitals has evolved over time. "Historically, hospital credentialing decisions have been based almost exclusively on qualitative criteria and a physician's clinical competence." Thereafter, the concept of "economic credentialing" evolved. "[E]conomic credentialing meant that hospitals would assess the insurance coverage of a physician's panel of patients before granting admitting privileges, to limit privileges to physicians caring predominantly for well-insured patients." Recently, economic credentialing has developed further, such that GSHs have denied privileges to doctors who are owners of competing specialty hospitals or who do not agree to refer all patients to the GSH.

GSHs argue that in order to be able to offer essential but unprofitable services, such as an emergency room, obstetrics, pediatrics, and critical care, they need to "protect" their market in highly lucrative practice areas, such as orthopedics and cardiology. As such, GSHs have been known to:

- refuse to grant initial or continuing staff privileges to physicians who own or have other financial interests in competing healthcare entities, refer patients to competing entities, have staff privileges at any other area hospitals, or fail to admit some specified percentage


13. Choudhry, Specialty Versus Community Hospitals, supra note 7.

14. See Jones, supra note 12.

of their patients to the hospital. Alternatively, the hospital might require a physician seeking privileges to sign a loyalty oath or pledge to perform a certain percentage of medical services at the hospital.\(^{16}\)

Given that GSHs complain that specialty hospitals foster conflicts of interest when physicians refer patients to their own hospitals for financial reasons,\(^{17}\) these loyalty oaths are particularly insincere as they result in the very same outcome about which GSHs complain. The difference, however, is that this hypocrisy inures to their benefit.

The AMA has stated its opposition to the use of economic criteria unrelated to patient care to grant privileges:\(^{18}\)

The AMA believes that the practice of conditioning a physician's medical staff privileges on an agreement to refer patients only to that hospital is a violation of the anti-kickback law . . . . Whether called loyalty oaths or conflict of interest policies, the effect is the same. These practices . . . negatively impact a physician's prerogative regarding patient care as well as patient choice.\(^{19}\)

Mahan v. Avera St. Luke's\(^{20}\) challenged this policy of economic credentialing in South Dakota.\(^{21}\) In that case, a hospital refused to credential doctors because they apparently had a competing financial interest.\(^{22}\) The doctors sued the hospital.\(^ {23}\) The South Dakota Supreme Court ruled that the hospital could base its decision to grant or

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16. \textit{Id.}
17. AAMC Reporter, \textit{supra} note 1; Choudhry, \textit{Specialty Versus Community Hospitals, supra} note 7.
18. AMA, \textit{Economic Credentialing, supra} note 11.
19. \textit{Id.}
21. \textit{Id.; Choudhry, Specialty Versus Community Hospitals, supra} note 7. But see Jones, \textit{supra} note 12:

In its 2005 Supplemental Compliance Program Guidance for Hospitals, OIG provides: “Certain medical staff credentialing practices may implicate the anti-kickback statute. For example, conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency, potentially raise substantial risks under the statute. On the other hand, a credentialing policy that categorically refuses privileges to physicians with significant conflicts of interest would not appear to implicate the statute in most situations. Whether a particular credentialing policy runs afoul of the anti-kickback statute would depend on the specific facts and circumstances, including the intent of the parties.”
23. \textit{Id.; Choudhry, Specialty Versus Community Hospitals, supra} note 7.
deny credentials for economic reasons rather than quality of care. The court...recognized that the hospital relied on ‘the profitable neurosurgical services’ in order to be able to continue offering ‘other unprofitable services’ in the...area. The court’s decision seemed informed by the unique economics of hospital financing that require cost-spreading [to] fund[] treatment for uninsured and underinsured patients.”

In Little Rock, the situation of Janet Cathey, a gynecologist, presents a conspicuous example of economic credentialing. For twenty years her medical practice was centered at Baptist Medical Center, Little Rock’s largest hospital. Baptist is the largest healthcare system in Arkansas and is the preferred provider for Arkansas Blue Cross and Blue Shield, the state’s biggest health insurer. Indeed, Baptist is Blue Cross’s only acute care hospital in Little Rock. Cathey’s husband joined a group of Baptist doctors who were opening Arkansas Surgical Hospital. In anticipation of competition from the new Arkansas Surgical Hospital, Baptist established an economic credentialing policy. The policy prohibits doctors “with a direct or indirect financial interest in a competing hospital” from having privileges at Baptist’s hospitals. Indeed, “the policy applies not only to physician investors in such facilities, but also to their immediate family members—with no right to a hearing or appellate review.”

Cathey was informed by Baptist that under the terms of the new conflict-of-interest policy, once Arkansas Surgical Hospital opened, her appointment and clinical privileges at Baptist would be terminated. Thus, as a result of her husband’s involvement in Arkansas Surgical Hospital, Cathey was no longer entitled to admit patients or perform procedures at Baptist. Because most of her patients were

27. Id.
28. Id.
29. Id.
30. Id.
31. Id.
34. Rice, supra note 26.
insured by Arkansas Blue Cross and Blue Shield, Cathey's loss of privileges at Baptist would destroy her practice and deny her patients the choice of care they once had.66 Similarly, Baptist stripped privileges from six cardiologists who are part-owners of Little Rock's Arkansas Heart Hospital.7 Cathey and the cardiologists sued separately.38 The cardiologists were granted an injunction, but, on appeal, the Arkansas Supreme Court remanded the case back to circuit court.39 On remand the circuit court granted an injunction on behalf of the cardiologists, which was appealed. The Arkansas Supreme Court affirmed the injunction.40

Although it is distasteful, the concept of economic credentialing is often found to be financially legitimate and legally permissible in a competitive market as long as hospitals comply with the laws on safety and competition. Hospitals are business entities that can seek to maximize their profits. Much has been written on whether economic credentialing is anti-competitive.41 Assuming that it is not so in all circumstances, which seems to be a conclusion often employed by courts,42 and assuming that hospitals are not compromising the safety

41. See Anne S. Kimbol, The Debate Over Specialty Hospitals: How Physician-Hospital Relationships Have Reached a New Fault Line Over These “Focused Factories,” 38 J. HEALTH L. 633 (2005) (arguing that specialty hospitals are helpful entities and that there should be limits on economic credentialing); Tracy A. Powell, The Permissibility of Conflicts Credentialing (A/K/A Economic Credentialing) by Traditional Hospitals as a Response to the Growth of Specialty Hospitals, 20 No. 1 HEALTH LAWYER 17 (2007) (concluding that laws governing economic credentialing are not settled but that economic credentialing may be legal in some cases); Weeks, supra note 15 (concluding that many of the new forms of economic credentialing violate state and federal antitrust statutes). See generally William E. Berlin, Antitrust Implications Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion, 20 No. 5 HEALTH LAWYER 1 (2008) (detailing recent developments in case law, antitrust legislation, and potential defenses to litigation against economic credentialing); Beverly Cohen, An Examination of the Right of Hospitals to Engage in Economic Credentialing, 77 TEMP. L. REV. 705 (2004) (surveying case law, state law, and federal law and concluding that there are few instances in which economic credentialing is foreclosed).
of their patients—which is best left open for another discussion—hospitals will continue to employ this tool. Businesses will usually not hire employees who are at the same time actively competing with them, and GSHs have successfully argued that the same should be true for hospitals. GSHs have relied upon these laissez-faire arguments to support their economic-credentialing policies.

The difficulty is that GSHs also employ wholly non-competitive arguments in opposing specialty hospitals. As discussed previously, GSHs critique specialty hospitals arguing that (1) the specialty hospitals threaten the viability of GSHs by skimming off revenue-generating cases that finance unprofitable basic services and (2) the specialty hospitals create conflicts of interest when physicians refer patients to their own hospitals for financial reasons. Neither of these arguments seeks to allow the marketplace to solve their concerns—the supposed rationale for allowing economic-credentialing policies. The first argument supports subsidizing unprofitable areas within the hospital through reduced consumer choice—a definitely non-market-based concern. The second basis is an ethical concern that, by implication, seeks to impose non-market-based (i.e., ethical) restrictions on the actions of doctors with financial stakes in specialty hospitals.

Even with economic-credentialing policies, GSHs success in thwarting the growth of specialty hospitals through competition will be impossible. As long as GSHs maintain unprofitable centers, they will lose out against specialty hospitals on a strictly competitive basis. As a consequence, GSHs have resorted to governmental intervention by actively lobbying Congress to extend a ban on the creation of new specialty hospitals. There is no doubt that society needs both the profitable and currently unprofitable groups within GSHs. The question is how to ensure GSHs continued viability. GSHs attempt to do so by running specialty hospitals out of business through competitive and non-competitive devices. The cost of such a proposal is that the generally better care provided at specialty hospitals—for the areas that they cover—will be lost in an effort to subsidize the unprofitable centers at GSHs. That seems wrong.

43. Cohen, supra note 10, at 729 (citing Rosenblum v. Tallahassee Mem'l Reg'l Med. Ctr., No. 91-589, slip. op. at 3 (Cir. Ct. Fla. June 18, 1992)).
44. See, e.g., Mahan, 621 N.W.2d at 156.
45. AAMC Reporter, supra note 1; see supra note 7.
46. Iglehart, Hospitals, supra note 3, at 83.
We should not saddle the owners of specialty hospitals with the responsibility of ensuring that both the profitable and currently unprofitable groups within GSHs survive—particularly as a mere coincidence of the fact they compete with GSHs. The alternatives are to develop a means to make the unprofitable centers profitable and/or to supplement the unprofitable but medically-necessary functions of GSHs. If we choose government intervention to prop up GSHs, society is better served by providing for subsidization rather than squelching healthy competition.

Moreover, as long as GSHs seek extra-competitive, governmental resolution to their concerns, they are profoundly subject to an equal attack. Supporters of specialty hospitals might well suggest that governmental entities and/or private regulating bodies such as the AMA regulate GSHs use of economic credentialing.

Such logic would not be without basis. For example, the AMA "adopted an opinion of the Judicial Council that declared that non-competition agreements were not 'in the public interest.'" The AMA Council on Ethical and Medical Affairs, Code of Medical Ethics states:

9.02 Restrictive Covenants and the Practice of Medicine: Covenants not to compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician.

Even had, as discussed above, the AMA not explicitly opposed the use of economic credentialing, the logic of Section 9.02 would equally speak to the AMA's disapproval of economic credentialing. Thus, before GSHs seek to continue to attack specialty hospitals with their new-found interest in unchecked business practices, they should

keep in mind that they may die by the very sword they have previously employed—non-market regulatory forces.