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DISCRIMINATION OF INTERNATIONAL MEDICAL GRADUATE PHYSICIANS BY MANAGED CARE ORGANIZATIONS: IMPACT, LAW AND REMEDY

Saeid B. Amini

INTRODUCTION

Professional and political concerns about the increasing numbers of International Medical School Graduates (IMGs), those who graduate from foreign medical schools and enter United States residency programs, has re-emerged during the past two years.¹ There is growing pressure by many national organizations, such as the Association of American Medical Colleges (AAMC), to limit the number of IMG physicians.² Previous attempts to limit the number of such graduates who fill residency positions failed mostly because many IMGs enroll in residency programs located in inner cities, rural communities, and poor neighborhoods, thus offering medical care to indigent patient populations that United States medical school graduates generally choose to avoid.³ The three main arguments made for limiting the size of IMGs are:

³Foreign Physicians: Exchange Visitor Program Becoming Major Route to Practicing in U.S. Underserved Areas, GAO HEHS-97-27. Available from the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD. 20884-6015.
(1) the current estimated thirty percent over-population of the United States physician market;
(2) over two-thirds of IMGs stay in the United States after completing their residency program; and
(3) allowing IMGs to enter the residency programs artificially changes the market equilibrium by infusing IMGs to the currently saturated market, and thus discourages intelligent United States born students from entering United States medical schools.\(^4\)

For many years, IMGs were a significant factor in the United States health care delivery market. For example, as Table 1 shows, of about 720,000 practicing physicians in the United States in 1995, about 165,000 (twenty-three percent) were IMGs of which only 19,275 (1994 data) were United States-born, but received their medical degrees overseas.

**TABLE 1**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All graduates</td>
<td>511,090</td>
<td>559,988</td>
<td>632,121</td>
<td>720,325</td>
</tr>
<tr>
<td>U.S. Medical Schools</td>
<td>398,430</td>
<td>437,165</td>
<td>483,039</td>
<td>554,827</td>
</tr>
<tr>
<td>International Medical Schools</td>
<td>112,660</td>
<td>122,823</td>
<td>149,082</td>
<td>165,498</td>
</tr>
<tr>
<td>Graduates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S.-born</td>
<td>16,344</td>
<td>18,905</td>
<td>19,275</td>
<td>–</td>
</tr>
<tr>
<td>Foreign-born</td>
<td>96,316</td>
<td>103,918</td>
<td>129,807</td>
<td>–</td>
</tr>
</tbody>
</table>

Moreover, of all IMG physicians who come to the United States to attend residency programs, about seventy-five percent decide to stay and practice

\(^4\)Id.  
\(^5\)Inglehart, *supra* note 1, at 1679.
While some IMG physicians become staff physicians in hospitals, a large majority practice medicine in a solo or small group setting (Table 2).

### TABLE 2

<table>
<thead>
<tr>
<th>Activity</th>
<th>Total Physicians</th>
<th>IMGS</th>
<th>Total Physicians</th>
<th>IMGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Physicians</td>
<td>467,879</td>
<td>97,726</td>
<td>720,325</td>
<td>165,498</td>
</tr>
<tr>
<td>Patient Care</td>
<td>376,512</td>
<td>72,935</td>
<td>582,131</td>
<td>136,812</td>
</tr>
<tr>
<td>Office Based Practice</td>
<td>272,000</td>
<td>45,764</td>
<td>427,275</td>
<td>94,920</td>
</tr>
<tr>
<td>Hospital Based Practice</td>
<td>104,512</td>
<td>27,171</td>
<td>164,856</td>
<td>41,892</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td>62,042</td>
<td>11,424</td>
<td>96,352</td>
<td>22,552</td>
</tr>
<tr>
<td>Full-Time Staff</td>
<td>42,470</td>
<td>15,747</td>
<td>58,504</td>
<td>19,340</td>
</tr>
<tr>
<td>Other Prof. Activity</td>
<td>38,404</td>
<td>8,656</td>
<td>43,312</td>
<td>7,494</td>
</tr>
<tr>
<td>Medical Teaching</td>
<td>7,942</td>
<td>1,589</td>
<td>9,489</td>
<td>1,672</td>
</tr>
<tr>
<td>Administration</td>
<td>12,209</td>
<td>1,533</td>
<td>16,345</td>
<td>2,217</td>
</tr>
<tr>
<td>Research</td>
<td>15,377</td>
<td>4,918</td>
<td>4,940</td>
<td>2,835</td>
</tr>
<tr>
<td>Other</td>
<td>2,676</td>
<td>636</td>
<td>3,158</td>
<td>770</td>
</tr>
<tr>
<td>Not Classified</td>
<td>20,629</td>
<td>10,235</td>
<td>20,579</td>
<td>9,486</td>
</tr>
<tr>
<td>Inactive</td>
<td>25,744</td>
<td>2,731</td>
<td>72,326</td>
<td>11,127</td>
</tr>
<tr>
<td>Address unknown</td>
<td>6,390</td>
<td>3,169</td>
<td>1,977</td>
<td>579</td>
</tr>
</tbody>
</table>

With the medical delivery system transforming from the customary fee-for-service to a managed care and integrated delivery system, most IMG physicians lawfully practicing medicine in this country find themselves being discriminated against or just left out by managed care organizations. This paper will discuss these various issues in detail and identify laws that could possibly protect IMGs from possible unfair discrimination or

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competition, and protect managed care organizations from false allegations.

The next section of this paper reviews the facts about IMGs and the recent attempts aimed at reducing the number of IMG residents in the United States. Further sections deal with managed care organizations (MCOs) and their relationships with physicians, in particular, IMGs. Also there will discussion regarding discrimination against IMG physicians. Legal theories will be addressed under which an IMG physician may bring a lawsuit against discriminatory MCO practice. The theories discussed include common law legal remedies under contract and tort claims. Statutory theories such as Title VII of the Civil Rights Act, Section 1981, and antitrust laws will also be considered. Finally, this article discusses remedies under state statutes such as "Physician Protection Acts" that various states are attempting to enact in order to protect physicians from unjust termination by HMOs.

BACKGROUND

International Medical Graduates (IMGs) and the United States Residency Program

During the 1960s and 1970s, IMGs were actively sought due to the shortage of physicians in many United States hospitals.\(^8\) While it is still cost-effective, as well as quicker, to import a qualified physician than to provide four years of training at a United States medical school, the situation has changed significantly in recent years because of the emergence of managed health care delivery systems. Now, IMGs are reluctantly offered spots not taken by United States medical graduates (USMGs). While the number graduating from United States medical schools has remained stable, about 17,000 a year since the early 1980s, the number of IMGs entering United States residency programs has increased from 2201 in 1988, to 5891 in 1994, an increase of about 170% (Table 3). IMGs include not only immigrant physicians, but also United States citizens who get their medical education in other countries and return to the United States after graduating from foreign medical schools.\(^9\)


\(^9\)Id. See also, supra note 3, at Table 1, and infra note 10, at Table 3.
Despite the tough talk against IMGs in recent years and concerted efforts at restricting IMG enrollments in United States residency programs, the latest statistics show that at least seventy-seven hospitals in the United States are dependent on the IMG residents, and many more have a significant need for their services. Nevertheless, the most popular solution for reducing the number of physicians entering the United States physician market is centered around eliminating the number of IMG residency slots. In fact, the Council on Graduate Medical Education (COGME) has recently recommended the number of residency slots be reduced from 142% of the number of USMGs to 110%, which will result

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10Iglehart, supra note 1, at 1680 (referring to Table 1, data compiled from the Association of American Medical Colleges).


12See Iglehart, supra note 1, at 1679.

in eliminating about 5400 residency slots ordinarily filled by IMGs. Some states are heavily dependent on IMGs to man their hospitals, and it would be problematic to abruptly cut the supply of IMGs to those hospitals. For example, more than fifty percent of all hospital residents in New York City are IMGs, as are more than forty percent in North Dakota and more than fifty-seven percent in New Jersey (Table 4). Nationwide, IMGs make up nearly twenty-four percent of all medical residents.

**TABLE 4**

<table>
<thead>
<tr>
<th>State</th>
<th>No. Of IMGs</th>
<th>As Percent IMG Of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Residents</td>
<td>All Residents</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1,704</td>
<td>57.5%</td>
</tr>
<tr>
<td>New York</td>
<td>5,459</td>
<td>45.1</td>
</tr>
<tr>
<td>Nevada</td>
<td>43</td>
<td>43.0</td>
</tr>
<tr>
<td>North Dakota</td>
<td>49</td>
<td>40.2</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,696</td>
<td>36.5</td>
</tr>
<tr>
<td>Connecticut</td>
<td>594</td>
<td>36.4</td>
</tr>
<tr>
<td>Total U.S.</td>
<td>19,677</td>
<td>23.9</td>
</tr>
</tbody>
</table>

**Competition for Residency**

Graduates of United States and international medical schools do not generally compete for the same residency positions. The majority of United States medical school graduates compete for positions by participating in the National Resident Matching Program (NRMP) in their fourth year of medical school. On the other hand, the majority of IMGs

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14 *See supra* note 8 (1994 data in table 3). This change will impact approximately 5400 IMG enrollments (142% times 16,869 minus 110% times 16,869 = 5,398).
15 *See infra* note 15, Table 4.
16 *Data is compiled from the American Medical Association master file.*
17 *See Whitcomb, supra* note 2, at 454.
18 *Report from the NRMP: Results of the National Resident Matching Program for 1994, 69 ACAD. MED. 508-10 (1994).*
fill residency positions that are either not offered by the matching program or not filled by United States graduates. \(^{19}\) American graduates are always given preference in residency positions. \(^{20}\)

**Required Visa**

There are three types of IMG physicians who participate in residency programs in the United States:

1. citizens of other countries who are in the United States on temporary or exchange visas (i.e., J-1 visa) or H-1B work permit which can be converted to permanent residency in the United States,
2. immigrants who are naturalized American citizens or have permanent-resident status, and
3. native-born American citizens who graduated from foreign medical schools and have returned to the United States for advanced training. \(^{21}\)

To enter residency training, IMGs must satisfy American standards established by the Educational Commission for Foreign (International) Medical Graduates, as well as the requirements from state licensing boards. \(^{22}\) Those who decide to stay in the United States do so in compliance with standard immigration procedures and find employment based on their qualifications and prevailing market conditions. Recently, the Immigration and Naturalization Service (INS) was considering eliminating the H-1B status and only allowing IMGs to obtain training with the J-1 visa. \(^{23}\) This will require all IMGs (discussed in group (1)), with a few exceptions, to return to their home countries after completing their residency training. Under the proposed plan, an IMG could still receive an H-1B visa if he or she has a state or teaching hospital

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\(^{19}\)Id.


\(^{22}\)See Mullan, *supra* note 6, at 1522.

sponsorship.\textsuperscript{24} The core issue in deciding what type of visa is appropriate for IMG residents is to decide whether residency is a training program or a specialty occupation.\textsuperscript{25}

Who Pays for Residency Training

The cost of residency training is generally financed through public and private revenues from third-party payments for medical care.\textsuperscript{26} Medicare and Medicaid programs are crucial sources of funding for teaching hospitals because they make payments for graduate medical education and set no limit on the number of residents they will support.\textsuperscript{27} The largest explicit source of funding for graduate medical education, Medicare, makes direct medical education payments to hospitals for residents' stipends, faculty salaries, related administrative expenses, and institutional overhead allocated to residency programs, as well as an indirect medical-education adjustment to per-case payments.\textsuperscript{28} During 1995, Congress considered revisions in the Medicare law regarding the direct and indirect support of residency programs.\textsuperscript{29} Specifically, it proposed limiting the number of residency positions as well as making sure that such funding first be made available to USMGs.\textsuperscript{30}

Efforts in Reducing IMGs

In the past several years there have been systematic efforts by the government and private medical associations to reduce the number of IMGs by making it more difficult for IMGs to receive required visas\textsuperscript{31} and by cutting Medicare support for IMGs in United States residency programs.\textsuperscript{32}

Similarly, in years past, several restrictions were sought for the use of federal Medicare money to partially finance IMG residency programs. For example, in 1985 then Senator Robert Dole (R-Kansas) introduced legislation that would have terminated Medicare payments for residency

\textsuperscript{24}Id.
\textsuperscript{25}Id.
\textsuperscript{26}Id.
\textsuperscript{27}Inglehart, supra note 1, at 1679.
\textsuperscript{28}Dunn, supra note 21, at 710.
\textsuperscript{29}Id.
\textsuperscript{30}Id.
\textsuperscript{31}Id. at note 21, at 712. See also, 28 AM. MED. NEWS, Dec. 9, 1996.
\textsuperscript{32}Id. at note 21, at 711. See also, Whitcomb, supra note 2, at 455.
positions filled by graduates of foreign medical schools who were not United States citizens.\textsuperscript{33} The measure was never enacted.\textsuperscript{34} During the debate over health care reform in 1993 and 1994, proposals supported by the Clinton administration and several congressional committees called for a strict limit on the number of physicians allowed to enter residency programs.\textsuperscript{35} This plan would have effectively closed United States training positions to all but a few IMGs.\textsuperscript{36} The reform died with no legislation enacted.\textsuperscript{37} The fiscal-year 1997 budget the Clinton administration submitted to Congress proposed a freeze on the current number of residencies supported by Medicare, a measure advocated by Dr. Kenneth I. Shine, president of the Institute of Medicine.\textsuperscript{38}

In 1995, as part of the Republican effort to balance the federal budget, Congress again considered reducing Medicare support for residency positions filled by IMGs.\textsuperscript{39} Testifying before the Senate Finance Committee in July of 1995, Association of American Medical Colleges president, Dr. Jordan J. Cohen, said:

While the association should consider all available options for addressing this oversupply [of physicians], it should first and foremost pursue options to diminish the number of international medical graduates [IMG] pursuing graduate medical education in the United States and remaining in the United States following the completion of their graduate trainings [sic].\textsuperscript{40}

While IMG physicians have no real power to influence congressional members, it is unlikely that Congress will completely stop the influx of IMGs. This is because a large majority of IMG physicians complete their residency programs in hospitals serving under-privileged patient populations and upon completion of their training, most practice medicine

\textsuperscript{33}Inglehart, supra note 1, at 1680.
\textsuperscript{34}Id.
\textsuperscript{35}Id.
\textsuperscript{36}Id.
\textsuperscript{37}Id.
\textsuperscript{38}Id.
\textsuperscript{39}Inglehart, supra note 1, at 1680.
\textsuperscript{40}\textit{The Importance of the Medicaid Program in Supporting Academic Medicine} (July 1995) (Testimony delivered on behalf of the Association of American Medical Colleges before the Senate Finance Committee). See also, Inglehart, supra note 1, at 1680.
with poor and under-privileged patient populations.\textsuperscript{41} As long as United States medical school graduates are reluctant to practice and seek residency positions in under-privileged areas, the influx of IMGs will likely continue in at least reduced numbers. It is clear to some federal and state policy makers that for patients in rural areas, there will be a longer wait to see a physician and fewer services if IMGs are prevented from entering and practicing in this country.\textsuperscript{42}

In addition to governmental efforts, several influential national organizations and their spokespersons have started fierce campaigns against IMGs. These groups have included the Pew Health Professions Commission, the Council on Graduate Medical Education, the Accreditation Council for Graduate Medical Education, the Physician Payment Review Commission, the Macy Foundation, and the Institute of Medicine.\textsuperscript{43} Probably the best known and most widely discussed of the reports are those of the twenty-one member bipartisan Pew Commission. Its latest report, issued in December 1995, made several recommendations including limiting the number of the residency slots and tightening visa restrictions for IMGs.\textsuperscript{44}

In another example, a recent report by a committee from the Institute of Medicine, co-chaired by Dr. Neal A. Vanselow, former chancellor at Tulane University Medical Center, openly blames the oversupply of physicians in the United States on IMGs.\textsuperscript{45} According to Dr. Vanselow, the “physician glut” is the result of increasing numbers of IMGs entering residency training in the United States.\textsuperscript{46} Furthermore, Dr. Vanselow claims the influx of IMGs “decreases the opportunity for talented young persons from this country to enter the medical profession.”\textsuperscript{47} At a subsequent television interview, Dr. Vanselow opposed the use of Medicare funds to support the training of IMGs.\textsuperscript{48}

\begin{itemize}
\item \textsuperscript{41}Scott, supra note 11.
\item \textsuperscript{42}A statement made by James Merritt, president of Merritt, Hawkins & Associates, the largest medical recruiting firm in the U.S. Mr. Merritt’s firm is responsible for 1,200 medical recruitment searches every year, about 30\% of them abroad.
\item \textsuperscript{43}Dr. Spencer Foreman., Graduate Medical Education, Medicare Financing, Congressional Testimony, June 11, 1996, available in 1996 WL 10164908.
\item \textsuperscript{44}Inglehart, supra note 1, at 1681.
\item \textsuperscript{45}Id.
\item \textsuperscript{46}Congressional Testimony, Apr. 16, 1996, available in 1996 WL 7138088.
\item \textsuperscript{47}Id.
\item \textsuperscript{48}Id. See also, Institute of Medicine, The Nation's Physician Workforce Options for Balancing Supply Requirements, Washington, DC: National Academy Press (1996).
\end{itemize}
Post Residency IMG Physicians
Approximately seventy-five percent of IMGs who finish their residency programs will establish medical practices in the United States. The majority of IMG physicians complete their residencies in hospitals serving poor people, and upon completion of their training, most practice medicine with poor and under privileged patient populations. Throughout the years, rural areas and poor urban areas have relied heavily on foreign medical personnel.

Overall, IMG physicians are less successful in obtaining medical board certification than their United States and Canadian-educated counterparts. Although the cause of this discrepancy is not fully explained, various reasons include several non-discriminatory factors such as inferior medical school training, individual differences in ability, and lack of proficiency in the English language.

Generally, IMGs are an easy target for politicians and legislators because they lack influence in physicians’ organizations, despite their substantial numbers. They are unorganized and do not have a voice in major medical associations such as the American Medical Association (AMA). For example, despite their large size, until recently IMGs did not have their own chapter within the AMA. As a result, they are being openly blamed and targeted by many organizations and agencies for the oversupply of physicians and specialists in the United States.

Considering the significant increase in the number of IMGs in recent years and the growth of managed care organizations, with their emphasis on reduced inpatient treatment and preventive programs, one would expect anti-IMG sentiment to increase further. This, therefore, would cause hardships and displacement to many IMGs, including those who have been practicing in this country for many years. Nevertheless, most of the IMGs

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47Mullan, supra note 6, at 1524.
49Id.
50Stein, supra note 8.
52Id.
53See Inglehart, supra note 1, at 1680; Whitcomb, supra note 2, at 455.
55Id., supra note 2, at 455.
will probably survive the hardship if they continue to serve the underserved areas that most managed care organizations avoid.

MANAGED HEALTH CARE DELIVERY SYSTEM

Background
With the exception of hospital-based physicians, the medical profession has always enjoyed operating on a fee-for-service basis.\(^\text{57}\) Under this system of payment, physicians received compensation for every office visit and for every procedure, thus creating a substantial financial incentive for physicians to increase the provision of health services.\(^\text{58}\) While in an adequately functioning market, consumers could defuse physicians' inflationary incentives by purchasing health services only when the benefits of a particular procedure or prescription outweigh its costs, this general economic theory has not worked because of inherent imperfections in the health care market. Without going into detail, the major reasons for this imperfection are thought to be the imbalance of information between health care providers, consumers and the third party payor system (i.e. health insurance).\(^\text{59}\) In the past, while the third party payor had an incentive to keep the cost down, they were unable to correct the problem mainly because they were unable to monitor health care providers closely and thus could not question their professional judgments. As a result, they passed the increased costs to the consumers.\(^\text{60}\) In the last decade a major move has been made toward managed health care delivery systems because of the inherent problems with the fee-for-service market.\(^\text{61}\)

"Managed care" is broadly defined as any effort to monitor and control health care utilization and cost by various methods including capitation, case management systems, utilization review, pre-admission screening, and the requirement of second opinions.\(^\text{62}\) Today, over 1,500

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\(^{57}\) Whitcomb, \textit{supra} note 2, at 455.

\(^{58}\) Id.

\(^{59}\) James P. Freiburg, \textit{The ABCs of MCOs: An Overview of Managed Care Organizations}, 81 ILL. B.J. 584, 585 (1993).

\(^{60}\) Id. at 584-85.

\(^{61}\) Id.

Health Maintenance Organizations (HMOs) cover an estimated 100 million Americans.63

There are many different forms of Managed Care Organizations (MCO) in operation.64 The three-way relationship among the MCOs, providers and enrollees varies substantially by the type and structure of the MCO. For the purpose of analyzing obligations and liabilities in this three-way relationship, the actual structure of MCOs may become a very important factor. Some MCOs may exercise close control over their health care providers, thus creating an employer-employee type relationship. On the other extreme, some open panel MCOs may have no control over the providers and just simply pay the monthly capitated payments on behalf of their enrollees.

Because of such extreme variations among MCOs, one must be very careful when analyzing the MCO's obligations, liabilities and relationship with the providers.65 Nevertheless, MCOs, as business and health care entities, are subject to both federal and state regulations and courts

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63 Due to the dynamic and volatile nature of the current health care system in the United States, the statistics on MCOs change almost daily. The following facts about MCOs are taken from the Internet as Sidebar 4. The document was created from RTF source version 2.7.5. Other Managed Care Facts include:

- Number of HMOs in the United States — 574
- Number of PPOs in the United States — 1036
- Number of Americans in HMOs — 51 Million
- Number of Americans in PPOs — 50.2 Million
- Number of Americans in All Managed Care Plans — 100 Million
- Percentage of Insured Employees in Managed Care Health Plans — 66%
- (Working in Firms with at Least 10 Employees)
- Percentage of Medicare Enrollees in HMOs — 9%
- Percentage of Medicaid Enrollees in HMOs — 11.8%
- Percentage of MDs with at Least One Managed Care Contact — 75%
- Percentage of MDs with at Least One HMO Contract — 48%
- Percentage of HMOs That Are For-profit — 69%
- Percentage of HMOs That Are Not-for-profit — 31%
- Percentage of HMO Members in For-profit Plans — 57.8%
- Percentage of HMO Members in Not-for-profit Plans — 42.2%
- Percentage of HMOs That Offer Nutrition Courses — 87%
- Percentage of HMOs That Offer Smoking Cessation Courses — 67.3%
- Percentage of HMOs with Lists of Approved Prescription Drugs — 100%
- Salary of CEO of U.S. Healthcare, a For-profit HMO — $3.9 Million
- Percentage of HMO Funds Spent on Health by U.S. Health Care — 73%

64 Jon Gabel, Ten Ways HMOs Have Changed During 1990s, 16 HEALTH AFF. 134, 135 (1997).

65 YOUNGER, LEGAL ANSWER BOOK FOR MANAGED CARE (1995).
generally use the "business judgment rule" when adjudicating contractual disputes with provider physicians and MCOs.

Generally speaking, the non-staff MCO's relationship with its providers can be based on "closed panel" contracts in which physicians serve its enrollees exclusively. Conversely, in an "open panel" contract, physicians are free to sign up with as many MCOs as they wish, and may agree to a fee-for-service or capitated payment contract. There are four major types of MCOs. The first, the staff model, is a closed panel plan setup with participating physicians as salaried staff members who provide health care to the MCO enrollees primarily in their own facilities. The second type, the group model, could be either a closed or open panel. In this model, an MCO contracts with independent multi specialty group practices that serve patients in MCO facilities or in their own offices. Dependent on the level of control exercised by the MCO, the physicians may be considered employees or contractors. The third type, Individual Practice Associations (IPA), are open panel MCOs that contract with individual physicians or specialty group practices to serve MCO enrollees but are free to care for their own private patients. Today, this is the dominant form of MCO and represents over fifty percent of all existing MCOs in the market. Finally, the network model is an open panel plan in which an MCO contracts with two or more group practices. These group practices may provide fee-for-service medical care for non-MCO members while maintaining separate contracts with one or more MCOs at the same time.

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67 Id.
68 Id.
69 Id.
71 Id. at 540.
72 Id. at 541.
73 Id. at 540.
74 Id.
75 Weiner, supra note 70, at 540-41.
76 Id.
77 Id. at 541.
78 Id. at 540.
There are also other types of loosely structured provider network organizations including the Preferred Provider Organization (PPO), Management Services Organization (MSO), Physician Hospital Organization (PHO), and other creative combinations or variations of these structures.

Under managed care health care delivery systems, the financial incentives to health care providers are often reversed from the customary fee-for-service system. In a managed care setting, groups of consumers (or government) that contract with an MCO make an annual (or monthly) payment to cover the health care needs of their members for the entire year (month). In exchange, the MCO agrees to handle all the health needs of the plan's members, regardless of the costs associated with members' treatment. The annual profit retained by the managed care group consists of the difference between the annual payment and the total cost of providing health care for the year. Thus, in contrast to the inflationary pressures facing providers in a fee-for-service environment, MCOs have a profound structural incentive to limit the costs of health care delivered to its members.

At the same time, the managed care insurers hold physicians accountable in several ways: through oversight controls, financial incentives, and/or punishment though termination or deselection. They use massive databases when evaluating whether to pay and how to pay providers. Most develop profiles on each physician’s practice and compare it to his or her peers or to national standards. As allowed in their contract, nearly all MCOs and PPOs can terminate or deselect physicians with or without any explanation. When a physician is terminated by an MCO for just cause it has an obligation to report the incidence to the National Practitioner's Databank. However, in the

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79 Id. at 540.
80 Weiner, supra note 70, at 540.
82 Id.
83 Id.
84 Id.
85 Id.
86 Liang, supra note 66, at 849.
87 Id.
majority of cases, to avoid complications that may arise from such reporting, the MCO simply terminates the contract without cause.\textsuperscript{88}

**Selection and Deselection of Physicians by Managed Care Organizations**

As business entities, MCOs are organized to minimize costs and maximize income through whatever means legally possible.\textsuperscript{89} When an MCO enters into a market, it attempts to secure or select the services of as many providers (e.g., physicians, hospitals) as possible so they may offer potential customers (e.g., employers, government) a desirable product.\textsuperscript{90} Typically, this results in a comprehensive network of physicians, hospitals, and other health care sources covering a large geographic area.\textsuperscript{91} However, once the MCO has determined and assessed its market needs, it adjusts its providers in order to minimize the costs associated with keeping a provider in the plan.\textsuperscript{92} This goal is achieved simply by deselecting\textsuperscript{93} the unwanted physicians or just by refusing to sign a new contract once the original contract has expired.\textsuperscript{94} While there is no concrete study on the subject, it is believed that the vast majority of terminations and deselections occur because of economic conditions unrelated to quality of care.\textsuperscript{95} Obviously, deselection affects both the physicians and hospitals, but since the physicians are more likely than

\textsuperscript{88}Id.
\textsuperscript{89}Id.
\textsuperscript{90}As business entities, managed care plans act to obtain market share through other means.
\textsuperscript{91}For example, in addition to minimizing costs, to obtain access to markets as indicated infra notes 6-8, and accompanying text, managed care plans may sign up physicians and then deselect them after securing their patients in the plan. Jim Montague, *Joining the Race: State Medical Societies Try to Beat Managed Care Integrators to the Punch*, HOSPS. & HEALTH NETWORKS, Sept. 5, 1994, at 50; Jim Montague, *Striking Back: Managed Care Plans Are Dumping Physicians, But the Doctors Are Fighting Back*, HOSPS. & HEALTH NETWORKS, Oct. 20, 1994, at 38.
\textsuperscript{92}Id. supra note 89, at 50.
\textsuperscript{93}Id. at 60.
\textsuperscript{94}Ken Terry, *When Health Plans Don't Want You Anymore*, MED. ECON., May 23, 1994, at 138. In order for an MCO to receive accreditation, it must file various quality and health outcome reports that require inspection of providers' facilities and audit of medical records with expenses paid by MCOs. Therefore, if a provider does not have enough enrollment from an MCO, it would probably more cost effective for the MCO to terminate the contract and requesting their enrollee to select another member provider to switch to another MCO. Id.
\textsuperscript{95}Id. Deselection is that process where providers have their contracts with MCOs terminated under the termination without cause clauses of their contracts.
hospitals to be deselected, it has a greater impact on physicians. In most cases, an MCO could terminate or deselect a physician without any fear of reprisal because the contract usually includes a "without cause" termination clause. There are also several quality and patient care related clauses in the contract that allow an MCO to terminate a physician for an agreed "just cause."

In many open panel MCOs, the relationship between a physician and an MCO is based upon a uniform and carefully drafted contract rather than a traditional at will employment relationship. Therefore, deselection and termination work through contract principles. Physicians who enter into agreements to serve as providers for MCOs must generally accept the standard "termination without cause" clauses, which allow either party to terminate the contract with some specified time of notice for any or no reason at all. While these clauses were initially demanded by the physicians, they now put all the power in the hands of the MCOs because it is less likely the physicians, especially IMGs, in the current health care climate would terminate their contract with an MCO. In fact, of the many physicians who have been deselected or terminated, only a few were successful in bringing actions against MCOs. This is because of the existence of an explicit "no cause termination clause" in the contract that allows both MCOs and contracting physicians to freely cancel their contracts at will. In the few existing successful cases, the challenges were mostly for the lack of due process before termination rather than the right to termination or deselection itself. The various theories under which an MCO's actions may be illegal will be discussed later in this Comment.

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96 See Termination Clauses as Managed Care Penetration Builds, MANAGED CARE WL., Dec. 11, 1995, available in 1995 WL 12838181.
97 Id.
98 Id. Physician can be terminated if his or her hospital privileges have been revoked, suspended or terminated.
99 Id.
100 See Howard Larkin, You're Fired; Physician Termination, 13 AM. MED. NEW 17 (1995). Nearly all HMOs and PPOs can abruptly fire, or 'deselect,' physicians without explanation.
101 Id.
102 Liang, supra note 66, at 805.
103 Id.
104 Id.
105 See infra pp. 508-37.
Physician Monitoring by Managed Care Organizations

The impetus for an MCO to evaluate and monitor the practice of physicians will depend on the type of MCO and on whether the MCO acquires the patients of the physicians it hires. In cases such as network model MCOs and IPA model MCOs, in which the MCO often acquires patients along with their physicians, the MCO will be discouraged from selecting physicians with poor and high risk patients because of the patients' inferior health status. In MCOs such as staff model MCOs, the patients normally do not follow the physicians into the MCO. While these MCOs may have fewer reasons to exclude physicians with low income patient enrollees, nevertheless they do not welcome physicians with poor patients because of the costlier treatment practices of such physicians.

Managed Care and IMG Physicians

Dislike of IMGs by some MCOs is due to several different factors. First, discrimination and discriminatory acts in this society have not been completely eradicated, and since most IMGs are foreign born, speak with accents and have foreign complexions, they are easy targets for discrimination. Second, IMG physicians tend to serve higher percentages of lower socio-economic patients known to have higher medical risks, and thus, are more costly to MCOs. Therefore, in an MCO environment, IMG physicians do not fare well. When making decisions regarding the selection or deselection of physicians, MCOs value cost-effectiveness in addition to medical quality. They take into account when physicians perform fewer procedures, order a lower number of prescriptions and minimize referrals. Physicians such as IMGs who mostly serve poor and under-privileged communities are faced with a higher percentage of sick patients who necessarily demand more intense and costly medical care compared to a healthier group of patients. These physicians, no matter how skilled and diligent, will appear to be less attractive to MCOs as a result of the needs of the population they serve.

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106 Liang, supra note 66, at 805.
107 Id.
108 Id.
109 Id.
110 Id.
111 Id.
112 Liang, supra note 66, at 805.
Therefore, it is natural MCOs do not value physicians such as IMGs, who treat poor and minority communities, as highly as physicians who serve more affluent communities, thus causing an obvious detriment to IMG physicians.

While the treatment of IMGs varies substantially by type of MCO, staff-type MCOs such as Kaiser Permanente groups and hospital based MCOs are more likely to hire IMGs as staff physicians because IMGs are more likely to accept lower pay than non-IMG physicians. On the other hand, open panel MCOs are less likely to select IMG physicians because of the reasons stated above.

**DISCRIMINATION AGAINST IMG PHYSICIANS**

**Discriminatory Intent**

America has a long history of discrimination against IMG physicians. IMG physicians have continuously encountered obstacles at nearly every stage of their residency programs, board exams, in the job market and securing hospital privileges. However, the consequences of discrimination have the potential to be far greater under managed care as compared to a fee-for-service system. Under managed care, the market power to discriminate against IMG physicians will be effectively concentrated in the hands of the MCO executives responsible for recruiting physicians. As the market becomes more efficient under the managed care system, the number of physicians seeking to join a plan is likely to increase. This undoubtedly will create an environment ripe for discrimination. Indeed, some IMG physicians already feel MCOs are discriminating against them, or will discriminate against them, on the basis of race or county of origin when selecting physicians with whom to contract. In the survey of 1500 IMG physicians practicing in Ohio, over

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113 Id.
114 Id.
116 Id.
118 Unpublished survey conducted by the author.
seventy percent of the respondents predicted that IMGs will face harder times in the future.\(^\text{119}\)

The potential for bias in the selection process is heightened by the subjective criteria MCOs employ in their selection process.\(^\text{120}\) In the absence of clear, objective criteria to judge quality, the subjective notion of a physician's reputation could create an environment resulting in biased judgment. In this setting, the MCOs that choose providers may be easily influenced by the discriminatory forces in the medical market, thus limiting the opportunities for IMG physicians.

In response to claims of discrimination under managed care, some market analysts might argue that discrimination against IMG physicians would actually decrease as the nation moves more toward managed care settings.\(^\text{121}\) Such an argument might contend, for instance, that the transformation of the medical industry to managed care would improve the efficiency of the market for medical services, and thus, drive out inefficient discriminatory behavior on the part of MCOs.\(^\text{122}\) Theoretically, the restructuring of the health industry to managed care would help stimulate consumer groups by empowering them to exercise their collective power to audit the activities of health care providers.\(^\text{123}\) According to one theory, an MCO that unfairly deselects or refuses to select IMG physicians because of their educational background will eventually face greater costs than its more efficient, non-discriminatory competitors.\(^\text{124}\) The result, according to efficient-market advocates, would be a trim health care industry in which only efficient providers would survive.\(^\text{125}\)

For several reasons, however, this view of managed care might not be accurate for IMG physicians. First, it is unclear if competitive markets eradicate discrimination since prejudicial practices often persist within efficient markets.\(^\text{126}\) Also, as the market power of MCOs increases and

\(^{119}\) Id.

\(^{120}\) Hall, supra note 117, at 5.

\(^{121}\) Id.

\(^{122}\) Id.


\(^{124}\) Id.

\(^{125}\) Id.

\(^{126}\) Id.
MCOs consolidate themselves, the incidence of discrimination by MCOs against IMG physicians is likely to increase. Second, if a sufficiently large number of MCOs engage in discrimination, the market would be unable to distinguish the MCOs that do discriminate from those that do not. Third, because information about the quality of individual physicians is difficult and costly to ascertain, generalizations encouraging the use of “foreign medical education” as a proxy for quality or lack thereof assume greater importance. Fourth, under an efficiently run MCO the need for physicians declines, which results in a market glut in which a large number of physicians are seeking employment and involvement with MCOs. Because of the foregoing arguments, it appears that the discrimination against IMGs by MCOs has just started, and it is foreseeable this discrimination will worsen as the health care market goes through the current reform phase. Whether the situation for IMGs changes for the better is dependent on many factors, including the situation of the United States medical schools which themselves are going through major changes and facing many budget cuts due to the reduction in affiliated hospital support and research funds.

The Consequences of Exclusion

IMG physicians constitute a twenty-three percent of all practicing physicians in the United States. Exclusion of such a large force from the American health care market could have grave consequences for the health care system, especially for the quality of health care delivered to the poor and minority patient population IMGs serve. Therefore, if a managed care organization excluded these physicians from its plan, it may find itself left out of the health care industry altogether. Although the managed care movement contemplates the elimination of some of the surplus of American physicians, IMG physicians and physicians who serve poor and minority communities should not be forced to bear a disproportionate share of the burden. In addition, the consequences of excluding an unfair number of IMG physicians would extend far beyond the burden imposed upon the excluded providers.

127 Id.
128 Enthoven, supra note 123, at 25.
129 Id.
130 Id.
131 Id.
The inappropriate elimination of talented IMG physicians by MCOs could decrease the quality of medicine practiced in managed care settings. As explained above, the algorithms used by many MCOs to assess physician practice styles are based on cost-effective decision making which most often do not properly adjust for the health status of a physician’s patient population. These flawed selection methods may, therefore, lead MCO executives to overlook skilled, efficient physicians who serve poor and underprivileged communities which are more likely to have members in poor health. Instead, they select less skilled, less efficient doctors who serve a higher percentage of healthy patients and, thus, incur lower costs. The natural and unfortunate result of such a biased process would be a decline in the quality of care given to the poor and an underserved patient population. Inner-city patients would have difficulty obtaining health care services even if they were able to enroll in a pre-paid health plan. Those patients who do not subscribe to a managed care plan would be inconvenienced because there would be fewer providers in their city to treat them.

As the system of health care delivery moves toward greater integration, more IMGs will probably find themselves out of MCO plans. Such a scenario is likely where the Integrated Delivery System (IDS) is initially structured as an open PHO, which subsequently reorganizes as a closed PHO. The “closed” system will allow only a select group of physicians to become members, whereas, as discussed earlier, the open system allows medical staff who are not owners or partners to provide services.

**REMEDIES AVAILABLE TO IMGs**

**Federal Government**

Using its constitutional power over immigration, the federal government can effectively limit or completely stop offering required visas to IMG

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132 Id.
134 Id.
135 Id.
136 Id.
137 Id.
physicians applying for residency programs in the United States.\textsuperscript{133} Also, the federal government can make it difficult for IMGs to remain in the United States once they have completed their residency program.\textsuperscript{139} For example, in the recent immigration bill President Clinton signed into law on September 30, 1996, the issue of IMGs studying in the United States on J-1 exchange visitor visas was addressed.\textsuperscript{140} Under the new law, an IMG holder of a J-1 exchange visa is required to remain on temporary H-1B visas for a minimum of three years before applying for permanent residency (i.e., green card).\textsuperscript{141}

The federal government is restrained from taking actions such as naked discrimination against foreign-born IMG's who remain in the country lawfully by virtue of the equal protection clause of the Fifth Amendment to the United States Constitution.\textsuperscript{142} Under the equal protection doctrine, governmental classifications on the basis of alienage, race, or national ancestry or origin are inherently suspect.\textsuperscript{143} To survive a challenge under equal protection, the policies excluding lawful practicing IMGs would have to advance a compelling governmental interest and be narrowly tailored to effect that interest.\textsuperscript{144} Although the need to increase the number of primary care physicians and decrease the number of specialists may be important, it is probably not compelling. Nevertheless, the Fifth Amendment protection may not be easily extended to those United States-born physicians who received their medical degree abroad, unless the challenger is a member of suspect class as stated above.\textsuperscript{145}

State Government

Many states with a large rural or poor population are generally willing to accommodate IMG physicians, as these physicians are willing to provide medical care that United States medical school graduates are typically

\textsuperscript{133}Congressional Testimony, \textit{available in} 1996 WL10830622, Sept. 12, 1996. In fact, under the U.S. Constitution Congress has plenary power over immigration issues. See Azizi v. Thomburgh, 908 F.2d 1130 (2d Cir. 1990).

\textsuperscript{139}Congressional Testimony, \textit{available in} 1996 WL10830622, Sept. 12, 1996.

\textsuperscript{140}Id.

\textsuperscript{141}28 AM. MED. NEWS 28, Dec. 9, 1996.

\textsuperscript{142}U.S. CONST. amend. V.

\textsuperscript{143}Graham v. Richardson, 403 U.S. 365, 376 (1971); Korematsu v. United States, 323 U.S. 214, 219-20 (1944); Hirabayashi v. United States, 320 U.S. 81, 100 (1943).

\textsuperscript{144}Plyler v. Doe, 457 U.S. 202, 216-17 (1986).

\textsuperscript{145}Id.
unwilling to provide. In fact, during the recent congressional debates on IMGs, states such as South Dakota, New Jersey and New York testified in support of IMGs and offered their financial support to those willing to study within their states and remain to practice medicine in designated areas after completion of their study. However, these states suggested that the federal government provide conditional visas to these IMGs, allowing their visas to remain valid as long as they are in that state and offer medical care in a region selected by the state. Under this proposal, states will request special waivers from the federal government for a limited number of J-1 holders so that these IMGs can remain in the United States after completing their residency programs and practice within the sponsored state. It appears that this is the prevailing policy regarding at least some IMGs who enter this country under J-1 visas.

Once an IMG physician receives permanent residency or becomes a United States citizen, state governments are restrained from direct discrimination against foreign-born IMGs because of the equal protection clause of the Fourteenth Amendment. To survive a challenge under equal protection, the state policies excluding IMGs would have to advance a compelling governmental interest and be narrowly tailored to effect that interest.

PRIVATE ENTITY

Although private parties have a wide range of discretion in hiring and firing their employees, these rights are generally limited by various federal and state laws. In general, private entities such as MCOs are restrained from taking prima facie discriminatory action against IMGs because of several protections available to IMGs by virtue of:

(1) state law (i.e., physician protection type statute),
(2) contract law,
(3) tort law,

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146 Id.
147 Id.
148 Id.
149 Id. at 216-17.
150 See e.g., Plyler, 457 U.S. at 216 (noting that the Equal Protection Clause "directs that 'all persons similarly circumstanced shall be treated alike'").
151 Id. at 216-17.
(4) anti-discrimination laws *(i.e. Title VII or section 1981)* and
(5) antitrust.

**State's "Physician Protection" Statutes**
The single most important law that may offer protection to all physicians, including IMGs, when facing unjust termination or deselection by MCOs is a "physician fairness act" statute which many states have already passed or are considering at this time.¹⁵² These acts are either a "stand alone" statute or part of a more general "managed care fairness" statute.¹⁵³ For example, in the state of Ohio a provision in Senate Bill number 33,¹⁵⁴ currently under consideration,¹⁵⁵ provides criteria for evaluating the participation and practice of health care providers, prohibits termination of providers for unjust causes and requires a hearing to explain the reasons for termination.¹⁵⁶ Specifically, sections 3924.84(A) and 3924.85(A) of the bill require an MCO, on request, to make available to a health care provider copies of the application procedures and minimum qualification

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¹⁵² Id.
¹⁵³ Id.
¹⁵⁴ S.B. 33, as passed Senate Health Committee.
¹⁵⁶ See S.B. 33, as passed Senate Health Committee, § (C)(1) No Health Maintenance Organization May Do Either of the Following Terminate the Participation of a Health Care Professional or Health Care Facility as a Provider under an Individual or Group Health Maintenance Organization Contract Solely for Making Recommendations for Inpatient or Follow-up Care for a Particular Mastectomy Patient, That Are Consistent with the Care Required to Be Covered by this Section;

(1) establish or Offer Monetary or Other Financial Incentives for the Purpose of Encouraging a Person to Decline the Inpatient or Follow-up Care Required to Be Covered by this Section.

§ (C)(1) No Sickness and Accident Insurer May Do Either of the Following:

(a) terminate the Participation of a Health Care Professional or Health Care Facility as a Provider under a Sickness and Accident Insurance Policy Solely for Making Recommendations for Inpatient or Follow-up Care for a Particular Mastectomy Patient, That Are Consistent with the Care Required to Be Covered by this Section;

§ (A) (1) No Managed Care Organization Shall Terminate a Contract or Employment with a Health Care Provider Unless the Organization Provides to the Health Care Provider Written Notice by Certified Mail, Return Receipt Requested, of the Reasons for the Termination and an Opportunity for a Hearing . . .

(b) the Notice Shall State the Reasons for the Proposed Termination and Include a Statement That the Health Care Provider May, Within Thirty Days of Receiving the Notice, Request a Hearing Before a Panel Described in this Section. The Request Shall Be Made by Certified Mail, Return Receipt Requested. The Hearing Shall Be Held Within Thirty Days after the Organization Receives a Request for Hearing from the Provider.
requirements a provider must meet to be employed by or enter into a contract with the MCO. The MCO must consult with the health care providers in developing the criteria.

Moreover, the MCO must annually notify each health care provider it employs or contracts with of the information and criteria it uses to evaluate the provider’s practice. The MCO must consult with health care providers in establishing and maintaining methods to collect and analyze information relating to the providers’ practices. Any information used to evaluate a provider’s practice must be measured against the criteria for evaluating providers’ practices and against an appropriate group of health care providers using similar treatments and serving a comparable patient population. Within fourteen days after notifying a provider of the MCO’s criteria for evaluating the provider’s practice, the MCO must give the provider an opportunity to discuss in person the evaluation and to work with the MCO in improving his or her practice.

In section 3924.85(B), entitled Termination of Provider Participation, the bill prohibits an MCO from terminating a contract with or employment of a health care provider unless the MCO provides written notice of the reasons for termination and an opportunity for a hearing. The bill specifies this provision does not apply to cases that involve fraud, imminent harm to a patient or final disciplinary action by a state licensing board or any other authority that affects the provider’s ability to practice. It also specifies that this provision does not affect the bill’s requirement that a transitional period of coverage be provided to beneficiaries when a provider is terminated.

The statute allows the provider to request a hearing within thirty days of receiving the notice of termination before a panel comprised of at least three individuals appointed by the MCO. Of the individuals appointed

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157 See S.B. 33, as passed by Senate Health Committee, §§ 3924.84(a) and 3924.85(a).
158 Id.
159 Id.
160 Id.
161 Id.
162 See S.B. 33, as passed by Senate Health Committee, §§ 3924.84(a) and 3924.85(a).
163 Id.
164 Id.
165 Id.
166 Id.
to the panel, at least one must be a member of the same profession and the same or a similar specialty as the health care provider under review. The panel may consist of more than three individuals, but at least one-third of the members must be of the same profession and the same or a similar specialty as the provider under review.

When a hearing is requested, the statute requires it be held within thirty days after the MCO receives the request. The panel appointed by the MCO must render a decision within fourteen days after the hearing is conducted and notify the provider. The decision may be reinstatement of the provider’s MCO participation, reinstatement subject to conditions established by the MCO, or termination. Termination of a provider’s contract or employment cannot be effective earlier than thirty days after the provider receives written notice of the panel’s decision.

Section 3924.85(B)(4) of the bill specifies its provisions regarding notice and hearings for termination of a provider’s participation with an MCO do not prohibit or otherwise restrict either an MCO or a provider from exercising the right not to renew a contract that expires. Nonrenewal on the part of an MCO, however, is subject to the notification and hearing requirements for termination of a provider’s participation. The act also requires the party intending not to renew a contract, whether the MCO or the provider, to provide written notice to the other party no later than sixty days prior to the contract’s expiration date. The notice must be made by certified mail, return receipt requested. If the contract has no stated expiration date, the contract is considered to expire on the first day of January after the contract has been in effect for one full year, and annually thereafter.

It is clear if this bill becomes a law it provides some protection for physicians who were terminated from a plan without just cause. It also sets formal review procedures that will help in reducing confusion.

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167 See S.B. 33, as passed by Senate Health Committee, §§ 3924.84(a) and 3924.85(a).
168 Id.
169 Id.
170 Id.
171 Id.
172 See S.B. 33, as passed by Senate Health Committee, §§ 3924.84(a) and 3924.85(a).
173 Id.
174 Id.
175 Id.
176 Id.
177 See S.B. 33, as passed by Senate Health Committee, §§ 3924.84(a) and 3924.85(a).
Dependent on the courts’ interpretation of this statute and what constitutes “just cause” termination, this law may be the most promising protection available for IMGs practicing in state of Ohio.

In the absence of “physician protection” statutes, some state courts have relied upon state anti-discrimination acts to offer relief to discharged physicians. For example, a California court in Ambrosino v. Metropolitan Life Insurance Company\(^\text{178}\) held the termination of a podiatrist as a provider under his contract with the insurance company violated California’s anti-discrimination statute.\(^\text{179}\) Termination of the provider was found to be discriminatory under the state’s civil rights statute.\(^\text{180}\) The court further stated that termination even under a “without cause” clause on the basis of “race, creed, religion, color, national origin, sex, or disability of the person” would violate the civil rights statute and thus be prohibited.\(^\text{181}\) In this case the court held for the physician despite the “termination without cause clause” within the contractual agreement.\(^\text{182}\) The court stated that regardless of the clause, a party cannot discriminate on the basis of prohibited criteria within civil rights statutes.\(^\text{183}\)

**Contract Law**

The relationship between an MCO and physicians is almost exclusively based on a well-written and well-documented contract. In staff model MCOs, this contract is usually similar to any other employment contract. The physician is an employee of the MCO, is subject to close control by the MCO and receives regular salary and benefits. However, in the majority of physician-MCO relationships, physicians serve as independent contractors and a formal contract specifies the responsibilities and obligations of each party that both sides agree to voluntarily.\(^\text{184}\) While the degree of control may vary among MCOs, the details of the relationship are basically controlled by the terms of contract. Therefore, contract law will apply if one side does not honor the agreed-upon terms. In general, however, the real disputes between the parties are not in the expressed

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\(^{179}\) Id. at 445.

\(^{180}\) Id. at 444.

\(^{181}\) Id. at 442-43 (citing CAL. CIV. CODE § 51.5 (West 1982 & Supp. 1998)).

\(^{182}\) Id. at 445.

\(^{183}\) Id.

\(^{184}\) Freiburg, supra note 59, at 585 (describing the different types of relationships between physicians and health maintenance organizations).
terms of the contract, but in those unwritten implied elements of the contracts. The following section discusses several contract theories that may be raised in the physician-MCO relationship. Note, this discussion is not restricted to only IMG physicians, but can also be applied to all physician-MCO contracts.

Employer Policies
Formal MCO policies may be enforceable under traditional contract analysis. When an MCO circulates a manual describing procedures for physician selection and deselection, it may constitute enforceable promises which could create reasonable expectations on the part of interested physicians. Generally, a managed care organization has its own internal bylaws and regulations used in dealing with outsiders such as enrollees, hospitals and physicians. The MCOs usually have detailed policies and bylaws regarding the criteria for selection and deselection of their physicians. Obviously, these bylaws can be used in favor of as well as against MCOs when deciding to select or deselect their providers. A clear violation of these bylaws by an MCO could be considered a violation of either an express or implied contract.

This result is usually reached by applying unilateral contract theory; that is, viewing a policy manual or MCO handbook as an offer by the MCO. However, there are several problems with these types of claims. First, some states do not recognize it as an actionable claim. Second, it is mainly applied to master-servant (employer-employee) type relationships, covering mostly staff or certain types of close panel MCOs. Third, a clear and conspicuous disclaimer in the handbooks and manuals can easily defeat the unilateral contract theory, especially for initial selection challenges, as long as it does not violate federal or state law.

On the other hand while clear disclaimers in MCOs' bylaws, handbooks or manuals could provide significant protection to MCOs, they may not, however, provide a fool proof defense. Some courts may still find that

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186 Leikvold, 688 P.2d at 172.
187 Id.
188 Freiburg, supra note 59, at 584.
189 Id.
contractual obligations exist, despite the presence of express disclaimers in the contract. ¹⁹⁰

In addition to bylaws, almost all MCOs have their own quality or utilization criteria to which physicians must comply.¹⁹¹ Under their express contractual agreement, an MCO may terminate its relationship with a physician provider if the physician acts in a manner which is materially injurious or detrimental to patients (or, in some settings, to the specialty network), or loses hospital privileges involuntarily or for other reasons stated in the contract.¹⁹² Usually, this is a complex contract form, and an MCO may take advantage of its complexity and terminate an IMG unjustly. While the affected IMG may challenge termination (or deselection) through internal grievance procedures which are normally available in all MCO contracts, it would be difficult for an IMG to prevail. This is because of the complexity of the contracts, and that most of these are form contracts drafted by MCOs.¹⁹³ Nevertheless, a clear violation of the contract by an MCO could be used against it in any court proceeding. In reality, however, these contracts are drafted so heavily in favor of MCOs that it would be a difficult task to find any blatant violations.

Promissory Estoppel
Another method of contractual analysis of the employment relationship is promissory estoppel, found in Section 90(1) of the Restatement (Second) of Contracts: “A promise which the promissor should reasonably expect to induce action or forbearance on the part of the promise or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise.”¹⁹⁴

While utilizing promissory estoppel to bind an employer to perform promises for benefits such as pensions has been used in the past, the use of promissory estoppel to enforce promises for job security is a new

¹⁹⁰Zaccardi v. Zale Corp., 856 F.2d 1473, 1476 (10th Cir. 1988) (stating that disclaimer did not warrant summary judgment for the company because it must be read in terms of the parties' expectations, which could have been affected because parts of the manual were phrased in mandatory language).
¹⁹¹Freiburg, supra note 59, at 584.
¹⁹²Id.
¹⁹³Id.
The main problem with promissory estoppel is that employees must rely on a promise. The more difficult issue becomes determining what, if anything, the employer promised. In order for promissory estoppel to provide any greater rights in this situation, the court must find an implied promise to employ a physician permanently, during good performance or at least for a reasonable period. Therefore, in practice the promissory estoppel theory may not offer any significant protections to non-staff IMG physicians.

Good Faith and Public Policy
A third "contract" theory of enforcement of an IMGs' rights can be based on implied covenant of good faith. Although this theory shares some characteristics of tort law because the duty is imposed by law and is non-disclaimable, good faith has achieved general acceptance in contract law. As with all such principles, the duty of good faith is easier to approve than to define.

The good faith principle applies when one party performs an act that is not expressly barred by the contract in question, but is contrary to the reasonable expectations of the other party. In the employment context, the classic case is Fortune v. National Cash Register, in which the plaintiff claimed that he was discharged the day after securing for his employer a $5 million contract that would have yielded him substantial commissions under the compensation system in effect. The court found the employment relationship contained an implied covenant of good faith

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195 In Grouse v Group Health Plan, Inc., 306 N.W.2d 114 (Minn. 1981), a pharmacist resigned one job and turned down another in reliance on the promise of employment from the defendant. The court dictated promissory estoppel to award the plaintiff his reliance interest. Id.

196 Id.

197 See generally, Note, Protecting At Will Employees Against Wrongful Discharge: The Duty to Terminate Only in Good Faith, 93 HARV. L. REV. 1816 (1980) (proposing "a comprehensive economic rationale for judicial revision of common-law rules to provide at will employees with an expanded private remedy for wrongful discharge").

198 Id.

199 See Tymshare, Inc. v. Covell, 727 F.2d 1145, 1152 (D.C. Cir. 1984) (explaining that "good faith" lacks general meaning of its own unless applied to a particular context).


202 Id. at 1253-54.
that prevented the employer from firing an employee merely to deprive him of the fruits of his labors.\textsuperscript{203}

Also, in the first victory by a physician for termination without just cause by an MCO, the New Hampshire Supreme Court applied the bad faith and public policy principal in reaching its decision.\textsuperscript{204} In Harper \textit{v. Healthsource},\textsuperscript{205} the court held if a physician's relationship is terminated without cause and the physician believes the decision to terminate was, in truth, made in bad faith or based upon some factor that would render the decision contrary to public policy, then the physician is entitled to a review of the decision.\textsuperscript{206} This is the first ruling of its kind and will undoubtedly offer some legal ammunition to disgruntled physicians, including IMGs, in other states.

However, the main problem with the good faith rule is that courts have applied it in varying degrees. In the broadest extension, the good faith principle requires an employer to show good cause for discharging an employee. In narrower formulations, the good faith theory is viewed as simply excluding certain reasons as legitimate bases for the employer's conduct, while leaving large areas to the employer's discretion.\textsuperscript{207} In short, a "good faith" claim could be a valid cause of action but its success depends on the specific circumstances and generally is unpredictable.

**TORT CLAIMS**

In addition to the contract law discussed above, several tort laws such as intentional infliction of emotional distress, intentional interference with contractual relations, deceit, defamation and invasion of privacy may offer...
some remedy to disgruntled IMGs. The following section addresses these theories in some detail.

**Intentional Infliction of Emotional Distress**

Intentional infliction of emotional or mental distress[^203] claims may be made if the MCO’s conduct was outrageous. A comment in the Restatement notes, “liability has been found only where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency and to be regarded as atrocious, and utterly intolerable in a civilized society.”[^209] An important factor in judging the outrageousness of the conduct is whether the defendant (i.e. MCO) is abusing a position of power over the plaintiff (i.e. IMG).[^210] In the employment setting, the landmark case is *Agis v. Howard Johnson Co.*[^211] In *Agis* the employer dealt with theft in a restaurant by announcing that waitresses would be discharged in alphabetical order until the person responsible for the theft was discovered.[^212] Plaintiff was first on the list and thus, was fired even though defendant had no reason to suspect she was the thief.[^213] The court recognized a cause of action for outrage.[^214] An intentional infliction of emotional harm claim is more likely to be applicable in a case of deselection when an IMG physician is discharged by an MCO in a manner where the conduct of the MCO was extremely outrageous, beyond the boundary of decency or utterly intolerable in a civilized community.

[^208]: *Restatement (Second) of Torts* § 46 (1965).
[^209]: *Id.* at cmt. d.
[^210]: *Id.* at cmt. e.
[^211]: 355 N.E.2d 315 (Mass. 1976); see also Contreras v. Crown Zellerbach Corp., 565 P.2d 1173, 1176-77 (Wash. 1977) (utilizing this tort by victims for racist slurs); Tandy Corp. v. Bone, 678 S.W.2d 312, 314-16 (Ark. 1984) (utilizing this tort by workers interrogated as to supposed misconduct); Dean v. Ford Motor Credit Co., 885 F.2d 300, 304-05 (5th Cir. 1989) (utilizing this tort by a worker who was framed by a supervisor who placed checks in her purse to make it appear as if she were a thief). *See generally,* Regina Austin, Employer Abuse, Worker Resistance, and the Tort of Intentional Infliction of Emotional Distress, 41 STAN. L. REV. 1 (1988).
[^212]: *Agis*, 355 N.E.2d at 317.
[^213]: *Id.*
[^214]: *Id.*
Fraud

Another potentially applicable tort action in cases of deselection is fraud.\textsuperscript{215} A good example of fraud in the employment setting is \textit{Bondi v. Jewels},\textsuperscript{216} in which the plaintiff was induced to close his shop and go to work for a competitor.\textsuperscript{217} He was found to have stated a cause of action of fraud against his new employer when he was discharged from his "at will" job after only two weeks.\textsuperscript{218} Proving fraudulent misrepresentation, however, is quite difficult. An IMG must show the defendant MCO knew when it made its representations that they would not be carried out.\textsuperscript{219} Further, not only must detrimental reliance be established, but also the reliance must be shown to be reasonable.\textsuperscript{220} Therefore, the fraud theory may apply if an IMG can show the defendant MCO has committed fraud during their selection or deselection process.

Defamation

A cause of action for defamation arises when statements are made in writing (libel) or orally (slander) tending "to harm the reputation of another so as to lower him in the estimation of the community or to deter third persons from associating or dealing with him."\textsuperscript{221} The elements of a defamation action are:

1. a defamatory statement,
2. made about the plaintiff,
3. published to a third party.\textsuperscript{222}

\textsuperscript{215} \textit{RESTATEMENT (SECOND) OF TORTS} § 525 (1965).
\textsuperscript{217} \textit{Id.}
\textsuperscript{218} \textit{Id.}
\textsuperscript{219} See Shebar v. Sanyo Business Sys., 526 A.2d 1144 (N.J. Super. Ct. App. Div. 1987), aff'd, 544 A.2d 377 (N.J. 1988) (intent not to perform promise of lifetime employment to employee made in order to keep him from going to a competitor was established by testimony of executive recruiter that Sanyo sought a replacement for plaintiff immediately after the promise was made).
\textsuperscript{220} See, e.g., Shelby v. Zayre Corp., 474 So. 2d 1069, 1072 (Ala. 1985) (reliance on promise of permanent employment unreasonable in face of signed application form that employment was at will).
\textsuperscript{221} \textit{RESTATEMENT (SECOND) OF TORTS} § 558 (1977).
\textsuperscript{222} \textit{Id.}
Defamatory statements often occur in the employment context. Words that impute a physician with fraud, dishonesty, misconduct, incapacity, or unfitness are defamatory. The test is how the words would be understood using the “reasonable person standard.”\textsuperscript{223} Given the breadth of the concept of defamation, one commentator has noted, “Any discharge for cause, negative evaluation, or unfavorable reference of a former employee gives rise to a potential cause of action for defamation, whether or not an employee has sustained actual economic harm.”\textsuperscript{224}

In most jurisdictions, the publication requirement can be satisfied even when the defamatory communication remains within the employer’s organization.\textsuperscript{225} However, truth is an absolute defense for a defamation claim, and only the “gist” or “sting” of the statement need be true.\textsuperscript{226}

### Intentional Interference with Contract

Tort law also protects parties in a contract from intentional interference with their relationship by third parties.\textsuperscript{227} This tort applies to employment contracts, including at-will employment.\textsuperscript{228} Intentional interference with a contract requires:

1. the existence of a contract between an employer and an employee;
2. knowledge of that relationship by the third party;
3. interference with that relationship by, for example, seeking the employee’s discharge;
4. lack of justification; and

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\textsuperscript{223}See, e.g., Falls v. Sporting News Publishing Co., 834 F.2d 611 (6th Cir. 1987). The court found a defamation claim stated when, in response to a reader’s inquiries about a newspaper’s decision to discontinue plaintiff’s column, one editor wrote: “I know Joe brightened a lot of hearts with his column through the years but we felt it was time to make a change, with more energetic columnists who attend more events and are closer to today’s sports scene.” Id. at 614.

\textsuperscript{224}Freeman, Employee Discharge: Defamation Through the Form of Termination, 39 N. Y.U. CONF. ON LABOR § 17.01, at 634 (1986).


\textsuperscript{226}Id.


proximately caused damages. 

A conceptual problem with applying this tort in a typical discharge situation is that there must be someone who counts as a third party to the contract who can be charged with interference.

In an IMG-MCO relationship, an IMG may bring an intentional interference with contract lawsuit against a defendant MCO if it had tortiously interfered with his contract with another MCO.

Privacy

Another possible tort action available for IMGs is “privacy.” Tort law recognizes a legally protected interest in privacy in four basic situations:

1. intrusion on seclusion,
2. appropriation of name or likeness,
3. publicity given to private life, and
4. publicity placing a person in a false light.

While all four varieties may arise in employment situations, perhaps the most likely application of the tort is intrusion on seclusion. For example, public disclosure of the contents of a personnel file of an IMG might give rise to a privacy action when publicity is given to the private life of a person even if it does not put the person in a false light.

The Public Policy Exception

The most important recent addition to the tort causes of action which may be applicable to the IMG-MCO relationship is the “public policy exception” to the at-will employment doctrine. The public policy exception may limit an MCO’s power to discharge an IMG when he has engaged in conduct protected by an important public policy. The public policy exception is frequently attributed to the New Hampshire Supreme Court’s decision in Monge v Beebe Rubber Co., which held the discharge of an employee for her refusal to accede to a supervisor’s sexual...

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229 Id.
advances was actionable as a breach of contract. However, the origin of this cause of action can be traced back to Petermann v. International Brotherhood of Teamsters Local, in which the court held it is impermissible to discharge an employee for refusing to commit perjury. This cause of action may be successful if an IMG is deselected or discharged from the plan because he was properly ordering tests for his patients. For example, courts applying this principle may uphold causes of action when an IMG is discharged for refusing to violate laws relating to the public health, for acting in accordance with professional responsibilities, or for refusing to assist in illegal acts. Therefore, public law exception may prevent some IMGs from being dismissed or deselected if they ordered more tests for their patients because their patient population, on the average, has higher medical risks. In fact, the New Hampshire Supreme Court in Harper v. Healthsource used the bad faith and public policy doctrine in deciding for the wrongfully terminated physician. While this is the first victory of its kind for physicians and will probably be applied by other state courts, its importance is not yet known.

Anti-Discrimination Statutes
Statutory law may offer greater protection for IMGs than common law actions. The primary laws concerned are anti-discrimination and antitrust statutes. Moreover, various states are currently attempting to pass laws aimed at protecting physicians against unreasonable MCO actions which may also be used to protect an IMG's legitimate interests.

There are no federal or state laws that explicitly prohibit discrimination against IMGs. It is probably not unlawful for MCOs to explicitly declare that it is their policy not to include IMGs in their plan. However, since the majority of IMGs are not born in the United States, such a discriminatory policy will have a systemic disparate impact on race.
and national origin which is clearly prohibited by the Title VII of the Civil Rights Act of 1964. \(^{241}\) Moreover, section 1981 demands that everyone be treated like a "white man".\(^{242}\) Therefore, because of the prohibitions on discrimination, an MCO is unlikely to have an explicit policy for excluding IMGs.

**TITLE VII PROTECTIONS**

**Title VII of the Civil Rights Act of 1964**

Title VII\(^{243}\) is a major component of the Civil Rights Act of 1964.\(^{244}\) Title VII, as amended by the Equal Employment Opportunity Act of 1972,\(^{245}\) and the Civil Rights Act of 1991,\(^{246}\) prohibits employment discrimination on account of race, color, religion, sex and national origin.\(^{247}\) Title VII provides in part:

> It shall be an unlawful employment practice for an employer -

1. to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or
2. to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin.\(^{248}\)

Thus, on its face, Title VII applies to employment discrimination on the basis of race, religion, gender or national origin. The underlying purpose of Title VII is to remove artificial, arbitrary and unnecessary barriers to
employment when those barriers operate to discriminate on the basis of race, sex, or other protected characteristics.\textsuperscript{249}

In general, the Title VII actions tend to take one of five forms:

1. a charge that an employer deliberately discriminated against the plaintiff(s) because of race, sex or another protected characteristic (known as an individual disparate treatment claim);
2. a charge that the employment or enrollment policies have a sweeping effect on specific protected groups (known as systemic disparate treatment claim);
3. a charge that the employer used a facially neutral policy or practice that unjustifiably resulted in discrimination against members of a protected group (a disparate impact claim);
4. a charge that an employer retaliated against an employee for filing a discrimination claim;
5. or a charge that the employer constructively discharged an employee because of his or her race, sex, etc.\textsuperscript{250}

In the absence of direct evidence of discrimination, Title VII requires only a showing of disparate impact to establish a \textit{prima facie} case of racial discrimination.\textsuperscript{251} Under the 1991 amendments, once a plaintiff has carried the burden of proving disparate impact, an employer must articulate a valid business justification for the practice in order to escape liability.\textsuperscript{252} The term "business justification," however, is not defined in the statute.\textsuperscript{253}

Since Title VII does not apply to independent contractors,\textsuperscript{254} one of the essential components of a Title VII claim is to first establish that the

\textsuperscript{251}See, 42 U.S.C. §§ 2000e-2(k)(1)(A)(i) providing that an unlawful employment practice based on disparate impact is established if: [A] complaining party demonstrates that a respondent uses a particular employment practice that causes a disparate impact on the basis of race, color, religion, sex, or national origin and the respondent fails to demonstrate that the challenged practice is job related for the position in question and consistent with business necessity. 42 U.S.C. §§ 2000e-2(k)(1)(A)(i).
\textsuperscript{253}Id. at § 1.04(b)(3).
\textsuperscript{254}Ost v. West Suburban Travelers Limousine, Inc., 88 F.3d 435 (7th Cir. 1996).
MCO is an employer, and the relationship between the MCO and physician is an employer-employee arrangement within the meaning of Title VII. While showing this could be a simple task, it is not so simple when the relationship is loosely arranged, such as those between physicians and open panel MCOs. Therefore, in practice, showing this will be dependent on the structure of the MCO and the amount of control the MCO exercises over the plan physicians. Unfortunately, the statute defines employer and employees rather loosely. It states:

(b) The term "employer" means a person engaged in an industry affecting commerce who has fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year, and . . . .

(d) Business--For the purposes of this section, the term 'business' includes--

(6) (A) a corporation including nonprofit corporations;
(B) a partnership;
(C) a professional association;
(D) a labor organization; and
(E) a business entity similar to an entity described in subparagraphs (A) through (D);
(2) an education referral program, a training program, such as an apprenticeship or management training program or a similar program . . .

Like all other definitions in Title VII, courts liberally interpret the definition of employer. In fact, some courts have gone beyond the traditional relationship, finding the employer-employee requirement satisfied in situations involving economic necessity and third-party interference with employment. In these situations, a cause of action was sustained even where the party alleged to have violated Title VII was not

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257Id.
259Chester, 869 F. Supp. at 702.
a direct employer of the plaintiff. To determine whether the defendant was an employer within the meaning of Title VII, the courts first determine whether the defendant had substantial control over significant aspects of compensation, terms, conditions or privileges of plaintiff’s employment. In order to distinguish between employees and independent contractors, courts generally use a test that combines the “right to control” and “economic realities” standards. Right to control an employee’s work means the right to direct the work of the individual not only as to the result, but also as to the details by which that result is achieved. Other factors, such as ownership of equipment necessary for the job’s performance, responsibility for costs associated with operating that equipment, responsibility for obtaining insurance, responsibility for maintenance and operating supplies, ability to influence profits, length of time commitment, form of payment and directions on schedules or on performing work, are considered in showing an employment relationship. Under the so-called hybrid test, courts consider all circumstances of the work relationship including right to control, rather than the borrowed servant doctrine, to determine whether a defendant is a contractor or an employer. Under this test, courts examine economic realities underlying the relationship between plaintiff and defendant in an effort to determine whether the defendant is likely to be susceptible to discriminatory practices which the Act was designed to eliminate.

Courts have applied this hybrid economic reality control test to non-traditional employment in the health care environment. For example, in Diggs v. Harris Hospital-Methodist the court applied the economic necessity test to the termination of an African-American physician’s staff

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260 Id.
264 Jason v. Baptist Hosp., 872 F. Supp. 1575 (E.D. Tex. 1994). See also, Vakharia v. Swedish Covenant Hosp., 765 F. Supp. 461 (N.D. Ill. 1991). Anesthesiologist alleged facts that would establish employment relationship, required for Title VII claim, between herself and hospital or between herself and her patients or prospective patients; anesthesiologist obtained patients through assignment by hospital and referral by staff physicians at the hospital who requested her services. Id.
265 Nowlin v. Resolution Trust Corp., 33 F.3d 498 (5th Cir. 1994).
266 Vakharia, 765 F. Supp. at 461.
267 847 F.2d 270 (5th Cir. 1988).
privileges.\textsuperscript{268} In addition to the basic analysis, the \textit{Diggs} court noted additional factors which could be considered in establishing an employer-employee relationship, including whether the work provided is an integral part of the business of the employer and the intention of the parties.\textsuperscript{269} Although the \textit{Diggs} court did not find an employer-employee relationship, the court stressed that the privileges at issue were not an economic necessity because the plaintiff enjoyed staff privileges at other institutions.\textsuperscript{270} This decision suggests that the existence of economic necessity may be sufficient to establish the required relationship. Thus, if a physician or IMG can prove a relationship with the defendant MCO is necessary for him to practice medicine, it is possible that a court applying the economic reality and common law control test would find a Title VII employment relationship. On the other hand, if there are several open panel MCOs the plaintiff physician can join, then in the absence of any legal requirements, it is unlikely any court would find board certification an economic necessity.

Title VII's broad definition of employer includes an agent of the employer if he, by virtue of supervisory position, participates in discriminatory actions that are the subject of the claim.\textsuperscript{271} The test for determining whether a person is an agent of an employer who can be held liable for discrimination under Title VII is whether the alleged agent has participated in the decision-making process that forms a basis of discrimination.\textsuperscript{272} Of great interest to IMGs, the Supreme Court has interpreted race discrimination to include discrimination based on national origin and ethnicity.\textsuperscript{273} Furthermore, an employee's status as "alien" (\textit{i.e.}, without proper work authorization) does not disqualify him from bringing Title VII action against his employer.\textsuperscript{274}

\textbf{Individual Disparate Treatment Discrimination}

Assuming that an employer-employee relationship is found, one needs to show \textit{prima facie} discrimination under an individual disparate treatment

\textsuperscript{268} Id.
\textsuperscript{269} Id. at 272-73.
\textsuperscript{270} Id. at 273.
\textsuperscript{274} Egbuna v. Time-Life Libraries, Inc., 95 F.3d 353 (4th Cir. 1996).
test.\textsuperscript{275} Under this test, an IMG may establish a \textit{prima facie} case of discrimination by showing:

(1) he belongs to a protected group (\textit{i.e.} race or national origin);
(2) he has applied to an MCO or has been deselected from a plan for which he was qualified;
(3) he was not selected (or hired) or subjected to some other adverse MCO decision; and
(4) the position remained open or other similarly-situated employees outside the protected group were not subjected to the same adverse employment decision.\textsuperscript{276}

Once an IMG establishes a \textit{prima facie} case of discrimination, the defendant MCO must articulate a legitimate, non-discriminatory reason for its action.\textsuperscript{277} The MCO need not persuade the court it was actually motivated by its proffered reasons.\textsuperscript{278} It is sufficient if the MCO’s evidence raises a genuine issue of fact as to whether it discriminated against the IMG.\textsuperscript{279} For example, the MCO could say it has not selected the IMG because he was not board certified or deselected him because the IMG’s patient satisfaction was poor. If correct, these are probably acceptable legitimate reasons to rebut an individual’s claim of disparate treatment discrimination. For example, in \textit{Betkenur, M.D. v. Aultman Hospital Association},\textsuperscript{280} the hospital successfully rebutted a \textit{prima facie} individual disparate treatment challenge by showing it relied on its search committee’s recommendation which was made after hearing presentations from both candidates and after reviewing a report prepared by an outside consultant.\textsuperscript{281}

\textsuperscript{275} McDonnell Douglas Corp. v. Green, 411 U.S. 792, 792 (1973).
\textsuperscript{276}\textit{Id.}
\textsuperscript{277}\textit{Id.}
\textsuperscript{278}\textit{Id.}
\textsuperscript{279}Texas Dep’t of Community Affairs v. Burdine, 450 U.S. 248 (1981).
\textsuperscript{280}Betkenur, M.D. v. Aultman Hosp. Ass’n, 78 F.3d 1079 (6th Cir. 1996).
\textsuperscript{281}\textit{Id.} at 1080. Hospital which selected a white, American-born doctor as Director of Neonatology rather than a doctor from India with comparable qualifications established a legitimate, non-discriminatory reason for its decision by showing that it relied on the search committee’s recommendation. The committee made its recommendation after hearing presentations from both candidates, and after reviewing a report prepared by an outside consultant, which recommended the white, American-born doctor. The report preferred the white doctor because of training programs, leadership in securing referrals from the medical community, and the ability to lead the hospital’s neonatal intensive care unit to a higher rating. \textit{Id.}
Once the defendant MCO articulates a legitimate, non-discriminatory reason for the adverse employment action, the IMG then must demonstrate that the proffered reason was not the true reason for the MCO's decision. This burden merges with the IMG's ultimate burden of persuading the court he was a victim of intentional discrimination. In *Warren v. City of Carlsbad*, a Mexican-American firefighter was successful in showing he was not promoted to a fire captain position because of his national origin. On the other hand, in *Gomez v. Allegheny Health Services, Inc.*, a Colombian staff surgeon who was terminated because he was not receiving enough referrals from cardiologists to support his position was not found to be subjected to national origin discrimination.

Systemic Disparate Treatment Discrimination

In addition to individual disparate treatment charges, IMGs also can challenge a MCO's sweeping selection and deselection policies that have a systemic effect on IMGs as a group. For example, an MCO policy selecting only United States medical school graduate physicians or separating physicians by country of origin raises systemic treatment issues. The theory of systemic disparate treatment is actionable under Title VII and section 1981.

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282 Id.

283 *Burdine*, 450 U.S. at 248.


285 Id. at 443-44. A Mexican-American firefighter established a genuine issue of material fact that he was not promoted to a fire captain position on the basis of his national origin by showing others who had scored lower on the fire captain's test and were white were promoted, only one fire captain in the last 19 years was a minority, he heard the Fire Chief make a derogatory comment about Hispanics, and he was denied the promotion based on a subjective determination of his lack of interpersonal skills. Id.


287 Id. at 1079. A Columbian staff surgeon, who was terminated because he was not receiving enough referrals from cardiologists to support his position, was not subjected to national origin discrimination, because the evidence showed the cardiologists made referrals based on their professional judgment as to what was best for their patients, and their refusal to refer patients to the plaintiff resulted from their own prior unsatisfactory experiences with him. In addition, criticisms by one doctor that the plaintiff looked and sounded foreign were insufficient to prove discrimination because that doctor praised and referred patients to other foreign doctors, had no control over other doctors' referrals, and had no authority to hire or fire plaintiff. Id. at 1084-85.

Systemic disparate treatment can be proven in two ways. First, IMGs may demonstrate that the MCO's formal policy of selection and/or deselection is discriminatory. Second, if IMGs fail to prove a formal discriminatory policy, they may still try to establish that the MCO's pattern of physician selection or deselection policy has disparate treatment on race or country of origin. Usually, sophisticated statistical analysis and inferential proofs along with actual cases of anecdotal evidence are required to show systemic treatment.

Similar to an individual disparate treatment claim, once the plaintiff establishes the *prima facie* evidence of discrimination, the defendant is allowed to rebut the presumption of discrimination through an individualized showing that no one particular person is a victim of the discriminatory practice pattern. Under a systemic disparate treatment claim, however, a plaintiff who establishes a *prima facie* case and proves that the defendants' legitimate, non-discriminatory decision are pretextual is not automatically entitled to prevail. Such proof is only sufficient for showing the evidence of intentional discrimination, especially if it is accompanied by suspicion of mendacity. In general, in order to prevail under systemic disparate treatment, a plaintiff must use fine tuned statistics such as identifying the most appropriate population and statistical comparison group.

Systemic Disparate Impact Discrimination
A disparate impact case is one in which a plaintiff alleges that a facially neutral policy of the defendant falls more harshly on one group than
another and cannot be justified by business necessity.\textsuperscript{296} Proof of discriminatory motive is not required under the disparate impact analysis.\textsuperscript{297} Once an IMG establishes a \textit{prima facie} case of disparate impact by statistical evidence, the MCO must articulate a legitimate, nondiscriminatory reason such as business necessity, job-relatedness or employment practice, and then the burden shifts back to the plaintiff to show either their employer's reason is pretext for discrimination, or there exists an alternative employment practice without a disparate impact that also serves the employer's legitimate interests.\textsuperscript{298}

In the past, disparate impact analysis has typically been applied to health care settings when a physician was denied hospital privileges or board certification.\textsuperscript{299} Assuming an employer-employee relationship was found, the courts applied the usual disparate impact test for finding a Title VII violation.\textsuperscript{300} A \textit{prima facie} case requires a showing that:

1. the plaintiff belongs to a racial minority;
2. the plaintiff was qualified for a job for which the employer was seeking applicants;
3. despite these qualifications, the plaintiff was rejected for the position; and,
4. after this rejection, the position remained open and the employer continued to seek applications from persons of the complainant's qualifications.\textsuperscript{301}

Even if a \textit{prima facie} case be demonstrated by the plaintiff, a claim still may be defeated by showing a valid business justification for the allegedly discriminatory practice.\textsuperscript{302} In fact, the Supreme Court has specifically

\begin{itemize}
\item \textsuperscript{297}\textit{Id}.
\item \textsuperscript{298}\textit{Id}.
\item \textsuperscript{299}Muzquiz v. W.A. Foote Mem'l Hosp., 70 F.3d 422 (6th Cir. 1995). A Mexican-American doctor failed to establish that requiring doctors who wished to obtain invasive cardiology privileges provide films and charts of their prior cardiac catheterizations had a disparate impact on doctors of Mexican heritage. The difficulty in obtaining the required items impacted on those who had trained in Mexico, not those who were of Mexican heritage. \textit{Id.} at 429.
\item \textsuperscript{300}\textit{Id.} at 429.
\item \textsuperscript{301}McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802 (1973).
\item \textsuperscript{302}\textit{Id}.
\end{itemize}
stated in *Furnco Construction Corporation v. Waters*, the test should not be applied rigidly, but is to serve as "a sensible, orderly way to evaluate the evidence in light of common experience as it bears on the critical question of discrimination."

**Limitation of Title VII Claims in Non-Staff MCO Settings**

Even if an IMG physician can show he is protected under Title VII, he may have difficulty proving a Title VII claim. Decisions concerning the quality of medical care provided by physicians are so subjective that proving racial or country of origin discrimination may be next to impossible except in particularly egregious circumstances. Without direct evidence of discrimination, aggrieved physicians would have to prove a disparate impact claim, which may be rather daunting under the 1991 amendments to Title VII. Establishing a *prima facie* case in the physician-discrimination context might require statistical evidence demonstrating that the exclusion of an inordinately large number of qualified IMG physicians was due to the selection criteria used by the MCO. Even after a showing of *prima facie* evidence of discrimination, the defendant MCO could rebut the presumption by proving the selection criteria is "consistent with business necessity." MCOs asserting selection criteria associated with cost-conscious assessments to help control business costs would likely clear this hurdle. Thus, IMG physicians would face an uphill battle in proving Title VII claims.

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304 *Id.* at 577.

305 The Civil Rights Act of 1991 provides statutory guidelines for the adjudication of disparate impact suits under Title VII. It does so by amending Title VII to add § 703(k)(1)(A) which states that:

An unlawful employment practice based on disparate impact is established under this title only if—

(i) a Complaining party demonstrates that a respondent uses a particular employment practice that causes a disparate impact on the basis of race, color, religion, sex, or national origin and the respondent fails to demonstrate that the Challenged practice is job related for the position in question and consistent with business necessity . . . .


307 *Finnegan v. Trans World Airlines, Inc.*, 967 F.2d 1161, 1163-64 (7th Cir. 1992).

308 *Id.*
Section 1981 Action

Section 1981 of the Civil Rights Act of 1870 provides independent causes of action reaching private acts of discrimination and does not preempt relief under Title VII. Section 1981 states:

all persons within the jurisdiction of the United States shall have the same right in every State and Territory to make and enforce contracts, to sue, be parties, give evidence, and to the full and equal benefit of all laws and proceedings for the security of persons and property as is enjoyed by white citizens.

This language addresses intentional racial discrimination by public and private parties. Coverage is limited to four specifically enumerated activities:

(1) making and enforcing a contract;
(2) suing in court and giving evidence;
(3) securing the benefits of law; and
(4) receiving punishment, licenses, taxes, and penalties.

Amendments in 1991 reinforced both the protection of contractual rights and the applicability to non-government actions. Specifically, the

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309 May 31, 1870, ch. 114, 16 stat. 140.
311 § 1981(a) (1994).
312 See General Bldg. Contractors Ass’n, Inc. v. Pennsylvania, 458 U.S. 375, 382-90 (1982) (proposing that § 1981 only reaches intentional and purposeful discrimination). There is some debate as to whether § 1981 covers white persons who are discriminated against on the basis of national origin, religion or race. See Zaklama v. Mt. Sinai Med. Ctr., 842 F.2d 291, 295 (11th Cir. 1988). Despite the reservation of some courts, it is not inconceivable that a court would find § 1981 coverage for an ostensibly “white” foreign national discriminated against on the basis of national origin, race, religious beliefs or other covered category.
314 Specifically, the 1991 Civil Rights Act added subsections (b) and (c) to address these issues:
(b) For purposes of this section, the term “make and enforce contracts” includes the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.
(c) The rights protected by this section are protected against impairment by non-governmental discrimination and impairment under color of State law. 42 U.S.C. § 1981(b), (c).
amendment now prohibits discrimination not just in the formation of contracts, but also in their performance, benefits, terms and conditions.\textsuperscript{315}

The language of section 1981 expressly prohibits race discrimination in the making and enforcement of contracts and in employment claims.\textsuperscript{316}

Thus, race discrimination claimants could join claims under section 1981 with claims under Title VII because section 1981, unlike Title VII, does not limit the recovery of compensatory and punitive damages.\textsuperscript{317}

Moreover, considering the Supreme Court holding in \emph{St. Francis College v. Al-Khazraji},\textsuperscript{318} which interpreted race discrimination to include discrimination based on national origin and ethnicity,\textsuperscript{319} claimants such as IMGs which may have a claim based on national origin or ethnicity, can bring claims under section 1981 along with Title VII.

In addition to action against direct discrimination, section 1981 can also be applied to parties having an indirect influence on a protected individual's right to contract. For example, in \emph{Zakloma v. Mt. Sinai Medical Center},\textsuperscript{320} section 1981 applied to a foreign-born IMG's claim to find that his dismissal from a residency program under the influence of a third party was discriminatory.\textsuperscript{321} This is an important holding since MCOs could become liable if they use their power to influence the physician group (\textit{i.e.} IPA) to drop their IMG members before contracting

\textsuperscript{315}For example, in\emph{Strother v. Southern Cal. Permanente Med. Group}, 79 F. 3d 859 (9th Cir. 1996) an African-American doctor who was a partner in a medical group was not entitled to challenge any of her promotion denials under § 1981 which occurred prior to the 1991 Civil Rights Act Amendments because they did not occur during the formation of the partnership contract, nor did they rise to the level of an opportunity for a new and distinct relationship between the plaintiff and the defendant. However, discrimination which occurred after the 1991 Civil Rights Act Amendments may be actionable under §1981 because the amendment prohibits discrimination not just in the formation of contracts, but also in their performance, benefits, terms and conditions. Therefore, a plaintiff's allegations that after November 12, 1991 she was excluded from meetings, denied appointments and secretarial support, and given an increased workload and heightened performance standards may be actionable discrimination under § 1981.

\textsuperscript{316}\emph{Johnson v. Railway Express Agency}, 421 U.S. 454 (1975); \textit{see also}, Swapshire v. Baer, 865 F.2d 948 (8th Cir.1989).

\textsuperscript{317}Id. at 454.


\textsuperscript{319}Id. at 606.

\textsuperscript{320}Zakloma v. St. Shai Med. Ctr., 842 F.2d 291 (11th Cir. 1988).

\textsuperscript{321}Id. at 295.
with them.\textsuperscript{322} In this case, to bring an action against an MCO there is need for privity between the disgruntled IMG and the MCO.\textsuperscript{323}

In general, a traditional contract need not be at issue for an individual to maintain a section 1981 challenge. As a result, section 1981 has been applied to situations where physicians were denied hospital privileges.\textsuperscript{324} Unlike Title VII of the Civil Rights Act of 1964, section 1981 requires intentional and purposeful discrimination and does not reach practices which are neutral on their face and neutral in intent, although discriminatory in effect.\textsuperscript{325} Under this statute, the jury must determine whether discrimination was a causal factor in the challenged employment decision.\textsuperscript{326}

It is not clear whether a \textit{prima facie} case of discrimination exists when an MCO has employed subjective criteria, such as clinical competency or character requirements, to deny an IMG's application or as reasons for deselection.\textsuperscript{327} However, considering that the courts are reluctant to apply section 1981 liberally, and in light of the holding in Betkerur, M.D. v. Aultman Hospital Association,\textsuperscript{328} the outlook for successful claims under section 1981 is not too promising for IMGs.

\textsuperscript{322}Id. at 292-95. Specifically, Zaklama was employed as a resident by Jackson Memorial Hospital. As part of his training, Zaklama was expected to rotate through three other local hospitals, while still technically remaining a resident in the Jackson Memorial Program. At one of these hospitals, Mt. Sinai Medical Center, Zaklama was subject to negative evaluations and was subsequently barred by Mt. Sinai staff from the hospital. On the basis of the Mt. Sinai actions, Jackson Memorial terminated Zaklama's participation in its residency program. Note that Zaklama alleged racial, national origin, and religious discrimination in his complaint against both hospitals. \textit{Id.} at 292-94.

\textsuperscript{323}Id. at 295 (citing Sibley Mem'l Hosp. v. Wilson, 488 F.2d 1338 (D.C. Cir. 1973)) (involving a challenge under Title VII of the Civil Rights Act of 1964)). \textit{See infra} notes 104-7 and accompanying text.


\textsuperscript{325}Swapshire v. Baer, 865 F.2d 948, 952 (8th Cir. 1989) (\textit{citing} General Building Contractors Ass'n v. Pennsylvania, 458 U.S. 375, 391 (1982)).

\textsuperscript{326}Model Civ. Jury Instr. § 5.20 (8th Cir.).

\textsuperscript{327}Given that such criteria are very infrequently invoked where an individual has successfully completed an ACGME-accredited residency, such an argument may be difficult to establish in practice.

\textsuperscript{328}Betkerur, M.D. v. Aultman Hosp. Ass'n, 78 F.3d 1079 (6th Cir. 1996). A neonatologist from India failed to show a § 1981 violation when other doctors refused to refer patients to her. The referring doctors established that their decision to refer more patients to a white, American-born neonatologist was based on her greater compatibility with their individual philosophies of care, and her more skillful interactions with them and their patients. \textit{Id.}
Note on Comparing Section 1981 and Title VII
When subjected to prohibited discrimination, one may choose to bring both a Title VII and a section 1981 action law suit concurrently. The Supreme Court has made it clear that both statutes may be invoked either concurrently or independently. In Johnson v. Railway Express Agency, Inc., the Supreme Court wrote: "We generally conclude, therefore, that the remedies available under Title VII and under section 1981, although related, and although directed to most of the same ends, are separate, distinct, and independent." Thus, section 1981 may be pursued without reference to Title VII.

To take advantage of both statutes, a plaintiff must meet the requirements of each statute as a precondition to the suit. Generally, the legal standards in section 1981 cases and Title VII cases are interchangeable. However, as noted earlier, section 1981 requires intentional discrimination. Unlike Title VII, under section 1981, a prima facie case of discrimination cannot be shown through disparate impact theory. On the other hand, section 1981 remedies are somewhat broader than those available under Title VII due to the absence of a statutory cap on damages. Another advantage of section 1981 is that, unlike Title VII, its coverage is not expressly limited to employment. For example, discrimination in partnership decisions is fully actionable. Also, the statute of limitations for section 1981 is generally longer than that of Title VII. Therefore, in a case of intentional discrimination by an MCO, section 1981 is probably the most relevant and useful statute to consider.

330 Id.
331 Taylor v. Safeway Stores, Inc., 524 F.2d 263 (10th Cir. 1975); Gresham v. Chambers, 501 F.2d 687 (2d Cir. 1974).
332 Taylor, 524 F.2d at 265.
335 Id.
336 Id.
337 Id.
338 Id.
Title VI of the Civil Rights Act of 1964

IMGs and MCOs should also be aware of Title VI of the Civil Rights Act of 1964. Section 601 of Title VI reads: “No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” In 1988, Title VI was amended to provide that the terms “program or activity” and “program” are defined as “all of the operations of . . . an entire corporation, partnership, or other private organization, or an entire sole proprietorship . . . which is principally engaged in the business of providing . . . health care, . . . any part of which is extended federal financial assistance.” Therefore, if an MCO has Medicare and Medicaid patient enrollees, it is also covered under Title VI and an aggrieved IMG could bring an independent cause of action under Title VI.

Antitrust Actions

Several provisions of antitrust laws may prove to be useful tools for disgruntled IMG physicians. Specifically, under the antitrust laws, conspiracy, predatory pricing, exercising monopoly power, barriers to entry and boycotts against or refusal to deal with IMGS could be unlawful. Therefore, under certain circumstances, an aggrieved IMG may bring an action against an MCO for antitrust violations. However, antitrust violations are generally more difficult and costly to adjudicate and chance of success is relatively low in the health care market. Nevertheless, a successful plaintiff may be awarded treble damages and reasonable attorney fees.

Antitrust Actions in Health Care

While the use of antitrust laws in the health care profession is not new, it has become more frequent in recent years because of dramatic changes in the delivery of health care. This is mainly due to the intense

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340 Id.
344 Id.
competition among health care providers, consolidation in health care facilities, managed care pressure, and the emergence of integrated delivery systems which resulted in an increasing number of mergers and foreclosure of the health care market for a large number of solo practitioners.

In general, for a plaintiff physician to be successful in antitrust litigation, he must show: (1) a contract, combination or conspiracy among the defendants that (2) resulted in an unreasonable restraint of trade. In addition to the naked conspiracy antitrust violation, the other concerns in the current health care delivery market posing potential antitrust violations are group boycotts, tying arrangements, monopolization, exclusive dealing arrangements and possibly price-fixing.

For many years physicians have used antitrust laws primarily to challenge the denial or termination of their hospital staff privileges, denial of referrals and refusal of some hospitals to deal with them (these

345Id.
347Id.
348Id.
350A tying arrangement is generally defined as an agreement by one party to sell a product only on the condition that the buyer also purchase a different ("tied") product. See Northern Pacific Ry. Co. v. United States 356 U.S. 1, 3 (1958). But see, Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984) (concerning a "tying arrangement").
352See Singer, supra note 349, at 219 (discussing non-price issues raised by alternative systems).
354Cooper v. Amster, 645 F. Supp. 46 (E.D. Pa. 1986). Two hospitals did not refer patients to a physician pursuant to their policy under which no referrals were made to a physician who had been on the staff for less than five years unless he or she was associated with other qualified physicians. The court summarily dismissed the physician's claim that the hospitals had combined to restrain trade in violation of § 1 of the Sherman Act (15 U.S.C.A. § 1). The court stated the physician was not in any way precluded from practicing medicine or from using the hospital's facilities to treat his patients, and observed that there was no evidence that he had been singled out for exclusion, that the hospitals' referral policy was unreasonable, or that any agreement concerning the plaintiff had ever existed between the two hospitals or their staffs. Id at 49. See also, Pontius v. Children's Hosp., 552 F. Supp. 1352 (W.D. Pa. 1982). Hospital patients who expressed no preference as to a surgeon were assigned a surgeon by the head of the department
actions are prohibited under section 1 of the Sherman Act\textsuperscript{355}. However, these actions were largely unsuccessful because plaintiff physicians were unable to prove all required elements of the Sherman Act, including showing an actual conspiracy or the defendant’s involvement in interstate commerce.\textsuperscript{356} In some cases, the defendant hospitals were not held liable because they were exempt from antitrust laws by the state entity exemption, or courts used the less rigorous “rule of reason” review instead of more demanding \textit{per se} standard of review.\textsuperscript{357}

of surgery. The court rejected the contention of a surgeon in private practice that the referral policy discriminated against him in that the department head had an interest in referring such patients either to himself or another staff surgeon not in private practice, and entered summary judgment for the defendant hospital and four of its staff physicians named as defendants against the surgeon’s claim of illegal restraint of trade in violation of § 1 of the Sherman Act (15 U.S.C.A. § 1). The court observed that if the surgeon’s allegations of discrimination were true, then the hospital and the staff physicians were acting as a single economic entity and could not, as a matter of law, have engaged in the concerted action required for liability under § 1 of the Sherman Act (§ 4). The court went on to say that the surgeon’s claim failed factually for the reason that none of the defendant staff physicians had any possible anticompetitive motive to engage in the alleged conspiracy, inasmuch as none of them received monies derived from private patient fees and so could not benefit economically from denying referrals to him. \textit{Id.} at 355.

\textsuperscript{355}Sections 1 and 2 of the Sherman Act (15 U.S.C.A. §§ 1, 2) provide in pertinent part as follows:

\begin{quote}
§1. Trusts, etc., in restraint of trade illegal; penalty. Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal.

§ 2. Monopolizing trade a felony; penalty. Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony[.]
\end{quote}

\textsuperscript{356}\textit{See} Miles & Philip, \textit{supra} note 353, at 493.

\textsuperscript{357}\textit{Id.} Liability under § 1 of the Sherman Act depends on the existence of a combination or conspiracy in restraint of trade. The required elements of a physician’s case under § 1 will depend upon whether the conduct of the defendant is deemed a \textit{per se} violation of § 1, in which case no proof need be offered as to its harmful effects on trade or the motivation of the defendant, or whether the defendant’s acts are analyzed under a “rule of reason,” in which case the physician must show either an anticompetitive purpose by the defendant hospital in acting as it did or an anticompetitive effect of its acts upon the relevant market.

Using mainly “rule of reason” standard, most courts have held that a hospital is legally incapable of conspiring with any of its officers, agents, or employees, including members of its medical staff who may pass judgment on a physician’s application for staff privileges. However, some cases held that individual members of a hospital medical staff may conspire among themselves in violation of § 1. In general, unless a plaintiff physician can show concerted, as opposed to unilateral, activity in restraint of trade, there can be no liability under § 1 of the Sherman Act. Moreover, courts held no antitrust violation of § 2 of the Sherman Act when a hospital denied staff privileges for a physician. \textit{Id.}
Using the rule of reason standard in denial of staff privilege cases, most courts have held a hospital is legally incapable of conspiring with any of its officers, agents or employees, including members of its medical staff who may pass judgment on a physician’s application for staff privileges. Nevertheless, in some cases courts have held the individual members of a hospital medical staff may conspire among themselves in violation of section 1. In general, unless a plaintiff physician could show evidence of actual concerted action or combination by different MCOs (or independent members of an MCO), as opposed to unilateral decision by an MCO, there can be no liability under section 1 of the Sherman Act. Moreover, courts found no antitrust violation of section

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360 In Friedman v. Delaware Cty. Mem'l Hosp., 672 F. Supp. 171 (E.D. Penn 1987), a physician whose hospital staff privileges were revoked sued under, inter alia, § 1 of the Sherman Act (15 U.S.C.A. § 1). The court held that no combination in restraint of trade had occurred, and granted summary judgment to the defendant. Although the physician contended that hospital administrators had conspired with two other physicians on the hospital staff to revoke his privileges, the court found no evidence that either of the other physicians had ever taken any action with respect to the plaintiff physician except as specifically requested by committees or heads of the medical staff responsible for physician peer review and patient care quality. Stating that the other physicians had acted only as agents of the hospital, the court noted that because the hospital could not conspire with itself, there could be no conspiracy as a matter of law.


See also, Sokol v. University Hosp., Inc., 402 F. Supp. 1029 (D.C. Mass. 1975), in which the court, in holding that a physician whose practice of cardiology surgery at a hospital had been restricted, had failed to state a claim under § 1 of the Sherman Act (15 U.S.C.A. § 1). The court said that when the act complained of is the act of a corporation, the fact that a number of the corporation’s personnel are required to concur to generate the corporation’s act does not satisfy the conspiracy requirement of the Sherman Act. Id.

In Vucicevic v MacNeal Mem’l Hosp. 572 F. Supp. 1424 (N.D. Ill. 1983), a physician alleged that a hospital and several of its staff members had engaged in a group boycott in violation of § 1 of the Sherman Act (15 U.S.C.A. § 1) by denying him staff privileges. The court, in denying summary judgment for the defense held that per se analysis of the claim was not appropriate because the judiciary had insufficient acquaintance with health care regulation to justify application of a per se rule in that context. The court went on to say that the denial of privileges could be regarded as a species of industry regulation, and cited authority for application of the rule of reason if a three-part test was satisfied: (1) a mandate for self-regulation, (2) action consistent with the policy justifying self-regulation and no more extensive than necessary, and (3) application of procedural safeguards. The court found the first requirement satisfied by the obligation of hospitals to insure the competence of staff physicians. The second requirement was met because staff physicians had advised the hospital with regard to its decision. The third
2 of the Sherman Act\textsuperscript{361} when a hospital denied staff privileges for a physician.\textsuperscript{362,363}

requirement was met because the hospital provided procedural safeguards which insured that anticompetitive intent was not disguised as regulation.\textsuperscript{361} 15 U.S.C.A. § 2 (prohibiting monopolization, attempted monopolization, or conspiracy to monopolize trade or commerce).\textsuperscript{362}

In Konik v. Champlain Valley Physicians Hosp. Med. Ctr., 733 F.2d 1007 (2nd Cir. 1984), the court affirmed the dismissal of the anesthesiologist's claim that the hospital and the corporation had conspired and attempted to monopolize the market for anesthesia services in the county where the hospital was located in violation of § 2 of the Sherman Act (15 U.S.C.A. § 2).\textsuperscript{363}

In Kaczanowski v. Medical Ctr. Hosp., 612 F. Supp. 688 (D. Ver. 1985), the court, in granting summary judgment to the defense, held that by denying staff privileges to two podiatrists pursuant to their bylaws, the defendant hospitals had not attempted or conspired to monopolize trade in violation of § 2 of the Sherman Act (15 U.S.C.A. § 2). Although conceding that individual physicians on the hospitals' medical staffs might have had an anticompetitive wish to exclude podiatrists from the staffs, this did not indicate an anticompetitive motive on the part of the hospitals. There was no evidence that the hospitals, in denying staff privileges, had acted in willful pursuit of a monopoly or for any purpose other than maintaining their professional standards for patient care. \textit{Id.}\textsuperscript{364}

In Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), the court, in reversing in part a judgment for an osteopathic physician who was denied hospital privileges, held that although he had sufficiently proven a local monopoly by the hospital in the provision of inpatient hospital services, he had failed to show that the hospital had willfully acted to maintain that monopoly and so could not prevail on a claim of monopolization in violation of § 2 of the Sherman Act. \textit{Id.}\textsuperscript{365}

In Miller v. Indiana Hosp., 814 F. Supp. 1254 (W.D. 1992), the court held that without evidence demonstrating hospital's ability to exert market dominance in relevant geographic market, physician whose staff privileges were revoked could not show violation of 15 U.S.C.A. § 2.\textsuperscript{366}

Smith v. Burns Clinic Med. Ctr., P. C., 779 F.2d 1173 (6th Cir. 1985). Hospital staff physicians alleged that physicians of an independent clinic, who had been hired by the hospital to staff the hospital's emergency room, were discriminating in favor of other clinic physicians in referring emergency room patients for follow up medical care, and that this conduct constituted monopolization and attempted monopolization in violation of § 2 of the Sherman Act. The court in affirming a summary judgment for the defense, held that even if the staff physicians could show they had been denied a fair share of referrals, they had failed to create an issue of fact as to necessary elements of their claims. The court noted that even if the defendant had engaged in anticompetitive behavior, the staff physicians had not shown what portion of the relevant market had been consumed by its actions and so had not created an issue of fact as to the clinic's intent to monopolize or its probability of success in doing so. \textit{Id.}\textsuperscript{367}

See also, Aron v. Michigan Health Care Corp., 593 F. Supp. 607 (D. Nev. 1984), in which a physician denied hospital referrals pursuant to a bylaw providing that a new physician could not receive referrals for a period of one year sued under § 2 of the Sherman Act, alleging that the referral policy constituted monopolization and attempted monopolization; the court, in denying the physician a preliminary injunction, stated that the hospital was justified in adopting the policy at issue because it gave the hospital an opportunity to observe a physician's work. \textit{Id.}\textsuperscript{368}
Managed Care and Antitrust Laws

Over the past several years, the number of antitrust cases involving MCOs has risen as MCOs become more accepted as alternative methods of health care delivery. These antitrust cases generally fall into four categories.

The first category consists of monopoly actions, including those brought by:

1. one MCO against another for foreclosure of the market;
2. actions by MCOs against large insurers;
3. actions by health care providers against large insurers for adopting cost-containment strategies.

The second category includes actions for tying arrangements brought by:
1. a small MCO against a larger MCO, or
2. physicians against hospitals.

The third category encompasses actions for group boycotts.

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365 Id. at 94.

366 See Blue Cross & Blue Shield United of Wis. v. Marshal Clinic, 65 F.3d 1406, 1411-13 (7th Cir. 1995) (finding HMO not liable for monopolization because of lack of market power within relevant product market, cert. denied, 116 S. Ct. 1288 (1996); United States Healthcare, Inc. v. Healthsources, Inc., 986 F.2d 589, 597-99 (1st Cir. 1993) (finding that HMO lacked sufficient market power within relevant product market to form monopoly).

367 See Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 853 F.2d 1101, 1109-11 (1st Cir. 1989) (holding insurer not liable in suit brought by HMO under Sherman Act § 2 for setting maximum insurance reimbursement at no greater than payment by competing HMO).

368 See Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1335-36 (7th Cir. 1986) (holding that formation of preferred provider organization ("PPO") by large insurer did not violate Sherman Act § 2 in suit brought by hospital because, inter alia, ease of entry for competing HMOs prevented attainment of market power); Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922, 927, 933 (1st Cir. 1984) (stating that despite market power, insurer's prohibition of "balance billing" by participating physicians does not violate Sherman Act § 2 unless payments fall so low as to constitute predatory pricing).


370 See Jefferson Parish Hosp. Diss. No. 2 v. Hyde, 466 U.S. 31-32 (1984) (holding hospital not liable for tying arrangement in violation of Sherman Act §§ 1 and 2 after hospital awarded exclusive contract for anesthesiology services to group practice). A tying arrangement occurs when a supplier uses market power over one product to attain power or to otherwise manipulate competition over another product. See id. at 12-13 (citing Fortner Enters. v. United States Steel Corp., 394 U.S. 495, 512-14 (1969) (White, J., dissenting)). Such an arrangement exists when the
brought by: (1) physicians against MCOs for exclusion from medical staff;\textsuperscript{371} (2) hospitals or MCOs against insurers for exclusion from a payment plan;\textsuperscript{372} or (3) MCOs and other payors against providers for attempting to create barriers to the entry of managed care entities into the market.\textsuperscript{373} The fourth category comprises actions for market division or price-fixing by an MCO, preferred provider organization (PPO), or insurer.\textsuperscript{374} Although some of these cases do not directly involve MCOs as parties, many have resulted from the increased concentration of MCOs.\textsuperscript{375} In all of these actions, with few exceptions,\textsuperscript{376} when the defendant had

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\textsuperscript{372}See Reazin v. Blue Cross & Blue Shield of Kan., Inc., 899 F.2d 951, 965-66 (10th Cir. 1990) (finding insurer liable for horizontal group boycott in violation of Sherman Act § 1 under rule of reason when it threatened to terminate contract of hospital recently acquired by competitor and lowered reimbursement of other providers doing business with competitor). \textit{But see}, U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 592-93 (1st Cir. 1993) (finding HMO not liable for horizontal group boycott under \textit{per se} analysis when it offered higher reimbursement to physicians for agreeing not to provide services to any other HMOs).

\textsuperscript{373}See, FTC v. Indiana Fed’n of Dentists, 476 U.S. 447, 458-66 (1986) (holding that group of dentists violated Sherman Act § 1 when it concertedly refused to provide x-rays to insurers). The Court in Indiana Federation of Dentists struggled with the question of whether the case fit into the group boycott “pigeonhole,” \textit{id.} at 458, or whether it was a price-fixing case. \textit{See id.} at 459-61. The Court, however, was interested more in avoiding application of a strict \textit{per se} test than in finding a perfect label for the case. \textit{See id.} at 458-59. Ultimately, the Court found that it was “not a matter of any great difficulty” to apply a rule of reason balancing test to the facts of the case. \textit{Id.} at 459. The Court thereby engaged in an early application of what now is known as the “quick look” test for determining violations of Sherman Act § 1. \textit{See U.S. Healthcare}, 986 F.2d at 594 (citing Indiana Fed’n of Dentists as early example of “quick look” formulation).

\textsuperscript{374}See Arizona v. Maricopa County Med. Soc’y, 457 U.S. 332, 342-57 (1982) (holding doctor-initiated PPO liable for \textit{per se} offense of price fixing under Sherman Act § 1, after physician members of PPO comprising 70% of all those practicing in county, set maximum reimbursement rates); Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1415-16 (7th Cir. 1995) (finding HMO liable for \textit{per se} offense of market division and price fixing in violation of Sherman Act § 1), \textit{cert. denied}, 116 S. Ct. 1288 (1996).

\textsuperscript{375}Maricopa, 457 U.S. at 345.

\textsuperscript{376}Price fixing and market division generally are held to be illegal \textit{per se} under Sherman Act § 1. \textit{See} United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 218 (1940). This rule obviates the need for a plaintiff to show that a defendant possessed market power and eliminates defenses
“market power,” the defendants were found not to have violated the antitrust laws.

Refusal to Deal

While historically the success of antitrust lawsuits against MCOs is rather small, nevertheless, it is possible that the effort to exclude IMGs as a group from MCO plans will increase the chance of successful antitrust litigation under the heading of a concerted refusal to deal.

Normally, any person is free to deal with whomever he pleases. This general rule, however, is limited by the essential facilities or bottleneck doctrine arising from the Supreme Court’s decision in United States v. Terminal Railroad Association. Under this doctrine, there are four requirements for establishing liability for a refusal to deal by a monopolist:

Based on reasonableness. See id. at 218. Courts, however, frequently engage in a balancing inquiry to determine whether a certain action can be properly characterized as price fixing. The Court in Maricopa County held a price fixing agreement to be illegal as a matter of law when prices charged by a physician group were set by members of the group. See id. On remand, however, the district court held that the arrangement was no longer a price-fixing agreement worthy of per se prohibition when consumers were placed on the price-setting committee. See id.

See Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 26, 29 (1984) (requiring showing of market power for per se liability to attach under Clayton Act § 3 for tying arrangement, and finding insufficient evidence of market power); Reazin, 899 F.2d at 965-66 (applying rule of reason and market power assessment to find insurer liable for horizontal group boycott in violation of Sherman Act § 1 when insurer terminated contract of hospital recently acquired by competitor and discouraged other health service providers from doing business with competing insurers as condition of reimbursement); Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101, 1109-11 (1st Cir. 1989) (holding insurer not liable in suit brought by HMO under Sherman Act § 2 for setting maximum insurance reimbursement at no greater than payment by competing HMO, despite existence of market power); Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc. 784 F.2d 1325, 1330, 1334-35 (7th Cir. 1986) (requiring market power for violation of Sherman Act § 2, but finding that defendant lacked market power in medical insurance when market share was 27% of patients in Indiana); Kartell v. Blue Shield of Mass., 749 F.2d 922, 924 (1st Cir. 1984) (finding no violation by insurer of Sherman Act § 2 for setting maximum reimbursement amount, despite 74% market share). But see, Marshfield, 65 F.3d at 1415-16 (finding HMO liable for market division and price fixing in violation of Sherman Act § 1 under per se analysis, without market power analysis).

Market power is defined as “the ability of a firm (or a group of firms, acting jointly) to raise price above the competitive level without losing so many sales so rapidly that the price increase is unprofitable and must be rescinded.” Such power can be assessed only after a “market” has been appropriately designated. The ability to define the relevant product market and determine market power within that market, therefore, is crucial to virtually all antitrust actions in the health care field.


United States v. Terminal Railroad Ass'n, 224 U.S. 383 (1912).
(1) control of the essential facility by a monopolist;
(2) no practicable or reasonable ability to duplicate the essential facility;
(3) the denial of the competitor's use of the facility; and
(4) the feasibility of providing the facility.  

In most cases the first and third requirements are easy to prove; the second requirement may be an area of dispute. The fourth requirement is generally the subject of conflict due to a business justification defense.

At present, refusal to deal actions have been effectively limited to actions under section 1 of the Sherman Act because hospitals and managed care entities operate in highly competitive markets. As a result, in the past several years numerous antitrust cases involving exclusions from managed care entities have been pled as conspiracies under section 1 of the Sherman Act. The reason is simple. When concerted action is present, evidence of market power in the relevant market is unnecessary because courts use a per se standard of review. However, at a minimum, it is still necessary to identify the actual harms resulting from the defendant's exclusionary action, as opposed to simply identifying harm to the plaintiff. Even though section 1 of Sherman Act may lessen the burden of market analysis, demonstrating the necessary conspiracy element presents its own difficulties. In Matsushita Electric Industrial Co. v. Zenith Radio Corporation, the Supreme Court articulated the standard for finding a conspiracy as follows: A plaintiff "must show that the inference of conspiracy is reasonable in light of the competing inferences of independent action or collusive action that could not have harmed the plaintiff." To satisfy the Matsushita standard, a plaintiff typically must

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380 Id. at 516.
381 Section 1 of the Sherman Act provides that "every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several states . . . is declared to be illegal . . ." The Supreme Court has recognized that Congress could not possibly have intended the word "every" to be given a literal interpretation. Thus, most alleged restraints of trade are subject to the "rule of reason," which requires the factfinder to evaluate all relevant market factors and to balance the procompetitive and anticompetitive effects of a challenged restraint to determine whether it restrains competition unreasonably. 15 U.S.C.A. § 1.
382 Todorov v. DCH Healthcare Auth., 921 F.2d 1438, 1455 (11th Cir. 1991)
383 Id.
384 Id.
386 Id. at 586.
show the defendants' alleged exclusionary goal could not have been obtained through independent action. In staff privilege cases, however, both the hospital and the defendant physician often have independent ability and incentives to exclude the plaintiff. If the defendant can demonstrate separate motives for the exclusion, the alleged conspiracy will not survive summary judgment under the Matsushita criteria unless the plaintiff provides direct evidence of conspiracy.

MCO Exclusion of IMGs under Section 1 of the Sherman Act: Conspiracy
A showing of conspiracy may be even more difficult when the defendant is a managed care organization rather than a hospital. Most managed care organizations are generally considered joint ventures and it is well established that restraints on competition are necessary for the joint venture to achieve efficiencies, to control free riders or even to market their product. Indeed, the only way managed care companies can control costs is to selectively contract with providers, thereby establishing a competitive bid situation reducing cost. For this reason, it is an accepted fact that courts use the rule of reason standard to analyze alleged conspiracies that restrain trade by a joint venture. This standard requires an analysis of the market impact relating to the exclusion and consideration of any legitimate business reasons for the exclusion.

MCO Exclusion under Section 2 of the Sherman Act
Because of the difficulties of proving conspiracy under section 1, excluded IMGs should consider whether section 2 is a more appropriate provision under which to bring suit. According to the Supreme Court, an excluded health care provider can bring a claim under section 2 only if two essential elements are present: (1) the possession of monopoly power by an MCO in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen or historic accident.

387 Id.
388 Id. at 576.
389 Id.
390 Matsushita, 475 U.S. at 576.
Traditionally, it is the first element, market power, that has been the primary barrier to unilateral refusal-to-deal claims.392

The Section 2 Conduct Requirement
In evaluating unilateral refusals to deal, one must first consider whether the conduct element can be factually supported before undertaking the more fact-intensive market analysis required to demonstrate the existence of market power. Courts have used two types of tests to evaluate conduct in a section 2 unilateral refusal to deal context: (1) the intent test, and (2) the essential facility test.393 The intent test requires that the plaintiff physician present evidence establishing both an anti-competitive consequence to the alleged exclusion as well as the absence of a legitimate business purpose.394 The intent test was most prominently applied by the Supreme Court in Aspen Skiing Co. v. Aspen Highlands Skiing Corp.395 In Aspen Skiing, the defendant operated three of the four ski areas in Aspen, Colorado.396 The plaintiff operated the fourth.397 For many years the parties offered an "all-Aspen" ski pass that allowed skiers to use all four mountains.398 At some point, the defendant refused to enter into the joint agreement, forcing the plaintiff to market its ski package on its own.399 The defendant made an important change that adversely impacted the market, and in the absence of any legitimate business justification, was liable under section 2.400 Accordingly, the intent test should be used in situations where the hospital or the managed care entity suddenly changes the rules of the game to the detriment of the provider.

The second approach to satisfying the conduct element of a section 2 refusal to deal claim is to demonstrate that the excluded provider is being denied access to an essential facility.401 In an excluded provider case, at least one circuit court has held that a prerequisite to the application of the essential facility test is an absence of legitimate business reasons for

392Id. at 571.
394Id. at 587.
395Id.
396Id.
397Id.
398Aspen Skiing Co., 472 U.S. at 585.
399Id.
400Id.
401Id.
the exclusion. There does not appear to be any principled reason for this prerequisite, and most courts have generally required only the following four elements to establish liability under the essential facility test:

1. control of the essential facility by a monopolist;
2. a competitor’s inability to practically or reasonably duplicate the essential facility;
3. the denial of the use of the facility to a competitor; and
4. the feasibility of providing the facility.

Thus, the essential facility test would require the provider to demonstrate an absence of all viable alternative hospitals or managed care opportunities, and prove that the absence has resulted in an absolute bottleneck following the exclusion. Such a showing will be easier for hospital-based providers such as anesthesiologists, but will be more difficult for clinic-based providers like pediatricians. Moreover, in the managed care context, the essential facility test may be even more difficult to meet because it requires a showing of absolute monopoly power or a showing of similar exclusion from all other managed care products.

Thus, a threshold issue for any excluded provider contemplating a section 2 action is to establish that the exclusion interferes with a genuine ability to provide medical services under either the intent test or the essential facilities test. If this can be demonstrated, the remaining hurdle for the plaintiff is to demonstrate is the defendant’s possession of market power.

**IMGs and MCOs’ Refusal to Deal**

An IMG physician’s membership denial may give rise to a boycott cause of action against the MCO (or network). Lower federal courts have applied the hybrid approach in several boycott cases involving the exclusion of physicians and other health care professionals from a network.

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403 MCI Communications Corp. v. AT&T, 708 F.2d 1081, 1132-33 (7th Cir.), cert. denied, 464 U.S. 891 (1983).
404 Id.
if the network lacks market power and offers legitimate efficiency justifications for the exclusion.\textsuperscript{405}

In an individual violation, for example, a single MCO refuses to deal with one IMG. The court uses the rule of reason test; thus, it would be almost impossible to show violation of antitrust law.\textsuperscript{406} On the other hand, if an MCO or group of MCOs refuses to deal with a group of IMGs, then the courts will probably use the \textit{per se} violation rule; thus, it would be easier to prove illegal violations because of the seriousness of the antitrust violation.\textsuperscript{407} The Court has also applied this formulation in a refusal to deal with a health plan.\textsuperscript{408}

Moreover, if the exclusion of an IMG from a particular contract is based on a unilateral payor decision, then the exclusion might be treated as a vertical boycott and subjected to a less rigid analysis.\textsuperscript{409}

Whatever the level of scrutiny employed by a court, the likelihood of a successful antitrust challenge from the excluded physician is very small. For example in \textit{Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.}\textsuperscript{410} a federal district court in New York held that the exclusion of a radiology practice from participation in an HMO was

\textsuperscript{405}Capital Imaging Assocs. v. Mohawk Valley Med. Assocs., 996 F.2d 537, 546 (2d Cir. 1993) (upholding the use of a rule of reason analysis in an IPA’s exclusion of radiologists due to the IPA’s lack of market power); Hahn v. Oregon Physicians’ Serv., 868 F.2d 1022, 1030-31 (9th Cir. 1989), 868 F.2d at 1030-31 (applying a rule of reason analysis to claims that podiatrists had been excluded from a health plan controlled by physicians, but finding that the refusal to admit podiatrists as a class raised a reasonable inference to refute the defendant’s efficiency justification); Hassan v. Independent Practices Assocs., 698 F. F. Supp. at 693-94 (E.D. Mich. 1988) (allowing an IPA’s exclusion of allergists to escape the \textit{per se} rule by offering legitimate efficiency justifications).

\textsuperscript{406}Hassan, 698 F. Supp. at 693-94.


\textsuperscript{408}In \textit{FTC v. Indiana Federation of Dentists}, 472 U.S. 284, 296-298 (1985), the Supreme Court examined a dental association’s refusal to submit X-rays to insurance companies for utilization review under a truncated rule of reason approach.

\textsuperscript{409}Id.

\textsuperscript{410}In \textit{Capital Imaging Associates, P.C. v. Mohawk Valley Med. Assocs., Inc.}, 791 F. Supp. 956 (N.D.N.Y. 1992), Capital Imaging had applied for, but was denied, membership in an independent practice association of member physicians (IPA), which was organized to provide medical care to an HMO’s policy holders. Capital sued both the IPA and the HMO on the theory that they were engaged in an illegal conspiracy to exclude it from IPA membership to protect the radiologists who were already members of the IPA. Id.
not a violation of antitrust laws. This holding is consistent with at least one earlier decision. In *Barry v. Blue Cross of California*, a federal court of appeals affirmed a lower court's dismissal of the antitrust claims brought by two physicians who argued the agreements between a Blue Cross organization offering medical insurance and the physicians participating in the plan unfairly foreclosed nonparticipating physicians from doing business with patients insured by the plan. In rejecting this claim, the appellate court observed that every contract between a buyer and a seller of services has precisely the effect of which the physicians complained. The court further stated that when a buyer contracts with one seller, the second seller no longer has access to the buyer's business to the extent it is covered by an existing agreement. This consequence, however, is not unlawful.

CONCLUSION

The growing popularity of MCOs and their inherent love/hate relationship with physicians will continue to change the fundamental structure of the health care delivery system. Doing so raises many interesting legal problems ranging from simple contract issues to discrimination and antitrust. During the past few years, while MCOs tended to make the health care delivery system more efficient, they also created major problems for the physicians who maintain independent practices because these physicians no longer have access to most patients. Now, with managed care, physicians' access to patients is on a wholesale basis instead of the traditional retail basis. As MCOs acquire more control over access to patients, physicians run the risk of being deselected from

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411 See Bhan v. NME Hosps., 929 F.2d 1404, 1414 (9th Cir.) (finding exclusion of one nurse-anesthetist insufficient to demonstrate actual detrimental effects), cert. denied, 502 U.S. 994 (1991); Reazin v. Blue Cross & Blue Shield of Kansas, 899 F.2d 951, 960 (10th Cir.) (stating that "the adverse impact must be on competition, not on any individual competitor or on plaintiff's business"), cert. denied, 497 U.S. 1005 (1990).

412 *Barry v. Blue Cross of California*, 805 F.2d 866 (9th Cir. 1986).

413 *Id.*

414 *Id.*

415 *Id.*


physician panels. In particular, specialists depend on referrals from primary care physicians and will find that their ability to practice medicine depends entirely on managed care participation. Moreover, the efficiency gained by managed care delivery systems has resulted in an estimated thirty percent physician oversupply, especially among the specialists. As a result, MCOs who initially signed almost all physicians requesting to be in the plan, are now deselecting or have stopped selecting more physicians to their plan.

This practice appears to have had a disproportionately adverse impact on IMG physicians because they are mostly specialists and have a history of caring for poor and under-served patients who are known to be high risk and more costly to treat. Furthermore, IMGs are often considered second class by their colleagues who were educated in the United States, and over ninety percent of IMGs are foreign born, thus having foreign complexions as well as accents. Considering that many powerful private and government organizations are openly speaking against IMGs, and IMGs as a group are unorganized and are unable to defend themselves, they have became an easy target for MCO managers. At this time, the problem appears to be worse in open panel MCOs, and there is abundant anecdotal evidence in support of the IMGs' claims of disparate treatment.

This article discussed various legal theories available to IMGs, including those based on contract, tort, state laws, anti-discrimination and antitrust statutes. Based on this analysis, state physician fairness statutes appear to be the most helpful laws and may offer some protection for IMGs when they face wrongful exclusion or deselection from an MCO plan. Also, contract law, especially the good faith dealing and public policy doctrine could offer some remedy to IMGs. Anti-discrimination and antitrust statutes may be used successfully if more than one IMG was discriminated against.

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418 Id.
420 Id.
421 Id.
422 Id.
423 Id.
424 Id.
425 Korenchuk, supra note 419, at 3.
It should be noted that the foregoing discussion, with the exception of the anti-discrimination statutes, could apply to any physician regardless of his race, gender, national origin or country of medical education. Moreover, if a physician is protected under Title VII, then the anti-discrimination statutes will also apply. Accordingly, discrimination need not be tolerated by any physician involved in today's managed health care environment.