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## Denying Medical Staff Privileges Based on Economic Credentials

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DENYING MEDICAL STAFF PRIVILEGES BASED ON  
ECONOMIC CREDENTIALS

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I. INTRODUCTION

A hospital should be able to deny a competitor physician medical staff privileges. The hospital administration, governing body, and peer review committee are qualified to determine whether a physician should be denied medical staff privileges. These three entities are able to consider the qualifications of the physician, the need for additional medical staff at the facility, and whether another staff member is in the

hospital's best "business" interest. The hospital administration oversees the performance of the executive duties of a hospital.<sup>1</sup> A governing body is the term that the Joint Commission on Accreditation of Healthcare Organization [hereinafter "JCAHO"] uses to describe who exerts the ultimate control and represents ownership of the facility.<sup>2</sup> The peer review committee consists of physicians on the medical staff; it is an evaluation of a physician's performance by other physicians, usually within the same geographic region and medical specialty.<sup>3</sup>

Under Ohio Revised Code § 4731, a physician who is licensed may lawfully practice medicine, thus, the professional license is a legal prerequisite to practice medicine.<sup>4</sup> Physicians are unable to build a successful practice without the ability to exercise hospital staff privileges.<sup>5</sup> Likewise, physicians are extremely important to a hospital because without its medical staff, a hospital would not be able to care for its patients.<sup>6</sup> A physician without hospital staff privileges would find it difficult to compete with those physicians who have been granted privileges and can offer patients a wide variety of services.

Although a physician needs staff privileges in order to provide his services to patients, a hospital cannot permit all physicians access to hospital facilities. The hospital has a duty to review the credentials of all the physicians who desire staff privileges and to allow privileges only to those deemed competent.<sup>7</sup>

Health care costs are continuing to rise. This forces hospitals to consider the cost and efficiency of each physician when making privileging decisions. However, hospitals cannot deny a competitor physician staff privileges strictly based on economic factors.<sup>8</sup> If this is the only consideration that the hospital utilizes, a denial or restriction of privileges based solely on competitive considerations may expose the hospital to liability under federal antitrust as well as state tort claims.<sup>9</sup>

This Note will focus primarily on Ohio laws and statutes. A comparison with other jurisdictions also will be analyzed. This Note will illustrate the complexities and ambiguities that exist regarding how a physician and hospital are associated with each other. This Note attempts to accomplish the following: (1) discuss what medical staff credentialing entails, (2) discuss what constitutes economic

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<sup>1</sup>BLACK'S LAW DICTIONARY 44 (6th ed. 1990).

<sup>2</sup>Healthcare Credentialing Information Supersite, *Health Care Terms*, at <<http://www.credentialinfo.com/cred/glossary.cfm>> (stating the JCAHO's term for the board of directors, board of trustees, or the body that exerts ultimate control and represents ownership of the facility).

<sup>3</sup>*Id.* (stating peer review is the evaluation of a physician's performance by other physicians, usually within the same geographic and medical specialty).

<sup>4</sup>OHIO REV. CODE ANN. § 4731.341 (West 1998) (pertaining to doctors of medicine; § 4731.43 pertains to doctors of osteopathy).

<sup>5</sup>MARCIA J. POLLARD & GRACE J. WIGAL, *HOSPITAL STAFF PRIVILEGES WHAT EVERY HEALTH CARE PRACTITIONER AND LAWYER NEEDS TO KNOW* 118 (1996).

<sup>6</sup>SUSAN O. SCHEUTZOW, *OHIO HEALTH CARE PROVIDER LAW* 73 (1994).

<sup>7</sup>POLLARD, *supra* note 5, at 118.

<sup>8</sup>*Id.*

<sup>9</sup>*Id.* at 2.

credentialing, (3) analyze the current law regarding medical staff credentialing, (4) analyze the current law regarding economic credentialing, and (5) propose a solution to the current system regarding the vague “relationship” that exists between a physician and a hospital. This solution would encourage hospitals to manage their affairs similar to a business operation. There would be an employer/employee relationship between a hospital and all physicians with medical staff privileges. This Note will explain why a hospital should be able to deny a competitor physician medical staff privileges.

## II. DEFINING MEDICAL STAFF CREDENTIALING IN OHIO

### A. Ohio Hospitals

In order for a hospital to operate in Ohio, it must either be accredited by the JCAHO, the American Osteopathic Association [hereinafter “AOA”], or certified by Medicare.<sup>10</sup> The JCAHO and AOA each require a hospital, that seeks accreditation, to have a single organized medical staff.<sup>11</sup> A hospital seeking certification from Medicare, a federal payment program, must also have an organized medical staff.<sup>12</sup> The JCAHO and AOA have detailed requirements as to what needs to be included in the medical staff bylaws.<sup>13</sup>

The Ohio Revised Code provides that each hospital must have a mechanism for determining who may obtain medical staff privileges.<sup>14</sup> This is the only statutory provision that Ohio has regarding who is eligible for medical staff privileges. Therefore, each hospital individually determines the mechanisms that it will employ regarding medical staff privileges. The statute requires the governing body of every hospital to set standards and procedures in considering applications for staff membership and staff privileges.<sup>15</sup> For example, the governing body of a hospital must consider the applicant’s respective state licensure in considering a physician for its staff.<sup>16</sup>

### B. Medical Staff Bylaws

Medical staff bylaws are legal documents that hospitals use as a means of governance for the facility.<sup>17</sup> Although the medical staff drafts policies and procedures, the governing body assumes legal responsibility for the hospital and thus is ultimately responsible for approving bylaws, policies, and procedures.<sup>18</sup> The

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<sup>10</sup>SCHEUTZOW, *supra* note 6, at 73-74.

<sup>11</sup>*Id.* at 73 n.4.

<sup>12</sup>42 C.F.R. § 482.22 (1999).

<sup>13</sup>*Id.*

<sup>14</sup>OHIO REV. CODE ANN. § 3701.351(A)-(B) (West 1999).

<sup>15</sup>*Id.*

<sup>16</sup>*Id.*

<sup>17</sup>Healthcare Credentialing Information Supersite, *supra* note 2.

<sup>18</sup>*Id.*

bylaws create a framework within which the medical staff can act with a degree of freedom in order to accomplish their tasks.<sup>19</sup>

A description of the medical staff's organization is found in the hospital bylaws. Each hospital has its own set of bylaws that the medical staff must follow. The JCAHO provides in part that the hospital bylaws must define the method of selecting officers for medical staff membership; the qualifications and responsibilities of officers; the conditions and mechanisms for removing officers from their positions; the requirements for frequency of meetings and for attendance; and a mechanism to provide for effective communication among the medical staff, hospital administration, and governing body.<sup>20</sup>

### C. Medical Staff Membership

The medical staff is a group of physicians and other health care professionals permitted by state law and a hospital to function as a group and manage different aspects of the hospital's business.<sup>21</sup> The medical staff is one of the three components of hospital governance, along with the governing body, and the hospital administration. One responsibility of the medical staff under the hospital bylaws is to review applications for medical staff membership and privileges.<sup>22</sup> The medical staff then makes its recommendations regarding the applicants to the governing body that makes the final determinations.<sup>23</sup>

The medical staff is self-governing and is responsible for the for the quality of the professional services provided by individuals with clinical privileges.<sup>24</sup> Physicians at the hospital who have obtained medical staff privileges must adhere to the medical bylaws, rules and regulations, and policies that are implemented as part of the medical staff's performance-improvement activities.<sup>25</sup>

### D. Hospital Credentialing

The medical staff is largely responsible for the credentialing process. Physician credentialing is the process of gathering relevant data regarding a physician's qualifications for membership to a particular medical staff.<sup>26</sup> This data will serve as

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<sup>19</sup>JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., 1996 ACCREDITATION MANUAL FOR HOSPITALS, VOL. 1, STANDARDS (photo reprint 2000) [hereinafter "JOINT COMM'N"].

<sup>20</sup>*Id.*

<sup>21</sup>Healthcare Credentialing Information Supersite, *supra* note 2 (defining medical staff-the semi-autonomous group of physicians, other licensed independent practitioners, and other such health care professionals permitted by state law and a hospital to take responsibility as a group for specified aspects of hospital operation).

<sup>22</sup>SCHEUTZOW, *supra* note 6, at 73-74.

<sup>23</sup>Healthcare Credentialing Information Supersite, *supra* note 2.

<sup>24</sup>See JOINT COMM'N, *supra* note 19, at 24.

<sup>25</sup>*Id.*

<sup>26</sup>American College of Emergency Physicians, *Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine*, available at <<http://www.acep.org/2,6350.html>>.

a factor in determining whether a physician is granted or denied staff privileges.<sup>27</sup> The specific data that is evaluated is at the discretion of the institution. Credentialing is usually a two-pronged process, which involves establishing requirements and evaluating individual qualifications for entry into medical staff membership.<sup>28</sup> First, credentialing involves considering and establishing the professional training, experience, and other requirements for medical staff membership.<sup>29</sup> Second, credentialing involves obtaining and evaluating evidence of the qualifications of individual applicants.<sup>30</sup>

A hospital has specific mechanisms which it utilizes when deciding whether to deny or grant a physician medical staff privileges. Based on medical staff recommendations and the hospital bylaws, the governing body has the final decision in staff privilege decisions.<sup>31</sup> If a physician has been denied staff privileges and feels that the decision was made in a discriminatory manner or was an adverse decision he is entitled to a fair hearing and an appeal process.<sup>32</sup> Decisions to deny a physician medical staff privileges must consider criteria that is directly related to the quality of patient care.<sup>33</sup>

A physician who desires membership at a hospital fills out an application for the medical staff; the physician is then given a written copy of the hospital bylaws, rules and regulations, and policies.<sup>34</sup> The applicant then signs an agreement, if granted medical staff privileges, the physician will be bound to the bylaws, rules and regulations, and policies.<sup>35</sup> In the hospital bylaws, there is a section that indicates the criteria that the medical staff and hospital board will evaluate.<sup>36</sup> The hospital then verifies this information from the primary sources.<sup>37</sup>

The credentialing process includes information regarding a suspended or pending suspension of the applicant's license.<sup>38</sup> It also inquires as to whether the applicant was denied or had privileges revoked at another organization.<sup>39</sup> Applicants consent

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<sup>27</sup>*Id.*

<sup>28</sup>Healthcare Credentialing Information Supersite, *supra* note 2.

<sup>29</sup>*Id.* (stating that credentialing involves considering and establishing the professional training, experience, and other requirements for medical staff membership).

<sup>30</sup>*Id.* (stating that credentialing involves obtaining and evaluating evidence of the qualifications of individual applicants).

<sup>31</sup>OHIO REV. CODE ANN. § 3701.351(B) (1999).

<sup>32</sup>*See infra* Section IV.B.

<sup>33</sup>POLLARD, *supra* note 5, at 9.

<sup>34</sup>*See* JOINT COMM'N, *supra* note 19, at 29.

<sup>35</sup>*Id.*

<sup>36</sup>*Id.*

<sup>37</sup>*Id.*

<sup>38</sup>*Id.* at 30.

<sup>39</sup>*See* JOINT COMM'N, *supra* note 19, at 31.

to the hospital verifying any of the information that they have disclosed.<sup>40</sup> The credentialing is made for a period of not more than two years.<sup>41</sup>

The applicant applies for privileges for which he has documented experience in performing.<sup>42</sup> Clinical privileging determines the minimum training and experience necessary for a clinician to competently carry out a particular procedure.<sup>43</sup> It also entails whether the credentials of the applicant meet the requirements of the hospital and its bylaws.<sup>44</sup> Finally, privileging allows authorization to carry out the procedures that a physician has requested.<sup>45</sup> According to JCAHO's 1998 Comprehensive Accreditation Manual for Hospitals, each hospital should have professional criteria as the basis for granting initial or reviewed/revised clinical privileges.<sup>46</sup> These criteria must pertain to, at the very least, evidence of current license, relevant training and/or experience, current competency, and health status.<sup>47</sup>

### III. ECONOMIC CREDENTIALING

#### A. Defined

Economic credentialing is a term used when a hospital makes a decision regarding an individual for medical staff membership based upon the impact that a physician has economically on the hospital.<sup>48</sup> The term is aimed at making a physician aware of how he is using the hospital's resources.<sup>49</sup> For example, assume that Dr. X has one hundred patients for whom his diagnostic tests and treatment costs are \$2000. Assume Dr. Y also has one hundred patients and that Dr. Y's prescribed diagnostic tests and treatment costs are \$3000. Dr. X has a cost ratio of twenty to one. Dr. Y has a cost ratio of thirty to one. In certain managed-care plans such as Health Maintenance Organizations [hereinafter "HMOs"] with prepaid premiums,

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<sup>40</sup>*Id.*

<sup>41</sup>*Id.*

<sup>42</sup>*Id.* at 33.

<sup>43</sup>Healthcare Credentialing Information Supersite, *supra* note 2.

<sup>44</sup>*Id.*

<sup>45</sup>*Id.* (stating that privileging is the three-pronged process of determining which diagnostic and treatment procedures a hospital is equipped and staffed to support, the minimum training and experience necessary for a clinician to competently carry out each procedure, and whether the credentials of applicants meet requirements and allow authorization to carry out requested procedures).

<sup>46</sup>Healthcare Credentialing Information Supersite, *Approach Our Credentialing*, at <<http://www.credentialinfo.com/cred/fundamentals/credapproach.cfm>> (stating, that according to the JCAHO's 1998 Comprehensive Accreditation Manual for Hospitals, each hospital should have professional criteria as the basis for granting initial or renewed/revised clinical privileges; these criteria pertain to, at the very least, evidence of current licensure, relevant training and/or experience, current competency, and health status).

<sup>47</sup>*Id.*

<sup>48</sup>POLLARD, *supra* note 5, at 117.

<sup>49</sup>*Id.*

Dr. X has preferable “economic credentials” as compared with Dr. Y. In order for the managed care company to make a profit, it would be prudent to have Dr. X on staff as opposed to Dr. Y.<sup>50</sup> This data is kept and used to grant membership to physicians in hospitals, HMOs, or Independent Practice Associations [hereinafter “IPAs”].<sup>51</sup>

When a hospital’s economic considerations are related to the quality of patient care or physician competency, they are not viewed as “pure” economic considerations.<sup>52</sup> For example, a physician’s economic credentials can be compared with other physicians’ economic credentials within the same hospital and other physicians caring for patients within the same specialty. Quality of care is implicated when the physician’s patients’ length of stay in the hospital for a particular diagnosis is compared to the hospital average.<sup>53</sup> Quality of care is also implicated where the hospital compares the individual physician’s charges with the hospital average in the same Diagnosis-Related Group [hereinafter “DRG”], and analyzes the physician’s hospital utilization rate.<sup>54</sup> Some hospitals have begun to use such economic criteria in reviewing physician activity and making their privilege decisions,<sup>55</sup> and courts have upheld such criteria as valid.<sup>56</sup>

### B. Prospective Payment System

In today’s increasingly competitive medical market, hospitals may legitimately choose to limit the number of physicians with staff privileges for economic reasons.<sup>57</sup> Legitimate reasons include administrative and quality control costs, as well as the need to establish and maintain the hospitals reputation as a quality provider.<sup>58</sup> Hospitals generally operate under a system of prospective reimbursement from payors such as Medicare and Medicaid, therefore, a physician’s ability to control costs is critical. One commentator has stated that between seventy to ninety percent

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<sup>50</sup>Robert Weinmann, *Medical Red-lining: Economic Credentials For Physicians*, S.F. EXAMINER, Jan. 12, 1996, at A19.

<sup>51</sup>*Id.*

<sup>52</sup>POLLARD, *supra* note 5, at 8.

<sup>53</sup>*Id.*

<sup>54</sup>*Id.* at 105.

<sup>55</sup>Anita J. Slomski, *Hospitals Wield a Heavy Club Against High-Cost Doctors*, MED. ECON., Oct. 7, 1991, at 57.

<sup>56</sup>*See, e.g.,* Maltz v. New York Univ. Med. Ctr., 503 N.Y.S.2d 570 (1986) (holding that the hospital is entitled to deny applications for privileges based on hospital bed limitation and adequate staffing in physician’s area of specialization); Saint Louis v. Baystate Med. Ctr., Inc., 568 N.E.2d 1181 (Mass. App. Ct. 1991) (holding that utilization of the hospital can be considered in making privilege decisions).

<sup>57</sup>Deborah Casey, *Austin v. McNamara and the Health Care Quality Improvement Act: From Speculation to Implementation*, 14 AM. J. TRIAL ADVOC. 389 (1990) (discussing of the importance of hospital reputation in the marketplace).

<sup>58</sup>*Id.*



of health care expenditures are within the control of physicians.<sup>59</sup> Because of this, hospitals are forced to consider a physician's economic impact on the hospital.

Under a prospective payment system, a hospital is paid a fixed amount per patient based on the patient's diagnosis, regardless of actual treatment costs.<sup>60</sup> The system is based on DRGs, which are used to establish a schedule of fixed treatment costs.<sup>61</sup> Thus, the DRG schedule limits the amount that the hospital may bill Medicare for each diagnosed patient illness.

The DRG reimbursement system is "prospective" because the cost of treatment is determined before, rather than after treatment.<sup>62</sup> This reimbursement scheme creates a "risk-based incentive for hospitals to economize."<sup>63</sup> Thus, the only way a hospital can substantially increase its operating revenue is to monitor the amount of tests and treatment costs that physicians incur.

Under the prospective payment system a physician may "cost" the hospital a substantial amount of money. For example, consider a patient admitted to the hospital with a diagnosis of a myocardial infarction. The hospital has agreed to accept a certain amount of money for the diagnosis. If the average length of stay without any complications for this diagnosis is three days and the patient remains in the hospital for one week the hospital will be unable to generate revenue. The same is true of the physician who orders excessive amounts of tests while the patient is hospitalized. Therefore, a hospital can successfully increase its operating revenue by examining a physician's economic credentials.

### C. Hospital Bylaws

If a hospital decides to examine economic criteria in determining whether to grant or deny a physician staff privileges, it must state in its bylaws how the economic criteria will be examined or utilized.<sup>64</sup> For example, attorney Jack Schroder, Jr. advises hospitals to include a bylaw that notifies physicians that they must:

[w]ork cooperatively with the quality assurance committee, the utilization review committee, the executive committee and administration to meet and practice within the guidelines established by the hospital, its medical

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<sup>59</sup>Katherine Besech, *Hot Topics in Medical Staff Credentialing: Economic Credentialing and HIV-Affected Practitioners*, 42 HEALTH 128 (1993).

<sup>60</sup>The federal government adopted a prospective payment system for Medicare hospital patients in 1983. See 42 U.S.C. § 1395 ww(d) (1988).

<sup>61</sup>Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 436 (1988). The system is based on DRGs, which are used to establish a schedule of fixed treatment costs. *Id.* The DRG schedule caps the costs that hospitals may bill Medicare for each diagnosed patient illness. *Id.* The DRG reimbursement system is "prospective" because the cost of treatment is determined before, rather than after treatment. *Id.* Obviously, this reimbursement scheme creates a "risk-based incentive for hospitals to economize." *Id.*

<sup>62</sup>Hall, *supra* note 61, at 436.

<sup>63</sup>*Id.*

<sup>64</sup>Jack Schroder, Jr., *Critical Revisions in Medical Staff Bylaws*, American Bar Assoc. Forum on Health Law Presentation (Spring 1994).

staff or the local Professional Review Organization, to minimize or eliminate disallowed admissions, to eliminate technical diagnosis entry and coding errors, to order or utilize supporting ancillary services only when necessary, and to shorten length of stay at the hospital where medically appropriate.<sup>65</sup>

Schroder states that this criteria should be included in the hospital bylaws because the bylaws use objective language.<sup>66</sup> The objective language of the bylaws assures that all physicians are reviewed objectively by the hospital.<sup>67</sup> Furthermore, because the criteria examined under the bylaws address quality of care concerns as well as economic issues, the bylaw requirement cannot be viewed as a “pure” economic consideration.<sup>68</sup>

#### IV. MEDICAL STAFF CREDENTIALING AND THE LAW

##### A. Discretion by the Courts

The courts have consistently stated that the main purpose of a hospital is to serve the public.<sup>69</sup> Courts have confirmed that a hospital, in making staff decisions, must consider the needs of the patients.<sup>70</sup> Hospital powers must be exercised reasonably for the public good and must genuinely serve public health objectives.<sup>71</sup> The hospital board is given broad discretionary powers in managing their affairs, including the selection of medical staff.<sup>72</sup>

Each state, along with the federal regulations, has statutes regarding hospital staff and professional privileges. The Code of Federal Regulations states in part that a “hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.”<sup>73</sup> Under Ohio Revised Code § 3701.351, hospitals “shall set standards and procedures to be applied to the hospital and its medical staff in considering and acting upon applications for staff membership or professional

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<sup>65</sup>*Id.*

<sup>66</sup>*Id.*

<sup>67</sup>CAROLINE R. WILSON & ANNE M. DELLINGER, STAFF MEMBERSHIP AND CLINICAL PRIVILEGES IN HEALTH CARE FACILITIES LAW: CRITICAL ISSUES FOR HOSPITALS, HMOS, AND EXTENDED CARE FACILITIES 18 (1991) (stating that hospital administrators who amend the bylaws to include economic criteria as a valid factor for denying or terminating staff privileges should consider that the JCAHO standards support a hospital’s right to enforce its interest in efficiency by requiring physicians to abide by hospital bylaws, policies, and regulations; the states of Indiana and Colorado have enacted statutes that recognize the hospital’s interest in efficient operation).

<sup>68</sup>POLLARD, *supra* note 5, at 104.

<sup>69</sup>*Belmar v. Cipolla*, 475 A.2d 533 (N.J. 1984).

<sup>70</sup>*Desai v. Saint Barnabas Med. Ctr.*, 510 A.2d 662, 666 (N.J. 1986).

<sup>71</sup>*Id.* at 668.

<sup>72</sup>*Sokol v. Akron Gen. Med. Ctr.*, 173 F.3d 1026, 1032 (6th Cir. 1999).

<sup>73</sup>42 C.F.R. § 428.22.

privileges."<sup>74</sup> Courts do not interfere with a reasonable management decision concerning staff privileges as long as that decision strengthens the health care mission of the hospital.<sup>75</sup>

A hospital may deny a physician medical staff privileges, but must not violate Ohio Revised Code § 3701.351.<sup>76</sup> Under this Statute, hospitals are prohibited from adopting standards for staff membership or clinical privileges that are not reasonably related to accepted measures of skill, education, and competence.<sup>77</sup> Ohio Revised Code § 3701.351(B) prevents a hospital from discriminating against qualified persons who are certified to practice medicine, osteopathic medicine, podiatry, dentistry, or psychology.<sup>78</sup> In *Dooley v. Barbarton Citizens' Hospital*, the plaintiff prevailed when the hospital discriminated against him for being a podiatrist.<sup>79</sup> The court held that the qualifications placed on a podiatrist for staff privileges were not reasonably related to a determination of whether or not a podiatrist was qualified.<sup>80</sup> Thus, the court held that the hospital violated § 3701.351.<sup>81</sup>

In granting a physician staff privileges, the hospital must consider the need for and impact of additional doctors on the existing hospital's staff.<sup>82</sup> Hospitals must balance the interests of its management with those of a doctor who desires to practice at a particular hospital.<sup>83</sup> Hospital officials are properly vested with large measures of managing discretion, and to the extent that they exert their efforts towards the maintaining of hospital standards and higher medical care, they will receive broad judicial support.<sup>84</sup>

In *Sosa v. Board of Managers*, the physician alleged the hospital violated his constitutional rights by denying him medical staff privileges.<sup>85</sup> The Fifth Circuit held that although the physician satisfactorily met all of the requirements for staff privileges on paper, it was not unconstitutional for the hospital to deny him staff privileges.<sup>86</sup> The court also noted that the hospital board may choose to exact additional standards reasonably related to the operation of the hospital.<sup>87</sup>

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<sup>74</sup>OHIO REV. CODE ANN. § 3701.351(A) (West 1999).

<sup>75</sup>*Greisman v. Newcomb Hosp.*, 192 A.2d 817 (N.J. 1963).

<sup>76</sup>OHIO REV. CODE ANN. § 3701.351 (West 1999).

<sup>77</sup>*Dooley v. Barbarton Citizens' Hosp.*, 465 N.E.2d 58 (Ohio 1984).

<sup>78</sup>OHIO REV. CODE ANN. § 3701.351(B) (West 1999).

<sup>79</sup>465 N.E.2d at 61.

<sup>80</sup>*Id.* at 63.

<sup>81</sup>*Id.* at 58.

<sup>82</sup>*Belmar*, 475 A.2d at 538.

<sup>83</sup>*Id.* at 539.

<sup>84</sup>*Id.* at 538.

<sup>85</sup>*Sosa v. Bd. of Managers of the Val Verde Mem'l Hosp.*, 437 F.2d 173, 174 (5th Cir. 1971).

<sup>86</sup>*Id.* at 176.

<sup>87</sup>*Id.*

A refusal must be based on “any reasonable basis, such as professional or ethical qualifications of the physicians or the common good of the public and the Hospital...”<sup>88</sup> The hospital must be given great latitude in prescribing the necessary qualifications for potential applicants.<sup>89</sup> A hospital board is given broad discretion in screening applicants, but it must only refuse applicants for those matters which are reasonably related to the operation of the hospital.<sup>90</sup> Consequently, a hospital may deny a qualified applicant staff privileges and not fear legal proceedings.

### B. Due Process

The JCAHO can require a hospital to include certain provisions in its bylaws.<sup>91</sup> When a physician is denied medical staff privileges, the bylaws state that mechanisms exist, including a fair hearing and appeal process if the physician feels he has been adversely denied.<sup>92</sup> The Supreme Court of Ohio held that medical staff members must exhaust all administrative remedies provided in the hospital bylaws, policies, and rules or regulations prior to bringing an action to the court.<sup>93</sup> Generally, courts accept these proceedings and do not substitute their judgments for that of the hospital’s judgment regarding the denial of a physician’s staff privileges.<sup>94</sup>

### C. Antitrust

When a hospital denies a physician staff privileges, it may face an antitrust challenge, because a hospital’s acts are subject to scrutiny under Sections One and Two of the Sherman Antitrust Act.<sup>95</sup> If the hospital violates the Sherman Antitrust Act, it faces civil damages, injunctions, and a possibility of criminal action.<sup>96</sup>

Antitrust statutes were enacted to protect unfair competition.<sup>97</sup> Section One of the Sherman Antitrust Act prohibits “every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or foreign nations...” and declares such contracts to be illegal.<sup>98</sup> The four elements that must be satisfied in order for an antitrust violation to arise are: (1) a contract, combination, or a conspiracy; (2) a substantial impact on interstate

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<sup>88</sup>Foster v. Mobile County Hosp. Bd., 398 F.2d 227, 230 (5th Cir. 1968).

<sup>89</sup>*Id.*

<sup>90</sup>*Sosa*, 437 F.2d at 176-77.

<sup>91</sup>SCHEUTZOW, *supra* note 6, at 64.

<sup>92</sup>JOINT COMM’N, *supra* note 19, at 36.

<sup>93</sup>*Nemazee v. Mount Sinai Med. Ctr.*, 564 N.E.2d 477 (Ohio 1990).

<sup>94</sup>*Khan v. Suburban Cmty. Hosp.*, 340 N.E.2d 398 (Ohio 1976); *Klinge v. Lutheran Charities Ass’n*, 383 F. Supp. 287 (E.D. Mo. 1974); *Duffield v. Memorial Hosp. Ass’n*, 361 F. Supp. 398 (S.D. W. Va. 1973); *Dillard v. Rowland*, 520 S.W.2d 81 (Mo. Ct. App. 1974); *Mauer v. Highland Park Hosp. Found.*, 232 N.E.2d 776 (Ill. App. Ct. 1967).

<sup>95</sup>15 U.S.C §§ 1-2 (1999).

<sup>96</sup>§§ 1, 2, 4, 15(a), 26.

<sup>97</sup>*See* BLACK’S LAW DICTIONARY 36 (Pocket ed. 1996).

<sup>98</sup>15 U.S.C. § 1 (1999).

commerce; (3) an anticompetitive purpose or effect; and (4) an effect on relevant services and markets.<sup>99</sup>

### 1. A Contract, Combination, or Conspiracy

In satisfying element number one, courts need to determine if a contract was formed between the parties.<sup>100</sup> Whether a contract exists between a hospital and its physicians pertaining to the staff bylaws remains uncertain. Some states, such as Alabama and Indiana, hold that hospital bylaws constitute a legally binding contract because if the bylaws do not legally bind the physician and hospital, in essence, they are meaningless.<sup>101</sup>

In Ohio, the general rule that courts tend to follow is that the bylaws do not form a *per se* contract. In *Munoz v. Flowers*, the court stated that each set of bylaws should be examined to determine if the parties intended to form a contract.<sup>102</sup> In this case, the court held that the hospital never intended to be bound by its bylaws because the preamble stated that the bylaws were “subject to the ultimate authority of the applicable governing bodies.”<sup>103</sup>

Courts have not ruled definitively on whether a contract is formed between a physician and hospital regarding the bylaws. Hospitals can argue that the bylaws are not a legally binding entity. There is no consideration between the hospital and the physician therefore, no contract exists.<sup>104</sup> Consideration is a basic, necessary element for the existence of a valid contract that is legally binding on the parties.<sup>105</sup> It consists of some right or inducement by one party while the other party suffers a detriment or loss.<sup>106</sup> Courts are reluctant to find consideration between a physician and a hospital regarding the bylaws.<sup>107</sup>

Case law has held that a conspiracy does not usually exist between a hospital and the medical staff. The hospital’s governing body, hospital administration, and the medical staff (in the form of a peer review)<sup>108</sup> convene to determine acceptance or denial of medical staff privileges.<sup>109</sup>

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<sup>99</sup>*See e.g.*, *Bus. Elecs. Corp. v. Sharp Elecs. Corp.*, 485 U.S. 717 (1988) (holding that the phrase “restraint of trade” in the Sherman Act refers not to a particular list of agreements, but to a particular economic consequence that may be produced by quite different sorts of agreements in varying times and circumstances).

<sup>100</sup>15 U.S.C §§ 1-2 (1999).

<sup>101</sup>*Clemons v. Fairview Med. Ctr. Inc.*, 449 So. 2d 788 (Ala. 1984); *Terre Haute Reg’l Hosp. Inc. v. El-Issa*, 470 N.E.2d 1371 (Ind. Ct. App. 1984).

<sup>102</sup>*Munoz v. Flower Hosp.*, 507 N.E.2d 360, 364-65 (Ohio Ct. App. 1985).

<sup>103</sup>*Id.* at 365.

<sup>104</sup>*Natale v. Sisters of Mercy of Council Bluffs*, 52 N.W.2d 701 (Iowa 1952).

<sup>105</sup>BLACK’S LAW DICTIONARY 308 (6th ed. 1990).

<sup>106</sup>*Id.*

<sup>107</sup>*Leider v. Beth Israel Hosp. Ass’n*, 182 N.E.2d 393 (N.Y. 1963).

<sup>108</sup>*Swatch v. Treat*, 671 N.E.2d 1004, 1007 (Mass. App. Ct. 1996) (stating that peer review is a process intended to encourage the rigorous and candid evaluation of a physician’s professional performance by his peers); Josephine M. Hammack, *The Antitrust Laws and the Medical Peer Review Process*, 9 J. CONTEMP. HEALTH L. & POL’Y 419, 423 (1993) (noting that

A peer review committee can be attacked as not being an objective system to evaluate physicians. It may be argued that one must always consider the possibility of a conspiracy against a competing physician regarding obtaining medical staff privileges. The United States Supreme Court addressed this issue in *Copperweld Corp. v. Independence Tube Corp.*, holding that an intracorporate agreement cannot constitute a conspiracy.<sup>110</sup> Because a peer review decision is usually based on the medical staff's recommendation, and the decision is ultimately made by the hospital's governing body, intracorporate immunity would likely apply.<sup>111</sup> In other words, a hospital staff cannot be held liable for a conspiracy with the governing body within the meaning of Section One of the Sherman Antitrust Act.<sup>112</sup>

A conspiracy was not found in *Todorov v. DCH Healthcare*, where a physician was denied additional staff privileges at a hospital.<sup>113</sup> The facts of the case did not exclude the possibility that the hospital acted unilaterally and procompetitively.<sup>114</sup> The court stated that the hospital may act to foster competition and to serve its own economic interest without constituting a conspiracy.<sup>115</sup>

In *Willman v. Heartland Hospital East*, the Court goes as far as stating that even if a hospital can conspire with its medical staff—although it does not concede this point—revocation or denial of medical staff privileges does not violate antitrust laws.<sup>116</sup> Even if a court finds that a conspiracy has been found, a hospital can defend itself by showing that it acted for an independent reason. Promoting quality medical

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the physicians on the committee become peer evaluators for the hospital while remaining an individual provider of health care services for the hospital, maintaining direct and indirect competition with those individuals he will review); Jacqueline Oliverio, *Hospital Liability for Defamation of Character During the Peer Review Process: Sticks and Stones May Break My Bones, But Words May Cost Me*, 92 W. VA. L. REV. 739 (1990) (asserting that the peer review process is based on the theory of self-regulation in that hospital physicians are asked to review and evaluate the performance of their co-workers and to restrict or deny hospital privileges if necessary).

<sup>109</sup>*Johnson v. Hosp. Corp. of Am.*, 95 F.3d 383 (5th Cir. 1996). A conspiracy was not found in this Fifth Circuit case between a hospital and hospital administrator because the parties stood in an agency relationship. *Id.*

<sup>110</sup>*Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984); *Cooper v. Forsyth County Hosp. Auth. Inc.*, 479 U.S. 972 (1986) (recognizing that making a peer review recommendation does not prove the existence of a conspiracy); *Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696, 706 (4th Cir. 1991) (commenting that where a peer review procedure is used, a conspiracy is hard to prove if the review committee has no power to make the final decision).

<sup>111</sup>*See Copperweld Corp.*, 467 U.S. at 776 (holding that (1) officers or employees of the same firm do not provide the same plurality of actors imperative of Section One of the Sherman Act conspiracy, and (2) a corporation does not violate Section One of the Sherman Act by agreeing to pursue a course of action with a wholly-owned subsidiary).

<sup>112</sup>*Id.*

<sup>113</sup>*Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1456-57 (11th Cir. 1991).

<sup>114</sup>*Id.* at 1456.

<sup>115</sup>*Id.* at 1457.

<sup>116</sup>*Willman v. Heartland Hosp. East*, 514 U.S. 1018 (1995).

care is a defense that hospitals can use in order to justify the reason a physician was denied staff privileges.<sup>117</sup>

## 2. A Substantial Impact on Interstate Commerce

A physician must try to show that a substantial impact on interstate commerce has occurred in order to satisfy the second element of the Sherman Act.<sup>118</sup> Before 1991, physicians had a difficult time bringing cases into federal court because they could not show the nexus between being denied medical staff privileges and interstate commerce.<sup>119</sup> Federal courts often dismissed the action because physicians were unable to show that the conspiracy which excluded them significantly impacted interstate commerce. In *Summit Health, Ltd. v. Pinhas*, the Court rejected the hospital's claim that by denying a physician staff privileges there was no impact on interstate commerce.<sup>120</sup> This made it easier for physicians to meet the second element, which shows a substantial impact on interstate commerce and thus bring claims into the federal court system.

## 3. An Anticompetitive Purpose or Effect

Next, a physician needs to establish the anticompetitive purpose or effect of the hospital's conduct.<sup>121</sup> In other words, to prove injury actionable under the antitrust laws, the physician must show an injury to competition, not just to themselves as competitors.<sup>122</sup>

A successful antitrust plaintiff must prove both injury to himself and to competition in the market.<sup>123</sup> The Court in *Summit Health* stated that the purpose of a federal antitrust law is "[t]he essence of any § 1 violation is the illegal agreement itself, [so] the proper analysis focuses upon the potential harm that would ensue if the conspiracy were successful, not upon actual consequences."<sup>124</sup> A physician who is excluded from the market is measured not by a particularized evaluation of the physician's practice but by a general evaluation of the restraint's impact on other physicians practicing in the area and particular specialty.<sup>125</sup>

The United States Supreme Court has held that no anticompetitive purpose was found where a physician was denied staff privileges.<sup>126</sup> Although the hospital utilized exclusive contracts with its anesthesiologists, this was legal and did not foster an anticompetitive purpose among other anesthesiologists.<sup>127</sup> In *Jefferson*

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<sup>117</sup>*Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 640 (3d Cir. 1996).

<sup>118</sup>*Id.*

<sup>119</sup>POLLARD, *supra* note 5, at 105.

<sup>120</sup>500 U.S. 322 (1991).

<sup>121</sup>*Id.*

<sup>122</sup>*Richter Concrete Corp. v. Hilltop Concrete Corp.*, 691 F.2d 818, 823 (6th Cir. 1982).

<sup>123</sup>*Boczar v. Manatee Hosp. & Health Sys. Inc.*, 731 F. Supp. 1042, 1045 (M.D. Fl. 1990).

<sup>124</sup>500 U.S. at 322.

<sup>125</sup>*Id.* at 323.

<sup>126</sup>*Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984).

<sup>127</sup>*Id.* at 8.

*Parish Hospital District No. 2 v. Hyde*, the Supreme Court stated if the exclusive contract foreclosed so much of the market as to reasonably restrain competition, the contract would then be unlawful.<sup>128</sup> The Court discussed whether it was necessary to determine if the exclusive contract had an adverse effect on competition among anesthesiologists.<sup>129</sup> The Court denied this claim and reasoned that the exclusive contract simply shifted the focus of competition among anesthesiologists.<sup>130</sup>

#### 4. An Effect on Relevant Services and Markets

In order to satisfy the final element, a physician who was denied staff privileges from a competitor hospital must claim that the denial of staff privileges limits his ability to serve patients in the relevant market.<sup>131</sup>

Establishing a relevant market entails analyzing the geographic areas from which hospitals draw their patients.<sup>132</sup> This approach relies on patient inflow and outmigration statistics.<sup>133</sup> The patient inflow statistic measures the percentage of patients from outside a particular area who come to the hospital within the area.<sup>134</sup> The patient outmigration statistic measures the percentage of patients from a particular area that uses hospital services outside the area.<sup>135</sup> If both the inflow and the outmigration statistics are low, the particular geographic area is probably the relevant market.<sup>136</sup>

In *Robinson v. Magovun*,<sup>137</sup> a thoracic surgeon was denied staff privileges at Allegheny General Hospital. The Court held that the physician's denial of staff privileges was lawful because it was based on the hospital's plan for quality control and fair competition.<sup>138</sup> Dr. Robinson was a board-certified thoracic surgeon who was seeking hospital privileges.<sup>139</sup> In Pittsburgh there were six hospitals which provided open heart surgery services.<sup>140</sup> After being denied privileges, Dr. Robinson brought an antitrust violation against the hospital alleging violations of Sections One and Two of the Sherman Act.<sup>141</sup> The hospital reasoned that the denial of Dr.

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<sup>128</sup>*Id.*

<sup>129</sup>*Id.* at 3.

<sup>130</sup>*Id.* at 31.

<sup>131</sup>15 U.S.C §§ 1-2 (1999).

<sup>132</sup>Roger D. Blair & James M. Fesmire, *Antitrust Treatment of Hospital Mergers*, 2 U. FLA. J.L. & PUB. POL'Y 25, 49 (1988-89).

<sup>133</sup>*Id.*

<sup>134</sup>*See id.* at 45-50.

<sup>135</sup>*Id.* at 52.

<sup>136</sup>*Id.*

<sup>137</sup>688 F.2d 824 (3d Cir. 1982).

<sup>138</sup>*Id.* at 846.

<sup>139</sup>*Id.* at 827

<sup>140</sup>*Id.* at 828.

<sup>141</sup>*Id.* at 859.



Robinson's staff privileges was made after it had determined that its addition to its medical staff would be inconsistent with the hospital's institutional objectives.<sup>142</sup>

In conclusion, if a physician can prove all of the above four elements then the hospital may be liable for civil, as well as criminal penalties, when a hospital denies a physician staff privileges. A physician could show that his denial of staff privileges had an effect on interstate commerce. A physician can often easily prove that his denial had an effect on the relative market. Recent case law affirms all of these points.<sup>143</sup> Difficulty arises when the physician tries to prove a contract or a conspiracy. If this element can be shown the physician then has to prove the hospital had an anticompetitive purpose for denying staff privileges. A hospital's defense to denying a physician staff privileges is that it was promoting quality medical care.<sup>144</sup> Courts give broad discretion to a hospital board in managing their affairs, including the selection of medical staff.<sup>145</sup>

#### D. Essential Facility Doctrine

The essential facility doctrine is a relatively new theory that utilizes both the law of monopolization and the refusal to deal.<sup>146</sup> The theory began to be utilized in the 1980's when plaintiffs began invoking the doctrine as a supplement theory of antitrust law in two situations, monopolization and refusal to deal.<sup>147</sup>

First, the law of monopolization involves a competitor who desires to gain access or use some "essential" facility.<sup>148</sup> The claim is that competitor can not compete effectively or enter into the marketplace without access to the essential facility.<sup>149</sup>

Second, a refusal to deal involves a group of firms which produce or control a facility to which a competitor desires access.<sup>150</sup> The claim is that a group has refused

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<sup>142</sup>See *Robinson*, 688 F.2d at 826 (arguing that his exclusion from the medical staff restrained trade by restricting his ability to practice medicine). Plaintiff also claimed that the hospital had an unlawful purpose or an unreasonable anticompetitive effect, thus violating Section One of the Sherman Act. *Id.* at 828. The United States District Court for the Western District of Pennsylvania affirmed the trial court's ruling that Dr. Robinson failed to establish that the hospital and certain surgeons on the hospital's staff unreasonably restrained trade. *Id.* When evaluating Dr. Robinson's application for staff privileges, the hospital noted his ability to provide continuous care to patients, his ability to contribute to the cardiothoracic residency program, and to work in harmony with fellow surgeons. *Id.* at 829. The Court ruled that these criteria were reasonably related to the hospital's legitimate institutional objectives. *Id.*

<sup>143</sup>See *supra* Section IV. C.

<sup>144</sup>*Mathews*, 87 F.3d at 644.

<sup>145</sup>*Sokol*, 173 F.3d at 1026.

<sup>146</sup>Phillip Areeda, *Essential Facilities: An Epithet in Need of Limiting Principles*, 58 ANTITRUST 841 (1990).

<sup>147</sup>Scott D. Makar, *The Essential Facility Doctrine and the Health Care Industry*, 21 FLA. ST. U. L. REV. 913, 915 (1994).

<sup>148</sup>*MCI Communications Corp. v. Am. Tel. & Tel. Co.*, 708 F.2d 1081 (7th Cir. 1983).

<sup>149</sup>Makar, *supra* note 147, at 915.

<sup>150</sup>*Century Air Freight, Inc. v. Am. Airlines, Inc.*, 738 F.2d 418 (2d Cir. 1984).

to deal with the competitor and has thereby unreasonably denied him the “essential” resource.<sup>151</sup>

The essential facility doctrine requires the owner of the facility or governing body to provide its business rivals with the use or access to the facility on fair terms.<sup>152</sup> The term has been successfully used in discussing railroads, electric utilities, and natural gas industries.<sup>153</sup> Recently, physicians have attempted to apply the term to instances where medical staff privileges have been denied.

Physicians have endeavored to use the theory in cases involving a physician attempting to gain access to a competitor hospital; the physician in this case claims that he cannot compete effectively in his profession without receiving admitting privileges from the facility.<sup>154</sup> Physicians often claim that the hospital is “monopolizing” the market.<sup>155</sup> It is argued that the competitor hospital is willingly attempting to monopolize its services in a particular geographical area.<sup>156</sup>

A unilateral refusal by a hospital against a physician usually is legal.<sup>157</sup> The current law generally allows facilities the freedom to deal or to refuse to deal with whomever they choose, unless the refusal supports an illegal restraint or constitutes illegal monopolization.<sup>158</sup> Even if a facility is deemed to be a monopolist, it has no general duty to cooperate with competitors.<sup>159</sup>

In order for a physician to be successful in his claim, it must be shown that a hospital is an “essential” facility.<sup>160</sup> Health care facilities are not “essential” in an antitrust sense.<sup>161</sup> Although arguably, health care services are “essential” to an individual’s well-being.<sup>162</sup> Courts usually reject claims that hospitals are “essential”

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<sup>151</sup>Makar, *supra* note 147, at 915.

<sup>152</sup>*Id.* at 913.

<sup>153</sup>William B. Tye, *Competitive Access: A Comparative Industry Approach to the Essential Facility Doctrine*, 8 ENERGY L. J. 337 (1987).

<sup>154</sup>Makar, *supra* note 147, at 915.

<sup>155</sup>15 U.S.C. § 2 (1999) (stating that “[e]very person who shall monopolize, or attempt to monopolize or combine or conspire with any other person or persons, to monopolize” shall be guilty of a felony).

<sup>156</sup>Makar, *supra* note 147, at 915 (stating monopoly is not illegal under the antitrust laws; it is only illegal if the hospital uses illegitimate business practices to achieve or maintain monopoly power); *United States v. Grinnell*, 384 U.S. 563 (1966) (holding monopoly power alone is not sufficient to establish a monopolization claim; there must also be anticompetitive conduct evidencing a general intent to monopolize-willful maintenance or acquisition).

<sup>157</sup>Makar, *supra* note 147, at 916.

<sup>158</sup>Robert H. Bork, *The Antitrust Paradox*, 52 ANTITRUST 344 (1978).

<sup>159</sup>*Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 600-01 (1985).

<sup>160</sup>*MCI Communications Corp.*, 708 F.2d at 1081.

<sup>161</sup>Makar, *supra* note 147, at 927.

<sup>162</sup>*Id.*

facilities.<sup>163</sup> Because physicians have a difficult time proving this element, claims against a hospital as violating the essential facility doctrine are likely to fail.<sup>164</sup>

Little coherent judicial guidance exists as to what “essential” means.<sup>165</sup> Courts have yet to define the terms “essential facility” or a “monopolized facility.”<sup>166</sup> A few courts have stated that to be essential “it is sufficient if duplication of the facility would be economically infeasible and if denial of its use inflicts a severe handicap on potential market entrants.”<sup>167</sup> Some courts have determined what essential is: a facility is not essential merely because it is better than or preferable to another.<sup>168</sup> Facilities that competitors can “practicably” or “reasonably” duplicate are not essential.<sup>169</sup> The lack of objectiveness provides courts with discretion in their interpretation and application of the term “essential facility.”

Physicians may try to claim that staff privileges are essential facilities. The claim is that the physician is unable to compete without privileges that permit access to the facility. A number of courts have rejected this claim and have held that the staff privilege relationship between a physician and a hospital is unique and not subject to significant antitrust scrutiny.<sup>170</sup> In *Pontius v. Children’s Hospital*,<sup>171</sup> the plaintiff-physician alleged that the hospital conspired in violation of the antitrust laws not to retain him on the hospital’s staff. The physician asserted a *per se* essential facility claim.<sup>172</sup> The court held that the essential facility doctrine is inapplicable to hospital staff privileges decisions.<sup>173</sup> The court’s decision appears to be based entirely on its

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<sup>163</sup>See *Advanced Health-Care Servs. Inc., v. Radford Cmty. Hosp.*, 910 F.2d 139 (4th Cir. 1990); *Key Enters. v. Venice Hosp.*, 9 F.3d 893 (11th Cir. 1993).

<sup>164</sup>*Makar*, *supra* note 147, at 927 (stating that courts are reluctant to grant antitrust claims to physicians where there is evidence that although the physician was denied staff privileges from one hospital a substantial income was made by the physician from another facility; courts reason that the facility is not essential if economic rivals continue to prosper even though staff privileges were denied).

<sup>165</sup>*Id.* at 922.

<sup>166</sup>*Id.*

<sup>167</sup>See *Fishman v. Estate of Wirtz*, 807 F.2d 520, 539 (7th Cir. 1986); *Hecht v. Pro-Football Inc.*, 570 F.2d 982, 992 (D.C. Cir. 1977).

<sup>168</sup>See, e.g., *Fishman*, 807 F.2d at 539.

<sup>169</sup>See, e.g., *Hecht*, 570 F.2d at 992.

<sup>170</sup>See *Tarabishi v. Northern Mich. Hosp. Inc.*, 703 F.2d 942 (6th Cir. 1983) (citing cases that have declared the essential facility doctrine inapplicable to staff privilege cases for public policy reasons); *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 995-96 (N.D. Ga. 1992) (stating access to hospital is necessary for practice of obstetrics but “inappropriate” to apply the essential facility doctrine that would prevent hospital from keeping unqualified doctors off its staff).

<sup>171</sup>552 F. Supp. 1352 (W.D. Pa. 1982).

<sup>172</sup>*Id.* at 1354.

<sup>173</sup>*Id.* at 1370 (“Even if we accept, without any evidence having been put forward, the proposition that [the hospital’s] thoracic and cardiovascular surgical facilities may not practically be duplicated, we believe that it would be singularly inappropriate to apply a

concern that mandatory access under a per se essential facility test could prevent a hospital from denying medical staff privileges to an unqualified applicant.<sup>174</sup>

In *Castelli v. Meadville Medical Center*,<sup>175</sup> the court concluded that the essential facility doctrine does not apply to “exclusive service contracts by hospitals.” The court stated that “if there were a case in which the hospital would be an essential facility, [the defendant] would not be that hospital.”<sup>176</sup> Within a forty mile radius of [the defendant-hospital], there are eight other hospitals at which Castelli could potentially practice.”<sup>177</sup> The court ultimately concluded that the presence of a significant number of competing facilities negated the essential facility claim presented.<sup>178</sup>

As shown in this section, physicians are generally unsuccessful in alleged violations of the essential facility doctrine. Courts continue to follow the trend that the hospital is given broad discretion in making decisions regarding staff privileges.

#### *E. Closed Staff Policy*

A hospital may restrict admission to the medical staff on a limited basis. An example is a hospital regulating staff privileges to only physicians practicing a certain specialty; this is often referred to as a “closed staff policy.”<sup>179</sup> If additional physicians on staff would cause over-utilization of the hospital’s limited resources, this would justify refusing a qualified physician to hospital staff.<sup>180</sup> Under Ohio law, hospitals are given broad discretion in determining who will obtain medical staff privileges.<sup>181</sup>

A New Jersey court held that closing the medical staff was legal; however, instances where exceptions were made to permit physicians to join the staff if they were joining the practices of other physicians on staff, was not legal and was found to be discriminatory.<sup>182</sup> It is permissible to have a closed staff as long as it is done in a nondiscriminatory and reasonable manner.<sup>183</sup>

Hospitals instituting a closed staff policy can do so without fearing legal proceedings. Case law defends the practice where the exclusion of the physicians

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doctrine which would prevent a hospital from keeping doctors it had adjudged unqualified off of its staff. Neither the public policy nor the Sherman Act can countenance such a result.”).

<sup>174</sup>Makar, *supra* note 147, at 939.

<sup>175</sup>702 F. Supp. 1201 (W.D. Pa. 1988); *see also infra* Section IV. F.

<sup>176</sup>*Id.* at 1205.

<sup>177</sup>*Id.* at 1209.

<sup>178</sup>*Id.* at 1211.

<sup>179</sup>SCHEUTZOW, *supra* note 6, at 83.

<sup>180</sup>*Desai*, 510 A.2d at 669.

<sup>181</sup>*Sosa*, 437 F.2d at 177.

<sup>182</sup>*Desai*, 510 A.2d at 672.

<sup>183</sup>*Id.*

was done as not to affect the quality of patient care and where the decision furthers the health care mission of the hospital.<sup>184</sup>

*F. Exclusive Contracts*

In Ohio, exclusive contracts for services of provider-based physicians are a valid and enforceable means of providing medical services in a hospital.<sup>185</sup> An exclusive contract is more prevalent regarding hospital contracts with provider-based physician groups, such as radiologists, pathologists, anesthesiologists, and emergency room physicians whereby the physician group is given the exclusive control to provide medical services in that specialty.<sup>186</sup>

Courts have held that exclusive contracts did not violate public policy and were a reasonable choice by the hospital.<sup>187</sup> The primary purpose of a hospital is to serve the public, regardless of the arrangement between physician and hospital.<sup>188</sup> Courts do not normally interfere with a reasonable management decision concerning staff privileges as long as that decision furthers the health care mission of the hospital.<sup>189</sup>

In 1984, the Supreme Court rendered a landmark decision *Jefferson Parish Hospital District No. 2 v. Hyde*.<sup>190</sup> In July 1977, Dr. Hyde, the defendant, applied for anesthesia privileges at the hospital.<sup>191</sup> The medical staff recommended that Dr. Hyde be granted privileges to the hospital.<sup>192</sup> Despite the recommendation, the hospital governing board denied the application because of the exclusive contract the hospital had with Roux & Associates.<sup>193</sup>

The Court held that the exclusive contract between the anesthesiology group and the hospital was valid and enforceable.<sup>194</sup> The Court noted, that like any contract, this contract would have been unlawful if it foreclosed so much of the market as to unreasonably restrain competition.<sup>195</sup>

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<sup>184</sup>*Rova Farms Resort v. Investors Ins. Co.*, 323 A.2d 495 (N.J. 1974); *Falcone v. Middlesex County Med. Soc'y.*, 170 A.2d 791 (N.J. 1961); *Desai*, 510 A.2d at 672.

<sup>185</sup>SCHEUTZOW, *supra* note 6, at 103-04.

<sup>186</sup>*Id.*

<sup>187</sup>*Belmar*, 475 A.2d at 539-40.

<sup>188</sup>*Id.* at 538.

<sup>189</sup>*Greisman*, 192 A.2d at 825.

<sup>190</sup>466 U.S. at 2. The hospital exclusively contracted with the Roux & Associates, a group of anesthesiologists. *Id.* The group agreed to provide twenty-four hour staffing, not to work elsewhere, to supervise the nurse anesthetists, and to perform all needed anesthesia services for the hospital. *Id.* In return for Roux & Associates' services, a five-year contract as the exclusive provider of anesthesia services at Jefferson Parish Hospital was established. *Id.*

<sup>191</sup>*Id.* at 3.

<sup>192</sup>*Jefferson Parish*, 466 U.S. at 3.

<sup>193</sup>*Id.* at 5.

<sup>194</sup>*Id.* at 3.

<sup>195</sup>*Id.* at 31.

Exclusive contracts dealing with provider-based physician groups are permissible.<sup>196</sup> Their specialty areas differ from surgeons, general practitioners, or other physicians who admit to hospitals. Provider-based physician groups generally do not admit patients to hospitals, and are not responsible for overseeing the patient's care while hospitalized.<sup>197</sup> Provider-based physicians usually rely on consultations from other physicians for business.<sup>198</sup> When a physician's business relies primarily on consults problems often ensue. Physicians who admit patients to hospitals may exert unreasonable demands on the provider-based physicians.<sup>199</sup>

For example, without exclusive contracts in an open system, a provider-based physician, like an anesthesiologist, may be called in by a surgeon on his day off.<sup>200</sup> The anesthesiologist at home, knowing he needs consults from surgeons, may come into the hospital even though there was adequate anesthesia coverage at the time in the hospital.<sup>201</sup> The anesthesiologist may fear not receiving consults from a particular surgeon if he does not meet the surgeon's expectations.<sup>202</sup>

The surgeon may favor one anesthesiologist over the others and may stop consulting him if he does not come in on his day off, rearrange his schedule to meet the needs of the surgeon, or care for the surgeon's patients in the manner that the surgeon prefers.<sup>203</sup> This would negatively affect the anesthesiologist's practice. Also, competition from surgeons in an open system can breed dissension among anesthesiologists, even if they are partners.<sup>204</sup> If one anesthesiologist is receiving considerably more consults than the others this may provoke a hostile working environment for the physicians.

Closed staff policies have been consistently upheld by the courts. Hospitals can institute closed staff policies, especially with provider-based physicians, and deny physicians medical staff privileges because of them.

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<sup>196</sup>*Capili v. Shott*, 620 F.2d 438, 439 (4th Cir. 1980) (holding that decision to enter an exclusive contract for anesthesia services by a public hospital had a rational basis and therefore did not discriminate); *Centeno v. Roseville Cmty. Hosp.*, 107 Cal. App. 3d 62 (1979) (stating that governing body's policy decision to enter an exclusive contract for radiology services does not arbitrarily or unreasonably exclude otherwise qualified radiologists from staff membership); *Lewin v. Saint Joseph Hosp. of Orange*, 82 Cal. App. 3d 368 (1978) (holding that decision of governing authority to operate chronic renal dialysis facility under exclusive arrangement with a single group of nephrologists was substantially rational).

<sup>197</sup>*Belmar*, 475 A.2d at 539.

<sup>198</sup>Provider-based physicians do not have admitting privileges. They rely on physicians who do have admitting privileges for business. Physicians request the services of the anesthesiologist in the form of a consult. Provider-based physicians provide the service requested by the physician but do not oversee the care of the patient.

<sup>199</sup>*Belmar*, 475 A.2d at 539.

<sup>200</sup>*Id.*

<sup>201</sup>*Id.*

<sup>202</sup>*Id.* at 541.

<sup>203</sup>*Id.*

<sup>204</sup>*Belmar*, 475 A.2d at 540.

## V. CURRENT LAW REGARDING ECONOMIC CREDENTIALING

Denying a competitor physician medical staff privileges is warranted under economic credentialing as long as the decision is made in furtherance of quality of care.<sup>205</sup> Federal and state law prohibits hospitals from making a privilege decision based solely on economic factors.<sup>206</sup> For example, a medical staff member may desire to negatively affect a competitor's private medical practice negatively through the denial of hospital access. The greater number of physicians in a geographic market with access to one or more hospitals, the more the physicians will need to compete with each other for patients. The resulting competition might motivate physicians on a hospital medical staff to deny privileges to competitors in an attempt to reduce the number of doctors in the market.<sup>207</sup> This would violate federal antitrust laws designed to protect the public from anticompetitive and monopolistic behavior.<sup>208</sup>

Another form of economic credentialing is prohibiting physicians from serving on the staff if they have strong ties or loyalties to competitor hospitals.<sup>209</sup> In Florida, a doctor was denied membership to a hospital staff because he already was a cardiovascular surgery director at another facility.<sup>210</sup> In other words, his services were declined, not because he was not qualified to practice cardiovascular surgery at another facility but because he was viewed as an economic competitor.<sup>211</sup>

Sherry S. Bahrambeygui, a plaintiff's attorney, says it is possible to look at economic factors when evaluating physicians: "Economic credentialing [can be done] if it's a fair process where the quality of care being provided is also considered in the mix," she said.<sup>212</sup> "But if you have an organization that is looking only to the economics, and not also considering other factors that could be influencing practices that bear on quality of care, then I do think there is a great deal of exposure there."<sup>213</sup>

In Los Angeles, a physician was denied privileges solely on a business and financial analysis; the physician was told "the decision is in no way a reflection of your performance."<sup>214</sup> In Ohio, a court held that a hospital could consider criteria unrelated to patient care if the criteria was rationally related to the operations of the

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<sup>205</sup>POLLARD, *supra* note 5, at 9.

<sup>206</sup>*Id.* at 8.

<sup>207</sup>Richard Griffith & Jordan Parker, *With Malice Toward None: The Metamorphosis of Statutory and Common Law Protections for Physicians and Hospitals in Negligent Credentialing Litigation*, 22 TEX. TECH. L. REV. 157 (1991).

<sup>208</sup>POLLARD, *supra* note 5, at 8.

<sup>209</sup>SCHEUTZOW, *supra* note 6, at 82.

<sup>210</sup>Robert Weinman, *Medical Red-lining: Economic Credentials for Physicians*, S.F. EXAMINER, Jan. 12, 1996, at A19.

<sup>211</sup>*Id.*

<sup>212</sup>*Id.*

<sup>213</sup>*Id.*

<sup>214</sup>Lewisburg Cmty. Hosp. Inc. v. Alfredson, 805 S.W.2d 756 (Tenn. 1991).

hospital and that the criteria be found in the hospital bylaws.<sup>215</sup> Case law has shown that courts have upheld decisions by a hospital to deny a physician staff privileges where economic criteria was a factor.

VI. PROPOSAL: CHANGE THE RELATIONSHIP BETWEEN A HOSPITAL AND A PHYSICIAN FROM BEING AMBIGUOUS TO A MORE STRUCTURED EMPLOYER/EMPLOYEE RELATIONSHIP

As this Note has shown, a hospital can legally deny a competitor physician staff privileges. A hospital's reasoning must include furtherance of quality of patient care in order to escape legal proceedings.<sup>216</sup> A solution to this difficult situation is for the hospital to maintain an employer/employee relationship with all of the physicians on the medical staff.

Employment entails a written or oral contract for hire.<sup>217</sup> The hospital-employer would have a contract with the physician-employee. This would clarify the uncertainty of whether a contract exists between a hospital and a physician. Under this contract, the physician would continue to render services at the hospital as an employee of the facility.

The key determination regarding an employer/employee relationship is the fact that the employer can influence or control the behavior of the employee.<sup>218</sup> The hospital could assert its power over the physician by requiring the employee to meet the standard of care of a reasonable physician in his particular specialty.

As an employer, the hospital would hire a physician when necessary to benefit the public. A decision to hire the physician would also be considered from the business aspect of the hospital. The governing body, hospital administration, and medical staff in the form of a peer review committee, would act as a system of checks and balances. Each would comport itself in accordance with the others. None could make an independent decision regarding the denial of a physician's medical staff privileges without the other two. Therefore, the fear of one of the three branches becoming too powerful is alleviated. Issues such as economic credentialing, a closed staff policy, antitrust, and exclusive contracts would then not be litigated as frequently when a physician is not hired by the hospital. In this manner, a hospital would be less prone to be a defendant in a suit by a physician who was denied medical staff privileges.

The physician and hospital would enter into a contract that would include terms such as salary, the duration of the contract, and the degree of skill that would be required by the employee in order to be employed by the hospital. The contract would be a legally binding entity for both employer and employee. If one party were to breach the contract then this would be the appropriate time for the courts to intervene.

A hospital is a business similar to any business such as a Fortune Five Hundred Company, a franchise, or a family owned business. Companies maintain

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<sup>215</sup>Siegel v. Saint Vincent Charity Hosp. & Health Ctr., 35 Ohio App. 3d 143 (Ohio Ct. App. 1987)

<sup>216</sup>POLLARD, *supra* note 5, at 9.

<sup>217</sup>Louismet v. Bielema, 457 N.W.2d 10 (Iowa Ct. App. 1990).

<sup>218</sup>41 AM. JUR. 2d *Independent Contractors* §§ 9-15 (1998).



employer/employee relationships and are able to become successful businesses. There are no other businesses that engage in the unique relationship that currently exists between a physician and a hospital. There is usually no exchange of money that occurs between a physician and hospital,<sup>219</sup> although the importance of each party is apparent. Hospitals could not exist without physicians and physicians could not adequately care for patients without the use of hospitals. The JCAHO has defined the governing body to be the one that exerts the ultimate control and represents ownership of the hospital.<sup>220</sup> Today, successful business owners engage in employer/employee relationships to manage their businesses. Hospitals should do the same.

As this Note has shown, ambiguities exist between a hospital and a physician regarding the authority of a hospital to deny a physician medical staff privileges. By instituting an employer/employee relationship between a physician and a hospital such ambiguities would decrease. By decreasing the ambiguities the number of judicial proceedings would decrease. If legal proceeding were decreased public policy will be served. Therefore, the concept of an employer/employee relationship should be utilized between a physician and a hospital.

#### VII. CONCLUSION

A hospital has a right and a duty to review the qualifications of physicians, but also to consider the need for and impact of additional physicians for its hospital staff.<sup>221</sup> The needs of the hospital must be balanced with the needs of the physician who desires to practice at the facility. Hospitals must make decisions that are based on the benefit of the public and must take into consideration the basis for their existence, which is to serve the public.<sup>222</sup>

Hospitals are able to deny physicians staff privileges based on different factors. Economic credentialing is a fair process that hospitals use when evaluating a physician's credentials. The hospital can use this tool along with others to deny a physician staff privileges. It is very difficult for a physician to be successful regarding an antitrust claim. Hospitals can deny a physician staff privileges without a substantial fear of engaging in an antitrust violation. Closed staff policies and exclusive contracts have been consistently upheld by the courts.

In conclusion, this Note has illustrated the complexities and ambiguities that exist regarding how a physician and hospital are associated with each other. One alternative that can be applied is to change the association between the two entities to a concrete employer/employee relationship. By doing so, hospitals can make decisions regarding denying a physician medical staff privileges without apprehension. Serving the public and managing the business would take precedence to court proceedings.

SANDRA DIFRANCO

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<sup>219</sup>SCHEUTZOW, *supra* note 6, at 73.

<sup>220</sup>Healthcare Credentialing Information Supersite, *supra* note 2.

<sup>221</sup>*Belmar*, 475 A.2d at 538.

<sup>222</sup>*Id.*