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The Medical Staff Privileges Problem in Florida

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THE MEDICAL STAFF PRIVILEGES PROBLEM IN FLORIDA

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I. INTRODUCTION

It is now well recognized that a physician's access to a hospital for the health care of his or her patients is indispensable in view of the enormously expensive equipment, continually upgraded medical technology, and professional support staff available in the modern hospital.[1] Medical staff privileges at one or more hospitals or similar health care facilities are essential to the professional and economic survival of most physicians, particularly specialists.[2] Indeed, one author, a physician-lawyer, remarked that "[a] physician without privileges is almost certain to become a physician without patients."[3] Consequently, when staff privileges are denied, terminated, or suspended, physicians fight back with a vengeance by bringing suits against the hospital, its governing board, and even their own peers on the hospital's medical staff.[4] These suits occur

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1. For an excellent discussion of the symbiotic relationship between the physician and the hospital, see Note, *Health Professionals' Access to Hospitals: A Retrospective and Prospective Analysis*, 34 VAND. L. REV. 1161, 1179 (1981).

2. A useful illustration of the specialist's reliance upon access to a well-equipped hospital is the practice of open heart surgery. *See, e.g.*, Robinson v. Magovern, 521 F. Supp. 842, 855 (W.D. Pa. 1981).

3. Goldsmith, *The Present Status of Physician Privileges*, 27 MED. TRIAL TECH. Q. 121, 121 (1980).

The physician's dependence on the hospital is apparently not something peculiar to American health care. *See, e.g.*, Saltsman, *Physicians' Staff Privileges in Ontario Hospitals*, 8 OTTOWA L. REV. 382, 383-84 (1976) ("[a]ccess to hospital staff appointments is of vital importance to most physicians"); Comment, *Hospital Privileges:* Re Macdonald and North York General Hospital, 35 U. TORONTO FAC. L. REV. 126, 128 (1977) ("hospital affiliation has become a professional and economic necessity for the physician").

4. In 1977, the Florida legislature enacted a limited statutory immunity for "peer review" participants, referred to collectively as "medical review committees," a designation which includes the medical staff of licensed hospitals. FLA. STAT. § 768.40 (1983). The statute insulates all "health care provider" participants on the committee from any "monetary liability" to the extent that they act in their capacity as committee members and only so long as they operate "without malice or fraud." The statute also bars discovery of any material used or compulsion of any testimony given during the committee evaluation in a subsequent civil action brought by the subject of the evaluation and review against committee participants. An exception may be made where the material is otherwise available and just happened to be used in the committee proceeding or where the testimony sought relates to matters already within the knowledge of the particular witness.

It should be noted that the discovery bar cannot be raised to preclude such evidence in the trial of a federal cause of action. Feminist Women's Health Center v. Mohammed, 586 F.2d 530, 544 n.9 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

See generally Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552 (1979); Comment, *The Legal Liability of Medical Peer Review Partici-*

in the form of actions alleging state[5] and federal[6] antitrust violations, substantive and procedural due process errors,[7] defamation,[8] federal civil rights violations,[9] conspiracy,[10] breach of contractual obligations,[11] and tortious interference with contractual and business relationships,[12] among many other theories of recovery and relief.

The threat of these suits, which are now well established in voluminous case law and legal literature,[13] significantly deters most hospitals from taking any adverse action with respect to the medical privileges of one of their staff without well-grounded and verifiable justification. But the concomitant exposure to suits by ag-

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pants for Revocation of Hospital Staff Privileges, 28 DRAKE L. REV. 692 (1978).

5. *See, e.g.*, Hackett v. Metropolitan Gen. Hosp., 422 So. 2d 986 (Fla. 2d DCA 1982).

6. The United States Supreme Court very recently addressed, for the first time, the issue of the exclusive contract for medical services in Jefferson Parish Hosp. Dist. v. Hyde, 104 S. Ct. 1551 (1984). In *Hyde*, the defendant hospital had a contract with a firm of anesthesiologists requiring all anesthesiological services for the hospital's patients to be performed by that firm. Because of the exclusive contract, an anesthesiologist who applied to the hospital's medical staff was denied admission. Following his rejection, he sued the hospital in federal court alleging that the exclusive contract was an illegal tying arrangement violative of the Sherman Act. A majority of the Court, per Justice Stevens, refused to apply the per se rule of illegality to the tie of otherwise separate services because the record, according to the Court, did not convincingly demonstrate that the market power of the defendant hospital was such that the patients in the hospital's locality were "forced" to also purchase the contracting firm's anesthesiological services. *Id.* at 1566-67. Nor did the record show in the absence of per se liability that the challenged contract unreasonably restrained competition in the market for anesthesiological services. *Id.* at 1567-68.

See also Cardio-Medical Ass'n v. Crozer-Chester Medical Center, 721 F.2d 68 (3d Cir. 1983); Feldman v. Jackson Mem. Hosp., 571 F. Supp. 1000 (S.D. Fla. 1983); Miller v. Indiana Hosp., 562 F. Supp. 1259 (W.D. Pa. 1983); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981); Drexel, *The Antitrust Implications of the Denial of Hospital Staff Privileges*, 36 U. MIAMI L. REV. 207 (1982); Grad, *The Antitrust Laws and Professional Discipline in Medicine*, 1978 DUKE L.J. 443; Heitler, *Health Care and Antitrust*, 14 U. TOL. L. REV. 577 (1983); Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595 (1982).

7. *See, e.g.*, Northeast Ga. Radiological Assocs. v. Tidwell, 670 F.2d 507 (5th Cir. 1982).

8. *See, e.g.*, Brandwein v. Gustman, 367 So. 2d 725 (Fla. 3d DCA 1979).

9. *See, e.g.*, Pao v. Holy Redeemer Hosp., 547 F. Supp. 484 (E.D. Pa. 1982).

10. *See, e.g.*, Buckner v. Lower Fla. Keys Hosp. Dist., 403 So. 2d 1025, 1027 (Fla. 3d DCA 1981) (court said that physician's pleading was "prolix, duplicitous, scandalous, and impertinent").

11. Berberian v. Lancaster Osteo. Hosp. Ass'n, 149 A.2d 456 (Pa. 1959).

12. Campbell v. St. Mary's Hosp., 252 N.W.2d 581 (Minn. 1977).

13. *See, e.g.*, Cray, *Due Process Considerations in Hospital Staff Privileges Cases*, 7 HASTINGS CONST. L.Q. 217 (1979); Horton & Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485 (1978); McCall, *A Hospital's Liability for Denying, Suspending and Granting Staff Privileges*, 32 BAYLOR L. REV. 175 (1980); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429 (1973); Comment, *Physician-Hospital Conflict: The Hospital Staff Privileges Controversy in New York*, 60 CORNELL L. REV. 1075 (1975).

grieved former patients blaming the hospital for its negligent review or retention of an impaired or inadequate physician forces the hospital into the treacherous, if untenable, position of having to navigate between potentially monstrous liabilities reminiscent of Scylla and Charybdis.[14]

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14. Because doctors were not considered employees of the hospital but rather independent contractors, the hospital traditionally was not liable to patients for the negligent acts or omissions of its medical staff under the theory of respondeat superior. Combined with charitable immunity this notion effectively precluded recovery against the hospital for medical malpractice. But the arrival of Darling v. Charleston Community Mem. Hosp., 211 N.E.2d 253 (Ill. 1965), spawned the ever increasing line of cases supporting the concept of "corporate negligence" or institutional liability. There are significant differences in the theoretical bases and specific applications of corporate negligence, but essentially the doctrine refers to the independent duty of the hospital to use reasonable care in the selection and supervision of its medical staff, since generally the governing board and not the medical staff or one of its subcommittees (e.g., the credentials committee) bears the ultimate responsibility for staff privileges decisions. *See* Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981), *noted in* Note, Johnson v. Misericordia Community Hospital: *Corporate Liability of Hospitals Arrives in Wisconsin*, 1983 WIS. L. REV. 453; Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?,"* 5 N. KY. L. REV. 27 (1978); Couch, *Hospital Corporate Liability for Inadequate Quality Assurance in Pennsylvania*, 2 J. LEGAL MED. 14 (1980); Goldberg, *The Duty of Hospitals and Hospital Medical Staffs To Regulate the Quality of Patient Care: A Legal Perspective*, 14 PAC. L.J. 55 (1982); Rubsamen, *Even More Legal Controls on the Physician's Hospital Practice*, 292 NEW ENG. J. MED. 917 (1975); Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146 (1968); Spero, *Hospital Liability*, 15 TRIAL 22 (1979); Walkup & Kelly, *Hospital Liability: Changing Patterns of Responsibility*, 8 U.S.F.L. REV. 247 (1973); Note, *Judicial Recognition of Hospital Independent Duty of Care to Patients:* Hannola v. City of Lakewood, 30 CLEV. ST. L. REV. 711 (1981); Comment, *The Hospital's Responsibility for Its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141 (1977); Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 RUTGERS L. REV. 342 (1979); Comment, *Hospital Liability for the Negligence of Physicians: Some Needed Legal Sutures*, 26 U. FLA. L. REV. 844 (1974); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975).

For a practical work with "how to do it" suggestions, see Strodel, *The Impaired Physician—Hospital Corporate Liability*, 24 TRIAL LAW. GUIDE 488 (1981).

One author argues flatly that the courts may have imposed corporate negligence because of the "ever-broadening 'deep pocket' theory of liability, namely, to place the burden of liability upon the party most able to absorb it. . . . [T]he hospital and, therefore, its insurance carrier are more capable of bearing the loss of malpractice cases." Stanczyk, *The Hospital Dilemma—To Staff or Not To Staff*, 25 FED'N INS. COUNS. Q. 138, 148 (1975). A much more principled and somewhat less cynical criticism of corporate negligence as applied to hospitals may be found in Comment, *Piercing the Doctrine of Corporate Liability*, 17 SAN DIEGO L. REV. 383, 400 (1980), which concludes that "[t]he most logical defendants are those physicians [on the medical staff] who are on actual notice of the primary defendant's incompetency." The theory of shifting away from corporate liability of the hospital in favor of holding liable individual members of the medical staff with actual knowledge of one of their peers' incompetency has severe practical difficulties in Florida because of Forster v. Fishermen's Hosp., 363 So. 2d 840 (Fla. 3d DCA 1978). In *Forster*, the chief of the medical staff filed suit against the hospital to challenge the hospital's reappointment to the medical

The purpose of this comment is to explore the medical staff privileges controversy in Florida, which hitherto has not been examined in any comprehensive manner. This is truly unfortunate, particularly because certain recent Florida decisions regarding medical staff privileges are patently incorrect and in direct contravention of Florida statutory law, as we shall see. This analysis of the medical privileges problem in Florida will include numerous useful references to authorities addressing certain troublesome aspects of this problem in other jurisdictions, not only by way of comparison, but also with a view towards assisting the practitioner whose usual metier is not what could be described under the amorphous ascription: "hospital law."

II. BACKGROUND: PUBLIC-PRIVATE DISTINCTION

The traditional rule in most jurisdictions has been that a "public" hospital is constrained by, among other things, substantive and procedural due process requirements in dealings with its medical staff, while a "private" hospital, so long as it does not violate its own internal bylaws,[15] is free to take adverse action against the privileges of one of its medical staff essentially at will.[16] In *West*

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staff of "a certain physician whose medical staff privileges had been previously revoked for unprofessionalism and patient neglect." *Id.* at 841. The Third District affirmed the trial court's dismissal for lack of standing because the board of trustees of the hospital bore ultimate authority and responsibility to reinstate the physician, such that the chief of staff's individual rights were not challenged. *Id.*

15. Even in those jurisdictions where the actions of private hospitals in dealing with their medical staffs are not considered judicially reviewable, private hospitals must generally still follow their own bylaws; if the bylaws of a given private hospital accord medical staff members certain procedural protections to which they would not otherwise be legally entitled, the hospital must provide these protections. *See* Margolin v. Morton F. Plant Hosp. Ass'n, 348 So. 2d 57 (Fla. 2d DCA 1977) (court remanded for possible injunctive relief against private hospital which violated its bylaws); Nagib v. St. Therese Hosp., Inc., 355 N.E.2d 211, 213 (Ill. App. Ct. 1976); McElhinney v. William Booth Mem. Hosp., 544 S.W.2d 216, 218 (Ky. 1976) ("whether the hospital is public or private, it must act in accordance with its charter and by-laws"). The usual reason for this rule is that the bylaws adopted by the medical staff and approved by the hospital constitute a binding contract between the former and the latter. Anne Arundel Gen. Hosp., Inc. v. O'Brien, 432 A.2d 483, 488 (Md. Ct. Spec. App. 1981); Miller v. Indiana Hosp., 419 A.2d 1191, 1193 (Pa. Super. Ct. 1981) (court held that hospitals are held to a "standard of strict compliance" with their bylaws); St. John's Hosp. Medical Staff v. St. John Regional Medical Center, 245 N.W.2d 472, 474 (S.D. 1976). *But cf.* Todd v. Physicians & Surgeons Community Hosp., Inc., 302 S.E.2d 378, 383 (Ga. Ct. App. 1983) (hospital held to have an "absolute right to change the bylaws with reference to the hospital's use by doctors"); Bello v. South Shore Hosp., 429 N.E.2d 1011, 1016 (Mass. 1981) ("[c]ontractual rights . . . do not arise upon an application for membership but only when such application is accepted by the corporation").

16. *See, e.g.*, Ascherman v. Presbyterian Hosp., 507 F.2d 1103, 1105 (9th Cir. 1974);

Coast Hospital Association v. Hoare,[17] the Florida Supreme Court accepted the following distinction between private and public hospitals:

> A private hospital is one founded and maintained by private persons or a corporation, the state or municipality having no voice in the management or control of its property or the formation of rules for its government. . . . A hospital . . . endowed by the government for general charity is a public corporation; and a public hospital may be defined in general as an institution owned by the public and devoted chiefly to public uses and purposes.[18]

With this definition in mind, the court in *Hoare* recognized that a private hospital may in reality be supported by state and local funds and that it is an entity affected with a public purpose, but the court concluded nevertheless that, absent legislative enactment, the governing authorities of private hospitals have virtually unbridled discretion to grant and control the privileges of their medical staffs.[19] Similarly, the Third District Court of Appeal, in *Monyek v. Parkway General Hospital, Inc.*,[20] rejected a physi-

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Ward v. St. Anthony Hosp., 476 F.2d 671, 675 (10th Cir. 1973); Sokol v. University Hosp., Inc., 402 F. Supp. 1029, 1032 (D. Mass. 1975); Shulman v. Washington Hosp. Center, 319 F. Supp. 252, 259-61 (D.D.C. 1970); Moore v. Andalusia Hosp., Inc., 224 So. 2d 617, 619 (Ala. 1969); Edson v. Griffin Hosp., 144 A.2d 341, 344 (Conn. Super. Ct. 1958); Todd v. Physicians & Surgeons Community Hosp., Inc., 302 S.E.2d 378, 383 (Ga. Ct. App. 1983); Settler v. Hopedale Medical Found., 400 N.E.2d 577, 579 (Ill. Ct. App. 1980); Yarnell v. Sisters of St. Francis Health Serv., Inc., 446 N.E.2d 359, 361 (Ind. Ct. App. 1983); Natale v. Sisters of Mercy, 52 N.W.2d 701, 709 (Iowa 1952); Clark v. Physicians & Surgeons Hosp., Inc., 121 So. 2d 752, 754 (La. Ct. App. 1960); Levin v. Sinai Hosp., 46 A.2d 298, 301 (Md. Ct. App. 1946); Bello v. South Shore Hosp., 429 N.E.2d 1011, 1015 (Mass. 1981); Hoffman v. Garden City Hosp.-Osteo., 321 N.W.2d 810, 813 (Mich. Ct. App. 1982); Akopiantz v. Board of County Comm'rs, 333 P.2d 611, 613 (N.M. 1958); Ponca City Hosp., Inc. v. Murphree, 545 P.2d 738, 741 (Okla. 1976); Hagan v. Osteopathic Gen. Hosp., 232 A.2d 596, 600 (R.I. 1967); Strauss v. Marlboro County Gen. Hosp., 194 S.E. 65 (S.C. 1937); Nashville Mem. Hosp. v. Binkley, 534 S.W.2d 318 (Tenn. 1976); Hodges v. Arlington Neuropsychiatric Center, Inc., 628 S.W.2d 536, 538 (Tex. Ct. App. 1982); Khoury v. Community Mem. Hosp., Inc., 123 S.E.2d 533, 539 (Va. 1962); State *ex rel.* Sams v. Ohio Valley Gen. Hosp. Ass'n, 140 S.E.2d 457, 462 (W. Va. 1965).

17. 64 So. 2d 293 (Fla. 1953).

18. *Id.* at 296-97 (quoting 41 C.J.S. *Hospitals* § 1 (1944)). This definition appears to be typical of those offered elsewhere in other jurisdictions. *See, e.g.*, Shulman v. Washington Hosp. Center, 222 F. Supp. 59, 61 (D.D.C. 1963), *remanded on other grounds*, 348 F.2d 70 (D.C. Cir. 1965).

19. *Hoare*, 64 So. 2d at 297-98. Lest the author be accused of hyperbole in the use of the description "virtually unbridled discretion" above, the Florida Supreme Court later itself declared the rule of private hospital control over its medical staff as one of "absolute discretion" in North Broward Hosp. Dist. v. Mizell, 148 So. 2d 1, 3 n.6 (Fla. 1962).

20. 273 So. 2d 430 (Fla. 3d DCA 1973).

cian's argument that a private hospital could be considered "quasi-public" and hence not immune from judicial review with respect to its medical staff decisions. Following the supreme court's lead in the *Hoare* decision, the *Monyek* court refused to deem a private hospital as quasi-public even in the face of allegations that fifty percent of the hospital's patients received Medicare benefits and that part of the land used by the hospital was donated by the City of North Miami Beach.[21]

Even when the Florida courts do consider a hospital a public institution, and therefore subject to substantive and procedural due process, hospital boards are regarded as having "great discretion" in dealing with medical staff privileges:[22]

> Usually, the [public] hospital's discretion is limited only by the constitutional requirement that the standards for privileges be reasonably related to furthering the goal of providing high quality patient care, that the power of the hospital not be exercised in an unreasonably arbitrary and capricious manner and that the decisions of the hospital be subject to judicial review.[23]

In affording substantial deference to public hospital boards in their decisions concerning medical privileges, the Florida Supreme Court in particular has staunchly followed a posture which could well be described by the oft-quoted injunction: "Courts must not attempt to take on the escutcheon of Caduceus."[24] Early decisions emphasized that the mere fact that a given hospital was public rather than private conferred no special right of access upon tax-paying citizen-physicians,[25] and that medical practice in public hospitals was a "privilege rather than a right."[26] The supreme court's last pronouncement in this area held that public hospitals are essentially exempt from the usual requirement that professional or occupational licensing authorities have precise and specific standards of competency and of review. By way of explanation

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21. *Id.* at 432-33.

22. Sarasota County Pub. Hosp. Bd. v. Shawhay, 408 So. 2d 644, 647 (Fla. 2d DCA 1981).

23. *Id.*

24. Sosa v. Board of Managers of Val Verde Mem. Hosp., 437 F.2d 173, 177 (5th Cir. 1971).

25. Green v. City of St. Petersburg, 17 So. 2d 517, 518-19 (Fla. 1944). Justice Chapman, concurring in *Green*, apparently took special solace in the city's minimum physician competency rules: "It is clear that these rules close the door against possible dope fiends, liquor heads, and practitioners not qualified to perform major surgical operations." *Id.* at 520.

26. Bryant v. City of Lakeland, 28 So. 2d 106, 110 (Fla. 1946).

for this broad latitude, the court stated: "Detailed description of [physician misconduct] is concededly impossible, perhaps even undesirable in view of rapidly shifting standards of medical excellence and the fact that a human life may be and quite often is involved in the ultimate decision of the board."[27]

It should be noted that while Florida courts have supported a sharp public-private distinction among hospitals, other jurisdictions have departed from this rule, largely because of judicial distaste for the seemingly excessive and hence potentially unfair power private hospitals have over their medical staffs. A few states, most notably California,[28] Hawaii,[29] and New Jersey,[30] have refused to follow this distinction and, consequently, subject medical staff decisions of private hospitals to thorough judicial scrutiny.

California courts, for instance, abolished the public-private distinction based upon their interpretation of legislative enactment and what is apparently a California common law notion that a private entity lacks absolute discretion to deprive one of a substantial right.[31]

The Supreme Court of New Jersey, on the other hand, looked to that state's common law to deem a private hospital "quasi-public." The court stated in *Greisman v. Newcomb Hospital*: [W]hile the managing officials [of a private hospital] may have discretionary powers in the selection of the medical staff, those powers are deeply imbedded in public aspects, and are rightly viewed, for policy reasons . . . , as fiduciary powers to be exercised reasonably and for the public good.[32]

Other courts have followed the lead of California, New Jersey, and Hawaii in finding that private hospitals, given their public functions and public funding, are really quasi-public and hence subject to judicial review in their dealings with their medical staffs.[33] Some courts, expressly under the influence of the growing

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27. North Broward Hosp. Dist. v. Mizell, 148 So. 2d 1, 5 (Fla. 1962).

28. *See, e.g.*, Anton v. San Antonio Community Hosp., 140 Cal. Rptr. 442, 448-52 (1977); Ascherman v. San Francisco Medical Soc'y, 114 Cal. Rptr. 681, 696 (Ct. App. 1974).

29. *See, e.g.*, Silver v. Castle Mem. Hosp., 497 P.2d 564, 570 (Hawaii), *cert. denied*, 409 U.S. 1048 (1972).

30. *See, e.g.*, Guerrero v. Burlington County Mem. Hosp., 360 A.2d 334, 340 (N.J. 1976); Greisman v. Newcomb Hosp., 192 A.2d 817, 822-24 (N.J. 1963).

31. *See Ascherman*, 114 Cal. Rptr. at 695-98.

32. *Greisman*, 192 A.2d at 824 (citing Falcone v. Middlesex County Medical Soc'y, 170 A.2d 791 (N.J. 1961)).

33. *See, e.g.*, Storrs v. Lutheran Hosp. & Homes Soc'y of America, 609 P.2d 24, 28 (Alaska 1980).

minority of jurisdictions abandoning the public-private dichotomy, have adopted what amounts to a hybrid approach between absolute discretion and quasi-public status, thereby subjecting the private hospital to limited judicial review typically to ensure that professional criteria are neither imposed nor applied arbitrarily, capriciously, or unreasonably.[34]

Although the specific reasons offered by the jurisdictions which have abandoned the public-private dichotomy vary somewhat in scope and character,[35] all appear to share a fundamental recognition that the absoluteness inherent in such a dichotomy is unrealistic and Manichaean because

> in this modern era of technical and therefore expensive health care, it is almost impossible for a hospital to be completely private in its ownership, operation and funding. Government grants are necessary for the survival of the modern hospital and the concommitant [sic] regulation by the government is increasingly pervasive. It is this local, state and federal assistance and involvement with formally private hospitals that provides the basis on which a court could decide that public involvement has become so great that the private hospital should be subjected to public treatment.[36]

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34. *See, e.g.*, Peterson v. Tucson Gen. Hosp., Inc., 559 P.2d 186, 191 (Ariz. Ct. App. 1976); Hawkins v. Kinsie, 540 P.2d 345, 349 (Colo. Ct. App. 1975); Bricker v. Sceva Speare Mem. Hosp., 281 A.2d 589, 592 (N.H.), *cert. denied*, 404 U.S. 995 (1971); Khan v. Suburban Community Hosp., 340 N.E.2d 398, 401-03 (Ohio 1976); Woodward v. Porter Hosp., Inc., 217 A.2d 37, 40 (Vt. 1966). *But see* Even v. Longmont United Hosp. Ass'n, 629 P.2d 1100, 1103 (Colo. Ct. App. 1981) (court stated that denial of medical staff privileges in a private hospital "is a matter solely within the discretion of its managing authorities and is not a proper subject of certiorari review").

35. Two excellent works offer well reasoned and compelling arguments in support of common law approaches to judicial review of staff privileges decisions by private hospitals. *See* McMahon, *Judicial Review of Internal Policy Decisions of Private Nonprofit Hospitals: A Common Law Approach*, 3 AM. J. LAW & MED. 149 (1977); Comment, *Hospital Medical Staff: When Are Privilege Denials Judicially Reviewable?*, 11 MICH. J.L. REF. 95 (1977).

36. Cray, *supra* note 13, at 226. A recent publication by the Florida Hospital Association offers the following breakdown in Florida:

> Community hospitals comprised 85.3% of Florida hospitals in 1981. . . . Non-government, not-for-profit community hospitals represented 33.7% of Florida's hospitals and 38.5% of Florida's hospital beds. Investor owned community hospitals had 29% of all hospitals and 23.6% of all hospital beds in Florida. State and local government hospitals represented 22.6% of Florida's hospitals and 18.3% of Florida's hospital beds. A salient feature of Florida's hospital industry is its healthy [no pun apparently intended] investor owned sector and the growth that the sector has experienced from 1972 to 1981.

FLORIDA HOSPITAL ASSOCIATION, FLORIDA HOSPITALS: THE FACTS (2d ed. 1983). From this very brief breakdown it is obvious that the absurdly simplistic public-private distinction is unwarranted in Florida, notwithstanding its perpetuation in Florida case law.

A phenomenon directly related to judicial recognition of the fallacy behind the public-private distinction was the appearance during the 1970's of state and particularly federal[37] court decisions holding that certain characteristics of private hospitals, especially heavy state and federal funding,[38] rendered them state actors for purposes of the fifth and fourteenth amendments. This state action designation in turn implicated due process guarantees in decisions by private hospitals on medical privileges. Thus, for instance, until very recently the rule in the Fourth Circuit was that the mere receipt of Hill-Burton funds[39] constituted state action such that otherwise private hospitals must act in accordance with federal precepts of due process.[40] But this perception of the constitutional impact of Hill-Burton and similar funding has been rejected in every other federal circuit that has confronted the issue, and the former view of the Fourth Circuit[41] is almost certainly incorrect in

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37. *See, e.g.*, Schlein v. Milford Hosp., 423 F. Supp. 541, 542 (D. Conn. 1976), *aff'd*, 561 F.2d 427 (2d Cir. 1977) (affirming result only and disagreeing with finding of state action).

38. The greatest amount of litigation concerning the question of when a hospital is deemed to be public has revolved around the effect that the receipt of funds under the Hospital Survey and Construction Act [42 U.S.C.A. § 291-291m (West 1983)] has on private hospitals. The purpose of the legislation, popularly known as the Hill-Burton Act, is to provide states with money to assist in the construction and modernization of public and private hospitals, develop new and improved medical facilities and promote research.

Cray, *supra* note 13, at 228-29 (footnotes omitted).

The Hill-Burton Act was merely one component of a package of health care legislation offered by President Truman beginning in 1946. The major thrust of the package was a program of national health insurance, an idea which President Truman carried forward from the Roosevelt administration and which he unsuccessfully sought to persuade Congress to enact during both of his terms in office. The American Medical Association (AMA) supported the Hill-Burton Act, but the organization vehemently, if disingenuously, denounced national health insurance as socialized medicine which, according to one AMA sponsored pamphlet, would be "the keystone to the arch of the Socialist State." P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 285 (1982). Indeed, in 1950 alone the AMA "spent $2.25 million in its 'national education campaign' against national health insurance." *Id.* at 287.

39. *See supra* note 38.

40. Christhilf v. Annapolis Emergency Hosp. Ass'n, 496 F.2d 174, 178 (4th Cir. 1974); Simkins v. Moses H. Cone Mem. Hosp., 323 F.2d 959, 967 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

41. The Fourth Circuit abandoned its obdurate view of the effect of Hill-Burton funding in Modaber v. Culpeper Mem. Hosp., Inc., 674 F.2d 1023 (4th Cir. 1982), where the court held that a private hospital which, inter alia, was built with 55% of its construction funds coming from a Hill-Burton grant and which accepted patients receiving Medicare and Medicaid funds, was not a state actor for purposes of the fourteenth amendment. *Id.* at 1026-27.

All of the other federal circuits, except the First and Eleventh, which have yet to address the issue squarely, are in accord with the revised Fourth Circuit position. *See* Loh-Seng Yo v. Cibola Gen. Hosp., 706 F.2d 306, 308 (10th Cir. 1983); Newsome v. Vanderbilt Univ., 653

light of the United States Supreme Court's holdings in *Rendell-Baker v. Kohn*[42] and *Blum v. Yaretsky*,[43] which were both decided by the Court on the same day.

In *Blum*, the Court looked at private nursing homes participating in a state program which provided Medicaid assistance to eligible people receiving care in those homes. The Court held that although a substantial ream of state and federal regulations controlled the program, the private nursing homes were not state actors with respect to their internal decisions regarding the variable levels of eligibility of those receiving nursing care.[44] The Supreme Court also noted that the decision to discharge or to refer the patients to lower levels of care was a medical judgment which could not be attributed to the state because it was rendered "in accordance with professional canons of ethics, rather than dictated by any rule of conduct imposed by the State."[45] This remark bears significant relevance for the governing boards of private hospitals, which are typically composed of laymen who rely heavily on the advice and recommendations of the hospital's medical staff in their decisions affecting medical privileges.

In *Rendell-Baker*, the receipt by a privately operated school for maladjusted high school students of public funds accounting for at least ninety percent of its operating budget did not transform the school into a person acting under color of state law.[46] Not surpris-

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F.2d 1100 (6th Cir. 1981); Hodge v. Paoli Mem. Hosp., 576 F.2d 563, 564 (3d Cir. 1978); Musso v. Suriano, 586 F.2d 59, 62-63 (7th Cir.), *cert. denied*, 440 U.S. 971 (1978); Schlein v. Milford, Inc., 561 F.2d 427, 431 (2d Cir. 1977); Madry v. Sorel, 558 F.2d 303, 305 (5th Cir. 1977), *cert. denied*, 434 U.S. 1086 (1978); Briscoe v. Bock, 540 F.2d 392, 394-96 (8th Cir. 1976); Watkins v. Mercy Medical Center, 520 F.2d 894, 896 (9th Cir. 1975).

42. 457 U.S. 830 (1982).

43. 457 U.S. 991 (1982).

44. *Blum*, 457 U.S. at 1002-12.

45. *Id.* at 1009.

46. *Rendell-Baker*, 457 U.S. at 839-43. Petitioner in the *Rendell-Baker* case, a former counselor at the school, sued the director of the school and others under the federal civil rights statute, 42 U.S.C. § 1983, alleging wrongful discharge from the school in violation of her first, fifth, and fourteenth amendment rights. The Court held, per Chief Justice Burger, that the question of whether the respondents acted under color of state law for purposes of § 1983 is the "same question" posed in cases presenting the issue of state action under the fourteenth amendment. Rendell-Baker, 457 at 830, 837-38.

Since Florida's own constitutional due process guarantees, FLA. CONST. art. I, § 9, are interpreted as offering merely the same and not broader protection as their federal counterparts, the effect of the *Rendell-Baker* and *Blum* decisions therefore controls the same issue under the state constitution. *See* South Fla. Chapter of the Assoc'd Gen. Contrs. of America, Inc. v. Metropolitan Dade County, 552 F. Supp. 909, 928 (S.D. Fla. 1982), *aff'd in part, rev'd in part*, 723 F.2d 846 (11th Cir. 1984); Florida Canners Ass'n v. Department of Citrus, 371 So. 2d 503, 513 (Fla. 2d DCA 1979), *aff'd sub nom.*, Coca-Cola Co., Food Div. v. Department

ingly, federal court decisions since *Blum* and *Rendell-Baker* have soundly rejected assertions that private hospitals receiving huge amounts of state and federal funding are either acting under color of state law or operating as state entities under the mandates of the fourteenth amendment.[47]

III. Florida Statutory Imposition of JCAH Standards

A. Outline of the JCAH

In 1975, the Florida legislature enacted section 395.065, Florida Statutes, which set forth the criteria by which the medical staff of any licensed hospital could control the staff privileges of its mem-

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of Citrus, 406 So. 2d 1079 (Fla.), *appeal dismissed sub nom.*, Kraft, Inc. v. Department of Citrus, 456 U.S. 1002 (1982).

47. Miller v. Indiana Hosp., 562 F. Supp. 1259, 1275-78 (W.D. Pa. 1983); Taylor v. Flint Osteo. Hosp., Inc., 561 F. Supp. 1152, 1157-59 (E.D. Mich. 1983); Chico Fem. Women's Health Center v. Butte Glenn Medical Soc'y, 557 F. Supp. 1190, 1194-97 (E.D. Cal. 1983); Pao v. Holy Redeemer Hosp., 547 F. Supp. 484, 491-92 (E.D. Pa. 1982).

It is important to note that the *Blum* and *Rendell-Baker* decisions do not necessarily overrule or even cast doubt on the opinions of those courts which have ruled that private hospitals are quasi-public, *see supra* notes 28-35 and accompanying text, because they, inter alia, receive Hill-Burton funds. These decisions are really a matter of *state* law dealing with such state policy concepts as the public responsibilities of private fiduciary bodies, e.g., hospital boards of trustees. *See, e.g.*, Davidson v. Youngstown Hosp. Ass'n, 250 N.E.2d 892, 895 (Ohio Ct. App. 1969) ("the power of the [medical] staff of such a [private] hospital to pass on staff membership applications is a fiduciary power to be exercised reasonably and for the public good").

Yet there is bound to be considerable confusion over this because once these courts arrive at the quasi-public designation in order to provide private hospital physicians with some measure of procedural protections, they invariably speak in terms of "due process," when really no process is due at all, at least in the federal constitutional sense. *See, e.g.*, Silver v. Castle Mem. Hosp., 497 P.2d 564, 571-72 (Hawaii), *cert. denied*, 409 U.S. 1048 (1972). What these courts actually mean (absent specific reliance upon state constitutional due process guarantees broader than the fourteenth amendment), is *due process-like* protections, conveniently borrowed from federal law to a designation arrived at through a state common law policy decision. Some courts clearly understand this distinction. *See, e.g.*, Jain v. Northwest Community Hosp., 385 N.E.2d 108, 111 (Ill. App. Ct. 1978). Other courts seem utterly confounded over the difference between analyzing the impact of Hill-Burton funding for purposes of the fourteenth amendment and for purposes of the quasi-public designation as a matter of state law. *See, e.g.*, North Valley Hosp., Inc. v. Kauffman, 544 P.2d 1219, 1221-24 (Mont. 1976); Miller v. Indiana Hosp., 419 A.2d 1191, 1194-95 (Pa. Super. Ct. 1980).

One very good approach for courts that wish to provide procedural protections for private hospital physicians while avoiding the muddle over the quasi-public analysis is to interpret the relevant state constitutional provision dealing with due process more broadly than its federal counterparts in the fifth and fourteenth amendments. For a discussion of how a growing number of state courts are finding real substance in their respective constitutions as a refreshing alternative (which even comports with the so-called "New Federalism") to mindlessly following federal constitutional interpretations jot for jot and case by case, see generally Collins, *Rebirth of Reliance on State Charters*, Nat'l Law J., Mar. 12, 1984, at 25.

bers.[48] This statute's current version, section 395.0115, with minor changes from the original,[49] authorizes the governing board of any "licensed facility" (hence including *both* private and public hospitals) to "suspend, deny, revoke, or curtail the staff privileges" of any physician for "good cause" after considering the recommendations of its medical staff.[50] The statute then gives nonexclusive illustrations of "good cause," which include: incompetence, habitual and dangerous addiction to intoxicants or drugs, an adjudication of medical malpractice liability, and mental or physical impairment.[51] The procedures required for both public and private hospitals in taking adverse action with respect to staff privileges "shall comply with the standards outlined" by, among other organizations, the Joint Commission on Accreditation of Hospitals (JCAH).[52] Finally, subdivision 2 of section 395.0115 immunizes the hospital, its governing board and its individual members, and the medical staff or other disciplinary body "for any action taken in good faith and without malice in carrying out the provisions of this section."[53] We shall hold any discussion of this immunity; for now, let us proceed to briefly review the JCAH.

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48. *See* FLA. STAT. § 395.065 (1975) (repealed 1982).

49. *See infra* text accompanying notes 132-35.

50. FLA. STAT. § 395.0115 (1983) provides in relevant part:

> (1) The governing board of any licensed facility, after considering the recommendations of its medical staff, is authorized to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause, including, but not limited to:
>
> (a) Incompetence.
>
> (b) Negligence.
>
> (c) Being found to be a habitual user of intoxicants or drugs to the extent that he is deemed dangerous to himself or others.
>
> (d) Being found liable for medical malpractice by a court of competent jurisdiction.
>
> (e) Mental or physical impairment which may adversely affect patient care.
>
> However, the procedures for such actions shall comply with the standards outlined by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, the Accreditation Association for Ambulatory Health Care, and the "Medicare/Medicaid Conditions of Participation."
>
> (2) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any licensed facility, its governing body and governing body members, medical staff, or disciplinary body, or its agents or employees for any action taken in good faith and without malice in carrying out the provisions of this section.

51. *Id.*

52. *Id. See* Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C.L. REV. 835 (1983).

53. FLA. STAT. § 395.0115(2) (1983).

The JCAH is a private, nonprofit corporation founded in 1951 which provides accreditation services primarily for public and private hospitals but also for other health related facilities.[54] JCAH accreditation is theoretically voluntary, and the JCAH does not view accreditation as a scheme of public regulation, but rather regards itself as a private quality control consultant paid by and responsible to the health care industry.[55] The hospital or other facility must request of its own volition an accreditation survey by the JCAH staff, who analyze and record the survey results and then recommend their decision for or against accreditation to a subcommittee of the JCAH Board of Commissioners, the organization's governing body.[56] JCAH accreditation follows only upon the facility's substantial compliance with JCAH standards overall, although a facility need not comply substantially with every JCAH standard.[57] As Professor Jost explains, JCAH accreditation is only voluntary in the de jure sense, since "hospital accreditation is either explicitly or implicitly a requirement for participation in many private or public licensing, certification and financing programs."[58] Specifically, for instance, JCAH accreditation essentially results in automatic qualification, referred to as "deemed" certification status, of a health care facility for participation in the Medicare program, thus supplanting the requirement otherwise for state health departments to survey hospitals in order to assess their compliance with Medicare regulations.[59]

Similarly, according to Professor Jost, thirty-eight states have, "to varying degrees," also "incorporated JCAH standards or accreditation decisions into their licensing programs for health care institutions."[60] Florida is one of these states which specifically accommodates JCAH hospital standards in the state's hospital licensing program. Section 395.006, for example, requires the Florida Department of Health and Rehabilitative Services (HRS) to "accept, in lieu of its own periodic inspections for licensure, the survey

54. Jost, *supra* note 52, at 841-42.
55. *Id.* at 842-43.
56. *Id.*
57. *Id.* at 842.
58. *Id.* at 843.
59. *Id.* at 843, 852-57.
60. *Id.* at 844. JCAH accreditation is very important for a hospital's "standing in the professional community" and its "public image." *See* American Int'l Hosp. v. Chicago Tribune, 458 N.E.2d 1305, 1308 (Ill. App. Ct. 1983) (hospital sued the JCAH and the Tribune alleging a false report of JCAH's refusal to accredit the hospital).

or inspection of an accrediting organization"[61] (which by statutory definition includes the JCAH[62]), so long as the facility's accreditation is not provisional and provided that the facility releases and sends to HRS the accreditation organization's survey.[63] In sum, the JCAH is a private entity which has had and continues to have "a significant impact on the development of institutional medical care in America, and continues to play a major role in determining the nature of that care."[64]

B. *JCAH Medical Staff Standards and Due Process*

We may now ask just what is meant by the Florida statutory mandate that the "procedures" used for adverse action vis-a-vis a physician's staff privileges must comply with the "standards outlined" by the JCAH.[65] The standards outlined by the JCAH are those found in the now annually updated JCAH *Accreditation Manual for Hospitals* and the procedures used are those revealed in the *Manual*'s chapter entitled "Medical Staff."[66] The chapter on the Medical Staff is notable for its distinct lack of anything resembling a model code of staff bylaws, something formerly attempted by the JCAH but since abandoned.[67] In fact, the chapter on the Medical Staff for the 1985 edition of the *Accreditation Manual for Hospitals* is somewhat more general and abbreviated where due process-like standards are concerned than its immediate predecessor in the 1984 edition.[68] However, the fundamental demands of a fair hearing, basic evenhandedness among the medical staff, and openness about requisite professional criteria and the internal

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61. FLA. STAT. § 395.006(2)(a) (1983).

62. *Id.* § 395.002(1).

63. *Id.* § 395.006(2)(a).

64. Jost, *supra* note 52, at 923. After an extensive overview of the JCAH, the balance of Professor Jost's article is a critical and comprehensive analysis of the pros and cons of private regulation of health care offered by the JCAH, particularly from a public interest and macroeconomic perspective.

65. FLA. STAT. § 395.065(1) (1975).

66. JOINT COMMITTEE ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 89 (1984) [hereinafter cited as MANUAL].

67. The JCAH once promulgated its GUIDELINES FOR THE FORMULATION OF MEDICAL STAFF BYLAWS, RULES, AND REGULATIONS (1971), which still is cited as authoritative by otherwise excellent works, *see, e.g.*, Cray, *supra* note 13, at 251 n.202, but which is considered obsolete by the JCAH.

68. The Medical Staff Standards for the 1985 edition of the ACCREDITATION MANUAL FOR HOSPITALS [hereinafter cited as Standards] were approved by the JCAH Board of Commissioners on December 10, 1983. *See JCAH Board Approves New Medical Staff Standards*, 4 JCAH PERSPECTIVES, Jan.-Feb. 1984, at 1.

structures of the medical staff—hallmarks of due process-like requirements—are still solidly maintained in the 1985 chapter. The applicants for medical staff privileges or the staff physician may not, for instance, be treated arbitrarily: "Professional criteria specified in the medical staff bylaws and uniformly applied to all applicants or medical staff members constitute the basis for granting initial or continuing staff membership."[69] Moreover, the professional criteria used in assessing the abilities and background of the medical staff applicant or member must be reasonably related to the primary JCAH goal of providing high quality patient care and they must be nondiscriminatory:

> (a) The criteria are designed to assure the medical staff and governing body that patients will receive quality care.
> (b) The criteria pertain to, at the least, evidence of current licensure, relevant training and/or experience, current competence, and health status.
> (c) The criteria may also pertain to other reasonable qualifications, such as
> (1) the ability of the hospital to provide adequate facilities and supportive services for the applicant and his patients;
> (2) patient care needs for additional staff members with the applicant's skill and training;
> (3) current evidence of adequate professional liability insurance; and
> (4) the geographic location of the applicant.
> (d) Sex, race, creed, or national origin are not used in making decisions regarding medical staff membership.[70]

Applications for medical staff appointments must be "acted on within a reasonable period of time" and the final decision by the governing body on each application must also be made within "a reasonable period of time." Following an adverse decision or recommendation regarding an applicant's request for initial appointment, accredited hospitals must have a "mechanism . . . defined in the governing body or the medical staff bylaws" for "appropriate action, including a fair hearing."[71] These same rules apply to those physicians not necessarily seeking membership on the medical staff but rather clinical privileges at the hospital.[72]

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69. Standards, *supra* note 68, at 2.
70. *Id.*
71. *Id.* at 2-3.
72. *Id.* at 8-11.

The JCAH protections apply, of course, not only to initial applicants but also to current members of the medical staff, whose bylaws must "include provisions for at least the following":

> 2. Fair-hearing and appellate review mechanisms, which may differ for medical staff members and other individuals holding clinical privileges and for applicants for such membership or privileges.
>
> 3. Mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership and/or clinical privileges.
>
> 4. A description of the organization of the medical staff, including categories of medical staff membership, when such exist, and appropriate officer positions, with the stipulation that each officer is a member of the medical staff. The bylaws define
>
> a) the method of selecting officers;
>
> b) the qualifications, responsibilities, and tenures of officers; and
>
> c) the conditions and mechanisms for removing officers from their positions.
>
> . . . .
>
> 6. A mechanism designed to assure effective communication among the medical staff, hospital administration, and governing body.
>
> 7. A mechanism for adopting and amending the bylaws, rules and regulations, and policies of the medical staff.
>
> . . . .
>
> 9. Medical staff representation and participation in any hospital deliberation affecting the discharge of medical staff responsibilities.[73]

By way of comparing and contrasting these JCAH standards with the requirements of federal due process, one feature in particular of the required bylaw characteristics listed above is the recognition that "fair-hearing and appellate review mechanisms . . . may differ for medical staff members and other individuals holding clinical privileges and for *applicants* for such membership or privileges."[74] In this context, "differ" obviously means less in the way of due process-like requirements. The question arises whether this "lesser" standard of JCAH protection for initial applicants is the same or some different level of procedural protection which must

73. *Id.* at 4.

74. *Id.* (emphasis added).

be afforded an initial applicant who is rejected by the governing board of a public hospital subject to the due process constraints of the fifth or fourteenth amendments. In answering this question, we begin with the United States Supreme Court's decision in *Board of Regents v. Roth.*[75]

In *Roth,* a nontenured state university instructor was not rehired, allegedly because of his vociferous criticism of university practices. Before considering Roth's constitutional claims, the Court announced its now familiar standard that the state action at issue must have deprived Roth of a protected liberty or property interest, since fourteenth amendment due process guarantees extend only to those state actions which can be said to deprive one of "life, liberty, or property."[76] Violation of a protected liberty interest requires the real possibility of serious damage to one's individual standing and associations in his or her community or the imposition of a stigma which would foreclose his or her freedom to pursue other employment opportunities.[77] The Court ruled that because the university made no charge against Roth to damage his community standing or to stigmatize him in such a way as to foreclose future employment, Roth therefore had no liberty interest at stake.[78] Meanwhile, the issue of whether he had a property interest involved in his employment rested in turn upon whether it could be said that his contract with the university conferred upon him certain "specific benefits" arising to the level of a "legitimate claim of entitlement" to them, regardless of his subjective, "unilateral expectations."[79] Since the provisions of Roth's employment contract called for termination after one year of teaching service without any promise or suggestion of reappointment, the Court found that there was no specific benefit and hence no legitimate claim of entitlement to reemployment. Therefore, there was no infringement of any property interest upon the university's refusal to renew the appointment.[80] Nor did the Court find, apart from the express terms of the contract, any informal policy or understanding between Roth and the university regarding reappointment.[81]

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75. 408 U.S. 564 (1972).
76. U.S. CONST. amend. XIV, § 1.
77. *Roth,* 408 U.S. at 573.
78. *Id.* at 573-74.
79. *Id.* at 576-77.
80. *Id.* at 578.
81. In the companion case of Perry v. Sindermann, 408 U.S. 593, 599-602 (1972), the Court ruled that where Perry was rehired annually in the absence of a formal tenure system, he nevertheless had a legitimate claim of entitlement to renewal of his employment contract

In two subsequent decisions, a majority of the Court agreed that a protected property interest is implicated if the terms of employment provide that the employee may only be discharged for cause,[82] but not where the employee holds his or her position "at the will and pleasure" of the public employer.[83] And as regards the protected liberty interest, the Court arguably narrowed the scope of the *Roth* decision to the extent that it held in *Paul v. Davis*[84] that reputation alone is not constitutionally protected. *Davis* holds that the protected liberty interest is confined rather to state action which alters or extinguishes a previously recognized right or status.[85]

A few illustrations may now be useful in applying *Roth* and its progeny to the context of medical staff privileges. For example, in *Stretten v. Wadsworth Veterans Hospital*,[86] a physician was terminated during a residency program which he reasonably could have expected to complete given the hospital's past practices (in other words, he was not employed "at will"). The Ninth Circuit found that the physician had a protected property interest in his

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because of a de facto tenure system predicated upon university practices and explicit understandings between the faculty and the administration.

82. Six members of the Court (i.e., Justices Powell and Blackmun concurring and dissenting, Justice White concurring and dissenting, along with Justices Brennan, Douglas, and Marshall dissenting separately) in Arnett v. Kennedy, 416 U.S. 134 (1974), concluded that an entitlement to dismissal for cause is a protected property interest.

83. Bishop v. Wood, 426 U.S. 341, 345 n.8 (1976).

84. 424 U.S. 693 (1976).

85. *Id.* at 711-12.

86. 537 F.2d 361, 366-67 (9th Cir. 1976). The *Stretten* court also held that the physician's untimely termination, with accompanying reasons therefor, did not, however, implicate a protected liberty interest because "[l]iberty is not infringed by a label of incompetence," though liberty is infringed by a "stigma of moral turpitude." *Id.* at 366.

On the other hand, the Supreme Court of Washington ruled that a physician who was terminated from a public hospital *during* a term of his one-year renewable staff appointment did not have a protected property interest in the remainder of his term of appointment. Ritter v. Board of Comm'rs, 637 P.2d 940, 944 (Wash. 1981). The effect of the court's ruling was that Dr. Ritter was an at will member of the medical staff notwithstanding the fact that he "could assume he would remain a member of the hospital staff absent cause for dismissal, and he was protected by extensive procedural protections established by the medical staff bylaws [which were violated in his case]." *Id.* at 944. The majority in *Ritter* cited Suckle v. Madison Gen. Hosp., 499 F.2d 1364 (7th Cir. 1974), in support of this proposition. But *Suckle* is crucially different in that the issue of whether a property interest existed there involved a denial of reappointment rather than termination during a term of service. *Id.* at 1365. The *Suckle* court concluded that absent some legitimate expectation of renewal, such as in Perry v. Sindermann, 408 U.S. 593 (1972), the physician had no property interest in reappointment. The lone dissenting justice in *Ritter* emphasized this crucial distinction, and it is submitted that his view is correct on this point. *See Ritter*, 637 P.2d at 951 (Dore, J., dissenting).

residency. But where a physician-director of pathology was appointed by a public hospital upon only an oral contract, absent any understanding of an entitlement to termination for cause, the Eighth Circuit recently ruled that his service contract was therefore at will, and that his termination by the hospital consequently did not violate a protected property interest.[87]

Since hospital bylaws usually provide that privileges are granted for a stated term of one or two years,[88] *Stretten* typifies the usual case that a physician will normally have a legitimate expectation of continued employment during any given term of appointment, while the situation of the physician whose contract is utterly at will during such a term as discussed in the Eighth Circuit opinion is somewhat unusual.[89] Dismissal during a term of service in which a physician has a legitimate expectation of continued employment must be distinguished, however, from appointment and reappointment. Following the end of his or her specified term of staff appointment, a physician has no property interest in renewal of appointment.[90] Similarly, the physician as initial applicant has no legitimate claim of entitlement and hence no property interest[91]

87. Englestad v. Virginia Mun. Hosp., 718 F.2d 262, 266 (8th Cir. 1983).

88. Cray, *supra* note 13, at 237.

89. *Englestad*, 718 F.2d at 266.

90. Cray, *supra* note 13, at 237.

91. *Id.* Remarkably, the Fifth Circuit, after correctly noting the rule that "physicians obtain by mere licensure no constitutional right to staff privileges at any particular hospital," went on to assume without discussion that a thrice rejected applicant was entitled to procedural due process following his rejection by a public hospital. Truly v. Madison Gen. Hosp., 673 F.2d 763, 765 (5th Cir.), *cert. denied*, 103 S. Ct. 214 (1982).

Even more bizarre is the decision in Shaw v. Hospital Auth., 614 F.2d 946 (5th Cir. 1980), where the same circuit (Judge Brown was the only judge common to both panels, however) issued a per curiam affirmance of a lower court opinion which was in turn decided upon remand from the Fifth Circuit's earlier opinion in Shaw v. Hospital Auth., 507 F.2d 625 (5th Cir. 1975). The *Shaw* cases arose out of a denial of an application for an initial grant of staff privileges to a podiatrist by a public hospital. *Id.* at 627. The earlier Fifth Circuit opinion held that the podiatrist "in seeking staff privileges at . . . [the] hospital, seeks to engage in his occupation as a podiatrist and this is a [protected] liberty interest." *Id.* at 628. On remand from this opinion, the lower court "corrected" itself and stated that it was "clear in the first instance" that the podiatrist's application invoked a liberty interest "emanating from his state created right to practice podiatry." *Shaw*, 614 F.2d at 950 (lower court opinion is appended to per curiam affirmance).

Thus, the *Shaw* opinions equate a mere denial of staff privileges, without more (and from only one hospital), as an affront to the legitimate liberty interest to pursue one's occupation. But the denial of the podiatrist's application in the *Shaw* situation did not in any way alter or extinguish Dr. Shaw's state created right to practice podiatry. His license was unaffected by the decision of the governing board of any hospital upon his mere application. The liberty interest in pursuing one's chosen vocation discussed in the United States Supreme Court opinion relied upon by the Fifth Circuit, *Shaw*, 507 F.2d at 628, dealt with a Ne-

because he or she has no constitutional right to practice medicine in a public hospital,[92] and because hospital administrators have broad discretion to set professional criteria for those physicians whom they appoint to the medical staff of the hospital.[93]

Thus, by providing the initial applicant with a comparatively limited right to a fair hearing and appellate review, the JCAH standards go considerably beyond the protection of procedural due process. But if the JCAH standards for the medical staff purport to offer more, or at least broader, protection from an unfair or an incorrect decision regarding a physician's staff privileges, one might reasonably ask why these standards do not address certain specific issues which have been litigated in staff privileges cases, such as representation by counsel,[94] the right to confront and

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braska statute which totally forbade throughout the state the teaching in any private or public school of any language other than English to any child who had not successfully completed the eighth grade. Meyer v. Nebraska, 262 U.S. 390, 397-98 (1923). As regards Dr. Shaw, the scenario envisioned by *Meyer* and its progeny would occur only if, for instance, a state examining board suspended his right to practice podiatry at *any* hospital. *See* Withrow v. Larkin, 421 U.S. 35 (1975); Ampuero v. Department of Prof. Reg., 410 So. 2d 213, 214 (Fla. 3d DCA 1982) (in response to the failure of the Department to grant a doctor a hearing within six months of an order prohibiting him from prescribing certain drugs, the court stated: "When the state undertook to temporarily restrict the petitioner's privilege to practice medicine it had an affirmative duty to grant a post-suspension hearing and one that would be concluded without appreciable delay.").

Not only was Dr. Shaw still free to practice his chosen field of podiatry, he was already a member of the medical staff of two private hospitals at the time he filed his complaint. *Shaw*, 507 F.2d at 626. It appears, therefore, that the *Shaw* cases are substantially incorrect in not distinguishing between "reduced economic returns" and "permanent exclusion from, or protracted interruption of, gainful employment." Stretten v. Wadsworth Veterans Hosp., 537 F.2d 361, 366 (9th Cir. 1976).

92. Hayman v. City of Galveston, 273 U.S. 414, 416-17 (1927).

93. Sosa v. Board of Managers of Val Verde Mem. Hosp., 437 F.2d 173, 177 (5th Cir. 1971).

94. The Supreme Court of New Jersey has opted for what appears thus far to be the minority view: "In view of the physician's substantial interest in proceedings of this nature, on balance we believe that the physician should have the right to have counsel present at mandated hospital hearings with respect to his application for admission to the staff." Garrow v. Elizabeth Gen. Hosp., 401 A.2d 533, 542 (N.J. 1979).

The Supreme Court of Hawaii adopted a somewhat contrary view:

> It should be within the discretion of the hospital board as to whether counsel may attend the hearing and participate in the proceedings. Participation by counsel would probably not be necessary unless the hospital's attorney is used in the proceedings or the extreme nature of the charges involved indicated that representation by an attorney would be advantageous.

Silver v. Castle Mem. Hosp., 497 P.2d 564, 571-72 (Hawaii), *cert. denied*, 409 U.S. 1048 (1972). The Supreme Court of California is in accord with the *Silver* view. *See* Anton v. San Antonio Community Hosp., 140 Cal. Rptr. 442, 457 (1977). Insofar as the board's discretion on this point is concerned, "[a]n abuse of discretion should be automatically found where the physician was denied counsel but there was a hearing officer who was an attorney since

cross-examine witnesses,[95] notice of hearing and of charges,[96] and possible conflicts or biases in the composition of the governing board or medical staff tribunal which conducts a hearing on privileges,[97] among many others.[98] One clear reason is that the process

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such a denial is patently unfair." Cray, *supra* note 13, at 254.

The 1984 JCAH chapter on the Medical Staff states that the medical staff bylaws should specify "the role, if any, of legal counsel." *See* MANUAL, *supra* note 66, at 99. The 1985 Medical Staff Standards, however, are silent on the role of the attorney. *See* Standards, *supra* note 68, at 4.

95. Owing to the rule that administrative proceedings dealing with medical staff privileges "need not be conducted as full blown trials," Christhilf v. Annapolis Emergency Hosp. Ass'n, 496 F.2d 174, 179 (4th Cir. 1974), cross-examination therefore "need not be a part of every hearing in order to satisfy due process." Woodbury v. McKinnon, 447 F.2d 839, 844 (5th Cir. 1971). "Whether [cross-examination] is required depends upon the circumstances." *Id.* Thus, where the hospital board or the medical staff conducting the hearing has no subpoena power, "there can be no right to confront and cross-examine persons who have made adverse statements of a doctor unless such persons testify at the hearing." Silver v. Castle Mem. Hosp., 497 P.2d at 571. *See* Koelling v. Board of Trustees, 146 N.W.2d 284, 294 (Iowa 1966). Similarly, where there were no witnesses appearing at the hearing because, for instance, it consisted of an "informal discussion by the medical staff" of the charges against the physician, procedural due process is not offended. *Woodbury*, 447 F.2d at 844. *See* Kaplan v. Carney, 404 F. Supp. 161, 164 (E.D. Mo. 1975).

96. Due process requires that the physician be notified that a hearing is available to him and that such notice be timely to allow adequate defense preparation. Silver v. Castle Mem. Hosp., 497 P.2d at 571. *See Christhilf*, 496 F.2d at 177-78.

With respect to notice of charges, written notice of specific reasons for denial of privileges, including descriptions of a physician's recent activities, satisfies procedural due process requirements. A physician may not require that notice of charges be so specific that it amounts to the pleading of evidence; although more particularization might help the physician it is not constitutionally required. Truly v. Madison Gen. Hosp., 673 F.2d at 766. Thus, where a physician was "charged in writing with lack of competence and judgment to perform surgery and surgical procedures," accompanied by a list of the names of specific cases and the hospital records thereto, notice of charges was sufficient even though the physician's request for separate allegations of the "exact nature of the fault in each case" was denied by the hospital. *Woodbury*, 447 F.2d at 843-44. The courts have consistently eschewed any requirement that the notice of charges be so exact and detailed so as to resemble, for instance, a criminal indictment. *Id.* The question is simply whether the notice of charges sufficiently affords the physician with an opportunity to answer and prepare an informed defense. *See* Klinge v. Lutheran Charities Ass'n, 523 F.2d 56, 62 (8th Cir. 1975); *Sosa*, 437 F.2d at 176; Silver v. Castle Mem. Hosp., 497 P.2d at 571; Miller v. Indiana Hosp., 419 A.2d 1191, 1193-94 (Pa. Super. Ct. 1980).

97. A fair hearing before an unbiased tribunal is essential to due process. Duffield v. Charleston Area Medical Center, 503 F.2d 512, 517 (4th Cir. 1974). In our context this means that a physician is "entitled to have his case judged by fair minded doctors who . . . [are] able and willing to . . . decide the case with 'good faith objectivity.' " Klinge v. Lutheran Charities Ass'n, 523 F.2d 56, 63 (8th Cir. 1975). But the physician is not "entitled to a panel made up of doctors who had never heard of the case and who knew nothing about the facts of it or what they supposed the facts to be." *Id.* In *Duffield*, a physician challenged as violative of due process the fact that certain members of the hospital's Joint Conference Committee, which was the final arbiter of staff privileges decisions, had also sat on the Governing Board which rendered a decision adverse to the physician. The court ruled that this fact alone did not necessarily indicate unfair bias, which "must stem from an extrajudicial

which is due is a fluid and arguably evolving concept which is very

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source and result in an opinion on the merits on some basis other than what the judge learned from his participation in the case." *Duffield*, 503 F.2d at 517. In support of this holding, the United States Supreme Court has ruled, in a case involving suspension of a physician's license by a state examining board, that it is not necessarily a violation of due process for the same agency or body to perform both an investigative hearing and then ultimately an adjudicative hearing. Withrow v. Larkin, 421 U.S. 35, 47-52 (1975). Participants in a later hearing need not be disqualified "simply because they have been exposed to evidence presented in non-adversary investigative procedures that were followed prior to the adversary hearing." *Klinge*, 523 F.2d at 63. Hence, where a physician was a witness before a medical hearing committee and was subsequently also a member of an appellate review body passing upon a staff privileges recommendation, there was no automatic bias shown; in fact, such illegal bias must be affirmatively shown by the aggrieved physician alleging it. Ritter v. Board of Comm'rs, 637 P.2d 940, 946-47 (Wash. 1981). Similarly, in Ladenheim v. Union County Hosp. Dist., 394 N.E.2d 770 (Ill. App. Ct. 1979), the fact that a physician-member of the Credentials Committee assisted the hospital attorney in the preparation of charges against an accused physician did not, absent a showing of unfair bias from an extra-judicial source resulting in an opinion on the merits, infringe upon the charged physician's due process rights. *Id.* at 774.

98. An example of one surprisingly recurring problem for hospitals is the disruptive physician. The Ninth Circuit described this problem well:

> A hospital staff is highly interdependent, both in the sense that one doctor depends upon the professional skill of other doctors and in the sense that the collegial nature of the body makes tolerable working relationships an absolute prerequisite to effective staff performance. The necessity for a healthy working relationship is a function of the nature of the work to be done. Incompatible workers on farms, ranches, or in certain types of factories can function reasonably well although even there it is doubtful that full efficiency is achieved. Effective performance by physicians on the staff of a hospital, whose tasks require a high degree of cooperation, concentration, creativity, and the constant exercise of professional judgment, requires a greater degree of compatibility.

Stretten v. Wadsworth Veterans Hosp., 537 F.2d 361, 368 (9th Cir. 1976). Numerous other courts have allowed the hospital wide latitude in requiring that the physician not be a disruptive force. *See, e.g.*, Truly v. Madison Gen. Hosp., 673 F.2d at 765 n.4 (upholding reasonableness of hospital's finding of doctor's "probable inability to work with administration and staff"); Laje v. R.E. Thomason Gen. Hosp., 564 F.2d 1159, 1162 (5th Cir. 1977) (allowing consideration of "ability to function smoothly in a hospital setting" as legitimate evaluation criterion); Robinson v. Magovern, 521 F. Supp. 842, 918 (W.D. Pa. 1981) (doctor's "alleged inability to work harmoniously with his fellow surgeons, the residents and the support personnel could have had an impact on the hospital's effort to achieve its primary objective . . . [of] outstanding patient care"); Schlein v. Milford Hosp., 423 F. Supp. 541, 544 (D. Conn. 1976) ("it is entirely consistent with due process for a hospital . . . to evaluate those personal qualities of a physician that reasonably relate to his ability to function effectively within a hospital environment"); Ritter v. Board of Comm'rs, 637 P.2d 940, 948 (Wash. 1981) (bylaw requirement of "ability to cooperate and satisfactorily relate with others . . . is . . . rationally related to the effective functioning of a hospital"); Ladenheim v. Union County Hosp. Dist., 394 N.E.2d 770, 776 (Ill. Ct. App. 1979) (physician's "inability to work with other members of the hospital staff was in itself sufficient grounds to deny him staff privileges"); Theissen v. Watonga Mun. Hosp. Bd., 550 P.2d 938, 940 (Okla. 1976) ("problems in getting along with other members of the Staff" constitute sufficient basis to deny staff privileges); Huffaker v. Bailey, 540 P.2d 1398, 1400 (Or. 1975) ("ability to work smoothly with others is reasonably related to hospital's object of ensuring patient welfare"). But see Miller v. Eisenhower Medical Center, 166 Cal. Rptr. 826, 837 (1980), where the

much a creature of the particular circumstances of a given case.[99] Other than imposing broad notice and fair hearing standards, there would be enormous difficulty and prolixity in conjuring up JCAH standards adequate to cover all or even most of the potential specific issues that could arise once a court decides that some process is due a physician. Moreover, such an excessive code would be imperious and would hardly comport with the goal of the JCAH to set reasonable standards without requiring oppressive or even ridiculous uniformity among the various aspects of all hospitals. Another reason for the brevity and generality of JCAH medical staff standards is an explicit desire on the part of the JCAH to accommodate various differences among the diffuse case law of different jurisdictions.[100] For example, even among the minority of jurisdictions which agree on the question of the quasi-public nature of the modern private hospital, there remains significant dispute over the scope of the physician's right to an attorney when his or her staff privileges have been or are about to be adversely affected by the hospital.[101] But unmistakably, the JCAH standards on the medical staff demand that the physician receive fair and unbiased treatment at the hands of the accredited hospital, be it public or private. Also, as noted previously, it purposefully avoids "technical loopholes" in federal due process jurisprudence which, at least in some jurisdictions, would limit the rejected physician to pursuing other remedies, such as tortious conspiracy or antitrust.

Supreme Court of California took a much more restrictive view, and said that rejection of an otherwise qualified physician from the medical staff was precluded

> unless it can be shown that [a physician] manifests an inability to "work with others" in the hospital setting which, by reason of its particular character, presents a real and substantial danger that patients treated by him . . . might receive other than a "high quality of medical care" if he were admitted to membership.

99. In Mathews v. Eldridge, 424 U.S. 319 (1976), Justice Powell, writing for the majority, set out the three factors which must be considered in deciding what particular elements of process are due:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Id. at 335.

100. Telephone interview with Dr. Becker of the JCAH Staff on Standards (Mar. 11, 1984).

101. *See supra* note 94.

IV. THE RESPONSE OF FLORIDA COURTS TO STATUTORY IMPOSITION OF JCAH STANDARDS

The previous discussion impels the conclusion that the statutory imposition of JCAH standards upon all Florida hospitals was clearly intended to overrule the judicially created rule of absolute discretion of the private hospital to grant, deny, or withdraw staff privileges at will. Accordingly, we may now evaluate whether Florida courts have understood the meaning of this statutory mandate.

The Second District Court of Appeal, in *Moles v. White*,[102] addressed the issue of the public-private dichotomy over one year after the passage and effective date of section 395.065, compelling JCAH procedural standards.[103] In *Moles*, two physicians who were specialists in open heart surgery applied for medical staff privileges at the Morton F. Plant Hospital, a private institution which was "the only facility in the Clearwater area authorized to provide open heart surgery and supportive services."[104] Both applicants were rejected, and at least one of them was rejected summarily "without referral of the application to the Credentials Committee for qualification, or to the medical staff . . . for a recommendation."[105] Upon rejection, the physicians sued the hospital, its corporate owner and manager, the hospital's executive director, and three members of its medical staff alleging "violation of state antitrust provisions, denial of due process, restraint of trade or commerce, and breach of a fiduciary trust and public purpose."[106]

After dismissing their antitrust claims as not within the province of the then current Florida antitrust statutes, the Second District also dismissed the physicians' due process claims, relying on the Florida Supreme Court decision in *West Coast Hospital Association v. Hoare*,[107] which, it will be recalled, affirmed the immunity of private hospitals "from adhering to the universally recognized requirements of due process."[108] The *Moles* court quoted that portion of the *Hoare* decision where the Florida Supreme Court conceded that the Florida legislature would probably have "the power and authority to regulate private hospitals" but also noted that it

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102. 336 So. 2d 427 (Fla. 2d DCA 1976).

103. *See* FLA. STAT. § 395.065(1) (1975) (repealed 1982).

104. *Moles*, 336 So. 2d at 429.

105. *Id.*

106. *Id.*

107. 64 So. 2d 293 (Fla. 1953). *See supra* notes 17-19 and accompanying text.

108. *Moles*, 336 So. 2d at 429.

"has not attempted to do so."[109] The Second District then remarked, purporting to bring the *Hoare* decision up to date, that "[o]ur hospital licensing laws have not been substantially changed since before the *Hoare* case,"[110] when, at least insofar as medical staff privileges were concerned, nothing could have been further from the truth.

It is not apparent whether the physician-appellants in *Moles* were aware of section 395.065 and what it could have meant for them by providing a cause of action to require due process-like treatment.[111] It is, of course, fairly arguable that the *Moles* court ought not be criticized too harshly for its decision, since, with few exceptions (e.g., jurisdiction), an appellate court is under no duty sua sponte to search out the law favorable to one side or the other, but only to consider those arguments raised before it, and it does not appear that the physicians even brought up the issue of section 395.065. But still, the Second District's loose declaration that Florida's hospital licensing laws, particularly those dealing with the medical staff, have not changed since before 1953 is a grossly incorrect statement which the court should have refrained from making without sufficient knowledge of its certainty.

The Second District repeated its grievous error in *Margolin v. Morton F. Plant Hospital Association,*[112] a case coincidentally involving the same private hospital involved in *Moles.*[113] In *Margolin,* a physician who was removed from the staff of the hospital sought injunctive relief on the theory that he had been denied procedural due process. The Second District in a per curiam response cited its previous opinion in *Moles,* along with *Hoare,* in noting that the hospital was private.[114] However, because Dr. Margolin also alleged in his complaint that the hospital had substantially departed from its bylaws, the Second District followed the established rule that even private hospitals must follow their own bylaws, such that if the staff bylaws of a private hospital provide due process-like treatment for its medical staff, these provisions must be followed by the hospital.[115]

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109. *Id.*

110. *Id.*

111. The *Moles* court dismissed the other contentions of the physicians having to do with their restraint of trade and quasi-public arguments. *Id.* at 429-31.

112. 348 So. 2d 57 (Fla. 2d DCA 1977).

113. Indeed, the private hospital involved in both the *Moles* and *Margolin* decisions was, incredibly, the same hospital involved over a generation earlier in the *Hoare* opinion.

114. *Margolin,* 348 So. 2d at 57.

115. *See supra* note 15.

The most recent Second District opinion concerning medical staff privileges in the context of a private hospital was *Hackett v. Metropolitan General Hospital,*[116] a case in which Dr. Hackett, a urologist, was denied admission to the all-osteopathic medical staff of a private hospital because of an alleged conspiracy between the hospital, through its board of trustees, and the osteopathic physicians on its medical staff to monopolize urology practice in favor of the one staff member practicing urology and to exclude medical doctors from the staff for fear of their competition with osteopaths.[117] Specifically, Dr. Hackett sued under Florida's Antitrust Act of 1980[118] and under the Florida law which prohibits discrimination against various medical disciplines.[119] The Second District ruled that Florida's antitrust laws, which had been amended since the *Moles* decision, clearly encompassed restraints upon the practice of medicine, and that Dr. Hackett's complaint was adequate to allege a violation of section 395.0653(1), the prohibition of discrimination against professional medical disciplines. But the *Hackett* court clearly preserved the validity of the *Hoare* rule which, in its words, allows private hospitals "the right to exclude a physician . . . for any reason,"[120] and thus the Second District still seemed unaware that the public-private dichotomy had been legislated out

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116. 422 So. 2d 986 (Fla. 2d DCA 1982).

117. *Id.* at 987.

118. FLA. STAT. ch. 542 (1981).

119. FLA. STAT. § 395.0653 (1981). This section was originally enacted in 1979 to abrogate prior holdings which allowed even public hospitals to discriminate against osteopaths, podiatrists, or dentists in staff privileges decisions merely on the basis of prejudice against these professions per se. *See* Richardson v. City of Miami, 198 So. 51 (Fla. 1940); Taylor v. Horn, 189 So. 2d 198 (Fla. 2d DCA 1966).

Section 395.0653, as amended up to 1981, prohibited any hospital from refusing to grant staff or clinical privileges "solely because" the applicant was licensed as an osteopath, dentist, or a podiatrist. FLA. STAT. § 395.0653(1) (1981). Moreover, hospitals were required to consider each applicant, whether medical doctor or podiatrist, for instance, "on an individual basis pursuant to criteria applied equally to all other disciplines." *Id.* § 395.0653(2). The term "disciplines" refers to "different fields of licensure rather than the narrower classifications within one of the disciplines." Sarasota County Pub. Hosp. Bd. v. Shahawy, 408 So. 2d 644, 646 (Fla. 2d DCA 1982). Thus, requiring a medical doctor who is not board certified by the American Board of Cardiovascular Diseases to demonstrate the higher standard of being "unusually qualified" because of the applicant's lack of certification is not discriminatory within the meaning of this statute because board certification refers to a classification *within* the discipline of doctor of medicine. *Id.*

These prohibitions against professional discrimination were carried over by the 1982 Florida legislative session into the new statute, FLA. STAT. § 395.011 (1983). This new section expanded the protection given to professional disciplines in several respects, which shall be discussed above in the text.

120. *Hackett,* 422 So. 2d at 988.

of existence for over seven years at the time of its decision.[121]

The apparently oblique message of section 395.065 was not lost upon the Fourth District Court of Appeal, however, which delivered a highly commendable opinion in *Carida v. Holy Cross Hospital, Inc.*[122] Dr. Carida was a member of the medical staff of Holy Cross Hospital, a private institution, who was refused reappointment to the medical staff. The trial court dismissed his complaint against the hospital for compensatory and punitive damages on the authority of the *Hoare* decision, notwithstanding the trial court's "apparent conclusion" that the denial of his reappointment was occasioned by malice and effectuated through severe procedural irregularities.[123]

The *Carida* court correctly ruled that section 395.065 "did away with the public versus private hospital distinction in denying or restricting medical staff privileges," and accordingly the court reversed the trial court's dismissal of the complaint.[124] In support of this ruling, the Fourth District quoted a portion of the then current JCAH standards on the medical staff which then, as now, were "predicated on fairness of hearing and appellate review mechanisms."[125] The *Carida* court also noted that Florida Administrative Code Rule 10D-28.58(2)(d), promulgated by HRS in 1977, "imposed upon all hospitals the requirements of a hearing and thorough investigation of applications for appointment and reappointment to medical staffs."[126]

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121. The Third District Court of Appeal demonstrated its awareness of § 395.065 in Buckner v. Lower Fla. Keys Hosp. Dist., 403 So. 2d 1025, 1028 (Fla. 3d DCA 1981). But the *Buckner* case involved a physician's suit against a public hospital, and therefore the issue of the intended effects of § 395.065 upon the public-private dichotomy did not arise.

122. 427 So. 2d 803 (Fla. 4th DCA 1983).

123. *Id.* at 805. The procedural irregularities stemmed from the hospital's blatant failure to follow its own bylaws as well as from certain alleged due process violations in the form of insufficient notice and denial of cross-examination.

124. *Id.*

125. *Id.* (footnote omitted).

126. *Id.* at 806 (footnote omitted). HRS, as the statutorily designated "licensing agency" for ch. 395, Florida Statutes, titled "Hospital Licensing and Regulation," FLA. STAT. § 395.01(4) (1977), promulgated FLA. ADMIN. CODE R. 10D-28.58(2)(d) pursuant to its rulemaking authority accorded by FLA. STAT. § 395.07 (1977). The rule requires:

> Review of all applications for appointment and annual reappointment to all categories of the medical staff, and recommendations on each to the hospital's governing authority, including delineation of privileges to be granted in each case, and right of hearing and appeal. Recommendation to the governing body for withdrawal of any privileges of a member of the medical staff or dismissal from the medical staff will be made only after a thorough investigation by the medical staff or a committee thereof, with the subject member being given the right of hearing before the medical staff or a committee thereof.

Having finally extinguished the public versus private medical staff distinction in Florida nearly a decade after section 395.065 was passed by the Florida legislature, the Fourth District confronted the problem of that section's grant of limited immunity, which states:

> There shall be no liability on the part of, and no cause of action of any nature shall arise against, any hospital, hospital medical staff, or hospital disciplinary body or its agents or employees for any action taken in good faith and without malice in carrying out the provision of this section.[127]

Despite this section's seemingly all encompassing language, the *Carida* court construed "liability" to mean "responsibility for damages proximately resulting from a tort" and interpreted the phrase " 'cause of action of any nature,' as referring to and limited by the word 'liability.' "[128] Because the section requires an allegation of malice to initially overcome the immunity, the court recognized that to construe the section "as completely eliminating any cause of action of any nature against a hospital which gave such inadequate notice of the reasons reappointment was not being recommended," but which did *not* act maliciously in so doing, would bear the anomalous result that any nonmalicious action taken by a hospital adverse to the privileges of one of its staff, no matter how arbitrary, capricious or even absurd, "would go totally unanswered."[129] Such an interpretation was viewed by the court as anathema to Florida's constitutional guarantee of access to the state's courts for redress of injury.[130] Thus, the *Carida* court concluded that section 395.065, along with Rule 10D-28.58(2)(d), allows a physician to sue in a Florida circuit court to compel a due process-like review of the hospital's decision regarding staff privileges. If in such a suit the physician does not seek pecuniary damages, but merely due process-like review, malice need not be alleged or established. If, on the other hand, the physician desires, in addition to the due process-like review, compensatory or punitive damages, malice must be alleged and ultimately proved. Presumably, a physician-claimant seeking injunctive relief to compel the private hospital to comply with its own medical staff bylaws with-

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127. FLA. STAT. § 395.065(2) (1975).
128. *Carida*, 427 So. 2d at 806 n.6.
129. *Id.*
130. *Id. See* FLA. CONST. art. I, § 21.

out an attendant prayer for money damages need not allege malice.[131]

In 1982, the Florida legislature renewed its commitment to its statutory imposition of JCAH procedural protections by extending the "sunset" expiration[132] date of the current version of section 395.065 until 1992. This renewed version of the statute appears in section 395.0115[133] with only minor changes in the language of section 395.065. An additional provision, however, was added in the 1982 legislation.[134] The new provision exempts the "proceedings and records of committees and governing bodies" of public hospitals from exposure to Florida's open-government, or "sunshine," laws.[135] By, in effect, equating the confidentiality of a public hospital's proceedings and records pertaining to staff privileges deliberations with the secrecy of the private hospital, section 395.0115 goes even further than its predecessor in abrogating the public-private hospital dichotomy in Florida.

One problem which seemed to remain after *Carida* was the scope of the statutorily mandated JCAH protections. Both section 395.065 and its current version, section 395.0115, require "good cause" limitations on adverse action taken by the hospital against the privileges of "any staff *member*," but what about the staff *ap-*

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131. *Cf.* Palm Beach-Martin County Medical Center v. Panaro, 431 So. 2d 1023 (Fla. 4th DCA 1983) (court recognized the right of injunctive relief against a private hospital to compel compliance with its own bylaws, citing *Carida*, with no mention of necessity of pleading malice).

132. *See* FLA. STAT. §§ 11.61, 395.0115 n.1 (1983).

133. FLA. STAT. § 395.0115 (1983).

134. FLA. STAT. § 395.0115(3) (1983) states:

> The proceedings and records of committees and governing bodies which relate solely to actions taken in carrying out the provisions of this section shall not under any circumstances be subject to inspection under the provisions of chapter 119; nor shall meetings held pursuant to achieving the objectives of such committees and governing bodies be open to the public under the provisions of chapter 286.

135. *See* FLA. STAT. chs. 119, 286 (1983). FLA. STAT. § 395.0115(3) (1983) will have a preemptive effect on future decisions which might otherwise have followed the lead of Gadd v. News-Press Pub. Co., 412 So. 2d 894 (Fla. 2d DCA 1982). The *Gadd* ruling allowed a newspaper to have access to the personnel files of present and past physicians at a public hospital, as well as access to the minutes and other documents relating to the activities of the hospital's utilization review committee of the medical staff, all pursuant to ch. 119, Florida Statutes. The Second District rejected the hospital's argument that the statutory imposition of JCAH standards forbade such access because those standards require confidentiality. The Second District, which as we have seen has been impervious to the message of § 395.065, concluded: "Simply requiring compliance with the *standards* of the JCAH, in our opinion, does not create an exemption or confidentiality 'provided by law.'" *Gadd*, 412 So. 2d at 896 (emphasis in original).

plicant? *Carida* involved the termination of a staff member's privileges only, rather than the potential staff privileges of an initial applicant. This apparent gap is easily closed, however, for two reasons. First, both the current and former versions of the statute evince a clear legislative intent of complete and unadulterated incorporation of JCAH procedural standards on the medical staff, which, as previously indicated, include procedural protections for the initial applicant. In this regard we might also note, by way of resort to the protean principles of statutory construction, that the term "deny," as distinguished from the terms "suspend," "revoke," or "curtail," is understood to mean either a denial of staff appointment to an initial applicant or a denial of reappointment to a physician whose term of staff membership has expired.[136] Second, and more convincingly, the licensing agency charged with the interpretation and enforcement of chapter 395—HRS—has through its interpretation of this statute promulgated Rule 10D-28.58(2)(d)[137] which, as the *Carida* court noted, requires a "hearing and thorough investigation of applications" for either initial appointment or reappointment to the medical staff.[138]

These two reasons should foreclose the question of whether the applicant for initial appointment was intended to be included in the statutory incorporation of JCAH procedural protections. But even if these arguments concerning the scope of section 395.0115 are considered unpersuasive by a Florida court, the question is still indubitably settled by virtue of new procedural protections for initial physician-applicants to the medical staff which were enacted by the Florida legislature in 1982. These protections were appended onto existing statutory provisions prohibiting professional discrimination against osteopaths, dentists, and podiatrists.[139] According to the 1982 amendments, the governing board of the hospital must now "set standards and procedures to be applied by the licensed facility and its medical staff in considering and acting upon applications for staff membership or professional clinical privileges."[140] And, "[t]hese standards and procedures shall be available for public inspection."[141] The standards or professional criteria which are set pursuant to this requirement must clearly be

136. *See* Cray, *supra* note 13, at 236-38; McCall, *supra* note 13, *passim*.
137. *See supra* note 126.
138. *Carida*, 427 So. 2d at 806.
139. *See supra* note 119.
140. FLA. STAT. § 395.011(4) (1983).
141. *Id.*

reasonably related to the primary hospital goal of providing high quality patient care:

> The applicant's eligibility for staff membership or professional clinical privileges shall be determined by the applicant's background, experience, health, training, and demonstrated competency; the applicant's adherence to applicable professional ethics; the applicant's reputation; and the applicant's ability to work with others and by such other elements as may be determined by the governing board, consistent with this part.[142]

Finally, the hospital is now required to submit in writing its reasons for rejection of a medical staff applicant to the "applicant's respective licensing board,"[143] in addition to providing these reasons for denial to the applicant within thirty days and upon written request.[144]

Thus, any doubt which might have arisen following *Carida*, as to whether the rejected applicant for staff privileges was required to be accorded certain due process-like protections similar to those required for staff members, has been quite commendably resolved by these 1982 amendments.

V. Statutory Imposition of Procedural Protections for Physicians in Other Jurisdictions

Florida is not unique in requiring its hospitals to comply with JCAH procedural standards in dealings with the medical staff.

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142. *Id.* § 395.011(3).

143. *Id.* § 395.011(5). The requirement that the hospital report its reasons for denial to the applicant's licensing board seems to dovetail with the separate statutory requirement that hospitals must report the "suspension or any other disciplinary action" taken by the hospital, its medical staff, or peer review group against a member of the medical staff. *See id.* § 458.337.

With respect to the earlier discussion in note 91 (concerning the fact that a mere rejection by a public hospital of an initial applicant for staff privileges, without more, did not infringe upon the applicant's liberty interest to pursue his or her chosen occupation), it was emphasized that, absent some sort of charge, the applicant's license to practice medicine was unaffected by the rejection of any given hospital. But the requirement of § 395.011(5) that the reasons for denial must be submitted to the applicant's licensing board would seem to directly affect the status of his or her license. Hence, it would also infringe upon a protected liberty interest such that if a mere rejection by a public hospital in Florida, notwithstanding the statutory due process-like protections now in place, did not previously implicate procedural due process because the requisite infringement upon the applicant's liberty interest was lacking, it now seems almost certain that a mere rejection in Florida of such an application implicates a protected liberty interest per se.

144. *Id.* § 395.011(5).

Rhode Island has a substantially similar law which requires the governing board of any licensed hospital (hence including both public and private hospitals) to comply with JCAH procedural standards when it seeks to "suspend, deny, revoke, or curtail" the privilege of any staff members.[145] Presumably Rhode Island's statutory requirement of JCAH procedural standards served to abolish a public-private hospital dichotomy in that state, thus resolving an issue which the Supreme Court of Rhode Island had previously left unsettled.[146]

The California courts, as previously discussed, adopted a common law "quasi-public" theory of the modern private hospital, thus according physicians at private hospitals the same procedural protections available to those staff physicians at public hospitals.[147] The issue then arose whether a physician could attack an adverse privileges decision of a private hospital through the same procedural means employed by public hospital physicians. More specifically, the question was whether section 1094.5 of California's Code of Civil Procedure, a provision which established a specialized review by mandate of certain types of administrative decisions and which appeared to apply only to administrative decisions by governmental agencies, was applicable to challenges lodged by private hospital physicians. The Supreme Court of California, in *Anton v. San Antonio Community Hospital*,[148] concluded: "It would be incongruous . . . to hold that the decisions of *private* hospital boards, which are required . . . to be based upon a hearing of substantially identical scope and purport, were to be subject to some different form of review."[149] Of several reasons offered in support

145. R.I. GEN. LAWS § 23-17-23 (1979 & Supp. 1983).

146. Hagan v. Osteopathic Gen. Hosp., 232 A.2d 596, 600 (R.I. 1967).

147. *See supra* notes 28 & 31 and accompanying text.

148. 140 Cal. Rptr. 442 (1977).

149. *Id.* at 450 (emphasis in original). The situation in Florida at this juncture is very similar to the one which was addressed in *Anton*. That is, to the extent that even though the public-private dichotomy has been abolished where the right to procedural protections is concerned, there are still two distinct methods of challenging a hospital's adverse privileges decision, depending upon whether it is a private or public institution. Since public hospitals are not considered administrative agencies within the meaning of Florida's Administrative Procedure Act, *see* FLA. STAT. § 120.52 (1983) and Siddeeq v. Tallahassee Mem. Hosp., 364 So. 2d 99, 100 (Fla. 1st DCA 1978), the quasi-judicial decisions of their governing boards affecting one's staff privileges are usually challenged in the state courts by means of a common law writ of certiorari in the circuit court. FLA. R. APP. P. 9.030(c). The circuit court's scope of certiorari review is to determine whether the hospital's governing board departed from the essential requirements of law and whether its decision was supported by competent substantial evidence. De Groot v. Sheffield, 95 So. 2d 912, 915-16 (Fla. 1957); McCray v. County of Volusia, 400 So. 2d 511, 512 (Fla. 5th DCA 1981). The decision of the

of this conclusion, the *Anton* court took emphatic judicial notice of JCAH procedural standards on the medical staff and of the fact that hospitals covered by the Local Hospital District Law in California were expressly subjected to these standards by statute, not unlike the situation in Florida.[150] In this regard, the court noted that "the practical necessity of securing JCAH accreditation has the effect of insuring that substantially all hospitals in this state, whether public or private, have bylaws governing hearing and appellate procedures which are designed to comply with JCAH standards. . . ."[151] Thus, "the use of the same judicial procedure for reviewing the adjudicatory decisions of all such hospitals" was deemed by the *Anton* court to be "peculiarly appropriate."[152]

In 1972, the New York legislature enacted a statutory scheme which, among other things, made it an "improper practice for the governing body of a hospital" to deny staff membership or to "curtail, terminate or diminish in any way" the professional privileges of a physician, dentist, or podiatrist "without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objective of the institution or the character or competency of the applicant."[153] The scheme allows an aggrieved physician to file a complaint with the New York Public Health Council, which in turn is required to make a "prompt investigation" of the hospital's decision.[154] If the Council then determines that "cause exists for crediting the allegations of the complaint," it must notify the governing body of the hospital which rendered the decision and direct it to review its decision.[155]

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circuit court reviewing the quasi-judicial decision of the governing board is in turn reviewable by the district court of appeal also through a writ of certiorari, and not by way of appeal. City of Deerfield Beach v. Vaillant, 419 So. 2d 624, 626 (Fla. 1982); FLA. R. APP. P. 9.030(b)(2)(B).

Because both the *Carida* decisions and the 1982 statutory amendments affecting physician-applicants to the medical staff are so recent, the procedural methods for review of a decision of the governing board of a private hospital with respect to staff privileges are still uncertain. Presumably such review will be by way of a suit for injunctive relief and/or damages filed within the original jurisdiction of the circuit court and not by means of the discretionary writ of certiorari. It is of course possible, however, that the Florida Rules of Appellate Procedure regarding common law writs of certiorari could be construed as covering the quasi-judicial decisions of private hospital governing boards, similar to the conclusion reached on the same issue in *Anton*.

150. *Anton*, 140 Cal. Rptr. at 451.

151. *Id.*

152. *Id.* at 452.

153. N.Y. PUB. HEALTH LAW § 2801-b(1) (McKinney 1977 & Supp. 1983).

154. *Id.* § 2801-b(2) to (3).

155. *Id.*

In *Fritz v. Huntington Hospital*,[156] New York's high state court interpreted these provisions to mean that New York's previous common law rule[157] allowing private hospitals sole discretion to exclude physicians from their staffs for any reason was "effectively limited."[158] The *Fritz* decision involved two osteopathic physicians who were both licensed by the State of New York and who had both completed accredited internships. The two applied for staff privileges at a New York private hospital, but were denied admission to the medical staff because neither had completed an internship or residency program approved by the American Medical Association (AMA). Upon their rejection they filed a complaint with the New York Public Health Council, and the Council found that the standards of accredited osteopathic institutions were comparable to those institutional training programs approved by the AMA.[159] The Council therefore concluded that the hospital's adverse decisions regarding the two applicants were not reasonably related to the goal of high quality patient care. But following the Council's conclusion and order of remand and review, the private hospital again adhered to its decision.[160] It was at that point that the *Fritz* court ruled that the physicians had standing to challenge the hospital decision in state court, because the Council's authority to do anything in the matter had ended.[161] On the merits, the court ruled that the hospital had not shouldered its burden of rebutting the Public Health Council's findings, which were presumptively

156. 384 N.Y.S.2d 92 (1976).

157. *See, e.g.*, Leider v. Beth Israel Hosp. Ass'n, 227 N.Y.S.2d 900 (1962); Van Campen v. Olean Gen. Hosp., 147 N.E. 219 (N.Y. 1925). In an unusual case the common law barrier could be set aside where both the economic necessity of the privileges to the physician and the monopoly power of the hospital were demonstrated. *See* Salter v. New York State Psychological Ass'n, 248 N.Y.S.2d 867 (1964); Moss v. Albany Medical Center Hosp., 403 N.Y.S.2d 568 (App. Div. 1978).

158. *Fritz*, 384 N.Y.S.2d at 96.

159. *Id.* at 95.

160. *Id.*

161. In a subsequent case, the New York Court of Appeals refined its view of the procedural requirements of § 2801-b. If, upon remand from the Public Health Council, the hospital still maintains its adverse position regarding the applicant's request for staff privileges, the next step for the physician is to file an action pursuant to N.Y. PUB. HEALTH LAW § 2801-c (McKinney 1977 & Supp. 1983) "to enjoin the hospital from discriminating against or unjustly denying professional privileges or staff membership in violation of section 2801-b of the Public Health Law." Cohoes Mem. Hosp. v. Department of Health, 424 N.Y.S.2d 110, 113 (1979). In the injunction action, the lower court reviews the privileges controversy de novo in a hearing in which the findings of the Public Health Council are admissible "only to the extent that [they serve] as prima facie evidence of any fact or facts found therein." *Id.* at 113. It is only at this point that the § 2801-c hearing decision is subject to appellate review at the request of either the hospital or the physician. *Id.*

correct, by demonstrating that AMA approved residencies or internships were superior to their accredited osteopathics counterparts.[162] The *Fritz* court concluded:

> By this determination we do not mean to indicate that hospitals are no longer free to be selective or that they must accept individuals licensed to practice medicine, regardless of competency, character or institutional objectives. However, judicial intervention is warranted where, as here, privileges are denied without proper foundation and without proper reason, and no challenge is made as to the actual medical credentials and capabilities of the applicants. . . .[163]

VI. CONCLUSION

By virtue of statutory mandate, Florida has joined those states which, through judicial decision or by positive law, require that members or applicants to the private hospital medical staff receive substantially the same procedural protections accorded the public hospital staff member or applicant. In fact, the required protections for the initial applicant to a private hospital significantly exceed the scope of federal due process protection available to an initial applicant to the public hospital, since, as we have seen, the initial applicant seldom has a protected liberty or property interest at stake. The public-private dichotomy in Florida, as elsewhere, amounted to little more than an absurd legal fiction, and it is hoped that Florida courts will interpret the new provisions of Florida law affecting physicians and hospitals correctly, as the *Carida* court has done.

162. *Fritz*, 384 N.Y.S.2d at 98.
163. *Id.* at 98-99.