

Chapter 11

Coprovers and Institutional Practice

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Coprovers
Institutional Practice

COPROVIDERS

Physicians do not practice alone. That fact is unalterable in our complex medical care system. Physicians depend on the expertise and competence of technicians, nurses, nurse practitioners, physician assistants, paramedics, administrators, nurse's aides, orderlies, medical records personnel, and even maintenance and repair staff, just to name a few. In addition, it is important to recognize that the relationships of coprovers are necessarily bilateral. The competence of the individuals working together is additive rather than independent. It is obvious that the observations and efforts of all those who provide care for a patient affect the outcome; as a result the legal interdependence of coprovers is unavoidable. The more complex that health care becomes and the more technical the capabilities of health care providers, the greater the interdependence of coprovers. Further, when coprovers work together smoothly and professionally, it is evident to the patient; this instills trust and facilitates communication, which, in turn, tends to minimize malpractice and malpractice claims. It is often feeling or perception that something was wrong that influences a patient to seek an attorney and file a claim. Good teamwork catches errors before untoward results occur. It also creates the perception in the patient that he or she is receiving competent, efficient, and high-quality health care.

The definition of coprovers in the context of the health care system can be greatly expanded. For example, the competence of the line worker involved in the manufacturing process of a piece of medical equipment could, in the most extreme assessment of the nature of "coprovers," affect the performance of nurses and physicians who use that particular piece of equipment.

The first part of this chapter focuses on the health care providers who are directly involved with the patient and who have some form of professional licensure or responsibility for patient care. These providers include physicians, nurses, nurse practitioners, physician assistants, dentists, podiatrists, licensed psychologists, vocational nurses, registered technicians, and other personnel who work in the health care system and directly affect the provision of care to the patient. In addition, the nature of relationships that create coexisting responsibilities and duties among these providers is discussed.

The second part of the chapter explores legal aspects concerning the hospital, the institution in which these health care providers work together. It focuses primarily on the hospital's legal relationship to its patients and to the physicians who serve on its staff and committees.

State Licensure

Licensed professionals are obligated not only to act within the authority and parameters set out by their own licensure act, but also, in most states, are required to report other professionals if they know that those professionals are acting in violation of the licensure acts. For example, state laws require that physicians report the incompetence of another physician if his or her act has the potential to harm a patient. Physicians are also required to report the incompetence or impairment of a nurse or any other health care provider. In this respect, licensure creates a public duty that, at times, can override the natural instinct not to be a "tattletale."

Once a physician has been reported to his or her licensing board, the board will meet with the physician if it believes the problem can be remedied informally. The licensing board may even ask the physician to voluntarily surrender his or her license if it is necessary to protect the public. Whether the license is surrendered or not, the physician can be diverted to a supportive program if he or she acknowledges the existence of a problem. If the physician refuses to acknowledge the problem, the board can formally charge the physician with violating the state's licensing act and order the physician's appearance before it at a formal hearing. In some states, under some conditions, the board may suspend the physician's license or impose less severe limitations on his or her practice privileges if doing so is deemed to be in the public's interest.

At such a hearing, the board usually receives evidence and testimony. It then makes findings of fact and forms conclusions of law as to the charges and appropriate action or sanction. Most states permit a sanctioned physician to request a stay of the sanction and to bring an appeal of the board's decision before a court of law. Of course, if the board finds insufficient proof (usually according to a preponderance of the credible evidence) in the facts to support

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an order or sanction, the matter is dismissed and, if necessary, the license and privileges are restored.

Practice in a Health Care Institution

Apart from the responsibility created by state licensure laws to report professional impairment, incompetence, or other acts in violation of licensing laws, institutional environments may create an additional burden and duty for professionals: monitoring the competence and performance of coproviders with whom they work. The interdependence of professionals within a particular institutional environment is best exemplified by the hospital, but it exists in other health care settings such as nursing homes, mental health institutions, and outpatient settings. Obvious examples would be the responsibilities of the medical staff to the institution to monitor the quality of health care in the hospital as outlined by state licensure laws, voluntary accreditation standards, and common sense, as well as the common law.

In many cases, institutions, which normally depend on the quality of the peer review conducted by their medical staffs, have been found liable for failure to discover or for choosing to ignore an individual health care provider's incompetence where that individual is practicing within that institution.¹ This well-established common law rule receives additional support as a reasonable interpretation of the Standards of Accreditation of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which are voluntary. In addition, the common law reflects the interpretation of state licensure laws requiring effective quality assurance programs in hospitals, medical association standards, and medical society standards. Further, the institutional duty to provide quality care ultimately rests with the hospital's governing body.

Thus, health care providers find themselves obligated and responsible for the competence and quality of their peers' performance and for discovering and preventing the incompetence or impairment of professionals at other levels—either above or below their own—from harming the public or an individual patient. Thus, nurses are obligated to report an impaired, incompetent, or otherwise deficient physician; but they would also be required to report a technician who fails to function at an acceptable level.

Peer Review

Quality assurance programs in hospitals depend on the process of peer review because coproviders with the same professional training are the best judges of the competence and capabilities of their peers and colleagues. The quality assurance process is described best in terms of problem solving and the promotion of desired levels of patient care. Although it is easy to talk in generalities about the importance of quality, the actual process of quality assurance is difficult in the health care setting. However, the duty to provide good and effective peer review is clear.

Quality Assurance Programs

All health care institutions, health care provider groups, health maintenance organizations (HMOs) and managed

care programs, and others directly or indirectly responsible for patient care necessarily deal with the developing field of quality assurance (QA) in health care. Small area analysis, comparison of health care practices, and widespread inconsistencies in approaches to various disease processes and surgical problems have created great concern and even governmental intervention in attempts to standardize approaches to health care problems. The unfortunate byproduct of this concern and resulting standardization is that it is difficult to be certain of the relative benefits of the various approaches to problems. It is clear that many management approaches are effective, and diversity in health care should not be discarded for a theoretical and unproven cost or quality benefit. In medicine as well as in other "arts," there are many ways to "skin a cat."

The *Journal of the American Medical Association* has published a column on clinical decision-making with the specific objective of studying the problems of variation in clinical approaches to medical problems.²

In QA programs, it is important to eliminate deviations below and outside of acceptable medical practice, particularly those deviations that put patients at risk. Therefore the JCAHO, medical societies, medical professional organizations, and others are actively involved in attempting to establish standards for practice. The American Medical Association has also studied standards in cooperation with Rand Corporation, and 20 medical specialty societies have published some form of standards.

Standards of Care

Quality assurance, peer review, and coprovider relationships are dependent on the personal perceptions of those providing the care together, regarding what are considered to be appropriate standards of care. Unfortunately, the legal system and professional liability litigation in particular have confused how such standards are considered and applied in a way not easily explained. This can cause "defensive medicine."

This does not mean that it is impossible to reconcile institutional practice with understanding these standards. What is necessary is the acknowledgment that quality assurance and risk management must work in tandem, with each complementing the other to ensure that medical care is provided which meets the patient's needs and interests. An understanding of those needs is the first step. The legal system defines the duty a health care provider owes to the patient in terms of what is in the patient's interest:

1. To use his or her best judgment in care and treatment.
2. To exercise reasonable care and diligence in the application of his or her knowledge and skills.
3. To act in compliance with the standard of health care required by law.³

Thus, risk management and quality assurance programs must be used to constantly educate the institution's staff regarding how to fulfill these duties during the day-to-day provision of health care.

Normative Versus Actual Standards of Care

Elsewhere in this text, the issues regarding standards of care are defined more completely. However, it is important to recognize that, generally, courts define a standard of care in

terms of that degree of skill and expertise normally possessed and exercised by a reasonable and prudent practitioner with the same level of training in the same or similar circumstances. What this means in a courtroom can become quite different from what the health care provider contemplates while treating the patient. Too often, medical testimony presented in a courtroom deals with issues as they relate to “normative” standards rather than “actual” standards. In reality, physicians hope to perform at one level but actually perform at another level. For example, John Holbrook, MD (personal communication), an emergency physician interested in risk management in Massachusetts, reviewed more than 100,000 emergency department records and found that fewer than 5% of patients treated at the emergency department for a headache actually received a fundoscopic examination. Whether this would be an actual standard that is acceptable is subject to debate, but it cannot be ignored as a reality. In a courtroom, the normative standard is described for the benefit of the judge or jury as expected performance recited by a “medical expert” adequately and sometimes superlatively qualified to discuss a particular area of professional expertise. It may not be an actual standard but rather a “normative” standard defined as the degree of skill and expertise that we strive to achieve rather than actually achieve as average prudent practitioners. Of course, states can and often do define who is a “medical expert” and what, generally, is the defined standard of care, for application in the courtroom.

In the quality assurance setting, it is important for those involved in the definitions of standards and practices to recognize the difficulties of defining appropriate standards of care and evaluating coproviders. Within those parameters, it is still possible to define unacceptable deviance and deal with it appropriately as part of the peer review mechanism. However, difficulty can arise, especially in evaluating coproviders, when disparity exists among researchers, instructors, and various schools and institutions that train the coproviders. Such disparities need to be considered in both individual evaluations and coprovider training. Such continuing training can be a useful tool for establishing the “normative” standard an institution adheres to, in order to avoid any conflicts and unnecessary disputes over adherence. It is possible that a significant number of investigations and staff disciplinary actions arise not from actual lack of knowledge or personal dedication to high quality of care, but from differences in training among coproviders.

Normally quality assurance programs are described in terms of the “controlled loop” process of identification of a problem, discussion, and evaluation resulting in proposed action, real action, and then reevaluation to determine whether the problem has been properly managed. Every professional organization that assumes responsibility for patient care, including hospital medical staffs, managed care organizations, and medical practice groups, must establish a quality assurance program. Without such a program, these patient care organizations will not be able to efficiently monitor the health care their coproviders provide.

There has been an increasing interest in and use of guidelines for comparing actual performance with the applicable

standard of care. Some institutions prepare internal guidelines for the most commonly encountered or performed conditions or situations, basing them on academic research. Other institutions make use of external sources, such as the National Guideline Clearinghouse (NGC). The NGC maintains a comprehensive database of evidence-based clinical practice guidelines and related documents produced by the Agency for Healthcare Research and Quality (AHRQ). It works with the American Medical Association and the American Association of Health Plans. Its stated mission is to provide physicians, nurses, and other health professionals with a source of objective, detailed information on clinical practice guidelines. By doing so, it is promoting the dissemination, implementation, and use of such guidelines. The NGC’s database is available on the Internet at <http://www.guideline.gov/>.

Disciplinary Activities in Peer Review

Practicing with coproviders necessarily results in disciplinary peer review actions when unacceptable and incurable deviance is identified. It is important for those involved in peer review and quality assurance matters that have a direct impact on an individual practitioner to be aware of the concept of due process and the laws of the state and nation that govern disciplinary and peer review activities in the health care setting. The Health Care Quality Improvement Act of 1986⁴ is a federal statute that provides guidance for establishment of due process within peer review through specific requirement:

1. The subject physician must be notified of an organization’s intent to bring disciplinary action.
2. The subject physician must have an opportunity to respond, request a hearing if he or she desires, and prepare a defense.
3. The subject physician must have adequate notice of the nature of the charges.
4. The subject physician must receive the right to advice and counsel of the physician’s choice, including an attorney, in any hearing conducted as part of peer review.
5. The subject physician must receive a fair hearing with an impartial panel of noncompeting peers for consideration of the proposed action to be taken.
6. The subject physician must be given an opportunity to examine the evidence against him or her, prepare a defense, cross-examine witnesses, and present arguments in his or her favor.
7. A written opinion must be provided by the hearing panel if disciplinary action is recommended, along with the written decision of the health care governing body or final arbitrator.

The importance of these guidelines lies in the statutory establishment of bilateral protection. The organization that is conducting peer review and following these guidelines ultimately derives as much benefit from them as the physician who is at risk. If a physician who has been disciplined under a peer review proceeding decides to sue individuals who participated in the process or the institution for having imposed the discipline, and if the defendants can show that the disciplinary action was undertaken in the “reasonable belief” that it was for the furtherance of good

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health care and with no malice or inappropriate motivations, this federal law provides “qualified immunity” from the civil claim. Further, if the defendants prove that the sanctioned physician’s suit was brought inappropriately, they can collect damages for defense expenses and court costs. The federal law provides this remedy to encourage physicians to participate in peer review. However, failure to conduct peer review can create potential liability under the common law theories described earlier.

Supervisory Liability

Physicians supervise nurses, technicians, assistants, paramedics, and, at times, other physicians. This supervision can be direct, but it is often done by telephone, radio, or written communication. Generally, a physician’s responsibility and potential liability for such injuries and mistakes resulting from the care given under such supervision are directly proportional to the degree of control held over the coproviders’ actions and the supervisor’s knowledge of such actions.

Physicians who are supervising their own employees bear special responsibilities because direct vicarious liability exists for any employees’ negligent actions. Likewise, where a state’s laws grant special status to nurse practitioners and physician’s assistants, authorizing expanded delegated duties, such laws generally require that physicians formally report to the state the supervisory relationship’s existence. Further, such reports or applications for approval often formally create delegated standard orders and other protocols to provide for proper guidelines. In addition, many states have established definite limits on the nature of the supervision that might be provided. For example, most states require the supervising physician to be physically available to the nurse practitioner or physician’s assistant for consultation and assistance. However, in many states these coproviders can act, within their standing orders, in a relatively liberal manner, sometimes even using signed prescription pads. Some state medical practice acts provide that a physician can delegate any responsibility to a properly trained person; thus the basic issue in determining vicarious liability can center on the physician’s judgment of that coprovider’s qualifications. Of course, one would not expect to find a physician delegating performance of a neurosurgical procedure to a physician’s assistant; it is far more common to find less critical responsibilities delegated to the coprovider, such as when a nurse harvests veins for cardiovascular surgeons.

Vicarious liability is that liability arising from an employer–employee relationship. Employee physicians, nurses, technicians, and others can create liability for their employer through their negligence, if such negligence causes an injury. One should also be aware of the “borrowed servant” doctrine; a physician using employees of another to carry out the borrower’s activities can be held liable for the “borrowed” employee’s negligence. One’s liability when borrowing another’s “servant” is proportional to the amount of control one exercised. For example, in the health care setting, the “captain of the ship” theory at one

time was used to resolve the issue of liability for the acts of nurses and others in the operating room. However, the courts have recognized that surgeons do not directly control the administrative duties of others in the operating room. Scrub technicians, circulating nurses, anesthesiologists, and others are working there, although they must defer to the judgment and authority of the surgeon on the case. Obviously, they have separate and independent duties and responsibilities proportional to their professional competence. It is therefore unreasonable to make the surgeon liable for an improper sponge, needle, or instrument count, just as it would be inappropriate for a surgeon to be responsible for the conduct of an anesthesiologist who fails to properly intubate the patient. If the problem comes to the surgeon’s attention and he or she fails to act in the patient’s interest, liability increases proportionately, but the primary responsibility still lies with that person who acts independently regardless of the level of professional expertise and who has separate and independent ministerial duties and authority.

Radio Control and Prehospital Care

An interesting and important area of medical care involving delegation of medical practice to a remote person is the use of radio control for prehospital care. Separate and independent duties and responsibilities are created for licensed prehospital care personnel. In addition, it is important to recognize that prehospital care services are required by law to have a medical director who establishes proper medical care/prehospital care protocols and monitors the competence of the prehospital care personnel through a functioning quality assurance program.

The physician who directs or controls the paramedic at the scene has the same liability as a physician who would direct or control a nurse and has ultimate responsibility for the patient. In the case of radio control, the physician has a responsibility proportional to his or her knowledge of the situation, recognizing that the physician is dependent on the eyes, ears, and observational skills of the paramedic or emergency medical technician (EMT).

Appropriate prehospital care protocols still vary widely throughout the United States. Variations easily result from the diverse qualifications of persons working in prehospital care settings, from personal opinions of medical directors, and from different state laws. State law specifically designates levels of skill in terms of basic care providers, special skill care providers, and full paramedic level providers. National and state registry and licensure are a part of the definition of these various levels of skill. The control of prehospital care personnel is similar to the type of remote control that exists when patients are in the hospital and nurses are used as observers reporting to physicians the condition of a patient and then carrying out appropriate therapeutic and diagnostic orders.

Ultimately, the health care professional who delegates responsibilities to others or controls others by providing care directly and in person or remotely by phone or radio, is still responsible to act in a professional manner and

within acceptable standards of care. A professional duty to monitor the coprovider's professional competence and ability, above or below one's level of licensure or professional skill, is a controlling factor and a legal principle that must be accepted by all professionals. In the institutional setting, coproviders are codependent and coresponsible. Even though direct responsibility may not exist, indirect responsibility for general considerations of quality assurance requires vigilance and appropriate action when problems and an incompetent coprovider are identified.

Independent Contractors

Whether a health care provider is an independent contractor is a question implicating labor, employment, and tax law, as well as a consideration that affects professional liability. If a person works as an employee, the employer's vicarious liability is direct, but if that person is an independent contractor, the liability would be in proportion to the amount of control exercised. For example, many physicians function as independent contractors in various settings, but they exercise independent judgment over their professional practice. The independent contractor concept is one that properly suits a professional role because professionals are licensed as individuals and are responsible for making personal professional decisions about patient care. However, hospitals, health care facilities, and professional individuals are still responsible for monitoring the competence of the independent practitioner.

Ostensible Agency

In most states, certain independent contractor relationships have been found to be ineffective to deflect liability from the party contracting for the services. For example, in a hospital situation, an independent physician contractor may be the only one available to the patient; therefore the hospital may automatically be considered to be vicariously liable through ostensible agency. It has used the agent physician for carrying out some of its institutional responsibilities.⁵ When the patient has no way of knowing that the physician is not an employee or when the hospital uses the physician just as the hospital would use an employee, many states accept the concept that the hospital is therefore vicariously liable for the physician's actions. This area has not been as well defined outside the hospital-based physician situation, because other members of the medical staff are more independent. The concept generally has widespread support in the case of hospital-based physicians when patients come to a hospital and have no choice as to which physician to pick.⁶

Independent contractors working within a hospital setting or in a medical group are still subject to the same basic peer review and quality assurance controls, and therefore the institution or the professional organization can be considered liable if it fails to properly conduct the following: (1) proper credentialing and application; (2) adequate peer review and quality assurance review; (3) monitoring of physicians for ongoing appropriateness of care, continued

education if indicated, and proper recertification, relicensure, and other matters related to ongoing practice requirements; and (4) proper corrective and disciplinary action when a physician performs inappropriately or below the standard of care.

Under the common law propounded by most states, the hospital may be considered liable for poor peer review. This liability of a health care institution as outlined in the common law has been extended to the medical staff when the medical staff knows that a physician has become incompetent and fails to take corrective action.⁷

Consultants and Referring Physicians

A consultant and the referring physician share responsibility for the patient's care based on their respective proportion of knowledge and control and the foreseeability for potential harm. For example, if the general practitioner refers the patient to a neurosurgeon for a neurosurgical problem, then his or her responsibility for the case decreases in proportion to his or her knowledge of the problem, control over the care given the patient, and actions taken in response to any problems identified. Failure to choose an appropriate consultant can occasionally create liability for the referring physician, particularly if the choice of consultant is based not on the competence of the consultant, but on other financial or personal relationships. If the consultant is known to be incompetent and it can be proven that the referring physician used that consultant anyway, then liability would revert to the referring physician.

Substitutes and sharing on-call time can create some liability if one chooses a substitute who is incompetent. This would generally depend on the facts and circumstances. For example, if a physician going on vacation is not careful in his or her choice of a competent substitute, the patient could easily consider this as failure to take proper care in choosing a substitute. In the case of sharing call with another physician, the responsibility is less because the other physician is independent. However, if a physician using shared call knows that another physician sharing call is incompetent or impaired, he or she exposes the patients in his or her practice to that physician and would be considered liable in proportion to his or her knowledge of the incompetence or impairment of the call-sharing physician.

Nursing and Other Technical Practices in the Hospital

State nurse practice acts are the laws that define the proper scope of nursing practice. These laws and hospital protocols and procedures control the scope of nurses' professional activities. The physician is not responsible for designing protocols and policies, although the medical staff is generally responsible for the quality of care in the hospital.⁸ In the case of a hospital setting or other health care institutional setting, the administration generally includes nursing administration and therefore sets policy

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for the nursing practices within that institution. The medical staff provides oversight for the governing body on the quality of care provided in the institution, but depends on the nursing administration to develop policies and protocols for nursing care. The physician would be responsible for incompetence or impairment of a nurse or an inappropriate nursing action.

The physician should either intervene to prevent harm to the patient or deterioration of the patient's condition or report the events so that actions can be taken by the health care institution. Failure to do so, to ensure that the professional staff of the hospital is functioning in a way that provides quality patient care, could result in liability for the physician. The same responsibilities exist for nurses toward other nurses or technicians and for technicians with regard to other professional personnel in the hospital.

Professionals within a hospital or health care institutional setting assume liability in proportion to their knowledge of the problem and their ability to effect change. Within the institution, following protocol and procedure for registering complaints and attempting to provide for corrective action satisfy the responsibilities of the individual. The failure of the institution to act after being informed will create a separate institutional liability.

State medical practice acts and nurse practice acts as well as federal law⁹ provide immunity for people who report in good faith the incompetence, impairment, or inappropriate practice of another professional.

Conclusion

The health care environment requires cooperation and teamwork. Physicians are dependent on many other health care professionals in a health care institution to ensure good patient care. These interdependencies are unavoidable and are increasing in magnitude and complexity; therefore it is important to understand that, generally, the team members' potential liability and legal responsibility are easy to analyze. The degree of duty and responsibility is in proportion to the amount of control and knowledge of the potential for foreseeable harm. The health care professional is obligated to take actions to protect the interests of patients, who are innocent parties in the health care environment. A failure to act in the interest of good patient care or in the protection of the public welfare creates liability. Apart from concern about becoming a codefendant because of a failure to discipline or supervise, health care professionals should consider the fact that there are many different ways to fail the patient, including allowing another to harm the patient. The public responsibility of licensed health care professionals is the "brother's keeper" responsibility. Health care institutions, on the other hand, have a separate and independent corporate responsibility to ensure quality of care within their organizations. Failure to require proper credentials, inappropriate hiring practices, and failure to develop proper quality assurance and peer review within the institution place the governing body and the institution at great risk if patient harm results from that failure.

INSTITUTIONAL PRACTICE

Historical Origins

Hospitals evolved in this country during the eighteenth, nineteenth, and early twentieth centuries along the lines of the European (particularly the British) model as charitable institutions and, in some cases, as almshouses for the poor. Because of this focus, many hospitals were affiliated with or originated from various religious orders. To foster and support these institutions, the law developed the doctrine of charitable immunity to protect hospitals from legal liability.¹⁰ The cases recognizing this doctrine represented a natural outgrowth of their community's origins and the interest in providing services primarily to the downtrodden in society.

It was not until the 1870s, when university teaching hospitals and municipal hospitals began to appear, that secular institutions began to flourish. Despite this shift away from religious affiliations, hospitals continued to enjoy insulation from legal liability, retaining charitable immunity, primarily because of their origins.

Evolution of Functional Hospital Organization and Management (1914 to 1984)

Early in the twentieth century, hospital organizations began to evolve into bipartite and tripartite institutions. The leading case to perpetuate this separation was *Schloendorff v. New York Hospital*, a New York Court of Appeals decision issued in 1914.¹¹ The administrative staff was regarded as the governing body responsible for the overall administration of the hospital, while the medical staff was in charge of rendering patient care. The artificial separation was promulgated in the courts by their erecting a distinction between the "purely ministerial acts" performed by the hospital administration and the medical acts performed by members of the hospital medical staff:

It is true, I think, of nurses, as of physicians, that in treating a patient, they are not acting as servants of the hospital. But nurses are employed to carry out the orders of the physicians, to whose authority they are subject. If there are duties performed by nurses foreign to their duties in carrying out the physician's orders, and having relationship to the administrative conduct of the hospital, the fact is not established by the record.¹²

This medical/ministerial dichotomy continued after *Schloendorff*, although the functional distinction between hospital administration and medical staffs became increasingly blurred. The forces behind this blurring were the increasing use of professional management and business practices, and the increasing professionalism of hospital-employed ancillary health care providers. Physicians are expected to understand, appreciate, and direct multifaceted teams, which often specialize within their own fields in very complex procedures, such as organ transplantation or treatment of specific communicable diseases. Thus, the difference between medical and administrative acts is often decided based on all of the surrounding circumstances, making for

limited consistency and predictability. For example, it was held that administering the right blood by transfusion to the wrong patient was a “ministerial act” in *Necolaff v. Genesee Hosp.*,¹³ while administering the wrong blood to the right patient was a “medical act” in *Berg v. N.Y. Society for the Relief of the Ruptured and Crippled*.¹⁴

This distinction was finally abrogated in 1957, in *Bing v. Thunig*.¹⁵ The New York Court of Appeals overturned *Schloendorff*. Since *Bing*, both regulatory and common law in the health care field have evolved to reflect the interrelationships and interdependencies of the hospital and its medical staff. The JCAHO guidelines also reinforce this corporate relationship.¹⁶ This view of the medical staff as an integral component of the hospital corporation has been confirmed in the decision of *Johnson v. Misericordia County Hospital*.¹⁷ The antitrust case of *Weiss v. York Hospital*¹⁸ may have muddied the water somewhat by referring to the medical staff as being independent to the extent that it may be the “sole decision maker.” Nevertheless, in terms of more practical economic realities, for both hospitals and their medical staffs to survive and, perhaps, thrive in the increasingly competitive health care marketplace, each must emphasize its common directives and capitalize on them in forming new partnerships. To paraphrase Benjamin Franklin, we must hang together or, surely, we shall hang separately.

Evolution of the Legal Responsibilities for Quality Assurance in the Hospital

The Movement Away from Captain of the Ship Doctrine The evolution of the legal responsibilities for quality assurance within the hospital paralleled to a great extent the organizational changes throughout this period. A major development in establishing the legal view that the hospital is more than just a physician’s workshop, but with independent responsibilities of its own, arose from the decision of *Tonsic v. Wagner*.¹⁹ In that decision, the Supreme Court of Pennsylvania overturned their “captain of the ship” holding (from *McConnell v. Williams*, in which a hospital might escape liability for the negligent acts of employees temporarily under the direction of independently contracting physicians): “But such an employee can be temporarily detached, in whole or in part, from the hospital’s general control.”²⁰ Thus the *Tonsic* decision firmly established the principle that a hospital should be held liable for the negligent act of any of its employees even if under the supervision of a non-employee at the time.

The Extension of Hospital Liability to the Acts of Independent Contractors: Apparent Agency The doctrine of apparent agency has substantially contributed to the demise of the hospital’s independent contractor defense. One of the most important judicial pronouncements of this doctrine came again from the Superior Court of Pennsylvania in the case of *Capan v. Divine Providence Hosp.*²¹ First, the hospital’s changing role creates a likelihood that patients will look to the institution rather than the individual physician for care. Thus patients commonly

enter the hospital seeking a wide range of hospital services rather than personal treatment by a particular physician. This is especially true for patients who have no family practitioner. It would be absurd to require such a patient to be familiar with the law of respondeat superior, meaning the patient would have to ask each health care provider whether he or she is an employee of the hospital or an independent contractor. Similarly, it would be unfair to allow this secret limitation on liability contained in a physician’s contract with the hospital to bind the unknowing patient.

Liability of Hospitals and Medical Staff Physicians

Hospital Admissions

Nonemergency In general, a hospital has no duty to admit a patient. However, it must not discriminate because of race, color, gender, religion, or nationality. Under limited circumstances, based on statutory (governmental hospitals), contractual (subscribes to an HMO or other similar arrangement), or common law principles (injury caused by the hospital), the hospital may have a duty to admit. In hospitals engaged in clinical research mandated by the government, the institution is usually allowed discretion to refuse admission, even if the patient may meet criteria for admission. A teaching hospital, however, may not admit a patient contingent on the patient’s participation in the teaching program. Otherwise, the patient’s constitutional right of privacy would be invaded.

Even if a patient otherwise has a right to be admitted, if there is no medical necessity or if the hospital does not possess the services needed, the hospital need not admit the nonemergency patient.²² The principle of no duty to admit reflects judicial restraint in dictating how a hospital should allocate scarce medical resources. Although many of the cases supporting this common law principle date back to the turn of the last century, the majority of the courts continue to apply this doctrine today.²³

Special circumstances may exist that obligate a hospital under common law doctrines to admit a patient if a prior relationship existed between the hospital and patient or where the hospital was the cause of patient injury (i.e., has placed the person in a position of peril). Such circumstances exist if the original injury or complication of treatment occurred as the result of the hospital’s acts or omissions or the hospital begins to provide care to the patient. The hospital may be liable for abandonment if admission is denied under such circumstances.

Emergency The national trend of the law is to impose liability on hospitals for refusal to treat emergencies or if negligent care is provided in their emergency departments. Theories supporting such liability include the following: (1) reliance, (2) agency (respondeat superior), (3) apparent authority (“holding” self out), (4) corporate negligence, and (5) nondelegable duty. These theories are discussed next.

Reliance theory. If the patient relies on a hospital’s well-established custom to render aid in an emergency situation, then the hospital may be found liable for refusing to

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provide the necessary care or for providing negligent care. In *Wilmington General Hosp. v. Manlove*,²⁴ the hospital was found liable under this theory. A child needing emergency care was not admitted to the hospital after the child's private pediatrician could not be reached to approve the admission. In *Stanturf v. Sipes*,²⁵ the hospital was held liable when the administrator refused to approve the admission because of the patient's inability to pay. The court stated:

*The members of the public... had reason to rely on the [hospital], and... that plaintiff's condition was caused to be worsened by the delay resulting from the futile efforts to obtain treatment from the... [hospital].*²⁶

Agency theory. If the emergency department personnel who deviate from the applicable standard of care and cause harm to the plaintiff are considered "servants" of the hospital, then the hospital is vicariously liable under the doctrine of respondeat superior. A servant is defined as "a person employed to perform services in the affairs of another and who with respect to the physical conduct in the performance of the service is subject to the other's control or right to control."²⁷ Other than house staff, staff physicians are usually considered "independent contractors" rather than "servants." Courts must determine that an agency relationship exists based on an analysis of the facts of the case before holding a hospital liable under this theory.²⁸

In *Thomas v. Corso*,²⁹ the hospital was found liable when the emergency room nurse failed to contact the on-call physician. *Citizens Hosp. Ass'n v. Schoulin*³⁰ is a similar case. The claim was based on nursing negligence in failing to report all the patient's symptoms to the on-call physician, failing to conduct a proper examination, and failing to follow the physician's directions. The court found the hospital liable under respondeat superior.

Apparent authority. A hospital may be found vicariously liable for an emergency room physician's negligence even if the physician is considered an independent contractor. The facts would have to establish apparent authority (also referred to as "ostensible agency" or "agency by estoppel"). This theory of liability exists because the hospital is "holding itself out." The hospital will be found liable when it permits or encourages patients to believe that independent contractor physicians are the hospital's authorized agents. The "holding out" must come from the hospital, not the physician.

The landmark case on which this theory is based is *Gizzi v. Texaco, Inc.*³¹ In *Gizzi*, Texaco was held liable for its representations to the public, "You can trust your car to the man who wears the star." This advertisement was sufficient to support the jury's finding against Texaco for the apparent authority it vested in an independent contractor/dealer. The contractor had sold a used car in which the brakes failed, injuring the purchaser. Texaco did not profit from the sale but was aware that the dealer was engaged in this collateral activity.

Corporate negligence. The doctrine of corporate negligence asserts that there exists an independent duty of the hospital for the medical care rendered in its institution. Like the apparent agency theory, it holds the hospital

liable for an independent contractor/physician's negligence. However, a corporate negligence claim is based on the hospital's independent negligence in allowing an incompetent physician to practice on its premise.

Nondelegable duty. The main reason for employers to use independent contractors is to "farm out" services that may be of benefit to the employers but that they may not be willing or able to provide themselves. They also may wish to avoid legal liability for such services. The immunity from liability may be misused or abused. The independent contractor immunity is therefore riddled with exceptions.³²

For public policy reasons, certain duties delegated to an independent contractor have been determined not to confer immunity on the employer. These exceptions have been termed nondelegable duties. They usually represent situations wherein the employer's duty is important, urgent, or imperative. Employers who have such responsibilities cannot avoid liability by delegating those responsibilities to an independent contractor.

In *Marek v. Professional Health Services, Inc.*,³³ the health service was held liable even though it entrusted the reading of a patient's chest x-ray film to a competent independent contractor/radiologist. The theory of liability was that reading the film was a nondelegable duty.

In another case, the Alaska Supreme Court ruled that the defendant hospital was vicariously liable for negligence in its emergency department.³⁴ Such a duty "may be imposed by statute, by contract, by franchise or by charter, or by common law."³⁵ As discussed in this landmark case, the hospital had a nondelegable duty to provide nonnegligent care in its emergency department, based on its state license as a general acute care hospital, JCAHO standards, and its own bylaws.

Statutory Bases for Hospital Liability for Emergency Room Care

Negligence through the provision of substandard care is not the only source of liability. In the last three decades, the law has made denial of emergency care grounds for liability. In *Guerro v. Copper Queen Hosp.*,³⁶ a privately owned hospital operated only for employees of one company was held liable for refusing treatment to an illegal alien who sought care. The Arizona Supreme Court reasoned that the state licensing statute precluded the hospital from denying emergency care to a patient.

A federal law, the Emergency Medical Treatment and Active Labor Act, commonly referred to as EMTALA or the *antidumping statute*, is contained in the miscellaneous provisions of the Budget Reconciliation Act (COBRA) of the Ninety-ninth Congress.³⁷ This statute is a codification of common law theories of liability and emergency department duties. It applies to all hospitals that participate in Medicare and other government medical assistance programs created by the Social Security Act.

The law has had a significant impact on emergency medical care in hospitals. It has improved the plaintiff's chances of recovering damages from hospitals because it eliminates the requirement of proving some of the elements of medical negligence. It governs hospitals with an emergency

department wherein a patient with an emergency medical condition or a woman in active labor seeks medical care. If such a patient is "transferred" from the health care facility to another facility or is discharged, the patient may recover damages for "personal harm" if the condition worsens during or after such transfer or discharge. The patient must prove only that the condition was not "stabilized" at the time of transfer and that the condition deteriorated because of the transfer. To avoid liability, the attending physician or other medical personnel at the hospital must sign a certification that, based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the "increased risks" of transfer.

In addition to the certification requirement, the transfer must also be an "appropriate transfer." Although the signed certification is a simple enough procedure for the hospital to incorporate within its medical record forms, the requirements that will satisfy the transfer include all the following: (1) the receiving facility... has available space and qualified personnel... has agreed to accept transfer... and to provide appropriate medical treatment; (2) the transferring hospital provides... appropriate medical records of examination and treatment; (3) transfer is effected through qualified personnel and transportation equipment; and (4) such other requirements as the Secretary [of Health and Human Services] may find necessary.

Presumably the physician or other medical personnel who transfer the patient have the requisite knowledge of the staffing and competence of the receiving facility and have sought agreement for acceptance by the receiving facility before transfer. These requirements seem applicable whether the receiving facility is an outpatient clinic, nursing home, day care program, or a more intensive treatment center.

Although the physician must be acting as an employee or under contract with the hospital and the hospital must be a participating Medicare provider for the penalty provisions of this law to apply, these are not required for recovery of damages under state law. In addition, the hospital will be liable for damages under this statute or state law whether or not the involved physician is considered an independent contractor under state law.

This federal law seems to preempt state law that "directly conflicts with any of its requirements." It further provides for federal jurisdiction and allows the injured individual to obtain "such equitable relief as is appropriate," giving the federal court discretion to award damages it considers to be warranted. Legal action may be brought up to 2 years after the violation.

A patient who suffers "personal harm" resulting from violation of provisions of this law will be entitled to those damages allowed under the state's substantive law of personal injury and wrongful death statutes. In addition to these damages, penalties of up to \$50,000 per violation against the hospital and the involved physician alike are applicable to provider hospitals and their employed or contracted physicians. The hospital receiving the transferred patient is also indemnified against any financial

losses by the transferring hospital if the transferring hospital has violated the statute.

Clearly, hospitals are no longer to be considered the "physician's workshop." Thus the modern hospital is an integrated center for delivery of health care services, possessing in-house staff and independent contractor/physicians with an array of staff privileges. The hospital can farm out professional services; however, based on public policy and other legal considerations, the trend of the law is to hold the hospital liable for harm resulting from negligence in handling admissions and transfers of patients in its emergency department. As hospitals have become more profitable and business-oriented, the adversarial relationship and the law governing hospitals, patients, and physicians have changed. Although there is no duty for nonemergency admissions by hospitals, under emergency circumstances, the trend of the law is for hospital liability if the patient is harmed as a result of denial of admission or improper care.

Corporate Liability of Hospitals

No doctrine exemplifies the notion of a hospital as a corporate entity with subsidiary components functioning interdependently to deliver a health care product better than the judicially pronounced theory holding a hospital corporately liable for the quality of care delivered by its medical staff. Under this doctrine, it does not matter whether the staff members are employees or purely independent contractors. Under corporate liability, the hospital may be held directly liable for its own negligence in ensuring the quality of health care delivered within its walls.

This doctrine of direct corporate liability of hospitals is traceable to the famous case of *Darling v. Charleston Memorial Hospital*.³⁸ In the *Darling* case, a patient was admitted for treatment of a broken leg through the emergency room of a private, nonprofit hospital, and was attended by a hospital staff physician who was rotating on emergency duty. The attending physician was not skilled in orthopedic work, and a cast was improperly applied so that circulation to the leg was blocked. Although the patient subsequently complained about the leg, and the nurses involved in his care observed the discoloration of his toes, nothing was done. When he was finally examined by another physician, the leg required amputation. The court's decision against the hospital could have been based on a finding of apparent agency on the grounds that the plaintiff had no reason to think that the hospital's attending physician was not employed by the hospital. However, the court went further in holding the hospital itself directly liable for breaching its own duty of care to the patient in failing to "require consultation" with a member of the hospital surgical staff skilled in such treatment or to review the treatment rendered to the plaintiff, and to require consultants to be called in as needed.

The court recognized the hospital's own central role in the overall treatment of the patient, thereby requiring the hospital itself to become directly involved in the health care delivery process. Hospitals could be held directly liable for their own corporate negligence in providing health care services.

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Before this case, the corporate duties of hospitals were limited to three areas, unrelated to direct patient care:

1. The duty of reasonable care in the maintenance and use of equipment.
2. The availability of equipment and services.
3. The duty of reasonable care in the selection and retention of employees.

Since *Darling* and its progeny, hospitals must be much more mindful of their selection and retention of staff physicians.³⁹⁻⁴³

Medical Staff Credentialing

Evolution of the Basic Hospital-Physician Relationship

The rights, duties, and protections afforded to the hospital and its medical staff have traditionally been analyzed by reference to the quality and quantity of the delivery of patient care. The law recognizes that the hospital's governing body must assess the qualifications of physicians who request admission to the hospital staff and must monitor the quality of medical care delivered to hospital patients.

The hospital is generally protected under the law when its decision whether to appoint or reappoint is based on considerations related to the quality of medical care rendered within the hospital or to a physician's professional conduct. Such considerations may involve an assessment of the physician's technical and clinical competence, as well as other relevant factors, such as his or her ability to cooperate with co-workers and support staff.

Although the hospital governing body has the duty to ensure the quality of patient care in the hospital, it has neither the expertise nor the proximity to specific situations to monitor adequately the actual delivery of medical services. Accordingly, the typical hospital governing body delegates much of its quality assurance responsibilities to the medical staff, and the governing body retains the ultimate monitoring or oversight responsibility. The medical staff organization usually uses its committee structure to provide the actual quality assurance mechanism by which the institution's quality of care may be maintained. This structure is formalized through the hospital and medical staff's bylaws, rules and regulations, standards of performance, and procedures for peer review.

The Professional and Economic Significance of Hospital Staff Privileges

The hospital, with its special care facilities and interaction of experts and trained professionals, has been the major centralized provider of medical services in the United States for over a century. However, more and more treatment procedures are becoming decentralized with the establishment of ambulatory surgery centers, less invasive treatments, and home health care. However, it remains true that a physician who is denied access to a hospital facility may be severely hampered in his or her practice. Gaining and retaining clinical privileges in at least one hospital has become practically essential for most physicians to practice medicine.

Still, staff privileges are just that—privileges. There is no fundamental or constitutional right to practice at a particular hospital.⁴⁴ In some jurisdictions, however, the procurement of a valid license may create a right to appointment in the absence of actual incompetence.⁴⁵ The current revolution in health care financing and competition is adding yet another layer of complexity to this decision-making process. As physicians seek to attain or retain clinical privileges, hospitals and medical staffs are becoming more selective with respect to whom they grant clinical privileges. In some cases, as part of long-term strategic planning, whole departments of clinical services may be eliminated or curtailed substantially because of economics, an adverse reimbursement climate, and patient population needs. All of these developments have brought the dilemma of hospital corporate liability versus physician staff privileges disputes into bold relief. These issues are discussed in more detail later in this chapter. The remainder of this part deals with the various types of staff privileges available, the process involved in obtaining and retaining them, and the protections, theories of liability, and remedies available in the denial, deferral, limitation, or withdrawal of these staff privileges.

Nature and Type of Staff Membership

Active Medical Staff

In most hospitals the active medical staff consists of practitioners who meet certain basic educational, training, and background experience requirements. Typically, they are either board certified or board eligible in their area of specialty. They may regularly admit patients to the hospital, or are otherwise involved in the care of hospital patients, or participate in a teaching or research program of the hospital. They are normally required to actively participate in the staff's patient care audit and quality assurance activities. It is not unusual for active staff members to be required to provide care within their area of specialty to those "unassigned" patients who are admitted through the emergency room. Each active medical staff member retains responsibility within his or her area of professional competence (as prescribed by clinical privilege delineation determinations) for the daily care and supervision of each patient in the hospital for whom he or she provides services.

Consulting Staff

Typically the consulting staff consists of practitioners who are members of the active staff of another hospital where they actively participate in the patient care audit and other quality assurance activities, who are of recognized professional ability in a specialized field, and who are not members of another category of the medical staff. Consulting staff members cannot admit patients and their clinical privileges are limited to their particular area of expertise.

Courtesy Staff

The courtesy staff consists of practitioners who admit a limited number of patients per year and who are members of another hospital's active medical staff where they actively participate in patient care audit and other quality assurance activities.

Affiliate Staff

The affiliate staff group consists of practitioners who are not active but have a longstanding relationship with the hospital. Typically, these practitioners may not admit patients or be eligible to hold office or vote in general staff and special meetings.

Outpatient Staff

The outpatient staff consists of practitioners who are regularly engaged in the care of outpatients on behalf of the hospital or in a program sponsored by or associated with the hospital, who do not wish to assume all the responsibilities incumbent on active staff membership. Each outpatient staff member retains responsibility within his or her area of professional competence for the daily care and supervision of patients under his or her care while actively participating in the patient care audit or other quality assurance activities required of the staff.

Honorary or Emeritus Staff

Members of the honorary or emeritus staff are practitioners who are not active in the hospital but are being honored for their outstanding accomplishments or reputation. These members may also be former members of the active staff who have retained and may retain admitting and clinical privileges to the extent recommended by the medical board and board of directors.

House Staff

Members of the house staff group are either fully licensed physicians or physicians who have received appropriate certification from the state medical board authorizing them to enter postgraduate study in a particular hospital. They may admit patients within the specialty department to which they are assigned with the approval of an active staff member in that department who is responsible for the care of that patient, and they may exercise clinical privileges as established within the residency training program.

Allied Health Professional Staff

Allied health professionals represent a group of nonphysician coproviders, including podiatrists, nurses, psychologists, and so forth, who may provide specified patient care services under the supervision or direction of a physician member of the medical staff. They may write orders to the extent established in the rules of the staff and department to which they are assigned, but not beyond the scope of their licenses, certificates, or other legal credentials. The 1990 JCAHO Accreditation Manual for Hospitals accommodates the entry of these nonphysician providers into the hospital's health care delivery system.

Staff Application and Renewal

The Public/Private Hospital Distinction

Constitutional and statutory protections typically have imposed more restrictions on public hospitals in the area of staff privileges decisions. Increasingly, however, acts of

formerly private hospitals have come under a level of scrutiny similar to that for public hospitals.

The two most common theories of medical staff guarantees advanced by physicians have been (1) that the hospital has a fiduciary relationship with the public because of its tax-exempt status, as well as its health and charitable activities, and (2) that by virtue of the hospital's receipt of certain public monies (e.g., Hill-Burton funds), its acts amount to "state action." Such hospital acts were therefore claimed to be subject to the Fifth and Fourteenth Amendments to the Constitution, requiring due process of law for the benefit of persons otherwise being deprived of life, liberty, or property rights. This justification finds its specific application to the physician appointment and reappointment process through the analysis of staff privileges as a necessary means of guaranteeing the liberty right of practicing one's profession.

Delegation of Credentialing Decisions to the Medical Staff

The governing body of the hospital (although ultimately responsible for the quality of care delivered) delegates to the medical staff the decision-making process for physician credentialing. The medical staff ordinarily then delegates these specific functions to a select credentials or peer review committee to make these determinations. Initial appellate decision-making authority for these determinations is usually passed to a medical executive committee. The composition of this committee is variable, but it usually consists of clinical department and division chiefs or service and section heads, as well as medical and hospital administrative personnel.

The Process

A current or aspiring member to a medical staff submits a completed application including proof of medical education, licensure, board eligibility or certification, supporting materials including recommendations concerning current clinical competence and ethical practice, recent (5 years) ongoing as well as adverse claim experience, and a completed privileges delineation request form to the secretary of the medical staff or the hospital administrator. After this, the physician may be interviewed by the department chair who prepares a written report and recommendation concerning staff appointment and clinical privileges, which is then transmitted to the credentials committee.

After initial processing, the application for past record is reviewed by the credentials committee. The credentials committee then transmits to the medical executive committee (sometimes known as the medical board) a written report and recommendation as to staff appointment, category, department, and clinical privileges delineation, including special conditions.

The medical executive committee then forwards to the executive director for transmittal to the board of directors a written report and recommendation for clinical privileges to be granted with any special conditions to be attached to the appointment. Physicians receiving adverse

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determinations may follow an appellate procedure roughly paralleling the foregoing process.

Considerations for Acceptance or Rejection

The following represent general criteria considered in the staff privileges decision-making process:

1. Education, training, background, and experience.
2. Need in the department.
3. Ability to work with others.
4. Ability to meet eligibility or other requirements specified in bylaws.
5. Freedom from conflict of interest.
6. Utilization of hospital experience facilities.
7. Maintenance of professional liability insurance.
8. Willingness to make a full-time commitment to the institution.
9. Whether the hospital is the physician's primary inpatient facility.
10. Status of medical record-keeping and risk management experience.
11. Freedom from false or misleading information.
12. Current clinical competence, ethical practice, and health status.
13. A willingness to comply with bylaws and regulations.
14. Continuing medical education as required.
15. Evidence of previous or current action taken in licensure or privilege matters.

Several of the preceding criteria might carry potential antitrust implications if applied to deny or limit clinical privileges in some contexts. Curtailment, based on these criteria, should specify with considerable particularity why privileges were denied, deferred, or limited.

Legal Protections Available to the Physician

Hospital and Medical Staff Bylaws

It is well settled under the law that hospitals acting through their medical staffs must comply with their own internal procedural rules (i.e., bylaws). Failure to do so, at the very least, will invite judicial review. On finding a significant failure, a court could nullify the whole process and require the hospital to review the physician's qualifications again in accordance with all internal policies, procedures, and bylaws. Examples of particular procedural rules that should appear in bylaws include (but are not limited to) the following:

1. Adequate notice to the physician of the adverse decision.
2. Making available a fair hearing process for aggrieved physicians.
3. Communicating adequately to physicians the factors governing the credentialing decision.
4. Allocating properly the burden of proof during the hearings.

Contract Theory of Medical Staff Bylaws

In Pennsylvania and some other states, the medical staff bylaws may be viewed as part of a contractual relationship

between the hospital and members of its medical staff, so that modifications may only be made pursuant to amendment procedures established in the bylaws themselves. In Pennsylvania, as well as other states adopting this approach, it may be considered a breach of contract for a hospital to violate procedural protections afforded under its medical staff bylaws in the physician credentialing process.

There may have been an inadequate number of court decisions to make it clear whether any such breach would make available to aggrieved physicians the whole panoply of common law contractual remedies. It is also unclear whether this contractual analogy may apply to the situation of an applicant who is not yet a member of the medical staff.

Protection from Economic Harm

There may be some protection from tortious interference with a physician's ability to practice his or her profession. In many jurisdictions (e.g., New Jersey), this has been recognized as a valid claim under tort law. In general the intent to deny privileges without legal justification is sufficient to permit this type of claim to go forward in litigation. In addition, interference with trade or business may be alleged as a violation of the federal or state constitution, if the hospital is considered to be a public institution as discussed earlier. If two or more individual staff members or other persons conspire to deny privileges wrongfully, then a "restraint of trade" claim may also be possible (i.e., a Sherman Act Section 1 violation as discussed later in the antitrust subsection). In addition to possible claims under federal antitrust laws, some state courts (notably New Jersey) also permit these suits.

Protection from Defamation

Physicians involved in the credentialing process are usually seen to be protected from defamation, or "the holding of a person up to ridicule, in a respectable and considerable part of the community." Typically, the hospital and medical staff may have several defenses available to claims by physicians that they have been defamed during the credentialing process.

First, no liability from defamation will attach to the hospital or its staff if the allegedly defamatory statements are true. Second, the physician applicant consents to the making of these statements by voluntarily going through the credentialing process. Third, public policy requires that persons who are asked to give statements to assist in the credentialing process should be protected by the law for such statements to guarantee that they are given without fear of reprisal and to ensure that the best possible decisions are made to ensure patient safety and welfare. In most contexts, this is a qualified privilege. In the absence of malice, this privilege applies to physicians and others involved in the credentialing decision—physicians, in making comments, must make them in a proper setting for statements to be protected.

Due Process Protection

In the case of hospitals owned or controlled by public agencies or private hospitals acting under the color of state law by

having a fiduciary relationship with the public, substantive and due process safeguards may become available to physicians seeking to attain or retain staff privileges.

Substantive due process requires that the reasons behind the denial of a physician's staff privileges must be rational and not arbitrary or capricious. Claims based on an alleged violation of substantive due process may involve, for example, challenges to per se rules imposed by the hospital, such as minimum educational requirements (beyond those required for licensure) or board certification in a clinical specialty.

Procedural due process requires that the physician receive adequate safeguards concerning the process itself in determining whether he or she should be granted staff privileges at a particular hospital. A significant number of federal court decisions have held that denial of privileges by a private health care provider is not sufficiently regulated or controlled by the state to invoke federal jurisdiction.^{46,47} However, it is now becoming clear that regardless of whether the hospital concerned is public or private, a physician has a federally protected right to due process.^{48,49} These procedural safeguards may include (but are not limited to) the following:

1. Notification of the adverse determination.⁵⁰
2. If the physician requests a hearing, written notice of the charges with sufficient specificity to give the physician adequate notice of the reason for an adverse ruling.⁵¹
3. Adequate time to prepare a defense.⁵²
4. Opportunity for prehearing discovery.⁵³
5. A hearing panel composed of impartial, fair-minded physicians.⁵⁴
6. Appearance before the decision-making panel.
7. Assistance of legal counsel during the hearing.
8. Cross-examination of witnesses.
9. Presentation of witnesses and evidence in defense.⁵⁵
10. Transcript of panel hearing available for review before appellate hearing.⁵⁶
11. Written decision from the panel for judicial review.

Employment Practices Discrimination

A newer theory that physicians might be able to assert comes under the umbrella of employment practices discrimination. Although this cause of action historically arose in occupations other than medicine, it may be available, at least, to employed physicians. Another type of action might become available to physicians who have lost or failed to obtain staff privileges as a result of their having made prior written or oral statements critical of peers or of the policies of the hospital at which they have lost privileges. A relevant court decision in this connection is *Novosel v. Nationwide Insurance Co.*⁵⁷ There, the federal appeals court in Philadelphia upheld an employee's right to sue his employer where he may have been wrongfully discharged for having asserted a right protected by an important public policy, namely, freedom of speech and political association.

Antitrust Safeguards

Approximately 26% of this country's physicians are involved in exclusive contracts with hospitals. These contracts with

providers such as radiologists, pathologists, anesthesiologists, and sometimes cardiologists or emergency physicians have become the subject of Sherman Act antitrust challenges in recent years. To invoke a violation of Section 1 of this act, a plaintiff must assert the following:

1. That the parties against whom the antitrust action is brought have agreed among or between themselves (i.e., conspired) to engage in activities that restrain trade.
2. That the effect of this conspiracy is to restrain trade and is anticompetitive in nature.
3. That these anticompetitive practices affect consumer choice of services in a relevant market population covered by the agreement or conspiracy.
4. That these anticompetitive practices have a substantial and adverse impact on interstate commerce.

Aggrieved parties have also alleged violation of Section 2 of the Sherman Antitrust Act. Section 2 prohibits the willful acquisition or maintenance of monopoly power in a relevant geographic market within which the provider of services operates, and as a practical matter to which the purchaser of those services may turn for these services. Acquiring or maintaining the power to control market prices and exclude competition in such an area could amount to a Section 2 violation involving monopolistic practice. Section 2 violations do not require a conspiratorial agreement. Assuming that federal jurisdiction may be established by showing that anticompetitive practices have a substantial adverse impact on interstate commerce, an analysis of the merits of an antitrust claim in a credentialing case may proceed.⁵⁸ In the most famous recent case analyzing the merits of an antitrust claim concerning the staff privileges of an unsuccessful applicant to a closed medical staff of anesthesiologists, the U.S. Supreme Court held that this type of exclusive contract did not violate Section 1 of the Sherman Antitrust Act.⁵⁹

The theory of liability was that, through the vehicle of this exclusive contract, consumer choice was limited because the anesthetic services of the hospital were illegally tied to its surgical services (i.e., if you went to a hospital to undergo surgery, then you had to accept the exclusive panel of anesthesiologists). The Supreme Court, however, held that there was no shortage of other hospitals with comparable services in the New Orleans area from which patient/consumers could choose other surgeons and anesthesiologists for their operations.

Justice O'Connor and three other justices concurred in the result, but stated that this type of practice should have been sustained because it was justified by matters of medical and administrative efficiency (i.e., it satisfied rules of reason while not constituting an illegal practice according to federal antitrust laws). This decision (although not finding an antitrust violation) may be most significant to the health care industry by confirming that relationships among hospitals, physicians, and their patients are subject to the same antitrust principles that apply to others involved in commercial activities.

The decision may also be just as notable for what it does not say. For example, exclusive contracts in areas with only one hospital near state borders, which involve services with

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independent markets, may well violate Section 1 of the Sherman Act. Clearly, now that the courts regard health care as a commercial activity, the range of antitrust violations may well increase depending on the specific facts and circumstances in each case.

In 1984 the Third Circuit United States Court of Appeals reconfirmed the applicability of traditional commercial analysis to the activities of hospitals and their medical staffs in excluding certain groups from staff membership.

In *Weiss v. York Hospital*,⁶⁰ Dr. Malcom Weiss had filed a Sherman Act antitrust action as a member of a group (osteopathic physicians) who had been excluded from membership on the hospital's medical staff. The lower court had found that this group boycott by York Hospital and its medical staff violated Sections 1 and 2 of the Sherman Act. The Third Circuit Court of Appeals in Philadelphia, while reversing the Section 2 violation finding, concurred with the lower court that this practice violated Section 1 of the Sherman Act. The appellate court found that regardless of whether or not the medical staff was acting as an agent or independently of the hospital in this practice, there was a conspiracy among individual staff physicians to exclude osteopathic physicians.

This case confirmed that whether or not the medical staff is an entity separate from the hospital, individual physicians compete with each other and thus may conspire to limit competition in violation of Section 1 of the Sherman Act. With the dramatically increasing numbers of MDs, DOs, DDSs, DPMs, DCs, MSNs, PAs, and other health care professionals, the impact that this case should have on future efforts by MDs to boycott certain non-MD groups cannot be overstated.

Available Remedies to Aggrieved Physicians

A physician denied clinical privileges may be entitled to a variety of remedies if he or she prevails in litigation against the hospital. The remedy usually depends on the infraction. An injunction may be available. The court may prevent the hospital from denying or curtailing staff privileges (permanently or at least until a full hearing and final decision is made by the hospital concerning appointment or reappointment).

To obtain injunctive relief, a physician must show that he or she could be irreparably harmed if the injunction is not granted. However, even if a physician can show this and gets an injunction, the finding will not act to prevent the hospital from denying staff privileges based on subsequent events. Furthermore, injunctive relief is inappropriate if internal hospital administrative remedies have not been exhausted or are still available as prescribed by hospital and medical staff bylaws. In appropriate circumstances (usually limited to federal cases involving public institutions), a court may order a hospital to appoint or reappoint a physician or at least grant a hearing or other procedural safeguards during the credentialing process.

Another remedy is monetary damages—compensatory or punitive. Compensatory (or civil) damages may be justified

if the court finds that the hospital or its medical staff interfered with the physician's right to practice his or her profession, or that the denial of privileges was part of a conspiracy to violate the applicant's civil rights. Such damages must be proven by the physician based on (1) his or her inability to admit patients to the hospital, (2) the denial of privileges at other hospitals because of the bad publicity generated by this adverse decision, (3) the physician's loss of patients or income because of the denial, or (4) the loss of the physician's professional standing or reputation in the community.

Punitive damages are unlikely to be imposed except when the denial of privileges was the result of legally willful, wanton conduct that the court seeks to prevent in the future by making an example of the defendants.

A group or even an entire class of physicians or non-physician medical personnel may seek any of these remedies. A class action may be brought in which the allegation concerns discriminatory exclusion of minorities, osteopathic physicians, dentists, nurse practitioners, physician assistants, chiropractors, podiatrists, or others.

Guidelines for Hospital and Medical Staff Credentialing

Hospital and Medical Staff Bylaws

There are many key people primarily responsible for staff privileges decisions. These department chairs and members of the medical executive and credentials committees must be well versed in the procedural and substantive safeguards provided to physicians by law and by the hospital and medical staff bylaws, rules, and regulations.

In determining whether to appoint or reappoint a physician, the decision-makers should identify the specific reason or reasons for restricting staff privileges. The medical executive and credentialing committee should specify as many reasonable grounds for denial as possible and, whenever appropriate or relevant, should reference these grounds to medical staff bylaw provisions.

Grounds for denial or limitation of privileges should be adequately documented. They must be reasonably related to a legitimate purpose or purposes, preferably in furtherance of the hospital's overall mission. Moreover, the hospital, through its medical staff and executive committee, should be sure that its actions demonstrate that it applies these grounds in a nondiscriminatory fashion using principles of fair play and due process as established in its hospital and medical staff bylaws.

Specific Measures to Minimize Liability

There are other, more specific measures a hospital can and should take to minimize its potential liability exposure in credentialing matters.

First, the hospital must ensure that it complies with the various statutes, regulations, and informal requirements governing the conduct of the hospital and its medical staff. This crucial goal should be achieved by drafting the hospital and medical staff bylaws carefully and clearly in accordance

with the guidelines of the state department of health, the JCAHO, and the Department of Health and Human Services. Further, if the hospital accepts Medicaid patients, its bylaws should comply with the guidelines of the state department of public welfare. Of particular importance, the medical staff bylaws must comply with state department of health regulations and JCAHO guidelines regarding the classification and delineation of privileges. They should provide mechanisms for review of decisions affecting clinical privileges, including guarantees that physicians may be heard at each step of the process. Even when the medical staff sets out to adopt bylaws that are as straightforward as possible, it should ensure that credentialing and hearing procedures are fully and clearly set forth and followed.

Second, the hospital should implement measures during the application and reapplication process that will reduce the likelihood that a rejected physician will have a basis for subsequent legal action. For example, during the initial evaluation or reevaluation of a physician, an interview between the physician and the chairman of the department of service is advisable. This interview should be more than cursory; it should be designed to determine the extent of the physician's commitment to the hospital and to identify any problems that might arise during the credentialing process.

The hospital should verify the applicant's credentials and solicit written recommendations. The facility must also query the National Practitioner Data Bank to check for reports of privilege actions or malpractice settlements on the applicant. For physicians just out of training, professors and program directors should be asked to submit evaluations. The hospital should specify that it will use the comments to assist in evaluating the physician's suitability for clinical privileges in the hospital, and may communicate the substance of the comments to the physician. After it has cleared this with the commentators, it should scrutinize all solicited and unsolicited information for bias.

Third, the hospital should notify in writing all physicians whose requested privileges are denied or restricted. The notice should sufficiently detail the reasons, supported by adequate documentation. The decision should be communicated as being irrevocable and mandated by an interrelated combination of factors, rather than because of one or another specific reasons. This reduces the likelihood that the applicant will attempt to challenge the decision by challenging one of its bases. The hospital must scrupulously avoid irrelevant or potentially prejudicial considerations (such as "the hospital already has enough female obstetricians"). Physicians involved in the decision-making process for a potential competitor may be advised to excuse themselves or to abstain in the voting process. It should base its decision primarily on its need to maintain high-quality medical care. The hospital must communicate the reasons to the physician with appropriately chosen language. Hospital counsel may assist in this drafting.

Fourth, the hospital should maintain thorough documentation throughout the evaluation period. This provides

protection to the hospital, medical staff, and individual members of the credentials and executive committee in the event of subsequent litigation by rejected physicians. The hospital, through its medical staff and various committees, should also take steps to enable applicants to withdraw gracefully before a formal denial of privileges, if that would be the likely outcome of a full review.

Minimizing Due Process Claims

Procedural Due Process Hospitals should satisfy procedural safeguards during the credentialing process to avoid claims by rejected physicians that they were not treated fairly or had an inadequate opportunity to be heard. At a minimum, the hospital should provide timely notice to physicians concerning the restriction of privileges, or of adverse decisions by the credentialing or executive committee or the governing body. Additional safeguards may include the following:

1. Independent legal counsel for the physician during the formal hearing process (although this may not extend to representation during the hearing itself).
2. Liberal discovery by the physician and his or her attorney before formal hearing.
3. The right to cross-examine evaluators.
4. Right of appeal to the governing board.
5. Notification in writing of all adverse decisions and the reasons for them.

Substantive Due Process Courts have recognized that there are many permissible justifications for denying or restricting clinical privileges. One such justification is the physician's inability to meet the legitimate eligibility requirements specified in the bylaws. These eligibility requirements may relate to the physician's education, the length or nature of the physician's residency, the amount or nature of the physician's professional liability insurance coverage, or other specifics regarding the physician's training, experience, competence, ethical practice, or adherence to professional standards.

Another legitimate reason for denying or restricting privileges is the perceived inability of the physician to make a full-time or otherwise adequate commitment to the responsibilities expected of staff members. This inability may be due to the physician's conflicting commitments at other hospitals, or simply because the physician does not choose to commit to the hospital's operational and administrative needs. If the physician would be a particular asset to the staff, however, then the hospital may wish to extend to him or her courtesy or consulting privileges. It is similarly appropriate to deny clinical privileges to a physician who fails to meet any other requirements imposed by the hospital or medical staff bylaws, such as the failure to submit the necessary references or to attend a sufficient number of meetings or pay dues.

As a final example, the hospital may base its denial on "interaction considerations." These may include the physician's poor patient relations, his or her uncooperative or disruptive behavior, or any similar perceived inability to

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contribute to the supportive atmosphere of trust and cooperation essential to the successful administration of the hospital and the delivery of high-quality health care.

Many other substantive criteria have been legitimately used by hospitals to justify restrictions or denials of clinical privileges. Some criteria, however, may have anticompetitive overtones. In the current procompetitive health care climate, these criteria should be evaluated carefully before being used as a basis for justifying the restrictions of a physician's clinical privileges, regardless of their legitimacy. Some of these suspect criteria may include, under appropriate circumstances, the services in the department, the lack of need for the physician's specific services, or any other alleged overburdening of the hospital's facilities.

Medical Staff Peer Review

The *Patrick* Decision

On May 17, 1988, the U.S. Supreme Court decided one of the most important cases affecting the medical staff peer review process in the last century. In *Patrick v. Burget*,⁶¹ the court held that where medical staff peer review was not actively administered or supervised by the state, physicians sitting on peer review committees were not entitled to absolute immunity from federal antitrust actions if their actions to exclude other physicians from staff membership were for anticompetitive or other reasons not directly related to improving the overall quality of care.

The *Patrick* decision established constraints on physician peer review, the reasons for excluding physicians from medical staffs, and the procedures used in achieving this. Following *Patrick*, physicians may not be excluded primarily for economic, as opposed to quality of care, considerations. Moreover, to escape federal antitrust liability, the peer review must allow physicians undergoing evaluation full fair hearing protection to ensure adequate procedural due process. Medical staff physicians and their hospitals can use a number of approaches to limit their federal antitrust liability. Specifically, some of these include (but are not limited to) the following:

1. Rewrite medical staff bylaws to ensure that all requisite procedural due process safeguards protecting the evaluated physician are in place and are enforced fairly;
2. Have each medical staff peer review member establish his or her freedom from economic conflicts of interest before making recommendations that could adversely affect the staff privileges of another potentially competing physician;
3. Have physician peer reviewers subject their own requests for continuing staff membership and clinical privileges to review bodies constituted by professionals not sitting on the same committees or departments that are chaired by the physician being evaluated to avoid possible claims of undue influence; and
4. Have, as chairs of credentialing committees and other sensitive medical care review committees, salaried physician executives who are not dependent on referrals from physicians being evaluated.

As instructed by the U.S. Supreme Court, if physician peer reviewers are still not satisfied with the protections afforded by the *Patrick* decision, then they may look to Congress—specifically to the protections from federal antitrust immunity following from compliance with the Health Care Quality Improvement Act of 1986.⁶²

The Health Care Quality Improvement Act of 1986

In an attempt to minimize the problem of unqualified physicians hopping from state to state and to improve the process of physician credentialing in general, Congress, on November 14, 1986, passed the Health Care Quality Improvement Act. This act, in conjunction with the Medicare and Medicaid Patient Protection Act of 1987 and the Social Security Amendments of 1987, created a National Practitioner Data Bank which will collect, store, and release information on the nation's 6 million health care practitioners, including the following:

1. The details of any professional liability actions filed against them following the implementation of the bank;
2. The circumstances behind any licensure restrictions;
3. Whether they have had their staff or clinical privileges restricted for a period of more than 30 days at any hospital or other health care entity; and
4. The facts behind any professional society membership loss or restriction.

Hospitals and other health care entities must access this information concerning all physicians and nonphysician health care practitioners whenever these persons are subject to credentialing or recredentialing. Failure to do so will result in the hospital or health care entity losing the act's limited federal antitrust immunity provisions. In any corporate liability or similar action it will be presumed that the hospital or other health care entity has knowledge of these practitioners' credentials (or relative lack thereof).

The hospital must also routinely (every 2 years) request information from the clearinghouse concerning all licensed health care practitioners with medical staff membership or clinical privileges at the hospital.

The act allows the Secretary of Health and Human Services to disclose clearinghouse information affecting a particular physician or health care practitioner, to that person. Procedures would also be established for disputing the accuracy of such information. The act enables parties involved in medical malpractice actions, including plaintiffs' attorneys, to obtain access to information held by the clearinghouse.

Risk Management Principles

One area in which risk management is particularly necessary involves exclusive contracts between hospitals and physicians. Exclusive contracts are usually permissible; however, they must have rational reasons to support their existence. Legitimate reasons for exclusive contracts include (but are not limited to) the following:

1. Controlling the efficient administration of a specific type of medical service;

2. Limiting the department's size to cope with bed limitations and the hospital's overall mission;
3. Maintaining the economics of hospital operations;
4. Optimizing the effective use of personnel and technologies by having such controlled by only one physician group;
5. Promoting uniform teaching and research methodologies; and
6. Limiting the utilization of certain technological equipment to those most qualified.

When negotiating exclusive contracts, it is usually unwise to specify too narrowly in the contract language the reasons for entering into the exclusive arrangement. Overspecification might restrict the hospital's maneuverability in the event that the exclusive contract is challenged on specific antitrust grounds. The exclusive contract should delineate reasons for its existence, but it is better to frame these reasons in general terms, such as those specified in the previous paragraph. Similarly, it is better to specify several reasons for the exclusive arrangement rather than merely one reason. Some attorneys believe it may be best simply to use broad language supporting the hospital's goal of optimal medical care within the limitations of the facilities and resources available.

Hospitals and their staff physicians have become more economically interdependent than ever. Both must be continually conscious of how their present health care practice styles may economically affect their ability to continue to provide high-quality care in the future. A hospital's ability to compete effectively will soon be related directly to its ability to influence the economic aspects of its physicians' medical practice styles. Similarly, a physician's ability to compete effectively will soon depend on his or her ability to gain ready access to the extensive resources of at least one economically viable hospital with state-of-the-art technology and high-quality personnel.

Hospitals have a legal right and duty to maximize the quality of care provided on the one hand, but they also must afford certain safeguards to physicians in the appointment and reappointment process. The key to minimizing litigation is to strike a delicate balance between the private rights of physicians to practice medicine and the public rights of patients to reasonable medical care.

Hospitals (and physicians) face unprecedented economic pressures to compete effectively in a buyer's market. Exclusive arrangements between hospitals and physicians in an attempt to insulate themselves from this free market competition may subject them to the risk of treble damages arising from Sherman Act Section 1 or 2 violations. These arrangements must be reasonable in light of the practices of comparable institutions, local market conditions, and the medical as opposed to the economic motivations behind such agreements.

The practice of medicine in America is in the midst of an unprecedented economic transformation. The traditional providers, including inpatient hospitals and fee-for-service private practitioners, must take the lead to respond to this changing environment. These providers have the unique skills and resources that permit them to compete effectively

with virtually any new alternative health care delivery system, without compromising the quality of care or the integrity of the medical profession.

Hospital Privileges and Due Process*

Because of the increasing number of practicing physicians⁶³ and expanding theories of liability against hospitals based on the granting of privileges⁶⁴ or the failure to restrict or revoke privileges,⁶⁵ there are now a significant number of judicial decisions dealing with the entire privileging process. What follows is a discussion on the legal issues involved with special emphasis on the due process rights that must be accorded to a physician when his or her privileges are denied, reduced, or revoked.

The Nature of a Physician's Interest in Hospital Privileges

As mentioned, the great majority of physicians need hospital facilities for the pursuit of their profession.⁶⁶ Although a physician does not have a constitutional right to practice medicine in a hospital,⁶⁷ obtaining a medical degree and a license to practice medicine does give the physician a property interest that is given certain constitutional protection. In *Anton v. San Antonio Community Hospital*,⁶⁸ the court described this interest as follows: "The essential nature of a qualified physician's right to use the facilities of the hospital is a property interest which directly relates to the pursuit of his livelihood."⁶⁹ The court in *Unterhiner v. Desert Hospital District of Palm Springs*⁷⁰ stated: "A doctor who has been licensed by the state to practice medicine has a vested right to practice his profession and it cannot be said that there are no elements of a right to be admitted to a hospital."⁷¹ Because the states and their subdivisions are prohibited by the United States Constitution from depriving any person of property without due process of law,⁷² a hospital must afford a physician substantive and procedural due process when it acts with regard to his or her hospital privileges.⁷³

Private Versus Public Hospitals Numerous decisions have dealt with the distinction between private and public hospitals.⁷⁴ When a public hospital is involved there is no question that the hospital is acting as an agency of the state.⁷⁵ In cases involving a private hospital, there usually must be a finding that the hospital's actions constituted state action or were done under color of state law.⁷⁶ This requirement of state action has been found where the hospital receives substantial federal or state funds,⁷⁷ licensing by the state,⁷⁸ or even contributions from the public during the hospital's annual fund drive.⁷⁹ Some courts have chosen to focus on the responsibilities of the hospital rather than the rights of the physicians and have held that a private hospital occupies a fiduciary trust relationship between itself, the medical staff, and the public, and the actions of the hospital are, therefore, subject to judicial review.⁸⁰ In cases involving

*From Hagerman, 13 L.A.M.P. 51 (July 1985).

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judicial review of hospital decisions regarding privileges, California has done away with the distinction between private and public hospitals altogether.⁸¹

A significant number of federal court decisions hold that denial of privileges by a private health care provider is not sufficiently regulated or controlled by the state to invoke federal jurisdiction.⁸² Nevertheless, it is becoming clear that regardless of whether the hospital concerned is public or private, a physician has a federally protected right to due process⁸³ and the right to be free from arbitrary action on the part of a hospital.⁸⁴

Initial Privileges Versus Existing Privileges The majority of decided cases dealing with hospital privileges involve a physician whose previously granted privileges are revoked or reduced.⁸⁵ Some cases, however, deal with the physician's rights on initial application for privileges.⁸⁶ It has been pointed out that a physician who has had privileges has more of a "vested interest than one who is newly applying."⁸⁷ In California, the extent and nature of judicial review depend on whether the decision of the hospital involved an initial application or existing privileges. In cases involving existing privileges, the court is to make an independent judgment review in determining whether the decision of the hospital is supported by the weight of the evidence. In cases involving new applications, the court is to make a substantial evidence review to determine whether the decision of the hospital is supported by substantial evidence in light of the whole record.⁸⁸ Even though a physician applying for new privileges may have less of a vested interest than one who has already been granted privileges, the physician must be afforded due process that is adequate to safeguard the physician's interest in pursuing his or her profession, and the hospital cannot act arbitrarily or discriminatorily with regard to his or her application.⁸⁹

The Physician's Due Process Rights in Hospital Proceedings

Hospital proceedings that affect a physician's privileges usually occur on four different levels. At the first level there may be a complaint brought against a physician who already has privileges by a patient, another physician, the administrator of the hospital, or the board of directors.⁹⁰ At the second level a committee of the hospital, usually the credentials committee when a new application for privileges is involved, or the executive committee of the medical staff where existing privileges are involved, conducts an inquiry into whether the subject physician's privileges should be granted, denied, restricted, or revoked. No reported cases have been found that give the physician any due process rights at these two levels. Once a decision has been made by a committee or other authority within the hospital that may adversely affect the physician's present or requested privileges, the physician should be given the following due process rights.

Notification of the Adverse Recommendation Once an adverse recommendation has been made that will result in

denial, revocation, or restriction of a physician's privileges, the physician must be notified and informed of his or her right to request a hearing before a panel established to review his or her privileges or application for privileges.⁹¹

Written Notice of the Charges If the physician requests a hearing, then he or she must be given written notice of the charges that will be presented against him or her at the hearing.⁹² The charges must be sufficiently specific to give the physician adequate notice of the nature of the charges.⁹³ A few courts have noted with apparent approval the practice of providing the physician with the hospital chart numbers of those cases that substantiate the charges against him or her.⁹⁴ Although this may be sufficient in view of the reasonable assumption that the physician can read his or her own charts, one court has said that the charges must state "in reasonable fullness the nature of the criticism in each case."⁹⁵

Adequate Time to Prepare a Defense After the physician has been advised of the charges, he or she must be given adequate time to prepare a defense.⁹⁶ The time interval between notification and the hearing date will necessarily vary somewhat according to the circumstances and the extent and complexity of the charges that the physician must defend against.

Prehearing Discovery The physician or the physician's attorney sometimes wishes to conduct discovery before the hearing before the panel. Courts have reached different decisions on this issue depending on the nature of the discovery sought. In *Garrow v. Elizabeth General Hospital*,⁹⁷ the court held that the information that was relied on in making the adverse recommendation should be made available to the physician before the hearing so as to enable the physician to make adequate preparations for a defense. Similarly, in *Suckle v. Madison General Hospital*,⁹⁸ the court held that the physician had a right to access all relevant hospital and medical records during the period in which he was preparing a response to the charges. In cases where the discovery sought is more formal in nature, however, it has not been allowed.⁹⁹ This is in keeping with the often made statement that, in hospital due process proceedings, the physician is "not entitled to a full blown judicial trial."¹⁰⁰ In *Woodbury v. McKinnon*,¹⁰¹ the physician involved was not allowed to conduct discovery by means of depositions and interrogatories to obtain evidence to support his contention that other members of the medical staff were not as good as he was.

A Hearing Panel Composed of Impartial, Fair-Minded Physicians The panel charged with the responsibility of giving the physician his or her due process hearing must be composed of physicians who are impartial and fair-minded.¹⁰² If any physician on the panel actively participated in the investigation of the subject physician or made the original adverse recommendation, then he or she will be subject to challenge on the grounds of bias or lack of impartiality.¹⁰³ In other words, if the functions of investigator,

prosecutor, and judge are being carried out by the same person, then a fair hearing will be presumed to be unavailable and actual bias need not be shown.¹⁰⁴ Courts have recognized, however, that prior involvement by a hearing panel member on some other level will not disqualify that person from sitting on the panel if the involvement was not substantial and did not bring about the adverse recommendation under review.¹⁰⁵ The following additional factors have been identified as having a high probability of destroying impartiality: (1) the panel member has a direct pecuniary interest in the outcome; (2) the member has been personally involved in a dispute with the subject physician or has been the target of his criticism; or (3) the panel member is embroiled in other matters involving the physician whose rights he or she is determining.¹⁰⁶ As stated in *Applebaum v. Board of Directors*: "Biased decision makers are constitutionally impermissible and even the probability of unfairness is to be avoided."¹⁰⁷ If the hospital is a small one and the matter has been particularly vitriolic and disruptive, then consideration should be given to having physicians from outside the immediate hospital area sit on the hearing panel. It has been said, however, that the physician under review is "not entitled to a panel made up of outsiders or of physicians who had never heard of the case and who knew nothing about the facts of it or what they supposed the facts to be."¹⁰⁸

In some instances the physician or his or her attorney has sought to *voir dire* the panel members to discover any bias or lack of impartiality. In *Duffield v. Charleston Area Medical Center, Inc.*,¹⁰⁹ the subject physician asked for and received permission to examine all members of the panel before the hearing began. The trial court in *Hackethal v. California Medical Association and San Bernardino County Medical Society*¹¹⁰ concluded that the subject physician's *voir dire* of the panel members was unduly restricted, and this was found to be a denial of procedural due process. Because a physician has a vital interest in having a fair and impartial panel, it appears that he or she should have a reasonable opportunity to question the panel regarding any matters that may affect their objectivity or lack thereof.

Appearance Before the Panel The right to personally appear before the decision-making panel and be heard has been held to be essential.¹¹¹ As stated in *Grannis v. Ordean*: "The fundamental requisite of due process of law is the opportunity to be heard."¹¹² The opportunity to speak on one's behalf must also be given at a time when it will be effective. As the court said in *Lew v. Kona Hospital*, "The fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner."¹¹³ Thus, in a case where all the proceedings leading up to a letter of termination of privileges were done in secret and without any opportunity to be heard, it was found that the physician had not received due process and his privileges were reinstated.¹¹⁴

Assistance of Legal Counsel During Hearing To date only one jurisdiction has recognized the right of a physician to be assisted by legal counsel in a hospital due

process hearing. In *Garrow v. Elizabeth General Hospital*,¹¹⁵ the Supreme Court of New Jersey examined the issue and found that in view of the physician's substantial interest in such proceedings, the ability of an attorney to marshal the evidence, counter adverse testimony, and present argument on the physician's behalf tipped the balance in favor of allowing the physician the right to an attorney at mandated hospital hearings.¹¹⁶ The court also pointed out that the attorney would be subject to the control of the person in charge of the hearings.¹¹⁷ A few courts have held that it should be within the discretion of the hearing panel as to whether legal counsel may attend the hearing and actively participate.¹¹⁸ Other courts have noted the participation of counsel for the physician without indicating whether the allowance of counsel in such proceedings is required in order to satisfy due process.¹¹⁹

Cross-Examination of Witnesses Although some courts have held that a physician is not constitutionally entitled to cross-examine witnesses who testify against him or her at the hearing,¹²⁰ the better rule clearly appears to be that a physician does have the right to confront and cross-examine any witnesses who appear and testify against him or her.¹²¹ Due process means fair procedure,¹²² and to allow a witness to testify against the physician without being subject to cross-examination would certainly seem to violate the rules of fair play.

Presentation of Witnesses and Evidence in Defense The right of a physician to present witnesses and evidence in his or her own behalf has been clearly recognized.¹²³ This is an integral part of fundamental fairness that has been equated with procedural due process.¹²⁴

Transcript of Panel Hearing It is advisable to have an accurate record made of the due process hearing so that any objections raised by the subject physician can be reviewed in a hospital appellate review of the panel's decision.¹²⁵ In addition, without an accurate record, it may be difficult for a court to determine whether the physician was accorded due process at the hearing.

Written Decision from Panel The decision of the panel should be written so that it can provide a record for hospital and judicial review.¹²⁶ A copy should be given to the physician.¹²⁷ In reaching its decision, the panel must not rely on *ex parte* communications that were not made known to the physician in question, and the decision must be based on evidence that was presented at the hearing and to which the physician had an opportunity to respond.¹²⁸ The decision of the panel should be based on substantial evidence.¹²⁹

The fourth level of hospital proceedings concerning a physician's privileges is appellate review of the decision of the hearing panel and a final decision by the governing authority. Hospital bylaws normally provide a mechanism whereby the physician can obtain review of the panel decision by an appellate review committee.¹³⁰ The physician is usually allowed to submit a written statement of his or her

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position to the committee, but the right to make an oral statement is within the discretion of the appellate review body.¹³¹ New or additional evidence not raised during the due process hearing or otherwise reflected in the record will be allowed to be introduced at the appellate review level only under unusual circumstances.¹³² After the appellate review committee issues its decision, the final decision must be made by the highest governing authority of the hospital. The final hospital decision is transmitted to the physician concerned, and the hospital proceedings are then complete.¹³³

The Scope of Judicial Review of Hospital Decisions

It is now well established that courts have jurisdiction to review hospital decisions that adversely affect a physician's privileges.¹³⁴ In addition to jurisdiction based on alleged violations of rights guaranteed by the Fifth and Fourteenth Amendments, federal courts often find jurisdiction under 42 U.S.C. §1983¹³⁵ in conjunction with 28 U.S.C. §1343(3).¹³⁶ However, the extent of judicial review in such cases is limited.¹³⁷ If the court finds that the physician was afforded due process in the hospital proceedings¹³⁸ and the hospital neither violated its bylaws¹³⁹ nor acted in an arbitrary or capricious manner,¹⁴⁰ the decision of the hospital will be upheld. This limited review is necessitated by the court's lack of medical expertise, as was pointed out in *Laje v. R.E. Thomason General Hospital*:

*Judicial intervention must be limited to an assessment of those factors which are within the court's expertise to review. For this reason, our cases have gone no further than to require that the procedures employed by the hospital are fair, that the standards set by the hospital are reasonable, and that they have been applied without arbitrariness and capriciousness.*¹⁴¹

It has also been said that "the decision of a hospital's governing body concerning the granting of hospital privileges is to be accorded great deference."¹⁴² Therefore once the court has determined that the decision of the hospital is "supported by substantial evidence and was made using proper criteria, after a satisfactory hearing, on a rational basis, and without irrelevant, discriminatory and arbitrary influences, the work of the court comes to an end."¹⁴³

Conclusion

In light of current judicial concepts of due process, it appears that the distinction between public and private hospitals will continue to lose viability where physicians' hospital privileges are concerned. It is also expected that more jurisdictions will follow New Jersey in allowing the physician to be represented by counsel at the due process hearing. Because the panel hearing is by far the most important proceeding for the physician, this seems both sensible and fair.

Although a physician applying for privileges may be seen as having less of a vested interest than one who has previously enjoyed them, it is apparent that both are equally entitled to due process. In every case, the hospital

must be guided by fundamental fairness; keep in mind the words of the U.S. Supreme Court in *Hannah v. Larche*: "Due process is an elusive concept. Its exact boundaries are undefinable, and its content varies according to specific factual contexts."¹⁴⁴

Hospital-Required Malpractice Insurance*

The increased number of suits against health care providers, the increased number of health care providers in each suit, and the increased amount of awards and settlements have created unrest, tension, and distrust between hospitals and their medical staff. Physicians have a decerebrate posturing response to being named in a malpractice suit. They have a lesser "knee-jerk" response when having to pay malpractice insurance premiums. Hospitals are developing the same responses because of escalating malpractice premiums and claims. Their corporate assets are being threatened, their costs continue to escalate, and the inevitable government regulation that results has added to their problems. When the hospital requires insurance for staff privileges, the effect is similar to adding sodium to water. The resulting explosion not only damages the hospital and its medical staff, but also involves the legal community, the state and federal legislature, and ultimately, as always, the public.

The National Association of Insurance Companies' 1975 to 1978 study showed that more than 70% of paid claims are a result of physician activity occurring in the hospital.¹⁴⁵ Hospitals have increasing legal "corporate responsibility" for physician activities. The trustees of hospitals have "fiduciary responsibility" to maintain corporate assets. Joint and several liability makes hospitals the "deep pocket" for uninsured or poorly insured physician staff members.

Physicians have not only patient care requirements, but also hospital-related functions such as teaching, emergency care, emergency coverage, and committee functioning, especially in credentialing and policy-making. The line between physician patient care activity and hospital patient care activity becomes more and more indistinct. Hospitals and their physician staff look to each other for support, but once sued, look to each other for money. This is a major problem that is frequently solved by hospitals paying more than their fair share to the injured patient.

Is mandatory fiscal responsibility as a requirement for staff privileges a viable answer? In some states, hospitals require this, and in other states, the requirement is linked with licensure. We shall discuss what happens with the two approaches. In the mid-1970s in response to the "malpractice crisis," Alaska, Hawaii, Idaho, Kansas, Kentucky, North Dakota, and Pennsylvania all required physicians to carry professional liability insurance as a condition of obtaining and maintaining licensure. In Hawaii, the Hawaii Medical Association sought to enjoin the state from

*From Goebert, 13 L.A.M.P. 1 (Nov. 1985).

enforcing the malpractice insurance requirement against them by a preliminary injunction.¹⁴⁶ This suit was dismissed but the licensing board did not enforce the requirement, so the next year Hawaii legislatively deleted it. Also, Alaska repealed the requirement in 1978.¹⁴⁷ Now individual hospitals are reacting by requiring financial responsibility as a condition for staff privileges.

Kentucky and North Dakota ruled the requirement unconstitutional. Kentucky found the statute a violation of due process.¹⁴⁸ The legislature had arbitrarily imposed and restricted the practice of medicine, mainly because all health care providers were being considered inherently negligent or financially irresponsible. There had not been a legislative finding that such was the case. On the other hand, in North Dakota the State Supreme Court found all statutory malpractice changes unconstitutional.¹⁴⁹ When addressing the mandatory insurance provision, the court specifically withheld a final decision but did have serious doubts as to the constitutionality of requiring malpractice insurance for all physicians without regard to their ability to pay when the law was silent on the effect of some physicians' inability to pay the premiums.

On the other hand, Pennsylvania, Idaho, and Kansas courts ruled in favor of the law. Pennsylvania stated that there existed a rational relationship between requiring insurance and the public interest in ensuring compensability.¹⁵⁰ There is no unconstitutional denial of equal protection nor a prohibition against pursuing one's occupation. The Idaho Supreme Court remanded the malpractice statutes back to the lower courts for further investigation, but they had no problem stating that protection to patients who may be injured as a result of medical malpractice is in the public welfare and compulsory insurance is constitutional.¹⁵¹ The Kansas Supreme Court also found its statute constitutional.

These cases are important because they give the legal arguments both pro and con for allowing a state to specifically regulate the medical profession by requiring insurance. They address the right to engage in a lawful occupation, the police power of the state, and substantive due process of individuals guaranteed by the constitution. Some courts required only a rational reason for the legislature to require insurance. Other states require a more serious constitutional scrutiny than the rational basis analysis, because the regulation is not truly related to competence and places some burden on the individual's right to engage in a lawful profession. Close scrutiny will balance the respective interest of both the physician and the public.¹⁵²

Can hospitals require malpractice insurance as a condition of privileges? Yes, but in the absence of a statute, state hospitals would have the same type of scrutiny placed on them as state statutes had in the preceding paragraphs. In an earlier case, a California hospital that required malpractice insurance as a condition of admission was challenged successfully. The rule was arbitrary and not related to the state's regulation of physicians.¹⁵³ Following this case, the California legislature passed a law allowing hospitals to require malpractice insurance, and this was found

constitutional.¹⁵⁴ In 1977, a survey of U.S. community hospitals showed that out of 4478 hospitals, 26.4% required physicians to have a minimum amount of malpractice insurance.¹⁵⁵

When private hospitals require malpractice insurance for staff privileges, physicians present a number of arguments.¹⁵⁶ First is "state action" because the private hospital is receiving either state or federal funds; therefore the court has jurisdiction to determine whether an impermissible imposition infringed on constitutional rights or the physicians' civil rights.¹⁵⁷ The physicians will allege a breach of contract action because hospital privileges were given for a longer length of time. The hospital is taking away privileges without showing that the physician is unqualified or unskilled. Many of the physicians have been members of hospital committees and have been on the teaching staffs of universities, and all have state licensure. Some arguments show a violation of the antitrust provisions of the Sherman Act if any of the deciding physicians involved with denying privileges are in competition with the physician being restricted.¹⁵⁸

A number of cases have addressed the question of a hospital acting under the color of state law. They have found that the specific activity complained of by the physician being denied privileges must be related to the way that the state is acting on the private hospital. There must be a nexus between state action and denial of privileges. These cases show that the granting of funds from Hill-Burton monies, Medicaid, Medicare payments, training of residents from state institutional programs, use of tax-free bonds, hospital licensure and inspection by the state, and reporting of privileges revocations to a state board all are state actions or federal actions; but none has a required nexus. The restricted physician must show that those state actions have something to do with a denial of privileges when the physician does not have insurance.¹⁵⁹⁻¹⁶¹ The due process hearings required in civil rights actions under U.S.C. §1983 have not been upheld, but state courts have said that hospitals need to show or need to give due process to physicians before a revocation of privileges.¹⁶² The test in these cases is whether a hospital acts arbitrarily and capriciously or denies the physician due process. Physicians have also argued that they are unable to afford the insurance, that they do not have a big enough practice, or that they have an indigent patient population in their practice and therefore the public will suffer.¹⁶³⁻¹⁶⁵

Hospitals argue, on the other hand, that this is not arbitrary and capricious. It is rational policy supported by good fiscal management and preservation of the hospital resources.¹⁶⁶ The requirement is not excessively burdensome and can be met by providing insurance or fiscal responsibility. The hospital must be able to show that it has done everything necessary to obtain facts supporting the policy. Meetings with concerned individuals, a review by the medical staff executive committee, surveys of the physicians, letters to other hospitals and to insurance people finding out the costs and alternatives, and attempts at legislative tort reform are all things that would be helpful to a hospital initiating these actions.

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The courts have supported and allowed the hospitals to initiate such action. Florida,¹⁶⁷ Arizona,¹⁶⁸ Louisiana,¹⁶⁹ and Indiana¹⁷⁰ have all heard arguments both pro and con and ruled in favor of the hospital and against the restricted physician as long as procedural due process and prior notice was afforded the physician. Physicians scream, but the courts have not listened.^{171,172}

Courts have addressed the California legislative policy of allowing a hospital to require malpractice insurance and they have stated that the interests of society served by such insurance requirements are not so arbitrary that it would be considered unreasonable. The amount of insurance established by the hospital and the requirement that the insurance company must be admitted to do business in California were reasonable.¹⁷³

The final argument in favor of this policy is that the real reason for such a policy is the requirement that the hospital pay its fair share of liability and the physician pay his or her fair share of liability. In *Holmes*, the situation is summarized as follows:

*We cannot ignore the realities of modern procedural practice. If a patient is injured while in the hospital regardless of who is at fault, the hospital will almost always be joined as a codefendant. Despite the outcome of such an action, the hospital must expend valuable financial resources in its own defense, and will, if innocent of wrongdoing, be more likely to recover its expenses from the tortfeasor physician if that physician is insured. If, indeed, some conscientious lawyer decides not to include the hospital in an action where the finger of negligence points directly and solely to the doctor, we can be certain it will only be because the physician does indeed have malpractice insurance.*¹⁷⁴

The hospital has the right to take reasonable measures to protect itself and the patient it serves. We cannot say, as a matter of law, that the hospital board's attention to its medical staff's malpractice insurance is unlawful, arbitrary, or capricious. As a practical matter, we cannot say it is irrational or unreasonable. In *Pollack*, the court states:

*We find the plaintiff (physician) has no liberty or property interest sufficient to invoke the due process requirements of the Fourteenth Amendment. While the right to practice an occupation is a liberty interest protected by the Fourteenth Amendment, ... plaintiff is not precluded from exercising that right by the insurance requirements in order to continue his membership on the hospital staff. ... Requiring its staff physicians to carry insurance and to submit proof to the hospital of that fact is surely a reasonable exercise of financial responsibility on the part of the hospital.*¹⁷⁵

Basically, the hospital has three alternatives regarding malpractice insurance:

1. To use the information regarding the physician's malpractice as one of the criteria to decide on appointment or reappointment;
2. To require malpractice coverage as a condition of appointment or reappointment; or
3. To take no policy position.

The first two of these alternatives are legally permitted. The last does not solve the problem. The hospital can avoid much internal stress by recognizing that this problem is a shared or joint problem with the medical staff. The hospital should involve the staff in trying to solve the problem as alternatives can be searched for and harmony fostered.

Acknowledgments

The authors gratefully acknowledge the past contributions of John Dale Dunn, MD, FCLM.; James B. Couch, MD, JD, FCLM.; Marvin Firestone, MD, JD, FCLM.; Gary N. Hagerman, LLB, FCLM.; and William Goebert, Jr., MD, JD, FCLM.

Endnotes

1. *Darling v. Charleston Community Hosp.*, 200 N.E. 2d 149 (Ill. Sup. Ct. 1965); *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156 (1982); *Corletto v. Shore Memorial Hosp.*, 350 A. 2d 534 (N.J. Sup. Ct. 1975).
2. D.M. Eddy, *Clinical Decision Making: From Theory to Practice—The Challenge*, 1 J.A.M.A. 287–290 (1990).
3. See, e.g., *Wall v. Stout*, 310 N.C. 184, 192, 311 S.E. 2d 571 (1984); also see *Physicians, Surgeons, Etc.*, 61 Am. Jur. 2d §167, 298–299 (1981).
4. Pub. L. 99-660, part IV; 42 U.S.C. §11111 *et seq.*
5. *Brownsville Medical Center v. Garcia*, 704 S.W. 2d 68 (Tex. App. Corpus Christi 1985).
6. *Smith v. Baptist Memorial Hosp. System*, 720 S.W. 2d 618 (Tex. App. San Antonio 1986, writ ref. n.r.e.).
7. *Corletto*, *supra* note 1.
8. Joint Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Hospitals*, Standard M.S. 6 *et seq.* (JCAHO, Chicago 1990).
9. *Supra* note 4.
10. *McDonald v. Massachusetts General Hosp.*, 120 Mass. 432, 21 A. 529 (1876).
11. *Schloendorff v. New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914).
12. *Id.* at 132 and 194.
13. *Necolaff v. Genesee Hosp.*, 296 N.Y.S. 936, 73 N.E. 2d 117 (1947).
14. *Berg v. N.Y. Society for the Relief of the Ruptured and Crippled*, 154 N.Y.S. 455, 456 (1956).
15. *Bing v. Thunig*, 2 N.Y. 2d 656, 143 N.E. 2d 3 (1957). But see *Weiss v. Rubin*, 9 N.Y. 2d 230, 173 N.E. 2d 791 (1961), in which the Court of Appeals found that the surgeon had a duty to inquire into details of how the hospital performed its duty (providing blood for transfusion) as part of his duty of reasonable care. Justice Van Voorhis' dissent called for strict application of *Bing*.
16. Cf. generally, *supra* note 8, at Medical Staff Section.
17. *Johnson v. Misericordia County Hosp.*, 99 Wis. 2d 708, 301 N.W. 2d 156 (1981), *aff'd*, 99 Wis. 2d 78, 301 N.W. 2d 156 (1981). The Wisconsin Supreme Court also held that a hospital has a legal duty to its patients to exercise reasonable care in selecting its medical staff and in granting privileges but, in *Humana Medical Corp. v. Peyer*, 456 N.W. 2d 355 (1990), declined to find or establish an ancillary duty requiring a hospital to disclose credentialing information to a third party.
18. *Weiss v. York Hosp.*, 745 F. 2d 786 (1984).
19. *Tonsic v. Wagner*, 329 A. 2d 497 (Pa. 1974).

20. *McConnell v. Williams*, 361 Pa. 355, 65 A. 2d 243 (1949). But see J. Jones' dissent, in *Yorston v. Pennell*, 153 A. 2d 255 (1959), which would have circumscribed application of this rule to matters only within the directing physician's responsibility.
21. *Capan v. Divine Providence Hosp.*, 410 A. 2d 1282 (Pa. Super. Ct. 1979).
22. *People v. Flushing Hosp. and Medical Center*, 471 N.Y.S. 2d 745 (N.Y. Cir. Ct. 1983), where the hospital was charged with a misdemeanor when it refused emergency care because the hospital was full; *People ex rel. M.B.*, 312 N.W. 2d 714 (S.D. 1981), where the South Dakota Supreme Court ruled that a lower court exceeded its jurisdiction by ordering an admission when no space was available; *contra*, see *Pierce County Office of Involuntary Commitment v. Western State Hosp.*, 97 Wash. 2d 264, 644 P. 2d 131 (1982), where the Washington Supreme Court interpreted a state mental health statute to require admission of all patients who sought treatment at the hospital, despite a lack of space.
23. See, e.g., *Fabian v. Matzko*, 236 Pa. Super. 267, 344 A. 2d 569 (1975).
24. *Wilmington General Hosp. v. Manlove*, 54 Del. 15, 174 A. 2d 135 (1961).
25. *Stanturf v. Sipes*, 447 S.W. 2d 558 (Mo. 1969).
26. *Id.* at 562.
27. Restatement (Second) of Agency §220 (1958).
28. See, e.g., *Smith v. St. Francis Hosp.*, 676 P. 2d 279 (Okla. App. 1983). However, Oklahoma's Supreme Court extended this reasoning, applying the patient's perception of whether the hospital merely served as the physician's work site, to avoid finding respondeat superior was applicable. See *Weldon v. Seminole Muni. Hospital*, 709 P. 2d 1058 (Okla. 1985).
29. *Thomas v. Corso*, 265 Md. 84, 288 A. 2d 379 (1972).
30. *Citizens Hosp. Ass'n v. Schoulin*, 48 Ala. App. 101, 262 So. 2d 303 (1972).
31. *Gizzi v. Texaco, Inc.*, 437 F. 2d 308 (3d Cir. 1971).
32. See F. Harper, F. James, Jr., & O. Gray, *Law of Torts* 26.11, 60-94 (2d ed. 1986) for a discussion of the immunity rule and its exception.
33. *Marek v. Professional Health Services, Inc.*, 179 N.J. Super. 433, 437 A. 2d 538 (1981).
34. *Jackson v. Power*, 743 P. 2d 1376 (Alaska 1987). In a comparison case, *Harding v. Sisters of Providence*, No. 371 (Alaska, Oct. 16, 1987), liability was extended to an independent contractor/radiologist's negligence on the basis of a nondelegable duty owed by the hospital to its patients. Distinguished: *Miltiron v. Franke*, 793 P. 2d 824 (1990).
35. W. Prosser & W. Keeton, *Law of Torts* §71 at 511-512 (5th ed. 1984).
36. *Guerro v. Copper Queen Hosp.*, 112 Ariz. 104, 537 P. 2d 1329 (1975). *Thompson v. Sun City Community Hospital*, 688 P. 2d 647 (1983).
37. 42 U.S.C. §1395dd (Apr. 7, 1986).
38. *Darling v. Charleston Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E. 2d 253 (1965); *cert. denied* 383 U.S. 946 (1966). Distinguish this situation from that in *Weldon*, *supra* note 28, wherein the patient's care "was never within the discretion of the hospital."
39. *Fiorentino v. Wagner*, 227 N.E. 2d. 296 (1967).
40. *Moore v. Board of Trustees of Carson City Hosp.*, 495 P. 2d 605 (Nov. 1972).
41. *Mitchell City Hosp. Authority v. Joiner*, 229 Ga. 140, 109 S.E. 2d 413 (1972). *Butler v. South Fenton Med. Center*, 215 Ga. App. 809, 452 S.E. 2d 768 (1994).
42. *Purcell v. Zimbleman*, 18 Ariz. App. 75, 500 P. 2d 335 (1972).
43. *Corletto v. Shore Memorial Hospital*, 138 N.J. Super. 302, 350 A. 2d 534 (1975).
44. *Hayman v. Galveston*, 273 U.S. 414, 47 S.Ct. 363 (1927).
45. *Porter Memorial Hosp. v. Harvy*, 279 N.E. 2d 583 (1972).
46. *Lubin v. Crittenden Hosp. Ass'n.*, 713 F. 2d 414 (8th Cir. 1983).
47. *Cardiomedical Assoc. v. Crozier-Chester Med. Ctr.*, 536 F. Supp. 1065 (E.D. Pa. 1982).
48. *Northeast Georgia Radiological Assoc. v. Tidwell*, 670 F. 2d 507 (5th Cir. 1982). In *Bellam v. Clayton County Hospital*, the U.S. District Court limited this principle to instances in which the privilege was terminated or withdrawn, declining to apply it where a privilege was just restricted. But see *Bloom v. Hennepin County*, 783 F. Supp. 418 (D. Minn. 1992), in which the court determined that there was no right to due process arising out of revocation of privileges when the plaintiff held the privileges pursuant to the bylaws and a contract with the hospital, which was terminated.
49. *Klinge v. Lutheran Charities Ass'n. of St. Louis*, 523 F. 2d 56 (8th Cir. 1975).
50. *Silver v. Castle Memorial Hosp.*, 53 Haw. 475, 497 P. 2d 564, *cert. denied* 409 U.S. 1048 (1972).
51. *Christhilf v. Annapolis Emergency Hosp. Ass'n., Inc.*, 496 F. 2d 174 (4th Cir. 1974).
52. *Id.*
53. *Garrow v. Elizabeth General Hosp.*, 79 N.J. 549, 401 A. 2d 533 (1979).
54. *Supra* note 49, at 60.
55. *Branch v. Hempstead County Memorial Hosp.*, 539 F. Supp. 908 (W.D. Ark. 1982).
56. California Medical Association-California Hospital Association, Uniform Code of Hearing and Appeal Procedures §3(e).
57. *Novosel v. Nationwide Insurance Co.*, 721 F. 2d 894 (1983).
58. *Cardiomedical Association, Ltd. v. Crozier-Chester Med. Ctr.*, 721 F. 2d 68 (1983).
59. *Jefferson Parish Hosp. District No. 2 v. Hyde, M.D.*, 466 U.S. 2 (1984).
60. *Supra* note 18.
61. *Patrick v. Burget*, 486 U.S. 94 (1988).
62. Health Care Quality Improvement Act of 1986 (Pub. L. 99-660, as amended by Pub. L. 100-93 and 100-177).
63. Tarlov, *Special Report, Shattuck Lecture: The Increasing Supply of Physicians—The Changing Structure of the Health-Services System and the Future Practice of Medicine*, 308 N. Engl. J. Med. 1235 (1983).
64. *Supra* note 17; Annot. 51 A.L.R. 3d 981 (1973).
65. *Supra* note 42; *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156, *modified*, 133 Cal. App. 3d 94 (1982).
66. See *Falcone v. Middlesex County Medical Society*, 34 N.J. 582, 170 A. 2d 791 (1961).
67. *Supra* note 44; *Sosa v. Bd. of Managers of Val Verde Memorial Hosp.*, 437 F. 2d 173 (5th Cir. 1971).
68. *Anton v. San Antonio Comm. Hosp.*, 19 Cal. 3d 802, 140 Cal. Rptr. 442, 567 P. 2d 1162 (1977).
69. *Id.* at 814, 140 Cal. Rptr. at 454, 567 P. 2d at 1174.
70. *Unterhiner v. Desert Hosp. Dist. of Palm Springs*, 33 Cal. 3d 285, 188 Cal. Rptr. 590, 656 P. 2d 554 (1983).
71. *Id.* at 297, 188 Cal. Rptr. at 598, 656 P. 2d at 562.
72. U.S. Constitution, amend. V, XIV.
73. *Supra* notes 49 and 51; *Woodbury v. McKinnon*, 447 F. 2d 839 (5th Cir. 1971).
74. See, e.g., *supra* note 50 and cases cited therein; *The Physician's Right to Hospital Staff Membership: The Public-Private Dichotomy*, 485 Wash. U.L.Q. (1966).
75. *Foster v. Mobile County Hosp. Bd.*, 398 F. 2d 227 (5th Cir. 1938).

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76. See, e.g., *Suckle v. Madison Gen. Hosp.*, 362 F. Supp. 1196 (W.D. Wis. 1973), *aff'd*, 499 F. 2d 1364 (7th Cir. 1974).
77. *Supra* note 51.
78. *Schlein v. Milford Hosp.*, 423 F. Supp. 541 (D. Conn. 1976). The Second Circuit United States Court of Appeals declined to adopt this case because it applies to the reasoning that clinical privileges do not create property interests. See *Greenwood v. New York*, 163 F. 3d 119 (2d Cir. 1998).
79. *Sussman v. Overlook Hosp. Ass'n.*, 231 A. 2d 389, 95 N.J. Super. 418 (1967).
80. *Supra* notes 50 and 53; *Greisman v. Newcomb Hosp.*, 40 N.J. 389, 192 A. 2d 817 (1963).
81. *Supra* note 68; *Ascherman v. St. Francis Memorial Hosp.*, 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975).
82. *Supra* notes 46 and 47, and cases cited therein.
83. *Supra* notes 48 and 49.
84. *Citta v. Delaware Valley Hosp.*, 313 F.Supp. 301 (E.D. Pa. 1970); *Avol v. Hawthorne Comm. Hosp. Inc.*, 135 Cal. App. 3d 101, 184 Cal. Rptr. 914 (1982); *Kelly v. St. Vincent Hosp.*, 102 N.M. 201, 692 P. 2d 1350 (1984).
85. See generally, Comment, *Hospital Medical Staff Privileges: Recent Developments in Procedural Due Process Requirements*, 12 Willamette L.J. 137 (1975).
86. *Sosa*, *supra* note 67; *supra* notes 70, 75, 78, and 79.
87. *Supra* note 70.
88. *Supra* notes 68 and 70.
89. *Supra* notes 70, 75, 78, and 79.
90. *Avol*, *supra* note 84.
91. *Supra* note 50; see JCAHO, *Accreditation Manual for Hospitals, Standards for Medical Staff*, standard III, 104 (JCAHO, Chicago 1995); California Medical Association–California Hospital Association, *Uniform Code of Hearing and Appeal Procedures*, 32 (1972).
92. *Supra* notes 51 and 53.
93. *Supra* notes 50 and 76. However, specificity that amounts to pleading of evidence is not constitutionally required. *Truly v. Madison Gen. Hosp.*, 673 F. 2d 763 (5th Cir. 1982).
94. *Supra* note 73; *Branch v. Hempstead County Memorial Hosp.*, 539 F. Supp. 908 (W.D. Ark. 1982); *supra* note 68.
95. *Woodbury*, *supra* note 73, at 1211.
96. *Supra* note 51; *Miller v. Eisenhower Med. Ctr.*, 27 Cal. 3d 614, 166 Cal. Rptr. 826, 614 P. 2d 258 (1980); *supra* note 50.
97. *Supra* note 53.
98. *Supra* note 76.
99. *Woodbury*, *supra* note 73; *Hackethal v. California Med. Ass'n. and San Bernardino County Medical Society*, 138 Cal. App. 3d 435, 187, Cal. Rptr. 811 (1982).
100. *Supra* note 49, at 60.
101. *Woodbury*, *supra* note 73.
102. *Supra* note 49; *Citta*, *supra* note 84; *Hackethal*, *supra* note 99; *Applebaum v. Board of Directors*, 104 Cal. App. 3d 648, 163 Cal. Rptr. 831 (1980).
103. See, e.g., *Applebaum*, *supra* note 102.
104. *Citta*, *supra* note 84.
105. *Duffield v. Charleston Area Med. Ctr., Inc.*, 503 F. 2d 512 (4th Cir. 1974); *Hoberman v. Lock Haven Hosp.*, 377 F. Supp. 1178 (M.D. Pa. 1974).
106. *Hackethal*, *supra* note 99; *Applebaum*, *supra* note 102.
107. *Applebaum*, *supra* note 102, at 104 Ca. App. 3d at 657, 163 Cal. Rptr., at 840.
108. *Supra* note 49, at 63.
109. *Duffield*, *supra* note 105.
110. *Hackethal*, *supra* note 99.
111. *Supra* note 51; *Poe v. Charlotte Memorial Hosp., Inc.*, 374 F. Supp. 1302 (W.D. N.C. 1974).
112. *Grannis v. Ordean*, 234 U.S. 385, 394, 34 S.Ct. 779, 783, 58 L.Ed. 1363, 1369 (1914).
113. *Lew v. Kona Hosp.*, 754 F. 2d 1420 at 1424 (9th Cir. 1985).
114. *Poe*, *supra* note 111.
115. *Supra* note 53.
116. *Id.*
117. *Id.*
118. *Supra* notes 50 and 68.
119. *Laje v. R.E. Thomason Gen. Hosp.*, 564 F. 2d 1159 (5th Cir. 1977); *Citta*, *supra* note 84; *Miller*, *supra* note 96.
120. *Woodbury*, *supra* note 73; *Kaplan v. Carney*, 404 F. Supp. 161 (E.D. Mo. 1975); *supra* note 79; in *Woodbury* and *Kaplan* no witnesses testified.
121. *Supra* notes 50, 51, and 55; *Poe*, *supra* note 111; *Hackethal*, *supra* note 99.
122. *Poe*, *supra* note 111.
123. *Supra* notes 50 and 55; *Hackethal*, *supra* note 99.
124. *Supra* note 53.
125. Section 3(e) of the California Medical Association–California Hospital Association *Uniform Code of Hearing and Appeal Procedures* provides: “Record of Hearing. The judicial review committee may maintain a record of the hearing by one of the following methods: a shorthand reporter present to make a record of the hearing, a recording, or minutes of the proceedings. The cost of such shorthand reporter shall be borne by the party requesting same.”
126. *Supra* note 50.
127. See *supra* note 49, at 60.
128. *Duffield*, *supra* note 105; *Suckle*, *supra* note 76; *supra* note 50.
129. *Storrs v. Lutheran Hosp. & Homes Society of America*, 661 P. 2d 632 (Alaska 1983); see *Laje*, *supra* note 119; *Sosa*, *supra* note 67; *Kaplan*, *supra* note 120.
130. See *Hershey & Purtell, Medical Staff Bylaws*. Art. XVI (1985).
131. *Id.* at §16.6-2.
132. *Id.* at §16.6-5.
133. See generally, *supra* note 49.
134. See, e.g., *supra* notes 50, 51, and 53.
135. “Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any state or territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.”
136. See, e.g., *Daly v. Sprague*, 675 F. 2d 716 (5th Cir. 1982).
137. *Supra* notes 49, 50, and 113.
138. See, e.g., *Woodbury*, *supra* note 73.
139. See, e.g., *supra* note 48; *In re Murphy v. St. Agnes Hosp.*, 484 N.Y.S. 2d 40 (App. Div. 1985); however, failure to strictly comply with the bylaws will not be fatal if due process is given. *Kaplan*, *supra* note 120; *Avol*, *supra* note 84.
140. See, e.g., *supra* note 75.
141. *Laje*, *supra* note 119, at 1162.
142. *Id.*; see Hollowell, *Decisions about Hospital Staff Privileges: A Case for Judicial Deference*, 11 Law Med. and Health Care 118 (1983).
143. *Woodbury*, *supra* note 73, at 846.

144. *Hannah v. Larche*, 363 U.S. 420, 442, 80 S.Ct. 1502, 1514, 4 L.Ed. 2d 1307, 1321 (1960).
145. Bulletin of the American College of Surgeons (Mar. 1982).
146. *Hawaii Medical Ass'n. v. State of Hawaii*, No. 49777 (Hawaii, 1st Cir. Feb. 4, 1977); Haw. Rev. Stat. §§4538, 67136 (1976); Haw. Rev. Stat. §§4538 (1977).
147. Alaska Stat. §§08.64.215a (1976); repealed 1978 Alaska Sess. Laws §§40 ch. 177.
148. *McGuffy v. Hall*, 557 S.W. 2d 401 (Ky. 1977).
149. *Arenson v. Olson*, 270 N.W. 2d 125 (N.D. 1977).
150. *McCoy v. Commonwealth Board of Medical Education and Licensure*, 37 Pa. Comwlth. 530, 391 A. 2d 723.
151. *Jones v. State Board of Medicine*, 97 Idaho 859, cert. denied (1976).
152. These constitutional issues are thoroughly discussed in Muranaka, *Compulsory Medical Malpractice Insurance Statutes: An Approach in Determining Constitutionally*, 12 U.S.F.L. Rev. 599 (Summer 1978).
153. *Rosner v. Peninsula Hospital District*, 224 Cal. App. 2d 115 (1964).
154. *Wilkerson v. Madera Community Hosp.*, 192 Cal. Rptr. 593 (Cal. App. 1983).
155. Unpublished results prepared by D.L. Matthews, Projects Director, American Hospital Association Hospital Data Center, in association with Andrew J. Korsak and Ross Mullner.
156. Propriety of Hospitals' Conditioning Physicians' Staff Privileges on his Carrying Professional Liability or Malpractice Insurance, 7 A.L.R. 4th 1238 (1981).
157. Action of Private Hospital as State Action under 42 U.S.C.S. §§1983 or Fourteenth Amendment, 42 A.L.R. Fed. 463.
158. *Watkins v. Mercy Hosp. Medical Center*, 520 F. 2d 894 (9th Cir. 1975).
159. *Pollack v. Methodist Hosp.*, 392 F. Supp. 393 (E.D. La. 1975).
160. *Kavka v. Edgewater Hosp., Inc.*, 586 F. 2d 59, cert. denied (7th Cir. 1978. reported sub nom, *Musso v. Suriano*).
161. *Asherman v. Presbyterian Hosp. of Pacific Medical Center, Inc.*, 507 F. 2d 1103 (9th Cir. 1974).
162. *Supra* note 50; *Silver v. Queen's Hosp.*, 63 Haw. 430, 629 P. 2d 1116 (1981).
163. Laird, *Requiring Liability Insurance Is Unfair*, Am. Med. News 20 (Apr. 24, 1981).
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166. *Sosa*, *supra* note 67.
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169. *Supra* note 159.
170. *Renforth v. Fayette Memorial Hosp. Ass'n., Inc.*, 383 N.E. 2d 368 (Ind. Ct. App. 1978).
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173. *Supra* note 154.
174. *Holmes v. Hoemaku Hosp.*, 573 P. 2d 477 (Ariz. 1977).
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