Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act

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In recent years, health care providers have faced growing public resentment caused by the belief that rapidly rising health care costs have not been met with commensurate increases in the quality of medical treatment. Legislators sympathetic to this view have enacted changes, such as the prospective payment system,¹ that have impacted the health care system profoundly. Public dissatisfaction with traditional medical services is also reflected in the proliferation of alternative health care delivery systems, such as health maintenance and preferred provider organizations.

Hospitals currently are experiencing increased pressure to meet the competition from these alternative health care providers. Ironically, attempts to contain the costs of medical care through competitive business practices often are outweighed by the costs of litigation resulting from these attempts. Hospitals face growing numbers of business-related lawsuits, and as courts become increasingly receptive to such suits, hospitals are incurring ever greater legal expenses.

One type of suit to which courts have become increasingly receptive is the action brought by a physician who has been denied staff privileges at a hospital. These suits often allege violations of the Sherman Antitrust Act² and generally name the hospital and its medical staff as defendants. This Note discusses the history of privilege suits and the changing response of the courts over several decades. It demonstrates that the judicial system has been unable to develop an effective test for summary disposition of meritless claims. As a result, hospitals are under pressure to accept physicians who may be of questionable competence. This practice jeopardizes both the quality of health care and the hospital’s ability to compete effectively in the health care market. The Note concludes

¹. See infra text accompanying notes 6-7.
with a discussion of congressional attempts to remedy this dilemma.

CHANGES AFFECTING THE BUSINESS OF HEALTH CARE

In the recent past, hospitals were not subject to widespread competition from health maintenance organizations (HMOs) and other alternative health care providers. Hospitals generally competed only with other hospitals for patients, and they received correspondingly little scrutiny from government entities. This environment enabled hospitals to engage in business practices that could have resulted in antitrust actions in other areas of business. For example, a group of hospitals might have joined together to negotiate reimbursement terms with a major insurer. Although such collusion ordinarily would have raised antitrust implications, it was considered normal business practice for hospitals.

Recent changes in the reimbursement system have stimulated competition among hospitals. Before the mid 1980s, third party payors reimbursed hospitals on the basis of allowable costs. Reimbursable expenses included services related to patient care, whereas such costs as fundraising, overhead, free care, bad debts, and noncovered patient services were not included. This system provided little motivation for hospitals to cut medical costs and limit patient stays. Patients themselves were not cost-conscious be-

4. Hospitals often would designate a specific agent to negotiate reimbursement terms on their behalf. In the Philadelphia area, the Delaware Valley Hospital Council represented many nonprofit hospitals in reimbursement negotiations with Blue Cross. Because terms for all hospitals could be worked out at one time, this was a convenient arrangement for Blue Cross. The hospitals also favored this procedure. Blue Cross was (and is) by far the major medical insurer in the area, and it possessed bargaining power that was overwhelming to any single hospital. It essentially could dictate “take it or leave it” terms of reimbursement to a hospital. By joining together, the hospitals could bargain with Blue Cross on a more equal level.

Neither the Federal Trade Commission nor the Department of Justice challenged this action, perhaps because it was viewed as two nonprofit groups negotiating for the public good. This practice is less popular among hospitals now due to the increased potential for antitrust problems. See Ohio ex rel. Brown v. Mahoning County Medical Center, 1980-1981 Trade Cas. (CCH) ¶ 63,100 (N.D. Ohio 1979); Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 Duke L.J. 1071, 1099.
cause their medical expenses were reimbursed. Hospitals therefore had little economic incentive to reduce operating costs.\textsuperscript{5}

One dramatic response to the problems of cost-based reimbursement was Congress’s establishment of the prospective payment system (PPS) in 1983.\textsuperscript{6} The PPS limited reimbursement to hospitals from Medicare and Medicaid by establishing several hundred “diagnosis related groups” (DRGs) for various medical treatments and procedures. Under the PPS, a hospital is under economic pressure to see that the patient stays no longer than necessary.\textsuperscript{7} If the patient stays longer than the PPS guideline allows, the hospital generally is not reimbursed for the excess costs.\textsuperscript{8}

Faced with these nonreimbursable costs, hospitals must increase income by seeking a larger share of the market, thereby increasing competition with neighboring hospitals and other health care entities. HMOs exert competitive pressure on hospitals because they offer most or all of the services available from hospitals, at purported bargain prices. Hospitals have responded to this pressure by cutting costs, providing higher quality care, and increasing their market shares. Preferred provider organizations (PPOs) present additional incentives for hospitals to market low-cost, high-quality health care. A major medical insurer may establish a PPO by selecting a small group of hospitals in a given market area to provide medical services to its large clients. A client of the insurer in that market area (perhaps a large company) will be told that in order for its employees to receive full benefits under their insurance plan, they must use the hospitals in the PPO network. The insurer selects the member hospitals by determining which ones can pro-

\textsuperscript{5} See Hamilton, Barriers to Hospital Diversification: The Regulatory Environment, 24 Duq. L. Rev. 425, 425-28 (1985). Physicians discovered that shortening hospital stays and increasing the activity of patients soon after surgery helped hasten recovery, or at least had no detrimental effect on patients. This discovery, combined with advances in medical technology and surgical techniques in the 1960s and 1970s, led to expectations of lower health care costs and shorter patient stays. However, these expectations had little effect on hospitals, which continued to operate by offsetting nonreimbursable costs against higher reimbursable costs.

\textsuperscript{6} 42 C.F.R. § 412 (1986).

\textsuperscript{7} See Hamilton, supra note 5, at 432-33, 432 n.24.

\textsuperscript{8} The PPS makes some exceptions for certain complications or other reasons that necessitate keeping the patient longer than the regulations mandate. See 42 C.F.R. §§ 412, 412.820-.84 (1986) (payment for day and cost outliers).
vide high-quality, cost-effective care. It then negotiates for favorable reimbursement rates by offering this “preferred” status to the hospitals.

One of the most important assets for effective competition in the health care market is skilled physicians. Competitive changes in the health care market have encouraged hospitals to employ the most highly skilled physicians available. These physicians minimize a patient’s stay without decreasing the quality of care, and because their patients recover faster and with fewer complications than the patients of less proficient physicians, hospital services can be used more efficiently. Additionally, a hospital’s reputation for high-quality health care may draw patients away from HMOs and PPOs.

A hospital with a respected staff and a reputation for high-quality care will be attractive to skilled physicians, who want access to the broad patient base and desire the prestige of membership on the hospital staff. Hospitals must limit the size of their medical staffs, however, in order to remain attractive to those physicians. If the physician is a specialist, the hospital must have a sufficient patient base to make his practice commercially viable, and to ensure that he remains proficient in his specialty. For nonspecialists, the hospital must generate sufficient admissions or consultations to keep that physician at the hospital for a substantial part of each business day.9

Staff privileges are one of the most important assets of a physician’s practice.10 The advantage of staff privileges becomes appar-

9. Although many physicians are on the staff of more than one hospital, their privileges at each hospital may be different. Thus, if association with a hospital is not generating much referral work and the fees are minimal, a physician may not wish to remain active on the staff. A physician who spends little time at a hospital will not feel obligated to participate in activities such as the teaching program or peer review, which are important to a hospital striving to maintain or improve its reputation. A hospital also requires its physicians to be available for emergencies and other needs of the patients, and expects them to develop a sense of institutional loyalty. Although staff membership responsibilities can be time consuming, eventually a physician may seek a relationship with one or more hospitals in order to broaden his referral base.

10. An analysis of staff privilege problems must begin with a discussion of the medical staff and its importance to hospitals. Three distinct groups control the day-to-day operations of most hospitals. These are the governing body, the executive body, and the medical staff. The governing body is, often called the board of directors, and is similar in function to that found in an ordinary corporation. The executive body consists of the president and
Physician Staff Privileges

ent when a physician’s patient must undergo surgery in a hospital. If the physician does not have staff privileges, he must refer the patient to a doctor with admitting privileges. The first physician may thus lose a large portion of fees from his patient to the admitting physician. More important, the patient may decide to retain the admitting doctor as his primary physician after discharge.

Although specific procedures for review of staff privilege applications may differ at various hospitals, some general similarities exist. Several groups within the hospital structure participate in the process of considering an application for privileges. The medical staff plays a significant role in that process by evaluating the professional capabilities of the applicant. The physicians on the hospital’s credentialing committee investigate the applicant’s background to determine the extent of his past medical training and performance, whether he is licensed and board certified, whether

management personnel, who correspond to the chief executive officer and the upper level management of a corporation. The medical staff has no analogous corporate entity, but nonetheless plays a very important role in the efficient operation of the hospital.

According to the Joint Commission on Accreditation of Hospitals (JCAH), the medical staff has the “overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefor to the governing body.” Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 109 [MS. 1] (1987) [hereinafter JCAH MANUAL]. This vast responsibility is broken down into various standards by the JCAH. Id. at 112 [MS. 2], 115 [MS. 3], 117 [MS. 4], 121 [MS. 5], 122 [MS. 6], 127 [MS. 7]. These standards and their “interpretations” provide guidelines for medical staff membership, for qualification for privileges, for procedures governing peer review, for monitoring the overall quality of care in the hospital, for evaluating the appropriateness of patient care, and for the continuing education of the medical staff. A physician’s staff duties may include serving on committees that examine surgical tissue, evaluating the hospital’s use of its blood supplies, ensuring the adequacy of medical records, or participating in the process of peer review. In addition, the staff physician attends regular meetings of the staff and the department. See id. at 115 [MS. 3.4], 116 [MS. 3.7]. See also Chayet & Reardon, Trouble in the Medical Staff: A Practical Guide to Hospital Initiated Quality Assurance, 7 Am. J. L. & Med. 301, 304-05 (1981).

11. It is important to differentiate between being accepted to the medical staff and being granted privileges. Membership on a medical staff may carry with it nominal privileges, such as admitting privileges, but it also includes responsibilities to the hospital. See supra note 10. Staff privileges are granted mainly on the basis of the needs of the hospital and the skills of the physician, and are required before a physician is permitted to use hospital facilities. One need not be a member of the staff to be granted privileges, but grants of privileges to nonstaff physicians are usually very narrow as well as infrequent. For one view of the importance of privileges and a more detailed discussion of the subject, see Dolan & Ralston, Hospital Admitting Privileges and the Sherman Act, 18 Hous. L. Rev. 707, 709-24 (1981).
he carries malpractice insurance, and any other information that they believe is relevant. The committee may report to the staff as a whole, to its executive committee, or directly to the governing board. The board is responsible for making the final decision, although many boards may give great weight to the findings of the committee. If the decision is unfavorable to the physician, the hospital generally provides an internal procedure for appeal and review.

Because staff privileges are of major economic importance to doctors, a physician who has been denied staff privileges may bring suit to contest a hospital’s action. Early suits were brought under a variety of theories. In one New Jersey case, the court held for the physician, reasoning that if a hospital was without competition in a geographical area, it had an obligation to exercise its “fiduciary power” regarding staff privileges reasonably and for the good of the public. In most early suits, however, courts denied physicians’ claims. A New York case decided over sixty years ago used principles of property and corporate law to determine that a physician had no right to membership on a medical staff and that courts could interfere only in limited situations. An Arkansas court held that individual physicians could not pursue an antitrust action because the medical profession was local in nature. The court also denied relief based on common law theories.

The United States Supreme Court has also denied relief in a staff privilege suit brought under the fourteenth amendment. In Hayman v. City of Galveston, osteopaths complained that they were denied the right to practice in a city hospital, and that as a

result their patients were denied treatment in that hospital. The Court found no equal protection violation and affirmed the suit's dismissal.

Creative attorneys have ignored such defeats and have attacked staff privilege denials on antitrust grounds. In the early 1960s, some state courts allowed these actions to proceed to the merits. Federal courts continued to deny jurisdiction under federal antitrust statutes, however, because of the local nature of hospital activities. In 1976, the Supreme Court decided the jurisdictional issue, but not in the context of staff privileges. In *Hospital Building Co. v. Trustees of Rex Hospital*, the Court considered a hospital's claim under the Sherman Act that its competitor had conspired illegally to block its expansion. The plaintiff claimed that the defendant had purchased substantial amounts of medical supplies out of state, and that it had other interstate ties. The Court allowed jurisdiction under the Sherman Act, concluding that the plaintiff's complaint alleged a restraint of trade "substantially affecting interstate commerce."

The lower federal courts quickly interpreted *Hospital Building Co.* to permit jurisdiction of physician privilege cases under the Sherman Act. Although not all cases have proceeded to litigation on the merits, the number of antitrust cases involving hospitals

17. *Id.* at 415. An osteopath, or D.O., is a physician whose approach to healing is somewhat different from that of an M.D. Most people are familiar with the latter, and tend to assume that D.O.'s are not as well trained or competent as M.D.'s. Although differences in the quality of education and the resultant level of skill may have existed years ago, today it is generally agreed that D.O.'s and M.D.'s are equally competent to treat patients.


21. *Id.* at 170.


23. *Id.* at 741.

24. *Id.* at 740.


26. *See, e.g.*, Cardio-Medical Assoc. v. Crozer-Chester Medical Center, 552 F. Supp. 1170 (E.D. Pa. 1982); Pontius v. Children's Hosp., 552 F. Supp. 1352 (W.D. Pa. 1982). The plaintiff must allege sufficient facts to permit a court to infer reasonably that the exclusion of the plaintiff from the medical staff would have commercial significance. If the plaintiff fails to do so, the court may dismiss the antitrust allegations as insufficient to state a claim under
has increased significantly.\textsuperscript{27} The Supreme Court heard only two antitrust cases relating to health care between 1890 and 1975, but since 1975 it has decided eight such cases.\textsuperscript{28}

\textbf{Issues and Analysis Under Federal Antitrust Law}

\textit{Applying Antitrust Law to Hospitals}

When considering claims under section 1 of the Sherman Act,\textsuperscript{29} courts generally apply one of two basic analyses delineated by the Supreme Court—the per se rule or the rule of reason. Under the per se rule, actions discouraging competition are “conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business reason for their use.”\textsuperscript{30} This rule minimizes the plaintiff’s burden because its conclusive presumption does not allow defendants to justify their anticompetitive activity.\textsuperscript{31}

Some of the earliest expressions of the rule of reason occur in \textit{Standard Oil Co. v. United States}\textsuperscript{32} and \textit{Chicago Board of Trade}. The Sherman Act. Rosenberg v. Healthcorp Affiliates, 663 F. Supp. 222 (N.D. Ill. 1987). See also Doe v. St. Joseph’s Hosp. 788 F.2d 411 (7th Cir. 1986) (dismissing the physicians’ antitrust claims); Seglin v. Essu, 769 F.2d 1274 (7th Cir. 1985) (same); but see Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984) (physician alleged facts sufficient to maintain action under Sherman Act).


31. Professor Sullivan notes that “assigning a particular kind of arrangement to the \textit{per se} category ends all inquiry about its validity.” L. SULLIVAN, \textit{HANDBOOK OF THE LAW OF ANTITRUST} 197 (1977).

32. 221 U.S. 1 (1911).
v. United States. This approach balances the anticompetitive and procompetitive effects of the challenged activity. An antitrust violation is found only if the anticompetitive effects outweigh the procompetitive effects, or if the challenged acts of the entity are "unreasonable." When considering barriers to professional entry, most courts have followed the rule of reason because "the nature and extent of...[the]...anticompetitive effect are too uncertain to be amenable to per se treatment."

The extent to which the professions were subject to antitrust scrutiny was left unclear after Goldfarb v. Virginia State Bar. In that case, the Supreme Court held that the state bar's enforcement of a minimum fee schedule violated section 1 of the Sherman Act. In dicta, however, the Court stated that "[t]he public service aspect, and other features of the professions, may require that a particular practice, which would properly be viewed as a violation of the Sherman Act in another context, be treated differently." Goldfarb therefore left open the possibility that courts could apply the rule of reason in these cases. In National Society of Professional Engineers v. United States, the Court refused to apply the rule of reason to a canon of the Society prohibiting competitive bidding by its members. The Court noted, however, that "[e]thical norms may serve to regulate and promote...competition, and thus fall within the Rule of Reason." The conflict between the holdings and dicta in these two cases has contributed to the confusion experienced by the lower courts when confronted with the complexities of staff privilege cases.

The Supreme Court recently decided two cases that may clarify the application of antitrust law to staff privilege cases. In North-
west Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., a retail store sued a nonprofit cooperative buying association after being expelled from the coop’s membership. This expulsion caused the retail store to lose rebates on wholesale purchases as well as other benefits that it claimed had helped it to compete effectively. In determining whether a per se analysis applied to concerted refusals to deal, the Court noted that “[t]he decision . . . turns on ‘whether the practice facially appears to be one that would always . . . tend to restrict competition and decrease output . . . or instead one designed to [increase economic efficiency and competition in the market].’” The Court pointed out that practices constituting traditional per se violations could not be justified by procompetitive arguments because the likelihood of procompetitive effects was remote.

The holding in Northwest Wholesale Stationers supports application of the rule of reason to medical staff privilege decisions. A major purpose of staff privilege determinations is to make hospitals more competitive by increasing efficiency through the selection of superior physicians. Although staff members may abuse the selection process for their own benefit, “[a] plaintiff seeking application of the per se rule must present a threshold case that the challenged activity [is] likely to have predominantly anticompetitive effects.” By this standard, medical staff privilege decisions are not predominantly anticompetitive because the entity receiving the benefit, the hospital, is not a competitor of the physician.

More recently, in Federal Trade Commission v. Indiana Federation of Dentists, the Supreme Court considered the particular

42. 472 U.S. 284 (1985).
43. Professor Sullivan distinguishes between “classic boycotts” and “concerted refusals to deal.” A boycott encompasses “a concerted refusal aimed at depriving competitors of some needed resource . . . thus making it harder for them to compete.” L. Sullivan, supra note 31, at 256. A boycott is thus a smaller, more specific category of concerted refusals to deal that, when undertaken, usually results in substantial harm to competition and seldom benefits it. Id.
44. Northwest Wholesale Stationers, 472 U.S. at 289-90.
45. Id. at 294.
47. Northwest Wholesale Stationers, 472 U.S. at 298.
problems of applying antitrust law to the health care industry. The FTC challenged an agreement among members of the Federation to refuse to submit x-rays to patients’ insurers. The insurers sought the x-rays to evaluate for themselves whether they should pay, deny, or discount particular claims. The insurers’ purpose was to contain costs by “limiting payment of benefits to the cost of the ‘least expensive yet adequate treatment’ suitable to the needs of individual patients.”

In order to determine whether this agreement violated section 1 of the Sherman Act, the Court applied the rule of reason. It noted that the members of the Federation appeared to be engaging in a group boycott, but it declined to follow precedent and invoke the per se rule. The Court expressed its reluctance to expand the category of group boycotts and condemn rules adopted by professional associations as unreasonable per se. More important was the Court’s observation that the per se rule generally applied when firms with market power boycotted suppliers or customers in order to discourage them from doing business with a competitor. Under this analysis, the per se rule would not extend to staff privilege cases because the medical staff is not attempting to discourage nonmember physicians from practicing at other health care centers.

Hospital Procedures

Even after federal antitrust jurisdiction had been established for staff privilege cases, courts remained uncertain about the application of antitrust law to the facts of these cases. Much of this problem resulted from the unclear procedures followed by hospitals in processing physicians’ applications for privileges. Anything more than minimal involvement by the medical staff in the final decision, which is made by the governing body, can be construed as a

49. Id. at 2013.
50. Id. at 2018.
51. Id.
52. Id.
53. Id.
54. This reasoning would also apply when a hospital revokes a physician’s privileges because he is spending too much time at another hospital and thus is not meeting his staff obligations. See supra notes 9-11.
conspiracy to exclude a competing physician from the benefits of staff membership. Staff members may advocate denial of privileges based on reasons unconnected with the physician's professional qualifications. If the hospital then relies on the staff not only for its opinion of the physician's skills but also for a recommendation on whether to approve or deny the physician's application, an illegal conspiracy may exist.\(^{5}\)

The Supreme Court's failure to crystallize antitrust doctrines into carefully delineated and limited tests has resulted in confusion when courts face antitrust problems in the health care industry.\(^{56}\) In lawsuits regarding denial of staff privileges, the confusion about the law has been exacerbated by particularly egregious cases. If a court believes that a hospital has unfairly denied privileges to a well-qualified physician, it may bend the law in the interests of justice.\(^{57}\) One Pennsylvania case provides an excellent example of the dilemma presented by staff privilege suits. In Weiss v. York Hospital,\(^{58}\) the plaintiff alleged that he had been denied staff privileges solely because he was an osteopathic physician. He contended

55. See infra text accompanying notes 58-65.

56. Although the rule of reason and per se theories of analysis have evolved, courts still are unsure which theory applies to certain questionable activities. For example, group boycotts have been held to be per se violations of antitrust law. See, e.g., United States v. General Motors Corp., 384 U.S. 127 (1966); Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959). Professor Sullivan has pointed out, however, that "[a] substantial number of factors must be considered as a preliminary to determining whether to characterize the arrangement as a boycott. Indeed, the scope of the analysis is so spacious that it matters little whether the inquiry is... aimed at determining whether [the] per se rule [or the rule of reason] governs." L. SULLIVAN, supra note 31, at 247-48.

Thus, when a court inquires into medical staff activities in order to determine if a boycott took place, it is taking the first steps of a rule of reason analysis. By engaging in extensive review of the activities, the court has moved away from the limited analysis of the per se rule. Because considerable judicial resources would already have been expended in that review, there is little reason not to extend the inquiry into a full rule of reason analysis. A major benefit of the per se rule, the lack of a need to inquire into circumstances surrounding the challenged activity, would have been negated.

57. Professor Havighurst has observed:

Much that goes on in competitive markets is apt to seem unfair to some participants, and judges hearing plaintiffs' complaints of such unfairness often are tempted to convert antitrust law into a federal law against unfair competition or unequal bargaining instead of maintaining it as a program for promoting dynamic competition for the ultimate benefit of consumers.

Havighurst, supra note 4, at 1108.

that various groups within the hospital had conspired to prevent him from obtaining privileges in violation of the Sherman Act. The court noted that the process to which Dr. Weiss' application had been subjected raised serious questions about whether the application had been evaluated fairly. At York Hospital, the normal procedure for evaluating privilege applications included several levels of recommendations before the governing body made a final decision. In the case of Dr. Weiss's application, the executive committee of the medical staff had overturned favorable recommendations by two lower committees. The executive committee then took the unusual step of recommending further investigation of Dr. Weiss' background.

The court outlined the requirements for establishing an antitrust violation under federal law. Under section 1 of the Sherman Act, a plaintiff must establish three elements to support an antitrust violation: "(1) a contract, combination, or conspiracy; (2) restraint of trade; and (3) an effect on interstate commerce." Relying on the Supreme Court's ruling in Copperweld Corp. v. Independence Tubing Co., the court held that the hospital could not conspire with the medical staff. The jury had determined, however, that the medical staff but not its individual members was involved in a conspiracy.

59. Dr. Weiss brought the suit as a class action on behalf of the osteopaths in the market area served by the hospital, and also on his own behalf. Id. at 791.
60. Id. at 797-98. Medical staff and/or hospital bylaws govern the application procedure, but myriad opportunities for abuse exist.
61. Weiss, 745 F.2d at 796.
62. Id. at 797. The court emphasized the irregularity of this action by the executive committee; it sensed the "unfairness" referred to by Professor Havighurst. See supra note 57.
63. Weiss, 745 F.2d at 812.
64. Id. at 817. According to the Copperweld doctrine, if corporate officers and employees are acting in the interest of the corporation, they cannot conspire with the whole corporation to restrain trade under section 1. See id. at 816, 817 & n.51.
65. Because a conspiracy usually is defined as "[a] combination ... between two or more persons," Black's Law Dictionary 280 (5th ed. 1979), the finding that one entity, the medical staff, constituted a conspiracy seems incorrect. The court in Weiss, however, found that the requirements for a conspiracy had been met. It reasoned that each physician on the staff was an independent entity competing with other staff physicians. Weiss, 745 F.2d at 815. As a matter of law, then, the medical staff was a "combination of individual doctors and therefore ... any action taken by the medical staff satisfies the 'contract, combination, or conspiracy' requirement of section 1." Id. at 814.
The court in *Weiss* cited two Supreme Court decisions to support its theory that "a single entity made up of independent, competing entities satisfies the joint action requirement of the Sherman Act . . . ."66 Those cases, however, involved single entities that were the ultimate policy or decisionmaking bodies for the component entities.67 Matters involving the denial of staff privileges are distinguishable because the final decision to deny privileges is made by the hospital's governing board, not the medical staff.68 The court in *Weiss* sidestepped this issue, however, by adopting the theory that the medical staff recommendation was in effect the final decision, and the governing body merely rubber stamped the staff's decision.69

Having determined the existence of a conspiracy, the court next addressed the restraint of trade issue. Although the court noted that several courts in other circuits had followed the rule of reason, it applied a per se analysis,70 reasoning that the discrimination


67. *Maricopa County Medical Society* involved a group of physicians who had voted to set the maximum fees they could claim in full payment from certain insurance plans. 457 U.S. at 335-36. At issue in *National Society of Professional Engineers* was a canon of ethics promulgated by the association prohibiting competitive bidding by its members. 435 U.S at 681.

68. See 28 PA. CODE § 107.2 (1983). "The governing body of the hospital, after considering the recommendations of the medical staff, may grant clinical privileges to . . . practitioners in accordance with their training, experience . . . competence, and judgment." Id. (emphasis added).

The JCAH standards, however, provide for a great deal of involvement by the medical staff in the privilege process. Peer recommendations "are part of the basis" for developing a recommendation on medical staff membership. JCAH MANUAL, supra note 10, at 111 [MS. 1.2.3.1.5]. If the medical staff and the governing body disagree about the disposition of a physician's application, the two groups are directed to resolve any "differences in recommendations." Id. at 51 [GB. 1.12].

69. *Weiss*, 745 F.2d at 796 n.14, 797 n.16, 817 n.51, 819. This theory ignores the fact that the governing body may have interests directly opposite to those of the medical staff due to the hospital's need to compete with other health care entities. Whereas the staff may want to limit access to privileges (and thus to the fee pool), the hospital may decide that it needs to expand the number of physicians who have privileges in order to increase its market share and keep its beds full. Cf. White v. Rockingham Radiologists, Ltd., 820 F.2d 98, 104 (4th Cir. 1987) (hospital is not competitor of physician in product market area).

70. Id. at 820. *Contra*, e.g., Desai v. St. Barnabas Medical Center, 103 N.J. 79, 97-99, 510 A.2d 662, 671 (1986).
against the osteopathic physicians was a "group boycott."\textsuperscript{71} It held that application of the rule of reason would be appropriate only if the hospital's policy was a form of self-regulation based on professional competence or unprofessional conduct.\textsuperscript{72} The court considered the "public service" or "ethical norm" exception to the per se rule,\textsuperscript{73} but concluded that because the hospital had discriminated against osteopathic physicians as a class, the per se rule applied.\textsuperscript{74}

The court's application of the per se rule appears justifiable on its surface. If York Hospital, through its medical staff, were arbitrarily denying privileges to osteopaths as a class, it could cite no procompetitive justifications except that all osteopaths were incompetent. This the hospital did not do. If the court had applied the rule of reason, however, it probably would have concluded that the anticompetitive effect of excluding Dr. Weiss outweighed any procompetitive justification offered by the hospital. Under the rule of reason, the court would have focused on whether the hospital or the medical staff actually had made the decision regarding Dr. Weiss's application. If the hospital had made the decision, a section 1 violation was unlikely.\textsuperscript{75}

The court also assumed that if Dr. Weiss was qualified, the medical staff had blocked approval of his application for their own personal reasons.\textsuperscript{76} This assumption fails to consider that the staff


\textsuperscript{72} Weiss, 745 F.2d at 821-22. But cf. Kaczanowski v. Medical Center Hosp. of Vermont, 612 F. Supp. 688, 695 (D. Vt. 1985) (although medical staffs had power to grant privileges, plaintiff did not prove that defendants were acting to further their own interests).

\textsuperscript{73} See supra text accompanying notes 36-41.

\textsuperscript{74} Weiss, 745 F.2d at 820-22. The court seems to have combined the concept of professional discrimination, which is basically a social phenomenon, with the concept of group boycott or concerted refusal to deal, which is an economic phenomenon. Professional discrimination can have an economic effect, but it is primarily socially motivated. Boycotts, such as the one alleged in Weiss, are economically motivated. Although boycotts may be characterized as "economic discrimination," the antipathy of M.D.'s toward osteopaths seems to be motivated not by economic reasons but by professional differences. See supra note 17. A clear distinction between the two concepts is necessary to avoid grounding antitrust violations solely on professional discrimination without a consideration of possible economic justification.

\textsuperscript{75} See supra note 68 and accompanying text.

\textsuperscript{76} Weiss, 745 F.2d at 797 nn.17-18.
might have had valid professional reasons for rejecting Dr. Weiss's application.77

The holding in Weiss is a potentially dangerous precedent in antitrust law for two reasons. First, the court held that as a matter of law the medical staff could constitute a “combination or conspiracy,” and second, it decided that the denial of staff privileges constituted a group boycott, which is a per se restraint of trade.78 If a court accepts these precedents, the burden of proof will be eased tremendously for future plaintiffs because the basis requirements for a section 1 violation already will have been met.79

THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

The proliferation of staff privilege cases and the accompanying burden of litigation costs are an added burden for physicians as well as hospitals. Greater exposure to antitrust liability makes physicians reluctant to engage in peer review procedures that may lead to denial or revocation of staff privileges. Potential damage awards to victorious litigants, trebled under antitrust law, could easily approach several million dollars. Even if the rejected applicant is unsuccessful in his suit, the costs of defending the suit may be sub-

77. The court mentioned the right of the medical staff to regulate admission to its membership based on competence, but ignored that issue in order to base its decision on the "group boycott" theory. Id. at 820; see id. at 820 n.60.

78. Professor Sullivan questions whether the per se doctrine should apply to all boycotts. He notes that all boycotts are not per se unlawful, for many concerted refusals to deal lack . . . distinguishing characteristics which invite application of the per se doctrine; one cannot say of them that they always or almost always do substantial harm to competition, that they seldom benefit it . . . and that the cases showing a net benefit are hard to identify.

L. SULLIVAN, supra note 31, at 256.

79. Under the per se rule, the defendants are not allowed to present reasons to justify their actions. See supra notes 29-31 and accompanying text. Although the holding in Weiss would seem to be limited to its fact pattern, some courts have adopted the antitrust theories developed in Weiss. E.g., Quinn v. Kent Gen. Hosp., 617 F. Supp. 1226, 1242 (D. Del. 1985) (holding that members of a hospital medical staff are a collection of independent economic actors capable of conspiracy with one another for purposes of the Sherman Act). Contra Cooper v. Forsyth County Hosp. Auth., Inc., 789 F.2d 278, 281 n.12 (4th Cir.), cert. denied, 107 S. Ct. 474 (1986) (questioning whether individual members of a hospital medical staff could conspire). The continued validity of the application of the per se rule in staff privilege cases is questionable, however, due to subsequent Supreme Court decisions. See supra notes 42-54 and accompanying text.
Physician Staff Privileges

1988]

Physician Staff Privileges

Substantial. Legislators recognized these problems, and in late 1986, Congress passed a bill designed to encourage effective peer review in hospitals. The legislation contains two major components: immunity from damages under federal and state law for qualifying groups and individuals and a system for keeping track of interstate movements of physicians who were denied staff privileges. Congress passed the legislation in response to recent decisions holding peer review groups liable for damages. In particular, Congress expressed concern for the millions of patients who may be at risk from physicians of questionable competence who are granted privileges by gun-shy peers.

Immunity from Liability for Damages

The Health Care Quality Improvement Act of 1986 (the Act) provides immunity from damages for the professional review group, both individually and as a whole, as well as for persons associated with the group under an agreement or during the peer review procedure. The review group must meet several requirements, however, before it will qualify for the protection of the

81. Id. at § 11111.
82. Id. at §§ 11131-37, 11151-52.
83. Congressmen from states within the geographical bounds of the United States Court of Appeals for the Ninth Circuit were a major force behind the legislation. Their concern arose as a result of the Ninth Circuit's decision in Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986) (holding that the existence of a state-mandated peer review process does not preclude antitrust liability for actions outside the peer review process and does not affect state law claims), cert. granted, 108 S. Ct. 65 (1987).
85. 42 U.S.C.A. § 11112(a). The section provides:
   (A) professional review action must be taken—
   (1) in the reasonable belief that the action was in the furtherance of quality health care,
   (2) after a reasonable effort to obtain the facts of the matter,
   (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
   (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
   Id.
Application of the Act to Federal Antitrust Suits

Recent Supreme Court decisions indicate that the rule of reason is the analysis that courts must apply to staff privilege cases, and the standards of the Act reflect considerations similar to those behind the rule of reason—reasonableness and an action that can be justified in good faith. Because of this similarity, courts can use the standards of the Act as a test for procompetitive justification for the action taken by the defendants.

The Act requires investigation of the background and medical experience of the physician applying for privileges. In the case of revocation of privileges, the circumstances surrounding the incident that led to the revocation must be investigated. The peer review group also must have a reasonable belief that the action was warranted after the investigation as well as a reasonable belief that the action was in the furtherance of quality health care.

The three standards are remarkably similar to the procompetitive justifications for denying privileges that would be asserted by the defendants in an antitrust action. A detailed investigation of the physician would uncover evidence of incompetence; the hospi-
tal therefore would not extend privileges to the incompetent physician because of the potential for harm to its reputation as well as malpractice litigation and liability. The review group's recommendation to deny privileges consequently would be "reasonable" because it would best serve the economic interests of the hospital. Under a rule of reason analysis, which weighs procompetitive and anticompetitive effects of an activity, the court would reach a similar conclusion. A hospital and its medical staff that have complied with the requirements of the Act thus have likely complied with the requirements of federal antitrust law.

A court hearing a privilege suit could use the requirements of the Act to test the viability of the plaintiff's action. If the court considers first the issue of whether the peer review procedure met the standards of the Act, then a finding for the defendants of exemption from liability for damages may lead the plaintiff to seek dismissal. Even if the plaintiff desires reinstatement or another nonmonetary remedy, the burden of litigation on the defendants can be reduced tremendously. When the antitrust issues are raised, the defendants should be able to use the finding of exemption as evidence of procompetitive effects that outweigh the anticompetitive actions taken.

Because the court's analysis under the Act is very similar to a rule of reason analysis, a court would not need to inquire further into the peer review group's action. If the plaintiff is unable to rebut a presumption that the hospital's decision was reasonable, the procompetitive effects of the action will outweigh its anticompetitive effects. A plaintiff might argue that only the circumstances surrounding the peer review action, and not the economic implications of that action, had been examined by the court. In these limited situations, the court may wish to continue an antitrust inquiry, but if the peer group's decision was based on a valid reason

93. See infra text accompanying notes 101-03.
94. If the peer review action involved a revocation of a limited number of privileges for reasons unrelated to incompetence, then the economic motives of individual peers might be more apparent. For example, a review group's revocation of a physician's privileges because he was spending less time at the hospital than was expected of him might satisfy the requirements of the Act. On the other hand, the peers' actions might be motivated by personal dislike or by feelings that the physician was being unjustly enriched. The loss or privileges may have enough of an effect on the physician that continued association with the
such as incompetence, then evidence of economic motive or bias on the part of the peer group during the application process is irrelevant.\textsuperscript{95}

Neither the Act nor its legislative history indicates at what point in the litigation the court should determine whether the defendants qualify for protection. The most effective point at which to decide this issue is prior to full trial on the antitrust issues. If the court decides that the peer review group meets the Act’s requirements for immunity, neither the group nor its members can be liable for damages.

\textit{Award of Attorney Fees}

In addition to the protection from liability for damages, the Act also provides for an award of attorney’s fees to defendants in cases brought frivolously or in bad faith.\textsuperscript{96} The longer the plaintiff pursues the suit after the initial ruling for the defendant, the more likely the plaintiff will be accused of bad faith and threatened with the burden of attorney fees and court costs.\textsuperscript{97}

Because privilege cases often continue for years, costs can be quite high. Courts have begun to recognize the economic pressure on defendants, and some have taken steps to discourage meritless lawsuits. Recently, a federal judge ordered a physician and his hospital is no longer economically practical, and the physician may decide to leave. In such a case, an antitrust argument would find some support.

\textsuperscript{95} Any decision to deny privileges to a physician always has some effect on trade because the physician is precluded from engaging in his practice at that hospital. Antitrust law, however, should provide remedies only when competent physicians are unjustly denied privileges; that is, when the anticompetitive effects of denial outweigh its procompetitive effects. In addition, no remedy deriving from antitrust allegations should be available if the elements of antitrust jurisdiction, especially those requiring an impact on interstate trade, are lacking.

\textsuperscript{96} 42 U.S.C.A. § 11113. The wording of the Act, which tracks language drafted by the House Judiciary Committee in the National Cooperative Research Act of 1984, 15 U.S.C. § 4304 (Supp. III 1985), allows defendants to recover attorney’s fees “only where the plaintiff’s claim or conduct during the litigation is frivolous, unreasonable, without foundation, or in bad faith.” Waxman Statement, \textit{supra} note 84, at H11,591.

\textsuperscript{97} The Act provides for the recovery of attorney fees and costs by a defendant who “substantially prevails” if the plaintiff's claim or conduct during the litigation is “frivolous, unreasonable, without foundation, or in bad faith.” 42 U.S.C.A. § 11113. A plaintiff who continues to litigate a claim that has strong indications of being meritless might be considered by a court to fall under this section.
counsel to pay almost $16,000 to the defendants in an antitrust case involving denial of surgical privileges. The court found that the attorney had not made a reasonable inquiry into the applicable law and had not based his case on current law or on a good faith argument for modification of existing law.98

Although the immunity and attorney fee provisions may discourage disgruntled physicians from suing, supporters of the Act hypothesized that it actually would increase the number of cases brought by physicians.99 This reasoning may not be valid with regard to the reporting system,100 and it may not reflect an accurate assessment of the physician's remedial opportunities.

The Act's Effect on Plaintiffs' Remedies

Although the Act specifies procedures by which defendants may obtain immunity from liability for damages and plaintiffs may become liable for attorney fees, the Act does not address directly the remedies that are available to plaintiffs who prove an antitrust violation. Most physicians who sue on privilege issues seek damages resulting from the hospital's revocation or denial of privileges.


99. Waxman Statement, supra note 84, at H11,590. Representative Waxman suggested that “[u]nder the present system ... doctors facing the loss of hospital privileges care enough about the need for such privileges that they will ... pick up their families and move to another jurisdiction ... just to practice medicine with clinical privileges.” Id. Because this alternative will be restricted by the new reporting system, and privileges are of primary economic importance, physicians may be more likely to sue rather than acquiesce to being stripped of the means to earn their livelihood. Id.

However, the disclosure of unfavorable action taken by the peer review group in the reporting system is not as cataclysmic as it sounds. The physician is not automatically precluded from practicing, nor must hospitals refrain from hiring him. During peer review at a subsequent hospital, a check of the reporting system will reveal the prior unfavorable action against the applicant. The proceedings may have resulted in a reduction or denial of privileges unrelated to the skill of the physician. If the action was taken as the result of poor performance by the physician, the hospital may decide to approve privileges pending successful completion by the physician of a probationary period during which a staff member supervises and/or instructs the physician.

100. The system works to inform hospitals and other entities rather than to prohibit a physician from moving or beginning a new practice. Representative Waxman's statement, see supra note 99, therefore will not always be correct. In those cases in which the physician believes that he can find a position on another medical staff, he may decline to involve himself in expensive and time-consuming litigation.
Both the hospital and the physician have interests in avoiding expensive public litigation. Furthermore, a physician whose privileges were revoked may alienate hospital personnel by words or actions that engender bad feelings, or by filing a lawsuit. In this situation, injunctive or declaratory relief mandating the reinstatement of the physician would be neither desirable nor practicable because future relations between the physician and the hospital would be strained at best. The filing of the complaint thus usually indicates a permanent break between the hospital and the physician.101

If the physician is precluded from recovering damages from the medical staff, he probably will not recover damages from any defendant.102 The only relief likely to benefit the physician if he can prove an antitrust violation is an injunction preventing entry of the peer review action in the reporting system. Under the Act’s reporting system, any health care entity that “takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days” must report the “name of the physician . . . reasons for the action . . . and . . . other [appropriate] information”103 to the Secretary of Health and Human Services. Hospitals failing to do so lose the protection of the Act.104 The physician will want to prevent this report from being filed, so that his search for employment at other hospitals will not be adversely affected.105

101. In unusual circumstances, the physician’s interest in remaining at the facility may outweigh the problem of strained relations. If the facility is the only one in the area, or the opportunity is exceptionally attractive, injunctive relief requiring re-evaluation of the application—not reinstatement—may satisfy the physician’s needs. See generally Chayet & Reardon, supra note 10, at 310-12 (indicating that courts are hesitant to interfere with substantive decisions of the medical staff through the imposition of injunctions).

102. Absent noncompliance with the requirements of the Act, the hospital, physicians on the medical staff, and other qualified individuals fall under the protection of the Act. 42 U.S.C.A. § 11111(a).

103. Id. § 11133(a)(1)(A), (a)(3)(A-C).

104. Id. § 11133(c)(1).

105. Hospitals are required to request from the Secretary of Health and Human Services any information regarding a physician that is contained in the reporting system at the time the physician applies to be on the medical staff. Id. § 11135(a). The Act gives the Secretary power to resolve disputes regarding the accuracy of the information reported, preventing hospitals from reporting incorrect or misleading information in the first place than seeking correction at a later date. Id. § 11136(2) If a physician does not want to be associated with the hospital that denied his privileges, he still must sue the peer review group if he does not want the unfavorable decision reported.
Even if a court finds an antitrust violation, it may decide to exempt the hospital and medical staff from liability damages.\textsuperscript{106} Under these circumstances, the physician may have no other meaningful remedy available and thus no incentive to continue the suit. Injunctive relief ordering reinstatement cannot be entered against the medical staff because they have no authority to grant privileges. The hospital, through its board of directors, has the authority to reinstate the physician, but cannot be ordered to do so unless the court determines that it has violated antitrust law. Because a hospital cannot conspire with the medical staff in violation of section 1 of the Sherman Act,\textsuperscript{107} it cannot violate antitrust law under these circumstances.

If, on the other hand, a plaintiff prevails on the issue of liability for damages, the hospital may choose to settle. If the plaintiff pursues the suit, several outcomes are possible. The review group may have met none of the standards of the Act, in which case antitrust liability is likely. Just as the losing plaintiff should not be allowed to challenge the finding that the review group made a reasonable decision, the defendants should be prevented from challenging a finding that the decision was not reasonable.

If the defendants fail to satisfy only one of the tests for immunity, they may still prevail on the merits. In these situations, the plaintiff might not be able to avoid relitigating the issues of reasonable effort and belief. For example, in deciding the question of exemption the court may not have found it necessary to consider all the standards of the Act. The defendants may have made a legitimate decision that would survive antitrust challenges, but they may not have afforded the plaintiff due process as required by the

\textsuperscript{106} The court may find that the denial of privileges was an unreasonable restraint of trade, but that the defendants made a reasonable decision to deny staff privileges. This situation would arise infrequently, and only in a decision involving a marginally competent physician. By recognizing that the defendants' decision was reasonable, the court preserves the purpose of the Act—promoting fair and effective peer review—without imposing the sanction of treble damages. Because it has found an antitrust violation, the court will be able to offer one remedy to the physician; his application can be sent back to the committee for reconsideration.

In such a circumstance, the defendants will not be able to claim the protection of the Act, but they may prevail nonetheless in the antitrust action. In these cases, a full trial probably would be required. Nonetheless, the Health Care Quality Improvement Act could have the effect of substantially reducing the costs of litigation on peer review defendants if it is applied not only to decide the issue of exemption from liability for damages but also to shorten antitrust cases or to encourage settlement.

**CONCLUSIONS**

Recent court decisions and legislative actions indicate that lawmakers are becoming more aware of the impact of privilege suits on the health care community. Hospitals trying to contain costs in order to comply with the PPS are faced with the added burden of litigation expenses from these cases. Physicians on medical staffs have become more reluctant to serve on peer review groups due to the potential for liability under federal antitrust laws. The expense of litigating, even if the defendant physicians are ultimately successful, is also a deterrent to service on peer review groups, although some hospitals may agree to pay this expense for staff members. As a result, improvement in the quality of health care is threatened.

Recent antitrust rulings by the Supreme Court appear to have established the rule of reason as the applicable analysis for staff privilege cases. Hospitals will benefit from this result because lower courts will be able to develop a more cohesive analysis for this type of case. Once the judicial analysis is established, hospitals and peer review groups can structure their activities to avoid antitrust liability.

108. The standard of "due process" is different from the other three standards set forth in 42 U.S.C.A. § 11112(a) because it is much more tangible. The Act gives a definition of due process that, if followed, will satisfy the requirement. *Id.* § 11112(b). The definition provides that failure to meet the conditions of due process described in the Act does not by itself "constitute failure to meet the standards of subsection (a)(3)." *Id.* Comments made during the House debate indicate that this section was not intended to diminish the due process rights of physicians; they would still enjoy at least the same due process rights that exist under current law. Waxman Statement, supra note 84, at H11,591. If the defendants complied with the due process standard in the Act, the physician will be precluded from arguing that the requirement was not met. The other three requirements are subjective and therefore subject to attack.
The Health Care Quality Improvement Act will also reduce litigation expenses and encourage better peer review. Plaintiffs who cannot make the threshold liability determination established by the Act may be less likely to pursue their lawsuits, thereby reducing overall litigation expenses. Defendants unable to qualify for exemption from liability for damages also may be more inclined to settle.

In sum, hospitals and peer groups should structure their relationships and procedures carefully in order to avoid antitrust liability. The courts and the legislature have taken steps to resolve some of the legal problems arising from staff privilege cases. Health care entities should act on these advances to insulate themselves as extensively as possible from antitrust liability.

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