



# **The Great Divorce: When Hospitals Use Economic Grounds to Deny or Curtail Medical Staff Privileges**

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## **Abstract**

Hospitals worldwide face ongoing challenges in determining whether individual physicians should be credentialed to practice medicine within hospitals or otherwise and to what extent clinical privileges should be granted. In the USA model, clinical privileges in a hospital can be lost due to poor clinical performance with patients, usually as determined in a peer-review process. In addition, clinical privileges can occasionally be lost due to non-clinical reasons, such as the physician's noncompliance with organizational rules or violating civil and/or criminal laws. Economic factors can bring the curtailment or denial of hospital privileges, such as with the completion of a contract term with a group practice or the facility, and where the hospital seeks to protect itself from unfair competition by medical staff with the hospital's business interests. These latter conditions are often referred to as "economic credentialing," something that the American Medical Association categorically condemns. Gaining and maintaining hospital clinical privileges are usually critical to the professional and economic well-being of the physician. As such, a physician who has lost privileges frequently challenges the adverse decision within the hospital medical staff's internal appeals process and then through the court system, if necessary. In countries with co-existing public and private insurance systems that pay providers more in the private model, including Germany, Switzerland, and the United States, a form of "cream skimming" occurs, leading to easier access for the more affluent patients. The authors employed qualitative legal research in this study, presenting broader implications and solutions as policy recommendations to balance the rights, needs, and goals of physicians, hospitals, and the local communities whose medical needs are being served.

**Keywords:** clinical privileges; economic credentialing; litigation; medical peer review; physician credentialing

## **Dedication**

This paper is dedicated to healthcare providers worldwide, their healthcare managers, and their staff support professionals, who go to work daily and give their best efforts to serve those needing care, advice, diagnosis, and treatment. This paper is dedicated in gratitude to caregivers who work in challenging situations yet fend off cynicism and persevere in environments where time constraints, resource challenges, and a chronic lack of appreciation may often seem the norm.

## **1. Introduction**

The monitoring of physicians' practices is a concern that relates to the safety of the public at large as well as to the cultivation of standards for various kinds of medical practitioners. The World Health Organization (WHO) in 2024 published its first global guidance on the regulation of health practitioners entitled *Health Practitioner Regulation: Design, Reform, and Implementation Guidance*, emphasizing Standards and Qualifications - ensuring professionals meet training and competency criteria before serving patients; Continuous Competency and Professional Development - encouraging ongoing education to keep practitioners' skills current with medical advancements and best practices; and Accountability and Misconduct - including methods for reporting and responding to malpractice (Institute for Healthy Urban Living, 2024). In the United States of America, the licensure of medical practices is essentially a matter of state (and not federal) jurisdiction (Federation of State Medical Boards, 2025).

This research article discusses a current healthcare management and delivery issue related to using "economic credentialing" to determine physician privileges in hospitals. In a highly competitive market that includes complex and costly facilities and staffing, hospitals have experienced multiple new challenges, such as when physicians establish competing organizations and/or facilities that directly compete for patients and resources or when the hospital does not reinstate contracts with employed physicians or independent physician groups because of changing needs and the competitive environment. When this occurs, hospitals have turned to using economic credentialing to deny or curtail hospital privileges to physicians, resulting in a myriad of legal challenges and resulting in a dynamic tension between organized medicine (represented by the American Medical Association, or AMA) and the hospital industry (represented by the American Hospital Association, or AHA).

### **1.1 Qualitative Legal and Health Administration Research Methodology**

To understand the scope, implications, and outcomes of this complex predicament, the authors pursued research in legal and health administration using Westlaw and PubMed databases, searching for relevant articles with the search terms "economic credentialing," "clinical privileges," "litigation," "medical peer review," and "physician credentialing." The research findings were grouped by (1) topics including basic definitions and explanations of terms, (2) articles discussing critical aspects and conflicting views on economic credentialing, and (3) legal case reports. These materials were reviewed and analyzed to consider the impact (positive and negative) of economic credentialing on physician practices, hospital and healthcare management, and public health implications and consequences.

### **1.2 Statement of Key Research Questions**

The following research questions guide this study:

1. How do hospitals justify the use of economic credentialing in limiting or denying medical staff privileges, and what are the legal frameworks that support or challenge such practices?
2. What are the ethical and professional implications of economic credentialing for physicians, patients, and hospital governance?

3. In what ways do state and international variations in law and policy affect the legitimacy and outcomes of economic credentialing?

4. How does economic credentialing intersect with broader healthcare challenges, such as rural hospital closures, physician employment trends, and inequities in patient access to care?

5. What policy approaches might balance the financial stability of hospitals with the professional rights of physicians and the healthcare needs of local communities?

## **2. Terminology Matters: Licensure, Board Certification, Credentialing, Privileging, and Enrollment**

### **2.1 Medical Licensure and Oversight of Physicians in the USA**

Medical licensure is the foundational mechanism for oversight and regulatory control over physicians' practice in the United States. It ensures that all practicing physicians meet a standardized level of education, training, and ethical conduct necessary for patient care. The licensure process is designed to protect public health by confirming that physicians have the requisite medical knowledge, clinical skills, and professional judgment to practice safely.

Medical students in the United States can pursue two primary educational tracks: **Allopathic Medicine (MD – Medical Doctor)** Allopathic medical school students follow a curriculum emphasizing biomedical sciences, clinical skills, and research. The training follows a traditional scientific approach to diagnosing and treating diseases, typically using pharmacological and surgical interventions (Association of American Medical Colleges, 2023).

**Osteopathic Medicine (DO – Doctor of Osteopathy)** Osteopathic medical education follows a similar curriculum to allopathic programs but incorporates an additional focus on osteopathic manipulative treatment (OMT), a hands-on approach to diagnosing and treating musculoskeletal conditions. Osteopathic medicine emphasizes a holistic approach to patient care, considering the interrelationship of the body's systems (American Osteopathic Association, 2023).

MD and DO programs require four years of medical education, typically divided into preclinical (basic sciences) and clinical (patient care) training phases. Through its structured education, examination, and residency requirements, medical licensure ensures the competency and oversight of practicing physicians in the USA. It serves as the first line of regulatory control, while residency and board certification further verify expertise in specific medical specialties.

### **2.2 Residency and Board Certification**

Following medical school, graduates seeking board certification must complete a residency program in their chosen specialty, typically lasting between three and seven years, depending on the field (e.g., family medicine, internal medicine, general surgery, neurosurgery). Residency training occurs under supervision in accredited hospitals and medical centers.

Board certification is not required for medical licensure but is often necessary for hospital privileges and employment. The two principal certifying bodies are:

**American Board of Medical Specialties (ABMS)** – Certifies MD and DO physicians in 24 recognized specialties.

**American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS)** – Provides specialty certification for DOs.

A more significant proportion of newly graduated physicians seek a residency and board certification. As of June 30, 2024, 997,864 physicians and medical specialists were actively certified by an American Board of Medical Specialties (ABMS) Member Board (American Board of Medical Specialties, 2024). According to the Association of American Medical Colleges (AAMC), there were 1,010,892 active physicians in the United States in 2023 (Association of American Medical Colleges, 2024). From this data, approximately 97% of active physicians in the United States are ABMS board-certified.

As a percentage, however, this number is beginning to drop. Despite a growing number of medical schools and medical graduates in the USA, the expansion of residency positions has not kept pace, and over 2,500 applicants did not "match" with a residency program in 2023 (Bernard, 2023). Securing a residency position after medical school is widely regarded as the "gold standard" for new physicians, serving as a crucial step in their professional development. However, the United States is experiencing a growing disparity between the increasing number of medical school graduates and the comparatively limited availability of residency program positions.

## **2.3 Verification of Credentials, Granting of Privileges, and Enrolling in Health Insurance Plans**

The third level of oversight and monitoring of clinical skills occurs for physicians in the United States interested in practicing at one or more hospitals and/or being accepted as a medical care provider on a health insurance company's medical panel. Credentialing and privileging in the USA apply to primary care physicians and surgical specialists. While credentialing processes exist in various forms worldwide, the specific practices of hospital credentialing and insurance paneling, as implemented in the United States, differ from those in other countries. In some healthcare systems, especially those with universal healthcare coverage, the processes for physician credentialing and integration into hospital systems and insurance networks may be centralized or standardized at a national level. In the United Kingdom, for example, physicians can practice medicine in any healthcare institute in the UK after registering with the General Medical Council. In addition, if the physician is a foreign medical graduate, the additional passing of the Professional and Linguistic Assessment Board test is required (Edwards, 2025).

**2.3.1 Credentialing** is the first part of the institutional process in which a physician's background is checked and verified. Hospital credentialing is a comprehensive process that verifies a physician's qualifications to ensure they meet the necessary standards for providing medical care within a hospital setting (Vital Health Services, 2025). The key components of this process typically include:

- **Verification of Education and Training:** Confirming the physician's medical school education, residency, and any specialized training.
- **Licensure Verification:** Ensuring the physician holds a valid and current medical license in the state where the hospital operates.
- **Board Certification:** Reviewing certifications from recognized medical boards relevant to the physician's specialty.
- **Work History and Experience:** Assessing the physician's employment history, clinical experience, and any gaps in practice.
- **Professional References:** Obtaining evaluations from peers or supervisors regarding the physician's clinical competence and professional conduct.
- **Malpractice History:** Reviewing any past medical malpractice claims or settlements involving the physician.

- **National Practitioner Data Bank (NPDB) Query:** Conducting a query of the NPDB to identify any reports of medical malpractice payments, adverse licensure actions, or other relevant issues.
- **Criminal Background Check:** Performing checks to identify any criminal history that could impact the physician's ability to practice safely.
- **Malpractice Insurance Coverage:** Verifying that the physician maintains current and adequate malpractice insurance coverage, as required by the hospital's policies.

**2.3.2 Privileging** is the second part of the institutional process, often using levels of peer review through physicians already on staff. This process typically focuses on the physician's scope of practice that is related explicitly to patient care. Different types of privileges can be extended to a physician by a hospital (Wood, 2023). These privileges can include:

**Admitting Privileges** – sometimes called "active privileges," allows the physician to admit their patients directly to the hospital and follow them during their inpatient stays.

**Courtesy Privileges** – allows the physician to treat hospital inpatients or occasionally admit patients to the hospital.

**Clinical and Surgical Privileges** – allows the physician to perform outpatient procedures or inpatient operating room surgeries, including the performance of a wide range of clinical procedures such as colonoscopy, cesarean delivery, angioplasty, endoscopy, radiologic interpretation, and so forth.

Privileging is required by hospital accreditation bodies such as The Joint Commission and The National Committee for Quality Assurance and governmental insurance bodies such as Medicare (federal-level insurance coverage for the elderly) and Medicaid (state-level insurance coverage for the indigent). In addition to hospitals, almost every healthcare facility, urgent care clinic, and long-term care facility requires credentialing and privileging, and physicians can expect to go through these processes every few years (Nabity, 2022).

**2.3.3 Enrolling In Health Insurance Plans** must occur next for the physician to be considered for inclusion in the insurance company's network of providers. This allows the physician to provide medical services and to bill for care rendered to the patient/members of the insurance plan. The health insurance plan may or may not accept the credentialing and privileging decisions made by the hospital regarding the physician.

## **2.4 The Role of Medical Staff Bylaws in Hospitals**

Medical staff bylaws are essential documents that establish the framework for governance, delineate responsibilities, and protect the rights of medical staff members within healthcare institutions, such as when a physician's medical credentials or privileges are in question (The Joint Commission, 2017). The bylaws serve multiple critical functions, including:

**2.4.1 Defining Governance Structures:** Bylaws outline the organization of the medical staff, detailing roles, responsibilities, and the hierarchy of leadership positions. This ensures a clear understanding of the medical staff's self-governance and accountability mechanisms.

**2.4.2 Establishing Membership Qualifications and Privileges:** Bylaws specify the criteria for medical staff membership and delineate the process for granting clinical privileges. This includes qualifications, credentialing procedures, and the scope of practice permitted within the institution.

**2.4.3 Outlining Decision-Making and Conflict Resolution Processes:** Bylaws provide structured methods for decision-making and mechanisms for resolving conflicts within the

medical staff. This ensures that disputes are managed fairly and consistently, promoting a collaborative working environment.

**2.4.4 Detailing Due Process and Disciplinary Actions:** Bylaws describe procedures for investigations, corrective actions, hearings, and appeals. This framework protects the rights of medical staff members by ensuring due process in cases where disputes arise or when privileges may be restricted or revoked.

**2.4.5 Specifying Meeting Attendance and Participation Requirements:** Bylaws often set expectations for medical staff meeting attendance and participation, fostering active engagement in governance and decision-making processes.

By encompassing these elements, medical staff bylaws function as comprehensive guides intended to uphold the integrity, accountability, and quality of care within the hospital.

## **2.5 Curtailing or Revoking Medical Staff Privileges – Legal Implications**

Physicians' credentials and privileges can be curtailed or revoked due to factors such as providing poor quality care or accumulating multiple malpractice suits. This process is integral to maintaining patient safety and upholding healthcare standards. The Health Care Quality Improvement Act (HCQIA) of 1986 offers legal immunity to those involved in peer review activities, encouraging the denial of medical staff appointments or privileges when necessary to uphold care standards (Laws, 2021). Hospitals can be liable for negligent credentialing if they grant privileges to physicians who provide substandard care. This liability underscores the importance of thorough credentialing processes to ensure patient safety (Rymarski & Angotti, 2016). These measures are essential to ensure that healthcare providers maintain the highest standards of care, thereby protecting patient well-being and maintaining public trust in medical institutions.

There are various legal theories under which a physician can bring a lawsuit against the hospital that seeks to deny or curtail privileges, including:

**2.5.1 Breach of Contract Claims:** Physicians may argue that the hospital violated its own bylaws or contractual agreements. Courts have recognized that while hospital bylaws alone may not constitute a contract, hospitals must generally adhere to their established procedures (*James B. Hurwitz, M.D. v. AHS Hospital Corp.*, 2014).

**2.5.2 Due Process Violations:** Physicians might claim that the hospital denied them fair procedures, such as adequate notice or a hearing, before restricting their privileges. The Health Care Quality Improvement Act (HCQIA) outlines standards for professional review actions, emphasizing fairness and due process (McKoy, 2004).

**2.5.3 Antitrust Actions:** If a physician believes the denial of privileges was intended to limit competition, they may pursue antitrust claims. Denying privileges based solely on economic factors can expose hospitals to liability under federal antitrust laws (O'Brien, 2010).

**2.5.4 Defamation Claims:** Physicians may allege that false statements made during the credentialing or peer review process damaged their reputation, leading to defamation lawsuits (McKoy, 2004).

**2.5.5 Civil Rights Violations:** If the denial is based on discriminatory factors such as race, gender, or religion, physicians can file claims under civil rights statutes (Levy, 2008).

**2.5.6 Tortious Interference:** Physicians might claim that the hospital unlawfully interfered with their ability to practice medicine or maintain patient relationships (*James B. Hurwitz, M.D. v. AHS Hospital Corp.*, 2014).

These legal avenues highlight the complex interplay between hospital administration and medical staff rights, emphasizing the importance of fair and transparent privileging processes.

### 3. Economic Credentialing by Hospitals

Economic credentialing refers to the practice of evaluating physicians for hospital privileges based on economic factors unrelated to their quality of care or professional competence. This section addresses Research Question 1 by examining how hospitals justify economic credentialing, and Research Question 2 by exploring its ethical and professional implications. Organized medicine, represented by the American Medical Association (AMA), and the hospital industry, represented by the American Hospital Association (AHA), hold differing positions on this practice.

The 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 hospital medical staff membership or privileges." The association's board of trustees strongly opposes this practice, asserting that credentialing decisions should be based solely on a physician's qualifications, competence, and quality of care rather than economic factors (AMA Policy Finder, 2020).

The American Hospital Association has no similar policy position on this matter. In fact, the majority of hospitals in the USA engage in a form of economic credentialing that has been settled in the courts for several decades now, the requirement by hospitals that physicians carry at least a minimum amount of malpractice insurance coverage as a condition of being credentialed on the hospital's medical staff. Hospitals vary widely in how they work with doctors to constrain costs, adhere to utilization management processes, and employ case management techniques. Physicians' practice patterns with their patients can put the hospital in a precarious financial situation. The point has been raised in recent years that it may be time for hospitals to expand the credentialing process universally to include *cost-effectiveness* in what is considered in reviewing the competence of physicians.

*Failure to do so contributes to the runaway healthcare costs that threaten so much of what we hold dear...Of note, this issue causes few problems when physicians share ownership of a hospital or ASC (ambulatory surgical center). If it's their own money at stake, they don't hesitate to "kick out" a fellow physician who does not act as a responsible steward of their shared resources. Is the day near when a similar decision will be made by a self-governed medical staff on behalf of a hospital? (Sheff, 2012)*

#### 3.1 Direct Financial Competition to the Hospital by Members of the Hospital's Medical Staff

In the typical situation involving community hospitals and independent physicians on the medical staff, the attending physician (and the other consulting physicians) bill the patient's health insurance company *professional fees* for services personally rendered to the patient. The hospital likewise bills the patient's insurance company the *facility fees* for everything else related to the episode of care for that patient. It is usually a symbiotic economic relationship between the hospital and the physicians, generating fees for the different components of care rendered to patients.

The symbiotic balance can be radically altered when physicians invest financially in developing a competing facility and then engage in "cream skimming," the practice of treating more affluent patients or patients with better-paying insurance plans at the competing facility and treating poorer or underinsured (including Medicaid – the government-sponsored coverage for the indigent) patients at the community hospital – to the financial detriment of the hospital

(Squire Sanders, 2009). To combat this, hospitals have developed a sort of “loyalty oath” in the credentialing and privileging processes, requiring doctors to divulge personal financial investments in competing facilities (hospitals, imaging centers, ambulatory surgery centers, etc.). Further, the hospitals sometimes condition the physicians’ privileges on an agreement that the physicians do not use the competing facilities if the same procedures can be performed at the hospital or to limit the use of the competing facilities to a designated percentage of the physicians’ patient cases (Showalter & Sanford, 2023).

All fifty states in the USA and the District of Columbia represent separate jurisdictions, and state legislators and courts in these jurisdictions have gone in different directions regarding the legality of hospital economic credentialing. These variations in state law provide insight into Research Question 3, highlighting the diversity of legal frameworks across jurisdictions. In states that have allowed economic credentialing in some form, a key factor often has been whether the hospital’s financial viability would be at risk without these restrictions (O’Brien, 2010). The law is far from settled as related to the form that economic credentialing occurs related to the competitive interests of the physicians, even in states that have “tilted” in one direction or the other on this matter, mainly because there are a wide range of factors and variables in these situations that make for unique situations. Jurisdictions such as Florida, Georgia, Indiana, Iowa, and New York have enacted laws permissive of economic credentialing, while states such as California, Colorado, Texas, Louisiana, and Virginia lean toward prohibiting economic credentialing (Powell, 2007).

### **3.2 “Cream Skimming” in Europe and the United States**

Interestingly, the practice of “cream skimming” in one form or another can be found in the healthcare delivery systems of various countries. German and American researchers in a fascinating study demonstrated that countries including Germany and Switzerland, which have co-existing insurance systems that pay providers differently (similar to the United States with typically higher provider payment from commercial insurance as compared to lower Medicaid payment for caring for indigent patients), could be shown to have easier access for the more affluent patients (Werbeck, Wübker, & Ziebarth, 2021). The authors indicated a two-tier system exists in Germany, and the private insurance outpatient payments to medical specialists are typically twice as much or more than those for patients on public insurance plans. Because of financial incentives to favor privately insured patients, the authors reported that in the study, “the same hypothetical patient followed standardized protocols and called almost one thousand private practices in 36 German counties to schedule allergy tests, hearing tests, and gastroscopies. Privately insured callers were 7 percent more likely to be offered an appointment, while publicly insured callers had to wait twice as long for an appointment.” This comparative perspective further informs Research Question 3, illustrating how international policy contexts shape healthcare access.

### **3.3 Hospitals Employing Physicians**

Profound trends in recent years in the healthcare field of the United States have directly and indirectly impacted the credentialing and privileging of doctors in hospitals. First, between 2012 and 2022, the share of physicians who work in private practices decreased by 13 percentage points from 60.1% to 46.7%. There has been a redistribution of physicians from small to large practices. The percentage of physicians in practices with 10 or fewer physicians fell from 61.4% in 2012 to 51.8% in 2022, and the percentage of physicians in practices with 50 or more physicians grew from 12.2% to 18.3% (AMA Research, 2024). Second, physicians are choosing to be employed by hospitals and hospital systems in greater numbers than ever, with over 77% of doctors employed today and 68% of final-year residents expressing a preference for hospital employment (Dailey, 2024). Third, hospitals, especially rural hospitals,



face unprecedented financial challenges, and many are permanently closing their doors. From 2010 to 2021, there were 136 rural hospital closures in the United States (Lopez, 2024), and another 700 rural hospitals, about one out of three, are at severe risk of financial failure (Southwick, 2024). Fourth, it is more challenging than ever after the COVID-19 pandemic to recruit physicians for non-urban opportunities, with a less than 1% likelihood that a new physician would accept a rural position, compared to a 3.4% likelihood before the pandemic (Mathewes, 2025). Fifth, approximately 20% of the active physicians in the United States are practicing in “hospital-based” specialties, which include radiology, pathology, anesthesiology, emergency medicine, critical care medicine, and more recently, as “hospitalists” who follow the care of inpatients but not outpatients (Dennen & Krivopal, 2024).

In recent years, two significant contractual terms have become prevalent in hospital-physician employment agreements: noncompete clauses and co-terminus clauses. Understanding these contractual terms is crucial for physicians to effectively navigate their employment agreements and safeguard their professional practice rights.

**Noncompete Clauses:** These provisions restrict physicians from practicing within a specified geographic area for a certain period after leaving an employer. While intended to protect the employer's business interests, they have raised concerns about limiting patient access to care and hindering physicians' career mobility. The American Medical Association (AMA) has adopted policies opposing noncompete contracts for physicians in clinical practice employed by hospitals or staffing company employers (Robeznieks, 2023).

**Co-terminus Clauses:** These clauses link the duration of a physician's clinical privileges directly to their employment status. If the employment contract is terminated, the physician's clinical privileges are automatically revoked. This arrangement can have significant implications for a physician's ability to practice independently within the hospital. It's crucial for physicians to be aware of such provisions, as their inclusion can impact the continuation of clinical privileges post-employment (Credentialing Resource Center, 2019).

These findings align with Research Question 4, demonstrating how economic credentialing intersects with evolving physician employment models and rural health vulnerabilities.

#### **4. Broader Implications: Rural Hospitals in Financial Peril and Attendant Challenges to Patient Care Quality**

Many rural hospitals are financially vulnerable and at risk of closure. More than 20% of rural hospitals in the United States are at risk of ceasing operations. In states like Alabama, Georgia, and Mississippi, that number increases to over 40% - even as the reality exists that nearly two-thirds of the country's at-risk hospitals are considered essential to their communities (Barone, 2020). According to an analysis by the National Bureau of Economic Research, rural hospital closures increase inpatient mortality by 8.7% for time-sensitive conditions such as heart attacks, asthma, and strokes (Gujral & Basu, 2020). Studies have demonstrated that financially distressed hospitals deliver a lower level of patient care quality, face higher rates of safety events and readmissions, and score lower on patient satisfaction measures (Akinleye, McNutt, Lazariu, & McLaughlin, 2019). This evidence links directly to Research Question 4, emphasizing the intersection between hospital financial distress, patient outcomes, and the use of economic credentialing.

#### **5. Toward a Solution: Economic Credentialing by Hospitals to Stave Off Predatory Financial Actions by Members of the Medical Staff**

This section addresses Research Question 5 by proposing policy approaches intended to balance hospital sustainability, physician rights, and community healthcare needs. This article

recommends that all jurisdictions within the United States permit economic credentialing of physicians by rural hospitals and facilities that are financially strained due to a disproportionately high patient population of uninsured, underinsured, and Medicaid recipients. This can serve as a crucial means for hospitals to safeguard against predatory “cream-skimming” by, for example, surgeons on the medical staff diverting only the fully insured patients to their proprietary outpatient surgical facility. Economic credentialing will likewise help the hospital to maintain a balanced mix of patients, thereby improving revenues, preserving quality, and stabilizing operations.

The South Dakota Supreme Court, in a significant decision, ruled that a hospital board has the authority to make administrative decisions to protect its financial stability, even over the interpreted rights of physicians as outlined in the medical staff bylaws. That is, in this situation, the hospital board can close admission to the medical staff of a specific specialty to favor an arrangement with a particular group of specialist physicians, especially when the excluded doctors were co-owners of a facility in competition with the hospital. The court indicated: “How can a doctor who is a part owner of the for-profit OSS be expected to fulfill his or her duties towards his or her co-owners and in the same instance fulfill the duties towards the principal, ASL, who is a not for profit hospital?” And a bit further: “We have often stated that an agent cannot serve two masters. This rule applies to medical professionals as well” (*Mahan v. Avera St. Luke’s*, 2001).

### **Conclusion: Interests Must be Balanced for Hospitals, Physicians, and the Communities Served**

As it pertains to the credentialing and privileging of physicians, including economic credentialing, the authors recommend the following principles to aid in the goal of balancing the interests of hospitals, physicians, and the needs of the community:

- It must be kept in the forefront that the needs of society and the local community are carefully considered when expanding or limiting medical privileges.
- Rural hospitals should be protected to the greatest degree possible to ensure that primary care, emergency services, obstetrics, and general surgery capabilities remain available.
- The medical peer review process must be safeguarded to ensure fair and bias-free determinations.
- The medical staff bylaws should require its physicians to maintain medical malpractice insurance and cost-effective clinical practice behaviors.
- Courts should construe liberally in favor of the physician when interpreting the extent of enforcement of noncompete and co-terminus clauses in hospital-physician employment agreements, especially when the outcome would be the continuation of needed medical skills in the local community.
- Hospitals should retain the open medical staff model with careful protections for physicians to receive due process and the right to a hearing when privileges are at risk.
- The financial survivability of the local hospital must be considered when determining what forms of economic credentialing should be allowed, especially when medical staff members would engage in “cream skimming” of the more affluent or better-insured patients, to the financial detriment of the hospital.

Taken together, the study’s findings respond to all five research questions, clarifying the legal, ethical, and policy dimensions of economic credentialing and providing guidance for future reforms. When considering policies that affect hospitals, their physicians, and the members of

society they serve, it would be prudent for governments and organizations to keep the words of Jana Kingsford in mind:

*Balance is not something you find; it's something you create.*

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