PHYSICIAN-HOSPITAL RELATIONS: THE ROLE OF STAFF PRIVILEGES

JAMES E. LUDLAM*

INTRODUCTION

The continual changes and conflicts in the relationships between physicians and hospitals are almost psychedelic. At one moment they make sweet music, only to degenerate abruptly into a cacophony of sound and light.

The changes are the result of a widely varied series of pressures not only upon the individual physicians and hospitals but affecting the entire system of health care. Many people and organizations—big government, big business, big labor, and the entire spectrum of varied interest groups—have ideas and commitments as to how the system should be reorganized—or revolutionized—to meet future needs. A central contact point of these pressures is found in the interrelationships between, on the one hand, the hospital and the physician, forming an essential partnership ingredient in the provision of health care, and, on the other hand, government, third-party payers, consumer representatives, and other purchasers of health care.

To the individual physician, the hospital may at successive moments represent his protection or a threat to his professional existence. To further complicate matters, when we refer to the hospital we may be referring to many quite different items. In one context it is an imposing structure of bricks and mortar; in another it is a teeming organism of nurses, aides, technicians, and volunteers, all overwhelming a defenseless patient; in still another it may be a governing board acting in the dark reaches of a paneled room, or an administrator thundering—or quivering—behind an oaken desk, or a medical staff consisting of a so-called organization of unorganizable individuals. To the legislature it is an entity responsible for the ever-accelerating cost increases that put budgets out of balance. To many it is to be the center for all health care delivery, organized under the concept of a Health Center or a Health Maintenance Organization.

Although the term *hospital* is used in so many ways, we will use it interchangeably regardless of the context. For example, when discussing medical staff privileges we may be using the term primarily as a reference to the medical staff organization—but only until such time as the issue becomes an issue for the governing board. Needless to say, for those who would damn hospitals as being inflexible, inefficient, and ineffective, one must assume that they are referring to all of the components.

This article is not intended as a legalistic treatise on the subject of physician-

* A.B. 1936, Stanford University; LL.B. 1939, Harvard University. Member, Musick, Peeler & Garrett, Los Angeles, California.

hospital relations but rather as an attempt to delineate current trends and cross-currents in physician-hospital relationships and then, from both objective and subjective viewpoints, to suggest patterns for the future. The opinions expressed, except as specifically credited, must be taken as the writer's own, based upon his thirty-one years of experience as a lawyer working with hospitals and hospital organizations.

The rapid changes that are occurring and the complexity of the inner and outside forces currently being brought to bear makes a critical view of the relationships between hospitals and physicians particularly appropriate at present. These problems may range from petty aggravations to major social and economic changes affecting the United States health care industry—which is now accepted as second only to the defense industry in size. And the general hospital and its physicians are the present focal point for change—or opposition to change.

Five years ago, if we were to define the major problem areas involved in physician-hospital relationships, we could have run down the list quite quickly, and none of the items would have been earthshaking. It would have included membership on medical staffs, malpractice and related problems, representation on hospital governing boards, specialist contracts, the question of doctor-owned hospitals, and the national level, there was conflict over the extent to which government involvethe rules of the Joint Commission on Accreditation of Hospitals (JCAH). And, at ment in the provision of health care for the aged was needed.

Now and for the future we see all of the above-listed problems continuing as well as the emergence of such new issues as the restructuring of the health delivery system, government payment for health care on a massive basis, requirements of due process in professional relations, legal recognition of the institutional responsibility for the quality of professional care in the hospital, comprehensive health planning, franchising of hospitals, public ownership of hospital chains, professional corporations, and demands for consumer involvement.

I

PHYSICIAN-HOSPITAL TRENDS

A. The Governing Body

Interestingly enough, the increasing impact of outside forces has brought about a recognition by hospitals and physicians of common interests at both the institutional level and the association level that bodes well for future problem-solving in this area. For example, there has been a dramatic shift in the attitude of hospital representatives on the related questions of the involvement of doctors in the management of hospitals and their service on hospital governing boards. Traditionally, the American Hospital Association and hospital leadership held the view that there would be a disqualifying conflict of interest if a representative of the medical staff were per-

mitted to serve on a hospital's governing board. As time proved, the conflict of interest issue rarely arose in actual practice and could be handled in the same way a conflict of interest of any other board member could be handled—simply by having the individual with such a conflict not vote on the issue affected. Indeed, long years of experience with hospital boards indicates that there are rarely split votes, making an occasional disqualification to vote meaningless.

The importance of medical staff representation on the governing board essentially involves the need for establishing two-way communication on a direct basis. Each group must have the opportunity to be heard by the other group, and each group must consider the other's viewpoint on particular issues which arise. Moreover, the need to have available the knowledge, experience, and even the influence of the other group in problem-solving cannot be overstated. Finally, and perhaps most importantly, the groups must consider the possible misunderstanding and mutual distrust which a failure to communicate might engender.

Structuarlly, the Joint Conference Committee, a top-level group whose membership is divided equally between the medical staff and the governing board, was developed by the JCAH as a mechanism to solve this problem. In many hospitals it was most effective, but in far more it became a paper tiger—developed to meet JCAH standards—which totally failed. Meeting at infrequent intervals, it never developed into a complete line of communication, and, since it had no authority, it became more of a social gathering than a business conference. Problems simply do not arise on a quarterly or semiannual basis, and the result was that the Joint Conference Committee became just another committee which met at mutually inconvenient times.

Experience indicates that the best solution is to have the chief of staff and his anticipated successor serve on the governing board, preferably with the right to vote, but, if for any reason such voting is not possible, at least to permit them to have full participation in the board discussions. It is most important that the chief of staff be used (and the medical staff president, if both offices exist) rather than a physician separately selected by the medical staff, as is recommended by the American Medical Association. The chief is recognized as the spokesman for the staff, and he is most likely to be fully apprised of the staff viewpoint or concern on any particular issue. He has immediate access to all medical staff committees, not only as an observer but to answer questions and explain governing board policy. Moreover, since his term of office is limited, he does not become so entrenched on the governing board as could an elected delegate or a physician selected by the board itself. The inclusion of his anticipated successor is important for ensuring continuity as well as eliminating the indoctrination period required for a new member to become a useful and effective addition to the governing board.

Rapid acceptance of the concept of physician representation on important governing board committees has also been most constructive in mutual problem-solving.

This is particularly important in the evolution of the hospital into a medical center and in relation to comprehensive health planning.

The nature of physician involvement beyond the governing board and committee level is often manifested by an increasing utilization of the full-time chief of staff in nonteaching hospitals. In nonuniversity teaching hospitals the full-time director of medical education's primary responsibility has become the recruiting and supervising of interns and residents. The full-time chief or medical director—an almost interchangeable title—is such a recent manifestation that the literature really has failed to define his role or the problems relating to his appointment. The creation of this new position with responsibility for the quality of professional care is a logical development of the pressures exerted upon the hospital's governing board and medical staff to assume greater responsibility for the quality of care rendered by, and for the over-all performance of, the individual physicians and departments of the hospital. Experience is proving that a volunteer chief serving for a relatively short term cannot give the necessary time and effort to see that the committees are functioning properly and that the necessary foundation material is developed to facilitate their functioning.

However, the appointment of a full-time chief as an employee of the hospital can be successful only with the support of the medical staff. Although he is a part of the hospital's administrative team, his primary role must be to assist and strengthen the functioning of the medical staff. Thus, to avoid conflict and misunderstanding he should not be the spokesman for the medical staff. That role should be fulfilled by an elected officer of the medical staff, who is usually titled president. Friction can develop if the employed chief is permitted to engage in private practice on a part-time basis in competition with other members of the medical staff. The nature of any such practice by the chief should be clearly defined and accepted by the medical staff leadership to avoid any claims that he is using his position unfairly to compete with other members of the staff in the same specialty.

As hospitals have increased in size and complexity, the employment of full-time department heads who may also be engaged in a clinic practice at the hospital has become increasingly popular. This extension of the full time chiefs' role can lead to overconcentration of authority outside of the volunteer staff, since full-time department heads, as a group, could achieve control of the medical staff executive committee. Here again it is important to clarify roles and, if necessary, create parallel representation on the executive committee for the full-time department heads and the voluntary staff.

B. Facilities

Another manifestation of the trend toward a closer identity of physicians and hospitals is the rapid increase in the number of medical office buildings being built on hospital sites or immediately adjacent thereto. The most advanced planning along these lines involves the location of medical offices in structures attached to or part of

the hospital buildings. Because the financial sources for hospital and medical building construction have historically been quite separate and have usually had conflicting interests, problems may arise in implementing this arrangement. Furthermore, if the medical building is owned by the hospital, its tax status might be in doubt, although a recent ruling by the Internal Revenue Service[1] allowing hospitals to maintain their tax-exempt status with regard to the rental income may encourage them to finance such structures. This trend has been and will be seriously hampered by the shortage of capital financing. Other practical problems in the planning of such complexes include the selection of physicians to occupy the buildings and the decision whether or not there will be separate x-ray, lab, and pharmacy services (resulting in duplication of costly equipment and facilities). In some instances it has been possible to share the project financing with the doctors, but this technique usually looks better in theory than in practice. Younger physicians often cannot spare the capital, while older physicians do not wish to tie up their capital in office space when they are close to retirement age. Furthermore, some of the physicians may already have substantial investments in competing structures.

Despite the difficulties, the pressure from the Department of Health, Education, and Welfare and other third-party payers for the expansion of group practice and health maintenance organizations should accelerate the construction of hospital-doctor office facilities. A group of physicians working together in a hospital-doctor medical building will be able to qualify without giving up much of the independence that is so important to medical practitioners. By organizing in this manner, physicians can eliminate duplicative facilities and equipment and can rely on the hospital or a specially created separate entity to provide central service for medical records, a library, night coverage, and so forth. The time and effort of both physicians and patients will be conserved, and hopefully costs will be minimized and quality of care emphasized. Various types of legal organization can be adapted to the needs and desires of such a group, ranging from the sharing of central services to the formation of full partnerships or professional corporations.

At this point we have only to allude to the fact that these new types of physician organizations are all manifestations of the development of the complete medical center concept, which may also include various types of specialized institutional facilities, such as extended care, rehabilitation, mental health, and mental retardation units, nursing home and home care service institutions, and so forth. The involvement of the doctor in the development and operation of these facilities and services will become increasingly important.

II

CURRENT AREAS OF CONTROVERSY

All of these factors and many more have rapidly increased the importance of the relationship between the practicing physician on the one hand and the hospital as

[1] Rev. Rul. 69-463, 1969-2 CUM. BULL. 131.

the center of institutional medicine on the other. This has not been a tranquil transition, and potential frictions have been aggravated by some extraordinarily rapid changes in judicially-devised law. Without any specific legislative or regulatory mandate, the courts have stepped in unilaterally to change the relationship between the practicing physician and the hospital within the relatively short span of less than ten years.

The judicial trend, reflected in a series of unrelated decisions, has been a restructuring of the classic hospital-physician-patient triangle of relationships in a manner very much more in favor of the patient. In attempting to put the jigsaw puzzle together, it is quite evident that this result has been achieved through a piecemeal resolution of individual conflicts and not as a part of any master plan.

A. Malpractice

What, then, are these conflicts? First, and most dramatic, is the impact of malpractice litigation upon both the physician and the hospital. Space does not permit an exhaustive review of the court decisions on this complex subject. For the purposes of this discussion the important fact is that the appellate courts are increasingly making the hospital, as an entity, legally responsible for the quality of care provided within its walls, even though such care may be rendered or directly supervised by licensed physicians in their roles as independent contractors. The most dramatic decision in this area is that of *Darling v. Charleston Community Memorial Hospital*.[2] Although the legal doctrines expounded in the *Darling* case were neither new nor novel, the application of these doctrines to the medical staff setting, involving not only the hospital's responsibility for the conduct of the individual physician but also an unprecedented application of the standards of the JCAH, gave the case widespread publicity, and even shock value.

Just where the courts will draw the line on the extension of joint and several liability imposed on the private physician and the hospital is difficult to predict at this point. It may well be that if the hospital and its medical staff establish proper guidelines and procedures for the screening of physicians, for the monitoring of their conduct on a peer review basis, and for taking appropriate actions by way of discipline or limitation of privileges when their patterns of conduct indicate deviations from established standards, the hospital can be insulated from responsibility for the negligence of private physicians on its staff. On the other hand, it may well be that the courts will find that, even as to a private physician, his acts and conduct in the hospital are so interwoven with the functions of the hospital that it must be held jointly liable for his negligence even though there was no basis on which to anticipate the particular negligent act or conduct. The parameters of such joint liability will also have major implications with regard to questions of indemnity and subrogation as between these parties and their respective insurers.

[2] 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

B. Staff Privileges

The second major area of development relates to the right of the individual physician to obtain medical staff privileges. Historically, the courts have made a distinction between legal standards regarding the right to practice in a public hospital as opposed to those very different standards applicable to a private hospital. In the public hospital the rule was and still is that

> [O]ne cannot be deprived of the right or privilege to practice in a public hospital by rules, regulations, or acts of its governing authorities which are unreasonable, arbitrary, capricious, or discriminatory.[3]

However, the physician "has no constitutional or statutory right, or right per se, to practice his profession in a public hospital."[4] There are many reported cases concerning physician pivileges in public hospitals, and the above rules—in effect requiring fair treatment—have been uniformly applied.

On the other hand, "In the case of private hospitals, it is generally held that the exclusion of a physician or surgeon from practicing therein is a matter which rests in the discretion of the managing authorities."[5] The cases indicate that in litigation involving private hospitals the physicians were almost uniformly unsuccessful unless they could prove a contract, a violation of the corporate or medical staff bylaws, or, more recently, some form of conspiracy by the staff.[6]

On public policy grounds and without the benefit of legislation the courts have recently acted to change the ground rules as to the private hospitals, starting with the case of *Greisman v. Newcomb Hospital.*[7] As yet these cases have not provided a clear pattern to delineate exactly what is required of a hospital medical staff or its governing board with regard to decisions involving medical staff privileges. However, certain principles appear to be evolving from the cases to date.

As indicated in the *Greisman* case, a hospital cannot require membership in a county medical society as a qualification for hospital membership. The courts consider this to be an improper delegation of control by the hospital's medical staff and thus an abuse of its fiduciary discretion. Of equal concern is the possibility

[3] Annot., 24 A.L.R.2d 850, 852 (1952).

[4] *Id.* (footnotes omitted).

[5] *Id.*

[6] *See* Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. 2d 806, 376 P.2d 568, 26 Cal. Rptr. 640 (1962).

[7] 76 N.J. Super. 149, 183 A.2d 878 (Super. Ct. L. Div. 1962), *aff'd*, 40 N.J. 389, 192 A.2d 817 (1963). The holding was followed by a rapid series of cases in various jurisdictions. *See, e.g.*, Foote v. Community Hosp., 195 Kan. 385, 405 P.2d 423 (1965); Koelling v. Board of Trustees, 259 Iowa 1185, 146 N.W.2d 284 (1966); Sussman v. Overlook Hosp. Ass'n, 92 N.J. Super. 163, 222 A.2d 530 (Super. Ct. Ch. Div. 1966), *aff'd*, 95 N.J. Super. 418, 231 A.2d 389 (Super. Ct. App. Div. 1967); Mauer v. Highland Park Hosp. Foundation, 90 Ill. App. 2d 409, 232 N.E.2d 776 (1967); Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d 246, 250 N.E.2d 892 (1969); Davis v. Morristown Memorial Hosp., 106 N.J. Super. 33, 254 A.2d 125 (Super. Ct. Ch. Div. 1969); Citta v. Delaware Valley Hosp., 313 F. Supp. 301 (E.D. Pa. 1970); Sosa v. Board of Managers, No. DR-69-CA-17 (E.D. Tex. Jan. 30, 1970) (mem.), *rev'd*, 437 F.2d 173 (5th Cir. 1971). These cases are discussed in more detail in the text immediately following.

that a hospital medical staff and the county medical society may be found to be in a conspiracy by reason of such interrelation. Some medical staff bylaws now use the term "qualified for membership in the County Medical Society." Although this may be a technical compliance with the rule against delegation, medical staffs have been urged to avoid such a reference. As a practical matter, if the medical staff believes that the qualification standards for the county medical society are sound, they can repeat such standards in the medical staff bylaws and avoid the delegation issue.

There must be some form of fair hearing for the physician, not only as to any disciplinary action but also in the decision made as to his initial application for medical staff membership. The effect of this requirement will be spelled out in more detail in the discussion of the problems relating to drafting a set of medical staff bylaws. The essential purpose of this requirement is to assure the physician that he has not been dealt with in an arbitrary or capricious manner.

Although there has been considerable reluctance by the courts to hold that a private voluntary hospital should be subject to the same requirements as are applicable to government hospitals merely because the voluntary hospital has received Hill-Burton funds, the courts have cleared this hurdle simply by making almost equally stringent requirements applicable to the private hospitals. What the courts have done is to find, by judicial fiat, that when private hospitals act upon staff membership applications they are exercising a fiduciary power which must be exercised reasonably and for the public good.[8]

Fortunately, the courts, by adopting a rule which requires that the final decision be one which advances the public good, have recognized the importance of maintaining a balance of rights between protecting the patient on the one hand, via the *Darling* route, and recognizing the physician's right to practice on the other. It is at this point that the hospital's governing board and medical staff find themselves caught on the horns of a dilemma with the need for the wisdom of Solomon. As pointed out in the *Sussman* case,

> We agree with the conclusion of Judge Mintz that Overlook's board of trustees owed a duty to Dr. Sussman and the public to conduct a more substantial inquiry into the fitness of Dr. Sussman to serve on its medical staff than the mere unilateral inquiries it made and information it gathered without according the doctor an opportunity to be heard. Conscientious physicians should not be deterred from speaking out against abuses in hospital practices by the fear that their criticisms to improve the quality of patient care may result in their being denied staff privileges in some other hospital solely by reason thereof.
>
> This is not to say that Overlook's board of trustees may not reasonably consider the factor of prospective disharmony, as Judge Mintz properly pointed out. But, as a fiduciary owing a duty to all concerned, valid and constructive criticism of hospital practices at Muhlenberg and Perth Amboy is not necessarily to be equated with potential disharmony at Overlook. The occasions which gave rise

[8] Sussman v. Overlook Hosp. Ass'n, 92 N.J. Super. 163, 222 A.2d 530 (Super. Ct. Ch. Div. 1966), *aff'd*, 95 N.J. Super. 418, 231 A.2d 389 (Super. Ct. App. Div. 1967).

> to the criticisms at those other institutions may have justified their having been made. To accept the personality evaluation of a doctor by those whom he may have criticized, without hearing the other side of the story, is not an adequate fulfillment of the fiduciary obligation owed in passing upon an application for medical staff membership.[9]

Or, as stated in *Sosa v. Board of Managers*,

> We think the stated factors used by the Credentials Committee of the Medical Staff to evaluate staff applicants are reasonable. This court has recently indicated that staff appointments may be constitutionally refused if the refusal is based on "any reasonable basis, such as the professional and ethical qualifications of the physicians or the common good of the public and the Hospital," . . . . Admittedly, standards such as "character qualifications and standing" are very general, but this court recognizes that in the area of personal fitness for medical staff privileges precise standards are difficult if not impossible to articulate . . . . The subjectives of selection simply cannot be minutely codified. The governing board of a hospital must therefore be given great latitude in prescribing the necessary qualifications for potential applicants. . . . So long as the hearing process gives notice of the particular charges of incompetency and ethical fallibilities, we need not exact a précis of the standard in codified form.[10]

Even the courts which follow the old rule recognize the impact of the *Darling* case upon the role of the governing board. As stated in *Mauer v. Highland Park Hospital Foundation*,

> Plaintiffs ask this Court to "modify" or "repudiate" the general doctrine reiterated and adhered to by the foregoing decisions, notwithstanding that this doctrine is supported by "the overwhelming weight of authority, almost approaching unanimity" . . . . However, the only reason the plaintiff gives in his request that we dishonor established law, namely, that the enjoyment of public funds and the tax-free status of the hospital impresses it with a public interest requiring judicial review of internal decisions, has *itself* been dishonored and repudiated by the decided cases. We elect to follow the teaching of these cases, and we refuse to substitute our judgment for that of the hospital authorities regarding the acceptance of plaintiff for staff membership in a private hospital. Indeed, this doctrine is all the more fitting by virtue of the current Illinois law imposing potential liability on a hospital for the imprudent or careless selection of its staff members, without limitation to the amount of its liability insurance. [Citing *Darling v. Charleston Community Memorial Hospital.*][11]

Again, fortunately, most courts have been quite flexible in the application of the doctrine of fair dealing, being far more concerned with the substance of the process rather than with its form. This concern is particularly important in delineating the respective roles of the medical staff and the governing board. Thus, even though the governing board is recognized as having the ultimate authority and responsibility

[9] 95 N.J. Super. at 424-25, 231 A.2d at 393.
[10] 437 F.2d at 176 (citations omitted).
[11] 90 Ill. App. 2d at 414-15, 232 N.E.2d at 779.

for decisions regarding staff privileges, the courts have generally been willing to accept a process under which the basic spade work of investigation and hearing are substantially completed at the medical staff level. As a result, the governing board's role is essentially limited to a determination of whether the process has been fully and fairly followed, more analogous to the role of an appellate court than to that of a lower court trier of fact. This is a desirable result because it makes it possible to place the basic decision-making function at the level where the greatest expertise on the issues to be judged is located. Few lay persons realize the complexity of the issues involved in making an adequate and fair determination of a physician's qualifications to practice in a particular hospital setting. The investigation preceding such a determination must include not only a review of his professional credentials but also an attempt to evaluate his ability to work effectively and cooperatively with his colleagues and the existing personnel in the highly-charged atmosphere of a modern hospital. Those responsible for such determinations must also be aware that their decisions will have a major impact on the over-all quality of care provided within the institution.

III

THE DUE PROCESS REQUIREMENT

The definition of the particular elements of due process required in the investigatory and hearing procedure has also been dealt with by the courts in relation to the substance of the issues under determination in such proceedings. The due process requirements applied have been molded with a view toward seeking a fair solution to the complex problems involved, and hospitals have not been forced to follow the entire laundry list of formal requirements for an administrative hearing usually provided under the state or federal administrative procedure acts. For example, in *Citta v. Delaware Valley Hospital Association* the court discussed the basic philosophy behind due process requirements as follows:

> [W]e proceed from well-settled principles. Due process requirements for a fair hearing *vary according to the circumstances and must be adapted to particular situations* . . . but the controlling principle is that the hearing must be meaningful . . . which we understand to mean a hearing that affords a reasonable opportunity to correct error. . . . In other words, we must ascertain whether the procedures employed at the Corporate Staff hearing provided for ". . . the protection of the individual against arbitrary action . . . ."[12]

It appears clear that to meet due process requirements the hearing procedure used should include (*a*) notice of the time and place of hearing; (*b*) a hearing before a properly authorized body; (*c*) the right of applicant to appear in person before the hearing body; (*d*) the right to present witnesses and appropriate documents; (*e*) consideration of and findings as to specific qualifications based on the evidence submitted;

[12] 313 F. Supp. at 310-11 (emphasis added) (citations omitted).

(*f*) notification of where and why the applicant fell short, if refused appointment; and (*g*) an appeal or final opportunity to rebut unfavorable evidence. The right to confront and cross-examine witnesses is usually granted but is not an absolute requirement.

The foregoing list is a paraphrase of the trial court's opinion in the *Sosa* case. Although the trial court's decision was subsequently reversed and remanded, the appellate court did not reject the above analysis of the due process requirement in its opinion, but grounded its action on the fact that the trial court had not had an opportunity to review the latest action of the hospital's board of managers.[13] The trial court's analysis offers the best approach of any of the judicial opinions which have discussed this complicated issue to date.

Certain elements that individual practitioners view as important aspects of due process are not included in the above list and must be considered by each hospital and medical staff in developing their own procedures. Some explanatory comments regarding these other elements are clearly indicated:

(1) *A statement of charges.* This is usually an element of due process in any governmental administrative hearing procedure. Certainly, the individual involved should be apprised of what the hearing is all about. However, although it is easy to spell out a requirement for a statement of charges, it is often very difficult to implement such a requirement in practice. It may be simple if the problem underlying the charges involves one or two flagrant occurrences, but it is much more difficult if the need for the hearing is based on a series of less repugnant incidents or practices that on a cumulative basis have led to an adverse evaluation of the physician's qualifications. In such cases a listing of a series of charts by chart number will often be sufficient. As long as the procedures followed insured that the physician is not taken by surprise or is provided adequate opportunity to respond, requirement of a statement of charges should not be so stringently applied as to impede appropriate action.

(2) *The availability of legal counsel at the hearing.* This is a highly controversial issue. The *Sussman* decisions state there is no such requirement,[14] and the author's firm has tried a case at the trial court level with a similar result. Certainly it is advisable to face this issue in the bylaws in order to avoid ambiguity at that level. It should be the prerogative of the hearing body to permit or exclude legal counsel, but the decision must be the same for all parties in any particular in-

[13] 437 F.2d at 175.

[14] *See* 92 N.J. Super. 163, 222 A.2d 530 (Super Ct. Ch. Div. 1966), *aff'd*, 95 N.J. Super. 418, 231 A.2d 389 (Super. Ct. App. Div. 1967). *See also* Koelling v. Board of Trustees, 259 Iowa 1185, 146 N.W.2d 284 (1966), which came to a similar conclusion on the issue of the right to counsel with regard to a meeting of a hospital medical staff which, after considering the report of its credentials committee listing the charges against a physician, voted to recommend an indefinite suspension of his staff privileges. The court noted that the physician claiming denial of the right to counsel had attended the meeting in his capacity as a member of the medical staff, rather than as the accused, and was neither required to be present nor to answer any questions. In addition he had been permitted to have legal counsel at two prior investigatory proceedings. *Id.* at 1202, 146 N.W.2d at 294.

stance. In actual experience, the author has recommended admitting legal counsel in about half of the cases he has supervised. In certain types of cases involving possible criminal conduct or strictly legal issues, legal counsel should always be available. On the other hand, in cases involving strictly professional issues related to standards of practice and the like, a group of physicians can more than adequately handle the procedural requirements on a problem-solving basis, and the presence of legal counsel in an adversary role often aggravates the conflicts and confuses the issues. In any event the physician should be permitted to have his chosen representative from the medical staff to assist him. In situations where legal counsel is excluded, the medical staff is usually represented by the chairman of the credentials committee, a department chief, or a designated representative of the executive committee.

(3) *The type of record to be maintained.* It is important to keep a record adapted to the nature of issues being considered at the hearing, whether done by court reporter, electronic transcription, or both. However, in many hearings adequate minutes taken by a trained secretary or physician will suffice. The question of the type of record which should be maintained may rest on the relative accuracy which will be required for purposes of review. For example, the need for an exact record would be far greater in a case where the nuances of the oral testimony were of crucial importance than in one where adequate and conclusive documentation was available.

(4) *The number of hearings.* Here, it is important to distinguish between the one due process hearing and the multiplicity of informal hearings or conferences that may be held with the physician. As a practical matter, the ongoing business of an effective medical staff is replete with a wide variety of hearings or conferences that do not and should not rise to the dignity of a due process hearing. When the physician is called in to explain a diagnosis or treatment, or to justify a length of stay or any other particular incident of his practice, or if a conference with a departmental committee in the nature of a warning is held, these conferences do not ordinarily require due process procedures, although appropriate records should be kept—including the date on which such a meeting was held, its nature, and the result. However, whenever the executive committee takes an action which is adverse to the physician's privileges or to his application for membership, he is entitled to a due process hearing. The bylaws should carefully distinguish this hearing and the procedure for triggering it from all other conferences and hearings held by the medical staff and its various committees. In other words, if the due process hearing is clearly distinguished from the others, then it will be the only one that need have all of the due process protections. If such a hearing is held, then any appeal taken may receive an appellate review rather than a trial de novo.

(5) *Who shall sit on the due process hearing body.* Historically, the executive committee of the medical staff has acted as the hearing body. This procedure is certainly justified on the ground that the executive committee is the action committee

for the medical staff and is generally responsible for the self-governance of the medical staff. However, in practice it is usually the action of the executive committee which triggers the request for the due process hearing. Thus, if it assumes jurisdiction, the executive committee is often really acting in the nature of a rehearing body regarding a matter upon which it has already expressed its opinion—resulting in an uphill battle for the physician in question. From a basic sense of fairness it would therefore appear best if an independent hearing body, such as a judicial review committee, were impaneled and authorized to conduct the hearing and then report its recommendations to the executive committee for final action. Such a committee may be selected on an ad hoc basis in order to avoid conflicts of interest or to limit representation of individuals directly involved in the proceedings that led to the due process hearing. In rare cases it may be necessary to go outside the medical staff to the county or state medical society to obtain an impartially constituted group. Use has been made of outsiders, including medical school faculty members and members of specialty societies, who were asked to review the records or conduct in question and then render an impartial opinion to the hearing body on the issues involved. Such a procedure may appear to be extraordinary, but it is not unusual for a controversy to have reached such an emotional peak that it is impossible to obtain unbiased expert opinions within the professional resources of the medical staff. A similar problem may arise if it becomes necessary to evaluate the practice of a super-specialist when the physician being challenged is the only member of that speciality on the staff.

(6) *The right to require a psychiatric examination.* At first blush, this may seem to be an unusual point to raise. However, the experience in this area has been that the emotional stability of one or more of the individuals involved is a critical issue in a high proportion of the cases reaching the due process hearing stage. In a substantial number of cases, the "encouragement" of psychiatric consultation before the hearing stage has led to successful rehabilitation and restoration of an effective working relationship. However, in other cases, the difficulties caused by paranoia, schizophrenia, and other psychiatric disorders are at the very root of the problem and prevent an effective resolution of the conflict. Lawyers must move gently and carefully into such conflicts, because a strictly legal solution often only makes a bad situation worse. Fortunately, there are often exceptional resources in a medical staff available to give assistance—particularly when the issue is squarely faced and all are assured that the motive must be to rehabilitate the man if possible, not destroy him. Such resources can and should be used at any stage of the proceedings where appropriate and where there is reasonable justification for their employment.

(7) *The use of a hearing officer.* Such an individual is usually an attorney, but he can be any person experienced in conducting a hearing—such as a staff executive of the county or state medical society. The hearing officer may give legal or administrative advice to the hearing committee and may participate in its deliberation, but he is not permitted to vote.

(8) *The nature of the appeal.* Nearly all due process hearings are held at the medical staff level, so an appeal to the governing board of the hospital is usually allowable. As previously indicated, the availability of an appeal may be a vital element of due process. Thus, aside from the decision over who is to conduct it, the real question is whether the appeal is to be structured as a full new hearing or whether it shall be in the nature of an appellate review. This question arises because many governing boards are very large and made up of persons who are well qualified in management or civil affairs but are not familiar with the complexities of the standards applicable to the conduct and practice of medicine. If the appeal is heard by the governing board, the hearing should be by a qualified committee of that board, which should limit its investigation to the issue of whether the original proceeding granted the physician a fair hearing which met the requirements of due process. New evidence should be permitted only at the discretion of the appellate body, and the use of a written statement or brief should be encouraged. The joint conference committee, if its members have not already been involved in earlier stages of the controversy, can be an appropriate body for this purpose. However, as practical matter, generally the medical component of the joint conference committee has been disqualified because of its prior involvement in an official capacity.

IV

REQUIREMENT OF MINIMUM MALPRACTICE INSURANCE COVERAGE

Another issue is the legality of a medical staff requirement of minimum professional liability insurance coverage as a condition of admission or continued membership on the medical staff. This issue has been confused by the 1964 decision in the case of *Rosner v. Peninsula Hospital District.*[15]

The *Rosner* case has often been cited as authority for the proposition that it is illegal for a voluntary hospital to establish such a requirement. The decision in the case is a typical example of bad facts making bad law, compounded by bad reporting. The case involved a government hospital—to wit, a district hospital. Furthermore, the district hospital law in California specifically sets forth the criteria for medical staff membership, and, since the criteria does not include the insurance coverage, the court ruled that such a requirement would not be permitted. To make matters worse, the particular requirement under attack was adopted *after* Dr. Rosner applied for medical staff membership with full knowledge that, as a result of other litigation in which he was engaged, his chances of having insurance were at best remote. No one can fault the decision, but its widespread application should be seriously questioned.

Is an insurance requirement appropriate, or does it constitute an illegal delegation of the right to approve medical staff membership to an insurance company—particularly if insurance is available only on a limited basis and only from a few

[15] 224 Cal. App. 2d 115, 36 Cal. Rptr. 332 (1964).

carriers? The consequences of inadequate malpractice coverage in cases where one of the principal joint defendants was an uninsured doctor have been nothing less than disastrous—not only for the other doctors but, if it is involved, for the hopsital as well. The uninsured doctor may not be able to finance a proper defense, and, as is more important, his ability to participate fairly in settlement negotiations is greatly impaired. The outcome is often a totally distorted and disproportionate loss for the insured physicians and may even include their forced settlement of an otherwise defensible case. Such a blot on the insurance records of the fully insured physicians is very serious, and all the physicians on a medical staff (as well as the hospital) have a justifiable interest and concern in requiring a minimum insurance coverage for all physicians who wish to practice in the hospital. In almost every case that the writer has seen, insurance was readily available, but the physician in question did not carry any because he had turned his assets over to his former wife or to a charity or because he did not personally believe in the concept of malpractice insurance.

To avoid any implication of improper delegation to the insurance carrier, the physician should be given the opportunity to show good cause why he does not have insurance and, if he convinces the executive committee of his cause, then, after due warning to all other members of the staff, he should be permitted to practice without it. The California Medical Association and the California Hospital Association, in a joint publication entitled *Professional Liability and Related Topics*, made the following statement on this issue:

> The C.M.A.-C.H.A. Joint Medicolegal Education Committee recommended that hospital medical staffs require that every member of the staff shall annually file an informal statement with the secretary of the staff, telling the amount of professional liability insurance he is carrying and the name of the underwriting company. This information will be reviewed by the executive committee of the staff in order that all staff members may be assured that each member has reasonably adequate professional liability insurance in force. No permanent record need be kept of this information. The executive committee shall develop, from time to time, criteria (informal), by which to measure what shall be considered reasonable, adequate limits of coverage and shall advise the members of the medical staff of their recommendations.
>
> These proposals are made in the interest of the profession and the public. They have been approved by the C.M.A. Council.[16]

V

IMPORTANCE OF BYLAWS

These, then, are some of the major problems relating to due process and interprofessional and physician-hospital relationships that must be resolved. Both the medical staff and the governing board of the hospital need to draw up a road map

[16] CALIFORNIA MEDICAL ASS'N & CALIFORNIA HOSPITAL ASS'N, PROFESSIONAL LIABILITY AND RELATED TOPICS 2 (undated).

outlining the courses which will be followed. This road map should then become the document known as the medical staff bylaws. Although it is possible to make due process available to a physician without an adeqaute set of bylaws, such an ad hoc solution is more difficult and almost inevitably lends to potential conflict and misunderstanding. Unfortunately, the very lack of a clearly defined procedure may itself become the central issue with the result that the merits of the particular situation are lost in disputes over procedure and never adequately considered.

The California Medical Association and the California Hospital Association were among the first official bodies to take cognizance of this problem and to publish broad recommendations regarding due process concepts at the medical staff level. These recommendations were set forth in a document entitled *Model Medical Staff Bylaws*,[17] which was distributed to all California hospitals, both public and private The original letter of transmittal which accompanied this publication is of particular significance. It read as follows:

> Both the Council of the California Medical Association and the Board of Trustees of the Californa Hospital Association have approved the *Model Medical Staff Bylaws* for general distribution in California. The document is the culmination of a two-year study, by the CMA-CHA Medical-Legal Education Committee, of the entire subject of medical staff appointments.
>
> In developing the *Bylaws*, the joint committee has taken into consideration recent court decisions in California and other states as well as hearings conducted by an Assembly Interim Committee on the matter of medical staff privileges. It is important to note that this subject will be a matter of continued legislative concern, in accordance with a resolution adopted at the 1965 Legislature, providing in part:
>
> "House Resolution No. 643
>
> WHEREAS, The physician's hospital membership and privileges constitute one of the most important facets of medical practice; and
>
> WHEREAS, There have been cases in California of physicians dismissed from hospitals or denied membership on hospital staffs without being accorded hearings; and
>
> WHEREAS, There has been a meaningful effort to accomplish on a voluntary basis the achievement of the goals of fair hospital staffing practices; and
>
> WHEREAS, Some hospitals in California have not adopted the procedures set forth in these voluntary standards; and
>
> WHEREAS, Close and continuing legislative scrutiny is necessary in this complex and sensitive area if Californians are to receive the best possible patient care; now, therefore, be it
>
> RESOLVED BY THE ASSEMBLY OF THE STATE OF CALIFORNIA, That the Committee on Rules is directed to assign to an appropriate interim committee for study the subject of physician-hospital relationships, including staff membership and privileges, and procedures relating to this process, and to direct such interim committee to report thereon to the Legislature not later than the fifth legislative day of the 1967 Regular Session."
>
> The new provisions in Articles III and IV of the *ByLaws* are primarily con-

[17] CALIFORNIA MEDICAL ASS'N & CALIFORNIA HOSPITAL ASS'N, MODEL MEDICAL STAFF BYLAWS (1965).

cerned with the provision for hearings, a subject of greatest concern to the Courts and the Legislature. Basically, the document is designed to assure the individual physician of "due process" and also to provide legal and practial protections for the doctors serving on committees.

Some concepts that will be new to many medical staffs are:

1. Provisional staff membership
2. Right to hearing on refusal of initial application
3. Statement of charges
4. Use of a judicial review committee
5. Waiver of liability

Most of these concepts are in general use by County Medical Societies; their utilization at the medical staff level appears to be a logical and useful extension, not only to assure fairness but also to avoid further preemption of this function by either the Courts or the Legislature.

These are recommended model provisions and must of necessity be adapted to the needs of the individual medical staff. However, in making changes, careful consideration should be given to the purposes of each section included.

It should be noted that, although the approach described in the *Bylaws* is somewhat formalized, the basic concept is to handle these matters on a professional basis of doctor to doctor. There is no requirement that the applicant be permitted to have an attorney present. However, there will be situations in which this may be permitted by the appropriate committee of the medical staff.

The joint committee recognized that the procedures set forth may place additional burdens on the committee work of the medical staff. However, experience has indicated that the mere existence of these procedures eliminates areas of friction and that the procedures are not utilized as often as might be anticipated.

The model provisions selected for inclusion are those that were felt to be of particular importance to medical staffs in California. Articles V through XI are copied from the Joint Commission Model Bylaws. However, provision for a Utilization Committee has been added to Article VII.

It is hoped that medical staffs throughout the state will find this document useful as a *guide* in developing their medical staff organizational patterns, particularly in the area of medical staff appointments.[18]

The initial reaction from medical staffs throughout the state was one of dismay at the detailed, and apparently cumbersome and legalistic, procedures they felt were being imposed upon them. However, the document received widespread acceptance, and, even when not formally adopted, the procedures for due process were usually utilized by board resolution when a hearing was indicated.

Six years of experience have proven the merit of the procedures suggested in the *Model Medical Staff Bylaws*, and it is anticipated that the new *Guidelines for Medical Staff Bylaws* being drafted and published by the JCAH will follow these basic principles, improving them by modifications which have been evolved as a result of actual experience. Before considering the concepts outlined in the *Model Medical Staff Bylaws*, one needs to understand the complex problems faced by an individual

[18] *Id.*, Letter of Transmittal.

medical staff and hospital governing board in achieving an appropriate balance between protecting the patient and recognizing the right of the individual physician to practice his profession. These are the problems which must be resolved within the parameters of due process.

We must begin with the premise that the state's granting the individual physician a license to practice his profession in itself constitutes no continued protection to the public. Licensure is a one-time hurdle that invariably leads to automatic renewal except in extraordinary circumstances not usually related to the individual's current qualifications. Similarly, specialty board qualification is also a one-time hurdle with very little continuing surveillance. Therefore, it is only in the hospital setting that a continual review of the physician's personal and professional qualifications is available. However, it is also in the hospital setting that we find many additional relevant issues complicating the judgment process.

Each individual hospital is permitted to establish its own standard of practice. Thus, one institution may have an open staff, made up primarily of general practitioners, while another will limit practice within its walls to the evolving superspecialties of today's medicine. While the frictions are minimized at each extreme, most hospitals are found in between, where there is always the question of what the current standard is. Should the applicable standard be that of the institution's historical past, or should a newly-established standard, with built-in "grandfather" rights for physicians who qualified under the old standards, be applied? Is the standard for judging an individual's qualifications to be limited *solely* to his professional qualifications or are there other factors to be considered? Because of the importance of maintaining a team effort in the modern hospital's highly-charged atmosphere, the emotional stability and compatibility of the staff membership may be a crucial factor. The willingness of each individual physician to bear his fair share of the load in the emergency room, to participate in the drudgery of committee work, or to attend the endless but necessary meetings to which the practice of medicine is addicted can be a critical issue. How far can the medical staff go in considering a man's moral qualifications—his marital relations or extramarital relationships with hospital employees, cheating on his income tax and the like, or the touchy issue of his losing his narcotics license? At first blush, this last would appear to be an open and shut case for exclusion, but he may still have his license to practice medicine and another physician can write his prescriptions for him. Perhaps the continuation of active practice in a supervised environment will lead to the very rehabilitation that is sought. Obviously, such questions pose issues over which strong-willed individuals can violently disagree.

Unfortunately, there may also be the question as to whether the particular issue raised is more apparent than real. Thus, the physician may claim that the questions as to his qualifications are only a sham and that the real issue is professional jealousy, fear of competition, race, religion, staff attitudes toward closed-panel medicine or involvement in community clinics, and so forth. In most instances those

on either side of the controversy all believe they are entirely correct. In the great majority of cases the individual physician simply cannot bring it upon himself to accept a judgment of his peers that is contrary to his own. This factor must be emphasized because it is critical in designing a system of due process to resolve these controversies. Because of his intense commitment to his position, an individual physician will quickly turn any appearance of unfair treatment to his own ends and make that the central issue, thereby obscuring the questions regarding his personal qualifications. Even a hardened trial attorney cannot help but admire the facility with which some physicians can divert attention from what should be the principal issue in this type of medical staff proceeding.

Although we start from the premise that the hospital's governing board has the ultimate responsibility for medical staff appointments and privileges, we must also assume that such a board made up of lay persons is not qualified to actually process an application involving issues of professional competency. Traditionally, the medical staff has been treated as being self-governing in that it actually does all of the work on the applications, and, except in very extraordinary circumstances, its recommendations are routinely approved by the governing board. Furthermore, the medical staff is exceedingly jealous of its prerogatives in this regard and should not be reversed except in extraordinary circumstances.

In developing a set of medical staff bylaws the draftsman should keep a few fundamental concepts in mind. First, physicians by inclination and experience have a basic distrust of the practice of law and legalisms. This is counterbalanced by the fact that many, if not most, physicians feel thoroughly qualified to make legal judgments and secretly enjoy being "sea lawyers."

Second, although a set of medical staff bylaws must be designed to protect all concerned effectively in the event of a legal crisis, the procedures should be outlined so as to permit the handling of routine matters in an informal manner which avoids unnecessary confrontations. The due process sections should be drafted so that they will be triggered only in the event of a crisis, yet they should be set forth in considerable detail so as to provide a clear, unambiguous road map which can be followed when needed. In other words, every effort should be made to assure that the informal procedures are given a chance to resolve the problem before the formal procedures are invoked, and, when and if they are invoked, everyone involved should know what steps to take.

Third, attorneys and physicians often forget that the most important role of a medical staff is to improve the quality of practice of each individual physician, while the need to punish, by limiting or denying privileges, represents an ultimate failure for an individual, and perhaps for the entire staff system. The medical staff must assure itself that it has done everything reasonable to save the man before such steps are taken. Obviously, it cannot jeopardize the welfare of its own patients, but turning him out the door to commit the same errors on another group of patients in a new setting is not an adequate solution to the problem.

With this groundwork, we can now explore some of the principles that should be the basis for the development of a good set of medical staff bylaws. The attempt will be made not to present a detailed draft but rather to highlight some of the issues that must be faced, making certain suggestions for solutions that may not be readily apparent from the inspection of bylaws currently in use.

First, the qualifications for membership should generally be set forth in broad terms of "best possible care." An effort should be made to avoid automatically qualifying an applicant simply because he has been granted licensure or achieved specialty status. Reference to standards of practice in the hospital or the community may also be used to define a standard for qualification.

Second, a one-year term-of-appointment section can be very important. Formerly, it was a basis for quietly dropping a member without fuss for any of a variety of reasons. Now this section has the more important purpose of requiring the appropriate committee of the medical staff to undertake an in-depth review of the physician's performance and current qualifications. It covers the need for automatic terminations due to failures to attend meetings, pay dues, and so forth, but it is not an adequate basis to terminate for other causes without the availability of a hearing. In other words, it can be anticipated that, except for those matters leading to automatic termination, the failure to renew an annual appointment will be subject to due process requirements. In the model bylaws discussed earlier, the concept of the "provisional medical staff" appointment was introduced. A new medical staff member was placed on a provisional staff basis for at least a year. At the end of that period he was to be evaluated and either granted full staff membership, terminated, or continued for an additional review period of up to three years. By providing exact time limits and clearly spelling out the purpose of the provisional staff membership status, the medical staff was encouraged to make use of a limited period in order to clearly determine whether a new member should be finally qualified. This concept will be contained in the new JCAH guidelines in a slightly modified form.

Third, the procedure for appointments must be more formalized now than in former years due to the necessity for allowing a due process hearing in the event of a denial. As a matter of draftsmanship, the due process sections may be separately set forth to make them applicable to all formal hearing procedures, including the denial of an initial application. However, the following requirements are peculiar to the initial application procedure:

(*a*) The burden of producing adequate evidence of his qualifications must be on the applicant. Failure to produce such evidence is, in itself, grounds for denial. This requirement can be particularly critical when the credentials committee is faced with a series of noncommittal reference letters.

(*b*) The applicant must present a full disclosure of all prior conduct and

actions taken by other hospitals or other appropriate bodies that would bear on his qualifications.

(*c*) The applicant must give a release so that all necessary information can be obtained, and he must waive his right to claim damages resulting from such disclosure.

(*d*) The applicant must be assured that upon his completion of the necessary application it will be reviewed and acted upon with reasonable diligence and within a certain specified time period.

Fourth, the categories of the medical staff must be more clearly delineated in recognition of the changing role of the hospital. Greater emphasis is being placed on the importance of the role of the active staff, and at the same time physicians who are not on the active staff are being limited to those who act in a true consulting capacity or who use the hospital quite infrequently. In other words, the physician who chooses to accept the privileges of medical staff membership must also accept his share of the concomitant burdens and responsibilities. The role of the courtesy or associate staff categories is generally being limited and downgraded.

Fifth, procedures for reappointment should be tightened up. Under the new JCAH recommendations reappointment will be on a two-year basis in order that only a portion of the medical staff will be reviewed each year. It is hoped that this change will emphasize the importance of the review process and thus avoid the existing pattern of routine reappointment that is far too widespread.

Sixth, the clinical privilege sections should also be upgraded to assure individual evaluations of a physician's qualifications on a current basis. The use of surgical cards and the availability of comparable information through Professional Activities Studies (PAS) and other sources has made the procedures for supervision of privileges much more effective. The sophistication of the supervision process has generally been much more effective with regard to surgical procedures than has been the case in such departments as pediatrics or internal medicine. However, with the rapid development of intensive care and coronary care units, as well as the proliferation of extraordinary drug therapies, the supervision of physicians in these specialty departments has become a serious problem which must be faced by all medical staffs.

Seventh, due process or corrective action provisions in the medical staff bylaws must be spelled out in much greater detail for the reasons previously discussed in this article. In addition to the points previously made, attention must be given to certain additional provisions which should be made part of the bylaws. Included should be a section which clearly spells out the basis for corrective action. Differentiating the circumstances which will justify summary suspension, as distinguished from the grounds for termination after hearing, is also important if the officers of the medical staff are to act swiftly and decisively in an emergency situation.

Eighth, the roles of the chief of staff and other staff officers must be more clearly

defined. The importance of the chief of staff in monitoring the quality of patient care is of rapidly increasing importance and is being recognized in a number of different ways. In some hospitals we are seeing the appointment of full-time chiefs or department heads, or at least of a full-time medical director or director of medical education (even in hospitals without major teaching programs). And, in hospitals where voluntary chiefs are elected, the term of office is no longer limited to one year. Clearly, it is impossible for such an important role to be effectively learned and implemented within that short a period.

The new JCAH *Guidelines for Medical Staff Bylaws* will deal with these and many other important questions. Of particular importance to both physicians and lawyers is the fact that these guidelines not only delineate the problems through suggested bylaws language and editorial comment but also provide wide latitude in which the individual hospital and medical staff can develop their own solutions.

As a lawyer I have long fought any legal interference with the good practice of medicine. The essential guiding principle for the attorney who works with hospitals and physicians is that the welfare of the patient must be the paramount concern. At times the right answers have been obscured by the conflicting forces discussed in this article. Yet the changes that have occurred have been progressive, and, as traumatic as they have been and promise to continue to be in the future, we are, as a result, headed for a better and more effective health care delivery system.