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## Peer Review and Public Policy

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# Peer Review and Public Policy

Leon S. Conlon\*

## I. INTRODUCTION

The private hospital is a unique community of doctors, nurses, allied health professionals, and managers in which no one seems to work for anyone else. The attending physicians are generally described as "independent contractors," but that title has little meaning in actual practice.<sup>1</sup> In some ways, the relationship between the hospital and its medical staff is similar to an employer-employee relationship.<sup>2</sup> For example, the negligence of attending physicians has been ascribed to the hospital in certain circumstances<sup>3</sup> and redress under Title VII of the Civil Rights Act has been extended by some courts to attending physicians.<sup>4</sup>

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1. See *Mousavi v. Beebe Hosp.*, 45 Fair Empl. Prac. Cas. (BNA) 746 (D. Del. 1987).

2. A frequently cited eleven-part test for the determination of "independent contractor" status is set forth in *Spirides v. Reinhart*, 613 F.2d 826 (D.C. Cir. 1979). The court observed that where an employer has the right to control and direct the work of an individual, an employer/employee relationship is likely to exist. 613 F.2d at 832. The court then set out additional facts to be considered:

(1) the kind of occupation, with reference to whether the work usually is done under the direction of a supervisor or is done by a specialist without supervision; (2) the skill required in the particular occupation; (3) whether the "employer" or the individual in question furnishes the equipment used and the place of work; (4) the length of time during which the individual has worked; (5) the method of payment, whether by time or by the job; (6) the manner in which the work relationship is terminated; i.e., by one or both parties, with or without notice and explanation; (7) whether annual leave is afforded; (8) whether the work is an integral part of the business of the "employer"; (9) whether the worker accumulates retirement benefits; (10) whether the "employer" pays social security taxes; and (11) the intention of the parties.

*Id.*

3. *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253, *cert. denied*, 383 U.S. 946 (1986). See, e.g., *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972) (hospital breached duty to take appropriate corrective action in the face of previous malpractice cases); *Johnson v. Misericordia Community Hosp.*, 99 Wisc. 2d 708, 301 N.W.2d 156 (1981) (hospital presumed to have knowledge regarding physicians' qualifications and malpractice history if reasonable investigation would have disclosed this information).

4. *Pardazi v. Cullman Medical Center*, 838 F.2d 1155 (11th Cir. 1988); *Doe v. St. Joseph's Hosp. of Fort Wayne*, 788 F.2d 411 (7th Cir. 1986).

The growth of medical staff peer review committees and the statutory recognition of such committees has underlined the importance of physician participation in hospital governance.<sup>5</sup> As peer review committees accept the decision making role in hospital administration, the courts must determine the proper governmental methods for reviewing and evaluating those peer review decisions. In addition, hospitals must decide whether or not they will indemnify and defend the physicians who serve on peer review committees.

## II. JUDICIAL DEFERENCE TO PRIVATE DECISION MAKERS: THE COMMON LAW RULE

State courts generally have been deferential to the decisions of peer review committees, particularly the credentials committees of private hospitals.<sup>6</sup> Illinois courts and the majority of other state courts allow private hospitals to act freely in deciding which physicians will be allowed to join the medical staff and admit patients into the hospital. A private hospital's refusal to appoint a physician to the medical staff generally is not subject to judicial review.<sup>7</sup> Several jurisdictions, however, have rejected this rule and have as-

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5. Hospitals traditionally have had standing committees within the medical staff, and, where necessary, special *ad hoc* committees to review the credentials of applicants for staff appointments, the utilization patterns of staff members, the quality of care in specific cases, and other elements of medical care. Some states have specific statutory requirements for medical staff organization. *See, e.g.*, MICH. STAT. ANN. § 14.15 (Callaghan 1988). Regulations promulgated pursuant to state licensing statutes also may detail the duty of the governing board and medical staff to review qualifications and performance. *See, e.g.*, FLA. ADMIN. CODE ANN. r. 10d-28.58 (1982) (implementing FLA. STAT. § 395.11 (1986)); ILL. ADMIN. CODE tit. 77 § 250.210 (1985).

Since 1972, these traditional peer review activities have been recognized under federal law and incorporated into the Medicare system as a regulatory device. Peer review is mandated by Congress when medical services are paid for with Medicare funds, and also when hospitals seek certification for participation in the Medicare program by obtaining accreditation from the Joint Commission for the Accreditation of Hospitals (now the Joint Commission for the Accreditation of Health Organizations). *See* 42 U.S.C. § 1395x(k), (r), and (s) (1982); 42 U.S.C. § 1396a (a)(19), and (26) (1982); 42 U.S.C. § 1395bb(a) (1982); ILL. REV. STAT. ch. 110, para. 8-2101 (1987). The JCAH standards of accreditation address the responsibility of the medical staff to review qualifications and performance of applicants for, and members of, the medical staff. JCAH, *Accreditation Manual for Hospitals*, Medical Staff, Standard MS.1., MS.6. (1987).

6. *See Note, Michigan Court Joins Majority in Denying Judicial Review of Staffing Decisions of Private Hospitals*, 6 AM. J. TRIAL ADVOC. 339 (1982).

7. *Rao v. St. Elizabeth's Hosp.*, 140 Ill. App. 3d 442, 488 N.E.2d 685 (5th Dist. 1986); *Knapp v. Palos Community Hosp.*, 125 Ill. App. 3d 244, 465 N.E.2d 554 (1st Dist. 1984); *Spencer v. Community Hosp. of Evanston*, 87 Ill. App. 3d 214, 408 N.E.2d 981 (1st Dist. 1980); *Mauer v. Highland Park Hosp. Found.*, 90 Ill. App. 2d 409, 232 N.E.2d 776 (2d Dist. 1967).

served judicial review over these private decision-makers.<sup>8</sup>

The Illinois Supreme Court recently reviewed this issue and reaffirmed the Illinois position of judicial deference.<sup>9</sup> In *Barrows v. Northwestern Memorial Hospital*,<sup>10</sup> the plaintiff, Dr. William Barrows, brought an action against Northwestern and several members of its medical staff challenging Northwestern's decision to deny him membership on its medical staff. Dr. Barrows alleged that he and another pediatrician had a working relationship with a group of obstetrical-gynecological ("ob-gyn") physicians.<sup>11</sup> Under their arrangement, the pediatricians would take over the care of babies born to the patients of the ob-gyn physicians. In January, 1984, Northwestern, a private hospital in Chicago, Illinois, granted the ob-gyn physicians admission to the staff of Prentice Hospital, a facility operated by Northwestern.<sup>12</sup> These ob-gyn physicians transferred their staff affiliation to Northwestern.

Dr. Barrows subsequently applied for admission to the staff at Northwestern, but he was informed that Northwestern's pediatrics department did not need another pediatrician of his particular qualifications and that his application for staff admission was denied.<sup>13</sup> After an appearance before the appropriate medical staff committee, Dr. Barrows' application for medical staff privileges was denied. He then filed suit against Northwestern and several individual physicians asserting, among other things, that the denial of hospital staff privileges should be reviewable as a matter of public policy.<sup>14</sup>

The trial court dismissed the complaint, holding that private hospitals have the right to refuse to appoint a physician to their medical staffs and that such decisions are not subject to judicial

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8. See, e.g., *Greisman v. Newcomb Hosp.*, 40 N.J. 389, 192 A.2d 817 (1963).

9. *Barrows v. Northwestern Memorial Hosp.*, 123 Ill. 2d 49, 525 N.E.2d 50 (1987).

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.* at 51, 525 N.E.2d at 51. Dr. Barrows filed a four-count complaint, naming as defendants Northwestern; Dr. John J. Boehm, chairman of Northwestern's pediatrics service; Dr. James R. Hines, chief of staff at the hospital; and Dr. James A. Stockman III, chairman of the department of pediatrics. Count I alleged that the actions of the defendants amounted to a conspiracy to interfere with his business relationship with the ob-gyn physicians. Count II alleged that the defendants' conduct unreasonably restrained trade in violation of the Illinois Antitrust Act (ILL. REV. STAT. ch. 38, para. 60-3 (1985)). Count III asserted that certain unwritten rules governing staff admission constituted fraud. Count IV alleged that denial of hospital staff privileges should be reviewable as a matter of public policy. *Id.*

review.<sup>15</sup> On appeal, Dr. Barrows contended that the rule of nonreview has fallen into disfavor and that the "modern view," which permits limited review of hospital staff decisions, has gained acceptance in recent years.<sup>16</sup> The appellate court agreed, holding that courts may review such decisions as a matter of public policy, to ensure that exclusions are not "unreasonable, arbitrary, capricious or discriminatory."<sup>17</sup>

The Illinois Supreme Court rejected the "modern view" and reaffirmed the doctrine of judicial deference or nonreview.<sup>18</sup> The court cited three reasons for its decision. First, the "trend" which Dr. Barrows identified was not widespread or compelling; a large majority of states continue to adhere to the rule of nonreview. Second, the special considerations which have caused some other states to abandon the rule of nonreview are not applicable to the case. Finally, the public policy of Illinois, as set forth in a number of statutory enactments, militates against recognition of Dr. Barrows' claim.<sup>19</sup>

The leading case opposing the rule of nonreview is *Greisman v. Newcomb Hospital*.<sup>20</sup> The plaintiff, an osteopath, was denied the opportunity to apply for staff membership at the defendant hospital because a by-law required staff members to be graduates of medical schools approved by the American Medical Association.<sup>21</sup> The plaintiff argued that courts should review hospital staff deci-

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15. *Id.* at 51-52, 525 N.E.2d at 51-52. In dismissing the plaintiff's complaint, the trial court relied upon two appellate court decisions, *Mauer v. Highland Park Hosp. Found.*, 90 Ill. App. 2d 409, 232 N.E.2d 776 (2d Dist. 1967); and *Jain v. Northwest Community Hosp.*, 67 Ill. App. 3d 420, 385 N.E.2d 108 (1st Dist. 1978).

16. *Barrows*, 123 Ill. 2d at 52, 525 N.E.2d at 52.

17. *Barrows v. Northwestern Memorial Hosp.*, 153 Ill. App. 3d 83, 505 N.E.2d 1182 (1st Dist. 1987). The opposite result was reached by another appellate panel in the same district. In *Rodriguez-Erdman v. Ravenswood Hosp. Medical Center*, 163 Ill. App. 3d 464, 470, 516 N.E.2d 731, 734-35 (1st Dist. 1987), the court held that:

Although plaintiff couches his argument in terms of statutory construction and legislative intent, it is apparent that what he seeks is judicial review of defendants' decision not to advance him to a non-probationary medical staff position. Initially, we note that a division of this court recently held that judicial review should extend to the question whether a private hospital's decision to exclude a physician from staff membership was arbitrary, capricious and unreasonable [citing to *Barrows*]. We note, however, that the weight of authority is that the scope of judicial review in cases in which a private hospital has denied staff membership or revoked or reduced a physician's staff privileges is limited to the issue whether in doing so it complied with its bylaws.

*Id.*

18. *Barrows*, 123 Ill. 2d 56-59, 525 N.E.2d 53-55.

19. *Id.*

20. 40 N.J. 389, 192 A.2d 817 (1963).

21. *Id.* at 392, 192 A.2d at 819.

sions to ensure that exclusions are made "in good faith and on reasonable grounds . . . related 'to the advancement of medical science or the elevation of professional standards.'"<sup>22</sup>

The Supreme Court of New Jersey acknowledged that the predominant view was that private hospitals may exclude physicians from their staffs without judicial interference.<sup>23</sup> The court, however, also recognized that although hospitals are private, they also have certain public characteristics. These "public" characteristics included public solicitation of funding from "public sources" as well as the receipt of tax benefits by virtue of the hospitals tax exempt status.<sup>24</sup> The court decided that the discretionary powers of the governing board were so "deeply imbedded in public aspects" that they were tantamount to "fiduciary" powers that must be exercised reasonably and for the public good.<sup>25</sup>

New Jersey subsequently extended the holding in *Greisman* in *Sussman v. Overlook Hospital Association*.<sup>26</sup> The *Greisman* decision partially was based on the fact that the defendant hospital was the only hospital in the area. Therefore, its staffing decisions could deprive patients of the doctor of their choice or negatively impact upon a physician's practice. This monopolistic situation weighed in favor of reviewing staff decisions because of the obvious adverse economic consequences to excluded doctors. Despite the absence of this factor in *Sussman*, the court applied the *Greisman* rule.<sup>27</sup> The court concluded that the function of the hospital was so "public" in nature that judicial review was available to hold the hospital to the high standard of a fiduciary.<sup>28</sup> A fiduciary duty was imposed upon the private hospital even though there was no evidence that the hospital had monopoly powers or that its discretionary decisions deprived others of economic opportunities.<sup>29</sup>

The New Jersey rule that was set forth in *Greisman* and expanded in *Sussman* is a "pure public policy" analysis of the societal role of the private community hospital. Under the New Jersey rule, private hospitals are held to be quasi-public institutions whose management decisions are subject to judicial review regardless of

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22. *Id.* at 395, 192 A.2d at 820.

23. *Id.* at 396, 192 A.2d at 820-21.

24. *Id.* at 396, 192 A.2d at 821.

25. *Id.* at 402, 192 A.2d at 824.

26. 92 N.J. Super. 163, 222 A.2d 530 (N.J. Super. Ct. Div. 1966), *aff'd*, 95 N.J. Super. 418, 231 A.2d 389 (N.J. Super. Ct. App. Div. 1967).

27. *Id.* at 176, 222 A.2d at 573.

28. *Id.*

29. *Id.*

their economic impact.<sup>30</sup>

When presented with the New Jersey rule in *Barrows v. Northwestern Memorial Hospital*, the Illinois Supreme Court rejected the "fiduciary" characterization of private hospitals, just as the Illinois Appellate Court had rejected the theory on several previous occasions.<sup>31</sup> The Illinois Supreme Court also rejected the proposition that the New Jersey rule was the "enlightened" view. The court surveyed the literature and found that since 1963, when *Greisman* was decided, only six other states had followed New Jersey's "fiduciary" status rule of review for hospital credentials committee decisions.<sup>32</sup> This, the court suggested, was not evidence "of a compelling trend."<sup>33</sup> The *Barrows* court concluded that the states which utilize the "pure" public policy rationale of New Jersey, represent "a tiny minority of the States of this nation."<sup>34</sup>

Because the court was confronted with a clear question of public policy, it looked to the legislature for guidance.<sup>35</sup> It relied on three recent statutes, all of which were enacted after the New Jersey

30. This analysis of the New Jersey rule was reached by the Illinois Supreme Court in *Barrows* where it observed:

Thus, by eliminating economic necessity as a basis for review of hospital staff decisions, New Jersey has come to adopt what might be termed a "pure" public policy position. Decisions of private hospitals are subject to judicial review merely on the basis of hospitals' "quasi-public," "fiduciary" status. It is this "pure" approach which the appellate court embraced in our case, and which the plaintiff urges this court to adopt.

*Barrows*, 123 Ill. 2d at 55, 525 N.E.2d at 53.

31. See *Mauer v. Highland Park Hosp. Found.*, 90 Ill. App. 2d 409, 232 N.E.2d 776 (2d Dist 1967); *Jain v. Northwest Community Hosp.*, 67 Ill. App. 3d 420, 385 N.E.2d 108 (1st Dist. 1978).

32. *Barrows*, 123 Ill. 2d at 55-56, 525 N.E.2d at 53-54. A recent law review note summarized the position of the states on this issue. See Note, *Michigan Court Joins Majority in Denying Judicial Review of Staffing Decisions of Private Hospitals*, 6 AM. J. TRIAL ADVOC. 339 (1982). This survey, bolstered by independent research, suggests that the New Jersey rule has been adopted by courts in Arizona (*Holmes v. Hoemako Hosp.*, 117 Ariz. 403, 573 P.2d 477 (1977)); California (*Miller v. National Medical Hosp. of Monterey Park, Inc.*, 124 Cal. App. 3d 81, 177 Cal. Rptr. 119 (1981)); Hawaii (*Silver v. Castle Memorial Hosp.*, 53 Haw. 475, 497 P.2d 564 (1972)); New Hampshire (*Bricker v. Sceva Speare Memorial Hosp.*, 111 N.H. 276, 281 A.2d 589 (1971)); Vermont (*Woodard v. Porter Hosp., Inc.*, 125 Vt. 419, 217 A.2d 37 (1966)); and New Mexico (*Kelly v. St. Vincent Hosp.*, 102 N.M. 201, 692 P.2d 1350 (1984)).

33. *Barrows*, 123 Ill. 2d at 57, 525 N.E.2d at 54.

34. *Id.* at 57, 525 N.E.2d at 54. The remaining states which have adopted the policy of judicial intervention have done so for economic reasons. Specifically, the *Barrows* Court found that New Mexico, Arizona, and New Hampshire predicated their reason for review of private hospital credentials decisions on the economic facts of spare population and scarcity of hospital resources. *Id.* at 56, 525 N.E.2d at 54.

35. *Id.* The rule of analysis offered by the court is significant: "It is a long-standing principle that the public policy of the State is to be found embodied in its constitution and statutes. (*Rouff v. Barrett* (1947), 396 Ill. 322, 71 N.E. 2d 660). We therefore look to

cases and the Illinois appellate court decisions.<sup>36</sup> The first of the three Illinois statutes cited was the Illinois Medical Practice Act.<sup>37</sup> This statute provides civil immunity for persons serving on hospital quality control committees.<sup>38</sup> The second Illinois statute was a recent amendment to the Illinois Hospital Licensing Act<sup>39</sup> which provided immunity from civil liability for persons participating in hospital quality assurance, medical audit, or credentials committee activities.<sup>40</sup> These statutes, the court said, indicate a general legislative intention that hospitals and medical staffs be free to exercise their professional judgment in the selection and retention of medical staff members.<sup>41</sup> The *Barrows* court found one further expression of legislative intent on the subject of medical peer review and public policy. The court quoted the Illinois Health Finance Reform Act,<sup>42</sup> a statute dealing with the negotiation of public aid

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those sources to determine whether Illinois' policy supports recognition of the plaintiff's cause of action." *Id.* at 57, 525 N.E.2d at 54.

36. *Id.*

37. ILL. REV. STAT. ch. 111, para. 4406 (1987).

38. The Act provides in pertinent part:

While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee, or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or the improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct.

ILL. REV. STAT. ch. 111, para. 4406 (1987).

39. ILL. REV. STAT. ch. 111½, para. 151.2 (1985).

40. In 1985, the Illinois Hospital Licensing Act was amended to provide as follows:

No hospital and no individual who is a member, agent, or employee of a hospital, hospital medical staff, hospital administrative staff, or hospital governing board shall be liable for civil damages as a result of the acts, omissions, decisions, or any other conduct of a medical utilization committee, medical review committee, patient care audit committee, medical care evaluation committee, quality review committee, credential committee, peer review committee, or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital, or the improving or benefiting of patient care and treatment, whether within a hospital or not, or for the purpose of professional discipline. Nothing in this Section shall relieve any individual or hospital from liability arising from treatment of a patient.

ILL. REV. STAT. ch. 111½, para. 151.2 (1987).

41. *Barrows*, 123 Ill. 2d at 58, 525 N.E.2d at 55.

42. ILL. REV. STAT. ch. 111½, para. 6501-1 *et seq.* (1987).



contracts: "It is not the intent of the General Assembly, nor shall it be the policy of the State of Illinois, to take from medical staffs and hospitals the determination as to the qualifications of practitioners for purposes of granting medical staff membership and privileges."<sup>43</sup>

Illinois courts and the Illinois General Assembly have addressed hospital peer review, specifically credentials committee work, on several occasions since the enunciation of the New Jersey rule in *Greisman*. The Illinois judiciary and the Illinois legislature both have rejected the contention that private hospitals are fiduciaries subject to judicial review.<sup>44</sup> It is the clear policy of Illinois and the majority of other states that hospital peer review committees be given broad immunity so that they can work toward the improvement of medical care. The federal courts, however, do not follow this policy of judicial deference. Indeed, federal courts have adopted a policy of judicial intervention in private hospital governance. This activist policy is particularly evident in the enforcement of the Sherman Antitrust Act.<sup>45</sup>

### III. THE IMPACT OF LEGISLATION ON PEER REVIEW

#### A. *The "State Action Doctrine" and Exemption from Antitrust Actions*

Physicians disappointed by the denial, curtailment, or revoca-

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43. ILL. REV. STAT. ch. 111 $\frac{1}{2}$ , para. 6503-4 (1987).

44. The temporal sequence of these events is crucial to the rule of construction, as the Illinois Supreme Court stated:

Thus, the General Assembly has made an express declaration of policy which, in our view, requires that we reject the public policy claim accepted by the appellate court. It is worthy of note that the above provisions of the Medical Practice Act, the Hospital Licensing Act and the Illinois Health Finance Reform Act were all enacted or amended since our appellate court's decisions in *Mauer* and *Jain*, which specifically declined to follow the minority view that decisions of private hospitals refusing appointments to their medical staffs are subject to judicial review. The legislature in these acts did not contradict but instead reaffirmed the policy supporting the holdings of the court in *Mauer* and *Jain*. We therefore reverse the holding of the appellate court in the case before us on the public policy issue, which is contrary to the public policy as stated in *Mauer* and *Jain*, and reaffirmed by the General Assembly in the acts referred to herein.

*Barrows*, 123 Ill. 2d at 59, 525 N.E.2d at 55.

45. Section 1 of the Sherman Antitrust Act, 15 U.S.C. § 1, provides, in pertinent part: "Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is declared to be illegal." 15 U.S.C. § 1 (1982). Section 2 of the Act defines as a felony the act of any person "who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States. . . ." 15 U.S.C. § 2 (1982).

tion of medical staff privileges often have brought suit against the subject hospital for alleged violations of the antitrust laws.<sup>46</sup> Typically, plaintiff doctors allege that they treat many patients from other states, receive payment from Medicare and other third party payors, purchase expensive medical equipment through interstate commerce, and that the affected hospital is also substantially involved in interstate commerce. Further, plaintiffs allege that the denial or revocation of medical staff privileges amounts to a conspiracy in restraint of trade or an attempt to monopolize medical practice in violation of the Sherman Antitrust Act.<sup>47</sup> The plaintiff must adequately aver that the defendant's alleged illegal conduct is "in interstate commerce" or has a "substantial and adverse effect" upon interstate commerce.<sup>48</sup>

The "state action doctrine," however, exempts actions conducted pursuant to state law from the application of the Sherman Antitrust Act. The state action doctrine applies if the challenged restraint is clearly articulated and affirmatively expressed as state policy, and if the regulatory system is actively supervised by the state.

When the United States Supreme Court examined the "state action doctrine" as it related to peer review activities of private hospitals, it held that the doctrine did not protect physicians from federal antitrust liability.<sup>49</sup> In *Patrick v. Burget*,<sup>50</sup> a surgeon declined an invitation to become a partner in the Astoria Clinic, a private group medical practice in Oregon. Rather, Dr. Patrick established an independent practice which competed with the surgical practice of the clinic. The only hospital in Astoria was the Columbia Memorial Hospital. Dr. Patrick was a member of the hospital's medical staff, and a majority of the staff members were employees or partners of the Astoria Clinic.<sup>51</sup>

After Dr. Patrick established his practice, the physicians associated with the clinic refused to deal with him.<sup>52</sup> Thereafter, in 1979, one of the clinic partners filed a complaint with the Executive

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46. *Tambone v. Memorial Hosp. for McHenry County, Inc.*, 825 F.2d 1132 (7th Cir. 1987); *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986), *reversed*, 108 S. Ct. 1658 (1988); *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984).

47. See *McLain v. Real Estate Bd. of New Orleans*, 444 U.S. 232, 242-44 (1980); *Hosp. Bldg. Co. v. Rex Hosp. Trustees*, 425 U.S. 738, 743 (1976).

48. *McLain*, 444 U.S. at 241-42; *Hosp. Bldng. Co.*, 425 U.S. at 743.

49. *Patrick v. Burget*, 108 S. Ct. 1658 (1988).

50. *Id.*

51. *Id.* at 1660.

52. *Id.* at 1661. The problems encountered by Dr. Patrick were summarized as follows:

Committee of the Columbia Memorial Hospital medical staff asserting that Dr. Patrick had left a patient in the care of a recently-hired associate, who then left the patient unattended. The Executive Committee referred the complaint to the state Board of Medical Examiners (the "BOME").<sup>53</sup> Dr. Franklin Russell, another partner of the Clinic, chaired the committee of the BOME that investigated the charge and subsequently drafted the letter of reprimand that was issued by the full BOME. The BOME retracted this letter in its entirety after Dr. Patrick sought judicial review of the BOME proceedings. Two years later, the Executive Committee of the hospital's medical staff initiated a review of Dr. Patrick's hospital privileges.<sup>54</sup> The committee recommended that the privileges be terminated because the care rendered by Dr. Patrick allegedly was below hospital standards. Before a final decision was made on the matter, Dr. Patrick resigned from the medical staff.<sup>55</sup>

During the pendency of the peer review proceedings, Dr. Patrick filed a lawsuit in United States District Court alleging that the partners of the Astoria Clinic had violated Sections 1 and 2 of the Sherman Act. The case was tried before a jury, which awarded \$650,000 in damages. The District Court, as required by law, trebled the antitrust damages.<sup>56</sup>

On appeal, the United States Court of Appeals for the Ninth Circuit reversed. It found substantial evidence that the clinic partners had acted in bad faith in the peer review process. Indeed, the Court went so far as to characterize the conduct as "shabby, unprincipled and unprofessional."<sup>57</sup> Nonetheless, the court held that even if the clinic partners used the peer review process to disadvantage a competitor rather than to improve patient care, their con-

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After petitioner established his independent practice, the physicians associated with the Astoria Clinic consistently refused to have professional dealings with him. Petitioner received virtually no referrals from physicians at the Clinic, even though the Clinic at times did not have a general surgeon on its staff. Rather than refer surgery patients to petitioner, Clinic doctors referred them to surgeons located as far as 50 miles from Astoria. In addition, Clinic physicians showed reluctance to assist petitioner with his own patients. Clinic doctors often declined to give consultations, and Clinic surgeons refused to provide back-up coverage for patients under petitioner's care. At the same time, Clinic physicians repeatedly criticized petitioner for failing to obtain outside consultations and adequate back-up coverage.

*Id.* at 1661.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.* at 1661-67 n.3.

duct in the peer review proceedings was immune from antitrust scrutiny.<sup>58</sup> The court found that the peer review activities of Oregon physicians fell within the "state action" exemption from antitrust liability because Oregon had articulated a policy in favor of peer review and actively supervised the peer review process.

Subsequently, the United States Supreme Court granted certiorari<sup>59</sup> to address the proper application of the "state action" doctrine of *Parker v. Brown*.<sup>60</sup> In *Parker*, the Court held that the Sherman Act was not intended to restrain state action, or official action directed by a state, even if that action was anticompetitive.<sup>61</sup> In order to determine the availability of this exemption, the Court established a two-pronged test. First, the challenged restraint must be clearly articulated and affirmatively expressed as state policy.<sup>62</sup> Second, the anticompetitive conduct must be actively supervised by the state itself.<sup>63</sup>

In *Patrick*, the Court concluded that traditional medical staff peer review procedures did not satisfy the "active supervision" prong of the state action doctrine.<sup>64</sup> The active supervision necessary to invoke the state action defense requires that state officials have the power to review particular anticompetitive acts and to disapprove of those acts that fail to accord with state policy. The Supreme Court observed that none of the state government regulators in Oregon reviewed or reversed the specific credentials decisions of the hospitals. In relation to the oversight activities of the Oregon Health Division and the statutory obligation on the part of hospitals to conduct peer review, the Court noted that the state agency could revoke a hospital's license or impose other sanctions if the required peer reviews were not conducted. This limited authority, however, was insufficient for purposes of the state action

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58. *Id.* at 1662.

59. *Id.*

60. 317 U.S. 341 (1943).

61. *Id.* at 351.

62. *Lafayette v. Louisiana Power and Light Co.*, 435 U.S. 389 (1978).

63. *California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

64. *Patrick*, 108 S. Ct. at 1663. The *Patrick* Court observed that:

The active supervision prong of the *Midcal* test requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy. Absent such a program of supervision, there is no realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests.

*Id.*

doctrine.<sup>65</sup> The regulatory activities of the Board of Medical Examiners likewise was held to be insufficient to sustain the state action defense even though Oregon hospitals were required by statute to notify the Board of all decisions to terminate or restrict privileges.<sup>66</sup>

The remaining contention of the clinic partners that peer review activities were subject to the review of the Oregon courts, was given short shrift: "[I]t is not clear that Oregon law affords any direct judicial review of private peer-review decisions. Oregon has no statute expressly providing for judicial review of privilege terminations."<sup>67</sup> Indeed, the judicial review reflected in the Oregon case law, according to the Court, was not directed toward the merits of the credentials decisions. Rather, it was directed toward ascertaining that "some sort of reasonable procedure was afforded and that there was evidence from which it could be found that plaintiff's conduct posed a threat to patient care."<sup>68</sup> This limited review was

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65. *Id.* at 1664. The Court observed that:

This statutory scheme does not establish a state program of active supervision over peer review decisions. The Health Division's statutory authority over peer review relates only to a hospital's procedures; . . . that authority does not encompass the actual decisions made by hospital peer review committees. The restraint challenged in this case (and in most cases of its kind) consists not in the procedures used to terminate hospital privileges, but in the termination of privileges itself. The State does not actively supervise this restraint unless a state official has and exercises ultimate authority over private privilege determinations. Oregon law does not give the Health Division this authority: under the statutory scheme, the Health Division has no power to review private peer review decisions and overturn a decision that fails to accord with state policy. Thus, the activities of the Health Division under Oregon law cannot satisfy the active supervision requirement of the state action doctrine.

*Id.*

66. *Id.* The Court found that although the BOME was notified of adverse credentials decisions, it could not disapprove those decisions. The Court stated:

Similarly, the BOME does not engage in active supervision over private peer review decisions. The principal function of the BOME is to regulate the licensing of physicians in the State. As respondents note, Oregon hospitals are required by statute to notify the BOME promptly of a decision to terminate or restrict privileges. See Ore. Rev. Stat. § 441.820(1) (1987). Neither this statutory provision nor any other, however, indicates that the BOME has the power to disapprove private privilege decisions. The apparent purpose of the reporting requirement is to give the BOME an opportunity to determine whether additional action on its part, such as revocation of a physicians's license, is warranted. . . . Certainly, respondents have not shown that the BOME in practice reviews privilege decisions or that it ever has asserted the authority to reverse them.

*Id.*

67. *Id.* at 1665.

68. *Id.* (citing *Straube v. Emmanuel Lutheran Charity Bd.*, 287 Ore. 375, 600 P.2d 381 (1979)).

seen to be insufficient.<sup>69</sup>

Finally, the Court rejected the argument that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability would prevent physicians from participating openly and actively in peer review proceedings. The Court then directed the health care providers to seek legislative relief.<sup>70</sup>

The Court's apparent deference to the legislature is somewhat suspect. Congress adopted a policy supporting medical peer review and providing a limited exemption from the federal antitrust laws. The Health Care Quality Improvement Act (the "HCQIA")<sup>71</sup> clearly was intended to exempt traditional peer review from the specter of antitrust liability. It was enacted after the *Patrick* controversy, and it was not retroactive. Accordingly, it was not available as a defense in *Patrick*.<sup>72</sup> The Court's brief dis-

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69. *Id.* The Court stated:

This kind of review would fail to satisfy the state action doctrine's requirement of active supervision. Under the standard suggested by the Oregon Supreme Court, a state court would not review the merits of a privilege termination decision to determine whether it accorded with state regulatory policy. Such constricted review does not convert the action of a private party in terminating a physician's privileges into the action of the State for purposes of the state action doctrine.

*Id.*

70. *Id.* at 1665-66. The Court reviewed the public policy argument, stating:

Because we conclude that no state actor in Oregon actively supervises hospital peer-review decisions, we hold that the state action doctrine does not protect the peer-review activities challenged in this case from application of the federal antitrust laws. In so holding, we are not unmindful of the policy argument that respondents and their amici have advanced for reaching the opposite conclusion. They contend that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings. This argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such is properly directed to the legislative branch. To the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny only if the State effectively has made this conduct its own. The State of Oregon has not done so. Accordingly, we reverse the judgment of the Court of Appeals.

*Id.*

71. 42 U.S.C. § 11101 (1982).

72. See *Patrick*, 108 S. Ct. at 1665-66 n.8, for a discussion of the HCQIA:

Congress in fact insulated certain medical peer-review activities from antitrust liability in the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. §§ 11101-11152 (Supp. 1987). The Act, which was enacted well after the events at issue in this case and is not retroactive, essentially immunizes peer-review action from liability if the action was taken "in the reasonable belief that [it] was in the furtherance of quality health care." § 11112(a). The Act expressly

cussion of the HCQIA indicates that it will be of little, if any, value as a defense against antitrust actions predicated upon adverse medical staff credentialing decisions.

### B. *Health Care Quality Improvement Act of 1986*

Increased litigation from peer review activities alarmed the medical community<sup>73</sup> and was a motivating force behind the enactment of the Health Care Quality Improvement Act of 1986.<sup>74</sup> The Act reflects two competing policy concerns. Congress was troubled by the migration of incompetent physicians from state to state without disclosure of prior episodes of medical malpractice. Congress also recognized, however, that antitrust liability was an impediment to candid and effective peer review.<sup>75</sup>

The Act has four subject areas: (1) limitation of liability for medical peer review;<sup>76</sup> (2) insurance and indemnity settlement disclosure;<sup>77</sup> (3) clinical privilege modification disclosure;<sup>78</sup> and (4) affirmative inquiry by hospitals as to the clinical privileges and loss

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provides that it does not change other "immunities under law," § 11115(a), including the state action immunity, thus allowing States to immunize 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 effective peer review. If physicians believe that the Act provides insufficient immunity to protect the peer-review process fully, they must take that matter up with Congress.

*Id.*

73. See *Tambone v. Memorial Hosp. for McHenry County, Inc.*, 825 F.2d 1132 (7th Cir. 1987); *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986), *reversed*, 108 S. Ct. 1658 (1988); *Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir. 1984); *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984).

74. 42 U.S.C. § 11101 (1982).

75. The legislative findings of fact in 42 U.S.C. § 11101 were quite specific:

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

42 U.S.C. § 1101 (1982).

76. 42 U.S.C. § 11111 (a)(1) (1982).

77. 42 U.S.C. § 11131 (1982).

78. 42 U.S.C. § 11133 (a)(1) (1982).

experiences of applicants for hospital clinical privileges.<sup>79</sup> The Act provides immunity from damages in private federal and state actions, including antitrust actions, for individuals engaged in certain physician peer review activities.<sup>80</sup> In order to qualify for immunity, the peer review process must be conducted in the reasonable belief that the actions are warranted by the facts obtained through investigation. Further, adequate notice and hearing procedures must be provided to the physician involved.<sup>81</sup> The immunities provided by the HCQIA are effective for suits brought under federal law based on professional review actions taken subsequent to November 14, 1986.<sup>82</sup> In most cases, the immunities will apply to suits brought under state law after October 14, 1989.<sup>83</sup> States may elect to immunize peer review activities from actions brought before October 14, 1989, by adopting a statute to that effect and "opting into" the program. Likewise, states can refuse to adopt the HCQIA standards by "opting out."<sup>84</sup>

There is little evidence to suggest that the HCQIA provides any meaningful protection to physicians or health care providers. In *Patrick v. Burget*,<sup>85</sup> the Supreme Court recognized that even if the Act had been in effect at that time, it probably would not have aided the defendants. The HCQIA provides immunity only when the adverse action is taken "in the reasonable belief that the action was in the furtherance of quality health care."<sup>86</sup> It established four standards for professional review actions and provided that the professional review action shall be presumed to have met the standards unless the presumption is rebutted by the preponderance of the evidence.<sup>87</sup> For example, evidence offered to rebut the pre-

79. 42 U.S.C. § 11135 (1982).

80. 42 U.S.C. § 11111 (a)(1) (1982).

81. 42 U.S.C. § 11112 (1982).

82. The Act became effective on November 14, 1986. 42 U.S.C. § 11111 (1982). It is not retroactive in application. *Id.* See *supra* note 72.

83. 42 U.S.C. § 11111(c) (1982).

84. *Id.*

85. See *supra* note 57.

86. 42 U.S.C. § 11112(a)(1) (1982).

87. The Act provides a limitation on damages for professional review actions. 42 U.S.C. § 11111(a) (1982). In order to qualify for that protection the professional review action must meet the following standards:

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken —

- (1) in the reasonable belief that the action was in the furtherance of quality health care,
- (2) after a reasonable effort to obtain the facts of the matter,
- (3) after adequate notice and hearing procedures are afforded to the physi-



sumption may include evidence of anticompetitive intent.<sup>88</sup>

The most important effect of the HCQIA on peer review actions will be in the area of the reporting of adverse decisions. This regulatory mechanism is a passive system of reportage and data exchange.<sup>89</sup> Sanctions against physicians are reported to a data

cian involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title *unless the presumption is rebutted by a preponderance of the evidence.*

42 U.S.C. § 11114(a) (1982) (emphasis added).

88. Hersey, *Hospital Law Newsletter*, July, 1988 at 5. On a related matter, physicians and hospital administrators may conclude that the notice and hearing requirements of the HCQIA are impractical and are not justified by the limited immunity offered by the Act. 42 U.S.C. 11112 (b)(3). The Act provides:

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B)—

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) —

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right—

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right—

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

*Id.*

89. It is important to note that the reporting mechanism has not yet been established. Congress has to appropriate funds for the creation of the National Data Bank, so the statutory deadline of November 14, 1987 for the commencement of mandatory reporting

bank.<sup>90</sup> Settlements and adverse verdicts in malpractice cases also are reported<sup>91</sup> and hospitals are required to make inquiries regarding physicians who apply for staff privileges.<sup>92</sup> There is no requirement that any state agency review, approve, or otherwise pass upon the specific decisions of the hospital credentials committees.

The immunities offered by the HCQIA, however, are largely illusory. There is no real benefit in adopting the hearing standards proposed in the statute. Moreover, there is little enthusiasm for the modification of state law to shelter peer review activities from antitrust attack following *Patrick*.<sup>93</sup> Actually, the HCQIA never fully insulated hospital peer review committees from judicial review by the federal courts. The Act contains another major exception which could, in many conceivable circumstances, allow disappointed physicians to contest credentials decisions in the federal courts.

### C. *Civil Rights Statutes and Hospital Credentialing Decisions*

The Health Care Quality Improvement Act of 1986 does not provide immunity to actions commenced under state and federal civil rights statutes.<sup>94</sup> This is a matter of considerable importance because of the racial, sexual, and national pluralism of the average hospital's medical staff.<sup>95</sup>

#### 1. Title VII

Title VII of the Civil Rights Act of 1964 makes it unlawful for an employer, as defined under the Act, to discriminate against any individual in employment because of the individual's race, color, religion, sex, or national origin.<sup>96</sup> In most hospitals the physicians

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was not met. The Department of Health and Human Services issued a Notice of Proposed Rulemaking disclosing the reporting rules which will apply when the National Data Bank is funded and operational. 53 Fed. Reg. Vol. 53, 9267 (1988).

90. 42 U.S.C. § 11133 (1982).

91. 42 U.S.C. § 11131 (1982).

92. 42 U.S.C. § 11135 (1982).

93. See Bierig, *Peer Review After Patrick*, 21 Health and Hospital Law (1988).

94. The Act states that the limitation on damages for professional review "shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. § 2000e et seq. and the Civil Rights Acts, 42 U.S.C. 1981 et seq." 42 U.S.C. § 11111(a)(1) (1982).

95. The courts read the civil rights statutes in a most inclusive manner. See, e.g., *St. Francis College v. Al-Khazraji*, 107 S. Ct. 2022 (1987); *Shaare Tefila Congregation v. John William Cobb*, 107 S. Ct. 2019 (1987).

96. Title VII provides in part:

(a) It shall be an unlawful employment practice for an employer—

(1) to fail or refuse to hire or to discharge any individual, or otherwise to

on the active medical staff are not hospital employees. They are independent contractors.<sup>97</sup> As a result, attempts to challenge the medical staff credentials decisions of private hospitals under Title VII were, until recently, dismissed due to the lack of an employment relationship between the physician and the hospital.<sup>98</sup> Recently, however, hospitals have been held accountable under Title VII even though the plaintiff was not an employee of the hospital.<sup>99</sup>

In *Doe v. St. Joseph's Hospital of Fort Wayne*,<sup>100</sup> the United States Court of Appeals for the Seventh Circuit held that a physician who was not an employee of the hospital which revoked her staff privileges was not precluded from maintaining a claim under Title VII.<sup>101</sup> The physician sued St. Joseph's Hospital, its corporate owner, its board of directors, its administrator, the president of its medical staff, and the members of the executive committee of the medical staff. She alleged that the defendants terminated her medical staff privileges because she was Korean.<sup>102</sup>

The District Court dismissed the action sua sponte.<sup>103</sup> On appeal, the Court of Appeals affirmed in part, and reversed and remanded in part.<sup>104</sup> The court held that Dr. Doe should have been allowed to show that the defendants discriminatorily interfered with her employment opportunities with those prospective patients who were her ultimate "employers."<sup>105</sup> The pivotal issue in the case was hospital influence and control over access to the supply of patients who might form "employment relationships"<sup>106</sup> with a

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discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin.

42 U.S.C. § 2000e-2(a)(1) (1982).

97. *Beverly v. Douglas*, 591 F. Supp. 1321 (S.D.N.Y. 1984).

98. *Id.* at 1328.

99. *Pardazi v. Cullman Medical Center*, 838 F.2d 1155 (11th Cir. 1988); *Doe v. St. Joseph's Hosp. of Fort Wayne*, 788 F.2d 411 (7th Cir. 1986).

100. 788 F.2d 411, 425 (7th Cir. 1986).

101. *Id.* at 425.

102. *Id.* at 413-14.

103. *Id.* at 414.

104. *Id.* at 426.

105. *Id.* at 425.

106. Judge Ripple, in his dissent, analyzed the relationship afforded to Dr. Doe by her staff privileges at St. Joseph and found that the hospital did not control her access to patients to such a degree as to prevent or preclude her from maintaining or establishing physician/patient relationships. *Id.* at 428 (Ripple, J., dissenting). Judge Ripple observed:

Dr. Doe has not established the connection between herself and the hospital necessary to state a claim under Title VII—an employment relationship with which there has been interference. Physicians with "staff privileges" such as Dr. Doe are independent contractors. Moreover, physicians are not considered

physician.

Other courts have followed the lead of the Seventh Circuit in allowing physicians, who are not hospital employees, to bring Title VII actions for adverse medical staff credentials decisions.<sup>107</sup> The decision in *Doe* was followed by the the decision of Court of Appeals for the Eleventh Circuit in *Pardazi v. Cullman Medical Center*.<sup>108</sup> In that case, Dr. Pardazi, an Iranian-educated physician, brought a Title VII action against the hospital alleging discrimination based on national origin.<sup>109</sup> The District Court granted the defendant's motion for summary judgment. The Court of Appeals accepted the District Court's finding that Pardazi was not an employee of the hospital.<sup>110</sup> It recognized, however, that Pardazi had entered into an employment contract with another physician which was contingent upon his being granted staff privileges at the defendant hospital. The court reasoned that if Dr. Pardazi could prove that the hospital's discrimination against him interfered with his employment opportunity with the other physician (who was incorporated as a professional corporation), then Title VII would encompass the claim.<sup>111</sup>

The *Pardazi* decisions seems to indicate that the relationship between a physician and his patient is that of an independent contractor.<sup>112</sup> Nevertheless, it was sufficient that Pardazi had an employment relationship with another professional corporation and that the hospital's actions interfered with that relationship.<sup>113</sup>

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to have an employment relationship with their patients. Rather, it is a client/professional relationship — much like that between an attorney and his client. . . .

*Id.*

107. *Pardazi v. Cullman Medical Center*, 838 F.2d 1155 (11th Cir. 1988); *Mousavi v. Beebe Hospital*, 45 Fair Empl. Prac. Cas. (BNA) 746 (D. Del. 1987).

108. 838 F.2d 1155 (11th Cir. 1988).

109. *Id.* at 1156.

110. *Id.* The court, in analyzing the business relationship between Pardazi and the hospital, applied the eleven-factor test for independent contractor status as set forth in *Spirides v. Reinhardt*, 613 F.2d 826, 832 (D.C. Cir. 1979). *See supra* note 2.

111. *Pardazi*, F.2d at 1156.

112. *Id.* at 1157 n.1.

113. *Cf. Gomez v. Alexian Bros. Hosp. of San Jose*, 698 F.2d 1019 (9th Cir. 1983). In *Gomez*, the plaintiff was a Hispanic physician who practiced medicine as a professional corporation under the name American Emergency Services Professional Corporation Medical Group ("AES"). In 1978, AES submitted a bid to run the defendant's emergency room. *Id.* at 1020. The plaintiff was to act as director of the emergency room, and five of the twelve participating physicians were to be Hispanic. The hospital rejected the bid. *Id.* The court found that Dr. Gomez stated a cause of action under Title VII because he alleged that the hospital's refusal, purportedly on racial grounds, "denied him the opportunity to be employed by AES as director of defendant's emergency room." *Id.* at 1021.

Other courts have followed this position by allowing physicians to bring Title VII challenges to medical staff credentials committee decisions.<sup>114</sup> Thus, the courts apparently will confer standing on a Title VII plaintiff, even when there is no employer/employee relationship, when the circumstances demonstrate a "highly visible nexus" between the defendant hospital and the plaintiff's employment relationships with third parties.<sup>115</sup>

The Title VII cases such as *Doe* and *Pardazi* exemplify the willingness of the federal courts to assert aggressively their authority over medical staff peer review decisions. Such judicial innovation is not likely to be confined to Title VII of the Civil Rights Act. Federal judicial review of hospital decisions also is likely to occur in the enforcement of Title VI of the Act.

## 2. Title VI

Title VI is spending power legislation. It rests on the principle that taxpayers' money, which is collected without discrimination, shall be spent without discrimination.<sup>116</sup> Title VI has been described as a typical contractual spending power provision which extends an option to potential recipients to accept or reject federal monies depending on whether they are willing to end discrimination.<sup>117</sup> Recent developments, such the enactment of the Civil Rights Restoration Act of 1987,<sup>118</sup> suggest that the scope of Title VI will be expanded greatly and that litigation pursuant to that Title probably will increase.

In the past, Title VI was of limited utility to disappointed physicians seeking medical staff privileges. Courts consistently held that in order to bring a private action under Title VI, the plaintiff must be the intended beneficiary of, an applicant for, or a participant in

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114. In *Mousavi v. Beebe Hospital*, 45 Fair Empl. Prac. Cas. (BNA) 746 (D. Del. 1987), the plaintiff brought a sex discrimination case against a private community hospital after she was denied the opportunity of providing neurology services to the hospital's patients. Following a trial on the merits, the case was dismissed. Nevertheless, the court found from the evidence that Dr. Mousavi had standing to bring the Title VII action.

The Court considered a number of factors, including the financial incentives that the hospital provided to the successful candidate for the neurology position and the limited employment opportunities within the community. The court concluded that the hospital had a "highly visible nexus" with the creation and continuation of employment relationships. This case is now pending on appeal in the United States Court of Appeals for the Third Circuit.

115. *Sibley Memorial Hosp. v. Wilson*, 488 F.2d 1338 (D.C. Cir. 1973).

116. *United States v. Alabama*, 828 F.2d 1532 (11th Cir. 1987).

117. *Id.* at 1547 (citing *Guardians Ass'n v. Civil Service Comm'n of City of New York*, 463 U.S. 582, 599 (1983)).

118. P.L. 100-259.

a federally funded program.<sup>119</sup> Physicians failed in attempts to invoke Title VI when their relationship to the hospital's federal funding was indirect. For example, in *Vuciecevic v. MacNeil Memorial Hospital*,<sup>120</sup> the plaintiff physician asserted that the receipt of Medicare and Medicaid funding subjected the hospital to Title VI. In *Doe v. St. Joseph's Hospital*,<sup>121</sup> the plaintiff alleged that the hospital received federal funds under various federal programs, including the Hill-Burton Act,<sup>122</sup> which provided money for the construction of medical facilities. In both cases the Title VI claim was dismissed.<sup>123</sup>

The same outcome may not be accomplished under present law. In the spring of 1988, Congress enacted the Civil Rights Restoration Act (the "CRRRA")<sup>124</sup> which may have serious repercussions in the area of hospital law. Under the Civil Rights Restoration Act, federal civil rights authority governs all of the operations of an enterprise which receives federal financial assistance.<sup>125</sup> Consequently, an applicant for medical staff privileges at a private hospital that receives federal funding apparently would have standing to

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119. *Doe v. St. Joseph's Hosp.*, 788 F.2d 411, 418 (7th Cir. 1986).

120. 572 F. Supp. 1424 (N.D. Ill. 1983).

121. 788 F.2d 411 (7th Cir. 1986).

122. 42 U.S.C. § 291 (1982).

123. The authorities in *Doe* followed or anticipated the Supreme Court decision in *Grove City College v. Bell*, 465 U.S. 555 (1984). The *Grove City College* decision serves as the leading case on the program specific nature of Title VI. The students at Grove City College received monies from federally funded student assistance programs. *Id.* at 559. This funding was claimed by the Department of Education to be sufficient to subject the entire college to the operation of Title IX of the Education Amendments of 1972 (a statute directly modeled after Title VI). The Supreme Court rejected that contention and ruled that only the specific program within the college receiving the federal assistance could be subjected to the statute. *Id.* at 575.

124. P.L. 100-259. In February of 1988, over President Reagan's veto, the Congress overrode the rule in *Grove City College*. In enacting the Civil Rights Restoration Act, Congress found that, in its view, the Supreme Court had "unduly narrowed" the application of Title VI and several other civil rights statutes. Congress then redefined "program or activity" as used in these statutes, thereby rejecting the Supreme Court's decision in *Grove City College*.

125. P.L. 100-259 states in relevant part:

(1) certain aspects of recent decisions and opinions of the Supreme Court have unduly narrowed or cast doubt upon the broad application of title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and title VI of the Civil Rights Act of 1964; and

(2) legislative action is necessary to restore the prior consistent and long-standing executive branch interpretation and broad, institution-wide application of those laws as previously administered.

*Id.*

bring a Title VI action for racial discrimination.<sup>126</sup> The CRRA redefines "program or activity" to mean all of the operations of an entity any part of which is extended federal financial assistance.<sup>127</sup>

Thus, the established hospital defense — that the plaintiff physician is not a beneficiary, applicant for, or a participant in, a federally funded program — has been foreclosed. Accordingly, staff privilege cases brought under Title VI of the Civil Rights Act should increase dramatically.<sup>128</sup>

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126. The operative section of Title VI provides:

No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination *under any program or activity* receiving Federal financial assistance.

42 U.S.C. § 2000d (1982) (emphasis added).

127. Section 6 of Title VI of the Civil Rights Act of 1964 was amended as follows:

Sec. 606. For the purposes of this title, the term 'program or activity' and the term 'program' mean all of the operations of — (1)(A) a department, agency, special purpose district, or other instrumentality of a State or of a local government; or

(B) the entity of such State or local government that distributes such assistance and each such department or agency (and each other State or local government entity) to which the assistance is extended, the case of assistance to a State or local government; (2)(A) a college, university, or other postsecondary institution, or a public system of higher education; or

(B) a local educational agency (as defined in section 198(a)(10) of the Elementary and Secondary Education Act of 1965), system of vocational education, or other school system; (3)(A) an entire corporation, partnership, or other private organization, or an entire sole proprietorship—

(i) if assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole; or

(ii) which is principally engaged in the business of providing education, health care, housing, social services, or parks and recreation; or

(B) the entire plant or other comparable, geographically separate facility to which Federal financial assistance is extended, in the case of any other corporation, partnership, private organization, or sole proprietorship; or (4) any other entity which is established by two or more of the entities described in paragraph (1), (2), or (3);

any part of which is extended Federal financial assistance. 42 U.S.C. § 2000(d) (1982).

128. The Civil Rights Restoration Act, at least in part, abrogates the doctrine of judicial deference toward the decisions of private actors. This may raise constitutional issues which far exceed the scope of this Article.

The policy of judicial deference, however, was extended to the actions of private decision-makers even where those decisions were wrongful or discriminatory. See *Aasum v. Good Samaritan Hosp.*, 542 F.2d 792, 794 (9th Cir. 1976). "Private conduct" was not proscribed; it was only "public conduct," that is, conduct under the color of state or federal law that was proscribed. For example, a claim for relief under Section 1983 of the Civil Rights Act must be based on the state's "affirmative support" of the private conduct challenged. *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974); *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972); *Cannon v. University of Chicago*, 559 F.2d 1063 (7th Cir. 1976); *Cohen v. Ill. Inst. of Technology*, 524 F.2d 818 (7th Cir. 1975).

## IV. PEER REVIEW IN FEDERAL COURT

The federal courts appear to be going against the tide by subjecting the peer review decisions of private hospitals to judicial review.<sup>129</sup> State legislatures have recognized the public benefit of candid medical peer review.<sup>130</sup> A majority of the state courts have rejected the concept of the private hospital as a fiduciary or public trust.<sup>131</sup> Finally, Congress specifically chose to insulate medical peer review activities from the threat of disruptive judicial review.<sup>132</sup>

In *Patrick v. Burget*, the United States Supreme Court adopted a contrary public policy; a policy of judicial review of the merits of private peer review decisions.<sup>133</sup> The Court acknowledged some continuing application of the antitrust laws to medical staff affairs,<sup>134</sup> and it rejected the customary state law framework for private peer review as it existed in Oregon and similar jurisdictions.<sup>135</sup> If the Court intends to expand this policy of judicial intervention, it has many opportunities to do so. For example, federal antitrust litigation and civil rights litigation over medical staff credentials decisions provides such an opportunity.

The recognition of federal jurisdiction over private hospital peer review decisions will entail pretrial discovery in any such lawsuits.<sup>136</sup> Discovery will subject defendant hospitals to considerable expense, both in time and money.<sup>137</sup> Further, pretrial discovery, in

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129. See *supra* note 22.

130. Statutory immunity from liability, in varying degrees, has been extended to persons participating in the quality review of health care organizations in forty nine states and the District of Columbia. Iowa has not yet adopted such a statute. For a state-by-state analysis, see *Hospital Law Manual*, Aspen Systems Corporation, Medical Staff, State-by-State Analysis.

131. See *supra* note 32 and accompanying text.

132. See *supra* notes 73-74 and accompanying text.

133. *Patrick*, 108 S. Ct. 1658 (1988). The Court reviewed the role of the Oregon courts in supervising the staffing decisions of private hospitals and found that the limited review available to disappointed physicians would not satisfy the supervision requirement of the "state action" doctrine. *Id.*

134. *Id.* at 1665. In this regard the *Patrick* Court held: "To the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny only if the State effectively has made this conduct its own. The State of Oregon has not done so." *Id.* at 1665-66.

135. *Id.*

136. In *Doe v. St. Joseph's Hosp. of Fort Wayne*, 788 F.2d 411 (7th Cir. 1986), the court refused to dismiss the plaintiffs' Title VII claim at the pleading stage. It concluded that the physician "should be allowed to make a showing that defendant has discriminatorily interfered with her employment opportunities. . . ." *Id.*

The plaintiffs also were allowed to proceed to the merits of their Title VII claims in *Pardazi v. Cullman Medical Center*, 838 F.2d 1155 (11th Cir. 1988) and *Mousavi v. Beebe Hosp.*, 45 Fair Empl. Prac. Cas. (BNA) 746 (D. Del. 1987).

137. The impact of pretrial discovery can be profound even for non-party witnesses.



and of itself, will have a deterrent effect on physician participation in peer review.<sup>138</sup>

## V. CONCLUSION

Mandated medical peer review and reportage is the order of the day. Active participation in peer review committee work is now an unavoidable duty in medical practice. Disappointed practitioners will continue to contest decisions which limit their clinical privileges by invoking the Sherman Antitrust Act as well as various Civil Rights Acts.

Physicians participating in peer review cannot escape expensive and time consuming litigation in the federal courts. Responsible hospitals, therefore, should contractually provide for the defense and indemnity of those members of the staff who serve in peer review activities. The costs of defending the hospital and its board from medical staff credentials litigation is simply a cost of doing business. Therefore, all of the participants, whether they are members of the governing body or members of the medical staff, should be afforded legal representation and indemnity.

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For example, two groups of Catholic bishops were held in civil contempt and subjected to a daily fine of \$100,000 for failing to produce subpoenaed church records concerning abortion-related lobbying. *U.S. Catholic Conference v. Abortion Rights Mobilization, Inc.*, 108 S. Ct. 2268. (1988).

The power to inquire can have a chilling effect on decision-makers. In *Bryan v. Koch*, 492 F. Supp. 212, 215-16 (S.D.N.Y. 1980), aff'd 627 F.2d 612 (2d Cir. 1980), the plaintiffs challenged the City of New York's decision to close a hospital serving a predominantly black community. They asserted that the closing violated Title VI of the Civil Rights Act as well as the fourteenth amendment. *Id.* at 216. The court rejected the argument, stating that 235: "Any disciplined analysis would reveal [HHS's] formula for what it really is—a vehicle by which HHS, and the other title VI agencies, may assert jurisdiction to review the merits of, and to require the justification for, virtually all important decisions by Federal fund recipients." The court noted that a Federal agency may not always find fault, "[b]ut the power to inquire, and to demand explanation, provides leverage that will inevitably delay or discourage many nondiscriminatory and essential decisions." *Id.* at 235.

138. Where state law does not supply the rule of decision as to a claim, the district court is not required to apply state law in determining questions of evidentiary privilege. *Memorial Hosp. for McHenry County v. Shadur*, 664 F.2d 1058, 1061 (7th Cir. 1981).