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Hospital Medical Staff Privileges

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HOSPITAL MEDICAL STAFF PRIVILEGES

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THE CHANGING ROLE OF THE HOSPITAL: RESPONSIBILITY FOR QUALITY CARE

THE ROLE of the private non-profit, community hospital has been changing rapidly as evidenced by the trend of economic, social, and legal events. It is clear that the expectations of the public shape legal developments. The hospital is becoming a community health center in response to public demand, and correspondingly, the legal position of the institution is undergoing fundamental changes which must be clearly recognized by those responsible for day-to-day management.

Perhaps the two most crucial legal matters currently on the minds of hospital trustees, administrators, physicians, and attorneys are cases involving hospital liability for negligence and controversies concerning medical staff privileges. These legal problems are inevitably interrelated. The first, hospital liability, has been reviewed recently elsewhere.[1] It is the primary purpose of this article to discuss some of the recent decisions concerning the rights of a physician to attain and retain medical staff privileges.

On one hand, the liability decisions have recognized that failure on the part of the hospital as a corporate institution to adequately control

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[1] *E.g.*, Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MARSH. L. REV. 146 (1968).

medical staff appointments and privileges, to "supervise" the attending physician, to require the attending doctor to seek consultation in problem cases, and even failure to remove him from a case in an extreme situation may result in legal liability for corporate negligence. In other words, the ultimate responsibility for the quality of patient care rests squarely on the hospital's governing board.[2]

The very purpose of a non-profit community hospital is to provide patient care of the highest possible quality. Accordingly, to implement this duty of providing competent medical care to the patient, it is the responsibility of the corporate institution to create a workable system whereby the medical staff of a hospital continually reviews and evaluates the quality of care being rendered within the institution. The staff must be well organized with a proper committee structure to carry out this role delegated to it by the governing body. All powers of the medical staff flow from the board of trustees and the staff must be held strictly accountable for its control of quality.

A hospital, therefore, does not consist of two organizations—business administration and medical. The medical cannot be separated from the business activities. Rather, a hospital is a single organization. All who serve the hospital must recognize this concept, especially the practicing attorney who advises the institution. Inevitably then, smooth and harmonious co-ordination between business administration and medical administration is an absolute necessity. The organizational structure of the medical staff, lines of communication among medical staff committees and between the board of trustees and medical staff, areas of responsibility, and the site of ultimate authority must be well expressed in the medical staff and hospital by-laws. The hospital attorney should play a key role in making this clear.

The concept of corporate responsibility for the quality of medical care, so forcefully advanced in the case of *Darling v. Charleston Community Memorial Hospital*,[3] is also recognized in the 1968 Michigan Hospital Licensure Statute.[4] Section 12(1) states unequivocally that "the governing body of each hospital shall be responsible for the operation of the hospital, the selection of the medical staff, and for the

[2] Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

[3] *Id.*

[4] MICH. STAT. ANN. § 14.1179 (1968).

quality of care rendered in the hospital." Moreover, the statute recites that the governing body shall:

> insure that physicians admitted to practice in the hospital are granted hospital privileges consistent with their individual training, experience, and other qualifications; and insure that physicians admitted to practice in the hospital are organized into a medical staff in such a manner as to effectively review the professional practices of the hospital for the purposes of reducing morbidity and mortality and for the improvement of the care of patients provided in the institution.[5]

Why has this concept developed in the 1960's in both case and statutory legal pronouncements? As noted at the outset, the role of the hospital vis-à-vis the community is changing rapidly, although some physicians, administrators, and attorneys have been slow in recognizing the change. Nevertheless, medical practice has inevitably become increasingly institutionalized with the physician dependent upon the hospital and the hospital dependent upon the doctor. Specialization of practice and the need for consultation leads inevitably to institutionalization. Moreover, the hospital's emergency room services, out-patient services, and diagnostic services all continue to expand rapidly; hospital based home-care programs are being developed; and contractual arrangements with extended care facilities are increasing in number and significance, the need having been accelerated by Medicare. In short, the hospital's role is no longer limited to the furnishing of physical facilities and equipment, whereby a physician treats his private patients and practices his profession in his own individualized manner. The hospital is no longer simply a place to house the acutely ill. As the hospital matures and develops into a true community health center, the legal result is the expansion of institutional responsibility for the quality of patient care. This is as it should be.[6]

With respect to the hospital-physician relationship, two interrelated issues emerge. The first is administrative or managerial in nature: how can the physician best be integrated into the picture of hospital management thereby facilitating his institutional responsibility and loyalty?[7] The second issue is more legal in nature: what are the rights of a licensed physician to attain and retain a hospital staff appointment?

[5] *Id.*

[6] A relevant recent article is Rosenberger, *Hospitals: Focus of the Search for Better Health Care*, 42 J. AM. HOSP. ASS. 50-55 (1968).

[7] *See, e.g.*, Crosby, *The Physician's Place in Health Care Administration*, 42 J. AM. HOSP. ASS. 47-49, 121 (1968).

It is clear that affiliation with a hospital is absolutely indispensable to the American doctor. Without staff privileges the physician is severely handicapped in practice and suffers an irreparable financial detriment.

In a sense, both case and statutory law surrounding the related problems of hospital liability and medical staff privileges are caught in a dilemma. How should American legal doctrines balance the sometimes conflicting interests and public policies? On one hand, as has been amply demonstrated for our purposes here, responsibility for adequate control of the quality of care is placed on the hospital. On the other, it is generally in the public interest to maximize the individual freedom of the licensed physician to practice his profession. Are these propositions irreconcilable? Control of quality implies, perhaps, maximum discretion on the part of the hospital in selecting staff physicians and in regulating their professional practice. Individual freedom to practice implies the opposite—an absence of hospital control with respect to medical staff appointments and a minimum of discretion in controlling the scope of individual privileges once a doctor has gained appointment.

MEDICAL STAFF APPOINTMENTS IN THE PUBLIC HOSPITAL

At the outset it can be noted that neither case nor statutory law of the United States has ever given a licensed physician an absolute legal right to attain or retain medical staff membership or privileges in either a public (governmental) hospital or a private, non-profit (voluntary) hospital, although efforts have sometimes been made to create such a right.[8] State medical licensing laws certainly do not constitute a satisfactory vehicle for establishing and controlling professional standards. In the first place, licensing statutes are notorious for specifying only minimal qualifications for the practice of medicine. They often make no satisfactory distinctions between or among various schools of medicine. Moreover, the disciplinary powers of the state licensing board are often quite limited in law or in fact. Licensing furnishes no continuing control with respect to an individual's professional competence; the statutes in no way recognize the demands placed upon the doctor by the ever increasing specialization of medicine, and accordingly, do not adequately protect the public from in-

[8] *E.g.*, two bills were introduced in 1968 in the Michigan Legislature to this effect. H.B. 3707, H.B. 3822.

competence. Hence, protection of the public must come from some other authority, usually, the governing body of the individual hospital. Furthermore, the present licensing statutes for physicians, nurses and other professional personnel impede rather than facilitate improvements in the quality of health care by failing to clarify scope-of-practice problems.[9]

In deciding medical staff privilege cases, the courts have traditionally drawn a distinction between the public or governmental hospitals and the private or voluntary hospitals. Thus, the governing body of a public hospital has always been under a duty not to act arbitrarily, capriciously, or unreasonably in granting, withholding, or restricting medical staff privileges. The case law has always indicated that a publicly owned hospital must have well stated, reasonable rules regarding staff appointments and also fair procedures pertaining to enforcement of the rules. Without question, the courts will inquire into the reasonableness of a given rule at issue, and will also require that due process of law be extended in hospital enforcement proceedings. Therefore, an individual physician may succeed in court by attacking a given rule as unreasonable, or, even if the rule is reasonable, he may succeed on the basis that he was denied procedural due process.

By way of contrast, historically, the courts have generally accorded the governing body of a private, voluntary hospital a far greater measure of discretion in selecting members of the medical staff. The courts have been far slower to inquire into the reasonableness of a rule pertaining to staff privileges and have not in general required procedural fairness, unless the hospital by-laws provide affirmatively for procedural steps such as a hearing upon initial application for staff appointment or notice and hearing upon failure to re-appoint. The judicial attitude has traditionally recognized that a private hospital can select staff members and discipline physicians on any basis the governing body determines, and the court will not interfere in the exercise of this discretion. Recent cases and a few statutes have cast grave doubt upon the permanence of this approach to the medical staff affairs of a private, non-profit hospital, and the clear trend of the law, statutory and case, reflects a narrowing of the line of distinction between public and private hospitals.

Illustrative of the traditional distinction between governmental and

[9] Forgotson and Cook, *Innovations and Experiments in Uses of Health Manpower—The Effect of Licensure Laws*, 1967 LAW & CONTEMP. PROB. 731.

voluntary hospitals is the case of *Group Health Co-operative v. King County Medical Society*.[10] In that case, it was said to be unreasonable for a public hospital to declare a physician who practices "contract medicine" to be ineligible for staff membership, and the exclusionary action was enjoined. The court, however, refused to grant relief to the same doctor who had also been excluded from a private hospital.

Over the years a number of cases involving controversies between governmental hospitals and physicians have accumulated. All the following rules and regulations have been held to be unreasonable, or arbitrary, or too vague and incapable of objective enforcement, and hence have been struck down: a requirement that staff physicians be members of the local medical society;[11] a rule that the board of the hospital must be satisfied that patients will be given the best possible care before an individual is given staff privileges;[12] a rule requiring staff doctors to carry malpractice insurance;[13] a rule stating that the doctor who seeks admission to a public hospital staff must first obtain an appointment at a private hospital;[14] a staff by-law which authorized the executive committee to reduce privileges "if in the opinion of such committee it appears that such a reduction would be in the best interests of the hospital and its patients."[15] The latter rule allowed the executive committee to reduce an individual's "privileges according to their whim or caprice, subject only to appeal to the staff and ultimately to the board, whose powers of review are equally arbitrary."[16] In the case of *Milford v. People's Community Hospital Authority*,[17] the Michigan court found that a suspended physician had been denied procedural due process of law, and held that he was entitled to a reasonably definite statement of the charges against him, notice of a hearing, the opportunity to be fully heard, the right to cross-examine witnesses, and the right to produce

[10] 39 Wash. 2d 586, 237 P.2d 737 (1951).

[11] Foster v. Mobile County Hosp. Bd., 398 F.2d 227 (5th Cir. 1968); Ware v. Benedikt, 225 Ark. 185, 280 S.W.2d 234 (1955); Hamilton County Hosp. v. Andrews, 227 Ind. 217, 84 N.E.2d 469 (1949).

[12] Wyatt v. Tahoe Forest Hosp. Dist., 174 Cal. App. 2d 709, 345 P.2d 93 (1959) (rule too vague, thus inviting arbitrary action).

[13] Rosner v. Peninsula Hosp. Dist., 224 Cal. App. 2d 115, 36 Cal. Rptr. 332 (1964).

[14] Bronaugh v. City of Parkersburg, 148 W. Va. 568, 136 S.E.2d 783 (1964).

[15] Milford v. People's Community Hosp. Authority, 380 Mich. 49, 155 N.W.2d 835 (1968).

[16] *Id.* at 62, 155 N.W.2d at 841.

[17] *Supra* note 15.

witnesses in his own behalf. In the California case of *Rosner v. Eden Township Hospital District*,[18] the court invalidated a by-law which required an applicant for staff membership to be "temperamentally and psychologically suited for cooperative staff hospital functions."[19]

Implicit in several of these cases is the proposition that the governing body of the public hospital may not have rules which, in practical effect, delegate responsibility for determining qualifications for staff appointment to an outside group, such as a medical society or a malpractice insurance carrier. Also, statutes bearing on the affairs of a governmental hospital had an impact in some of the cited cases supporting holdings that the board must not act arbitrarily and unreasonably. By way of further example, an Indiana statute provides that:

> Any hospital supported by funds provided by a county . . . shall provide the use of its facilities to all taxpayers . . . under the care of the physician of their choice if such physician possesses a license without limitations . . . . Provided, that the provisions of this act shall not deprive the governing board of such a hospital of the right to adopt and enforce reasonable rules and regulations concerning the use of such hospitals and its facilities by such physicians.[20]

Rules requiring an applicant to be a graduate of a school of medicine approved by the American Medical Association and to have completed a one-year internship in a hospital accredited by the Joint Commission on Accreditation of Hospitals were declared to be unreasonable by the Indiana Appellate Court.[21]

Clearly, no public hospital or private institution receiving financial aid under the federal Hill-Burton or Medicare legislation can discriminate in medical staff appointments on the basis of race, color, creed, or national origin.[22] To so discriminate not only violates specific statutory prohibitions but also violates the equal protection clause of the fourteenth amendment.[23]

A governmental hospital, however, may exercise a considerable de-

[18] 58 Cal. 2d 592, 375 P.2d 431 (1962).

[19] *Id.* at 596, 375 P.2d at 433.

[20] IND. ANN. STAT. § 22-3314 (1964).

[21] McCray Memorial Hosp. v. Hall, 226 N.E.2d 915 (Ind. App. 1967).

[22] Civil Rights Act of 1964, 42 U.S.C.A. § 2000(d) (Supp. 1966); 42 U.S.C.A. § 1395 *et seq.* (Supp. 1966).

[23] Foster v. Mobile County Hosp. Bd., *supra* note 11; Meredith v. Allen County War Memorial Hosp., 397 F.2d 33 (6th Cir. 1968); Eaton v. Grubbs, 329 F.2d 710 (4th Cir. 1964); Simkins v. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

gree of discretion with respect to medical staff appointments and privileges when the motive is to enhance the quality of care and when the physician is extended due process of the law. For example, it has been held to be proper for a governmental hospital to have and enforce rules regarding the maintenance and completion of medical records.[24] Rules stating well-recognized professional qualifications as a prerequisite for defined privileges will be upheld by the courts as long as they are reasonable, definite, certain and capable of objective application.[25] The key to validity of a particular rule is apparently that it be related to individual qualifications to perform professionally the particular privileges sought or held by the physician. In the formulation of the rules, which should be stated in the hospital by-laws or the medical staff by-laws adopted by the governing board, the board may rely upon professional standards recommended by the medical staff. Thus, in *Selden v. City of Sterling*,[26] the court approved a rule which stated that an associate medical staff member could not perform major surgery without having a full staff member in attendance.

Similarly, in the interests of patient care, a governmental hospital may have a closed staff in the radiology department as long as the reasons for such a decision can be adequately documented.[27] Does a like philosophy prevail with respect to practitioners who do not possess an M.D. degree? In the majority of states, at present, the governing body of a public hospital can deny privileges to licensed osteopathic doctors and to members of other schools of the healing arts.[28] With respect to osteopathic physicians, however, legislation is an important consideration. If the licensing statutes and other legislation equate doctors of medicine and osteopathy, it is then recognized that the osteopathic physician must be accorded equal rights and opportunities based upon

[24] Board of Trustees of the Memorial Hosp. v. Pratt, 72 Wyo. 120, 262 P.2d 682 (1953).

[25] Green v. City of St. Petersburg, 154 Fla., 399, 17 So. 2d 517 (1944); Selden v. City of Sterling, 316 Ill. App. 455, 45 N.E.2d 329 (1942); Jacobs v. Martin, 20 N.J. Super. 531, 90 A.2d 151 (1952).

[26] 316 Ill. App. 455, 45 N.E.2d 329 (1942).

[27] Rush v. City of St. Petersburg, 205 So. 2d 11 (Fla. App. 1967); Benell v. City of Virginia, 258 Minn. 559, 104 N.W.2d 633 (1960). *See also*, Letsch v. County Hosp., 246 Cal. App. 2d 673, 55 Cal. Rptr. 118 (1966); Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).

[28] Hayman v. City of Galveston, 273 U.S. 414 (1927). Exclusion does not violate equal protection clause of fourteenth amendment.

his individual training and qualifications.[29] As the trend toward "merger" of the medical and osteopathic professions continues, as has occured in California, it will likely be more difficult for the boards of individual hospitals to exclude osteopathic physicians. Likewise, statutory enactments are crucial in determining the rights of chiropractors to practice in governmental institutions. For example, the statutes of North Carolina and North Dakota extend to chiropractors the right to practice in public hospitals within the scope of other licenses.[30] On the other hand, the statutes of Oklahoma make a clear distinction between "physicians" and chiropractors, and, accordingly, the latter can be excluded from the staff of a county hospital.[31]

A public hospital, again in the interests of quality patient care, may discipline, suspend, or refuse to reappoint a staff physician if there is sufficient evidence of incompetence or intolerable behavior.[32] In *Koelling v. Skiff Memorial Hospital*,[33] the Iowa court upheld an indefinite suspension of a staff physician charged with the preparation of deceptive and misleading medical records, the giving of fabricated, inconsistent explanations for his handling of a case, and the rendering of seriously inadequate medical care. The physician is entitled to, and was accorded in the *Koelling* case, a hearing, the right to defend himself, the right to present proof, and the right to cross-examine witnesses. The disposition of the problem by the hospital authorities in the *Koelling* litigation should be carefully compared with the procedures followed in the *Milford* case. The true issues in both cases would seem to be the same—whether a reasonable, objective standard of medical prac-

[29] Stribling v. Jolley, 253 S.W.2d 519 (Mo. 1952). A new Wisconsin statute, WIS. STAT. ANN. ch. 222 § 140.27(2) (1967), prohibits denial of hospital staff privileges to any licensed physician solely on the basis that he is an osteopath. The crucial importance of statutory law with respect to the rights of osteopathic physicians is also illustrated by *Taylor v. Horn*, 189 So. 2d 198 (Fla. App. 1966).

[30] N.C. GEN. STAT. § 90-153 (1965); N.D. REV. CODE §§ 43-06-17, 43-14-23 (1960). These statutes also apply to private hospitals.

[31] Boos v. Donnell, 421 P.2d 644 (Okla. 1966).

[32] *See, e.g.*, Mizell v. North Broward Hosp. Dist., 175 So. 2d 583 (Fla. App. 1965). Proof that the frequency of a physician's erroneous diagnoses was excessive is an adequate basis for suspension of surgical privileges.

[33] 259 Iowa 1185, 146 N.W.2d 284 (1966). *See also* Anderson v. Caro Community Hosp., 10 Mich. App. 348, 159 N.W.2d 347 (1968), where the Michigan Appellate Court upheld the right of a public hospital to dismiss a staff physician who was extended the right of a hearing, where his documented behavior clearly violated adequately defined standards of conduct.

tice in the genuine interests of quality care had been adopted by the governing body, and then whether the physician subject to disciplinary action had been accorded due process of law. In short, a licensed physician cannot be charged with the violation of a non-existent standard, nor can he be deprived of procedural safeguards. Having first adopted recognized professional standards capable of objective application for the control of medical practice and personal behavior within the hospital, the governing body of the governmental hospital must then be certain that in all situations involving medical staff appointments and privileges proper hearings are conducted on the merits of each individual situation. Both the standards and the procedural safeguards should be clearly provided for in the medical staff by-laws adopted by the governing board.

MEDICAL STAFF APPOINTMENTS IN THE PRIVATE NON-PROFIT HOSPITAL

The foregoing is also good advice for the private, voluntary hospital because the fundamental trend of the law in some jurisdictions points in the direction of equating public and private institutions. Important court decisions have recognized the changing role of the private non-profit hospital, speaking in terms of "public interest." Moreover, state statutes dealing with particular issues, such as the rights of osteopathic physicians vis-à-vis the private hospital, are appearing with increasing frequency.[84] Constitutional law has become significant by prohibiting racial and other types of discrimination. The licensed physician can allege an unlawful restraint of trade or malicious interference with his right to practice when he is excluded from a private hospital. All four of these relatively recent developments have the effect of reducing the range of freedom and discretion previously enjoyed by the voluntary hospital's governing body in appointing, or reappointing, staff physicians. Correspondingly, the doctor's ability to gain privileges has been considerably enhanced.

Historically and traditionally, the posture of the courts has been that a voluntary hospital is a private institution, and hence, the governing body could adopt and enforce whatever rules it wished in order to control staff appointments and privileges. The range of discretion extended

[84] *See, e.g.*, WIS. STAT. ANN. ch. 222 § 140.27(2) (1967). Private as well as public hospitals may not deny staff privileges to a physician solely on the basis that he is an osteopath.

to the hospital board of trustees by this traditional approach is almost unlimited and absolute.[35] In other words, the courts have hesitated to inquire into the issue of whether or not a rule concerning appointments is arbitrary or unreasonable. Procedurally, an applicant for a staff appointment, or a staff physician not to be reappointed or subject to discipline, has not been entitled to a hearing or other procedural safeguards unless the by-laws of the hospital affirmatively provide for such safeguards.

Receipt of federal funds through the Hill-Burton program, or receipt of tax revenues from state or local governments, or tax-free status, do not *ipso facto* change the private status of a voluntary hospital and accordingly, do not bring into play the rules pertaining to a governmental hospital.[36] The recent cases of *Shulman v. Washington Hospital Center*[37] and *Foote v. Community Hospital of Beloit*[38] reaffirm the traditional approach, granting to the voluntary hospital's governing board a nearly absolute discretion in denying staff privileges, provided only that voluntarily adopted by-law requirements relative to procedural safeguards be followed. In the *Foote* case the Kansas court indicated that it was not necessary for the hospital to grant a hearing to an applicant for a staff position. It was proper to give a summary judgment for the hospital which denied the doctor privileges.[39] In other words, the decision of the hospital's governing board is final and not subject to judicial review.[40]

[35] *See* West Coast Hosp. v. Hoare, 64 So. 2d 293 (Fla. 1953); Levin v. Sinai Hosp., 186 Md. 174, 46 A.2d 298 (1946); State v. LaCrosse Lutheran Hosp. Ass'n, 181 Wis. 33, 193 N.W. 994 (1923).

[36] *See* Shulman v. Washington Hosp. Center, 222 F. Supp. 59 (D.D.C. 1963); West Coast Hosp. v. Hoare, *supra* note 35; Halberstadt v. Kissane, 51 Misc. 2d 634, 273 N.Y.S.2d 601 (Sup. Ct. 1966).

[37] Shulman v. Washington Hosp. Center, *supra* note 36.

[38] Foote v. Community Hosp., 195 Kan. 385, 405 P.2d 423 (1965).

[39] *Id.* A sequel to this case is *Kansas State Board of Healing Arts v. Foote*, 200 Kan. 447, 436 P.2d 828 (1968), where the Supreme Court of Kansas upheld the Board of Healing Arts decision in revoking Dr. Foote's license to practice for "extreme incompetency," even though the statute authorizing revocation for unprofessional conduct did not specifically itemize incompetency as embraced within unprofessional conduct. Under a similar statute the Attorney General of Michigan rendered an opinion contrary to the *Foote* case. *Opinion of the Michigan Attorney General*, No. 4423 (1967). This opinion would appear to support the author's assertion earlier in this paper that medical licensing laws are not adequate to cope with the problem of the quality of medical care rendered within hospitals. *See* note and text, *supra* note 9.

[40] *See also* Sams v. Ohio Valley General Hosp. Ass'n, 149 W. Va. 229, 140 S.E.2d 457 (1965), where the doctor was apparently denied staff privileges as a consequence of his participation in a closed panel group practice, although such was never formally stated as a reason for his exclusion.

Citing *Shulman, Sams v. Ohio Valley General Hospital Association*,[41] and earlier cases, the Illinois Appellate Court has also recently restated this traditional approach.[42] The hospital rejected an application from an osteopathic physician because his two physician references were unable, or unwilling, to comment upon his professional capabilities, and furthermore, the applicant possessed an educational background lacking an undergraduate degree. The court upheld the rejection, stating, "We refuse to substitute our judgment for that of the hospital authorities regarding the acceptance of the plaintiff for staff membership in a private hospital."[43] Significantly, the court observed that: "[T]his doctrine is all the more fitting by virtue of the current Illinois law imposing potential liability on a hospital for the imprudent or careless selection of its staff members without limitation to the amount of its liability insurance."[44] There was no problem of unlawful monopoly, the court said, because there were other hospitals in the geographical area available to the plaintiff.

In 1963, however, the New Jersey court departed from the traditional judicial attitude in the case of *Griesman v. Newcomb Hospital*.[45] The case could eventually take its place in history as the basis for a new philosophy with respect to medical staff privileges in a private, non-profit hospital. The court invalidated by-law requirements that all staff physicians be graduates of a medical school approved by the American Medical Association and be members of the county medical society. Specifically, the court held that the voluntary hospital must at least consider the application of an osteopathic physician. In reaching this conclusion, the case relied heavily upon *Falcone v. Middlesex County Medical Society*[46] which had determined that the defendant's

[41] *Id.*

[42] Mauer v. Highland Park Hosp. Foundation, 90 Ill. App. 2d 409, 232 N.E.2d 776 (1967).

[43] *Id.* at 415, 232 N.E.2d at 779.

[44] *Id.*, citing Darling v. Charleston Community Memorial Hosp., *supra* note 2.

[45] 40 N.J. 389, 192 A.2d 817 (1963).

[46] 34 N.J. 582, 170 A.2d 791 (1961). *See* a similar decision in *Blende v. Maricopa County Medical Society*, 96 Ariz. 240, 393 P.2d 926 (1964), where the court ruled that a local medical society cannot arbitrarily deny membership if there is a relationship between society membership and hospital staff privileges. But later litigation established that there was no definite, formal relationship between society membership and hospital staff privileges, and, therefore, the society could not be required to admit the doctor to membership. Maricopa County Medical Soc'y v. Blende, 5 Ariz. App. 454, 427 P.2d 946 (1967).

denial of medical society membership to a licensed osteopathic physician was in violation of the state's public policy. The *Griesman* case indicated that a private hospital is vested with a public interest through its purpose of serving the ill and possesses a fiduciary relationship to the community. This is especially true where the hospital is the sole institution in the immediate geographical area, thus constituting a monopoly. Accordingly, the New Jersey court has indicated its willingness to inquire into the reasonableness of a rule pertaining to staff privileges, and to strike down the rule, if the court finds it to be arbitrary and not necessarily directly related to standards of patient care and the situation of an individual doctor.

Following *Griesman*, New Jersey held that a voluntary hospital could not refuse an applicant without giving him the opportunity for a hearing and the opportunity to learn the reasons for his rejection.[47] The hearing need not be in the nature of a courtroom trial, but the applicant has the right to appear in person if he wishes and present evidence and witnesses in his behalf. An appeal procedure should be provided. This, of course, does not mean that all applicants must be admitted to hospital privileges. It was proper to defer the application of an osteopathic physician where the evidence showed that his academic record was only fair, where there was an absence of post-graduate training, and where the applicant had privileges elsewhere.[48] In other words, these New Jersey cases have established that all applications must be fully considered and evaluated and that all applicants are entitled to fair consideration in accordance with due process of law.

Courts other than those of New Jersey are speaking in terms of procedural due process and unreasonable, capricious and discriminatory action when considering the range of discretion allowed a private hospital in appointment and reappointment of staff physicians.[49] The implication is that the court will intervene on behalf of the doctor if it finds the hospital's action to be unreasonable, or arbitrary, or pro-

[47] Sussman v. Overlook Hosp. Ass'n, 95 N.J. Super. 418, 231 A.2d 389 (1967).

[48] Schneir v. Englewood Hosp. Ass'n, 91 N.J. Super. 527, 221 A.2d 559 (1966).

[49] Woodard v. Porter Hosp., 125 Vt. 419, 217 A.2d 37 (1966). *See* Hagan v. Osetopathic General Hosp., 232 A.2d 596 (R.I. 1967) (where the court held for the hospital in a privilege controversy, stressing that due process of law had been observed and that there were adequate reasons for rejection of the applicant); Halberstadt v. Kissane, *supra* note 36 (a case involving restriction and suspension of privileges for alleged professional incompetence).

cedurally inconsistent with fairness and objectivity. Essentially then, the position of the voluntary hospital is being equated in New Jersey and perhaps other jurisdictions with that of the governmental institution.

Consistent with this judicial attitude enhancing the physician's ability to gain staff privileges in a private, non-profit hospital and guaranteeing procedural safeguards are state statutes which restrict the discretionary powers of the hospital's board of trustees. The Wisconsin statute prohibiting discrimination against osteopathic physicians has been referred to earlier.[50] A Louisiana statute provides that a voluntary hospital may not deny medical staff membership solely because of participation in group practice or lack of membership in a specialty body or professional society.[51] In the same spirit of non-discrimination, both public and private hospitals in New York may not deny staff membership to a participant in group practice or a non-profit health insurance plan.[52] Hospital counsel must be alert to these relatively recent statutory developments.

State common law pertaining to unlawful restraints of trade can be used as a legal theory, or vehicle, to attack a voluntary hospital's arbitrary denial of medical staff privileges. The action can be brought against individual members of the board of trustees on the medical staff, as well as the hospital corporation, when a trustee or corporation prevents admission to hospital practice due to criteria other than the plaintiff's professional qualifications or standards of patient care.[53] In such an action the major problem consists of balancing the respective interests of the physician to practice his profession and of the hospital in regulating his practice. Certainly, public policy must play a large role in the court's approach. In *Blank v. Palo Alto-Stanford Hospital Center*,[54] the court held that an exclusive privilege contract with a group of radiologists for the operation of a hospital's radiology department did not violate the California restraint of trade concepts when it

[50] *Supra* note 34.

[51] LA. REV. STAT. ANN. § 37:1301 (1964).

[52] N.Y. PUB. HEALTH LAW, § 206a (Supp. 1966).

[53] Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. App. 2d 806, 376 P.2d 568 (1962).

[54] 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965). *See also* Rush v. City of St. Petersburg, 205 So. 2d 11 (Fla. 1967) (where the court rejected the plaintiff's argument that an exclusive privilege contract with a medical specialist constituted illegal corporate practice of medicine); Letsch v. Northern San Diego County Hosp. Dist., *supra* note 27.

was established that the contract was entered into to assure high quality care, thus being in the best interests of both the public and the hospital's medical staff. In general, statutory enactments regarding restraint of trade cannot be used as a basis for a private cause of action for either the reason that medical practice does not constitute a "trade" under statutory definitions, or the reason that the doctor is unable to show an injury to the public, thereby falling outside the purpose of such statutes.[55]

Interference with a physician's right to practice, committed maliciously, constitutes a cause of action.[56] There is never a privilege to act with malice. Accordingly, where it was established that certain doctors were motivated by their own financial interests in preventing the plaintiff from obtaining staff privileges in the single hospital in the county, an action could be brought against the hospital, the doctors, and the individuals on the governing body.[57]

The climate of our times and the moral and legal trends are rather clear: A community voluntary hospital is never strictly private in character and influence. It is perfectly evident that social and economic factors shape law and public policy; the result inevitably is that the non-profit hospital should consider itself to be at least a quasi-public institution with positive responsibilities to the public and members of the medical profession. The line of New Jersey cases emphasizes the court's willingness to judicially review the hospital's decision-making process, applying standards of reasonableness and fairness. State stautory pronouncements prohibiting specified forms of arbitrary discrimination against particular individuals or classes of licensed physicians are appearing more frequently. Moreover, as federal and local governmental financing increases, constitutional law plays an increasing role in medical staff privilege controversies. Even prior to the Civil Rights Act of 1964, which specifically prohibits all hospitals from discriminating on the basis of race, color, creed, or national origin, and the Medicare legislation with similar provisions,[58] the federal courts had decided that a private hospital receiving Hill-Burton funds could

[55] Riggall v. Washington County Medical Soc'y, 249 F.2d 266 (8th Cir. 1957).

[56] Raymond v. Cregar, 38 N.J. 472, 185 A.2d 856 (1962).

[57] Cowan v. Gibson, 392 S.W.2d 307 (Mo. 1965). *See also* Burkhart v. Community Medical Center, 432 S.W.2d 433 (Ky. App. 1968).

[58] *Supra* note 22.

not discriminate on the basis of race or creed.[59] The same result followed, aside from the federal Hill-Burton program, where a local governmental unit had appointed the members of the original governing board of a private hospital, where certain local taxes were appropriated to the hospital's use, and where the deed to the hospital's land provided for title to revert to the county if hospital use should cease.[60] In both cases the discrimination was found to be "state action" denying equal protection of the laws and hence in conflict with the fourteenth amendment to the Constitution.

Moreover, the state action concept applies to forms of discrimination other than racial. The fourteenth amendment prohibits all forms of discriminatory decision making; thus, a private hospital receiving federal Hill-Burton funds may not exclude doctors participating in a prepaid group practice plan solely on that basis.[61]

In conclusion, hospital counsel should advise that the sole, overall guideline for policy with respect to medical staff appointments and privileges must be simply the quality of hospital care to be rendered to the community. Each individual physician should be considered on the basis of his professional qualifications, training, experience, and behavior. He should be accorded procedural fairness and due process of law. All forms of unreasonable, arbitrary, and discriminatory decision-making must be eliminated. It is suggested, for example, that a medical staff privilege controversy decided by the hospital solely on the basis of economic considerations, or on alleged lack of bed space, without reference to the physician's professional training and experience and the needs of his patients and in the absence of clear proof that hospital overcrowding would seriously interfere with patient care, could well be reviewed and reversed by a court following the New Jersey line of decisions on the reasoning that such an exclusion from the hospital represented arbitrary and unreasonable action.

Hospital and medical staff by-laws controlling privileges must be brought up to date and should be precise, concise, and reasonably related to professional excellence. Ideally, each new applicant for appointment should be given an opportunity for a hearing, focusing upon

[59] Simkins v. Cone Memorial Hosp., *supra* note 23.

[60] Eaton v. Grubbs, *supra* note 23.

[61] Sams v. Ohio Valley General Hosp. Ass'n, 257 F. Supp. 369 (D. W. Va. 1966). *Cf* the state court litigation involving Dr. Sams, Sams v. Ohio Valley Gen. Hosp. Ass'n, *supra* note 40.

his professional qualifications and abilities. Certainly, a current member of the staff who is not to be reappointed or whose privileges are to be restricted should be provided a hearing before the appropriate medical staff committee which would then make recommendations to the governing body of the hospital on the basis of the evidence gathered. Applications for appointment and disciplinary cases should not be finally determined by the chief of the medical staff, or a committee of the staff, for such a procedure would be an abdication by the board of trustees of its ultimate responsibility for standards of hospital care. Hence, an active and responsible medical staff credentials committee is a necessity for every community hospital, even a small institution. By the same token, regular, objective review of the tissue committee reports will furnish evidence of competence, or incompetence, and thereby support the governing board's action in individual disciplinary cases.

It is to be hoped that the case law will fully protect and sanction sincere, bona fide efforts to establish and maintain professional standards. In the light of the hospital liability cases and the new Michigan Hospital Licensing Statute,[62] courts must protect the ability of hospital management to strive for excellence. But in so doing, the law must also concern itself with the balancing of sometimes competing interests, in the promotion of fairness and justice for the individual physician.

The modern concept of justice and fairness is well illustrated by the litigation in *Cypress v. Newport News General and Non-Sectarian Hospital Association*.[63] The private voluntary hospital refused a Negro doctor's application for medical staff membership. The refusal was by secret ballot of the medical staff and without a hearing. As a matter of fact, the hospital's medical staff had no Negro physicians. Although the burden of proving discrimination rests upon the plaintiff physician, the district court said that the circumstances presented an inference of discrimination requiring rebuttal by the hospital.[64] Rebuttal can be accomplished by a reasonable explanation that racial discrimination was not involved in the denial of hospital privileges. Therefore, a hearing to establish professional competence was required although it need not be public, nor need the procedure adhere to the legal rules of evidence.

[62] *Supra* note 4.

[63] 251 F. Supp. 667 (E.D. Va. 1966), *rev'd*, 375 F.2d 648 (4th Cir. 1967).

[64] Cypress v. Newport News General and Non-Sectarian Hosp. Ass'n, 251 F. Supp. 667, 673 (E.D. Va. 1966).

The circuit court reversed the district court in part and went further by saying that a hearing would likely prove meaningless in view of the medical staff's past record.[65] Even after a hearing, it was highly unlikely that a Negro applicant would receive a three-fourths majority vote from the over 100 white physicians on the staff as required in the hospital by-laws. Accordingly, in effect, the circuit court struck down these by-law provisions which facilitated discriminatory conduct and ordered the hospital to admit the doctor. This litigation, of course, involved alleged racial discrimination by a hospital receiving federal financial assistance. But the reasoning process leading to the invalidation of by-law provisions could well be applied to other forms of arbitrary, discriminatory decision-making in medical staff privilege controversies. The attitudes of some influential courts indicate forcefully that the trend in public policy is to open more widely the doors of the voluntary hospital to the practicing physician.

[65] Cypress v. Newport News General and Non-Sectarian Hosp. Ass'n, 375 F.2d 648, 655 (4th Cir. 1967).