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Time for a Change in Hospital Governance

The SWJPCCS has been following the case of nine oncologists who filed a lawsuit against the Anne Arundel Medical Center (AAMC), in Annapolis, Maryland, last year (1). The oncologists claimed that the hospital chose profit over the needs of cancer patients, as it slashed oncology care services to cut costs, and both fired and denied them hospital privileges when they complained. At that time, the oncologists were not free to respond because of the ongoing litigation, but now that the lawsuit is over and the dust has settled, they are free to speak, and they contacted Medscape Medical News to tell their side of the story (2).

AAMC is a private, not-for-profit corporation that operates a large acute care hospital in Annapolis, Maryland. It is affiliated with Luminis Health, the parent company of the medical center. Until October 23, 2020, the nine oncologists were employed by the Anne Arundel Physician Group. The oncologists had privileges at AAMC for many years and their "capability as physicians is unquestioned," according to the court filing made on behalf of the oncologists." AAMC created "a very toxic and difficult interpersonal work environment, and that made it difficult to do patient care," said Carol Tweed MD, who served as the unofficial spokesman for the group. "We would go to them and let them know that we were having difficulty delivering optimal patient care because we didn't have enough staff or the resources we needed for safety — and it got to the point where we were being ignored and our input was no longer welcome." There was a continuing cascade of events, and the oncology group mulled over some ideas as to how to provide optimal patient care. The decision they reached was to discuss running their own practice. Within a week of sending their proposal for setting up their own practice, all nine physicians were fired. "Instead of arranging a discussion, we received termination letters," "We were terminated without cause."

The oncologists' case illustrates several problems with hospital ownership of physician practices. First, the oncologists had signed a contract with a noncompete clause. "The only thing we wanted was to be able to practice in this town," said Tweed. "And what is important to know is that it was never for money, and that was never our motivation for wanting to form our own practice." The second problem is that AAMC removed the oncologist's hospital privileges. Removal of hospital privileges carries a special stigma making it difficult to apply for hospital privileges at other hospitals.

It disturbs me that physicians or physician executives would want to practice and patients would want care from a system where quality of care was alleged to be an issue. That aside, it is clear that the hospital used its position as the credentialing agent to limit competition and solicit patients. "This isn't ethical, but they tried to do everything to

keep us from seeing our patients," Tweed said. This is patient choice, but they were telling patients they could not choose us as your doctors.

Below are several solutions which could potentially improve the credentialing process and allow the oncologists and other physicians to practice high quality medicine.

1. Physician candidates should have their contract negotiated by a lawyer or agent experienced in the appropriate areas of labor law. Candidates should not sign a contract with a noncompete clause. Even though such a clause is unlikely to hold up in court, the process of fighting a large healthcare organization is expensive and medical centers have deeper pockets. The hospital administration is not necessarily a physician ally. Even if the administration is easy to work with at present, hospital administrations change and the next administration might be more concerned with profit than quality of care.
2. Credentialing should be a function of an independent medical staff overseen by an elected chief of staff. Mitchell Schwartz, MD was chief medical officer at AAMC until January 2020 and succeeded by Stephen Selinger MD in May 2021. It is unclear what role Dr. Swartz or Selinger played in this dispute. Physician candidates should be wary if the chief of staff seems to represent the hospital administration to the physicians rather than the hospital staff to the administration. Potential physician candidates should request meetings with the chief of staff to assess for themselves their sincerity in working with the medical staff.
3. An independent hospital staff could vote to require administrators to be credentialed. An administrator's credentials could be removed by a majority physician vote if there is extensive evidence that business decisions jeopardize patient safety. It seems likely that administrators would be less likely to use credentialing as a weapon when credentialing is counterbalanced in this fashion.
4. Physicians witnessing suboptimal patient care in the face of a nonresponsive hospital administration, could use their power as physicians to advise their patients to seek care elsewhere. I personally have seen such a nuclear option lead to hospital closure if sufficient physicians believe the hospital care is inadequate.
5. Healthcare credentialing agencies could become more responsive to physician complaints. This could avoid confusing evaluations such as the Phoenix VA being named to the Joint Commission of Healthcare Organization's "Top Performer" honor in 2011 but 3 years later being accused of suboptimal care (4). JCAHO inspections usually are conducted by a retired hospital administrator, physician and nurse. They usually review policies and procedures but rarely meet with physicians, nurses, technicians or clerks directly involved in patient care.
6. State Board of Medical Examiners should concern themselves with quality of care rather than disruptive physicians. In some cases, disruptive physicians advocating for better care are likely justified (4).
7. Insurers, including the Centers for Medicare and Medicaid Services, could remove the incentive for hospitals to own practices by limiting payments to centers with hospital-employed physicians. These centers have charges that average about

5.8 percent higher than those that do not employ their physicians (5).

These are just a few ideas many of which will be difficult to establish. Regardless, it is time to discard the notion that physicians are just waiting to collude and fix prices but to recognize that hospital administrators have self-granted themselves too much power leading to increased charges and poorer patient care. The time for change in hospital governance is now!

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