CHAPTER 1

Hospital Organizational Structure

Chapter Contents

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§ 1.01 Introduction

Before discussing the legal problems encountered by hospitals, it is helpful to have a working knowledge of common hospital organizational structures. Hospitals are generally corporate in form (rather than partnerships or propriety establishments) and may be public or private in nature.

(Text continued on page 1-3)

[1]—Public Hospitals

Public hospitals may be created by the acts of state, county or municipal authorities and are controlled by those governmental units both economically and managerially. For instance, unlike private hospitals, the members of the governing body of a public hospital are often elected by the public or appointed by elected officials.

[2]—Private Hospitals

Privately owned hospitals may be divided into three categories: (1) voluntary; (2) investor-owned; and (3) multi-unit hospital systems.

[a]—Voluntary

Voluntary hospitals are charitable in nature and are usually incorporated under a not-for-profit corporation act or other statutes of the state designed specifically for charitable organizations. Although this type of organization does not generally issue corporate shares, memberships in the corporation may often be purchased for a designated amount.

[b]—Investor-Owned

Investor-owned medical care facilities are established for the purpose of producing a profit for its shareholders. As with any other business corporation, substantial authority is vested in the corporate shareholders although the burden of managing the facility is carried by the shareholder-elected governing body. A holder of stock in this entity is vested with the same advantages and disadvantages as any shareholder in a for-profit corporation.[1]

[c]—Multi-Unit

Multi-unit hospital systems are the product of the desire of multiple facilities under single ownership to take advantage of shared management, common services and other operational efficiencies. These systems are often utilized by governmental and religious organizations and provide continuity of institutional mission and patient care policy. Multi-unit hospitals attempt to realize economies of scale. Of course, care must be taken to ensure that health care services will be provided which serve both the financial interests of the hospital and community needs.

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[1] Kwiecinski, "Limiting Conflicts of Interest Arising From Physician Investment In Specialty Hospitals," 88 Marq. L. Rev. 413-439 (2004)

§ 1.02 Governing Body

[1]—Duties

The governing body of a hospital is invested with overall responsibility for the hospital's operation. The Joint Commission on Accreditation of Hospitals (hereinafter referred to as the JCAH) has outlined three standards applicable to the governing body.

> (1) It is responsible for establishing policy, maintaining quality patient care and providing for institutional management and planning;
> (2) It is to avoid conflicts of interest; and
> (3) It is to ensure that all members of the governing body understand and fulfill their responsibilities.[1]

In summary, the governing body must ensure that proper professional standards are maintained. It must also determine and coordinate hospital policy and the professional interests of hospital personnel with administrative, financial and community needs. In addition, the governing board directs the administrative personnel who carry out these policies and provides financial security for the hospital.[2]

[a]—Bylaws

The internal legislation of any corporation is its bylaws. To maintain accreditation with the JCAH, the governing body must adopt bylaws which specify the role and purpose of the hospital. These bylaws should also outline the method for selecting governing body members and officers as well as procedures for directing its activities.[3] Such mundane topics as the frequency of governing body meetings as well as forum requirements are usually set forth in the bylaws.

The JCAH requires that the bylaws contain a sketch of the hospital's organizational structure. This sketch should include provisions detailing the structure of the governing body's committee system. The bylaws should also contain provisions governing the selection of officers and should provide for the inclusion of medical staff members on governing

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[1] Joint Commission of Accreditation of Hospitals, *Accreditation Manual for Hospitals* 47-51 (1988). The JCAH is a private accrediting body which promulgates minimal standards of hospital operation and periodically reviews hospital performance. For a detailed discussion of the JCAH see Chapter 15 *infra*. See also Humana Medical Plan, Inc. v. Erdely, 785 So.2d 714 (2001) (physician's application to an HMO was privileged).

[2] See, Hayt, Hayt and Groeschel, *Law of Hospital, Physician and Patient* 84 (1952).

[3] Joint Commission of Accreditation of Hospitals, *Accreditation Manual for Hospitals* 47-48 (1988).

body committees that deliberate on issues affecting the discharge of medical staff responsibilities.[4]

The bylaws must also particularize the relationship of responsibilities between the governing body and the chief executive officer, the medical staff and the authority superior to the governing body, if any.[5]

[b]—Committees

[i]—Executive

Any efficient system of management includes provision for appropriate delegation of responsibilities. this is generally accomplished in the hospital corporate environment by the establishment of committees. For instance, most hospitals find it advantageous to form an executive committee of the governing body to provide continuity of control and policy formation in the interim period between meetings of the entire governing body.[6]

[ii]—Joint Conference

To enhance communication and inter-action between the governing body, administration and the medical staff, a joint conference committee is often established.[7] The membership of this committee generally includes an equal number of representatives from the medical staff and governing body in addition to the chief executive officer. This joint conference committee functions primarily as an open forum for discussion and development of hospital policy and organization plans.

[iii]—Institutional Planning

The hospital is charged by the JCAH with the responsibility for periodically examining the mission of the hospital and the adequacy of its current programs to carry out those purposes. To fulfill this responsibility, an institutional planning committee is frequently established with participation of the governing body, administration, and the medical and nursing staffs. Another function of this institutional planning committee may be to develop a long-term capital expenditures plan

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[4] *Ibid.*
[5] *Id.*
[6] See, 42 C.F.R. § 1021(c).
[7] Joint Commission of Accreditation of Hospitals, *Accreditation Manual for Hospitals* 32 (1985); 42 C.F.R. § 4.05.1021(d). See Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 49 (1988).

for the hospital. This planning process should be coordinated with the needs of the community.[8] This is a key factor in the accreditation decision process.

[c]—Supervision of Medical Staff

[i]—Medical Staff Bylaws

In addition to establishing its own bylaws, the governing body must also approve the rules, regulations and bylaws of the medical staff. Although the JCAH requires that approval must not be unreasonably withheld, these bylaws, rules and regulations must be consistent with hospital policy and with any legal or other requirements.[9]

[ii]—Privileges

The medical staff is charged with responsibility for conferring and denying staff privileges. However, the JCAH has made it clear that this delegation does not relieve the governing body of its ultimate responsibility for the appointment of medical staff members.[10] Under current JCAH guidelines, an executive committee of the medical staff makes recommendations to the governing body pertaining to the structure of the medical staff; processes for the review of credentials and privilege delineation; individual staff memberships; specific clinical privileges for each eligible individual; quality assurance organization for the medical staff; mechanisms for termination of medical staff privileges; and fair-hearing procedures.[11] These

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[8] See 42 C.F. R. § 405.1021(j).

[9] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 50 (1988). See also, Hulston, Jones, and Gammon, "Do Hospital Staff Bylaws Create A Contract?" 51 J. Mo. B. 352-356 (1995).

[10] *Id.* See also:

Florida: Forster v. Fishermen's Hospital, Inc., 363 So.2d 840 (Fla. App. 1978), *cert. denied* 376 So. 2d 71 (1979).

Oklahoma: Ponca v. Murphree, 545 P.2d 738 (Okla. 1976).

Texas: Charter Medical Corp. v. Miller, 605 S.W.2d 943 (Tex. App. 1980).

Wisconsin: State *ex rel.* Wolf v. LaCrosse Lutheran Hospital Association, 191 Wis. 33, 193 N.W. 994 (1923).

[11] Lester, "Physician Privileges: Judicial Treatment of the Discharged Physician," 76 Notre Dame L. Rev. 1491 (2001); Joint Commission Accreditation of Hospitals, *Accreditation Manual for Hospitals* 49 (1988).

Florida: Paracelsus Santa Rosa Medical Center v. Smith, 732 So.2d 49 (App.1999) (staff privileges files protected from discovery even if given to noncommittee physicians).

Tennessee: Eyring v. Fort Sanders Parkwest Medical Center, Inc., 991 S.W.2d 230 (Tenn.App.1999) (Tennessee Peer Review Law protected committees from liability for good faith effort).

recommendations must be made directly to the governing body for its approval. Prior ratification of the recommendations by the entire medical staff is not necessary.

The governing body is responsible for rendering a final decision of any application for or termination of staff privileges. If a privilege issue is a matter of dispute between the governing board and the medical staff, bylaws will generally provide for a review of the medical staff recommendation by a combined committee of the governing board and medical staff prior to a final decision.

[d]—Chief Executive Officer

To manage the daily operation of the hospital, the governing board appoints a chief executive officer who is qualified through education and experience.

This administrator is responsible for the implementation of the policies set by the governing board.

In addition, the chief executive officer advises the governing board on the practical aspects of hospital administration such as governmental regulations and JCAH accreditation requirements. Depending on the size of the hospital, the chief executive officer may be assisted by a variety of administrators directly responsible for a particular segment of hospital operations. Of course, it is imperative that these officers of the corporation have the highest qualifications with extensive experience and training in hospital administration and management.[12]

[e]—Governing Body Membership

Preconditions for membership on the governing body and rules regarding selection of members are specified in the corporate bylaws of the hospital. When the hospital is a public corporation, members are generally appointed by elected officials in the governmental unit controlling the hospital. In investor-owned corporations, the members of the governing board are elected by the shareholders.

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[12] See e.g.,

Fifth Circuit: Reserve Life Insurance Co. v. Salter, 152 F. Supp. 868 (S.D. Miss. 1957) (applying Mississippi law).

Seventh Circuit: Dimensions Medical Center v. Principal Financial Group, 1996 U.S. Dist. (N.D. Ill. Aug. 20, 1996).

State Courts:

Pennsylvania: Second Breath v. Dept. of Public Welfare, 731 A.2d 674 (1999) (court denied appeal by a residential health care facility for a waiver of the requirement that its chief executive officer hold a college degree).

See also, 42 C.F.R. § 405.1021(f).

The JCAH suggests that members of the medical staff are eligible for full membership on the hospital governing body in the same manner as are other knowledgeable individuals.[13] However, the Attorney General of one state has found that permitting the Chief of Staff of a public hospital to serve on the Board of Governors may occasion a conflict of interest, or at least the appearance of impropriety since, having been elected by the hospital staff, he might be called on as a member of the Board to discipline staff members.[14] Nevertheless, the JCAH states that, at the very least, the medical staff has the right of representation through attendance and voice at governing body meetings.[15]

[f]—Member Liability

The courts have generally refused to hold board members liable for the malpractice of private physicians once the physician's competency has been passed upon by the medical staff.[16] Recently, however, the courts of several jurisdictions have accepted hospital liability premised on a theory of corporate negligence.[17] Under this doctrine, a court may find a hospital liable for the negligent grant of medical staff privileges to a physician or for the failure to adequately monitor his conduct in the hospital. Moreover, some courts have recognized a non-delegable duty on the part of the governing board to assure that patients receiving treatment in the institution are provided care by competent physicians.[18] Hospital and governing board member liability may be derived from the JCAH recognition of the governing body as the ultimate authority in the medical staff privilege conferral and delineation process as well as the requirement that the governing body design processes to ensure that all individuals who provide patient care are competent.[19] This is another key factor in the hospital accreditation decision process.

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[13] Joint Commission of Accreditation of Hospitals, *Accreditation Manual for Hospitals* 48 (1988).

[14] Arkansas Attorney General Opinion No. 81-105 (1981).

See also, New York Attorney General Opinion (Inf.) (September 21, 1979).

[15] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 48 (1988).

[16] See, e.g.:

Illinois: Mavigliano v. McDowell, 1995 U.S. Dist. (N.D. Ill. May 3, 1995); Simon v. Pelouze, 263 Ill. App. 177 (1931).

Massachusetts: Fanigan v. Pevear, 193 Mass. 147, 78 N.E. 855 (1906).

[17] See § 3.03 *infra* for a discussion of the basis of hospital corporate liability.

[18] *Ibid*.

[19] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 49 (1988); Wiehl, "Roles and Responsibilities of Nonprofit Health Care Board Members in the Post-Enron Era" 25 J. Legal Med. 411 (2004).

Governing body members of investor-owned hospitals are susceptible to derivative action suites brought by shareholders. Thus, the JCAH requirement that members avoid a conflict of interest and promulgate a written conflict of interest policy is of particular significance in these institutions.[20]

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[20] *Ibid.*

§ 1.03 Medical Staff

[1]—Introduction

The hospital medical staff has responsibility for the overall quality of patient care it provides as well as for the ethical and professional conduct of its members.[1] The governing body requires that the medical staff establish mechanisms to ensure high quality medical practice and patient care. The medical staff performs these functions through the staff appointment process, the delineation of clinical privileges and continuous monitoring of the performance of each staff member.

[2]—Organization

The standards promulgated by the JCAH direct the medical staff to adopted bylaws, rules and regulations, subject to governing body approval, which create a framework within which staff members may work with "a reasonable degree of freedom and confidence."[1.1] Included in these bylaws is a description of the organization, a method of selecting officers and requirements for frequency of meetings and for attendance.[2]

The bylaws must also provide for and require documentation in medical records of the use of special treatment procedures. These special treatment procedures include orders for restraint or seclusion; electroconvulsive and other forms of convulsive therapy; psychosurgery and behavior modification. There must be special justification for these procedures. Additionally, restraint or seclusion orders are time-limited to twelve hours and the patient must be attended to at least every fifteen minutes.[3]

[3]—Membership

[a]—In General

The JCAH requires that the medical staff consist of fully licensed physicians and *may* include other licensed individuals permitted by law and by the hospitals to provide patient care independently in the hospital.[4] These non-physician members may include dentists, podiatrists and nurse practitioners.

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[1] Kadzielski et al, "Hospital Medical Staff: What Is Its Future?" 16 Whittier L. Rev. 987-1004 (1995).

[1.1] Joint Commission on Accreditation of Hospital *Accreditation Manual for Hospitals* 114 (1988).

[2] *Id.* at 115.

[3] *Id.* at 115-116.

[4] *Id.* at 111.

[b]—Application for Appointment

To be appointed to the medical staff, applicants must meet certain minimum professional criteria specified in the staff bylaws and designed to assure the medical staff and the governing body that patients will receive quality care. These criteria pertain to education, experience, health status and current licensure and competence.[5]

The JCAH recommends that the application call for information pertaining to any involvement in medical malpractice actions, challenges to licensure, and loss of staff membership or clinical privileges at another hospital. This information is especially important in jurisdictions which have accepted the corporate negligence doctrine. Courts in these jurisdictions will impose liability upon hospitals for the malfeasance of independent contractor physicians where the overall competency of the physician is in question. It has been held that a hospital is on notice of this incompetency where the physician has had malpractice claims asserted against him prior to the grant of staff privileges at the hospital.[6]

Each hospital has an obligation under federal law to report to the secretary of Health and Human Services any professional review action or surrender of clinical privileges involving a position at the hospital.[7] At the time a physician applies to a medical staff for clinical privileges or renewal of those privileges, each hospital is obligated to request from the secretary any reports pertaining to that physician.[8] In a medical malpractice action, a hospital will be presumed to have knowledge of any information reported to the agency with respect to the physician.[9] However, documents in a hospital file pertaining to a physician's credentials, as well as his application for privileges, may not be discoverable in a medical malpractice action.[10]

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[5] *Id*. at 112. See also, Richter, "*Silver v. Castle Memorial Hospital* [497 P.2d 564 (Haw. 1972)]: The Doctor is Out! Judicial Review of Medical Staff Appointments," 20 Am.J. Trial Advocacy 197-210 (1996); Kadzielski, "The Hospital Medical Staff: What Is Its Future?," 16 Whittier L. Rev. 987 (1995).

[6] See § 3.03 *infra* for discussion of the basis of hospital corporate liability. See also: McCall, "A Hospital's Liability for Denying, Suspending and Granting Staff Privileges," 32 B.L. Rev. 175 (1980); Annot., "Hospital Liability for Negligence in Selection or Appointment of Staff Physician or Surgeon," 51 A.L.R.3d 981. But see, Hunt v. Rabon, 275 S.C. 475, 272 S.E.2d 643 (1980).

[7] 42 U.S.C. § 11133.

[8] 42 U.S.C. § 11135.

[9] *Id*.

[10] *Michigan:* Dye v. St. John Hospital and Medical Center, 584 N.W.2d 747 (Mich. App.1998).

West Virginia: State ex rel Charles Town General Hospital v. Sanders, 556 S.E.2d 85 (W.Va.2001) (application for admission to hospital staff is covered by peer review privilege).

[c]—Delineation of Clinical Privileges

As part of the process of accepting an applicant on the hospital medical staff, it is general practice to delineate specific privileges appropriate to the physician's professional experience and training.[11] This delineation of privileges is required to be reasonably comprehensive and their effect is to exclude certain physicians from practicing in areas in the hospital in which they have no experience. Additionally, the medical staff may impose a requirement upon its members to obtain appropriate consultation when treating specified conditions.

Significantly, the JCAH requires that the granting of delineated clinical privileges be based upon information regarding the applicant's licensure, training, experience and competence which have been verified. To ensure quality patient care and protect itself from civil liability for negligent retention of an incompetent independent contractor or for corporate negligence, a hospital may no longer safely rely upon the face of the application but must check references, former employees, medical societies, etc. to verify the truth of the information contained on the application. The law has traditionally imposed upon employers the duty to exercise reasonable care in the selection of independent contractors.[12] The acceptance of the corporate negligence theory of liability in several jurisdictions, however, may require greater diligence by the hospital in this regard.

The failure of a hospital to restrict staff privileges for a physician who is no longer covered by insurance may state a claim against the hospital.[13] As a New York appellate court recently noted:

> Here, while the doctor's lack of coverage did not, in itself, cause the alleged physical injury, had [the hospital] followed its own procedures in seeing that he met his affiliation requirements, the fact that he was unable to obtain coverage would have put [the hospital] on notice that he had lost his privileges at other hospitals and, as the facts, when developed, are likely to show, that he

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[11] Burnet v. Spokane Ambulance, 933 P.2d 1036 (Wash. App. 1997) (plaintiffs were permitted to pursue a negligent credentialing claim against a hospital in a lawsuit alleging that two unqualified doctors were negligently granted privileges). See also, Rivers v. Wash. State Conference of Mason Contractors, 145 Wa.2d 674, 41 P.3d 1175 (2002).

[12] Kiester v. Humana Hospital of Alaska, Inc., 843 P.2d 1219, 1225 (Alaska 1992) (hospital's responsibility to the public requires it to deny clinical privileges to physicians who do not meet appropriate standards). See also Spindle v. Sisters of Providence in Washington, 61 P.3d 431 (Alaska 2002).

[13] Megrelishvili v. Our Lady of Mercy Medical Center, 291 A.D.2d 18, 739 N.Y.S.2d 2 (2002).

had a history of malpractice claims against him, thus placing those patients of his using [the hospital's] facilities at risk.[14]

[d]—Staff Categorization

The medical staff bylaws set forth the organization of the staff including provisions for the election of officers and departmentalization. In addition to delineation of privileges into specific practice areas, privileges may also be categorized according to each member's level of participation in the hospital. For instance, "active" staff members conduct most of the medical practice within the hospital and perform the medical staff's organizational and administrative functions. "Associate" members of the medical staff practice in the hospital and will be considered for advancement to the active level of membership at the end of a period designated in the medical staff by laws. "Courtesy" staff privileges entitle physicians in the locality to admit and treat only occasional patients to the hospital. The "consulting" medical staff of the hospital are practitioners of recognized professional ability practicing in the facility on an on call or regular basis. Finally, physicians are designated honorary members of the medical staff for outstanding contributions to patient care and long service to the hospital.

Decisions by hospital boards may affect privileges also. A board may enter into a contract for exclusive services with a group of physicians, such as radiologists. If that group terminates a physician, it may result in clinical privileges being withdrawn from that physician.[15]

[4]—Committees

[a]—Executive

The medical staff bylaws are required by the JCAH to include provisions for an executive committee of the staff which is empowered to act in the intervals between meetings of the entire medical staff.[16]

All members of the medical staff are eligible for executive committee membership but the JCAH requires that the majority of members composing the committee be fully licensed physician members of the staff actively practicing in the hospital.[17] Thus, while non-physician members of the staff may participate in the executive committee,

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[14] *Id*.

[15] *Pennsylvania:* Lyons v. Saint Vincent Health Center, 731 A.2d 206 (Pa.App.1999).

South Dakota: Mahan v. Avera St. Luke's, 2001 S.D. 9, 621 N.W.2d 150 (2001).

[16] Joint Commission of Accreditation of Hospital, *Accreditation Manual for Hospitals* 114 (1988).

[17] *Id*. at 117.

control continues in the hands of the physicians. According to an analysis by a task force of the Office of Legal and Regulatory Affairs of the American Hospital Association and the American Academy of Hospital Attorneys:

> "This is based, in part, on the traditional concept that it is the physician component of the medical staff that has the responsibility and the knowledge to define for the governing body the proper quality of medical care standards which will apply to all practitioners that treat patients in the hospital."[18]

Additionally, the members of the executive committee are selected either by the medical staff or appointed in accordance with governing body bylaws.[19] Consequently, the government body may handpick the members of the executive committee who will later make recommendations to the governing body on privilege and administrative matters.

The executive committee is responsible for making recommendations directly to the governing body for its approval regarding issues such as the structure of the medical staff, the conferral of medical staff membership and clinical privileges, quality assurance mechanisms and fair hearing procedures. The executive committee also receives and acts on reports and recommendations for medical staff committees, and clinical departments.[20]

[b]—Review Committees

[i]—In General

As part of its function to ensure high quality patient care, the medical staff, in conjunction with other hospital services, organizes and appoints members to various committees. These committees contribute to the evaluation of the quality and appropriateness of patient care in the hospital by: routine collection of information about important aspects of patient care; periodic assessment of this information; identification of problems; taking action; evaluating the effectiveness

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[18] Adjunct Task Force of the Office of Legal and Regulatory Affairs and the American Academy of Hospital Attorneys of the American Hospital Association, *An Analysis of the Revised Medical Staff Standards of the Joint Commission of Accreditation Of Hospitals* 26 (1984).

[19] Joint Commission of Accreditation of Hospitals, *Accreditation Manual for Hospitals* 117 (1988).

[20] Joint Commission Accreditation of Hospitals, *Accreditation Manual for Hospitals* 117-118 (1988).

of the action taken; and making periodic reports.[21] A malpractice plaintiff is not entitled to information regarding prior incidents committed by a particular doctor, nor is the plaintiff entitled to any quality assurance or peer review committee reports.[22] The records generated by a peer review committee may[23] or may not[24] be protected from disclosure in a medical malpractice suit depending upon the law of the jurisdiction and the facts.

[ii]—Tissue Committees

The JCAH requires that a surgical case review be performed monthly by those departments performing surgical procedures to ensure that surgery in the hospital is justified and of high quality.[25] The committee responsible for this function is often denominated a Tissue Committee since tissue specimens removed during surgery are often analyzed to determine whether there was a discrepancy in the preoperative and postoperative diagnoses. However, regardless of whether tissue was extracted, the JCAH requires a surgical case

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[21] *Florida:* Beverly Enterprises-Florida, Inc. v. Ives, 832 So.2d 161 (2002); Good Samaritan Hospital v. American Home Products, 569 So.2d 895 (Fla. Dist. App. 1990) (Quality Assurance records may not be available in litigation.).

Missouri: Herrera v. DiMayuga, 904 S.W.2d 490 (Mo. App. 1995) (Committee meeting minutes, inasmuch as they discuss various acts of negligence at a hospital, may not be relevant to one particular malpractice action and can be excluded from trial on that basis).

[22] *Alabama:* Ex parte Anderson, 789 So.2d 190 (Ala. 2000).

Colorado: North Colorado Medical Center, Inc. v. Nicholas, 27 P.3d 828 (Colo.2001), cert. denied Nicholas v. N. Colo. Medical Center, Inc., 122 S.Ct. 820 (2002)

South Carolina: Prince v. Beaufort Memorial Hospital, 709 S.E.2d 122 (S.C. App. 2011).

Texas: Roe v. Walls Regional Hospital, Inc., 21 S.W.3d 647 (Tex.App.2000).

Graham, "Hide and Seek: Discovery in the Context of the State and Federal Peer Review Privileges," 30 Cumb. L. Rev. 111 (2000).

Wisconsin: Braverman v. Columbia Hospital, Inc., 2001 WI App. 106, 244 Wis.2d 98, 629 N.W.2d 66 (Wis.App.2001).

See also §. 15.02 *infra*.

[23] Hughes v. Hughes, 2003 N.C. App. (N.C. App. 2003); Fallis v. Watauga Medical Center, Inc., 510 S.E.2d 199 (N.C. App.1999).

[24] *Kentucky*: Hyatt v. Commonwealth, 72 S.W.3d 566 (Ky. 2002); Sisters of Charity Health System, Inc. v. Raikes, 984 S.W.2d 464 (Ky. 1998).

Missouri: State ex rel Kirksville Missouri Hospital Company L.L.C. v. Jaynes, 328 S.W.3d 418 (Mo. App. 2010) (an independent surgeon hired to evaluate instrumentation cases of a surgeon granted temporary privileges fell outside the scope of peer review privilege; the independent reviewer was not a member of the hospital's committee, and the evaluation did not reflect information from committee deliberations).

[25] Adjunct Task Force of the Office of Legal and Regulatory Affairs, *supra,* N. 9 at 126.

review be conducted for each operation—unless such reviews consistently support the justification and appropriateness of individual surgical procedures or the surgical procedure performed by individual practitioners; a review of an adequate sample of cases is then acceptable.[26]

[iii]—Pharmacy

In conjunction with pharmacy, nursing and management, the medical staff participates in a quarterly review of drug therapy and drug utilization practices within the hospital. This review includes the development of policies with respect to the selection, distribution and administration of drugs and an evaluation of protocols in the use of investigational or experimental drugs. Additionally, the committee analyzes all significant untoward drug reactions and maintains the hospital formulary.[27]

[iv]—Medical Records

The JCAH requires that the quality of medical records be reviewed quarterly. This review is designed to ensure that each medical record, or a representative sample, reflects the diagnosis, results of diagnostic tests, therapy rendered, patient progress throughout hospital stay and the patient's condition on discharge. Committee members also recommend the format of the forms used in the medical record. The use of electronic data processing and storage systems is also considered by the committee.[28]

[v]—Blood

A committee of the medical staff also performs a blood usage review on a quarterly basis. This committee reviews the appropriateness of all transfusions and evaluates all confirmed transfusion reactions. The JCAH also requires the committee to evaluate the adequacy of transfusion services to meet patient needs.[29]

[vi]—Antibiotics

As with the pharmacy review, the medical staff may review the appropriateness, safety and effectiveness of the prophylactic, empuric and therapeutic use of antibiotics in the hospital.[30] The JCAH requires

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[26] *Ibid.*
[27] *Id.* at 126-129.
[28] *Id.* at 127. For a detailed discussion of medical records, see Chapter 14 *infra*.
[29] *Id.* at 128.
[30] See, e.g., Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 87 (1985).

that a multi-disciplinary committee institute antibiotics susceptibility/resistance trend studies as appropriate.[31]

[vii]—Other Committees

Additional committees include a credential committee to assist the medical staff in determining the appropriateness of granting or renewing the staff privileges of a physician. A multidisciplinary infection control committee is responsible for reporting significant nosocomial infections to the appropriate regulatory bodies and for ensuring that the necessary equipment and facilities are available for implementation of isolation protocol. The medical staff may also establish peer review, medical audit and utilization committees which seek to positively effect patient quality care through review of staff performance and length of stay.

[5]—Staff Privileges

[a]—Due Process

[i]—In General

The duty of the medical staff to bestow clinical privileges only upon qualified practitioners is an essential link in the discharge of the hospital's overall obligation to provide optimal patient care.[32] On the other hand, certain courts have recognized a concurrent constitutional obligation running to the practitioner to ensure that privilege determinations are made in accordance with the constitutional guarantee of due process.[33] However, a patient lacks standing to seek judicial review of a hospital's administrative decision to deny privileges to the patient's doctor.[34]

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[31] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 76 (1988).

[32] See, e.g.,

Fifth Circuit: Tigua General Hospital, Inc. v. Feuerberg, 645 S.W.2d 575 (Tex. Civ. App. 1982).

Sixth Circuit: Meyers v. Logan Memorial Hospital, 82 F. Supp.2d 707 (Ky. 2000) (Health Care Quality Improvement Act gave committee immunity for reporting decision to deny reappointment to National Practitioner's Data Bank).

State Courts:

Texas: Stephan v. Baylor Medical Center, 20 S.W.3d 880 (Tex. App. 2000).

[33] See Ns. 19-42 *infra* and accompanying text. See also, DiFranco. "Denying Medical Staff Privileges Based on Economic Credentials," 15 J. L. & Health 247 (2000/2001).

[34] Nawaz v. University Hospital of State University at Stony Brook, 166 A.D.2d 593, 560 N.Y.S.2d 878 (N.Y. App. Div. 1990); Brindsi v. University Hospital, 516 N.Y.S.2d 745 (N.Y. App. Div. 1987).

The substantive and procedural due process rights guaranteed by the Fourteenth and Fifth Amendments to the federal Constitution are applicable only when state action can be demonstrated. Traditionally, private hospitals have not been subject to judicial review for the fairness of their staff appointments.[35] Where this common law rule has been changed by statute, the physician may be able to enjoin the hospital's action but not sue for damages.[36] However, in recent years, some courts have imposed a fairness requirement on the selection procedure utilized by private institutional medical care providers.[37]

Hospital by-laws may not support a breach of contract claim by a physician whose privileges at the hospital have been suspended or curtailed. Courts have determined that breach of contract claim in such a scenario must be explicitly stated in the employment contract between the physician and the hospital for such a claim to be valid. A New York court denied a claim brought by a physician against a

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[35] *Third Circuit:* Hodge v. Paoli Memorial Hospital, 576 F.2d 563 (3d Cir. 1978).

Fifth Circuit: Greco v. Orange Memorial Hospital Corp., 513 F.2d 873 (5th Cir. 1975), *cert. denied* 423 U.S. 1000 (1975); Grossling v. Ford Memorial Hospital, No. Ty-84-1-CA (E.D. Tex. Jan. 3, 1984).

Sixth Circuit: Jackson v. Norton - Children's Hospitals, Inc., 487 F.2d 502 (6th Cir. 1973), *cert. denied* 416 U.S. 1000 (1974).

Seventh Circuit: Doe v. Bellin Memorial Hospital, 479 F.2d 756 (7th Cir. 1973).

Eighth Circuit: Briscoe v. Bock, 540 F.2d 392 (8th Cir. 1976).

Ninth Circuit: Watkins v. Mercy Medical Center, 520 F.2d 894 (9th Cir. 1975).

Tenth Circuit: Ward v. St. Anthony's Hospital, 476 F.2d 671 (10th Cir. 1973).

State Courts:

Colorado: Evan v. Longmont United Hospital Ass'n, 629 P.2d 1100 (Col. App. 1981). But see, Taylor v. Goldsmith, 870 P.2d 1264 (Col. App. 1994).

Illinois: Miller v. Suburban Medical Center at Hoffman Estates, Inc., 584 N.E.2d 323 (Ill. App. 1991).

New York: Guibor v. Manhattan Eye, Ear & Throat Hospital, Inc. 46 N.Y.2d 736, 413 N.Y.S.2d 638, 386 N.E.2d 247 (1978); Leider v. Beth Israel Hospital Assoc'n, 11 N.Y.2d 205, 227 N.Y.S.2d 900, 182 N.E.2d 393 (1962); Faroog v. Millard Filmore Hospital, 569 N.Y.S.2d 320 (N.Y. App. Div. 1991).

Cf.:

Supreme Court: Rendell-Baker v. Kohn, 457 U.S. 830, 102 S.Ct. 2764, 73 L.Ed.2d 418 (1982).

Tenth Circuit: Loh-Seng Yo v. Cibola General Hospital, 706 F.2d 306 (10th Cir. 1983).

[36] See, e.g., N.Y. Pub. Health L. §§ 2801-b and 2801-c. See also:

Fourth Circuit: Wahi v. Charleston Area Medical Center, 453 F. Supp.2d 942 (S.D. W. Va. 2006).

State Courts:

New York: Chuz v. St. Vincent's Hospital, 589 N.Y.S.2d 17 (N.Y. App. Div. 1992); Dolgin v. Mercy Hospital, 511 N.Y.S.2d 360 (N.Y. App. Div. 1987).

[37] See, e.g.:

Alaska: Kiester v. Humana Hospital, 843, P.2d 1219 (Alaska 1992). But see, Valley Hospital Association v. Mat-Su Coalition for Choice, 948 P.2d 963 (Alaska 1997).

New York: Murphy v. St. Agnes Hospital, 107 A.D.2d 685, 484 N.Y.S.2d 40 (1985).

hospital that curtailed his surgery privileges for "flawed" skills and judgment. The court cited public policy considerations in making its decision, stating that "it is preferable for hospital administrators who decide whether to grant or deny privileges to make those decisions free from the threat of a damages action by the hospital."[37.1]

[ii]—State Action

Although certain courts have based imposition of this fairness requirement upon a common law right to due process,[38] other courts have scrutinized the nature and purposes of the hospital to determine the existence of implicit state action for purposes of constitutional due process requirements. In this regard, there are three indicia of state action by private hospitals.

(1) A direct connection between the state and the failure to grant medical staff privileges at the hospital.[39]

(2) Significant financial assistance to the hospital by the government; it is sufficient for purposes of state action that the hospital is receiving Medicare, Medicaid, or Hill-Burton funds.[40]

[37.1] Mason v. Central Suffolk Hospital, 3 N.Y. 3d 343, 786 N.Y.S.2d 413 (2004).

[38] See e.g.:

California: Anton v. San Antonio Community Hospital, 19 Cal.3d 802, 140 Cal. Rptr. 442, 567 P.2d 1162 (1977).

New Jersey: Garrow v. Elizabeth General Hospital & Dispensary, 79 N.J. 549, 401 A.2d 533 (1979); Sussman v. Overlook Hospital Association, 95 N.J. Super. 418, 231 A.2d 389 (1967).

See Cruz, "The Duty of Fair Procedure and the Hospital Medical Staff: Possible Extension in Order to Protect Private Sector Employees" 16 Capital U.L. Rev. 59 (1986).

[39] *Second Circuit:* Barrett v. United Hospital, 376 F. Supp. 791 (S.D.N.Y. 1974), *aff'd* 506 F.2d 1395 (2d Cir. 1974).

Ninth Circuit: Aasum v. Good Samaritan Hospital, 395 F. Supp. 363 (D. Ore. 1975), *aff'd* 542 F.2d 792 (9th Cir. 1976).

[40] *Second Circuit:* Schlein v. Milford Hospital, 383 F. Supp. 1263 (D. Conn. 1974), *aff'd* 561 F.2d 427 (2d Cir. 1977).

Sixth Circuit: Chiaffitelli v. Dettmer Hospital Inc., 437 F.2d 429 (6th Cir. 1971).

State Courts:

California: Ascherman v. San Francisco Medical Society, 39 Cal. App.3d 623, 114 Cal. Rptr. 681 (1974).

Colorado: Hawkins v. Kinsie, 540 P.2d 345 (Col. App. 1975).

New Jersey: Griesman v. Newcomb Hospital, 76 N.J. Super. 149, 183 A.2d 878 (1962), *aff'd* 40 N.J. 389, 192 A.2d 817 (1963).

But see, Pariser v. Christian Health Care Systems, Inc., 627 F. Supp. 39 (D. Mo. 1984), applying Missouri law.

See generally: Groseclose, "Hospital Privilege Cases: Braving the Dismal Swamp," 26 S.D. L. Rev. 1 (1981); McCall, "Hospitals Liability for Denying, Suspending and Granting Staff Privileges," 32 Bailer L. Rev. 175 (1980); Note, "Health Professionals Access to Hospital: A Retrospective And Prospective Analysis," 34 Vand. L. Rev. 1161 (1981).

(3) The hospital's performance of a public function; however, these cases usually involve hospitals whose governing board has a significant connection with local political units or where the hospital maintains a geographic monopoly over patient care.[41]

[iii]—Procedural Due Process

Procedural due process encompasses the notion that a practitioner who has been denied staff privileges must be given reasonable notice of the reasons therefor and an opportunity to be heard with respect to those allegations.[42] Although the practitioner is entitled to have these charges heard before a panel of fair minded members of the medical staff, these members need not have prior knowledge of the occurrences to be discussed at the hearing.[43]

Although summary suspension of medical staff privileges without prior notice of hearing is *prima facie* evidence of a violation of due process,[44] it may be excused in the face of an emergency.[45]

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[41] *Colorado:* Park Hospital District v. District Court of Eighth Judicial District, 192 Col. 69, 555 P.2d 984 (1976).

Illinois: Settler v. Hopedale Medical Foundation, 80 Ill. App.3d 1074, 400 N.E.2d 577 (1980).

Kentucky: McElhinney v. William Booth Memorial Hospital, 544 S.W.2d 216 (1976).

New Jersey: Joseph v. Passaic Hospital Association, 26 N.J. 557, 141 A.2d 18 (1958).

New York: Chalasani v. Neuman, 97 A.D.2d 806, 468 N.Y.S.2d 672 (1983), *rev'd* 64 N.Y.2d 879, 487 N.Y.S.2d 556, 476 N.E.2d 1001 (1985).

Pennsylvania: Miller v. Indiana Hospital, 277 Pa. Super. 370, 419 A.2d 1191 (1980).

But see:

Missouri: Pariser v. Christian Health Care Systems, Inc., 627 F.Supp. 39 (D.Mo. 1984), applying Missouri law.

New York: Konik v. Champlain Valley Physicians Hospital Medical Center, 88 A.D.2d 678, 450 N.Y.S.2d 914 (1982).

Pennsylvania: Posner v. Lankenau Hospital, 645 F. Supp. 1102 (E.D. Pa. 1986).

[42] *Second Circuit:* Birnbaum v. Trussell, 371 F.2d 672 (2d Cir. 1966).

Eighth Circuit: Klinge v. Lutheran Charity Association of St. Louis, 523 F.2d 56 (8th Cir. 1975); Kaplan v. Carney 404 F. Supp. 161 (E.D. Mo. 1975).

State Courts:

Alabama: Murdoch v. Knollwood Park Hospital, 585 So.2d 873 (Ala. 1991).

Illinois: Garibaldi v. Applebaum, 653 N.E.2d 42 (Ill. App. 1995).

See Bailey and Bell, "Procedural Due Process Requirements in Hospital Medical Staff Decisions," 49 Tex. B.J. 981 (1986).

[43] *Third Circuit:* Citta v. Delaware Valley Hospital, 313 F. Supp. 301 (E.D. Pa. 1970). But see, Hodge v. Paoli Memorial Hospital, 433 F. Supp. 281 (E.D. Pa. 1977).

Eighth Circuit: Klinge v. Lutheran Charities Association of St. Louis, 523 F.2d 56 (8th Cir. 1975).

[44] Poe v. Charlotte Memorial Hospital, Inc., 374 F. Supp. 1302 (W.D.N.C. 1974), applying North Carolina law. But see, Aluko v. Charlotte-Mecklenburg Hospital Authority, 959 F. Supp. 729 (W.D.N.C. 1997).

[iv]—Substantive Due Process

Once a court has determined that it will review the denial of medical staff privileges, the next issue is the standard against which that process will be judged. The traditional substantive due process standard followed by many courts will require reversal of a hospital's denial of medical staff privileges only when the decision of the medical care facility was unreasonable, arbitrary or capricious.[46] The *Fifth Circuit* has held, in the context of staff privileges at hospitals that, "[s]ubstantive due process is satisfied if applicants are judged and considered on grounds that are reasonably related to the purpose of providing adequate medical care."[46.1] Other courts, however, limit their scrutiny of the hospital decision to a determination of whether "substantial evidence" existed.[47]

Before a court will apply either of these standards, however, the practitioner must exhaust all his administrative remedies as provided for in the bylaws of the medical staff,[48] or by statute.[49] In fact, Cali-

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[45] Avol v. Hawthorne Community Hospital, Inc., 135 Cal. App.3d 101, 184 Cal. Rptr. 914 (1982) (opinion withdrawn by order of court). See also, Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 114 (1988).

[46] *Second Circuit:* Schlein v. Milford Hospital, 423 F. Supp. 541 (D. Conn. 1976), *aff'd* 561 F.2d 427 (2d Cir. 1977); but see, Greenwood v. Office of Mental Health, 163 F.3d 119 (2d Cir. 1998).

Fourth Circuit: Freilich v. Upper Chesapeake Health, Inc., 313 F.3d 205, 2002 U.S. App. LEXIS 25534 (4th Cir. 2002).

State Courts:

Arizona: Holmes v. Hoemako Hospital, 117 Ariz. 403, 573 P.2d 477 (1977).

Colorado: Hawkins v. Kinsie, 540 P.2d 345 (Col. App. 1975).

Vermont: Woodward v. Porter Hospital, Inc., 125 Vt. 419, 217 A.2d 37 (1966).

[46.1] Gaalla v. Citizens Medical Center, 407 Fed. Appx. 810 (5th Cir. 2011), *cert. denied*, ____ U.S. ____ (2011). A resolution adopted by a hospital prohibiting all physicians who were not contractually obligated to the hospital from practicing in its cardiology department satisfied substantive due process since there was a conceivable reason for the Resolution that was "reasonably related to the purpose of providing medical care" under a rational basis review (citing Hyde v. Jefferson Parish Hospital District No. 2, 764 F.2d 1139 (5th Cir. 1985)); Hyde v. Jefferson Parish Hospital District No. 2, 764 F.2d 1139 (5th Cir. 1985).

[47] See, e.g.:

Eighth Circuit: Schueller v. Goddard, 631 F.3d 460 (8th Cir. 2011),

Kaplan v. Carney, 404 F. Supp. 161 (E.D. Mo. 1975).

State Courts:

California: Pick v. Santa Ana-Tustin Community Hospital, 130 Cal. App.3d 970, 182 Cal. Rptr. 85 (1982); Miller v. National Medical Hospital of Monterrey Park Inc., 124 Cal. App.3d 81, 177 Cal. Rptr. 119 (1981).

[48] *Sixth Circuit:* Early v. Bristol Memorial Hospital, Inc., 508 F. Supp. 35 (E.D. Tenn. 1980).

State Courts:

Alaska: Eidelson v. Archer, 645 P.2d 171 (1982).

California: Bartschi v. Chico Community Memorial Hospital, 137 Cal. App.3d 502, 187 Cal. Rptr. 61 (1982).

fornia requires that a physician seeking review of a staff privileges decision must first attempt to have the hospital's action overturned in a proceeding for administrative mandamus.[50] On the other hand, exhaustion of all administrative remedies will not be required where such efforts would be futile and irreparable harm will result in the interim.[51]

[b]—Bylaw as Contract

The medical staff bylaws pertaining to staff privileges are required by the JCAH to contain provisions establishing a fair hearing and appellate review mechanisms. These mechanisms must specify the period of time beyond which the right to request a hearing is waived, must grant the right to introduce witnesses and evidence and must define the role, if any, of legal counsel. In an effort to extend the substantive and procedural fairness requirements to privilege processes in private hospitals, some courts have construed these bylaws as a contract between the hospital and medical staff and have required strict compliance.[52] Significantly, the JCAH allows these fair-hearing and

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Georgia: Sanchez v. Hospital Authority of Walker, Dade & Catoosa Counties, 146 Ga. App. 734, 247 S.E.2d 534 (1978).

New York: Gelbard v. Genesee Hospital, 626 N.Y.S.2d 894 (N.Y. App. Div. 1995) (hospital terminated staff privileges of anesthesiologist due to billing problems, disruption of operating room schedules, and violation of acceptable medical practice standards; appellate court found physician had failed to exhaust administrative remedies, and, therefore, trial court lacked subject matter jurisdiction); Guibor v. Manhattan Eye, Ear, Nose & Throat Hospital, Inc., 56 A.D.2d 359, 392 N.Y.S.2d 628 (1977), *aff'd* 46 N.Y.2d 736, 413 N.Y.S.2d 638, 386 N.E.2d 247 (1978).

[49] N.Y. Public Health Law § 2801-b.

[50] McNair v. Pasadena Hospital Association, Ltd., 111 Cal. App.3d 841, 169 Cal. Rptr. 39 (1980); Westlake Community Hospital v. Superior Court, 17 Cal.3d 465, 131 Cal. Rptr. 90, 551 P.2d 410 (1976).

[51] Garrow v. Elizabeth General Hospital & Dispensary, 79 N.J. 549, 401 A.2d 533 (1979).

[52] *Third Circuit:* Posner v. Lankenau Hospital, 645 F. Supp. 1102 (E.D. Pa. 1986), applying Pennsylvania Law.

Fourth Circuit: Modaber v. Culpeper Memorial Hospital Inc., 674 F.2d 1023 (4th Cir. 1982); Doe v. Charleston Area Medical Center, 529 F.2d 638 (4th Cir. 1975); Christhilf v. Annapolis Emergency Hospital Association, Inc., 496 F.2d 174 (4th Cir. 1974).

Eighth Circuit: Pariser v. Christian Health Care Systems, 627 F. Supp. 39 (E.D. Mo. 1984).

Ninth Circuit: Ennix v. Stanten, 2007 U.S. Dist. LEXIS 66032 (N.D. Cal. 2007).

State Courts:

Alaska: Kiester v. Humana Hospital, 843 P.2d 1219 (Alaska 1992).

Florida: University Community Hospital Inc. v. Wilson, 1 So.3d 206 (Fla. App. 2008); Naples Community Hospital v. Hussey, 918 So.2d 323 (Fla. App. 2005).

Georgia: Todd v. Physicians & Surgeons Community Hospital, Inc., 165 Ga. App. 656, 302 S.E.2d 378 (1983). But see, Robles v. Humana Hospital Cartersville, 785 F. Supp. 989 (N.D. Ga. 1992).

appellate review mechanisms to differ for members of the medical staff and other individuals holding clinical privileges and for applicants for such membership or privileges.[53]

[c]—Grounds for Denial

[i]—School for Practice

There are various grounds for denial of medical staff privileges which have been consistently upheld by the courts. For instance, the courts have upheld the blanket exclusion of chiropractors and podiatrists from privileges at hospitals.[54] Osteopaths, however, have had more success in challenging exclusion from medical care facilities.[55]

Illinois: Garibaldi v. Applebaum, 653 N.E.2d 42 (Ill. App. 1995); Noah v. Suburban Medical Center at Hoffman Estates, Inc., 584 N.E.2d 323 (Ill. App. 1991).

Massachusetts: Bello v. South Shore Hospital, 384 Mass. 770, 429 N.E.2d 1011 (1981). *Cf.*, Vakil v. Anaesthesiology Associates of Taunton, Inc., 744 N.E. 2d 651 (Mass. App. 2001).

Michigan: Hoffman v. Garden City Hospital-Osteopathic, 115 Mich. App. 773, 321 N.W.2d 810 (1982).

New York: Chuz v. St. Vincent's Hospital, 589 N.Y.S.2d 17 (N.Y. App. Div. 1992); Murphy v. St. Agnes Hospital, 107 A.D.2d 685, 484 N.Y.S.2d 40 (1985).

Pennsylvania: Miller v. Indiana Hospital, 277 Pa. Super. 370, 419 A.2d 1191 (1980).

Cf.:

Fifth Circuit: Grossling v. Ford Memorial Hospital, 614 F. Supp. 1051 (E.D. Tex. 1985.

Eighth Circuit: Lubin v. Crittenden Hospital Association, 713 F.2d 414 (8th Cir. 1983), *cert. denied* 465 U.S. 1025 (1984).

State Courts:

Florida: Carida v. Holy Cross Hospital, Inc., 427 So.2d 803 (Fla. App. 1983).

Ohio: Munoz v. Flower Hospital, 507 N.E.2d 360 (Ohio App. 1985).

[53] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 114 (1988). See Ez Peleta v. Sisters of Mercy Health Corp., 621 F. Supp. 1262 (N.D. Ind. 1985) (probationary staff not entitled to formal hearing with right of counsel).

[54] *Colorado:* Green v. Board of Directors, 739 P.2d 872 (Col. App. 1987).

Oregon: Samuel v. Curry County, 55 Ore. App. 653, 639 P.2d 687 (1982).

Tennessee: Attorney General Opinion No. 317 (March 10, 1981).

Texas: Malini v. Singleton & Associates, 516 F. Supp. 440 (S.D. Tex. 1981), applying Texas law.

See also, N.Y. Pub. Health L. § 2801-b relating to improper practices by hospitals in the extension of professional privileges to physicians, podiatrists and dentists.

[55] See, e.g.:

Fifth Circuit: Stern v. Tarrant County Hospital District, 565 F. Supp. 1440 (N.D. Tex. 1983), *aff'd* 755 F.2d (5th Cir. 1985).

State Law:

New Jersey: Greisman v. Newcomb Hospital, 40 N.J. 389, 192 A.2d 817 (1963).

But see:

Eleventh Circuit: Silverstein v. Gwinnett Hospital Authority, 861 F.2d 1560 (11th Cir. 1988), construing federal and Georgia state law.

In general, the trend is toward equal treatment and consideration for medical staff privileges no matter what the school of practice of the applicant.[56] Nevertheless, it has been held that even in states that prohibit discrimination against doctors of osteopathy, a hospital may require those doctors to complete postgraduate training programs certified by an allopathic organization.[57] Nurses are generally not given similar rights pertaining to the extension of professional privileges.[58]

[ii]—Maintenance of Adequate Liability Insurance

The hospital governing board and its administrators are charged with the obligation of ensuring the financial security of the institution. To this end, courts have held that it is not unreasonable to require all members of the hospital medical staff to purchase and maintain professional liability insurance. It is clear that this precondition is reasonably related to the legitimate purpose of sound financial management since plaintiffs often look to the hospital as a "deep pocket" to pay judgments in the absence of adequate insurance coverage or substantial economic resources of a private physician.[59]

State Law:

Arizona: Limmer v. Samaritan Health Service, 710 P.2d 1077 (Ariz. App. 1985).

[56] See, e.g.:

California: Cal. Health & Safety Code § 1316.

Kansas: Kan. Stat. Ann. § 65-2801.

Louisiana: La. Rev. Stat. Ann. § 37:1301.

Missouri: Mo. Rev. Stat. § 205.300.

New Mexico: N.M. Stat. Ann. § 61-10-4.

Texas: Tex. Rev. Civ. Stat. Ann., Art. 4551K.

See also, Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 111 (1988).

[57] Silverstein v. Gwinnett Hospital Authority, 861 F.2d 1560 (11th Cir. 1988), construing federal and Georgia law.

[58] See, e.g., Ashley v. Nyack Hospital, 67 A.D.2d 671, 412 N.Y.S.2d 388 (1979).

[59] *Fifth Circuit:* Pollock v. Methodist Hospital, 392 F. Supp. 393 (E.D. La. 1975).

State Courts:

Arizona: Holmes v. Hoemako Hospital, 117 Ariz. 403, 573 P.2d 477 (1977). But see, Bill Alexander Ford, Lincoln Mercury v. Casa Ford, 187 Ariz. 616, 931 P.2d 1126 (Ariz. App. 1996).

California: Wilkinson v. Madeira Community Hospital, 144 Cal. App.3d 436, 192 Cal. Rptr. 593 (1983).

Indiana: Renforth v. Fayette Memorial Hospital Association, Inc., 178 Ind. App. 475, 383 N.E.2d 368 (Ind. App. 1979), *cert. denied* 444 U.S. 930 (1979).

New York: Jones v. Yonkers General Hospital, 143 A.D.2d 885, 533 N.Y.S.2d 522 (1988).

Annot., "Propriety of Hospitals Conditioning Physicians' Staff Privileges On His Carrying Professional Liability or Malpractice Insurance," 7 A.L.R.4th 1238 (1981).

See also, Joint Commission of Hospital Accreditation, *Accreditation Manual for Hospitals* 112 (1988).

[iii]—Personality

It has also been held that it is reasonable for hospitals to insist that their medical staff members obey hospital rules,[60] and demonstrate an ability to work with others without disruptive personality traits.[61] The trend in the cases supports the position that hospitals may deny or terminate staff privileges based solely on the practitioner's behavior.[61.1] The courts have upheld such actions for personal attacks on other

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[60] *Arizona:* Peterson v. Tucson General Hospital, Inc., 114 Ariz. 66, 559 P.2d 186 (1976).

Georgia: Todd v. Physicians & Surgeons Community Hospital, Inc., 165 Ga. App. 656, 302 S.E.2d 378 (1983); Yeargin v. Hamilton Memorial Hospital, 229 Ga. 870, 195 S.E.2d 8 (1972).

Missouri: Dillard v. Rowland, 520 S.W.2d 81 (Mo. 1974).

Wyoming: Board of Trustees of Memorial Hospital v. Pratt, 72 Wyo. 120, 262 P.2d 682 (1953).

[61] *Third Circuit:* Brown v. Our Lady of Lourdes Medical Center, 767 F. Supp. 618 (D.C N.J. 1991).

State Courts:

California: Hongsathavij v. Queen of Angels Etc. Medical Center, 62 Cal. App. 4th 1123, 73 Cal. Rptr. 2d 695 (Cal. App. 1998); Pick v. Santa Ana-Tustin Community Hospital, 130 Cal. App.3d 970, 182 Cal. Rptr. 85 (1982).

Delaware: Sternberg v. Nanticoke Memorial Hospital Inc., 15 A.3d 1225 (Del. 2011).

Georgia: Robbins v. Ong, 452 F. Supp. 110 (S.D. Ga. 1978), applying Georgia law.

Hawaii: Silver v. Queens Hospital, 629 P.2d 116 (Hawaii 1981).

Illinois: Ladenheim v. Union County Hospital, 394 N.E.2d 770, 76 Ill. App.3d 90 (1980). But see, Finnerty v. Personnel Bd., 303 Ill. App. 3d 1, 707 N.E.2d 600 (Ill. App. 1999).

Michigan: Anderson v. Board of Trustees of Caro Community Hospital, 159 N.W.2d 347 (Mich. App. 1968).

New Hampshire: Finnerty v. Personnel Board, 303 Ill. App. 3d 1, 707 N.E.2 600 (Ill. App. 1999); Bricker v. Sceva Speare Memorial Hospital, 111 N.H. 276, 281 A.2d 589 (1971).

New Jersey: Sussman v. Overlook Hospital Association, 95 N.J. Super. 418, 231 A.2d 384 (1967).

Oregon: Straube v. Emanuel Lutheran Charity Board, 287 Ore. 375, 600 P.2d 381, *cert. denied* 445 U.S. 966 (1979); Huffaker v. Barley, 540 P.2d 1398 (Ore. 1975).

Washington: Rao v. Auburn General Hospital, 573 P.2d 834 (Wash. App. 1977).

West Virginia: Bronaugh v. City of Parkersburg, 148 W. Va. 568, 136 S.E.2d 783 (1964).

Wyoming: Guier v. Teton County Hospital Dist., 2011 WY 31; 248 P.3d 623 (2011).

But see, McElhinney v. William Booth Memorial Hospital, 544 S.W.2d 216 (Ky. Sup. 1977).

See generally, Hirsh, "The 'Disruptive' or 'Bad' Physician in the Hospital," 35 Medical Trial Tech. Q. 304 (1989).

[61.1] See e.g., Mileikowsky v. Tenet Healthsystem, 128 Cal. App.4th 531, 27 Cal.Rptr.3d 171 (Cal. App. 2005) (peer review committee's power to terminate proceedings against a physician as a sanction for conduct during the hearing was reasonably inferable from provisions of governing statute, where the physician was

staff members,[62] inappropriate comments within patient medical records[63] and sexual harassment.[64] "The hospital has the right, indeed the duty, to ensure that those who are appointed to its medical staff meet certain standards of professional competence and personal conduct so long as those standards are reasonably related to the hospital's mission of providing quality medical care in an efficiently run hospital. Most courts express reluctance to substitute their judgment for that of the governing board."[65] When a healthcare employee is terminated for a state reportable incident, the merits of which the worker disputes, the courts are split on whether to recognize a claim by the employee for compelled self-defamation. This claim has been defined as permitting:

a discharged employee [to] sue for defamation . . . if the employer knows, or should know, of circumstances where the employee is later put in a position in which he or she has no reasonable means of avoiding publication of the statement and must repeat such statement; usually when seeking new employment.[65.1]

Some courts have rejected this claim to discourage a flood of litigation by disgruntled, terminated employees.[65.2] Other courts have upheld the claim on the basis that there exists a causal link between the originator of the alleged defamatory statement and a foreseeable, compelled republication by the terminated worker.[65.3]

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repeatedly disruptive, disdainful of the hearing officer's authority, and flagrantly violated the rules pertaining to discovery and documentary exhibits).

Washington: Rao v. Auburn General Hospital, 573 P.2d 834 (Wash. App. 1977).

West Virginia: Bronaugh v. City of Parkersburg, 148 W. Va. 568, 136 S.E.2d 783 (1964).

But see, McElhinney v. William Booth Memorial Hospital, 544 S.W.2d 216 (Ky. Sup. 1977).

See generally, Hirsh, "The 'Disruptive' or 'Bad' Physician in the Hospital," 35 Medical Trial Tech. Q. 304 (1989).

[62] Hoberman v. Lock Haven Hospital, 377 F. Supp. 1178 (M.D. Pa. 1974).

[63] Cipriotti v. Board of Directors of Northridge Hospital, 147 Cal. App. 3d 144, 196 Cal. Rptr. 367 (1983).

[64] Belanoff v. Grayson, 98 A.D.2d 353, 471 N.Y.S.2d 91 (1984).

[65] Springer and Casale, "Hospitals and the Disruptive Health Care Practitioner—Is the Inability to Work with Others Enough to Warrant Exclusion?" 24 Duquesne L. Rev. 377, 414 (1985). See, e.g., Gabaldoni v. Washington County Hospital Ass'n, 250 F. 3d 255 (4th Cir. 2001).

[65.1] Weider v. Chemical Bank, 202 A.D.2d 168, 169-170 (N.Y. App. 1994).

[65.2] Weider v. Chemical Bank, 202 A.D.2d 168, (N.Y. App. 1994); Weintraub v. Phillips, Nizer, Benjamin, Krim & Ballow, 568 N.Y.S.2d 84 (N.Y. App. 1991). See also, Fedrizzi v. Washingtonville Cent. School Dist. 611 N.Y.S.2d 584 (N.Y. App. 1994); Kiblitsky v. Lutheran Medical Center, 922 N.Y.S.2d 769 (N.Y. Sup. 2011).

[65.3] *California:* McKinney v. County of Santa Clara, 110 Cal. App.3d 787, 168 Cal. Rptr. 89 (1980).

New York: Van-Go Transp. Co., Inc. v. New York City Board of Education 971 F. Supp. 90 (E.D.N.Y. 1997). See also, Wright v. Guarinello, 635 N.Y.S.2d 995 (N.Y. Sup. 1995).

[iv]—Miscellaneous Grounds

The JCAH also suggests that the professional criteria that constitute the basis for granting initial medical staff membership and clinical privileges may also pertain to:

(1) the ability of the hospital to provide adequate facilities and supportive services for the applicant and his patients;[66]
(2) the hospital's needs for additional staff members with the applicant's skill and training;[67] and
(3) the geographic location of the applicant.[68]

The reappointment, renewal or revision of clinical privileges is based upon information concerning the individual's current licensure, health status, special performance, judgment and clinical/technical skills as indicated by the results of quality assurances activities and other reasonable indicators of continuing qualifications.[69]

A Colorado appellate court found that a psychiatrist was properly dismissed after receiving three successive "not effective" ratings. The psychiatrist purportedly had difficulty performing job duties, failed to complete evaluations promptly and adequately, and failed to treat emergency room patients in a timely manner.[70]

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[66] See also:

New Jersey: Garrow v. Elizabeth General Hospital, 79 N.J. 549, 401 A.2d 533 (1979); Guerrero v. Burlington County Memorial Hospital, 254 A.2d 125 (N.J. Super. 1969).

New York: Biller v Long Beach Memorial Hospital, 120 A.D.2d 634, 502 N.Y.S.2d 95 (1986).

Cf., Walsky v. Pascack Valley Hospital, 367 A.2d 1204 (N.J. Super, 1976), *aff'd* 156 N.J. Super. 13, 383 A.2d 154 (1978).

See generally, Isele, "Hospital/Medical Staff Relationships," N.J. Law, 21 (Feb. 1987).

[67] See also: Kleinplatz v. Novello, 14 A.D.3d 946, 788 N.Y.S.2d 505 (2005) (included allegations that a physician had not completed all medical school requirements); Maltz v. New York University Hospital, 503 N.Y.S.2d 570 (N.Y. App. Div. 1986).

[68] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 112 (1988).

See generally, Annot, "Exclusion of or Discrimination Against Physician or Surgeon by Hospital," 37 A.L.R.3d 648.

[69] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 124 (1988). See also, Kerth v. Hamot Health Foundation, 989 F. Supp. 691 (Pa. 1997) (privileges revoked because surgery volume was so low it was no longer possible to evaluate quality of care).

[70] Cruzen v. Career Service Board of City and County of Denver, 899 P.2d 373 (Colo. App. 1995). See also, Miller v. Boulder County Board of Equalization, 990 P.2d 1114 (Colo. App. 1999).

Ordinarily, hospitals are allowed broad discretion in making medical staffing decisions. In the absence of evidence that the hospital acted in bad faith, a court will not generally substitute its judgment for that of the hospital when it is justified by such factors as bed limitations and current adequate staffing.[71] For instance, it has been held that a hospital has acted properly when it terminated a surgeon's privileges for the seemingly mundane yet potentially significant transgression of failing to complete medical records within a prescribed time.[72]

Additionally, it has been held that patients, as opposed to physicians, lack standing to seek judicial review of a hospital's clinical privileges decision. It is reasoned that the patient's right of autonomy over medical decisions effecting his body cannot be extended to establish a right to countermand hospital decisions pertaining to resource allocation and the attainment of reasonable hospital objectives.[73]

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[71] See, e.g.:

Fourth Circuit: Payman v. Ahsan, 187 Fed. Appx. 282 (4th Cir.), *cert. denied sub nom* Payman v. Shelbourne, 127 S.Ct. 564 (2006).

State Courts:

Kansas: Newell v. Kansas Department of Social & Rehabilitation Services, 22 Kan. App. 2d 514, 917 P.2d 1357 (1996); Dutta v. St. Francis Regional Medical Center, Inc., 850 P.2d 928 (Kan. App. 1993).

New York: Jackaway v. Northern Dutchess Hospital, 139 A.D.2d 495, 526 N.Y.S.2d 599 (1988) (delineation of courtesy privileges as opposed to active staff privileges was made by a hospital in good faith since doctor had admitted no more than twenty-five patients in the previous year); Maltz v. New York University Medical Center, 503 N.Y.S.2d 570 (N.Y. App. Div. 1986).

[72] Jones v. Yonkers General Hospital, 143 A.D.2d 885, 533 N.Y.S.2d 522 (1988).

See also Lee v. Trinity Lutheran Hospital, 408 F.3d 1064 (Mo. 2005). (Numerous instances of substandard care had been identified, and, therefore, the hospital had the right to revoke privileges.)

[73] *Ninth Circuit:* Domingo v. Doe, 985 F. Supp. 1241 (Haw. 1997) (patient provided no evidence that hospital had notice of surgeon's incompetence due to substance abuse and should have denied privileges).

State Courts:

New York: Brindisi v. University Hospital, 516 N.Y.S.2d 745 (N.Y. App. Div. 1987).

Pennsylvania: Adler v. Montefiore Hospital Ass'n, 453 Pa. 60, 311 A.2d 634 (1973), *cert. denied* 414 U.S. 1131 (1974).

§ 1.04 Antitrust Liability

[1]—Introduction

Hospital liability for antitrust violations has been the subject of discussion by courts and commentators with increasing frequency, especially over the last several years. This phenomenon contrasts with the federal government's apparent willingness to allow market forces greater reign in other economic sectors during the same period. It is likely that the growth of the health care industry and its concomitant share of the gross national product has attracted the attention of those in the Justice Department and the Federal Trade Commission who wish to encourage pro-competitive factors.

It has also been suggested, however, that this commitment to promoting competition in the health care field is not new. Any increase in antitrust enforcement activities is thought instead to reflect fundamental changes in the identities of health care providers and, therefore, the nature of the industry. These changes have lead to intensified competition which certain providers then seek to minimize or eliminate. For example, hospital networks, HMOs, PPOs, and exclusive contract groups have made a significant impact on the economics of health care in recent years. One knowledgeable source noted that "as old players are finding new ways to interact with each other and with and with new actors in the competitive arena, it is important that all participants remain alert to antitrust principles that may affect their conduct . . . Where providers or purchasers appear to be responding to competitive pressure with concerted actions that attempt to thwart competition . . . the Antitrust Division (of the Department of Justice) is prepared to take appropriate action to protect the competitive process."[1]

[2]—Applicable Antitrust Law

[a]—The Sherman Act

Hospital acts are subject to scrutiny under Sections 1 and 2 of the Sherman Act.[2] Section 1 prohibits concerted actions taken by different

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[1] Robert E. Block, Assistant Attorney General, Chief, Professions and Intellectual Property Section, U.S. Department of Justice, "Antitrust Enforcement and Health Care: Current Developments and Future Trends," delivered before the Twenty-Third Annual New England Antitrust Conference, Harvard Law School (November 4, 1989) at 2. See Havighurst and Richman, "The Provider Monopoly Problem in Health Care," 89 Ore. L. Rev. 847 (2011).

See also, Highmark Inc. v. W. Penn Allegheny Health Systems, Inc., 627 F.3d 85 (3rd Cir. 2010), *cert. denied* _____ U.S. _____, 132 S. Ct. 98, 181 L.Ed.2d 26 (2011) (antitrust claims upheld against market's dominant hospital system and insurer).

[2] 15 U.S.C. §§ 1, 2.

entities that unreasonably restrain trade.[3] It has been held that four elements must be shown before an antitrust violation arises under Section 1:

(1) a contract, combination of conspiracy;[3.1]
(2) a substantial impact on interstate commerce;
(3) an anti-competitive purpose or effect; and
(4) effect relevant services and markets.[4]

Traditional antitrust exemptions for "learned professions" and "the business of insurance"[5] do not apply to medical care providers. State immunity laws may also exempt otherwise suspect restraints of trade by hospitals.[5.1]

Violations of the antitrust laws can result in civil damages,[6] injunctions[7] and criminal penalties.[8] Hospital activities may be analyzed under the antitrust laws employing either a *per se* standard or a "rule

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[3] 15 U.S.C. § 1.

"Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations is declared to be illegal."

[3.1] *Kentucky:* Stevens v. Saelinger, 2011 U.S. Dist. LEXIS 10248 (E.D. Ky. Feb. 2, 2011) (where plaintiff's claims of conspiracy were inconsistent and in conflict with her complaint; plaintiff relies on the assertion that actions by defendants occurred after the merger and defendants were the same entity; the law clearly states "a parent and its subsidiaries 'are incapable, as a matter of law, of conspiracy'" quoting Total Benefits Planning Agency v. Anthem Blue Cross & Blue Shield, 552 F.3d 430, 435 (6th Cir. 2008)).

[4] See e.g.,

Supreme Court: Business Electronics Corp. v. Sharp Electronics Corp., 485 U.S. 717, 723, 108 S.Ct. 1515, 99 L.Ed.2d 808 (1988).

Second Circuit: Balaklaw v. Lovell, 822 F. Supp. 892 (N.D.N.Y. 1993).

Third Circuit: Pao v. Holy Redeemer Hospital, 547 F. Supp. 484 (E.D. Pa. 1982).

Ninth Circuit: Morgan, Strand, Wheeler & Biggs v. Radiology Ltd., No. 89-15022 (Feb. 1, 1991); Bahn v. NME Hospitals, Inc., 929 F.2d 1404 (9th Cir. 1991).

State Courts:

Kentucky: Stevens v. Saelinger, 2011 U.S. Dist. LEXIS 10248 (E.D. Ky. Feb. 2, 2011) (where plaintiff registered nurse and former employee failed to supply sufficient factual allegations so that an agreement in violation of the Sherman Act could be plausibly inferred).

[5] See: Group Life and Health Insurance Co. v. Royal Drug Co. 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979); Goldfarb v. Virginia State Bar, 421 U.S. 773, 95 S.Ct. 2004, 44 L.Ed.2d 572 (1975).

[5.1] Dintelman v. Chicot County Memorial Hospital, 2011 U.S. Dist. LEXIS 36560 (E.D. March 31, 2011).

[6] 15 U.S.C. § 15 a. See also, Gilbert v. Hall, 620 So.2d 533 (Miss. 1993).

[7] 15 U.S.C. §§ 4, 26.

[8] 15 U.S.C. §§ 1, 2. See also, 18 U.S.C. §§ 3551, 3623.

of reason." If the activity is considered *per se* illegal, criminal sanctions may be sought. Example of such activities include price fixing, bid rigging, certain types of group boycotts and schemes to allocate geographical practice areas or patients.[9] For activities to which a rule of reason can be applied, a court will consider the procompetitive effects of a particular practice in addition to the anticompetitive effects. If the practice promotes efficiencies or creates a new product or service, a court may conclude that these effects outweigh the potential of the practice to raise consumer prices or reduce services.[10]

Section 2 of the Sherman Act[11] prohibits health care providers from monopolizing or conspiring to monopolize any part of interstate commerce.[12] In order to succeed on a claim under either Section 1 or 2, the plaintiff usually must establish that the hospital or other defendant obtained market power, that is, the power to control prices or exclude competition.[13] Nevertheless, when there is a blatant restriction of trade or an actual effect on competition, such a finding is not required.[14]

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[9] See e.g., Armstrong Surgical Center, Inc. v. Armstrong County Memorial Hospital, 185 F.3d 154 (3d Cir. 1999), *cert. denied* 120 S.Ct. 2716 (2000).

See generally "Antitrust Enforcement and the Medical Profession: No Special Treatment," remarks of Charles F. Rule, Assistant Attorney General, Antitrust Division, before the Interim Meeting of the American Medical Association House of Delegates at 12-13 (Dec. 6, 1988).

[10] *Supreme Court:* See Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 49, n.15, 97 S.Ct. 2549, 53 L.Ed.2d 568 (1977).

Eighth Circuit: Minnesota Assoc. of Nurse Anesthetists v. Unity Hospital, No. 98-2677 (8th Cir. 2000) (sole source contracts between anesthesiologists and hospital groups did not violate Sherman Act §1 because the contracts were not properly analyzed as boycotts and the plaintiff failed to show the actual sustained adverse effects on competition).

See also, "Antitrust Enforcement and Health Care: Current Developments and Future Trends," N. 1 *supra* at 7.

[11] 15 U.S.C. § 2.

"Every person who shall monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several states, or with foreign nations, shall be deemed guilty. . . ."

[12] Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), *cert. denied* 470 U.S. 1060 (1985).

[13] *Supreme Court:* Eastman Kodak Co. v. Image Technical Services, 504 U.S. 451, 119 L. Ed. 2d 265 (1992); United States v. E.I. duPont de Nemours & Co., 351 U.S. 377, 391, 76 S.Ct. 994, 100 L.Ed. 1264 (1956).

Third Circuit: Brown v. Our Lady of Lourdes Medical Center, 767 F. Supp. 618 (D.C.N.J. 1991).

See also, Anesthesia Advantage, Inc. v. Metz Group, 759 F. Supp. 638 (D. Col. 1991).

[14] *Supreme Court:* FTC v. Indiana Federation of Dentists, 476 U.S. 447, 460-461, 106 S.Ct. 2009, 90 L.Ed.2d 445 (1986).

Ninth Circuit: Bahn v. NME Hospitals Inc., 929 F.2d 1404 (9th Cir. 1991); Oltz v. St. Peter's Community Hospital, 861 F.2d 1440, 1448 (9th Cir. 1988).

Various factors are considered in determining whether a defendant has acquired market power. These factors include the defendant's percentage of market share and the ability of consumers to obtain substitutes for the defendant's services outside the defined relevant market.[15] The plaintiff bears the burden of proof on the definition of the relevant service and geographic markets.[16] The purpose of defining

(Text continued on page 1-31)

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[15] Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), *cert. denied* 470 U.S. 1060 (1985).

[16] *Fourth Circuit:* Terry's Floor Fashions, Inc. v. Burlington Industries, 763 F.2d 604 (4th Cir. 1985).

Ninth Circuit: Bahn v. NME Hospitals Inc. 929 F.2d 1404 (9th Cir. 1991).

the markets is to locate the areas within which the defendant's power to restrain trade is to be measured. The larger the market is defined, the more beneficial it is for a defendant.

Once the market is defined, the plaintiff must plead and prove, not merely injury to himself, but to competition within the market generally.[17] Moreover, the plaintiff must also establish a nexus between the defendant's challenged actions and interstate commerce. These activities must either be "in" or have an "effect on" interstate commerce.[18] In a case involving the exclusion of a surgical ophthalmologist from a hospital's medical staff, the Supreme Court rejected a defense argument that the exclusion of one physician had no clear effect on interstate commerce and held that the issue turns on the potential harm to interstate commerce and not actual harm.[19] Additionally, the court held there to be a sufficient nexus to interstate commerce not just with reference to the effect of the defendant's actions on the plaintiff's own practice but also by a general evaluation of the impact those actions could have upon other potential participants in the market.

[b]—The Clayton Act

Section 7 of the Clayton Act prohibits the acquisition by one entity of the stock, share capital or assets of another entity which leads to a monopoly or tends to lessen competition.[20] In the health care area, this statute impacts mostly on hospital mergers. It has been sug-

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Tenth Circuit: Reazin v. Blue Cross and Blue Shield of Kansas, 899 F.2d 951 (10th Cir.). *cert. denied* 497 U.S. 1005 (1990).

Eleventh Circuit: Key Enterprises of Delaware, Inc. v. Venice Hospital, 919 F.2d 1550 (11th Cir. 1990).

[17] See, e.g.: *Third Circuit:* Miller v. Indiana Hospital, 814 F.Supp. 1254 (W.D. Pa. 1992).

Second Circuit: Balaklaw v. Lovell, 822 F. Supp. 892 (S.D.N.Y., 1993) *aff'd* 14 F.3d 793 (2d Cir. 1994).

Seventh Circuit: VCB Anesthesia Care Limited v. Passavant Memorial Hospital Association, 36 F.3d 664 (7th Cir. 1994) (holding that termination of a contract with certified registered nurse anesthetist failed to state a Sherman Act claim).

State Courts:

Florida: Boczar v. Manatee Hospital & Health Systems Inc., 731 F. Supp. 1042 (M.D. Fla. 1990).

Georgia: Robles v. Humana Hospital Cartersville, 785 F. Supp. 989 (N.E. Ga. 1992).

[18] McLaon v. Real Estate Board of New Orleans, Inc. 444 U.S. 232, 100 S.Ct. 502, 62 L.Ed.2d 441 (1980).

[19] Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 111 S.Ct. 1842, 114 L.Ed.2d 366 (1991). See Note, "Summit Health, Ltd. vs. Pinhas: The Supreme Court's Eye-Opening Decision to Allow Sherman Act Jurisdiction in a Hospital Exclusion Case," 23 U. Toledo L. Rev. 793 (1992).

[20] 15 U.S.C. § 18.

gested that the legal standards of proof imposed by Section 7 of the Clayton Act may be less demanding than those under the Sherman Act.[21] This argument is based upon an evaluation of whether an act, such as a merger, "may" substantially lessen competition upon formation. Section 1 of the Sherman Act, on the other hand, allows for a contemporaneous analysis of the actual anticompetitive effects.[22]

[3]—Antitrust Immunity

[a]—State Action

An exemption from federal antitrust laws exists for actions taken or authorized by a state.[23] The "state action" exemption applies to private parties if the anti-competitive conduct is permissible under a clearly articulated and affirmatively expressed state policy.[24] Additionally, the challenged restraint must be something which is actively supervised by the state itself.[25]

The state action immunity granted to states and those private parties acting under state authority does not necessarily extend to municipalities. Public hospitals and authorities of a municipality will be accorded this immunity when the subject acts can be construed as the authorized implementation of state policy.[26] The courts will look

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"No person engage in commerce . . . shall acquire . . . the whole or part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce, where . . . the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."

[21] *Compare:* United States v. First National Bank & Trust Co., 376 U.S. 655, 84 S.Ct. 1033, 12 L.Ed.2d 1 (1964), *and* United States v. Third National Bank, 390 U.S. 171, 885 S.Ct. 882, 19 L.Ed.2d 1015 (1968), *with* Minnesota Mining and Manufacturing Co. v. New Jersey Wood Finishing Co., 381 U.S. 311, 85 S.Ct. 1473, 14 L.Ed.2d 405 (1965), *and* White Consolidated Industries v. Whirlpool Corp., 781 F.2d 1224 (6th Cir. 1986).

[22] Murphy, "Application of Federal Antitrust Laws to Hospital Mergers: Understanding the Evolving Rules," 23 J. Hlth. & Hosp. L. 101 (1990). See § 1.04[4][a] *infra* for further discussion. The Federal Trade Commission Act, 15 U.S.C. § 45, also may be applicable to hospital actions. See also, Miles, "Physician Practice Mergers, Integrated Delivery and the Antitrust Laws," vol. 6, no. 3 (Summer 1994).

[23] Parker v. Brown, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed 315 (1943).

[24] Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 105 S.Ct. 1721, 85 L.Ed.2d 36 (1985); California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 100 S.Ct. 937, 63 L.Ed.2d 233 (1980).

[25] Patrick v. Burget, 486 U.S. 94, 108 S.Ct. 1658, 100 L.Ed.2d 83 (1988).

[26] *Supreme Court:* City of Columbia v. Omni Outdoor Advertising Inc., 499 U.S. 365, 111 S.Ct. 1344, 113 L.Ed.2d 282 (1991).

Eighth Circuit: Bloom v. Hennepin County, 783 F. Supp. 418 (D.C. Minn. 1992).

Eleventh Circuit: FTC v. Hospital Board Directors of Lee County, 38 F.34 1184 (11th Cir. 1994). Askew v. DCH Regional Health Care Authority, 995 F.2d 1033

closely at the underlying facts of each case to determine if each precondition for state action immunity is present.[27]

[b]—Local Government Antitrust Act of 1984

Under the Local Government Antitrust Act of 1984,[28] local governments, any official or employee acting in an official capacity of a local government, or other persons engaged in an official action directed by a local government, official or employee thereof acting in an official capacity, are immune from antitrust suits. The scope of local governments granted immunity includes special function governmental units established by state law. These units include school districts, sanitary districts and hospital districts as well.

In particular, non-profit corporations which a state has created to establish and administer hospitals for counties and municipalities are immune from antitrust lawsuits and prosecutions.[29] Hospital employees are immune if their actions were taken within their official capacity. Actions taken in an official capacity "include those lawful actions undertaken in the course of defendant's performance of his duties,

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(11th Cir. 1993); Crosby v. Hospital Authority of Valdosta, 873 F.Supp. 1568 (M.D.Ga. 1995).

[27] See e.g.:

Supreme Court: City of Columbia v. Omni Outdoor Advertising Inc., 499 U.S. 365, 111 S.Ct. 1344, 113 L.Ed.2d 282 (1991) (applying immunity to municipality).

Third Circuit: Miller v. Indiana Hospital, 930 F.2d 334 (3d Cir. 1991) (withholding immunity for failure to comply with the requirement that state regulation scheme expressly permit anti-competitive conduct); Posner v. Lankenau Hospital, 645 F. Supp. 1102 (E.D. Pa. 1986) (withholding immunity for failure to comply with requirement that state regulatory scheme expressly permit anticompetitive conduct); Quinn v. Kent General Hospital, Inc., 617 F. Supp. 1226 (D. Del. 1985) (declining to apply state action immunity).

Fourth Circuit: R. E. Cohn, D.C., D.A.B.C.O. v. Bond, 953 F.2d 154 (4th Cir. 1991) (state action immunity applied when chiropractor denied staff privileges at municipal hospital).

Seventh Circuit: Marrese v. Interqual, Inc. 748 F.2d 373 (7th Cir. 1984). *cert. denied* 472 U.S. 1027 (1985) (applying state action immunity).

Ninth Circuit: Lancaster Hospital v. Antelope Valley Hospital District, 923 F.2d 1378 (9th Cir. 1991) (declining to apply immunity because the state never articulated a policy to displace competition with regulation).

Eleventh Circuit: FTC v. Phoebe Putney Health System, 663 F.3d 1369 (11th Cir.) *cert. granted* 133 S.Ct. 28; Todorov v. DCH Health Care Authority, 921 F.2d 1438 (11th Cir. 1991) (immunity applied). Bolt v. Halifax Hospital Medical Center, 891 F.2d 810 (11th Cir.), *cert. denied* 495 U.S. 924 (1990) (immunity not applied to a municipality because it was not acting pursuant to the state's expressed policy of acting consistently with the public good).

[28] 15 U.S.C. §§ 34-36.

[29] *Ninth Circuit:* Palm Springs Medical Clinic, Inc. v. Desert Hospital, 628 F. Supp. 454 (C.D. Cal. 1986).

Eleventh Circuit: Crosby v. Hospital Authority of Valdosta, 873 F. Supp. 1568 (M.D. Ga. 1995).

that reasonably can be construed to be within the scope of his duties and consistent with the general responsibilities and objectives of his position."[30] For immunity to attach, there is no requirement of an affirmative grant of explicit authority.[31] Nevertheless, private attending physicians who have admission privileges at a hospital but are not hospital employees or agents are not immune from antitrust liability under the Act.[32]

[c]—The Noerr-Pennington Doctrine

The Supreme Court established an additional immunity from lawsuits and prosecutions for antitrust violations known as the *Noerr-Pennington* doctrine which recognizes that the federal antitrust laws do not regulate the conduct of private individuals in seeking anti-competitive action from the government.[33] The immunity arises for private entities which can establish that they were acting within the First Amendment right to petition the government for a redress of grievances.

Noerr-Pennington immunity does not apply when the petitioning of the government officials is a sham. This "sham exception" allows for the imposition of antitrust liability if it is found that the defendant used the governmental process, as opposed to the outcome of the process, as an anti-competitive weapon. For example, if the defendant sought to use the governmental process to increase expense and delay rather than to procure a redress of grievances, immunity will not be granted.[34]

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[30] Sandcrest Outpatient Services, P.A. v. Cumberland County Hospital System, Inc., 853 F.2d 1139, 1143 (4th Cir. 1988).

[31] Griffith v. Health Care Authority of City of Huntsville, 705 F. Supp. 1489 (N.D. Ala. 1989). See also, Wicker v. Union County General Hospital, 673 F. Supp. 177 (N.D. Miss. 1987). See generally: Fox, "Practical Considerations in Minimizing Antitrust Liability and Defending Peer Review Litigation," in *Hospital Law,* at E-1 (Defense Research Institute 1991); *Antitrust Issues in Health Care,* A.B.A. Section of Antitrust Law, and Forum on Health Law (1988); Miles and Phelp, "Hospitals Caught in the Antitrust Net: An Overview," 24 Duquesne L. Rev. 489 (1985); Comment, "Antitrust and Health Care Law," 8 Whit. L. Rev. 490 (1986).

See also, FTC v. Hospital Board Directors of Lee County, 38 F.3d 1184 (11th Cir. 1994).

[32] Sweeney v. Athens Regional Medical Center, 705 F. Supp. 1556 (M.D. Ga. 1989).

[33] United Mine Workers of America v. Pennington, 381 U.S. 657, 85 S.Ct 1585, 14 L.Ed.2d 626 (1965); Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127, 81 S.Ct. 523 5 L.Ed.2d 464 (1961).

[34] City of Columbia v. Omni Outdoor Advertising Inc., 499 U.S. 365, 111 S.Ct. 1344, 113 L.Ed.2d 1344 (1991); Allied Tube & Conduit Corp. v. Indian Head, Inc., 486 U.S. 492, 108 S.Ct. 1931, 100 L.Ed.2d 497 (1988); California Motor Transportation Co. v. Trucking Unlimited, 404 U.S. 508, 92 S.Ct. 609, 30 L.Ed.2d 642 (1972).

[d]—Health Care Quality Improvement Act of 1986

Congress has enacted legislation, the Health Care Quality Improvement Act of 1986 (HCQIA), which exempts members of professional review bodies from civil damages, including federal antitrust violations, for review actions taken on or after November 14, 1986.[35] This immunity provides protection only from damages sought in private actions and does not preclude the Department of Justice, the Federal Trade Commission, or any state Attorney General from bringing criminal prosecutions for antitrust violations. Additionally, physicians who are the subject of peer review actions are not precluded from petitioning the courts for an injunction or for declaratory relief.[36] Thus, the statute confers immunity from damages, not immunity from suit.[37]

In enacting this legislation, Congress found that the increasing occurrence of medical malpractice and the need to improve the quality of medical care had become nationwide problems by warranted greater efforts than those than can be undertaken by individual states.[38] HCQIA was enacted to provide incentive and protection to physicians engaging in effective professional peer review, a process

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[35] 42 U.S.C. § 11111. See, e.g.:

Ninth Circuit: Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992).

Eleventh Circuit: Crosby v. Hospital Authority of Valdosta, 873 F. Supp. 1568 (M.D. Ga. 1995).

State Courts:

Connecticut: Harris v. Bradley Memorial Hospital & Health Center, 50 A.3d 841 (Conn. 2012).

Georgia: Davenport v. Northeast Georgia Medical Center, 542 S.E. 2d 525 (Ga. App. 2000).

New York: Heimlich v. St. Luke's Roosevelt Hospital Center, NYLJ, p. 27, col. 2 (Oct. 19, 1992), *aff'd* 202 A.D.2d 361, 610 N.Y.S.2d 3 (1994), *leave to appeal denied* 84 N.Y.2d 1017, 647 N.E.2d 117, 622 N.Y.S.2d 911 (1995).

Ohio: Fox v. Parma Community General Hospital, 827 N.E.2d 787 (Ohio App. 2005).

See also: § 15.02[3] *infra*; Koepke, "Physician Peer Review Immunity: Time to Euthanize a Fatally Flawed Policy," 22 J. L. & Health 1 (2009); Kinney, "Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?" 13 Mich. St. U. J. Med. & L 57 (2009).

[36] 42 U.S.C. § 11111(a)(1).

Third Circuit: Mathews v. Lancaster General Hospital, 883 F.Supp 1016 (1995), *aff'd* 87 F.3d 624 (3d Cir. 1995).

Ninth Circuit: Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992).

[37] *Supreme Court:* Summit Health, Ltd. v. Pinhas, 500 U.S. 322 (1991) (alleged boycott of a single physician may be sufficient to support federal jurisdiction).

Tenth Circuit: Decker v. IHC Hospitals, Inc., 982 F.2d 433 (10th Cir. 1992) (peer review case seeking injunction could not be dismissed even with a showing of due process and fairness).

[38] 42 U.S.C. § 11101.

described as an "overriding need" in view of the movement of incompetent physicians from state to state.[39] HCQIA immunity attaches if there are certain minimal procedural safeguards employed and reports of any review actions are filed with the state's Board of Medical Examiners and the Secretary of Health and Human Services.[40] These standards include a reasonable belief that a professional review would further quality health care; a reasonable effort to obtain the facts; adequate notice and hearing procedures as delineated in the statute; and a reasonable belief that the action taken was warranted.[41] The legislation establishes a presumption that a professional review action has met the standards necessary for civil immunity unless the presumption is rebutted by a preponderance of the evidence.[42] For example, a physician's claim that a peer review was motivated by a conspiracy[43] or the bad faith of a competitor[44] may be insufficient to rebut a reasonable belief based on the collected facts that a review would further quality health care. The presumption of immunity applies to summary suspensions of privileges undertaken to protect patients.[44.1]

However, if the physician can demonstrate that some review committee members knowingly provided false information, this may preclude application of HCQUIA immunity, at least at the summary judgment stage of the proceedings.[44.2] HCQUIA does not affect any other immunity from antitrust lawsuits that may also be applicable. Additionally, the legislation does not affect or modify any provision of federal or state law with respect to activities of professional review bodies regarding health care professionals who are not physicians.[45] Each separate peer review action of a hospital, e.g., meeting of the Medical Executive Committee, administrative hearings, etc., must independently meet the HCQIA requirements.[46]

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[39] *Id.*

[40] 42 U.S.C. § 11101.

[41] 42 U.S.C. § 1112(a).

[42] 42 U.S.C. § 11112. See also, Smith v. Ricks, 31 F.3d 1478 (9th Cir. 1994).

State Courts:

Washington: Cowell v. Good Samaritan Community Health Care, 225 P.3d 294 (Wash. App. 2009).

[43] Smith v. Ricks, 31 F.3d 1478, *cert. denied* 115 S.Ct. 1400 (1994).

[44] Mathews v. Lancaster General Hospital, 883 F. Supp. 1016 (E.D. Pa. 1995), *aff'd* 87 F.3d 624 (3d Cir. 1995).

[44.1] Harris v. Bradley Memorial Hospital, 50 A.3d 841 (Conn. 2012).

[44.2] Colantonio v. Mercy Medical Center, 73 A.D.3d 966, 901 N.Y.S.2d 370 (N.Y. App. Div. 2010); 42 U.S.C. § 11111(a)(1).

[45] 42 U.S.C. § 11115(c).

[46] See, e.g.:

Fourth Circuit: Hein-Muniz v. Aiken Regional Medical Centers, 2012 U.S. Dist. LEXIS 153164 (4th Cir. 2012).

California: Dustin v. McNamara, 731 F. Supp. 934 (C.D. Cal. 1990).

Colorado: Peper v. St. Mary's Hospital & Medical Center, 207 P.3d 881 (Col. App. 2008).

An award of attorney's fees and costs may be permitted in the defense of a suit stemming from a peer review under some circumstances. The defending party must "substantially" prevail and the claim or conduct of the plaintiff must be "frivolous, unreasonable, without foundation, or in bad faith."[47]

The Act also requires that any entity which settles a claim or satisfies a judgment in a medical malpractice action must report it to the government or face sanctions.[48] The report includes the name of the physician or practitioner for whom the payment is made; the amount; the name of the hospital with which the individual is affiliated; a description of the acts and injuries which form the basis of the claim; and any further information required by the government to interpret the report.[49] However, the report of a settlement is not a presumption that malpractice has in fact occurred.[50]

The Act mandates that a health care entity report professional review actions which

> (1) adversely affect the clinical privileges of a physician for more than 30 days; or
>
> (2) accept the physician's surrender of clinical privileges either during an investigation or in exchange for not conducting an investigation.[51]

Reporting information must be provided to the state licensing board, as well as the federal government, and it must be done at least monthly.[52]

Hospitals are required by the Act to obtain information from the government's data bank when a physician or other licensed health care practitioner applies to be on the medical staff, whether as a cour-

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Kansas: Hancock v. Blue Cross & Blue Shield of Kansas City, Inc., No. 92-2408-GTV (D. Kan. Feb. 10, 1993).

Maryland: Imperial v. Suburban Hospital Association Inc., 862 F. Supp. 1390 (D. Md. 1993).

Ohio: Reyes v. Wilson Memorial Hospital, 102 F. Supp.2d 798 (D. Ohio 1998).

Pennsylvania: Troescher v. Grody, 466 EDA 2004 (Pa. Super 2005) (Personal and credential files not discoverable under HCQIA as well as state PRPA).

Texas: Monroe v. AMI Hospitals of Texas, Inc., 877 F. Supp. 1022 (S.D. Tex. 1994).

The particular requirements of HCQIA are discussed in more detail at § 1.04[4][b] *infra*.

[47] 42 U.S.C. § 11113.

[48] 42 U.S.C. § 11131(a) and (c).

[49] 42 U.S.C. § 11131(b).

[50] 42 U.S.C. § 11137(d).

[51] 42 U.S.C. § 11133(a)(1)(A) and (B).

[52] 42 U.S.C. § 11134(c).

tesy or otherwise, or applies for clinical privileges.[53] In addition, a hospital must obtain updated information from the data bank on current members of the medical staff or individuals with clinical privileges at least once every two years.[54] Knowledge of the contents of the data bank will be imputed to the hospital in the event such information is not requested.[55]

Information that is confidential is to be disclosed in accordance with the Act and federal regulations.[56] A physician or practitioner who disputes information contained by the data bank has 60 days from the time a copy is mailed to him within which to submit a rebuttal.[57] The HCQIA does not establish a privilege against discovery of peer review materials—only immunity for those providing information to peer review bodies.[57.1]

(Text continued on page 1-35)

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[53] 42 U.S.C. § 11135(a)(1).

[54] 42 U.S.C. § 11135(a)(2).

[55] 42 U.S.C. § 11135(b).

[56] 42 U.S.C. 11137(b).

[57] 45 CFR 60.14. See generally, Sullivan and Anderson, "The Health Care Debate: If Lack of Tort Reform is Part of the Problem, Federalized Protection for Peer Review Needs to be Part of the Solution," 15 Roger Williams U.L. Rev. 41 (2010).

[57.1] *Second Circuit:* Johnson v. Nyack Hospital, 169 F.R.D. 550 (S.D.N.Y. 1996).

State Courts:

Florida: West Florida Regional Medical Center v. See, 79 So.3d 1 (Fla. 2012).

[4]—Specific Applications of Antitrust Law in Health Care

[a]—Hospital Mergers

A variety of factors, not the least of which is increased competitiveness among the parties, has led hospitals and others in the health care industry to develop new strategies designed to enhance efficiencies. Many hospitals, both charitable and for-profit institutions, have responded by merging with other hospitals or joining multi-hospital networks.[58] These actions have come underincreased scrutiny from federal agencies responsible for enforcing the antitrust laws. It has been noted by an Assistant Attorney General that "on a practical level, the basic question we try to answer in examining a hospital merger is whether purchasers are likely to be hurt by it; that is whether after the merger there is an increased likelihood that the merged entity and its remaining rivals will increase prices or restrict output to price-sensitive third-party payers, such as PPOs or HMOs . . . . If a hospital merger would substantially increase concentration in a market where entry is difficult, and neither merging hospital is in danger of financial failure, and true efficiencies are insignificant, we are likely to challenge the merger under either the Clayton or Sherman Acts."[59]

It is clear that Section 7 of the Clayton Act applies to mergers of for-profit hospitals.[60] However, Section 7 may not apply to charitable hospitals. These institutions have argued that because they lack stock or other share capital their mergers are not covered by Section 7. The government has argued that Section 7 applies to any merger regardless of the nature of the parties.

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[58] See: Jacobs, "Presumptions, Damn Presumptions & Economic Theory: The Role of Empirical Evidence in Hospital Merger Analysis," Jacobs, 31 Ind. L. Rev. 125 (1998); Greaney, "Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law," 23 Am.J.L. & Med. 191-220 (1997); Yao, "Analysis of Hospital Mergers and Joint Ventures: What May Change?" 1995 Utah L. Rev. 381-402 (1995).

[59] Block, "Antitrust Enforcement and Health Care: Current Developments and Future Trends," N. 1 *supra,* at 13. See e.g., State v. Sutter Health System, et al. 84 F. Supp. 2d 1057 (Calif. N.D. 2000).

[60] See e.g.:

Fifth Circuit: United States v. Hospital Affiliates International, 1980-81 CCH Trade Cas. ¶ 63,721 (E.D. La. 1980), *consent decree entered* 1982 CCH Trade Cas. ¶ 64,696 (E.D. La. 1982).

Seventh Circuit: In re Hospital Corp. of America, 807 F.2d 1381 (7th Cir. 1986), *cert. denied* 481 U.S. 1038 (1987) (upholding the blocking by the FTC of a merger between two for-profit entities).

This issue has received conflicting resolutions with one court holding that Section 7 is not applicable to not-for-profit hospitals,[61] and another finding that the reference in Section 7 to asset acquisitions is sufficient to cover mergers between not-for-profit hospitals,[62] a decision that also held that the FTC has jurisdiction to enforce Section 7 for all character of commerce not governed by other enumerated agencies. Regardless of whether Section 7 applies to mergers of not-for-profit hospitals, it is clear that Section 1 of the Sherman Act does apply.[63]

Under Section 7, it is presumed that if a hospital merger is illegal it will result in undue market share in a sufficiently concentrated market. In order to rebut this presumption, defendants may introduce evidence of the pro-competitive effects of the merger and that the market power of the merged entity has been overstated.[64]

Key factors in determining whether a hospital merger is lawful, whether under Section 1 of the Sherman Act or Section 7 of the Clayton Act, are the definitions of the relevant service and geographic markets. One court limited the relevant service market to in-patient hospital services on the ground that consumers were unlikely to substitute the services of out-patient providers if the merged entity significantly increased its prices of impatient services.[65] The court also defined the relevant geographic market as the municipality the hospital served and the immediate vicinity. It determined that because of convenience, as well as quality and range of services provided, local residents were unlikely to turn to other hospitals in this geographic market if the merged entity attempted to exercise its market power.

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[61] United States v. Carilion Health Service, 707 F. Supp. 840 (N.D. Va. 1989), *aff'd* 892 F.2d 1042 (4th Cir. 1989).

[62] United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd* 898 F.2d 1278 (7th Cir. 1990), *cert. denied* 498 U.S. 920 (1990).

[63] See Ns. 45 and 46 *supra.*

[64] Murphy, "Application of Federal Antitrust Laws to Hospital Mergers: Understanding the Evolving Rules," 23 J. Hlth. & Hosp. L. 101 (1990). See also: Callahan, "Preparing for a Hospital Merger Challenge: A Practical Approach," 23 J. Hlth. & Hosp. L. 115 (1990); Note, "Antitrust and Hospital Mergers: A Law and Economics Rationale for Exemption," 30 Duquesne L. Rev. 61 (1991); Note, "Clayton Act Scrutiny of Non-profit Hospital Mergers: The Wrong RX for Ailing Institutions," 66 Wash. L. Rev. 1041 (1991). See also Winston et al. v. American Medical International, Inc., et al. 930 S.W.2d 945 (Tx. Ct. App. 1996).

[65] United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd* 898 F.2d 1278 (7th Cir. 1990), *cert. denied* 498 U.S. 920 (1990).

See also United States of America, v. Long Island Jewish Medical Center and North Shore Health System, Inc., 983 F. Supp. 121 (E.D.N.Y. 1997); Westchester Advocates for Disabled Adults, et al. v. George E. Pataki, et al., 931 F. Supp. 993 (E.D.N.Y. 1996).

In contrast, another court defined the relevant service market as both in-patient and outpatient services because many patients may be treated either as in-patients or as outpatients.[66] The geographic market in this instance was determined to be a county area stretching seventy to eighty miles beyond the immediate area of the defendant hospital.

The Eighth Circuit rejected data regarding the zip codes of patients within a 27 mile radius, offered by the FTC as evidence of geographic market. The court found the data to be insufficient evidence of the availability of alternative facilities offering acute care inpatient services.[67]

Even when market power has been found, non-profit hospitals have argued that they had no incentives to exercise their market power. In accepting this argument, one court noted that the presence of business leaders on the hospital's board of directors would insure that savings from the merger would be applied to reduce prices, which are often paid for by employers either directly or indirectly.[68] However, in another case, the argument was rejected on the theory that hospital administrators or directors may be motivated to act in an anti-competitive manner to advance the institution even absent any profit gain.[69]

Another unresolved questions is whether the state action doctrine immunizes hospitals from antitrust actions when those hospitals engage in merger activity in states which require a certificate of need before a merger is concluded. One court has held that the acquisition of a hospital for which a certificate of need has been obtained is not exempt from antitrust scrutiny under the state action doctrine.[70] The court found that there was no ongoing state supervision and stated that "after a proposed acquisition passes certificate of need review, the state makes no attempt to monitor the use of the acquisition. . . ."[71]

No court has thus far applied the state action doctrine to these types of activities. However, it is conceivable that this defense will succeed when there in fact is active supervision for the merger or perhaps when

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[66] United States v. Carilion Health Service, 707 F. Supp. 840, 848-849 (N.D. Va. 1989), *aff'd* 892 F.2d 1042 (4th Cir. 1989).

[67] Federal Trade Commission v. Freeman Hospital, 69 F.3d 260 (1995). See also In the matter of Adventist Health System/West and Ukiah Adventist Hospital, 117 F.T.C. 224; 1994 FTC LEXIS 54 (1994).

[68] *Id.,* 707 F. Supp. at 849. See also, Reiffer, "Antitrust Implication in Nonprofit Hospital Mergers," 27 J. Legis. 187-214 (2001).

[69] United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd* 898 F.2d 1278 (7th Cir. 1990), *cert. denied* 498 U.S. 920 (1990).

[70] North Carolina v. P.I.A. Ashville, Inc., 740 F.2d 274 (4th Cir.), *cert. denied* 471 U.S. 1003 (1984).

[71] *Id.,* 740 F.2d at 278.

the state's overall regulation of the field is so pervasive that it would effectively prevent the hospital from increasing consumer prices in violation of the antitrust laws.

[b]—Medical Staff

Another fertile area for the growth of antitrust law has been decisions by hospitals and physicians impacting upon the membership of the hospital medical staff.[72]

In order to succeed under a claimed violation of Section 1 of the Sherman Act, a plaintiff must demonstrate that there is a plurality of actors because it takes at least two to contract, combine or conspire.[73] There is no violation if the defendants are in fact a unitary economic entity. Some courts have held that a hospital and its medical staff are one economic entity or have identical economic interests and, therefore, Section 1 does not apply.[74] Other jurisdictions have determined that they are separate entities which are subject to Section 1.[75] The FTC considers medical staffs as separate economic entities from hospitals.[76]

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[72] See generally: "Antitrust Safety Zones for Physicians Network Joint Ventures: Physician, Heal Thyself," Fisher, 48 Okla. L. Rev. 89-101 (1995); Blumstein and Sloan, "Antitrust and Hospital Peer Review," 51 Law & Contemp. Probs. 7 (1988); Enders, "Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges," 17 Loyola Univ. L.J. 331 (1986); Havighurst, "Professional Peer Review and the Antitrust Laws," 36 Case W. Res. L. Rev. 1117 (1985/1986); Comment, "Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?," 19 Ind. L. Rev. 1219 (1986).

[73] Cooperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 104 S.Ct. 2731, 81 L.Ed.2d 638 (1984).

[74] *Second Circuit:* Balaklawv, Lovell, 822 F. Supp. 892 (S.D.N.Y. 1993), *aff'd* 14 F.3d 795 (2d Cir. 1994).

Third Circuit: Nanavati v. Burdette Tomlin Memorial Hospital, 857 F.2d 96 (3d Cir. 1988), *cert. denied* 470 U.S. 1060 (1989).

Fifth Circuit: Seidenstein v. National Medical Enterprises, Inc. 769 F.2d 1100 (5th Cir. 1985).

Sixth Circuit: Nurse Midwifery Associates v. Hibbett, 918 F.2d 605 (6th Cir. 1990), *modified on rehearing* 927 F.2d 904 (6th Cir. 1991).

Seventh Circuit: Tambone v. Memorial Hospital, 825 F.2d 1132 (7th Cir. 1987).

[75] *Fourth Circuit:* Oksanew v. Page Memorial Hospital, 912 F.2d 73 (4th Cir. 1990).

Ninth Circuit: Oltz v. St. Peter's Community Hospital, 861 F.2d 1440 (9th Cir. 1988).

Eleventh Circuit: Todorov v. DCH Health Care, 921 F.2d 1438 (11th Cir. 1991); Bolt v. Halifax Hospital, 891 F.2d 810 (11th Cir.), *cert. denied* 495 U.S. 924 (1990).

[76] See, e.g.:

Tenth Circuit: Anthony Diaz, et al. v. Michael Farley, et al., 215 F.3d 117 (10th Cir. 2000).

Administrative Agencies:

The medical staff alone is generally considered to consist of individuals who can conspire with one another for purposes of Section 1.[77]

Hospitals are given board discretion in making medical staff decisions.[78] In defending a Section 1 claim, hospitals are entitled to show the pro-competitive effects of their decisions in providing more efficient or better quality care.[79] In fact some courts have found that medical

(Text continued on page 1-39)

Federal Trade Commission: In re Medical Staff of Memorial Medical Center, 110 F.T.C. 541 (1988); In re Sherman A. Hope, 98 F.T.C. 58 (1981).

[77] See, e.g., Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), *cert. denied* 470 U.S. 1060 (1985).

[78] See § 1.03[5][c] *supra*.

[79] *Supreme Court:* Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. 2, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984).

Third Circuit: Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), *cert. denied* 470 U.S. 1060 (1985); Brown v. Our Lady of Lourdes Medical Center, 767 F. Supp. 618 (D.C.N.J. 199).

staff decisions do not warrant the application of antitrust laws and to do would present "an almost classic example of the use of the antitrust laws to obtain relief of doubtful social or economic value. . . ."[80]

Antitrust violations have been commonly alleged to circumvent hospital contracts with groups of physicians to provide exclusive care in a particular area of the hospital[81] and have also been used by members of traditionally excluded schools of practice.[82] However, the Supreme Court has held that a hospital may enter into an exclusive contract for the provision of ancillary service without committing a *per se* violation of the federal antitrust laws.[83] Although the Supreme

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Ninth Circuit: Bahn v. NME Hospitals, Inc., 929 F.2d 1404 (8th Cir. 1991).

Tenth Circuit: Tarabishi v. McAlester Regional Hospital, 951 F.2d 1558 (10th Cir. 1991) (holding that *per se* analysis did not apply to denial of staff privileges).

But see, Nicholas v. North Colorado Medical Center, Inc., 902 P.2d 462 (Colo. App. 1995).

[80] *Fifth Circuit:* Robles v. Humana Hospital Cartersville, 785 F. Supp. 989 (N.D. Ga. 1992).

State Courts:

Colorado: North Colorado Medical Center v. Committee on Anticompetitive Conduct, No. 95SC256 (Colo. Apr. 1, 1996) (state medical board anticompetitive committee properly declined to use federal antitrust principles in applying a state professional review law).

New York: Jaffee v. Horton Memorial Hospital, 680 F. Supp. 125, 127 (S.D.N.Y. 1988).

See also, Harrow v. United Hospital Center, Inc., 522 F.2d 1133 (4th Cir. 1975), *cert. denied* 424 U.S. 916 (1976). *Cf.,* Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 111 S.Ct. 1842, 114 L.Ed.2d 366 (1991).

But see, Boczar v. Manatee Hospitals and Health Systems Inc., 993 F.2d 1514 (11th Cir. 1993).

[81] *Second Circuit:* Furlong v. Long Island College Hospital, 710 F.2d 922 (2d Cir. 1983).

Fifth Circuit: Malini v. Singleton Associations, Inc., 516 F. Supp. 440 (S.D. Tex. 1981).

Tenth Circuit: Coffey v. Healthtrust Inc., 955 F.2d 1388 (10th Cir. 1992).

[82] *Third Circuit:* Weiss v. York Hospital, 548 F. Supp. 1048 (M.D. Pa. 1982), *aff'd* in part, rev'd in part 1984-2 CCH Trade Cas. ¶ 66.211 (3d Cir. 1984), *cert. denied* 470 U.S. 1060 (1985).

Eleventh Circuit: Feldman v. Jacksonville Memorial Hospital, 509 F. Supp. 815 (S.D. Fla. 1981), *aff'd* 752 F.2d 647 (11th Cir.), *cert. denied* 472 U.S. 1029 (1985).

See also: Shores, "Exclusive Medical Service Contracts: An Antitrust Minefield?," Med. Trial Technique Quarterly 321 (Winter 1986); Comment, "Anti-trust Implications of Denial of Hospital Staff Privileges: Testing the Conventional Wisdom," 70 Calif. L. Rev. 595 (1982); Comment, "Denial of Open Staff Hospital Privileges: An Antitrust Scrutiny," 26 St. Louis U.L.J. 1074 (1982).

[83] *Supreme Court:* Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. 2, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984).

Tenth Circuit: Coffey v. Healthtrust Inc., 955 F.2d 1388 (10th Cir. 1992).

See generally: Allen, Polsky & Reed, "Medical Staff Privileges a Radiology Contracts: Do Practice Rights Survive Hospital Contracting Decisions?," 2 Hlth. Lwr. 5

court's decision "is generally regarded as having approved such exclusive contracts, it should be noted that the Court relied heavily upon its analysis of the particular services involved, as well as the market conditions in the relevant area. These must, therefore, be assessed in each case, along with attention to the extent and necessity of the restraints which accompany the exclusive arrangement."[84]

The Court held in this case that no illegal "typing arrangement can exist unless there is sufficient demand for the purchase of anesthesiological services separate from hospital services making it possible to identify a distinct product market in which it is efficient to offer anesthesiological services separately from hospital services.[85] The Court concluded that two product markets existed for anesthesia and other hospital services. This may not be the case for other hospital-based physician groups.[86]

State action immunity is particularly applicable to medical staff decisions because many states have enacted regulations pertaining to peer review. The Supreme Court has upheld the state action exemption as applied to peer review committees, but only when the regulatory scheme provides for active state supervision of the peer review process.[87] The Court ruled that hospital peer review committees are not absolutely immune from antitrust liability, and held that the state must review these private decisions to determine if they comport with state policy. The Court held that to the extent Congress declined to

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(1985); Note, "*Jefferson Parish Hosp. Dist. No. 2 v. Hyde:* An Omen for Future Physician Antitrust Challenges," 20 New Eng. L. Rev. 175 (1984-1985).

[84] Manager and Webb, "Current Antitrust Issues," N.J. Law. 49, 51 (Feb. 1987).

[85] *Supreme Court:* Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. 2, 21-22, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984).

Tenth Circuit: Coffey & Healthtrust Inc., 955 F.2d 1388 (10th Cir, 1992).

[86] *Id.,* 466 U.S. at 23, n.36. See also:

Second Circuit: Konik v. Champlain Valley Physicians Hospital Medical Center, 733 F.2d 1007 (2d Cir. 1984); Rockland Physicians Ass'n v. Grodin, 616 F. Supp. 945 (S.D.N.Y. 1985).

Fifth Circuit: Seidenstin v. National Medical Enterprises, Inc., 796 F.2d 1100 (5th Cir. 1985); Jackson v. Radcliffe, 795 F. Supp. 197 (S.D. Tex. 1992).

Sixth Circuit: Stone v. William Beaumont Hospital, 782 F.2d 609 (6th Cir. 1986).

Seventh Circuit: Ez Peleta v. Sisters of Mercy Health Corp., 621 F. Supp. 1262 (N.D. Ind. 1985), *aff'd* 800 F.2d 119 (7th Cir. 1986).

Tenth Circuit: Coffey v. Healthtrust Inc., 955 F.2d 1388 (10th Cir. 1992) (Hospitals' exclusive contract with Radiology Group held not to violate antitrust act).

See generally, DeWolfe, "Separability of Products Since *Jefferson Parish v. Hyde,*" 20 Hosp. L. 33 (1987).

[87] Patrick v. Burget, 486 U.S. 94, 108 S.Ct. 1658, 100 L.Ed.2d 83 (1988). See generally: Comment, "Antitrust Law Immunity and Medical Peer Review Boards," 37 Buffalo L. Rev. 831 (1989); Note, "Antitrust Liability for Hospital Peer Review: *Patrick v. Burget,*" 141 J. Corp. L. 757 (1989); Note, "*Patrick v. Burget* and the Health Care Quality Improvement Act: The future Scope of Peer Review," 35 Wayne L. Rev. 1181 (1989).

exempt medical peer review from the reach of the antitrust laws,[88] peer review is immune only if the state has made the conduct its own. Although the Court recognized that its ruling might have a chilling effect on the efforts of the medical profession to weed out incompetent medical practitioners, it stated that such a concern was properly directed to the legislative branch.

Since this Supreme Court decision, the courts have looked closely to determine if the state regulatory scheme satisfied all the requirements of the state action doctrine, especially the precondition of active supervision. Immunity under the state action doctrine has been accorded in some cases[89] but denied in others.[90]

As previously discussed, the HCQIA also provides immunity for civil antitrust liability for peer review decisions if certain procedural and notice requirements are met.[91]

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[88] *Patrick v. Burget,* N. 70 *supra.*

> "Congress in fact insulated certain peer-review activities from antitrust liability in the Health Care Quality Improvement Act of 1986. . . . The act, which . . . is not retroactive, essentially immunizes peer-review action from liability if the action was taken 'in the reasonable belief [it] was in the furtherance of quality health care.' . . . The Act expressly provides that it does not change other 'immunities under law' . . . including the state action immunity, thus allowing states to immunized peer-review action that does not meet the federal standard. In enacting this measure, Congress clearly noted and responded to the concern that the possibility of antitrust liability will discourage peer-review. If the physicians believe that the Act provides insufficient immunity to protect the peer-review process fully, they must take that matter up with Congress."

[89] *Third Circuit:* Miller v. Indiana Hospital, No. 90-3331 (3d Cir. 1991).

Ninth Circuit: Lancaster Community Hospital v. Antelope Valley Hospital District, 940 F.2d 397, 1991 U.S. App. LEXIS 15260 (9th Cir. 1991).

Eleventh Circuit: Shahawy v. Hanson, 875 F.2d 1529 (11th Cir. 1989).

[90] Health Care Equalization Committee v. Iowa Medical Society, 851 F.2d 1020 (8th Cir. 1988).

[91] See the discussion in § 15.02[3]. Roediger, "Antitrust Implications of Peer Review Organizations." 39 Med Trial Tech Q 389, 1993.

§ 1.05 Nursing Staff

The JCAH standards provide that the medical care institution must establish a nursing department which takes all reasonable steps to provide optimal achievable quality nursing care and maintains the professional conduct and practices of its members.[1] The department is to be directed by a registered nurse administrator. It is suggested that this administrator have at least a baccalaureate degree in nursing, although this is not required.[2]

Similar to medical staff bylaws, the nursing department is required to set forth a "written organizational plan" delineating lines of authority, accountability and communication. The management functions of the nursing department include: reviewing and approving policies for employment qualifications of nurses; establishing standards of nursing care; appointing committees to conduct nursing department functions; and encouraging participation by members of the nursing staff.[3] It is recommended that the professional performance of these members be evaluated annually. Nurses obtained from outside agencies are also subject to this evaluation procedure unless a verifiable evaluation mechanism acceptable to the hospital is implemented by the outside agency.[4]

It is incumbent upon the hospital to ensure that a sufficient number of qualified registered nurses are on duty at all times to provide patients with an optimal level of nursing care. Specific nursing staffing for each unit must be commensurate with the patient care requirements, staff expertise, unit geography, availability of support services and method of patient care delivery.[5] This recommendation is often unfulfilled. Nevertheless, hospitals may be found liable for damages proximately caused by a shortage of nursing staff in the hospital.[6]

It is recommended that the nursing staff be appropriately integrated with the medical staff and other units and committees of the

(Text continued on page 1-41)

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[1] Joint Commission on Hospital Accreditation, *Accreditation Manual for Hospitals* 141 (1988). See also Dyers, "Are Nurses Supervisors? A Critical Look At The Circuit Split After NLRB v. Hillary Development Corp. [187 F.3d 133 (1st Cir. 1999)], 3 U. Pa. J. Lab. & Emp. L. 671 (2001).

[2] *Ibid.*

[3] *Id.* at 142.

[4] *Id.* at 144.

[5] *Id.* at 145.

[6] For a detailed discussion on hospital liability for nurse-employees, see Chapter 11 *infra.*

hospital.[7] The degree of integration of the nursing staff with other policy making and implementing committees should be in direct proportion to the overwhelming influence of the nursing staff on the quality of patient care provided in the hospital. For instance, the JCAH now requires that the institutional planning committee include a representative of the nursing staff even though this committee was traditionally limited to the governing board, administration and medical staff members.[8]

The "nursing plan" is a central element in the provision of individualized, goal directed nursing care which the JCAH requires.[9] The nursing aspect of each patient's care at a hospital must be documented from admission through discharge. This nursing process includes assessment, planning, intervention and evaluation. Each patient's nursing needs must be assessed by a registered nurse at the time of admission or within the period established by the nursing department policy.[10] The Joint Commission requires that this assessment be consistent with the medical plan of care and that the nursing goals which are designed to achieve be realistic and measurable.[11] The plan of care must reflect current standards of nursing practice and include nursing measures that will facilitate the medical care prescribed and that will restore, maintain or promote the patient's well-being.[12] When a patient is transferred within, or discharged from, the hospital, a nurse must note the patient's status in his or her medical records.[13]

The Sixth Circuit found that an issue of fact existed as to whether it was proper to pay male-dominated Physician Assistants more money than female-dominated Nurse Practitioners. It was asserted that both were performing essentially the same job, yet not earning equal pay. The Circuit court reversed the district court's grant of summary judgment for a V.A. Hospital and remanded the case for further proceedings.[14]

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[7] Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* 148 (1988).

[8] *Compare* Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 32 (1985), *with* Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 54 (1980).

[9] Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 146 (1988).

[10] *Id.*

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] Beck-Wilson v. Principi, 441 F.3d 353 (6th Cir. 2006).

In another case, a hospital agreed to pay the tuition for a nurse to become a nurse anesthetist, provided she continue working at the hospital for five years upon completion of the program. When the hospital failed to offer her a job as a nurse anesthetist, she left and took a job elsewhere. A Tennessee appellate court ordered the nurse to reimburse the hospital for her tuition.[15]

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[15] Sweetwater Hospital v. Carpenter, 2005 Tenn. App. LEXIS 63 (Tenn. Ct. App. 2005).

§ 1.06 Health Care Fraud

[1]—Self-Referrals

Federal and state statutes prohibit referrals by physicians to an entity providing health care services which has a financial relationship with the physician or with an immediate member of his family.

[a]—Federal Law

Federal law prohibits certain physician referrals involving Medicare or Medicaid patients.[1]

Generally, a "referral" is a request by a physician for an item, service, consultation, test or procedure to be performed by or under the supervision of another physician.[2] The statute provides a list of health services which constitute a referral: clinical laboratory services; physical therapy services; occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.[3]

Certain services considered "integral" to a consultation by certain specialists are excepted, specifically: a request by a pathologist for clinical diagnostic laboratory tests and examination services to be performed by him or under his supervision; a request by a radiologist for diagnostic radiology services to be performed by him or under his supervision; and a request by a radiation oncologist for radiation therapy to be performed by him or under his supervision.[4]

The statute prohibits a physician referral for a designated health service to an entity which has a financial relationship with either the referring physician or a member of his immediate family. Additionally, the entity itself cannot make a claim for such services.[5] Generally, the financial relationship in issue is an ownership or investment

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[1] 42 U.S.C. § 1395nn.

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 (2012).See: Learn, "Applying Medicare and Medicaid Anti-Kickback Laws to Disease Management Programs: Ramifications for the Pharmaceutical Industry and a Regulatory Proposal," 69 Temple L.Rev. 245 (Spring 1996); Blumstein, "The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy," 22 Am. J. L. and Med. 205 (1996); Bucy, "Crimes by Health Care Providers," 1996 U. Ill. L. Rev. 589 (1996).

[2] 42 U.S.C. § 1395nn(h)(5)(A).

[3] 42 U.S.C. § 1395nn(h)(6).

[4] 42 U.S.C. § 1395nn(h)(5)(C).

[5] 42 U.S.C. § 1395(a)(1).

interest or a compensation arrangement.[6] "An ownership or investment interest . . . may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service."[7]

There are certain exceptions for specific types of physician services, in-office ancillary services, prepaid plans and other relationships permitted by federal regulations.[8] The statute also makes provision for certain exceptions related only to ownership or investment, such as: publicly traded securities and mutual funds under certain conditions; hospitals in Puerto Rico; rural providers; and hospital ownership if the physician is authorized to perform services there and the interest is in the hospital itself and not merely a subdivision.[9]

There are also certain exceptions for compensation arrangements, under specified conditions, for rental of office space or equipment; bona fide employment relationships; personal service arrangements; unrelated remuneration; physician recruitment; isolated transactions, such as a one-time sale of property or a practice; certain group practice arrangements with a hospital; and payments by a physician to a laboratory in exchange for provision of clinical laboratory services or to an entity as compensation for items or services furnished at fair market value.[10]

An entity furnishing covered items or services may be required to furnish reports specifying those items or services and identifying the physicians who have a financial relationship with them or who have immediate family members who have a financial relationship with them.[11] Failure to satisfy the reporting requirement may result in the imposition of a fine of $10,000 per day for each day for which reporting is required.[12]

Federal law provides sanctions for violations of the statute pertaining to referrals, including denial of payment; refunding of payments made; a $15,000 penalty for presenting a bill for payments which an individual knows or should know may not be made; a $100,000 payment for "circumvention schemes" to assure referrals; and exclusion from further participation in the program.[13] It has been suggested that Integrated Delivery Networks such as joint ventures between physicians

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[6] 42 U.S.C. § 1395(a)(2).
[7] 42 U.S.C. § 1395nn(a)(2).
[8] 42 U.S.C. § 1395nn(f)(2).
[9] 42 U.S.C. § 1395nn(c) and (d).
[10] 42 U.S.C. § 1395nn(e).
[11] 42 U.S.C. § 1355nn(f).
[12] 42 U.S.C. § 1355nn(g)(5).
[13] 42 U.S.C. § 1395nn(g).

and hospitals may improve both cost effectiveness and quality assurance and thus should be given more flexibility under federal and state statutes.[13.1]

[b]—State Statutes

Various states have also enacted prohibitions against self-referrals.[14]

For example, in New York, the prohibitions apply to clinical laboratory services, pharmacy services and x-ray or imaging services,[15] with each of these services defined by statute.[16] The statute applies not only to a licensed or registered physician, but also to the following practitioners: dentist, podiatrist, chiropractor, nurse, midwife, physician's assistant or specialist assistant, physical therapist and optometrist.[17]

[2]—Kickbacks and False Claims

Civil and criminal penalties may be imposed for fraud, kickbacks and other prohibited activities involving Medicare, Medicaid and health care programs.[18]

[a]—Civil Monetary Penalties Law

The federal statute imposes a financial penalty not to exceed $2,000 for each item or service falsely claimed in billing,[19] or $15,000 per patient for false or misleading information regarding a hospital discharge.[20] "In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each item or service in lieu of damages sustained by the United States or a State agency because of such claim.[21] The person may also be excluded from further participation in the program.[22]

[13.1] Blumstein, "Hospital-Physician Joint Ventures: A Promising Partnership?" 4 Ind. Health L. Rev. 209 (2007).

[14] *California:* Cal.Bus. & Prof. Code § 650.01 *et seq*.

New York: Public Health Law § 238 *et seq*.

[15] N.Y. Pub. Health Law § 238-a(1).

[16] N.Y. Pub. Health Law § 238(1), (13) and (14).

[17] N.Y. Pub. Health Law § 238(11).

[18] 42 U.S.C.A. §§ 1320-7a and 1320a-7b, as amended by The Health Insurance Portability & Accountability Act of 1996, Public Law 104-191, §§ 204 and 231; 31 U.S.C. §§ 3729 *et seq*. See Landfair, "Transforming Physicians into Business Savvy Entrepreneurs: Patient Surcharges Charge onto the Scene of Physician Reimbursement," 43 Duquesne L. Rev. 257-71 (2005).

[19] 42 U.S.C.A. § 1320-7a(a)(2), as amended by The Health Insurance Portability & Accountability Act of 1996, Public Law 104-191, § 231.

[20] *Id*.

[21] 42 U.S.C.A. § 1320a-7a(a)(2).

Similarly, a hospital may be assessed a $2,000 penalty if it knowingly makes a payment to a physician as an inducement to limit services provided to a covered individual.[23]

(Text continued on page 1-45)

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[22] 42 U.S.C.A. § 1320a-7, as amended by The Health Insurance Portability & Accountability Act of 1996, Public Law 104-191, §§ 212, 213, 214, 215 (1996).

[23] 42 U.S.C.A. § 1320a-7a(b).

Federal law looks at three factors to determine the amount or scope of the penalty:

"(1) the nature of claims and the circumstances under which they were presented;
(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and
(3) such other matters as justice may require."[24]

The purpose behind the statute is to reimburse the government for monies paid on fraudulent submissions and the cost of investigations.[25] However, the assessments need not be limited to the actual damage sustained by the Government because the law permits double assessments or twice the amount of the false claim.[26] Thus, the law permits, for example, $2,000 per false claim, plus an assessment of double the amount falsely claimed.[27]

The government has six years commencing from the filing of the false claim in which to start an action.[28]

[b]—Criminal Penalties

Federal law imposes criminal penalties for certain acts involving federal health care programs,[29] including: false statements; illegal remunerations; false representations with respect to institutions, such as a hospital, rural primary care hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other eligible entity; illegal patient admittance and retention practices; and violation of assignment terms. The criminal penalties cited by the statute can be monetary fines or imprisonment or both.

The Anti-Kickback Act[30] prohibits the offer or acceptance of any payment for referral of a patient under Medicare, Medicaid or a health program.

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[24] 42 U.S.C.A. § 1320-7a(d).

[25] Bernstein v. Sullivan, 914 F.2d 1395 (10th Cir. 1990).

[26] Chapman v. U.S. Dept. of Health & Human Services, 821 F.2d 523 (10th Cir. 1987).

[27] *Id.*

[28] United States v. Anthony, 727 F. Supp. 792 (E.D.N.Y. 1989).

[29] 42 U.S.C.A. §§ 1320a-7b, as amended by The Health Insurance Portability & Accountability Act of 1991, Public Law 104-191, §§ 204, 217, 241-249.

[30] 42 U.S.C.A. §§ 1320a-7b *et. seq.*; See Love, "Toward a Fair and Practical Definition of 'Willfully' in the Medicare/Medicaid Antikickback Statute," 50 Vand. L. Rev. 1029 (1997); Bucy, *Health Care Fraud: Criminal, Civil & Administrative Law* 2.13 (Law Journal Seminars-Press 1996).

Specifically, it is a felony to solicit or receive "any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind"[31] for the referral of an individual for an item or service paid for by federal funds or in return for "purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item"[32] paid for by federal funds.

"Remuneration" is a broad term which can include a variety of activities. For example, the act prohibits "gifts" by a pharmacist to nursing home operators in return for the opportunity to supply medication;[33] the referral of specimens to a lab in return for payments to physicians;[34] and the offer of a rebate in return for referrals of business.[35] Even a gift of alcoholic beverages may constitute a kickback if such gifts make federal funds available to the supplier of services or products.[36] Even if the inducement for a referral is one of several reasons for the remuneration, it is still a violation of the statute.[37]

The government must show that the kickback was accepted knowingly and willfully:

> "The statute regulates only economic conduct. It chills no constitutional rights. While the statute allows for criminal penalties, it requires 'knowing and willful' conduct, a requirement which mitigates any vagueness in the statute."[38]

Penalties include up to $25,000 or five years in prison or both. There are, however, five statutory exceptions.[39] They are:

(1) Discounts obtained by a service provider which are properly disclosed;

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[31] *Id.*

[32] *Id.*

[33] United States v. Ruttenberg, 625 F.2d 173 (7th Cir. 1980).

[34] United States v. Weingarden, 468 F. Supp. 410 (D. Mich), *aff d* 625 F.2d 111, *cert. denied* 101 S.Ct. 609, 449 U.S. 34 (1979).

[35] United States v. Duz-Mor Diagnostic Laboratory, Inc., 650 F.2d 223 (9th Cir. 1981).

[36] United States v. Perlstein, 632 F.2d 661 (6th Cir.), *cert. denied* 101 S.Ct. 871, 449 U.S. 1084 (1980).

[37] United States v. Greber, 760 F.2d 68, 69-72 (3rd Cir. 1985).

[38] The Hanlester Network v. Shalala, 51 F.3d 1390, 1412 (9th Cir. 1995). But see, United States v. Jain, 93 F.3d 436 (8th Cir. 1996), *reh. den.* 1996 US App LEXIS 27478 (1996).

See also: Kucera, "Hanlester Network v. Shalala: A Model Approach to the Medicare and Medicaid Kickback Problem," 91 N.W.U.L. Rev. 412 (Fall 1996); Vavonese, "Comment: The Medicare Anti-Kickback Provision of the Social Security Act - Is Ignorance of the Law an Excuse For Fraudulent and Abusive Use of the System?" 45 Cath. U.L. Rev. 943 (Spring 1996).

[39] 42 U.S.C.A. § 1320a-7b(b)(3).

(2) Payments made by an employer to a bona fide employee "for employment in the provision of covered items or services;"
(3) Payments by a vendor of goods or services to a purchasing agent for a group if (a) the purchasing agent has a written contract specifying the amount he is to be paid by each individual or entity, and (b) the purchasing agent discloses to the service provider (and to the government, if requested) the amount received from each vendor for purchases made on its behalf;
(4) certain waivers of coinsurance by a federal health care center; and
(5) any payment practice specified in the regulations.

The federal regulations also list certain payment practices which are not treated as criminal offenses.[40] The regulations specify a variety of provisions covering certain types of investment interests; space rental; equipment rental; personal services and management contracts; sale of a practice; referral services; warranties; discounts; compensation to an employee; group purchasing organizations; waiver of beneficiary coinsurance and deductible amounts; and price reductions to health plans. Additional exceptions have been proposed.[41]

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[40] 42 C.F.R. § 1001.952 (1996).
[41] 58 Fed. Reg. 49088.

§ 1.07 Malpractice Information Available to the Public

Pressure is now being applied to state legislatures to require health care providers to collect data pertaining to malpractice incidents. This data is then in turn reviewed by the applicable state health department and released to the public as consumer information.

The Rhode Island version of such a statute requires consumers to be warned up front:

> This profile contains certain information which may be used as a starting point in evaluating the physician. This profile should not, however, be your sole basis for selecting a physician.[1]

The Rhode Island statute mandates that malpractice payment data be accompanied by certain explanatory information, such as:

- An explanation that cases may be settled for reasons other than liability or without the physician's consent;
- An explanation of the effect of treating high-risk patients on a physician's malpractice history;
- An explanation that an incident giving rise to a malpractice payment may have occurred years prior to the payment;
- An explanation that certain patients and certain procedures are more likely the subject of litigation; and
- An explanation that the consumer should take into account the number of years a physician has practiced and not just the practitioner's reported ten years of history.[2]

New York's Health Information and Quality Improvement Act[3] may be an indication of the type of statutes that may eventually exist in every state. Essentially, the Act enables the State Health Department to collect data from a wide variety of health care providers, which will then be released to the public as physician profiles and hospital report cards, as discussed below.

[1]—Physician Profiles

The physician profile[4] to be disseminated to the public under New York legislation includes the following information:

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[1] R.I. Rev. L. Ann. §5-37-9.2(a).
[2] R.I. Rev. L. Ann. §5-37-9.2(a)(2).
[3] N.Y. Pub. Health L. Art. 29-D.
[4] N.Y. Pub. Health L. §2995-a. See Baczynski, "Do You Know Who Your Physician Is? Placing Physician Information on the Internet," 87 Iowa L. Rev. 1303 (2002).

- A statement of criminal convictions within the past ten years.
- A statement regarding any current limitations on the license to practice.
- A statement regarding loss of hospital privileges for reasons related to quality of patient care within the past ten years.
- tration awards and, to some extent, settlements.
- Biographical information, e.g. medical school, board certification; date of admission to practice; hospitals where the physician has privileges; appointments to medical school facilities; publications in peer reviewed literature (optional); professional or community service activities (optional).
- The location of the physician's primary practice and the names of any other physicians with whom he shares a group practice (optional) and the identification of any translating services available at the primary practice location.
- The identification of health care plans (optional), as well as state or federally financed health programs, in which the physician participates.

The statute requires the physician to report this information on health department forms. The physician is given a copy of his profile to review prior to its dissemination. The physician also has the right to file a concise statement concerning the information contained in the profile and this statement is to be disseminated along with the profile. A physician who knowingly provides inaccurate information is guilty of professional misconduct. The state department of health is required to establish a toll-free number so that the public can order the profiles or make complaints about suspected misconduct. Profiles shall also be available through the Internet.

The existence of such physician profiles marks a radical change with the past. Part of the problem inherent in such profiles can be seen with the difficulty that the legislature evidently experienced in handling the reporting of medical malpractice settlements. Settlements, for example, can be urged by an insurance company making a cost-benefit analysis that may have nothing to do with the practitioner's quality of care. The statute provides that malpractice settlements made within the past ten years are to be reported if the number exceeds two or if the commissioner determines any such settlement is relevant to patient decisionmaking.[5] The statute then requires the profile to state:

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[5] N.Y. Pub. Health L. §2995-a(e)(ii).

> Settlement of a claim may occur for a variety of reasons, which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim does not necessarily mean that a medical malpractice has occurred.[6]

The statute also directs the state department of health to analyze the collected data for factors such as frequency, severity and geographic area. Further statutory changes may be recommended if the department determines that the collected data is not useful for quality healthcare determinations.[7]

[2]—Hospital Report Cards

The New York law also provides for Hospital Report Cards that are similar in intent to the physician profiles. Utilization and performance information already collected by the state health department shall be prepared in a form for public review. Hospitals will have the opportunity to review the data before it is disseminated to the public and the opportunity to correct any factual inaccuracies. The hospital will also have the opportunity to submit a statement regarding the data that will be published along with the data.[8]

[3]—Other Provisions

The New York State Health Department is further directed to analyze collected quality assurance data on health care plans and to prepare it for public dissemination;[9] to determine whether there are other licensed health care providers apart from physicians from whom it would be useful to collect similar data;[10] and to establish a clearinghouse for physician credentialing that will streamline inquiries by health care providers.[11]

It should be noted that Tennessee's version of this consumer data legislation does apply to health care providers other than physicians and hospitals. The Tennessee statute[12] sets certain threshold amounts for each type of provider below which judgments or settlements are not reportable (e.g. chiropractors $50,000 or dentists $25,000).

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[6] N.Y. Pub. Health L. §2995-a(e)(ii)
[7] N.Y. Pub. Health L. §2995-a(16).
[8] N.Y. Pub. Health L. §2995-b
[9] N.Y. Pub. Health L. §2995-c.
[10] N.Y. Pub. Health L. §2995-d.
[11] N.Y. Pub. Health L. §2996.
[12] Tenn. Code Ann. §63-51-105.