HEALTH LAW—ECONOMIC CREDENTIALING OF PHYSICIANS—THE SUPREME COURT OF ARKANSAS'S DECISION IN BAPTIST HEALTH V. MURPHY AND ITS IMPACT ON A HOSPITAL'S ABILITY TO MAKE CREDENTIALING DECISIONS: WHAT TRULY IS BEST FOR PATIENTS? *Baptist Health v. Murphy*, 2010 Ark. 358, ___ S.W.3d ___ (2010).

I. INTRODUCTION

The hospital, a highly regulated "business" aimed at providing necessary medical services, has consistently been at the forefront of this nation's political and legal discourse. The most commonly recognized type of hospital, the general-care hospital, provides medical services over a large spectrum of specialties, such as emergency services, acute cardiac care, general surgery, obstetrics, and psychiatric services.

Physicians, however, have become dissatisfied with their reimbursement at these general-care hospitals.[1] As a result of this dissatisfaction, some physicians have decided to enter the healthcare market as owners of their own created-and-managed specialty-care hospitals, rather than as persons with privileges to practice at general-care hospitals. These specialty hospitals typically are in the most profitable fields of medicine, such as cardiology, orthopedics, or general surgery.[2] Intuitively, this practice seems fair in a free market.

A problem arises when these same physicians seek privileges at general-care hospitals that are in direct competition with the specialty hospitals that the physicians either own or have an ownership interest in. This often creates a conflict of interest, which in many contexts, medical and otherwise, is a source of scrutiny among regulations and codes of ethics.

Take the following analogous example: Marla, a partner at the well-respected Soap Law Firm, conducts an initial meeting with a potential client, Tyler. He states to Marla that he is looking for representation in a complex tort case with criminal undertones involving a condominium, and he noted that Soap Law Firm has a great reputation for success in this type of matter. Marla agrees that Soap Law Firm has a great reputation, but tells Tyler that she has a friend named Jack who is even more efficient and skillful at handling these types of matters and that he should go see him. Marla had previously loaned Jack funds to create his firm, and in return, he promised her she would get a portion of any proceeds he receives through his law prac-

tice. Fundamentally, this is questionable.[3] Marla is using the Soap Law Firm's reputation and business connections to foster her own side business. The Soap Law Firm has both a moral and business imperative to restrict this kind of conduct.

Similarly, in response to the rise of physician-owned specialty hospitals, some general-care hospitals have used economic-credentialing-like conflict of interest policies, preventing physicians with any ownership interests in specialty hospitals from having privileges at the general-care hospitals' facilities. These policies have stirred controversy throughout the healthcare industry. Many general-care hospitals have accused the physician owners of specialty hospitals of "choosing the most lucrative cases or best insured patients" and transferring them to the specialty hospitals in which they have an ownership interest while referring patients with poor insurance or unprofitable illnesses to the general-care hospitals.[4]

Specialty-care hospitals claim that economic credentialing is purely anticompetitive and is designed to prevent physicians from having ownership in competing facilities.[5] Furthermore, physicians at specialty-care hospitals also claim that they have an improved quality of care and higher patient satisfaction than general-care hospitals.[6] Ultimately, the question is one of policy. The Supreme Court of Arkansas has recently weighed in on this controversy in *Baptist Health v. Murphy*, in which it upheld an injunction that prevented Baptist from using a conflict of interest policy to restrict a physician's privileges if he or she has an ownership interest in a specialty-care hospital through the vehicle of tortious interference with the physician-patient relationship.[7]

This note will examine the *Baptist Health* series of decisions and the policy arguments explicated in it. The court affirmed the circuit court's decision that the physician-patient relationship is too important for society to prevent physicians with ownership interests in specialty-care hospitals from practicing at general-care hospitals on the basis of those ownership interests. Its decision also affirmed the use of tortious interference with a business expectancy. [8]

The court's decision is complicated by the recent passage of the Patient Protection and Affordable Care Act, which effectively bans the expansion of physician-owned specialty hospitals existing at the time of the passage of the Act and the creation of new ones by restricting Medicare payments.[9] Furthermore, conflict of interest policies that exist in other contexts, such as the legal profession, deal extensively with economic interests and are aimed

at protecting the client-attorney relationship; it is paradoxical that a conflict of interest policy enacted by a general-care hospital is harmful to the physician-patient relationship.

In the wake of uncertainties regarding the implementation of the Patient Protection and Affordable Care Act, the *Baptist Health* decision is a problematic, murky decision that provides little guidance as to what is best for patients in the context of physician ownership in specialty-care hospitals, even though this was purportedly the basis of the decision. Therefore, this note argues that *Baptist Health* is contrary to public policy in that it does little to protect patients from the inevitable conflict of interests that arises when a physician has an ownership and financial interest in a specialty-care hospital. This lack of protection is contrary to the passage and substance of the Patient Protection and Affordable Care Act.

II. BACKGROUND

A. The Conflict Between General- and Specialty-Care Hospitals

The debate over the existence of specialty-care hospitals is extensive. Increasing economic dissatisfaction by physicians, resulting from limited reimbursements from managed care plans,[10] is largely responsible for the existence of the specialty hospital.[11] Managed care plans control reimbursement through physician fee schedules, and these plans require that physicians assume economic risk.[12] Allegedly, these restrictions are aimed at promoting more efficient practice of medicine.[13]

As a result, physicians have begun to invest and obtain ownership interests in physician-owned specialty-care hospitals. The problem, however, is that many of these physicians obtain or renew their staff privileges at general-care hospitals that are competing directly with the specialty-care hospitals.[14] The issue is further convoluted because these specialty-care hospitals usually conduct the most profitable services available to medical care professionals.[15] General-care hospitals argue that this has the potential to divert the most profitable cases away from them, ultimately resulting in their inability to subsidize the less profitable, but necessary services provided by a general-care hospital.[16] This result has led some general-care hospitals to create conflict of interest policies in the form of economic credentialing.[17]

This economic credentialing has caused a political war between the American Medical Association ("AMA") and American Hospital Associa-

tion ("AHA"). The AMA officially opposes all economic criteria that are unrelated to the patient's quality of care in its staffing decisions due to the effect on patient choice and his or her relationship with his or her physician.[18] The AHA, on the other hand, approves of economic credentialing,[19] stressing that general-care hospitals provide care to every member of a community regardless of whether he or she is insured and this obligation is sufficiently important enough to warrant economic credentialing to prevent the narrow economic interests of specialty hospitals.[20] Moreover, it is the AHA's contention that economic credentialing criteria can actually benefit patient care by forcing physicians to be integrated into the daily routine of the hospital.[21]

The AMA defines economic credentialing as "the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges."[22] Although there are numerous ways in which a hospital may engage in economic credentialing,[23] the focus of this note will be on a hospital's decision to prevent physicians from investing, or otherwise becoming financially involved, with competing institutions while providing services at the hospital.[24]

This type of economic credentialing is more specifically known as "conflicts credentialing" or "competitive credentialing."[25] Under this type of economic credentialing, physicians are granted staff privileges based on competitive criteria; for example, whether a physician has a competing interest in another hospital in the form of direct or indirect ownership may be an important aspect influencing a general-care hospital from granting medical staff privileges to a physician.[26] This is precisely the type of economic credentialing that Baptist initiated, which led to *Baptist Health v. Murphy*.[27]

B. The Debate Comes to the Supreme Court of Arkansas

At its quarterly meeting in May 2003, Baptist adopted an "Economic Conflict of Interest Policy," ("Policy") which required the denial of initial and renewed medical staff privileges at any Baptist Hospital to any physician who directly or indirectly held an ownership interest in a competing hospital.[28] The appellees were cardiologists and partners in the Little Rock Cardiology Clinic ("Clinic") who held an indirect interest in the Arkansas Heart Hospital ("AHH") because the Clinic owned 14.5% of the AHH.[29]

Appellees were also on the professional staff at Baptist [30] and, therefore, were in violation of the Policy.[31]

The appellees alleged that Baptist violated the federal anti-kickback statute,[32] the Arkansas Medicaid Fraud Act, the Arkansas Medicaid Fraud False Claims Act, and the Arkansas Deceptive Trade Practices Act.[33] The most significant allegation, however, was that Baptist tortiously interfered with the doctor-physician relationship, a version of the economic tort of tortious interference with a business expectancy.[34] This was the vehicle by which the Supreme Court of Arkansas invalidated Baptist's conflict of interest policy.

The case first came before the Supreme Court of Arkansas in 2006 ("*Baptist I*") on appeal from the circuit court's grant of a preliminary injunction against Baptist, which prevented the hospital from enforcing its conflict of interest policy.[35] To grant a preliminary injunction, a court must consider whether the moving party has demonstrated a likelihood of success on the merits and whether irreparable harm will result in the absence of the injunction.[36] The circuit court found that the physicians would likely establish that the Policy would violate the federal anti-kickback and similar state statutes,[37] the Arkansas Department of Health Rules and Regulations for Hospitals and Related Institutions,[38] and the Arkansas Deceptive Trade Practices Act.[39] In addition, the circuit court found that the Policy would cause the physicians reputational injury and that Baptist's economic interest was substantially outweighed by the irreparable harm to the disruption of the physician-patient relationship and with the physicians' ability to provide proper healthcare to their patients.[40] The court granted the preliminary injunction, concluding that the physicians would likely succeed on their tortious-interference-with-a-business-expectancy claim based on these findings.[41]

The Supreme Court of Arkansas reviewed the decision under an abuse of discretion standard.[42] To establish a claim of tortious interference with a business expectancy, the plaintiff must prove four elements:

> (1) the existence of a valid contractual relationship or a business expectancy; (2) knowledge of the relationship or expectancy on the part of the interfering party; (3) intentional interference inducing or causing a breach or termination of the relationship or expectancy; and (4) resultant damage to the party whose relationship or expectancy has been disrupted.[43]

The court quickly disposed of these elements, stating that Baptist had the requisite intent and knowledge to be found liable under the tort. The court, however, added an additional requirement to the tort; for an interference to be actionable, it has to be improper.[44]

The Court adopted seven factors to guide it in its impropriety analysis:

> (1) the nature of the actor's conduct; (2) the actor's motive; (3) the interests of the other with which the actor's conduct interferes; (4) the interests sought to be advanced by the actor; (5) the social interests in protecting the freedom of the actor and the contractual interests of the other; (6) the proximity or remoteness of the actor's conduct to the interference; and (7) the relations between the parties.[45]

Despite these factors, however, the Supreme Court of Arkansas proceeded to analyze the impropriety requirement by analyzing the numerous violations of federal laws, state laws and regulations alleged by the physicians.[46] The court found that Baptist had not violated the anti-kickback statutes or the Arkansas Department of Health Rules and Regulations for Hospitals and Related Institutions.[47] However, the court held that it was not clearly erroneous for the circuit court to conclude that Baptist violated the Arkansas Deceptive Trade Practices Act;[48] in fact, this seems to be the court's sole basis for concluding that Baptist had met the impropriety requirement.[49]

The case returned to the Supreme Court of Arkansas in 2010 ("*Baptist II*") after the circuit court granted a permanent injunction.[50] The court reviewed the circuit court's decision by a clearly erroneous standard.[51] The Arkansas Supreme Court again held that the four elements of tortious interference with a business expectancy were met.[52] When the court was presented with the impropriety requirement, it faced the question of whether Baptist truly violated the Arkansas Deceptive Trade Practices Act, the sole conduct that satisfied the impropriety requirement in *Baptist I* in 2006.[53] The court determined that Baptist did not violate the Arkansas Deceptive Trade Practices Act, but upheld both the circuit court's permanent injunction against Baptist's Policy and its decision that Baptist tortiously interfered with the doctor-patient relationship.[54]

The court agreed with the circuit court's justifications for its finding of improper conduct despite concluding that Baptist was not liable under the Arkansas Deceptive Trade Practices Act.[55] The court stated that "[t]he nature of Baptist's conduct was against public policy because the Policy would disrupt the patient-physician relationship, discouraged specialty hospitals,

suppressed competition, and harmed the institution of marriage."[56] Furthermore, the physicians' interest "was in patient-physician relationships and the continuity of care, which outweighed Baptist's interest in protecting its economic viability because no evidence supported Baptist's purported need for the Policy."[57]

Baptist did not dispute these findings.[58] Instead, Baptist argued that refusal to deal in terms of its contractual relationships, as a matter of law, cannot be improper conduct.[59] The court responded that "a private hospital cannot 'insulate itself from suit' where there are findings that its conduct violated state law."[60] This statement was also made in *Baptist I* in regards to a rule of non-review argument made by Baptist.[61] The Supreme Court of Arkansas stated that the alleged tortious interference claim was the violation of state law. Thus, the court's response to the refusal-to-deal argument is not convincing; Baptist argued that refusal to deal cannot meet the impropriety requirement set forth by the tort of tortious interference. Therefore, it is circular to conclude that Baptist's refusal to deal argument has no merit because it violated the very same state law that Baptist argues it is not liable for. Arguably, one can no longer refuse to deal without engaging in tortious interference. [62] However, the tort of tortious interference with a business expectancy is not without its controversy, however. Tortious interference has blurred the line between lawful competition and illegal action.

III. ARGUMENT

A. Tortious Interference is A Transformation of a Free Market Regime

The four elements of tortious interference are fairly easy to demonstrate, at least in a competitive market. Arkansas now follows the *Restatement* view in which the burden of proof is allocated to the plaintiff and requires that the interference was both intentional and improper.[63] Although not clear from *Baptist Health v. Murphy*, the Supreme Court of Arkansas's discussion of the rule of non-review, for example, could be seen to imply that the Supreme Court of Arkansas still acknowledges justifications as affirmative defenses to tortious interference.[64]

Interestingly, the *Restatement* allows a person to interfere with a competitor's business expectancy for the purpose of legitimate competition.[65] In fact, in *Stebbins & Roberts, Inc. v. Halsey*,[66] the court held that a defendant who is acting to protect his or her own financial interest is justified to pre-

vent the performance of another's contract if it threatens this interest.[67] The Supreme Court of Arkansas stated:

> Where the defendant acts to further his own advantage, other distinctions have been made. If he has a present, existing economic interest to protect, such as the ownership or condition of property, or a prior contract of his own, or a financial interest in the affairs of the person persuaded, he is privileged to prevent performance of the contract of another which threatens it.[68]

The court also stated, however, that this rule does not apply to prospective advantage; therefore, the court held that "the sanctity of the existing contract relation takes precedence over any interest in unrestricted competition."[69]

Essentially, tortious interference represents a fundamental tension between the stability of contractual and business relations and the freedom of competition.[70] The problem is that the pendulum has swung too far to the stability of contractual and business relations, effectively stifling competition that is beneficial and necessary for a free-market, capitalist society.[71] *Baptist Health v. Murphy* is a prime example of this unfortunate consequence.

The current system allows too much discretion in determining whether an actor's conduct was improper or wrongful. Such a system provides little guidance and allows personal prejudice in the deliberation process.[72] According to the opinion, the motive behind Baptist's Policy was to "discourage competition by physicians who considered investing in specialty hospitals."[73] This is not by itself improper; it is the result of a competitive hospital market. Because some animosity will likely be present in any alleged interference, a judge or a jury is effectively granted the power to impose liability regardless of how incidental the motive is.[74] As Elisa M. White states, "[a] lawful act should not become unlawful solely because of its motive."[75] A plaintiff attempting to prove wrongful motive will often have to resort to circumstantial evidence, thus proving this motive is moot.[76]

The better choice is to adopt a standard for impropriety that utilizes concrete violations of law to illustrate when an action has been improper. Under this standard, parties would be liable for tortious interference only if they violated a statute, regulation, common law rule,[77] standard of trade or profession, or ethical rule.[78] The crucial aspect of this proposed standard of impropriety is that the improper conduct which justifies liability for tortious

interference must be independently unlawful activities either in civil law or otherwise.[79] Ruthless competition will not impose liability if that competition was acted through lawful means.[80]

The *Baptist II* court, in support of its impropriety requirement, held that Baptist's conduct would disrupt the patient-physician relationship.[81] This reasoning is circular: The purpose of tortious interference is to interfere with a contract or relationship. By equating interference with the improper conduct, the circuit court has effectively made the impropriety inquiry irrelevant.[82]

Only unlawful acts should be remedied through claims of tortious interference, not their subsequent and incidental effects on business expectancies or contractual relationships. Arguably, this is the point of the impropriety requirement. In terms of the impropriety requirement in *Baptist Health v. Murphy*, the Supreme Court of Arkansas found that no state law had been violated outside of the tort of tortious interference itself.[83] This type of circular analysis is extremely problematic. As Gary D. Wexler writes:

The maintenance of commercial stability rationale actually does more harm to commercial activity than its label suggests. Contractual stability is not necessarily desirable and should not be pursued as an end in itself…Maximization of the number of contracts formed should not be the goal; optimization of the number of contracts formed is a better objective.[84]

Instead, this tort has stifled competition and forced Baptist into a business involuntary servitude to its competitor, the specialty-care hospital, unless it can show some other reason in refusing to enter into the contracts with physicians with interests in a specialty-care hospital.[85] Regardless, the permanent injunction represents a type of restriction of business freedom; Baptist had chosen to regulate who may practice at its hospitals, and the Supreme Court of Arkansas has barred Baptist from enforcing that policy.[86] This would be acceptable if Baptist's Policy violated important public policy concerns as the court suggested, but such a result is difficult to reconcile with existing law and policy.

B. Conflict of Interest Policies are a Result of Public Policy Concerns

The court affirmed the circuit court's ruling that public policy disfavors disruption of the physician-patient relationship.[87] While this may be partly correct, public policy also favors the prevention of conflicts of interests because of the risks involved in obtaining qualified performance. Because

conflict of interest policies are such a prominent element of the legal field, it is counterintuitive that a court would strike down a hospital's method of preventing such a conflict—conflict that the legal profession would likely not condone.

Although some argue that it is hypocritical for general-care hospitals to engage in this type of economic credentialing because it promotes profits above the Hippocratic Oath,[88] it is important to recognize that specialty-care hospitals are highly profitable entities that typically perform the most profitable medical care services.[89] Professor Robert Steinbuch is correct in his assertion that the AMA does not approve of economic credentialing, but AMA principles do not address conflict of interest principles in the context of physicians with ownership interests.[90] The only mention of any type of conflict of interest in this context is in AMA Opinion 8.03:

Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical.[91]

This definition by the AMA has thus allowed physicians to define conflicts of interest broadly and resist required disclosures or other "precautionary measures."[92] A broad definition of conflict of interest makes it difficult to regulate it.[93] Therefore, the AMA rejects economic credentialing, but refuses to adopt any internal conflict of interest policy with regard to physician ownership. It is problematic, then, that *Baptist II* struck down a general hospital's attempt to monitor these types of conflicts of interests, especially when the legal profession has recognized a need to address financial conflict of interests among its own practitioners.[94]

The legal profession has not defined conflict of interest so broadly. According to the Arkansas Rules of Professional Conduct, a lawyer shall not represent a client if the representation involves a concurrent conflict of interest.[95] The most relevant portion of this rule in the physician conflict of interest is subsection (2) which states that a concurrent conflict of interest exists if "there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer."[96]

Comment 10 to rule 1.7 of the Arkansas Rules of Professional Conduct states that "a lawyer may not allow related business interests to affect representation, for example, by referring clients to an enterprise in which the lawyer has an undisclosed personal interest."[97] Once an attorney identifies a conflict that could potentially disqualify him or her from representing the client, the attorney must determine whether he or she can still represent the client with informed consent [98] or whether the conflict is impermissible, even with informed consent.[99] A violation of the conflict of interest provision constitutes misconduct and can result in sanctions.[100]

Most conflicts of interest within the context of the medical profession will require at the very least, disclosure to the patient; The Patient Protection and Affordable Care act forces physicians with ownership interests to disclose this fact to patients.[101] Large financial incentives cause a substantial risk that physicians will be biased in their decisions regarding patient care.[102] Presumably, this risk would also be present when physicians have significant financial interests in specialty-care hospitals.[103]

The *Baptist II* holding results in similar consequences and concerns shown in clinical trials in which a physician has an ownership or other direct incentive in its results.[104] Once patients become aware of their physicians' financial incentives, they might not be as willing to trust their physicians and their physicians' decisions regarding patient care in specialty-care hospitals.[105] Interestingly, Nancy J. Moore argues that it might be beneficial to ban the payment or receipt of financial incentives for enrolling patients in clinical studies.[106] According to Moore, "[i]t is hard to imagine what the benefits might be of permitting such payments, either to society at large or to patients themselves."[107]

It may seem that a complete ban on specialty-care hospitals is a drastic and overly broad means to accomplish the goal of restricting physicians from referring patients from the general-care hospital to the specialty-care hospital and is contrary to a free market capitalist society. It is important to recognize, however, that the AMA has refused to adopt any type of specific standard to govern this issue. In the absence of any such standard, the AMA cannot complain that the method Baptist took to prevent conflicts of interests is overly broad. In fact, it is arguable that a conflict of interest policy with regard to physician ownership is necessary to protect the patient-physician relationship.[108]

Baptist, by enacting its conflict of interest policy, has authorized an internal regulation that the legal profession recognizes as necessary: the pro-

tection of clients (patients) from the conflicts of interest that arise when a professional has a financial stake in his or her decisions in the course of the relationship. If public policy is to protect patients, conflict of interest policies like those found in the legal profession are necessary. While Baptist's Policy is broader than the legal standard for conflict of interest, it is better than no such standard.

Interestingly, through the Patient Protection and Affordable Care Act (PPACA), Congress has accomplished a broad interpretation on conflict of interests within the specialty-care and physician ownership context. The PPACA dictates that specialty-care hospitals should be limited, and restrictions on those currently in existence are necessary.

C. Section 6001 of the PPACA: The New Public Policy[109]

In 1989, Congress attempted to decrease overutilization of services by physicians who stood to profit from referring patients to facilities in which they had financial interests by enacting the Stark laws.[110] The Stark laws create stern penalties for any physician who refers a patient for any designated service to a facility with which the physician or an immediate family member has a financial relationship.[111] Effectively, it prevents Medicare and Medicaid payments for such self-referrals.[112] The Stark Laws, however, also include "safe harbors," or exceptions, that allow physicians to circumvent the restrictions imposed by the Stark Laws.[113]

One such exception is known as the "whole hospital" exception. Essentially, the exception allows physicians to circumvent the Stark restrictions if the ownership or investment interest is in the hospital itself and not merely in a subdivision of the hospital.[114] This exception was used immensely to support the creation and expansion of physician-owned hospitals.

Section 6001 of the PPACA[115] limits this exception greatly and otherwise effectively prevents the creation of any additional specialty-care hospitals. The section adds a time limit in which a hospital must meet the requirements under 42 U.S.C. § 1395nn(i)(1) in order to qualify for the whole hospital exception.[116] It also prohibits physician-owned hospitals from participating in Medicare if they did not have provider agreements enacted prior to February 1, 2010.[117] In addition, any facility included in this category is barred from expanding its number of operating rooms, procedure rooms, and beds.[118] There are also reporting requirements for physicians with ownership interests.[119]

These new restrictions in the PPACA make it practically impossible for specialty-care hospitals to exist as they have before now. Presumably, section 6001 is a statement of public policy against physician-owned specialty-care hospitals. In fact, Congressman Stark, for whom the Stark Laws are named, stated:

The development of specialty hospitals is of great concern to our health care system and to communities across our nation because they deprive full-scale hospitals of their most profitable business, leaving those existing hospitals much worse off financially. The investors in these joint ventures and specialty hospitals skim the profits off full-scale hospitals, leaving them to struggle financially. Then the hospitals must look to Medicare and to their local communities to help them financially.[120]

The PPACA is not merely health insurance reform; it is a substitute "law" or "act" that promotes the public's health. Stated generally, the statute was aimed at improving health care services, patient health outcomes, and ultimately, population health.[121] Clearly, the Supreme Court of Arkansas's holding in *Baptist II* that public policy dictates protecting physicians and, by association, the specialty-care hospitals in which they maintain ownership interests, is contrary to the public policy enacted through the democratic process of this country.

VII. CONCLUSION

Undoubtedly, the Supreme Court of Arkansas was dealt a very complex and difficult hand: it was forced to decide a controversial issue that ultimately impacts the health of this state's citizens and limited by the fact finding of the trial court. The problem, however, is that the medical profession has refused to create firm standards to analyze conflict of interest problems in the specialty-care hospital context. The *Baptist Health v. Murphy* holding rejects one hospital's attempt to create a solution when the AMA has refused to do so.

Baptist had not engaged in any unlawful activity, yet Baptist's conflict of interest policy exposed its lawful competitive decisions to liability under the theory of tortious interference. Ultimately, this decision provides evidence of the questionable consequences that can arise through the application of this tort. Whether Baptist's conduct was improper is essentially a moot point. Competition has been stifled, and this is contrary to the free market society in which we live.

Because of the importance of the patient-physician relationship, physicians should be guided by conflict of interest policies similar to what the courts provide to attorneys through the Arkansas Rules of Professional Conduct. Baptist's decision to restrict physicians with ownership interests in competing, specialty-care hospitals could be in patients' best interests. Just as conflict of interest policies created by the Arkansas Rules of Professional Conduct are aimed at protecting clients, a policy such as Baptist's is one solution to the real risk of financial conflicts of interest, a risk now addressed by the PPACA.

With the passage of section 6001 of the PPACA, Congress has firmly established a public policy of protecting patients. As part of this policy, Congress has firmly restricted the continued establishment of specialty-care hospitals and physician ownership. Arguably, the affirmance of the circuit court's findings could be viewed as encroaching upon the territory of Congress's legislative decisions (at least in a macro scale).

Baptist's end result is an uncertain future for those engaged in the specialty-care and physician ownership debate. An uncertain, problematic tort has caused a ripple through the debate, providing a controversial result in a time of healthcare reform. At least in Arkansas, physicians with ownership interests in specialty-care hospitals have earned a victory, but it is questionable at best whether this victory is in the patient's best interest.

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1. *See* Beverly Cohen, *An Examination of the Right of Hospitals to Engage in Economic Credentialing*, 77 TEMP. L. REV. 705, 712–13 (2004) (discussing the reasons physicians have sought alternate means of increasing their income levels).

2. Robert Steinbuch, *Placing Profits Above Hippocrates: The Hypocrisy of General Service Hospitals*, 31 U. ARK. LITTLE ROCK L. REV. 505, 505–506 (2009) (arguing that the economic credentialing of physicians is against societal interests and medical regulation).

3. In fact, this type of situation could arguably cause conflict of interest problems barred by the Model Rules of Professional Conduct. *See* ARK. RULES OF PROF'L RESPONSIBILITY R. 1.7(a)(2). The Soap Law Firm could potentially have a tortious interference claim as well. *See infra* Part III.A.

4. Tracy A. Powell, *The Permissibility of Conflicts Credentialing (A/K/A Economic Credentialing) by Traditional Hospitals as a Response to the Growth of Specialty Hospitals*, 20 NO. 1 HEALTH LAW. 17, 18 (2007).

5. *Id.*

6. *Id.*
7. Baptist Health v. Murphy, 2010 Ark. 358, at 31, ___S.W.3d___, ___.
8. To be fair, the court was limited by its standard of review. *See infra* Part II.B. The Court was limited by the facts found by the circuit court; the question was not purely one of law, and thus the end result of the court's decision is unfortunate, but not criticism-worthy.
9. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684–89 (codified at 42 U.S.C. § 1395nn (2010)).
10. Cohen, *supra* note 1, at 712.
11. *Id.* at 712–13; *see also* Steinbuch, *supra* note 2, at 505 (arguing that general-care hospitals' economic credentialing is hypocritical for utilizing financial concerns over patient care).
12. Cohen, *supra* note 1, at 712. Professor Cohen provides a great explanation of this phenomenon in her article. *Id.* at 712 n.32, 714.
13. *Id.* at 712 n.32.
14. *Id.* at 713.
15. *Id.*
16. *Id.* For example, it is generally thought that emergency rooms are typically either low in profit or are not profitable at all due to a large number of uninsured patients. Joanne Silberner, *Uninsured Patients, Few Beds Keep ERs Maxed Out*, NPR (June 15, 2006), http://www.npr.org/templates/story/story.php?storyId=5486114.
17. Cohen, *supra* note 1, at 714–15.
18. Powell, *supra* note 4, at 17.
19. *Id.*
20. *Id.*
21. *Id.*
22. *Economic Credentialing*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/medical-staff-topics/economic-credentialing.page (last visited Apr. 8, 2013).
23. *See* Powell, *supra* note 4, at 17.
24. *See* Cohen, *supra* note 1, at 714–715.
25. Powell, *supra* note 4, at 18.
26. *Id.*
27. 2010 Ark. 358, 2–3, ___S.W.3d___, ___.
28. *Id.* at 2, ___S.W.3d at ___.
29. *Id.* at 2, ___S.W.3d at ___.
30. *Id.* at 2, ___S.W.3d at ___.
31. *Id.* at 2, ___S.W.3d at ___.
32. *See* William E. Berlin, *Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?*, 20 NO. 5 HEALTH LAW. 1, 8–9 (2008), for a detailed analysis of antitrust laws in relation to competition between general-care and specialty-care hospitals.
33. Baptist Health v. Murphy, 365 Ark. 115, 119, 226 S.W.3d 800, 805 (2006) [hereinafter *Baptist I*].
34. *Id.* at 119, 226 S.W.3d at 805.
35. *Id.* at 120, 226 S.W.3d at 805.
36. *Id.* at 120, 226 S.W.3d at 806.

37. *See* 42 U.S.C. §§ 1320a-27b(b) (2010); ARK. CODE. ANN. § 5-55-111 (1993); ARK. CODE. ANN. § 20-77-902 (2003).

38. Arkansas Department of Health Rules and Regulations for Hospitals and Related Institutions § 5(A)(10) (2005), Arkansas Department of Health, *available at* http://www.sos.arkansas.gov/rulesRegs/Arkasnas %20Register/2005/jan_2005/007.05.04-003.pdf.

39. *Baptist I*, 365 Ark. at 120, 226 S.W.3d at 806. The Arkansas Deceptive Trade Practices Act can be found at ARK. CODE. ANN. § 4-88-107.

40. *Baptist I*, 365 Ark. at 121, 226 S.W.3d at 806.

41. *Id.* at 120, 226 S.W.3d at 805.

42. *Id.* at 121, 226 S.W.3d at 806.

43. *Id.* at 122, 226 S.W.3d at 807 (citing Stewart Title Guar. Co. v. Am. Abstract & Title Co., 363 Ark. 530, 540, 215 S.W.3d 596, 601 (2005)).

44. *Id.* at 122, 226 S.W.3d at 807 (citing *Stewart*, 363 Ark. at 540, 215 S.W.3d at 601).

45. *Id.* at 125, 226 S.W.3d at 810. These factors are those found in the RESTATEMENT (SECOND) OF TORTS § 767 (1979).

46. *Baptist I*, 365 Ark. at 126–29, 226 S.W.3d at 809–11.

47. *Id.* at 126–27, 226 S.W.3d at 810.

48. *Id.* at 128, 226 S.W.3d at 811.

49. *See id.* at 130, 226 S.W.3d at 812.

50. Baptist Health v. Murphy, 2010 Ark. 358, ___ S.W.3d ___ [hereinafter "*Baptist II"*].

51. *Id.* at 14, ___S.W.3d at ___.

52. *Id.* at 16–24, ___S.W.3d at ___. I focus primarily on the impropriety requirement because in any free market in which competition is expected, the first four elements of tortious interference with a business expectancy are easily met. In fact, this case blurs the line between competition and tortious conduct, an ultimately problematic result. This notion will be discussed subsequently. *See infra* Part III.A.

53. *Baptist II*, 2010 Ark. at 27, ___S.W.3d at ___.

54. *Id.* at 31, ___S.W.3d at ___.

55. *Id.* at 25, ___S.W.3d at ___.

56. *Id.*, ___S.W.3d at ___.

57. *Id.*, ___S.W.3d at ___.

58. *Id.* at 26, ___S.W.3d at ___. This turned out to be fatal for Baptist because the Supreme Court of Arkansas rejected its defenses. *Id.*, ___S.W.3d at ___.

59. *Baptist Health II*, 2010 Ark. at 26, ___S.W.3d at ___.

60. *Id.* at 26, ___S.W.3d at ___.

61. Baptist Health v. Murphy, 365 Ark. 115, 129, 226 S.W.3d 800, 812 (2006). The rule of non-review was set forth in *Brandt v. St. Vincent Infirmary*, 287 Ark. 431, 437, 701 S.W.2d 103, 106 (1985). The Supreme Court of Arkansas held that the private hospital had a right to set its own policies regarding medical treatment. *Id.*, 701 S.W.2d at 106. The court stated, "in light of the deference accorded even public hospital boards, we believe the Chancellor's order dismissing the complaint should be affirmed." *Id.* at 437, 701 S.W.2d at 107. In *Baptist I*, the Supreme Court of Arkansas got around Brandt by quoting language from that case: "We see no compelling reason to conclude that a private hospital *which is following appropriate state regulations* must also be subject to judicial scrutiny as to the reasonableness standard of public hospitals in order to preserve the public interest." *Baptist I*, 365 Ark.

at 129, 701 S.W.2d at 812 (emphasis in original) (quoting *Brandt*, 287 Ark. at 437, 701 S.W.2d at 106). Because the Supreme Court of Arkansas affirmed that Baptist violated the Arkansas Deceptive Trade Practices Act, Brandt did not apply. *Id.* at 130, 701 S.W.2d at 812.

62. Baptist Health v. Murphy, 2010 Ark. 358, at 12, ___S.W.3d___, ___.

63. Elisa Masterson White, Comment, *Arkansas Tortious Interference Law: A Proposal for Change*, 19 U. ARK. LITTLE ROCK L.J.81, 85–86 (1996) (arguing that competition should have extensive protection under the laws); *see also Baptist I*, 365 Ark. at 123, 226 S.W.3d at 808.

64. White, *supra* note 64, at 87; *see also Baptist I*, 365 Ark. at 129–30, 226 S.W.3d 807, 811–12. The Supreme Court of Arkansas seems to make little distinction between tortious interference with a contractual relationship and tortious interference with a business expectancy. *Baptist II*, 2010 Ark. 358, at 17, ___S.W.3d___, ___.

65. RESTATEMENT (SECOND) OF TORTS § 768 (1979):

> (1) One who intentionally causes a third person not to enter into a prospective contractual relation with another who is his competitor or not to continue an existing contract terminable at will does not interfere improperly with the other's relation if
>
> (a) the relation concerns a matter involved in the competition between the actor and the competitor and
>
> (b) the actor does not employ improper means and
>
> (c) his action does not create or continue an unlawful restraint of trade and
>
> (d) the actor's purpose is at least in part to advance his interest in his competition with the other.
>
> *Id.*

66. 265 Ark. 903, 906, 582 S.W.2d 266, 267 (1979).

67. White, *supra* note 64, at 93; *see also* Stebbins & Roberts, Inc. v. Halsey, 265 Ark. 903, 906, 582 S.W.2d 266, 267 (1979).

68. *Stebbins*, 265 Ark. at 906, 582 S.W.2d at 267.

69. *Id.* at 906, 582 S.W.2d at 267.

70. White, *supra* note 64, at 100.

71. *Id.* at 101.

72. *Id.* at 104.

73. Baptist Health v. Murphy, 2010 Ark. 358, at 25, ___S.W.3d___, ___.

74. White, *supra* note 63, at 106.

75. *Id.* at 106–07.

76. *Id.* at 106–07; *see* Baptist Health v. Murphy, 365 Ark. 115, 123, 226 S.W.3d 800, 808 (2006) (holding that intent is inferred if actor believes effect is substantially certain to occur). As a practical matter, it is questionable whether Baptist was substantially certain that a disruption of the patient-physician relationship would occur; nothing prevented the patients from following appellee physicians to the hospital in which they have an ownership interest. *See id.* at 123, 226 S.W.3d at 808 (stating that the circuit court's holding that many of appellee's patients are covered by health insurance policies that use Baptist as their sole carrier of healthcare). Baptist could not foresee the mental process of the patients.

77. There has been no such violation in the current case because Baptist has an actual advantage and not prospective advantage in accordance with *Stebbins & Roberts, Inc. v. Halsey*, 265 Ark. 903, 906-07, 582 S.W.2d 266, 267 (1979).

78. White, *supra* note 64, at 108.

79. Hazel Carty, *The Economic Torts and English Law: An Uncertain Future*, 95 KY. L.J. 845, 863 (2006–07) (analyzing the state of economic torts in English law).

80. *Id.* at 868.

81. Baptist Health v. Murphy, 2010 Ark. 358, at 25, ___S.W.3d ___, ___.

82. Practitioners should be weary of this result. At least in the trial context, tortious interference has taken a new form. In practical terms, it is arguable that the future of the impropriety requirement is in question.

83. *Baptist II*, 2010 Ark. 358, at 25–29, ___S.W.3d___ at ___.

84. Gary D. Wexler, *Intentional Interference with Contract: Market Efficiency and Individual Liberty Considerations*, 27 CONN. L. REV. 279, 301 (1994) (arguing that legislative action should repeal tortious interference).

85. Gary D. Wexler describes the slavery implications of this tort. *Id.* at 326–28. As he explains, "it is at least worth asking the question of whether the old malevolent purposes have been replaced with modern rectitude. Or, does some form of the evil remain, albeit now more disguised?" *Id.* at 328.

86. In this case, appellant Baptist would have been better served by disputing the factual findings of the circuit court. Nevertheless, this holding causes some concern for parties that might find themselves on the other side of a tortious interference claim.

87. Baptist Health v. Murphy, 2010 Ark. 358, __ S.W.3d ___, ____.

88. *See* Steinbuch, *supra* note 2, at 508.

89. Cohen, *supra* note 1, at 713.

90. *See* Nancy J. Moore, *What Doctors Can Learn from Lawyers About Conflicts of Interest*, 81 B.U. L. REV. 445, 449 (2001) (suggesting that a workable conflict of interest doctrine needs to be established for the medical profession).

91. OPINION 8.03, AM. MED. ASS'N, CONFLICTS OF INTERESTS GUIDELINES (1994), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion803.page.

92. Moore, *supra* note 91, at 450.

93. *Id.*

94. The Supreme Court of Arkansas has stated that "[d]isqualification of an attorney is an absolutely necessary measure to protect and preserve the *integrity* of the attorney-client relationship." Whitmer v. Sullivent, 373 Ark. 327, 331, 284 S.W.3d 6, 9 (2008) (emphasis added). Disqualification is a drastic measure that should only be utilized when clearly required under the circumstances, and a court has wide discretion in imposing it. *Id.* at 331, 284 S.W.3d at 9. Similarly, it is fair to say that this should be true in the patient-physician relationship as well. Section 6001, the section that is possibly contrary to the *Baptist II* holding, lies within Title VI, which is labeled "Transparency and Program Integrity." Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684–89 (codified at 42 U.S.C. § 1395nn) (2010). The use of "integrity" is a fortuitous coincidence.

95. ARK. RULES OF PROF'L CONDUCT R. 1.7.

96. *Id.*

97. ARK. RULES OF PROF'L CONDUCT R. 1.7 cmt. 10. The debate between general-care and specialty-care hospitals ultimately comes down to one issue; general-care hospitals allege that physicians with ownership interests in specialty-care hospitals will refer the most profit-

able patients from the general-care hospital to the specialty-care hospital. Thanks to Section 6001, physicians now have to disclose their ownership interest. Patient Protection and Affordable Care Act § 6001.

98. ARK. RULES OF PROF'L CONDUCT R. 1.7.

99. Moore, *supra* note 91, at 452–53; *see also* ARK. RULES OF PROF'L CONDUCT R. 1.7 cmt. 14.

100. ARK. RULES OF PROF'L CONDUCT R. 8.4.

101. Moore, *supra* note 91, at 453; *see infra* Part III.C.

102. *See* Moore, *supra* note 91, at 453.

103. *See id.*

104. For a detailed analysis of conflict of interest in relation to clinical trials, see *Moore*, *supra* note 91, at 451–56.

105. *See id.* at 455. The AMA has established a conflict of interest policy in regards to clinical trials. *See* OPINION 8.0315, AM. MED. ASS'N, MANAGING CONFLICTS OF INTEREST IN THE CONDUCT OF CLINICAL TRIALS (1994), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion80315.page.

106. Moore, *supra* note 91, at 455. It does not seem the AMA endorses this idea. *See* OPINION 8.0315 (4-6), AM. MED. ASS'N MANAGING CONFLICTS OF INTEREST IN THE CONDUCT OF CLINICAL TRIALS (1994), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion80315.page.

107. Moore, *supra* note 91, at 455.

108. I argue this point by comparison to ARK. RULES OF PROF'L CONDUCT R. 1.7 cmt. 10.

109. For a more detailed discussion of the PPACA and the specialty-care hospital debate, *see* Joshua E. Perry, *Physician-Owned Specialty Hospitals and the Patient Protection and Affordable Care Act: Health Care Reform at the Intersection of Law and Ethics*, 49 AM. BUS. L.J. 369, 407–16 (2012).

110. Jo-Ellyn Sakowitz Klein, *The Stark Laws: Conquering Physician Conflicts of Interest?*, 87 GEO L.J. 499, 510 (1998) (arguing that the Stark laws should be repealed).

111. *Id.* at 511.

112. *Id.*

113. *Id.* at 512. This is only a brief discussion of the Stark Laws. For a more detailed analysis, see *id.*

114. 42 U.S.C. §1395nn(d)(3) (2010).

115. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684–89 (codified at 42 U.S.C. § 1395nn) (2010).

116. 42 U.S.C. § 1395nn(3)(D) (no more than 18 months after March 23, 2010).

117. Ultimately, this was changed by the Health Care and Education and Reconciliation Act of 2010 to its present form as of December 31, 2010. Pub. L. No. 111-152 § 1106, 124 Stat. 1029, 1049–50 (codified at 42 U.S.C. § 1395nn(i)(A)(i)).

118. 42 U.S.C. § 1395nn(i)(1)(B).

119. 42 U.S.C. § 1395nn(i)(1)(C).

120. Pete Stark, INTRODUCTION OF THE HOSPITAL INVESTMENT ACT, STAY CONNECTED, http://www.stark.house.gov/index.php?option=com_content&view=article&id=1827:introduction-of-the-hospital-investment-act&catid=32 (last visited Apr. 8, 2013).

121. James G. Hodge, Jr. et al., *Congress, Courts, and Commerce: Upholding the Individual Mandate to Protect the Public's Health*, 39 J.L. MED. & ETHICS 394, 394–95 (2011) (arguing that the PPACA's individual mandate is squarely within Congress's commerce power to regulate the interest of the public health).

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