Unlocking the Hospital Doors:
Medical Staff Membership and
Physicians Who Serve the Poor

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Children's health, a key measure of any nation's well being, is a leading indicator of the soundness of a nation's health system and its ability to provide economically for all of its citizens. Children's basic living conditions and their access to medical care in turn are major determinants of children's health.¹

No matter what statistical measure is used, the current economic status and physical health of America's children are appalling. In 1988, for instance, almost 12.6 million American children lived in families with incomes below the federal poverty line.² Another equally large number of children lived in families with incomes below 200% of the federal poverty level. Nearly half the babies born today are born to mothers whose family incomes are below 200% of the federal poverty level.³

These bleak economic conditions have had a particularly sharp effect on infant mortality. Thirty-five years ago the infant mortality rates of France and Japan almost doubled the American rate. In 1988, the U.S. infant mortality rate lagged behind those countries and many others.⁴ The U.S. infant mortality rate had steadily improved over the fifteen years following the Great Society's health and economic development programs. But the rate of progress in improving infant mortality began to slow significantly in the early 1980s following reductions in these programs. By 1988 the progress ground to a virtual halt.⁵

The infant mortality statistics for black infants are even worse than the aggregate data. In 1988 the black infant mortality rate more than doubled the

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2. CHILDREN'S DEFENSE FUND, S.O.S. AMERICA!: A CHILDREN'S DEFENSE BUDGET 147 (1990) [hereinafter S.O.S. AMERICA!].
Unlocking the Hospital Doors

white rate, the largest disparity since the federal government began reporting data by race in 1940.6 Most of this disparity can be traced to poverty,7 which in 1987 claimed 45% of all black children.8

America's disturbing child health statistics, however, do not stop with infant mortality. During the 1980s, the proportion of infants born at low birth weight stagnated. Low birth weight is the single greatest predictor of both infant death and lifelong disability.9 Moreover, the mortality rate for young children (that is, those who have passed infancy), is higher in the United States than in many other industrialized nations.10 And low birth weight infants who survive often face other obstacles. For each low birth weight child who dies in infancy another ten will live the rest of their lives with disabilities.11

As long as such deplorable health conditions persist for so many American children, access to comprehensive medical and hospital care will be critical. Ensuring such access, however, has never been easy. Indeed, racial and economic disparities in access to hospital care are two of the American health system's most extensive and persistently documented problems.12 To its credit, Congress has passed legislation aimed at reducing these barriers: it has expanded Medicaid to include one-half million more pregnant women and four million more children,13 and prohibited hospitals that participate in Medicare

6. Id. at Table I (unnumbered).
7. Infant mortality is closely associated with low birth weight, which in turn is closely related to poverty and low educational attainment. Of all infants who die, about 60% are low birth weight, even though low birth weight infants comprise only seven percent of all U.S. births. U.S. PUBLIC HEALTH SERVICE, PHS/CDC News, DHHS PUB. No. (PHS) 90-1232, HEALTH UNITED STATES 1989 12 (1990)(hereinafter HEALTH UNITED STATES). Highly educated, non-poor black mothers nonetheless tend to experience a somewhat greater incidence of low birth weight births. However, the incidence of low birth weight among infants born to non-poor black women is about half that of infants born to poor black women. Health researchers have concluded that while a somewhat elevated incidence of low birth weight can be found among black infants even at upper income levels, it is impossible to determine if the disparity is biological or can be traced to the residual effects of generations of poverty and reduced access to health care.
8. S.O.S. AMERICA!, supra note 2, at 151.
10. CHILDREN 1990, supra note 4, at 23.
11. S.O.S. AMERICA!, supra note 2, at 140.
from denying emergency care to any patient who needs it.14 Both policymakers and the media have addressed the problems that poor people face when trying to get medical care. Nonetheless, enormous problems persist.

This Article explores a little understood factor in the continued pattern of diminished access to inpatient hospital care: hospitals that deny what are known as "staff membership privileges" to qualified physicians who serve poor and minority patients. Staff privileges are essentially the right to admit patients to a particular hospital; patients whose doctors lack such privileges cannot be admitted for hospital care. The disturbing problem we document here is that physicians who meet the hospitals' education and training requirements, are often refused the right to admit their patients for reasons unrelated to either the patients' need for services or the physician's ability to furnish quality care.

Part I of the Article examines the need for inpatient hospital services among low-income and minority pregnant women and children. Part II reviews the procedure hospitals use to control which doctors have staff privileges. Part III presents the results of a survey we conducted recently to determine the extent to which qualified physicians who serve predominantly low-income and minority patients experienced difficulties admitting their patients for hospital care. Part IV assesses the legal safeguards currently in place to assure hospital access for poor, uninsured and minority persons and to protect physicians who treat such patients against unfair denial of admitting privileges. Part V sets forth legal and policy recommendations to alleviate these access problems.

We conclude that the practice of denying or delaying staff privileges to well-qualified physicians who serve poor patients may be widespread. Moreover, existing federal laws designed to promote hospital access for poor, minority, and uninsured persons fail to address the problem. We ultimately recommend federal legislation designed to make it easier for qualified physicians who serve poor patients to gain hospital staff privileges.

I. HOSPITAL CARE FOR LOW-INCOME AND MINORITY PREGNANT WOMAN AND CHILDREN: NEED AND ACCESS

Inpatient hospital care is a fundamental component of good health care. Pregnant women in particular need prompt, timely access to inpatient services.

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Unlocking the Hospital Doors

Although children generally use hospital care infrequently\textsuperscript{15}, when a medical need arises children also require prompt access to inpatient services.

Indeed, prompt access to inpatient care is a critical aspect of an adequate maternity healthcare program. Women's greatest need for inpatient hospital care arises during the perinatal period (from conception through the child's first year).\textsuperscript{16} Sixty percent of all pregnancies involve one or more complications. Three in ten pregnancies involve major complications.\textsuperscript{17} Pregnant women often require hospital access for other conditions that may also affect their pregnancies—for example, high blood pressure, infection, or diabetes.\textsuperscript{18}

Medicaid and other War on Poverty programs have helped ensure prompt access to inpatient hospital care for many pregnant women.\textsuperscript{19} Increased access to hospitals resulting from these programs has in fact, been widely credited as a leading factor in the U.S. national infant mortality rate's decline between 1965 and 1980.\textsuperscript{20} Because poor women's access to prenatal care remains unacceptably low,\textsuperscript{21} access to comprehensive inpatient care will remain a critical factor in the continuing battle to reduce our infant mortality rates and to care for pregnant women.\textsuperscript{22}

Children need hospital services less often than pregnant women or infants. After the perinatal period, children use inpatient hospital services far less frequently than other segments of the population,\textsuperscript{23} especially older people. Children who do require hospitalization, however, often have a serious need for inpatient care. For instance, one-third of all low birth weight survivors

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15. \textit{Health United States}, supra note 7, at 184, Table 70. Children experience both relatively few discharges per 1000 persons and relatively short lengths of stay per admission. For example, in 1988 there were 117.8 hospital discharges per 1000 persons on an age-adjusted basis but only 49.2 discharges per 1000 children under 15 years of age. In that same year the average length of stay was 6.4 days, while children under 15 who were hospitalized stayed an average of 5 days.


18. \textit{Committee to Study the Prevention of Low Birth Weight, Institute of Medicine, Preventing Low Birthweight 241-248} (1985).


21. \textit{Health United States, supra note 7, at 31. In 1987, one-fourth of all U.S. infants and nearly 40% of non-white and Latino infants were born to women who failed to receive prenatal care during the first three months of pregnancy. Early receipt of prenatal care is closely associated with increases in birth weight and decreased risks of infant mortality.

22. The cost of relying on inpatient intensive care to reduce infant mortality is high in both human and financial terms. Infants born at low birth weight are 40 times more likely to die in the first 28 days of life and 20 times more likely to die in infancy. Low birth weight infants who do survive are at significantly increased risk for such lifelong disabilities as retardation, cardiac palsy, and vision and learning disabilities. It has been estimated that by simply expanding access to relatively low-cost preventive health services for pregnant women and infants, the nation could save billions of dollars in reduced hospital and long-term institutional, special education, and social services, as well as improved productivity. White House Task Force Report, supra note 1, at 21.

23. \textit{Health United States, supra note 7, at 170, Table 70.}
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require re-hospitalization during the first year of life.\textsuperscript{24} In situations like these, hospital access is vital.

Low-income and minority children and pregnant women need prompt access to inpatient services at higher rates than their non-low-income counterparts. Low-income children, for example, suffer chronic illnesses and conditions at rates far higher than economically better-off children.\textsuperscript{25} Poor, uninsured, or publicly insured children are significantly more likely to require hospitalization for conditions like asthma, upper respiratory infections, influenza and other acute and chronic illnesses and conditions than children of affluent parents. Non-poor children are commonly treated for these conditions as outpatients.\textsuperscript{26}

While outpatient settings can (and should) furnish the vast majority of maternal and child health services, an adequate maternity and pediatric health care system must also ensure ready access to hospital care. Such a system of care should provide access to medically necessary hospitalization before the problem becomes an emergency.\textsuperscript{27} Although sudden medical emergencies requiring immediate hospitalization will inevitably arise, such emergency access is not the criterion by which a maternal and child health system should be measured.

Poor women and their children have a greater need for hospital care than affluent people. Ironically, however, they have greater difficulty gaining access to hospitals than more affluent people. For low-income and minority women and children, inpatient hospital care is too often delayed until severe damage or death has occurred. Even when provided, hospital services may be available only in overcrowded and substandard settings. Stories abound of inner city public hospitals maternity wards operating beyond capacity and unable to properly manage high risk deliveries.

In America's rural areas, the situation is no better. Millions of poor women and children there suffer from medical personnel shortages, and are severely segregated from mainstream health care. A serious lack of available, accessible, adequately equipped, and fully staffed hospitals partly explains the substandard maternity and pediatric care rural Americans often receive.\textsuperscript{28} However, even in communities—both rural and non-rural—with an adequate supply of hospital facilities, uninsured low-income and minority women and children

\textsuperscript{24} COMMITTEE TO STUDY THE PREVENTION OF LOW BIRTHWEIGHT, \textit{supra} note 18, at 223.
\textsuperscript{26} Id. at 551.
\textsuperscript{27} ALAN GUTTMACHER INSTITUTE, \textit{supra} note 17, at 10.
\textsuperscript{28} Hughes & Rosenbaum, \textit{An Overview of Maternal and Infant Health Services in Rural America}, 5 J. FAM. HEALTH 299 (1989).
Unlocking the Hospital Doors

often receive inadequate hospital care.29

The problem of hospital access is exacerbated because children and women of childbearing age are pervasively uninsured. Recent data indicate that more than eleven million children lack any form of public or private insurance.30 Maternity hospital care alone has been estimated to comprise 27% of all uncompensated hospital discharges.31

Because of their higher poverty rates, women and children rely heavily on Medicaid, the nation's largest source of third-party financing for uninsured low-income families with children.32 As Medicaid has expanded, and as coverage of women and children by private health insurance has declined,33 women and children depend more and more on Medicaid. Numerous states reported that in 1990—following successive years of Medicaid expansion in the face of eroding private insurance coverage—as many as half of all births to state residents were financed by Medicaid.34

In most states, Medicaid payments are far less than hospitals charge for care. For at least some facilities, Medicaid payments are alleged to be below the reasonable cost of furnishing care.35 Hospitals thus have a natural incentive to avoid admitting low-income maternity and pediatric patients. These patients not only will require more intensive hospital services, but are also likely to be either completely uninsured or dependent upon Medicaid.

II. CONTROLLING THE HOSPITAL DOORS

A. A Background on Staff Privileges

To understand why hospital access problems persist, it is first necessary to understand the U.S. system for determining who is admitted to a hospital. One possible system would allow people who believed themselves to need

30. ALAN GUTTMACHER INSTITUTE, supra note 17, at 44; Cunningham & Monheit, Insuring Children: A Decade of Change, HEALTH AFF., Winter 1990, at 80.
31. ALAN GUTTMACHER INSTITUTE, supra note 17, at 46.
32. HOUSE COMM. ON ENERGY & COMMERCE, SUBCOMM. ON HEALTH AND THE ENVIRONMENT, CONG. RES. SERVICE, 100TH CONG., 2D SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 1 (Comm. Print 1988).
34. Data provided to authors by Dr. Peter Van Dyke, Director Division of Family Health Services, Utah State Health Dept., January 1991; Judy Barber, Chief of Social Work, Mississippi Health Dept., October 1990; Maxine Hayes, Director, Division of Maternal and Child Health, Washington State Health Dept., October 1990; Dr. James Quilty, Head of Division of Family Health Services, Ohio State Health Dept., October 1990.
hospital-based services simply to admit themselves. Under this self-referral arrangement, hospitals could employ staffs of physicians available to consult these self-admitted patients.

Such a system, however, does not exist in U.S. hospitals. Instead, physicians largely determine who will be admitted. This arrangement is consistent with physicians' historical domination of American hospitals. While a few patients are admitted to a hospital via their own self-referrals to a hospital's emergency room, most patients enter hospitals because their doctors possess staff privileges and decide to admit them.

Control over who gets staff privileges is the strongest weapon hospitals possess for determining which physicians—and therefore which patients—can gain access to a facility. Under hospital corporate law, it is the medical staff itself that has the authority to make this decision. And medical staff decisions can carry important consequences. Suppose, for instance, the staff was considering for staff privileges a physician whose practiced consisted mainly of low-income and minority patients. Some members of the medical staff might not want such patients in their hospital, and might therefore deny staff privileges for that physician.

Having hospital admitting authority is essential in an age when so much medical care is furnished on an inpatient basis. Staff privileges are vital not only to a physician's capacity to provide adequate quality care but also to her economic livelihood. It is unthinkable, for example, that any pregnant woman would choose a physician who could not provide access (either personally or through direct practice affiliations) to hospitals that offer both basic and specialized inpatient obstetrical facilities. Any physician who lacked staff privileges would therefore find it difficult to earn a living. The numerous legal challenges to the denial of admitting privileges signal medical staffs' business interest in rejecting or placing restrictions on candidates who apply for privileges.

When an applicant for staff privileges has a practice that consists largely

38. See, e.g., Tabor, The Battle for Hospital Privileges: The Antitrust Frontier, reprinted in HOSPITAL PRIVILEGES & SPECIALTY MEDICINE 315 (1986). Neither constitutional challenges based on alleged abridgment of substantive due process rights nor antitrust actions have succeeded by and large. Procedural due process claims appear to fail so long as hospitals operate in accordance with published bylaws and afford basic procedural due process protections for applicants who are affected by a staff decision. See, e.g., Johnson v. Fulton-DeKalb Hosp. Auth., 423 F. Supp. 1000 (N.D. Ga. 1976). Cases brought under the Sherman Act, 15 U.S.C. §§ 1, 2 (1988), have rarely reached the trial stage and those that have gone to trial have generally failed. The major basis for these losses has been plaintiffs' inability to show a conspiracy: courts have held that hospitals and their staffs are a single entity and thus cannot conspire with each other. Allegations of monopolization under section 2 of the Sherman Act similarly have failed because of plaintiffs' inability to demonstrate the requisite monopolization of the service area by the hospitals. Johnson, 423 F. Supp. 1000.
Unlocking the Hospital Doors

of low income patients, the hospital staff's financial concerns may influence the decision. Such an applicant's patients can contribute only marginally—if at all—to the cost of their own care. Moreover, these patients might also require an enormous amount of ancillary support from nursing, allied health care, administrative and other staff, which would increase the financial drain on the hospital. It would be difficult for an obstetrical ward to survive if it was filled with patients who were either uninsured or covered by insurance that paid at rates inadequate to reimburse the costs of necessary medical services.

Beyond simple economic concerns, however, the staff may wish to avoid the added responsibilities toward applicants who treat low income or minority patients. Medical staff privileges frequently carry with them certain obligations—such as availability for specialty referrals and consultation and coverage in the event that a patient's primary physician is unavailable. If an applicant's practice consists of uninsured or publicly insured patients with a high potential for medical difficulties (such as pregnant women with high medical risks), existing medical staff may have an economic interest in keeping the applicant off the staff. Similarly, a medical staff that otherwise refuses to accept minority patients, may have racially discriminatory motives for denying privileges to an applicant whose practice is comprised largely of minority patients.

In effect, control over who admits patients can screen out "undesirable" patients—save for the few who are admitted through a hospital's emergency room. Hospitals with emergency rooms can avoid large numbers of medically indigent admissions simply by directing ambulance companies to transport medical emergencies involving uninsured persons to public hospitals. Hospitals without emergency room facilities can avoid virtually all unwanted admissions simply by denying privileges to physicians who treat undesirable patients.

Identifying such physicians is not difficult. In most communities, only a small fraction of private physicians provide treatment for sizable numbers of poor patients. For example, about 25% of all pediatrists and 37% of all obstetricians do not treat any Medicaid patients. Most physicians who do accept them accept only a small number of Medicaid patients. A very small proportion of physicians maintain sizable Medicaid practices. Thus, by denying or curtailing privileges to applicants who treat the poor, and by carefully

39. Cases abound in which patients have been denied care because they do not have a personal physician with staff privileges at a hospital and because hospital by-laws only allow admission to the facility by a physician with staff privileges. See, e.g., Cook v. Ochsner Found. Hosp., 61 F.R.D. 354 (E.D. La. 1972) (suit brought by Medicaid patients who had been denied admission because no staff physician treated Medicaid patients); Campbell v. Minney, 413 F. Supp. 16 (N.D. Miss. 1975) (pregnant patient denied delivery services because she was not under care of local physician with staff privileges); In re Madera Community Hosp. (Dept. of Health & Human Svcs., Office of Civ. Rts., Region IX, San Francisco, Cal.) (No. 09-81-3222) (Aug. 31, 1981).

selecting their own patients, a hospital’s staff can control who gets through the hospital door.

B. The Role of JCAHO

Congress has not legislated that medical staffs control staff privileges. Rather, the mandate of a separate body governs the hospital industry. This body, the Joint Commission on Accreditation of Health Care Organizations (JCAHO),\(^1\) has the authority to accredit U.S. hospitals. JCAHO’s accreditation standards determine which facilities can be licensed as hospitals, and in turn, which licensed hospitals are qualified to participate in major public and private health insurance programs.\(^2\) JCAHO standards require that admitting privileges be controlled by a hospital’s medical staff.

A private non-profit organization, JCAHO is a professional accreditation and licensure body that develops and monitors health, safety, and organizational standards in hospitals and other institutions. For example, a facility that desires a state license to operate as a hospital must usually first show that it complies with JCAHO standards. Moreover, Congress has granted JCAHO the authority to certify which hospitals qualify to participate in the Medicare program.\(^3\) Because hospitals must meet Medicare conditions of participation in order to qualify as Medicaid providers,\(^4\) JCAHO effectively determines hospitals’ Medicaid participation as well. Private insurers use JCAHO standards in a similar way—to determine which hospitals are qualified to treat their patients.

The result of this system is that the hospital industry, which exists because of both direct and indirect federal financial support, is given enormous latitude to determine which facilities may operate and who will be allowed to practice there. Not only do hospitals receive tens of millions of dollars in Medicaid payments—but employer-provided health insurance is tax-exempt,\(^5\) and not-for-profit hospitals similarly do not pay taxes. Yet at the same time, a direct Congressional grant of statutory authority to JCAHO authorizes a private accreditation system to set conditions for staff privileges and therefore ultimately to determine who receives hospital care.

In addition, the JCAHO standards for granting staff privileges are extreme-

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\(^1\) Formerly the Joint Commission on Accreditation of Hospitals.
\(^2\) Fraiche, supra note 37, at 67.
\(^5\) Enthoven, Health Policy Mismatch, 4 Health Affairs 5, 11 (Winter 1985).
Unlocking the Hospital Doors

ly vague and vest remarkable discretion in existing medical staffs. Addition-
al standards require the “expeditious” processing of applications, and that com-
pleted applications be acted on within a “reasonable” period of time. Finally, the JCAHO criteria require a “fair hearing” when an applicant’s privileges are denied.

The danger of these standards is the vast discretion they grant to a hospi-
tal’s medical staff. For instance, an applicant who otherwise meets the hospi-
tal’s education and training requirements could be denied privileges for reasons unrelated to her competency. These reasons could include adverse peer recom-
mendations, assertions that the hospital’s “patient care needs” are already met, lack of “adequate” professional liability insurance, and “geographic” consider-
atations.

The most obvious criterion that could be used to deny an “undesirable” physician staff privileges is the peer recommendation. Other criteria, however,

46. These standards provide that:

Required Characteristics . . . .
Appointment to the medical staff is made through a hospital specific mechanism that is . . . approved and implemented by the medical staff and the governing body; . . . fully documented in the medical staff bylaws, rules and regulations, and policies; and . . . described to each applicant. . . .

The mechanism provides for, but need not be limited to, the following:

. . . Medical staff membership is granted by the governing body in accordance with the bylaws, rules and regulations and policies of the medical staff and of the hospital.

. . . Each applicant for membership is oriented to these bylaws, rules and regulations, and policies and agrees in writing that his activities as a member of the medical staff will be bound by them.

. . . Professional criteria specified in the medical staff bylaws and uniformly applied to all applicants or medical staff members constitute the basis for granting initial or continuing staff membership.

. . . The criteria pertain to, at the least, evidence of current licensure, relevant training and/or experience, current competence, and health status.

. . . The [professional] criteria may also pertain to other reasonable qualifications, such as
. . . the ability of the hospital to provide adequate facilities and supportive services for the applicant and his patients;
. . . patient care needs for additional staff members with the applicant’s skill and training;
. . . current evidence of adequate professional liability insurance; and
. . . the geographic location of the applicant.

. . . Sex, race, creed, and/or national origin are not used in making decisions regarding the granting or denying of clinical privileges. . . .

Peer recommendations are part of the basis for the development of recommendations for medical staff membership.

47. Id. at 97.
are equally open to abuse. Consider, for example, the “patient care needs” provision, which allows a medical staff to base its decision solely on the needs of those patients currently able to gain admission to the facility. The problem with this criterion is that patients who have been denied access to the hospital in the first place—most likely low-income and minority people—do not figure in the “patient need” decision. A doctor who served such patients therefore would likely be denied staff privileges. Adequate liability insurance is another problematic criterion. A physician practicing at a publicly funded health clinic able to afford only professional liability insurance with a maximum of $250,000 in payments per incident can be rejected for membership if the hospital requires protection of $1 million per claim. Physicians working at clinics located in rural, medically underserved areas can be rejected because they practice at a “geographically remote” distance. Further, the accreditation criteria clearly make consideration of the applicant’s race, ethnicity or creed unlawful. But the criteria say nothing about the race of an applicant’s patients.

JCAHO standards do not set time limits for making decisions on applications for staff membership. If an application is denied or not acted on with reasonable promptness, the hospital is required to provide only an internal fair hearing. Especially with private hospitals, courts have confined their review of medical staff denial cases to procedural issues, leaving applicants denied privileges with virtually no relief. 48

To complicate matters, little information exists that allow outside bodies to evaluate how JCAHO uses its standards. The accreditation body appears to maintain no aggregate records of hospitals’ actual medical staff requirements. Nor is there a body of written administrative decisions on staff membership. Our own contacts with JCAHO staff yielded virtually no written guidance beyond the summary criteria set forth above. Nonetheless, it is easy to infer widespread use by hospital staff of non-competency criteria in granting or denying staff privileges. The criteria, after all, have been developed by a body that represents hospitals and physicians, and thus presumably reflect the industry’s chief concerns.

In a nation in which health care is largely a private enterprise, hospitals are in one sense businesses that need to survive. For ordinary businesses, the types of non-competency economic criteria developed by JCAHO may reflect routine economic concerns. But a hospital is not simply an ordinary business. The JCAHO standards, viewed against both the market-transcendent nature of health care and the reality of how individuals needing hospital care gain admission, raise a host of serious concerns. Consequently, if an applicant’s practice is comprised of low-income and minority patients (or if the applicant

Unlocking the Hospital Doors

is one of only a few physicians who cares for a community’s minority and low-income patients) then denial of privileges to that physician effectively denies access to all but the handful of poor persons who are admitted through a hospital’s emergency room. Keeping a doctor out the hospital inevitably means closing the hospital door to all but that doctor’s emergency patients.

III. ASSESSING STAFF MEMBERSHIP BARRIERS CONFRONTING PHYSICIANS WHO SERVE THE POOR: THE CASE OF COMMUNITY HEALTH CENTERS

JCAHO staff membership criteria have a strong impact on whether poor and minority persons can gain access to hospitals. Yet, there is a dearth of hard evidence that examines what happens when competent physicians who serve the poor seeks staff privileges in hospitals. To examine the problem, in the summer of 1990 the Children's Defense Fund undertook a study of the barriers to obtaining staff privileges and making patient referrals encountered by physicians serving medically underserved low-income and minority women and children.

A. Community Health Centers

Locating such physicians in sufficient numbers to construct a reliable survey poses great difficulties. No single national or state registry identifies all U.S. physicians who meet minimum standards of competency and maintain a practice involving a large percentage of low-income patients. Nonetheless, there is a proximate means both to determine the prevalence of hospital access barriers and to identify competent physicians who serve the poor: the federal Community Health Centers Program and its companion, the Migrant Health Centers Program.

Created in 1965 as part of the War on Poverty, the Community Health Centers Program was initially administered by the Office of Economic Opportunity. The program was an unprecedented effort to bring comprehensive primary health care to the tens of millions of poor and minority Americans denied access to comprehensive primary health services. The operating statute required that all community health centers be located in areas that the federal government had designated as either medically underserved or as “high-impact” (a special designation given to areas with large numbers of migratory

51. One of the guiding forces behind the Office of Economic Opportunity was Jean Camper Cahn, to whom this issue of the Yale Law & Policy Review is dedicated. See A Tribute to Jean Camper Cahn, 9 YALE L. & POL’Y REV. 1 (1991).
52. HEALTH AND THE WAR ON POVERTY, supra note 19, at 163.
Factors that make an area medically underserved or high impact include infant mortality, poverty, and other indicators of unmet health needs among community residents. Original estimates predicted that 1000 health centers would be required to meet the needs of the medically underserved. Twenty-five years later, because of severe underfunding by the federal government (which directly finances and administers the program), only 540 centers—employing 2500 full-time physicians—are operating nationwide. Although these centers serve more than six million patients, experts estimate that another 2400 health centers are needed in order to reach all medically underserved persons.

Health center patients reflect the nation’s high childhood poverty rate. More than 30% of all health center patients are women of childbearing age, and 44% are children under eighteen. Half of all health center patients are uninsured, between 60 and 70% are members of racial and ethnic minority groups, and virtually all have family incomes below 200% of the federal poverty level. In 1988 health center patients accounted for more than 10% of all low-income births below 200% of the federal poverty level nationally, and for 30% of all births to women under age fifteen. Nearly three million children are served by health centers.

As for the physicians, health centers are federally administered and are subject to extensive oversight and regulation. This regulation includes detailed requirements regarding the education, training and overall competence of their medical staff. Physicians employed by health centers therefore are uniformly well-trained and educated.

The graduate medical education of about 25% of the health center physicians was financed in whole or in part by loan repayments and scholarships provided under the National Health Service Corps program. The Corps, established in 1970, has financed graduate medical education for thousands of physicians, nurses and other health professionals. Under the program,
Unlocking the Hospital Doors

Scholarship and loan recipients are obligated to practice for a certain period in areas of the nation designated “health professionals shortage areas.” Most of these areas have also been designated as “medically underserved.”

The National Health Service Corps has historically provided thousands of physicians to the nation’s most neglected areas. In 1981, however, the Reagan Administration reduced Corps scholarship recipients from 3200 in 1986 to just 123 by 1990. In 1990, Congress restored limited funding to underwrite scholarships and loans for approximately 1000 new trainees, but medical students now being educated with the financial assistance of a revived Corps will not be ready for placement for several years. As a result, health centers now must recruit physicians whose medical educations were not financed by the program and who are not under a compulsory service obligation.

Health centers are known among health care authorities for the scope and quality of the medical care they furnish. Studies document their positive impact on infant and child mortality and morbidity rates in the communities they serve. But recruiting health professionals to work in underserved areas is extremely difficult, especially given the low salaries for health center physicians and the extremely difficult conditions under which these physicians often must practice.

The hostility of local physicians historically has been an obstacle in recruiting health center physicians. Because local physicians hold staff privileges at area hospitals, they have the power to grant staff privileges to new applicants. While many private physicians have lent support to establishing community health centers, studies and anecdotal evidence suggest repeated incidents involving attempts by local medical societies to undercut and derail such facilities. For example, physicians have attempted to prevent National Health Service Corps and community health center physicians from obtaining

66. 42 U.S.C. §§ 2541, 2541-1 (1990). Previously these areas had been known as health manpower shortage areas. National Health Service Corps Revitalization Amendments of 1990, Pub.L. No. 101-597, § 401, 104 Stat. 3013, 3035 (1991). In designating HPSAs (or HMSAs as they formerly were termed) the Secretary of the Department of Health & Human Services is required to calculate shortage areas by an arithmetical formula of 1 primary care physician per 3500 persons. This formula overstates the average physician practice load by about a factor of two. Therefore, although 4100 primary care professionals (pediatrics, family practice, obstetrics, general internal medicine, dentistry, mid-level practice such as nurse midwifery and mental health) are estimated as necessary to meet the need in all 1935 shortage areas designated to date, this is clearly an understatement.

68. Communication with Bohrer, supra note 63.
70. Id.
71. HEALTH AND THE WAR ON POVERTY, supra note 19, at 169-70, 174.
staff membership at local hospitals. In other situations, hospital medical staff have refused to cooperate with health center physicians who had successfully obtained staff membership. Professional courtesies reportedly have been withheld, and emergency back-up and coverage have been denied. Moreover, health center staff frequently report that physicians in many communities refuse to accept patients referred by center physicians who have been denied privileges.

The Health Centers and National Health Service Corps Programs together represent the single most important set of federal programs for dealing with the widespread shortage of basic health services for the poor. However, if center physicians are denied hospital privileges for reasons unrelated to their education, training, and overall competence, the fundamental purpose of the programs—comprehensive medical care for low-income and medically underserved Americans—will be frustrated.

While the denial of staff privileges hurts patients immediately, the practice also hampers the centers’ ability to recruit and retain staff. Highly trained physicians are understandably reluctant to work in a community where the physicians in private practice do not want them.

More is at stake, however, than the popularity of a few physicians. Maintaining a medical practice without staff privileges is nearly impossible. Without hospital privileges, admitting indigent patients who need hospitalization degenerates into a struggle to find a physician willing to admit the patient as a referral. Patients can lose crucial time as their doctors haggle with hospital staff over each admission.

**B. The Children’s Defense Fund Survey**

In order to measure the success of health centers in obtaining hospital privileges for their medical staff and in establishing patient referral arrangements when center staff are unable to admit and treat patients, we surveyed community health centers during the summer of 1990 to evaluate their medical staff’s experience in securing hospital privileges.

1. **Methodology.** We prepared a detailed questionnaire that surveyed health centers’ experience both in obtaining privileges for their staff and in making referral arrangements for the admission of their patients. We administered the survey by telephone to a total of 118 out of 540 health centers (22% of all health centers). We selected centers with an eye toward creating a sample that would be representative by location (according to geographical region and whether location was urban or rural) and size. Slightly more than half of the centers surveyed (67 centers, or 56.8%) were located in rural areas. We interviewed the health center director, the associate director, or the medical staff director.
Unlocking the Hospital Doors

2. Overall findings. Table I (p. 70) lists our survey’s summary results. Nearly 70% of all respondents encountered difficulties in one or more of three separate categories: (1) obtaining hospital staff privileges; (2) securing admission (even when center physicians had privileges) for both uninsured and publicly insured patients; and (3) maintaining adequate referral arrangements for patients whose specialized care needs could not be met by center staff either because staff lacked appropriate expertise or because they could not secure admitting privileges.

Almost one-fourth of the centers reported either current or past problems in obtaining staff memberships for the medical staffs; two-thirds of these respondents were rural. More than one-third of all health centers also reported problems obtaining membership for their medical staff who are not physicians, especially certified nurse midwives.

Reasons for denying staff privileges fell into three categories: (1) denial based on the physician’s own credentials or experience; (2) denial based on geographic distance; and (3) denial based on other reasons. Approximately one-third (9 out of 28) reported that staff privileges were denied because center physicians failed to satisfy local hospitals’ board certification requirements in their areas of specialization. The remaining respondents reported that privileges were denied either because of geographic distance or, most commonly, for other unstated reasons.

Denial of privileges for geographic reasons occurred only at rural sites. This is particularly troubling, because rural residents necessarily must travel greater distances to hospitals than the urban poor. Thus distance alone should not play a central role in determining whether privileges are granted. Common “other” reasons for denial at both urban and rural sites included lack of sufficient malpractice insurance, lack of teaching staff status, or the desire of private physicians on the hospital staff to restrict competition. Three centers (all rural) reported lengthy and unreasonable delays by local hospitals in granting staff membership, and six centers reported that when approval was given, it came with significant limiting conditions.

In addition to problems in obtaining staff privileges, many centers—whether or not their physicians had staff privileges—reported problems obtaining admission on a referral basis for their patients. Eighteen centers, 72% of which were rural, reported either absolute refusal or great reluctance on the part of community physicians to admit patients in need of care. The barriers to referrals of patients with specialized and urgent needs tend to underscore the problems inherent in any remedy to the hospital access problem that turns on requiring existing staff physicians to accept referrals of poor patients. Health center staff physicians, well aware of the difficulty in obtaining specialized care for their uninsured and publicly insured patients, do not often attempt to make specialty referrals. Were physicians and patients required to depend on
referral arrangements for all hospitalization needs (including patients who fall within the center staff's own area of competence) we anticipate that the hospital access problem would be even more severe.

Whether or not their own staff had privileges, centers routinely reported problems in admitting Medicaid-insured and uninsured patients. Centers outside of rural areas were slightly less likely to encounter such problems. This is not surprising given the low occupancy rates in many rural hospitals that may make them more willing to take underfinanced patients.

The patient access barriers confronted by centers whose staff have admitting privileges, in fact, indicate the importance of medical staff privileges in overcoming barriers to hospital care. A physician with medical staff privileges who seeks admission of an "undesirable" patient may indeed face problems, but these physicians also can use their "elevated" status as staff members on their patients' behalf.

Physicians have also developed strategies to outwit hospitals. For instance, some physicians care for their patients as best they can at the health center until the hospital business office closes for the day and then insist on admission from a less rigorous night staff. Others hold a patient until a medical condition (such as active labor or a pregnant patient with high blood pressure) becomes so severe that the physician can demand the patient be admitted as an emergency case. Still others accompany the patient to the facility and use their authority as medical staff to insist upon admission. Thus, as difficult as securing the admission of "undesirable" patients can be, the task is probably easier when the demand is made by a physician with admitting privileges. While we were not surprised to find that even health center physicians with privileges reported significant hospital access barriers, we do not therefore conclude that the staff privileges are of no consequence to the patients.

Several centers also reported the denial of privileges by teaching hospitals that grant privileges only to faculty staff. This requirement poses a significant barrier by establishing a criterion that may have no relation to physician competency. Requiring faculty status in order to obtain privileges has inherent problems. First, a teaching program needs only a limited number of faculty, and these numerical limits themselves inhibit the granting of privileges to qualified physicians. Second, the decision to admit a patient for reasons related to teaching has no necessary connection to the patient's need for care. For example, a teaching staff's decision that its interns and residents have enough obstetrical cases may cause the staff to avoid more obstetrical admissions. In such a situation women and infants in need of the advanced care frequently available only through teaching facilities may find themselves unable to gain admission because of quotas on the type of case. Health center physicians qualified to furnish obstetrical care but unable to admit their own patients may find themselves unable to get a patient into a particular hospital, not because
Unlocking the Hospital Doors

they are incompetent to care for their patients, but because the faculty medical staff do not believe they need any more patients in that unit.

In short, the use of faculty status as a measure of medical qualifications is a means for regulating the cases to which medical students are exposed rather than the quality of physicians who wish to practice at a teaching hospital. Given the advanced medical care frequently available only at teaching hospitals, this barrier may pose particular danger for poor women and children who are in special need of the highly specialized services these institutions offer.

The responses by center staff carry a note of caution even for centers that have been able to obtain staff privileges for their physicians at area hospitals. Centers denied privileges unrelated to staff competency reported that hospitals were often unwilling to treat large numbers of indigent patients. This type of hospital behavior can occur at any time, in any community, if sufficient resentment builds against a particular clinic. Thus, we believe that the difficulties in gaining admitting privileges encountered by a sizable portion of health centers could spread to the majority of centers as the number of uninsured Americans grows and as hospital medical staff increasingly resent the additional economic burdens created by health center patients.

IV. THE ADEQUACY OF EXISTING LEGAL PROTECTIONS AGAINST THE USE OF STAFF MEMBERSHIP REQUIREMENTS TO DENY ACCESS

The best way to avoid discriminatory access to hospital care would be a national health insurance system that provided uniform reimbursement and coverage standards. The United States, however, remains virtually the only western nation that does not have uniform national health insurance despite decades of debate on this issue.72

Even if the U.S. were to implement national health insurance, discriminatory access to hospitals would persist. Considerations other than an individual patient's need for care would continue to play a role in determining who obtains access. To avoid such discrimination, Congress has enacted three laws—the Medicare Emergency Treatment and Active Labor Act,74 the Hospital Construction and Survey Act of 1946 (the Hill-Burton Act),75 and Title VI

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of the Civil Rights Act of 1964—\textsuperscript{76}—that create important rights against economic and race-based discriminatory treatment by hospitals. All three statutes set legal limits on the right of hospitals to deny access and provide remedies for such unlawful denial. Yet these statutes also leave hospitals and staff with enormous discretion in complying with their access requirements.

\textbf{A. The Medicare Emergency Treatment and Active Labor Act}

The Medicare Emergency Treatment Act offers the most limited legal protection for poor patients. The Act was a response to repeated incidents of "patient dumping," that is, hospitals who refused to treat indigent patients with medical emergencies. Under the Act, when a person with an emergency condition comes to a hospital emergency department and requests examination or treatment (or requests a medically appropriate transfer into a specialized facility), the hospital must provide for "an appropriate medical screening examination and necessary stabilizing treatment for emergency medical conditions."\textsuperscript{77} The law applies only to medical emergencies and only to hospitals with emergency departments.\textsuperscript{78} A hospital with specialized facilities, however, must accept the transfer request if the hospital has the capacity to treat the patient.\textsuperscript{79} No transfer of an emergency patient may occur until the patient has been stabilized and the receiving facility has agreed to the transfer.\textsuperscript{80} The Act expressly conditions hospitals' participation in the Medicare program (and thus in Medicaid) on compliance with its provisions.\textsuperscript{81}

Because the Act was designed to guard against the denial of only emergency service, it offers limited protection for larger instances of restricted hospital access. As a result, hospitalization needs that have not yet reached emergency status are outside the law's reach. Moreover, the Act was designed to deal with unsponsored patients who appear at emergency rooms with emergency conditions. It does not address the general problem of medical admissions for poor patients whose physicians lack admitting privileges.

The statute authorizes civil money penalties as well as private actions for damages and "equitable relief when appropriate."\textsuperscript{82} The effectiveness of isolated suits for damages and individual injunctive relief in gaining widespread emergency hospital access for the poor is doubtful. Furthermore, even if successful, litigants in the end would gain access only to emergency treatment.

\begin{footnotesize}
\begin{enumerate}
\item 42 U.S.C. § 1395dd(b) (1988).
\item 42 U.S.C. §§ 1395dd(a) (1988).
\item 42 U.S.C. §§ 1395dd(b)-(c) (1988).
\item id.
\item 42 U.S.C. § 1395dd(d) (1988).
\end{enumerate}
\end{footnotesize}
Unlocking the Hospital Doors

B. The Hill Burton Act

The Hospital Survey & Construction Act of 1946\textsuperscript{83}—better known as the Hill-Burton Act—established a federally financed program to construct thousands of hospitals. The law was enacted in response to economic and geographic barriers to health care identified during the 1930s and 1940s.\textsuperscript{84} The Act contains two substantive federal standards applicable to both states and to individual hospitals.\textsuperscript{85} The first, known as the uncompensated care assurance, requires hospitals to provide “a reasonable volume of services” to persons unable to pay.\textsuperscript{86} The second, which pertains directly to denial of admission to persons living in the community, is known as the community service assurance. It requires facilities to be made available to all persons residing in the hospital’s service area.\textsuperscript{87} Unlike the uncompensated care requirement, which lasts for only a term of 20 years,\textsuperscript{88} the community service assurance is perpetual. The assurance prohibits hospitals from using admissions policies that exclude persons who need the services the facility offers.

Federal Hill-Burton regulations require hospitals to participate in federal financing programs for indigent persons such as Medicaid,\textsuperscript{89} prohibit hospitals from failing to have staff physicians who participate in Medicaid,\textsuperscript{90} and prohibit hospitals from admitting only those patients cared for by physicians with staff privileges.\textsuperscript{91} While such provisions go far beyond the Medicare Act, thousands of today’s hospitals were not built with Hill-Burton funds and therefore are not bound by its requirements. Moreover, while the requirements cited above appear to curb Hill-Burton hospitals’ authority to deny privileges to physicians who treat poor persons, the regulations also expressly provide that:

The facility is not required to abolish its staff physician admissions policy as a usual method of admission. . . . [T]o be in compliance with this community service assurance it must make alternative arrangements to assist area residents who would otherwise be unable to gain admission to obtain services available in the facility.\textsuperscript{92}

The regulations thus give hospitals the option either of modifying their staff privilege rules to assure access or requiring existing staff to accept referrals of such patients. Even this requirement, which preserves hospitals’ near total

\textsuperscript{85} Id. at 266-67.
\textsuperscript{86} 42 U.S.C. § 291c(e) (1988).
\textsuperscript{87} The rule also requires hospitals to be accessible to persons employed in the service area even if they live outside of it. 42 C.F.R. § 124.603(a) (1990).
\textsuperscript{89} 42 C.F.R. § 124.603(c)(1) (1990).
\textsuperscript{90} 42 C.F.R. §§ 124.603(c)(2)&(d) (1990).
\textsuperscript{91} 42 C.F.R. § 124.603(d)(1) (1990).
\textsuperscript{92} Id.
discretion to select their staff, was highly controversial at the time the relevant regulations were adopted. In the Preamble to the final 1979 Hill-Burton regulations, the United States Public Health Service stated:

Not surprisingly proposed § 124.603 provided the area of greatest controversy in the proposed community service regulations. Providers generally argued that regulation of admissions procedures is inappropriate and improper. . . Numerous providers pointed out that they have power to . . . require staff physicians to participate in governmental programs . . . that the regulations would have the effect of driving doctors away from Hill Burton facilities; and that the Secretary has no direct authority to require doctors to treat particular classes of patients.94

The Service went on to provide "illustrative examples" of how admitting privilege barriers could be removed—including requiring existing staff to accept publicly insured and minority patients or hiring physicians who agree to treat such patients.94 Even though the Service granted hospitals broad discretion to determine how best to ensure equal access to care, the American Hospital Association challenged the constitutionality of the rules95 and made its opposition to the patient admission rules a centerpiece of its suit.96

Although the Seventh Circuit upheld the regulations, their effectiveness as a remedy for securing privileges for physicians who serve the poor is uncertain. A hospital found to have violated the anti-exclusion regulations can still choose to come into compliance by regulating its own physicians. This leaves physicians treating poor and minority persons (and the patients themselves) dependent on the cooperation of a hostile medical staff who, under the terms of a judgment or settlement, would be required to accept referrals. Such a remedy is fraught with practical problems. A medical staff remains free to engage in subtle (and not so subtle) practices designed to discourage referrals. Staff can claim that the referrals were never made, that they were made in an untimely fashion, that the services sought by the referring physician were unavailable, or that in specific instances an admission was unnecessary in their professional judgment. Injured persons would have to return to court repeatedly to demonstrate that a remedy was unworkable. The proof required in such a case is difficult, since, as with the Medicare Emergency Treatment Act, a physician’s medical judgment about the need for admission would be at issue, and expert witnesses in a local, hostile atmosphere would be needed.

94. Id.
Unlocking the Hospital Doors

C. Title VI

Title VI of the Civil Rights Act of 1964, unlike the Hill-Burton Act, applies to all hospitals that accept funding under any federal financial assistance program. However, Title VI reaches only those admissions policies that have the effect of discriminating on the basis of race, color or national origin. Title VI does not reach conduct that results in discrimination based solely on economic factors (for instance, public insurance status). Given the high level of uncompensated or poorly compensated care in the case of maternal and child health services, a hospital could demonstrate, for example, that admissions policies permitting a large portion of its obstetrics unit to be populated by publicly insured or uninsured women and infants would spell the unit’s end.

Beyond the threshold problems inherent in proving a Title VI violation remain the same remedial issues that limited Hill-Burton’s effectiveness. Title VI regulations provide that in the event that exclusionary practices (or practices that have the effect of overly excluding minority persons) are found, an offending institution can be required to modify its admissions and referral policies in order to assure that excluded persons have reasonable access. However, as with Hill-Burton, Title VI vests enormous discretion in institutions to decide how to comply with the statute. Thus, hospitals found in violation of Title VI clearly could revise their policies and require medical staff to accept minority patients on referral. The aggrieved parties would then have to show, as they must under Hill-Burton, that the remedies are unworkable. Therefore a court would likely be unwilling to modify staff privilege rules to make a facility grant privileges to a physician serving the poor.

No current federal law that regulates access to hospital care for low-income and minority patients provides direct relief against a hospital staff that refuses to grant membership to physicians who treat the poor. The approach of current federal laws requires hospitals to modify their own staff’s behavior rather than affirmatively to open their doors to competent physicians treating the poor. In the end, these legal protections, important as they are, do not challenge the traditional notion that medical staffs alone should determine who receives admitting privileges to a particular hospital.

There is, however, one notable exception to the dearth of remedies that deal directly with discrimination by hospitals against competent applicants who serve the poor. The National Health Service Corps statute conditions a hospital’s right to participate in Medicare on its agreement to extend staff privileges to Corps physicians. The statute reflects Congressional understanding of the extraordinary protections needed to protect the hospital practice rights of Corps physicians.99

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98. 45 C.F.R. § 80.3(b)(6) (1990).
physicians. The perceived need to move practitioners into poorly served communities was so compelling that the federal government was willing to limit the historic autonomy of hospitals in medical staff selection. This statute is a precedent for the remedy we propose in the next section.

V. RECOMMENDATIONS

Recruiting and retaining physicians for America's community health centers is a daunting task. The country is fortunate that many well-trained physicians are willing to serve America's needy, but policy makers must also remove constraints on these physicians' effectiveness in order that their service not be in vain. Guaranteeing hospital staff privileges to such doctors would be an important step in ensuring quality health care for those they serve.

Mandatory staff membership reforms will not erase the barriers to hospital access that confront poor patients who need care beyond the training and competence of health center physicians. We believe, however, that assuring staff membership for center physicians who meet hospitals' training and education requirements would improve overall health care provision. The statutory protection provided to National Health Service Corps physicians against the arbitrary denial of privileges provide a sound basis for securing staff membership for all health center physicians. Moreover, the remedy would not vastly increase beyond its historical levels the pool of physicians serving the poor who hold federally guaranteed staff privilege rights. Indeed, extension of the right to all 2400 full-time physicians in practice at community health centers would still not equal the number of physicians guaranteed the right to staff membership in 1985 when the National Health Service Corps was at its zenith. Extension of the National Health Service Corps guarantee to all health center physicians is especially compelling at a time when congressional support for the Corps is insufficient to meet the national need for physicians.

We therefore propose that the Medicare and Medicaid statutes be amended to require that, as a condition of participation, hospitals grant staff membership to physicians employed by federally funded health centers who meet appropriate training, education, and licensure requirements. We also propose that, as a condition of participation in Medicare and Medicaid, hospitals require doctors with staff privileges to accept medically necessary referrals from health center personnel, regardless of whether the patients' conditions have reached emergency status. These remedies have an immediate precedent in the National Health Service Corps. They are consistent with the intent underlying the access guarantees created by the Hill-Burton and Title VI statutes and the Medicare Emergency Treatment Act. They can also be justified on humanitarian grounds—as compensation for the nation's failure to guarantee basic health care coverage. We also believe that these remedies can be justified despite the
Unlocking the Hospital Doors

additional economic burdens they create. In light of the federal government's general support of hospitals, the latitude accorded hospitals to regulate themselves is remarkable. The added financial burdens, if any, created by easing the admission process for uninsured and under-insured health center patients can also be alleviated in ways that do not deny the poor access to medical care. Federal law already provides for higher reimbursement levels under Medicare and Medicaid in the case of hospitals serving disproportionately large numbers of low-income and uninsured patients. Special payment requirements can be extended to any facility whose medical staff includes health center personnel.

To be sure, physician and hospital lobbies may resist these recommendations. As we have noted earlier, hospitals are deeply opposed to ceding the authority to determine who practices within their facilities. Their resistance to such change is evident in the extraordinary latitude the industry gives itself, through its own accreditation standards, to select which practitioners can unlock hospital doors.

Perhaps the central lesson of this article is that improving access to health care means more than removing obvious roadblocks like the lack of insurance. Improving access also means altering the way hospitals and the medical profession make their decisions about who receives care. Granting staff privileges to doctors who serve our nation's low income and minority citizens will unlock the hospital doors for patients who have had too many doors closed on them in the past.

100. Id. §§ 1395ww(2)(b), 1396a(a)(13) (1988).
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Source: Children's Defense Fund