Delineating privileges for osteopathic physicians

Background

According to the American Osteopathic Association (AOA), osteopathic medicine emphasizes the relationship among the body’s nerves, muscles, bones, and organs. As opposed to treating specific symptoms, “the osteopathic philosophy or treating the whole person is applied to the prevention, diagnosis and treatment of illness, disease and injury,” the AOA states.

Both DOs (doctors of osteopathic medicine) and MDs (doctors of medicine, allopathy) are licensed by each of the 50 states as medical practitioners who may provide treatment, perform surgery, and prescribe medication to their patients. Any attempt by a hospital board to base medical staff membership and clinical privilege decisions on the difference between the medical education of an MD and a DO is almost assured of a legal challenge.

Most hospital boards now recognize that there may be differences between the postgraduate training received in an allopathic residency and that received in an osteopathic residency, but just how hospitals handle this difference may decide whether osteopathic physicians challenge the hospital’s decision.

According to the AOA, osteopathic postgraduate training is simply a separate, parallel avenue of specialty training with the duration and intensity of the programs equivalent to American Medical Association-approved residencies. Hospitals that have traditionally had only MDs on staff have been repeatedly challenged over the years by osteopathic physicians seeking medical staff membership and clinical privileges. But most challenges have not been successful and the courts have upheld an institution’s right to set minimum training and experience requirements.

Hospitals that seek to limit their memberships to physicians who have completed training at an Accrediting Council for Graduate Medical Education (ACGME)-approved program often argue that DOs are free to attend ACGME-approved training programs. In fact, in some specialties, 45% of the students with osteopathic degrees go on to take their training in ACGME-approved programs.

But many argue that it is sometimes difficult for osteopathic medical school graduates to gain acceptance into allopathic residencies. Depending on the specialty, osteopathic physicians come up against stiff competition from graduates already in the MD track.
This is especially true for highly competitive specialties such as dermatology. Competition is less intense in areas where there is a greater demand for physicians, such as primary care. (Interestingly enough, while DOs can attend ACGME-approved training programs, MDs are not free to attend AOA-approved programs.)

According to the AOA, by the year 2000, 45,000 osteopathic physicians will be in practice in the U.S. Currently, there are over 33,000 DOs practicing in the U.S. They represent 5% of the total U.S. physician population, 9% of all primary care physicians, 10% of all U.S. military physicians, and 1% of all physicians practicing in towns of 10,000 people or less. Over half of U.S. DOs practice in the primary care areas of general practice, internal medicine, obstetrics/gynecology, and pediatrics with 100 million patients visiting them annually. Strong concentrations of DOs are found in Florida, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, and Texas.

As of July 1992, 8,649 DOs were certified in a specialty. There are AOA certifying boards in the following specialties and subspecialties:

- allergy and immunology (also pediatric),
- anatomic pathology,
- anesthesiology,
- cardiology (also pediatric),
- child neurology,
- child psychiatry,
- diagnostic radiology,
- dermatology,
- emergency medicine,
- endocrinology,
- forensic pathology,
- gastroenterology,
- general practice,
- general vascular surgery,
- gynecologic oncology,
- hand surgery,
- hematology and oncology (also pediatric),
- infectious diseases (also pediatric),
- internal medicine,
- laboratory medicine,
- maternal and fetal medicine,
- neonatology,
- nephrology (also pediatric),
- neurological surgery,
• neurology and psychiatry,
• nuclear medicine,
• obstetrics and gynecology,
• ophthalmology and otorhinolaryngology,
• oro-facial plastic surgery,
• orthopedic surgery,
• osteopathic manipulative medicine,
• pediatrics,
• pediatric intensive care,
• plastic and reconstructive surgery,
• preventive medicine and aerospace medicine,
• preventive medicine and occupational-environmental medicine,
• preventive medicine and public health,
• proctology,
• pulmonary diseases,
• radiation oncology,
• rehabilitation medicine,
• reproductive endocrinology,
• rheumatology,
• thoracic cardiovascular surgery, and
• urological surgery.

In addition, the AOA offers special certificates in these areas:

• angiography and interventional radiology,
• adolescent and young adult medicine,
• blood banking and transfusion medicine,
• chemical pathology,
• critical care medicine,
• cytopathology,
• dermatopathology,
• diagnostic ultrasound,
• geriatrics,
• hematology,
• immunopathology,
• medical microbiology,
• neuropathology,
• neuroradiology,
• radiological imaging, and
• sports medicine.

Positions of other interested parties

Weiss v. York Hospital

In the 1984 case of Weiss v. York Hospital [745 F.2d 786 3rd Cir. (1984)], Malcolm Weiss, an osteopathic physician, filed a lawsuit after York Hospital denied his application for appointment. The suit named the hospital, the medical staff and dental
staff, and 10 physicians who served on the medical executive committee and hearing panel as defendants.

Weiss and another osteopathic physician applied for medical appointment and clinical privileges in 1976. Both applications were recommended favorably by the family practice department chair and the credentials committee. The executive committee decided to conduct a further investigation of the two DOs and made extensive oral and written inquiries concerning the professional competence and moral characters of the physicians. The investigation found some questions about Weiss' personality and his medical competence. After a negative executive committee recommendation, the board denied Weiss' application. The board appointed the other physician.

Weiss then asked that his application be reconsidered. Again, he received a favorable recommendation until his application reached the executive committee. This time, Weiss requested a hearing. The hearing panel recommended against him and then the board determined not to appoint him.

Weiss filed suit on his own behalf and on behalf of the class of osteopathic physicians practicing in the area.

The district court held that the defendants could not apply different standards to DOs and found that the hospital violated the Sherman Antitrust Act by engaging in willful behavior designed to acquire and maintain monopoly power. The appeals court reversed part of the district court's holding, but upheld the certification of the suit as a class action and the district court's underlying finding, based on the jury's verdict that the medical staff had engaged in a conspiracy. A multi-million dollar settlement was paid by the hospital.

In Hull v. Board of Commissioners of Halifax Hospital Medical Center [453 So.2d 519 (Fla. Dist. Ct. App. 1984)], a group of osteopathic physicians sued Halifax Hospital, a public facility, claiming its requirement that all applicants complete an allopathic residency violated state requirements prohibiting discrimination against osteopathic physicians on the basis of their education and training.

When examining the claims, the appeals court ruled that requiring osteopathic physicians to take ACGME-approved residency, rather than AOA-approved residency, did not violate the Florida statute.
The court concluded that since some MDs do not finish their residency training, the criteria excluded “a larger number of medical doctors than osteopathic physicians.” The court also noted that the hospital could set standards, but could not apply different standards to physicians with osteopathic training than those applied to physicians with allopathic training.

In Hottentot v. Mid-Maine Medical Center [549 A.2d 365 (Me. 1988)], Hottentot, an osteopathic orthopedic surgeon, was twice denied staff privileges because he did not meet the hospital’s requirement that an applicant for surgical privileges be qualified for examination by the American Board of Surgery or one of its subspecialty boards. He sued the hospital alleging that the rule violated regulations promulgated by the State Department of Human Services (SDHS), and also that it was “arbitrary, capricious, unreasonable and unlawful because [his] residency program was equivalent to the American Medical Association-approved residency program and he was excluded solely because it was osteopathic rather than allopathic.”

Maine’s hospital licensing regulations provide that under no circumstances can the accordance of staff membership or professional privileges in a hospital be “dependent solely upon certification, fellowship, or membership in a specialty body or society . . . all qualified candidates [must be] considered by the credentials committee.” The regulations go on to state that the criteria for selection are individual character, competence, training, experience, and judgment.

The trial court ruled that it “had no jurisdiction to review the staffing decision of a private, non-profit hospital” and granted the hospital’s motion for summary judgment. Hottentot appealed. The appeals court affirmed the trial court’s ruling.

The Supreme Judicial Court of Maine agreed with the trial court and the appeals court and further stated that physicians have no cause of action to enforce hospitals’ licensing regulations that prohibit hospitals from adopting criteria for appointment and clinical privileges based solely on certification by a specialty body.

“Obviously the Department [of Human Services] did not intend to prohibit all credentials requirements (such as graduation from a medical school)” wrote the court. However, even if the hospital’s requirement did violate the regulation, the court found that only SDHS could enforce the regulation; Hottentot could not ask the court to enforce the regulation on his behalf.
Hospitals can set standards, the court said, but could not apply different standards to physicians with osteopathic training than those it applied to physicians with allopathic training. The court noted that three DOs had qualified under the requirement that all applicants complete an allopathic residency; they had been granted staff privileges at the hospital.

According to Lisa D. Taylor, Esq., of the law firm of Shanley & Fisher P.C., Morristown, NJ, “If a hospital insists on differentiation between post-graduate training received in an allopathic residency and that received in an osteopathic residency, its decision has to be based on the best interest of patient care.” If, for example, the board decides on allopathic training only, it must be able to defend its position, she explains. “The board must be able to prove that this type of formal training is better, in the name of patient care, than that taken by osteopathic physicians,” Taylor concludes.

William Copeland of the health care law firm of Copeland & Brown in Cincinnati, says, “If a hospital’s medical staff is largely made up of MDs and its board set about asking for only allopathic residency training, it is probably asking for a legal challenge.

“Boards can’t base a privileging decision on education and training alone,” he says. Instead the board should open up the application process to both MDs and DOs and those graduates with MD and DO training. “Then the hospital must evaluate each applicant’s individual competency,” Copeland says. “If the board is just looking for one cardiologist, its privileging decision should be based on getting the very best cardiologist to fill the available slot.”

Generally, criteria for medical staff membership and privileges will survive legal scrutiny if it can be demonstrated that it is related to quality of care issues. However, to the extent that they are found to be unrelated to quality of care issues or unreasonably susceptible to discriminatory application, they will not survive challenge.

“Any hospital should first check its state’s post-graduate discrimination statute,” Copeland explains. “Many states forbid discrimination based on academic criteria and that includes residency programs.”

According to Linda Haddad, partner with Hory, Springer & Mattern in Pittsburgh, hospital boards seem free under the requirements of most states and based upon our analysis of
relevant case law to establish training requirements that will assure that individuals granted appointment and clinical privileges have been trained in residency programs of high quality.

"Many U.S. hospitals now require physicians to complete ACGME-accredited training, however, hospitals should review their own state law carefully and evaluate the characteristics of all training programs to establish a final policy regarding the type of training it will require."

The federal government

The federal Medicare statute defines inpatient hospitals' services to include the services of interns and residents in postgraduate training programs approved by the AMA or the AOA. Federal statute also includes osteopathic physicians for commission in the Medical Corps.

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According to the American Association of Colleges of Osteopathic Medicine, osteopathic medical schools saw a 29% jump in applications in the fall of 1992. More than 5,700 students applied to the 15 osteopathic medical schools in the United States. Moreover, more than 6,700 students were enrolled in colleges for osteopathic medicine for 1992-93. The following are the osteopathic schools accredited by the Bureau of Professional Education of the AOA with Lake Erie College of Osteopathic Medicine added in the fall of 1993:

- Chicago College of Osteopathic Medicine of Midwestern University, Chicago, IL
- College of Osteopathic Medicine of the Pacific, Pomona, CA
- Kirksville College of Osteopathic Medicine, Kirksville, MO
- Lake Erie College of Osteopathic Medicine, Erie, PA
- Michigan State University, College of Osteopathic Medicine, East Lansing, MI
- New York College of Osteopathic Medicine of New York Institute of Technology, Old Westbury, NY
- Ohio University College of Osteopathic Medicine, Athens, OH
- Oklahoma State University/College of Osteopathic Medicine, Tulsa, OK
- Philadelphia College of Osteopathic Medicine, Philadelphia, PA
- Southeastern University of Health Sciences, College of Osteopathic Medicine, North Miami Beach, FL
- University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO
- University of Medicine & Dentistry of New Jersey, School of Osteopathic Medicine, Stratford, NJ
- University of New England, College of Osteopathic Medicine, Biddeford, ME
The best way to deal with physicians holding different types of education, training, and experience is to set minimal formal training criteria for each clinical area of the hospital. For example, as a minimum education requirement, the hospital board could ask each applicant to hold either an MD or a DO degree. (All states require that hospitals make no differentiation between an MD’s and a DO’s medical degree.)

Next, the board should require applicants to demonstrate completion of formal training. In areas where there are no AOA-approved training programs the choice may be clear. However, if there are training programs approved by both the ACGME and AOA, the **Credentialing Resource Center** recommends that the board not specify one accreditation over another unless such differentiation is based upon an evaluation of the specific characteristics of the training program.

When hospitals consider the adequacy of basic training they should consider the following issues:

- duration of program (i.e. number of months),
- the type and volume of experience gained in the program (i.e. number and type of cases),
- whether the program had full-time attendings dedicated to training and supervision,
- the qualifications of instructors and professors (i.e. board certified, school affiliation),
- accreditation status and size of the facilities where training takes place, and
- roles and responsibilities of the residents in the program.

The information contained in this document has been designed and is intended for use by hospitals and their credentials committees in developing their own local approaches and policies for various credentialing issues. These materials, opinions, and draft criteria should not be adopted for use without careful consideration, discussion, and additional research by physicians in local settings. The **Credentialing Resource Center** does not provide legal or clinical advice; for such advice, the counsel of competent individuals in these fields must be obtained.