University of Florida Journal of Law & Public Policy

Volume 2 | Issue 1 Article 9

1988

Does Medical Peer Review Immunity Exist After Patrick v. Burget? A Review of the Legal Fundamentals

F. M. Langley

Follow this and additional works at: https://scholarship.law.ufl.edu/jlpp

Recommended Citation
Langley, F. M. (1988) "Does Medical Peer Review Immunity Exist After Patrick v. Burget? A Review of the Legal Fundamentals," *University of Florida Journal of Law & Public Policy*: Vol. 2: Iss. 1, Article 9.
Available at: https://scholarship.law.ufl.edu/jlpp/vol2/iss1/9

This Article is brought to you for free and open access by UF Law Scholarship Repository. It has been accepted for inclusion in University of Florida Journal of Law & Public Policy by an authorized editor of UF Law Scholarship Repository. For more information, please contact kaleita@law.ufl.edu.

DOES MEDICAL PEER REVIEW IMMUNITY EXIST AFTER *PATRICK V. BURGET*? A REVIEW OF THE LEGAL FUNDAMENTALS

*F. M. Langley**

I. INTRODUCTION

Serving on a hospital credentials committee was once a privilege. That privilege has now become a hazard. Following the Supreme Court's decision in *Patrick v. Burget*,[1] physicians are questioning whether they want to assume the potential litigation risks inherent in serving on a credentials committee. For the first time, liability insurers are inquiring into physicians' peer review committee activities.

---

* D.V.M., 1967, Texas A & M University; M.D., 1973, University of Texas; J.D. Candidate, South Texas College of Law. The author wishes to thank Professor Catherine G. Burnett, South Texas College of Law.

1. 486 U.S. 904, 108 S. Ct. 1658 (1988).

Physicians face a new threat in the medical malpractice litigation arena — *M.D. v. Hospital Peer Review Committee.* Anytime a medical peer review committee either denies an applying physician staff privileges or revokes a physician's current clinical privileges, some sort of legal hearings or actual litigation under the Sherman Antitrust Act[2] or other doctrines[3] almost inevitably ensues.

The damages awarded in such legal actions can be substantial. When compared to a malpractice suit, a restraint of trade action can be more formidable for two reasons. First, an antitrust action is not covered under the usual liability insurance policy since antitrust has nothing to do with the "practice" of medicine in a negligent manner. Second, successful plaintiffs can obtain substantial damages for antitrust violations. The potentially staggering measure of liability is three times the physician's earning power loss resulting from the hospital privileges denial.

The Supreme Court of the United States, in *Patrick v. Burget,* addressed the antitrust peer review liability issue.[4] Affirming a lower court judgment of 2.2 million dollars, the *Patrick* Court ruled in favor of a physician whose clinical privileges were revoked by a credentials committee.[5] Although *Patrick* presented several issues on appeal,[6] the main question was whether federal antitrust rules prevailed over the state medical peer review immunity statute's protection of peer review committee members.[7] Focusing narrowly on the antitrust issue,[8] the Court failed to establish standards for medical peer review immunity.

The American Medical Association (AMA) and the Joint Commission of Accreditation of Healthcare Organizations (JCAH) filed amicus briefs on behalf of the peer review committee defendants in the case. The AMA sought to convince the Court that its decision did little to resolve the broader peer review liability issues.[9] Justice Marshall, writing for the Court, noted that Congress had declined to exempt

---

2. 15 U.S.C. §§ 1-7 (1982).

3. See *infra* notes 16, 186, 270 and accompanying text.

4. 108 S. Ct. at 1662.

5. *Id.* at 1666.

6. The Court of Appeals, despite the finding "that evidence, viewed in the light most favorable to Patrick, revealed shabby, unprincipled, and unprofessional conduct on the part of the defendants" reversed on the ground that respondents' conduct was immune from antitrust scrutiny under the state action doctrine of *Parker v. Brown* and its progeny. 800 F.2d 1498, 1509 (9th Cir. 1986).

7. 108 S. Ct. at 1662.

8. *Id.* at 1659 (state action doctrine does not protect Oregon physicians from federal antitrust liability for their activities on hospital peer review committees).

9. *Id.* at 1665.

medical peer review from the reach of the antitrust laws.[10] The Court explained that physicians desiring greater protection from antitrust challenges to peer review must address their concerns to Congress.[11]

What appeared to be a relatively settled issue dealing with the Health Care Quality Improvement Act (HCQIA) [12] in the spring of 1988 became a red hot topic in the summer of 1988 when the Court decided *Patrick*. Until all the fundamental considerations of medical peer review immunity have been addressed and defined in a way that is consistent with state and federal statutes and previous case law, physicians who choose to serve on medical peer review committees may do so at great risk of liability under the Sherman Antitrust Act. Consequently, hospitals which are required by state law to periodically review the medical practice of its staff physicians (by medical review committees comprised of physicians) are anxious to have the matter resolved. Although the JCAH can mandate peer review as a condition for hospital accreditation and receipt of federal funds, it cannot compel physicians to serve on committees. With no immunity, physicians are reluctant to assume litigation risks in order to satisfy a governmental regulatory agency.

A hospital credentials committee is unlikely to limit or deny privileges to a member of a hospital staff based solely upon its concern about an antitrust violation. However, the committee exercising peer review should consider the antitrust ramifications of its staff privileges decisions. A basic knowledge of the committee's available defenses to an antitrust challenge will aid the committee in evaluating its peer review decisions.[13]

II. STATE ACTION DOCTRINE

Patrick addressed the issue of whether the state action doctrine[14] protects physicians in the State of Oregon from federal antitrust liability for their activities on hospital peer review committees.[15] The state action doctrine, defined in *Parker v. Brown*,[16] exempts from

---

10. *Id.* at 1665 n.8. Congress insulated certain medical peer review activities from antitrust liability in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-52 (Supp. 1987). The Act, which was enacted well after the events at issue in this case and is not retroactive, immunizes peer review action from liability if the action was taken in the reasonable belief that it was in the furtherance of quality care.

11. *Id.*

12. 42 U.S.C. §§ 11101-52 (Supp. 1987).

13. *See infra* note 16 and accompanying text.

14. *See infra* note 17 and accompanying text.

15. Patrick v. Burget, 108 S. Ct. 1658, 1662 (1988).

16. 317 U.S. 341 (1943).

antitrust liability acts by the state or actions that bear a close relationship to state power or authority.[17] In *Parker*, the Supreme Court, relying on principles of federalism and state sovereignty, held that Congress did not intend the Sherman Act to prohibit states from imposing restraints on competition.[18] The state, in *Parker*, established a private raisin producers cartel designed to stabilize prices and increase economic efficiency in the raisin industry.[19] Although the scheme reduced competition among raisin producers, the Court determined that in passing the Sherman Act, Congress did not intend to prevent states from regulating their domestic commerce.[20] The critical issue was whether Congress, in enacting the Sherman Act, had intended to occupy the field of state-sanctioned anticompetitive activity.[21] The Supreme Court concluded that Congress had not, and thus the state's legislative interests had to be accommodated.[22] While the defendant in *Parker* was a state official, the Supreme Court has also applied the *Parker* doctrine to suits against private parties who implement state policies.[23]

In the years following *Parker*, the Supreme Court has narrowed the scope of the state action doctrine. The legislative actions of a state legislature and the "legislative" decisions of a state supreme court are state actions exempt from antitrust liability.[24] However, anticompetitive activity not directly that of the state legislature or state supreme court, but carried out by others pursuant to state authorization,[25]

---

17. *Id.* at 350.
18. *Id.* at 353.
19. *Id.* at 346.
20. *Id.* at 352.
21. *Id.*
22. *Id.*
23. *See* Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985). Private carriers formed a rate bureau that submitted joint proposals on rates to state regulatory agencies. The Supreme Court held that the activity was immune from antitrust attack, reasoning that *Parker* did not require compulsion because it was an attempt to reconcile state displacement with federal antitrust goals.
24. Hoover v. Ronwin, 466 U.S. 558, 567-68 (1984) (state supreme court that denied unsuccessful applicant to state bar exempt from antitrust action under the Parker doctrine because the challenged conduct was that of the State itself) (citing Bates v. State Bar of Arizona, 433 U.S. 350, 360 (1977)).
25. Typically, a state legislature enacts a "medical practice act" creating a regulatory agency which, in turn, promulgates rules governing the examination and licensure of physicians. Generally, members of the "board of medical examiners" are largely comprised of physicians who are actively engaged in the private practice of medicine.

requires "closer analysis" to determine whether it is attributable to the state and thus an immune state action.[26]

Any attempt to invoke the *Parker* state action immunity doctrine must surmount the strong federal interest in maintaining unrestrained competition. Congress enacted the Sherman Act pursuant to its power under the commerce clause,[27] and the Supreme Court has acknowledged the importance of the Act's procompetitive policy.[28] The federal antitrust laws preempt state laws authorizing or compelling private parties to engage in anticompetitive behavior.[29]

The Supreme Court articulated the circumstances under which *Parker* immunity is available to private parties in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*[30] The California statute at issue in *Midcal* required all wine producers and wholesalers to file fair trade contracts and price schedules with the state.[31] If a producer failed to set prices by contract, the wholesalers were required to post a resale price schedule.[32] All wine had to be sold at the prices set by contract or by price schedule.[33] Defendant Midcal was a wine producer charged with selling wine at a price below that set by a producer's price schedule.[34] Midcal petitioned the state court for an injunction against the California Department of Alcoholic Control, acknowledging that under the challenged system, the state could fine Midcal or suspend its license.[35] The Court held that because the state neither established prices nor regulated the terms of the fair trade contracts or price schedules, but merely authorized and enforced the private parties' price fixing, the California statutory scheme did not satisfy the requirements of the state action doctrine.[36]

---

26. *Hoover*, 466 U.S. at 568; Patrick v. Burget, 800 F.2d 1498, 1505 (9th Cir. 1986). *See also* Bates v. State Bar of Arizona, 433 U.S. 350, 359-63 (1977) (state supreme court rule that restricted advertising by lawyers is act of the state). *Contra* Goldfarb v. Virginia State Bar, 421 U.S. 773, 775, 793 (1975) (enforcement by state bar of county bar's minimum fee schedule for lawyers is not act of state).

27. U.S. CONST. art. I, § 8, cl. 3.

28. California Retail Liquor Dealers Assoc. v. Midcal Aluminum, Inc., 445 U.S. 97, 110-11 (1980).

29. 324 Liquor Corp. v. Duffy, 479 U.S. 335 n.8 (1987).

30. 445 U.S. 97 (1980).

31. *Id.* at 99.

32. *Id.*

33. *Id.*

34. *Id.* at 100.

35. *Id.*

36. *Id.*

The Supreme Court, in *Midcal*, fashioned a two-pronged test to determine whether state regulation of private parties is immune from antitrust liability. First, the anticompetitive conduct must be undertaken pursuant to a "clearly articulated and affirmatively expressed policy of the state" to displace competition.[37] Second, the state must actively supervise any private anticompetitive conduct.[38] Only if an anticompetitive act of a private party meets both of these requirements is it fairly attributable to the state.[39] The state scheme in *Midcal* failed the active state supervision prong of the test.[40]

This test is applicable to private parties as well as state officials.[41] When a state acts in its sovereign capacity, the two-pronged *Midcal* test is inapplicable; the act is simply immune from antitrust laws.[42] But when the anticompetitive activity is carried out by private parties pursuant to state authorization, which includes authorization by a state agency, both prongs of the *Midcal* test must be satisfied.[43] Satisfying both parts of the test demonstrates that the state intended anticompetitive conduct as part of its regulatory scheme.[44]

A. *The Second Prong: Active Supervision by the State*

The *Patrick* Court turned to the second prong of the *Midcal* test and attempted to define what constitutes active state supervision for medical peer review committees.[45] Justice Marshall, writing for a unanimous Court, noted that the issue presented was whether the *Parker v. Brown* state action doctrine protects Oregon physicians from federal antitrust liability for their activities on hospital peer review committees.[46] The Court did not consider the "clear articulation" prong of the *Midcal* test because it found that the "active supervision" requirement had not been satisfied.[47]

---

37. *Id.* at 105.

38. *Id.*

39. Patrick v. Burget, 108 S. Ct. 1658, 1663 (1988).

40. *Id.*

41. Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 56-57 (1985).

42. Consolidated Gas Co. v. City Gas Co., 665 F. Supp. 1493, 1524 (S.D. Fla. 1987).

43. *Southern Motor Carriers*, 471 U.S. at 60-63.

44. *Id.* at 65-66 (state public service commissions, permitted by statute in three states and permitted pursuant to clearly articulated state policy in fourth state, immune from antitrust laws). *Contra Midcal Aluminum*, 445 U.S. at 105-06 (although legislative policy clearly articulated, the program was not immune from antitrust laws due to inadequate state supervision).

45. Patrick v. Burget, 108 S. Ct. 1658 (1988).

46. Parker v. Brown, 317 U.S. 341 (1943).

47. *Patrick*, 108 S. Ct. at 1668.

The *Midcal* test recognizes that a private party engaging in anti-competitive conduct could be acting to further his own interests, rather than the governmental interests of the state."[48] The requirement of active state supervision in the second prong of the test ensures that the state action doctrine will shelter only the particular anticompetitive acts of private parties that, in the judgment of the state, actually further state regulatory policies.[49] To accomplish this purpose, the active supervision requirement mandates that the state exercise ultimate control over the challenged anticompetitive conduct.[50] The mere presence of some state involvement or monitoring does not suffice.[51] The active supervision prong of the *Midcal* test requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to be consistent with state policy.[52] Absent such a program of supervision, there is no realistic assurance that a private party's anti-competitive conduct promotes state policy.[53]

In *Patrick*, the petitioner was a surgeon who declined an invitation by respondents to join them as a partner in their clinic.[54] Instead, he began an independent practice in competition with the clinic.[55] Following difficulties in his professional dealings with the clinic, the hospital peer review committee terminated petitioner's privileges at the town's only hospital.[56] The committee suspended petitioner's clinical privileges on the ground that his patient care was below hospital standards.[57]

Petitioner filed suit in federal district court, alleging that respondents had violated sections 1 and 2 of the Sherman Act.[58] The complaint

---

48. *Id.* at 1663 (quoting Town of Hallie v. City of Eau Claire, 471 U.S. 34, 47 (1985)).

49. *Id.*

50. *Id.* (citing Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 51 (1985)) (noting that state public service commissions have and exercise ultimate authority and control over all intrastate rates).

51. *See* 324 Liquor Corp. v. Duffy, 479 U.S. 335, 345 n.7 (1987) (holding that certain forms of state scrutiny of a restraint established by a private party did not constitute active supervision because they did not exert any significant control over the terms of the restraint).

52. *See* California Retail Liquor Dealers Assoc. v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

53. Tambone v. Memorial Hosp. for McHenry County, 635 F. Supp. 508, 514-15 (N.D. Ill. 1986), *aff'd*, 825 F.2d 1131 (7th Cir. 1987) (physician who was denied staff privileges at hospital brought antitrust action against hospital and hospital peer review committee members).

54. Patrick v. Burget, 108 S. Ct. 1658, 1660 (1988).

55. *Id.*

56. *Id.* at 1661 (majority of the hospital's staff members were employees or partners of the clinic).

57. *Id.*

58. *Id.*

alleged that respondents initiated and participated in the peer review proceedings in order to reduce competition rather than to improve patient care.[59] The court entered a judgment against respondents, but the Ninth Circuit Court of Appeals reversed.[60] Despite finding that the evidence "viewed in the light more favorable to Patrick, revealed shabby, unprincipled and unprofessional conduct on the part of the defendants," the court of appeals held that respondents' conduct was immune from antitrust scrutiny under the state action doctrine of *Parker*.[61] The appellate court reasoned that Oregon had articulated a policy in favor of peer review and actively supervised the peer review process.[62] Thus, both the clearly articulated state policy and active state supervision prongs of the *Parker* test were satisfied.

The Supreme Court, however, disagreed with the Ninth Circuit's interpretation of "active supervision."[63] The Court held that the state action doctrine did not protect peer review decisions in Oregon because no state actor in Oregon actively supervised hospital peer review decision.[64]

The state health agency in Oregon, the Health Division, has general supervisory powers over matters relating to the preservation of life and health,[65] including licensing hospitals[66] and enforcing health laws.[67] Hospitals in Oregon have a statutory obligation to establish peer review procedures and to review those procedures regularly.[68] Under its enforcement powers, the state Health Division, may initiate judicial proceedings against any hospital violating this law.[69] In addition, the Health Division may deny, suspend or revoke a hospital's license for failing to comply with statutory requirements.[70] Oregon law specifies no other ways in which the Health Division may supervise the peer review process.

This statutory scheme does not provide active state supervision over peer review decisions.[71] *Patrick* established that merely mandat-

---

59. *Id.*
60. *Id.*
61. Patrick v. Burget, 800 F.2d 1498, 1509 (9th Cir. 1986).
62. *Patrick*, 108 S. Ct. at 1663.
63. *Id.*
64. *Id.* at 1664.
65. OR. REV. STAT. § 431.110(1) (1987).
66. *Id.* at § 441.025.
67. *See id.* at §§ 431.120(1), .150, .155(1).
68. *See id.* at § 441.055(3)(c), (d).
69. *See id.* at §§ 431.150, .155.
70. *Id.* at § 441.030(2).
71. *Patrick*, 108 S. Ct. at 1664.

ing medical peer review without actively taking part in that review process is not active supervision.[72] Actively taking part in the review process, under *Patrick*, means that a state official exercises ultimate authority over private privilege decisions.[73] Since the Oregon Health Division has no power to overturn private peer review decisions that are inconsistent with state policy, the activities of the Health Division cannot satisfy the active supervision requirement of the state action doctrine.[74]

Nor does the Oregon Board of Medical Examiners (BOME) actively supervise private peer review decisions. Its principal function is to regulate the licensing of physicians in the state.[75] Although Oregon hospitals are required by statute to notify the BOME promptly of a decision to terminate or restrict privileges, the statutory provision does not indicate that the BOME can overturn private privilege decisions.[76] The reporting requirement merely gives the BOME an opportunity to determine whether additional action on its part, such as revocation of a physician's license, is warranted.[77] In *Patrick*, respondents did not show that the BOME actually reviewed privilege decisions or that it had ever asserted the authority to reverse those decisions.[78]

Although the case did not require the Court to decide the broad question of whether judicial review of private conduct can ever constitute active state supervision, the *Patrick* Court did discuss the judicial review system in Oregon.[79] Previous Supreme Court cases concerning state supervision over private parties have involved administrative agencies[80] or state supreme courts with agency-like responsibilities over the organized bar.[81] Oregon has no statute expressly providing

---

72. *Id.*

73. *Id. See also* n.6. The statutory scheme indicates that the Health Division has only limited power over even a hospital's peer review procedures. The statute authorizes the Health Division to force a hospital to comply with its obligation to establish and regularly review peer review procedures, but the statute does not empower the Health Division to review the quality of the procedures that the hospital adopts. *Id.*

74. *Id.*

75. *See* OR. REV. STAT. § 441.820(1) (1987).

76. *See id.* at § 441.820(1).

77. 108 S. Ct. at 1664 n.7. The statutory provision requiring hospitals to inform the BOME of a decision to terminate privileges in only one of several statutory reporting requirements involving the Board of Medical Examiners. Oregon law also provides that hospitals and licenses shall report medically incompetent conduct to the BOME. *Id. See also* OR. REV. STAT. § 743.770.

78. 108 S. Ct. at 1664 n.7.

79. *Id.* at 1664-65.

80. *See* Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985).

81. *See* Bates v. State Bar of Arizona, 433 U.S. 350 (1977).

for judicial review of privilege terminations.[82] The Oregon Supreme Court, in its most recent decision on the subject, stated that a court "should [not] decide the merits of plaintiff's dismissal," and that "[i]t would be unwise for a court to do more than to make sure that some sort of reasonable procedure was afforded and that there was evidence from which it could be found that plaintiff's conduct posed a threat to patient care."[83] Under the Oregon Supreme Court's standard, a state court would not review the merits of a privilege termination decision to determine whether it was consistent with state regulatory activity.[84] The Ninth Circuit found that such limited review did not convert a private party's act of terminating a physician's privileges into state action.[85]

The Supreme Court in *Patrick* left open the question of whether judicial review in the context of a traditional lawsuit may constitute active state supervision.[86] Three months after the *Patrick* decision, in *Bolt v. Halifax Hospital Medical Center*,[87] the Eleventh Circuit accepted the implied invitation by the *Patrick* Court and used judicial review to satisfy the requirement of active state supervision in a Florida case involving a medical peer review committee.[88] *Bolt* is particularly significant in that it may provide a mechanism for legislatures to impose, and for courts to continue, active state supervision.

In *Bolt*, a physician, whose staff privileges were revoked at each of three hospitals, brought suit against the hospitals and their medical staffs.[89] The issue was whether the state of Florida actively supervised peer review.[90] The Eleventh Circuit relied on *Patrick*, which held that "the State does not actively supervise the termination of hospital staff privileges unless a state official exercises ultimate authority over private privilege determinations."[91] The Eleventh Circuit held that the

---

82. Some states may follow the Texas statute which provides for judicial review in a state district court only for suspension or revocation of the medical license and not for loss of clinical privileges. TEX. REV. CIV. STAT. ANN. art. 4495b(4.09) (Vernon Supp. 1988).

83. 108 S. Ct. at 1665 (quoting Straube v. Emmanuel Lutherian Charity Bd., 600 P.2d 381, 386 (Or. 1979)).

84. Only seven states fail to follow this approach: New Jersey, Arizona, California, Hawaii, New Hampshire, Vermont, and New Mexico. *See* Note, *Michigan Court Joins Majority in Denying Judicial Review of Staffing Decisions of Private Hospitals*, 6 AM. J. TRIAL ADVOC. 339 (1982).

85. *Id.*

86. 108 S. Ct. at 1665.

87. 851 F.2d 1273 (11th Cir. 1988).

88. *Id.* at 1274.

89. *Id.* at 1273-74.

90. *Id.* at 1274, 1281.

91. *Id.* at 1281 (quoting Patrick v. Burget, 108 S. Ct. 1658, 1664 (1988)).

Florida peer review statute[92] failed to indicate that Florida's BOME had power to overturn a peer review decision.[93] The court reasoned that the apparent purpose of the notification requirement was to enable the BOME to take further disciplinary action if it deemed such further action appropriate.[94]

The Eleventh Circuit then concluded that judicial review may constitute active state supervision for purposes of the state action exemption.[95] Although not authorized by the legislature, judicial review is nonetheless state regulation.

> It is sufficient if the legislature clearly articulates a policy and then acquiesces in the courts' implementation of that policy . . . . Indeed, regulation through the judiciary may be more likely to ensure accurate implementation of the state's policy, for courts are especially well suited to divine, interpret, and enforce legislative policy.[96]

After entering the door opened by *Patrick*, the Eleventh Circuit reviewed time-tested case history that reaffirmed the courts' competency to scrutinize medical peer review cases.[97]

> [J]udicial review cannot constitute active state supervision unless it is available on an established basis and is of a sufficiently probing nature. To be sufficiently probing, the scope of judicial review must first of all encompass the fairness of the procedures used in reaching the decision. Furthermore, it must involve consideration of whether the criteria used by the decisionmakers were consistent with state policy and whether the decision had a sufficient basis in fact.[98]

Upon examining both Florida case law and Florida statutes, the court determined that such judicial review was available in the state.[99] For example, Florida courts have recognized that a physician whose

---

92. *Id.* Defendants asserted that Florida actively supervised peer review determinations by virtue of Fla. Stat. § 458.337(1)(b) (1981), which requires notification of the Florida Board of Medical Examiners, a state agency, whenever a physician "[h]as been disciplined . . . by a licensed hospital or medical staff of said hospital." *Id.*

93. *Id.*

94. *Id.* at 1281-82.

95. *Id.* at 1282.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

staff privileges at a hospital have been revoked has a cause of action for injunctive relief.[100] Florida hospitals are required by statute to establish rules for granting and terminating staff privileges.[101] Such rules ensure that hospitals base review decisions on fair procedures, valid criteria, and sufficient evidence. The courts enforce the rules by granting injunctive relief against the hospital.[102]

The Eleventh Circuit's decision has greatly expanded the definition of active state supervision in the context of medical peer review decisions. Judicial review of medical staff decisions is sufficiently probing to constitute active state supervision if the courts review (1) the fairness of the procedures, (2) the validity of the criteria used, and (3) the sufficiency of the evidence.[103] The Fifth Circuit described the limits of court review: "In short, so long as staff selections are administered with fairness, gauged by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere."[104]

Several cases have addressed the issue of adequate supervision. In *Midcal Aluminum v. Rice*, where the state simply enforced the prices established by private parties, the court held that this did not meet the requirement of active supervision.[105] The district court in *Coin Call, Inc. v. Southern Bell Telephone & Telegraph Co.*[106] found, however, that where the defendant initiated a coin telephone tariff, the action met the second prong of *California Retail Liquor Dealers Association v. Midcal Aluminum Inc.* because a state agency actively enforced the original tariff and participated in its revision.[107]

In the pre-*Patrick* case of *Quinn v. Kent General Hospital*,[108] the court also considered the issue of peer review immunity under the

---

100. *See, eg.*, Margolin v. Morton F. Plant Hosp. Ass'n, 348 So. 2d 57, 57 (Fla. 2d D.C.A. 1977); *see also* Lawler v. Eugene Westhoff Memorial Hosp. Ass'n, 497 So. 2d 1261, 1263-64 (Fla. 5th D.C.A. 1986); Palm Beach-Martin County Medical Center, Inc. v. Panaro, 431 So. 2d 1023, 1024-25 (Fla. 4th D.C.A. 1983).

101. FLA. STAT. § 395.0653(3) (1981).

102. *Bolt*, 851 F.2d at 1284 n.15. Florida courts have recognized this cause of action for injunctive relief even though FLA. STAT. § 395.065(2) (1981) provides that "[t]here shall be no liability on the part of, and no cause of action of any nature shall arise against, any hospital . . . for any action taken in good faith and without malice (in conducting peer review pursuant to Florida law)."

103. *Id.* at 1284.

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

105. 90 Cal. App. 3d 979, 983-84, 153 Cal. Rptr. 757, 760 (3d Dist. 1979).

106. 636 F. Supp. 608 (N.D. Ga. 1986).

107. *Id.* at 614.

108. 617 F. Supp. 1226 (D. Del. 1985).

Parker doctrine.[109] Because Delaware did not mandate peer review, and thus did not actively supervise a clearly articulated policy, the court denied summary judgment for the defendants.[110] In dicta, however, the *Quinn* court said that the peer review process would not necessarily impose any additional restriction on competition.[111] The court thought that the peer review process was arguably procompetitive when conducted within the bounds of the medical profession.[112] By monitoring the qualifications and performance of physicians, a review board may enhance competition by enabling consumers to make a more informed choice.[113]

In *Marrese v. Interqual, Inc.*,[114] the Seventh Circuit held that a hospital staff conducting peer review was immune from antitrust liability under the state action doctrine.[115] The Seventh Circuit later upheld a district court decision in *Tambone v. Memorial Hospital*,[116] requiring evidence that the state actively supervised the peer review.[117] The circuit court stated that although the Department of Health had access to peer review records, inspectors were not obligated to inspect these records.[118] Since the state did not engage in a regular organized supervision of the peer review process, peer review was not immune under the state action doctrine.[119]

In the recent Supreme Court decision of *324 Liquor v. Duffy*,[120] the Court said that where a state simply authorizes a particular practice and enforces the consequences through private parties, there is no active supervision.[121] In *324 Liquor*, the New York statute at issue allowed individual wholesalers of certain beverages to "post" monthly price schedules and prohibited retailers from selling below the posted price plus a certain markup percentage.[122] The state agency in *324 Liquor* did not review or establish the posted wholesale prices,[123] nor

---

109. *Id.* at 1236.
110. *Id.*
111. *Id.* at 1239.
112. *Id.*
113. *Id.*
114. 748 F.2d 373 (7th Cir. 1984).
115. *Id.* at 391.
116. 635 F. Supp. 508 (N.D. Ill. 1986).
117. *Id.* at 510.
118. *Id.* at 514.
119. *Id.* at 515.
120. 479 U.S. 335, 107 S. Ct. 720 (1987).
121. *Id.* at 725.
122. *Id.* at 722.
123. *Id.* at 726.

did the state monitor market conditions, supervise the private wholesalers' posting decisions or "engage in any 'pointed reexamination' of the program."[124]

Following *Patrick*, states will need to supervise medical peer review more actively if members of the review committee are to have immunity from actions under the Sherman Antitrust Act. Although *Patrick* did not discuss the first prong of the *Midcal* test, it will still remain the first consideration in determining whether the *Parker* doctrine will apply to the questioned action.

B. *The First Prong: Clearly Articulated State Policy*

Parker addressed the question of whether the federal antitrust laws prohibited a state, in exercising its sovereign powers, from imposing certain anticompetitive restraints.[125] Noting that the language of the Sherman Act did not suggest that its purpose was to restrain a "state or its officers or agents from activities directed by its legislature," the Court held that the Sherman Act does not apply to the anticompetitive conduct of a state acting through its legislation.[126] However, the Court asserted that a state cannot grant immunity to individuals by authorizing them to violate the Sherman Act.[127] Instead, the challenged activity must be "one clearly articulated and affirmatively expressed as state policy . . . ."[128]

To establish that a state's policy is clearly articulated and affirmatively expressed, the defendant must show that there is a state policy to displace competition and that the legislature contemplated the kind of anticompetitive actions alleged.[129] Mere state neutrality toward the challenged action does not meet this clear articulation and affirmative expression requirement.[130] *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*[131] set the standard for "clearly articulated and affirmatively expressed" state policy. Analyzing the Califor-

---

124. *Id.* (quoting California Retail Liquor Dealers Assoc. v. Midcal Aluminum, Inc., 445 U.S. 97, 106 (1980)).

125. Parker v. Brown, 317 U.S. 341, 350 (1943).

126. *Id.* at 368.

127. *Id.* at 351.

128. *Id.*

129. Reazin v. Blue Cross & Blue Shield, 663 F. Supp. 1360, 1419 (D. Kan. 1987) (quoting California Aviation, Inc. v. City of Santa Monica, 806 F.2d 905, 907 (9th Cir. 1986)).

130. Sterling Beef Co. v. City of Fort Morgan, 810 F.2d 961, 963 (10th Cir. 1987) (quoting Community Communications Co. v. City of Boulder, 455 U.S. 40, 55 (1982)).

131. 445 U.S. 97, 105 (quoting California Aviation Inc. v. City of Santa Monica, 806 F.2d 905, 907 (9th Cir. 1986)).

nia regulatory scheme, the *Midcal* court first determined that the challenged restraint had met the standard since the regulations explicitly permitted resale price maintenance.[132]

The Supreme Court recently applied the *Midcal* test to a regulatory agency in *Southern Motor Carriers Rate Conference, Inc. v. United States*.[133] Alleging that defendants, a private association of interstate common carriers, had conspired with their members to fix rates for the interstate transportation of general commodities, the petitioner sought injunctive relief under section 1 of the Sherman Act.[134] The defendant associations, known as "rate bureaus," submitted joint rate proposals to the public service commissions in their respective states.[135] In all four states involved, common carriers were allowed to agree on rate proposals prior to submitting them to the states' regulatory agencies.[136]

The *Southern Motor Carriers* Court declared that the first prong of the *Midcal* test did not require that the state policy in question compel anticompetitive conduct by the regulated parties.[137] The Court stated that "[t]he federal antitrust laws do not prohibit the states from adopting policies that permit, but do not compel, anticompetitive conduct by *regulated* private parties."[138] Referring to the first prong of the *Midcal* test, the Court reasoned that a state policy that expressly permits, but does not compel, anticompetitive conduct may be "clearly articulated" within the meaning of *Midcal*.[139] Since the government conceded that the states' public service commissions actively supervised the collective ratemaking activities of the rate bureaus, the outcome of the case turned on the Court's analysis under the first prong of the *Midcal* test.[140]

The *Southern Motor Carriers* Court asserted that to satisfy the first prong of the *Midcal* analysis, the state legislature must have clearly sanctioned collective ratemaking.[141] Three of the four states involved had passed statutes which explicitly permitted collective ratemaking by common carriers.[142] Mississippi, the only state which

---

132. *Id.* at 105.
133. 471 U.S. 48 (1985).
134. *Id.*
135. *Id.* at 51-52.
136. *Id.* at 51.
137. *Id.* at 55-62.
138. *Id.* at 60.
139. *Id.* at 61.
140. *Id.* at 64.
141. *Id.*
142. *Id.*

had not directly addressed collective ratemaking, had a statute which allowed the Mississippi Public Service Commission to set "just and reasonable" rates for intrastate transportation of general commodities.[143] The Court determined that the Mississippi legislature had clearly expressed its intent to allow a regulatory agency, rather than the market, to determine intrastate rates.[144] The Court held that when a state as the sovereign clearly intends to displace competition in a particular field with a regulatory structure, the first prong of the *Midcal* test is satisfied.[145]

A private party acting pursuant to an anticompetitive program need not point to a specific, detailed legislative authorization for its challenged conduct.[146] If more detail than a clear intent to displace competition were required of the legislature, states would have difficulty implementing their anticompetitive policies through regulatory agencies. Agencies are created to deal with problems unforeseeable to or outside the competence of the legislature. Requiring express authorization for every action that an agency might find necessary to implement state policy would diminish, if not destroy, the agency's efficacy.[147] If the state has a clear intent to establish an anticompetitive regulatory program, then the state's failure to describe the details of implementing the program will not subject the program to antitrust restraints.[148]

States regulate and supervise physician licensing through specific state agencies. This agency in Florida is the Florida Department of Professional Regulation, Board of Medicine.[149] The Florida Medical Practice Act requires medical peer review committees to report any disciplinary action taken against a physician to the Board of Medicine.[150] The Act grants immunity from civil liability to committee members and to individuals providing information to the committee.[151] Both groups, however, must act without "intentional fraud."[152]

---

143. *Id.*

144. *Id.* at 63-64.

145. *Id.* at 65-66.

146. Lafayette v. Louisiana Power & Light Co., 453 U.S. 389, 415 (1977).

147. *Cf.* Town of Hallie v. City of Eau Claire, 471 U.S. 34, 44 (1985) (citing Justice Stewart's dissenting opinion in *Lafayette*, 435 U.S. at 434-35, requiring explicit legislative authorization of anticompetitive activity, would impose "detrimental side effects upon municipalities' local autonomy.").

148. Consolidated Gas Co. v. City Gas Co., 665 F. Supp. 1483, 1527 (S.D. Fla. 1987) (quoting *Southern Motor Carrier Rate Conf., Inc.*, 471 U.S. at 64-65).

149. *See* FLA. STAT. § 458.307 (1989).

150. *Id.* § 458.337(1)(a)(1).

151. *Id.* § 766.101(3)(a).

152. *Id.*

With the passage of the HCQIA,[153] Congress recognized the need to protect physicians who participate in peer review committees.[154] The HCQIA limits liability of peer review committee members acting in the reasonable belief that their actions are furthering quality health care.[155] The disciplining party seeking protection of the HCQIA must make a reasonable effort to obtain the pertinent facts, give adequate notice and hearing to the physician involved, and take only such action as is reasonably warranted by the facts obtained.[156] However, the HCQIA provides no immunity from civil rights actions.[157]

Compulsion is the best evidence of state policy. Florida demonstrates its peer review policy by compelling hospitals, as a condition of licensing, to establish peer review committees.[158] By compelling physicians to review their competitors, Florida has expressed a policy to regulate competition among physicians. Florida law clearly contemplates that peer review activity may replace competition in some instances.[159] The state has thus chosen to replace competition in order to promote quality health care.

Congress recognized the need to protect medical peer review committees from antitrust actions.[160] Congress, therefore, provided reporting systems in the HCQIA that require state regulatory agencies to monitor and report activities of peer review committees.[161] Congress' intent thereby is to replace competition with carefully monitored and supervised review activity.

---

153. 42 U.S.C. §§ 11101-52 (Supp. IV 1986).

154. *Id.* § 11101 provides that:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state.
>
> . . . .
>
> (3) This nationwide problem can be remedied through effective professional peer review.
>
> (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
>
> (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

Id.

155. *Id.* § 11111(a)(1).

156. *Id.* § 11112(a).

157. *Id.* § 11111(a)(1).

158. FLA. STAT. § 458.313 (Supp. 1988).

159. *Id.*

160. 42 U.S.C. § 11101 (Supp. IV 1986).

161. *Id.* §§ 11133-34.

The ultimate benefactor of any antitrust action is the consumer. Requiring reporting of incompetent medical personnel enables the consumer to obtain better quality medical care. By monitoring the qualifications and performance of physicians, the review process compensates for consumers' lack of medical care information. The peer review process is thus actually procompetitive.

A close examination of the health care regulations of many states reveals that they do not expressly permit anticompetitive conduct by hospitals and their medical staffs. The regulations typically prohibit denials made for purely anticompetitive reasons and permit the denial of medical staff privileges only on professional or ethical grounds. Such regulations could be viewed as procompetitive. Since many personnel decisions made in competitive job markets are based on professional or ethical grounds, allowing medical staffs to make hospital staffing decisions on such grounds is not tantamount to approving anticompetitive conduct.[162]

Instead of allowing the market to establish intrastate common carrier rates, the regulations in *Southern Motor Carriers* explicitly provided that a regulatory agency determine the rates.[163] In addition, the California statutory scheme in *Midcal* expressly required that a state regulatory agency determine a price schedule for all wines sold in the state.[164] Accordingly, state health care regulations must indicate an intent to permit hospitals and their medical staffs to engage in anticompetitive conduct or demonstrate that the logical result of the regulation-authorized activities would inhibit competition.[165] If the state's regulatory scheme does not expressly authorize anticompetitive conduct, the scheme may not satisfy the first prong of the *Midcal* test.

Since the *Patrick* Court chose not to define what constitutes "clearly articulated and affirmatively expressed" in medical peer review statutes, the lower courts provide the only guidance. Courts adjudicating peer review actions have liberally interpreted the first

---

162. Posner v. Lankenau Hosp., 645 F. Supp. 1102, 1117 (E.D. Pa. 1986) (Although some medical staffs may engage in anticompetitive conduct while in compliance with the state regulatory scheme, this does not necessarily demonstrate the legislature's intent to permit such conduct.). *See also infra* notes 163-65 and accompanying text.

163. 471 U.S. 48, 63-64 (1985).

164. California Retail Liquor Dealers Assoc. v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

165. *See* Town of Hallie v. City of Eau Claire, 471 U.S. 34, 42 (1985); Goldfarb v. Virginia State Bar, 421 U.S. 773, 789-90 (1975) (state did not indicate intention to do away with competition among lawyers merely because it authorized its highest court to regulate the practice of law).

prong of the *Midcal* test. In *Marrese v. Interqual, Inc.*,[166] a surgeon brought an antitrust action against a hospital and its executive committee for revoking his hospital privileges.[167] The Seventh Circuit Court of Appeals upheld the district court's dismissal of the complaint, holding that defendants were immune from antitrust liability pursuant to the *Parker* "state action" doctrine.[168]

Applying the *Midcal* standard, the court first examined Indiana's statutory scheme governing hospitals.[169] Indiana requires all hospitals to establish peer review committees to ensure quality health care.[170] To achieve that goal, the peer review committees were required to review and evaluate the qualifications and performance of medical staff members.[171] The court of appeals reasoned that a necessary and reasonable consequence of the state mandated medical peer process was that members of the hospital medical staff must review the performance of competing staff members and recommend the revocation of staff privileges in some situations.[172] Accordingly, the first prong the *Midcal* test was satisfied.

Interestingly, the *Marrese* court never actually applied the *Midcal* standard since it never determined whether Indiana clearly expressed an intent to permit anticompetitive conduct.[173] Applying the *Parker* doctrine, the *Marrese* court considered the effect that a denial of antitrust immunity would have on the willingness of physicians to participate in peer review activities.[174] The court noted that the Indiana statutory scheme provided members of peer review committees with absolute immunity from civil liability for actions taken in good faith.[175] The court reasoned that this grant of statutory immunity furthered the underlying purpose of the Sherman Act, the protection of consumer welfare, by assuring the competency and quality of hospital medical staffs.[176]

---

166. 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).

167. *Id.*

168. *Id.* at 395.

169. *Id.* at 387-88.

170. *Id.* at 387 (quoting IND. CODE § 16-10-1-6.5 (1982)).

171. *Id.* at 388 (quoting IND. CODE § 34-4-12.6-1 (1982)).

172. *Id.*

173. *Id.* at 387 ("Our initial inquiry is whether the defendants' review of Dr. Marrese's surgical 'back' procedures at Deaconess and the recommendation that his clinical privileges be revoked is conduct clearly articulated and affirmatively expressed as state policy.").

174. *Id.* at 391.

175. *Id.* at 391-93.

176. *Id.* at 392.

In a later Seventh Circuit decision, *Tambone v. Memorial Hospital*,[177] the court determined that a statute granting good faith immunity from civil liability to peer review committee members was sufficient to meet the first prong of the *Midcal* test.[178] The *Tambone* court, while conceding that it was bound by the *Marrese* decision, reasoned that the peer review immunity statute proved that the legislature intended to affect competition in the marketplace.[179] Some states' peer review protection acts may provide members of hospital peer review committees with qualified immunity from civil liability.[180] However, the acts may not demonstrate that the legislature intended to permit anticompetitive activity as a necessary consequence of the regulatory scheme which it designed for health care facilities.[181] Still, other courts have stated that whether the antitrust exemption would frustrate the policy of the peer review statute is irrelevant: the relevant inquiry is not whether the exemption would foster the statute's purpose but whether restricting competition is a necessary consequence of engaging in the state-promoted activity.[182]

III. APPLICATION OF THE SHERMAN ANTITRUST ACT TO MEDICAL PEER REVIEW IMMUNITY

Applicants denied privileges at hospitals frequently allege that members of the hospital staff used the medical peer review committee as a trade restraint mechanism. Although section 1 of the Sherman Antitrust Act[183] provides that every conspiracy in restraint of trade violates the law, the Supreme Court has narrowly construed the term "every" as used in section 1 to refer only to those agreements which "unreasonably" restrain trade.[184] Depending upon the nature of the case, two different forms of legal analysis are used to determine whether a business practice "unreasonably" restrains trade and violates section 1 of the Sherman Act: the per se rule and the rule of reason.[185]

---

177. 825 F.2d 1132 (7th Cir. 1987).

178. *Id.* at 1135.

179. *Id.* at 1134-35.

180. *See, e.g.*, FLA. STAT. § 766.107(3)(a) (1981).

181. *Southern Motor Carriers*, 471 U.S. at 51 (noting that state public service commissions have and exercise ultimate authority and control over all intrastate rates).

182. *See* Quinn v. Kent Gen. Hosp., Inc., 617 F. Supp. 1226 (D.C. Del. 1985).

183. 15 U.S.C. § 1 provides that "[e]very contract combination in the form of trust or otherwise or conspiracy in restraint of trade or commerce among the several states, or with foreign nations is declared to be illegal."

184. *See* Standard Oil Co. v. United States, 221 U.S. 1, 59 60 (1911).

185. *See* United States v. Topco Assocs., Inc., 405 U.S. 596 (1972).

A. *Per Se Rule of Analysis*

Through the course of antitrust litigation, the courts have found that some restraints are so patently contrary to free market principles and so deficient in redeeming economic virtue, that they are illegal per se.[186] The Supreme Court has applied the per se rule to four different kinds of agreements: horizontal and vertical price fixing, horizontal market division, group boycotts or concerted refusals to deal, and tying arrangements.[187] These arrangements are presumptively illegal because they typically function only to stifle competition.[188]

Initially medical peer members who deny or revoke a physician's clinical privileges appear to be analogous to a group boycott or a concerted refusal to deal.[189] Exactly what types of activities fall within the forbidden group boycott category are, however, far from certain.[190]

Cases to which courts have applied the per se approach have generally involved joint efforts by firms to disadvantage competitors by persuading suppliers or customers to deny relationships the competitors need in order to compete in the market.[191] In those cases, the boycott often cuts off access to a supply, facility or market necessary to enable the boycotted firm to compete.[192]

The actions of peer review committee members who deny a competing physician access to a particular hospital may be construed as denying the boycotted physician an advantage required to compete in the marketplace. Physicians on a medical peer review committee clearly possess a dominant position in the relevant market. Without the ability to admit patients to a medical facility, a physician must transfer patients to a competing physician with admitting privileges. Refusing to admit a physician to a hospital staff or restricting clinical privileges thus decreases market competition and impairs overall market efficiency.

---

186. Northern Pacific Ry. v. United States, 356 U.S. 1, 5 (1958).

187. *See* Cascade Cabinet Co. v. Western Cabinet & Millwork, Inc., 710 F.2d 1366, 1370 (9th Cir. 1983) (citing A.H. Cox & Co. v. Star Mach. Co. 653 F.2d 1302, 1305 (9th Cir. 1981)); Gough v. Rossmoor Corp., 585 F.2d 381, 386 (9th Cir. 1978), *cert. denied*, 440 U.S. 936 (1979).

188. *See* White Motor Co. v. United States, 372 U.S. 253, 263 (1963).

189. *See* Klor's, Inc. v. Broadway-Hale Store's, Inc., 359 U.S. 207, 212 (1959).

190. Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 294 (1985) (quoting L. SULLIVAN, HANDBOOK OF LAW OF ANTITRUST 229-30 (1977)). *See also* St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 543 (1978).

191. 472 U.S. 284, 294 (quoting L. SULLIVAN, HANDBOOK OF LAW OF ANTITRUST 261-62 (1977)).

192. *Id.*

Although a concerted refusal to deal need not possess all of these traits to merit per se treatment, not every cooperative activity involving a restraint or exclusion will have the predominantly anticompetitive consequences exhibited by the boycotts.[193] In *National Collegiate Athletic Association v. Board of Regents of University of Oklahoma*,[194] the Supreme Court recognized that per se treatment of the NCAA's restrictions on the marketing of televised college football was inappropriate.[195] Despite the NCAA's obvious restraint on output, the Court did not apply per se analysis since the case involved an industry in which horizontal restraints on competition were essential if the product was to be available at all.[196]

If the per se rule applies to the questioned practice, the court must presume that the practice is unreasonable as a matter of law without elaborate inquiry as to the precise harm caused or the business excuse used.[197] But the courts have been reluctant to declare business practices or agreements illegal per se. Courts employ the per se rule only after long experience reveals a business practice's "pernicious effect on competition and lack of any redeeming virtue . . . ."[198]

In *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*,[199] the Supreme Court defined the category of group boycotts that mandate per se condemnation.[200] The plaintiff, a retailer, was summarily expelled from a purchasing cooperative for failing to report a change in its stock ownership as required by cooperative regulations.[201] The plaintiff alleged that the defendants engaged in a group boycott which was a per se violation of section 1 of the Sherman Act.[202] The Court stated that a plaintiff invoking the per se rule must establish that the challenged activity is likely to have *predominantly* anticompetitive effects.[203] The Court then noted that the expulsion did not imply an anticompetitive intent because the rule violated by the plaintiff served the useful purpose of allowing the cooperative to monitor its member's creditworthiness.[204]

---

193. *Id.* at 295.
194. 468 U.S. 85, 104 (1984).
195. *Id.* at 100.
196. *Id.* at 120.
197. United States v. Topco Assocs., Inc., 405 U.S. 596, 607 (1972).
198. *Id.*
199. 472 U.S. 284 (1985).
200. *Id.* at 293.
201. *Id.*
202. *Id.* at 287.
203. *Id.* at 298.
204. *Id.* at 296.

Similarly, the promotion of quality care and treatment of patients requires hospitals to thoroughly evaluate the professional competence, ethics, and reputation of medical staff applicants. Further, quality conscious hospitals will periodically review the qualifications of its staff through a peer review or medical audit mechanism. Hospitals, like doctors, must consider the welfare of their patients above all else and must establish basic procedures to prevent incompetent or unethical physicians from inflicting injury.[205]

1. Relevant Product Market

The Supreme Court in *Pacific Stationery* used the concept of market power to determine whether the per se rule applied to group boycotts.[206] Since market power is measured in relation to a particular product market, the market definition bears directly upon a firm's degree of market.[207] Thus, to prove that a defendant has market power, the first step is to establish the bounds of the relevant market. In general, the relevant market is "the area of effective competition" as to a particular product.[208] A relevant product market describes groups of producers with similar products, who have the ability, actual or potential, to take significant amounts of business away from each other.[209] Hospitals within reasonable proximity to each other may typically provide the same or similar products. Hence, a hospital's ability to attract consumers from other facilities will depend upon its business practices and medical staff.

Properly identifying a market in any given case requires consideration of the market's geographic, product, and production dimensions.[210] The geographical dimension is the physical area within which the particular product or service is or may be sold to consumers.[211] The plaintiff has the burden of defining and proving the scope of the relevant market for medical services.[212] The main consideration in defining the market for medical services is the geographical dimension since it establishes the boundaries within which a particular product

---

205. Marrese v. Interqual, 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).

206. *Northwest Wholesale Stationers, Inc.*, 472 U.S. at 284.

207. *Id.* at 293.

208. Brown Shoe Co. v. United States, 370 U.S. 294, 324 (1962).

209. Kaplan v. Burroughs Corp., 611 F.2d 286, 292 (9th Cir. 1979), *cert. denied*, 447 U.S. 924 (1980).

210. P. AREEDA & D. TURNER, II ANTITRUST LAW ¶ 518, at 347 (1978).

211. *See* Grason Elec. Co. v. Sacramento Mun. Util. Dist., 571 F. Supp. 1504, 1523 (E.D. Cal. 1983); II ANTITRUST LAW ¶ 522, at 299 (Supp. 1986).

212. *Cf.* Devoto v. Pacific Fidelity Life Ins. Co., 618 F.2d 1340, 1344 (9th Cir.), *cert. denied*, 449 U.S. 869 (1980).

is presently available.[213] Hospitals that are within thirty miles or thirty minutes of each other are competitors.[214]

Proximity alone, however, does not determine the relevant market. Market share is not synonymous with market power. Market imperfections may exist that permit medical care providers to charge noncompetitive prices for hospital services. For example, the prevalence of third-party payment for health care costs reduces price competition. In addition, lack of adequate information prevents consumers from evaluating the quality of the medical care provided by competing hospitals.[215]

One hospital may offer particular facilities or equipment to a specializing physician that another in the same area may not offer.[216] However, consumers of medical care are unlikely to be fully aware of the differences between the two competing facilities. The two hospitals should thus be differentiated when defining the geographical market.

Product dimension refers to the availability of similar products that may be used in place of the disputed product.[217] Where one product can easily replace another product, the two "cross-products" are called substitutes. These products should be considered to be in the same market if there is a high degree of substitution between them.

Members of professional peer review committees can similarly provide the disputed product of medical services. However, due to the highly specialized nature of modern medicine, only physicians of like specialty qualify to judge the appropriateness of their fellow specialist's medical care. Thus, the review committee should be viewed as substitutes for the very person they are evaluating. In fact, the review committee and the aggrieved plaintiff can, for all practical purposes, be considered perfect substitutes.

The production dimension has to do with the capacity of other companies to produce or make available the product or service in response to a price increase by a particular entity.[218] The production dimension is important because the ability to raise prices by restricting

---

213. Jefferson Parish Hosp. Dist. 2 v. Hyde, 466 U.S. 2 (1984).

214. Bhan v. N.M.E. Hospitals, Inc., 669 F. Supp. 998, 1019 (E.D. Cal. 1987), *rev'd and remanded on other grounds*, 772 F.2d 1469 (9th Cir. 1985).

215. *Jefferson Parish Hosp.*, 466 U.S. at 27 & n.45.

216. For example, of two hospitals on the same block, one may offer obstetrical services with "state of the art" facilities and the other may offer services that are at best only marginal, or perhaps none at all.

217. *Grason Elec. Co.*, 571 F. Supp. at 1521-23; *see also* II ANTITRUST LAW ¶ 517, at 346.

218. II ANTITRUST LAW ¶ 517, at 346.

output is limited by other firms' abilities to profitably expand their output in response.[219]

The capacity to fill the gap in production left by another entity seeking to limit its output is measured by the cross-elasticity of supply.[220] When a hospital can easily increase production, or otherwise make the product or service available, the cross-elasticity of supply is said to be high.[221] Peer review members can conceivably raise their own production by seeing more patients or extending office hours to make the medical services product more available. Accordingly, the cross-elasticity of the medical service product by members of a medical peer review committee is high.

2. Market Power

After establishing the dimensions of the relevant product market, the trier of fact can reasonably infer whether a hospital has market power.[222] Market power is different from monopoly power. Monopoly power, which is required to prove a Sherman Act section 1 violation, is the power to control prices or exclude competition in the relevant market.[223] Conversely, market power, is the power that permits a firm to force a purchaser to do something that the purchaser would not do in a competitive market.[224] Market power can be established by showing that the firm has a predominant share of the market.[225] Even if a hospital or member of the professional review committee does not have a predominant share of the market, it can possess market power if it offers a product that is unique or that has special consumer appeal.[226] So long as the seller can exert power over some of the buyers in the market, even if this power is not complete, the seller has market power.[227]

The Supreme Court set the contemporary standard for market share in *Times-Picayune Publishing Co. v. United States*.[228] The Court held that a newspaper that attracted forty percent of sales classified lineage did not possess market dominance.[229] In *Jefferson Parish*

---

219. II ANTITRUST LAW ¶ 519, at 349.
220. Twin City Sportservice v. Charles O. Finley & Co., 512 F.2d 1264, 1271 (9th Cir. 1975).
221. *Id.*
222. *Bhan*, 669 F. Supp. at 1019.
223. United States v. E.I. Dupont, 351 U.S. 377, 391 (1956).
224. *Jefferson Parish Hosp.*, 466 U.S. at 14.
225. United States v. Loew's, Inc., 371 U.S. 38, 45 (1962).
226. *Id.*
227. Fortner Enterprises v. U.S. Steel Corp., 394 U.S. 495 (1969).
228. 345 U.S. 594, 612 (1953).
229. *Id.*

Hospital District 2 v. Hyde,[230] the Court extended the standard to hospitals.[231] The Court found that a hospital did not possess market power when it attracted only thirty percent of patients residing in the geographic market.[232]

The Fifth Circuit Court of Appeals in *Goss v. Memorial Hospital System*[233] addressed a similar market share issue. Defendants, members of a Houston hospital's Ob-Gyn committee, suspended the privileges of plaintiff obstetrician.[234] Plaintiff then brought an antitrust action against the hospital and certain physicians on the committee.[235] The *Goss* court held that the per se rule of antitrust violation did not apply to the alleged Ob Gyn committee boycott.[236] The hospitals were only two out of approximately sixty hospitals located in the county, and each had less than six percent of the county's total patient admissions.[237] The Fifth Circuit reasoned this was insufficient to present a threshold case of market power.[238] A threshold case is where the alleged boycott of the physician is likely to have an anticompetitive effect.[239]

In *Bhan C.R.N.A. v. N.M.E. Hospital, Inc.* the district court noted that a trier of fact must focus on the hospital's share of the surgical market to ascertain the hospital's power to influence area patients' choices of anesthesiologists.[240] The court held that a 7.9% share of the medical/surgical beds and 6.8% of the total number of patient days presented unrebuttable evicence of the hospital's nondominant share of the surgical services market.[241] According to the court, the patients in the competition area had a wide spectrum of alternatives to the defendant hospital's surgical services.[242] The hospital clearly lacked sufficient economic power to affect the market.[243]

---

230. 466 U.S. at 26 & n.43.
231. *Id.*
232. *Id.*
233. 789 F.2d 353 (5th Cir. 1986).
234. *Id.*
235. *Id.*
236. *Id.* at 355.
237. *Id.*
238. *Goss*, 789 F.2d at 355.
239. *Id.*
240. *Bhan*, 669 F. Supp. at 1019.
241. *Id.* at 1020.
242. *Id. See also* Ezpeleta v. Sisters of Mercy Health Corp., 621 F. Supp. 1262 (1985), *aff'd*, 800 F.2d 119 (7th Cir. 1986) (exclusive service contract between contractor anesthesiologist and hospital not illegal per se as violation where hospital's market share for surgery patients was nine percent, as the hospital did not have sufficient market power in field of hospital surgery to force patients to use anesthesiologist's services).
243. *Id.*

While courts have not specified an exact percentage determining market share, extremes on the high end have been recently noted. In *Oltz v. St. Peters Community Hospital*,[244] a nurse anesthetist brought an antitrust conspiracy suit against the hospital and certain of its anesthesiologists.[245] The court found that the hospital was the only one available in the community to the general public.[246] In addition, it was the only hospital equipped to do general surgery.[247] The hospital had a market share of eighty-four percent.[248] The *Oltz* court reasoned that when the defendant's capacity to control prices or exclude competition is in question, it may be necessary to determine the defendant's market power as to a given product in a given market.[249] In such cases, the trier of fact must ascertain the relevant market.[250] When a defendant has a monopoly in a given area, however, further inquiry is unnecessary.[251] The court then held that the hospital's eighty-four percent market share determined its monopoly on anesthesia services.[252] Hence, the plaintiff nurse anesthetist did not have to establish a relevant product and geographic market.[253]

When a peer review committee revokes a hospital staff member's hospital privileges, this revocation does not necessarily imply an anticompetitive act. To establish anticompetitive behavior, the evidence must show that the hospital possessed the "market power" necessary to suppress effective competition.[254] Plaintiffs should present evidence tending to establish that the services offered by the hospital are unavailable at other hospitals. Further, plaintiffs must demonstrate that the hospital had unique access to a business element which plaintiff needed to compete with other physicians in his field.

In sum, a plaintiff seeking application of the per se rule must present a threshold case showing that the challenged activity is likely to have a predominantly anticompetitive effect. The mere allegation of a concerted refusal to deal does not suffice because not all concerted refusals to deal are predominantly anticompetitive. A plaintiff challenging expulsion from a joint buying cooperative must show that the

---

244. 656 F. Supp. 760 (D. Mont. 1987).
245. *Id.*
246. *Id.* at 763.
247. *Id.*
248. *Id.*
249. *Oltz*, 656 F. Supp. at 763.
250. *Id.*
251. *Id.* (quoting United States v. Grinnell Corp., 384 U.S. 563, 576 (1966)).
252. *Id.*
253. *Id.*
254. *Jefferson Parish Hosp.*, 466 U.S. at 3.

cooperative possesses market power or unique access to a business element for effective competition.[255] Absent such a showing, courts would apply a rule of reason analysis.[256]

B. *Rule of Reason Anaylsis*

If unsuccessful in showing that concerted action is illegal under a per se analysis, a plaintiff may show that it is illegal under the rule of reason test. To prevail under that test, the plaintiff must prove (1) that defendants acted in concert, (2) that the concerted action was intended to harm or unreasonably restrain competition, and (3) that the concerted action actually caused an injury to competition.[257] Plaintiff's injury alone is insufficient to prove injury to competition.[258] Plaintiffs must instead prove that competition in the relevant product market has been harmed in some way.[259] To prove harm to competition in a relevant market, a plaintiff must first show the existence of a relevant market.[260]

The relevant market for determining the anticompetitive effect of defendants' conduct under a rule of reason analysis is not necessarily the same as the relevant market for a per se analysis.[261] Defining the relevant market requires an examination of the geographic dimension, the product dimension (measured by cross-elasticity of demand), and the production dimension (measured by cross-elasticity of supply).[262]

In large metropolitan areas with many health care facilities, it may be impossible to infer the market's geographical boundaries for specific physician services. Conversely, in a small rural area with only one hospital, the relevant market may be identified with great specificity. Factors used to determine the relevant market include the distribution in the area of physicians and hospitals.[263] Other pertinent factors in-

---

255. Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 298.

256. *Id.* at 284.

257. O.S.C. Corp. v. Apple Computer Co., 792 F.2d 1464, 1469 (9th Cir. 1986); *Jefferson Parish Hosp.*, 466 U.S. at 29; DeVoto v. Pacific Fidelity Life Ins. Co., 618 F.2d 1340, 1344. *See also* Cascade Cabinet Co. v. Western Cabinet & Millwork, Inc., 710 F.2d 1366, 1373 (summary judgment appropriate when plaintiff fails to produce evidence of harm to competition).

258. *O.S.C. Corp.*, 792 F.2d at 1469.

259. *Devoto*, 618 F.2d at 1344-45.

260. *Jefferson Parish Hosp.*, 466 U.S. at 29. *See also* L.A. Draper & Son v. Wheelabrator-Frye, Inc., 735 F.2d 414, 422-23 & n.14 (11th Cir. 1984).

261. *See Jefferson Parish Hosp.*, 466 U.S. at 29.

262. Bhan v. N.M.E. Hospitals, Inc., 669 F. Supp. 998, 1021 (E.D. Cal. 1987).

263. For example, a small rural community may have several family practice doctors, but few, if any, obstetricians.

clude cross-elasticity of demand[264] and cross-elasticity of supply.[265] Finally, a plaintiff must demonstrate that the denial of privileges foreclosed so much of the market from plaintiff's penetration that the denial constituted an unreasonable restraint on competition.[266]

Under the rule of reason analysis, courts must weigh all of the facts to decide whether a restrictive practice is an unreasonable restraint on competition.[267] To make this determination, courts may examine the facts peculiar to the business, the history of the restraint, the reasons for the restraint's imposition, and the restraint's actual impact on competition.[268] The aggrieved physician must, therefore, show some restraint on competition. If a physician is denied privileges at one hospital, but has privileges at other hospitals, that physician may be able to persuade patients to follow him to another hospital. Therefore, to demonstrate the impact of the peer review committee's competitive restraint, the physician plaintiff should show the loss of patients as a result of the committee's action. Under the rule of reason analysis, a court may properly grant summary judgment to the defendant hospital and its peer review committee if the physician cannot demonstrate an unreasonable restraint on medical practice.[269]

IV. CIVIL RIGHTS ACTIONS, 1983 CLAIMS

Complaints against medical peer review committees frequently allege a civil rights violation under 42 U.S.C. § 1983.[270] The complaint typically alleges that the hospital committee acted under state supervision and thus under "color of state law" in denying plaintiff privileges. Other claims contend that a hospital which receives either state or federal funds acts under color of state law.[271]

---

264. For example, patients could reasonably substitute the services of a thoracic surgeon with that of a general surgeon or an internal medicine specialist with that of a cardiologist.

265. *Bhan*, 669 F. Supp. at 1021.

266. *Cf.* Jefferson Parish Hosp. Dist. 2 v. Hyde, 466 U.S. 2, 30 n.51 (1984).

267. Continental T.V., Inc. v. G.T.E. Sylvania, Inc., 433 U.S. 36 (1977).

268. Hornsby Oil Co. v. Champion Spark Plug Co., 713 F.2d 1384, 1392 (5th Cir. 1983).

269. *Bhan*, 669 F. Supp. at 1021.

270. Civil Rights Cases, 3 S. Ct. 18, 21-24 (1883). *See also* Shelly v. Kramer, 68 S. Ct. 856 (1948); Burton v. Wilmington Parking Auth., 81 S. Ct. 856 (1961); Moose Lodge No. 107 v. Irvis, 92 S. Ct. 1965 (1972). Section 1983 states in relevant part:

> [E]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

Id.

271. *See infra* note 286 and accompanying text.

A section 1983 claim in a medical peer review action raises several issues. The first is whether or not the state, in passing a medical practice act, created a sufficiently close nexus between the activities of the hospital's credentials committee and the state for the actions of the committee to be reasonably attributed to the state.[272] A second issue frequently contested is whether the receipt of state funds creates a sufficient nexus to qualify as a state action.[273]

Section 1983 requires an element of state action or state involvement in the alleged deprivation of constitutional rights, privileges or immunities.[274] However, the precise nature and scope of the state action requirement has been the subject of ongoing litigation.[275] *Patrick v. Burget* did not address the issue of a section 1983 claim in the context of a medical peer review committee who denies or revokes a physician's clinical privileges. This question has yet to be presented to the Supreme Court.

The circuit courts, however, have considered the state action issue in light of present legislation without regard to *Patrick*. In *Goss v. Memorial Hospital System*,[276] the plaintiff physician contended that the state statute providing immunity to peer review members effectively made the peer review committee an investigatory arm of the state.[277] The Fifth Circuit in *Goss* rejected the argument.[278] Following *Rendell-Baker v. Kohn*,[279] the *Goss* court held that a finding of state action requires a nexus between the committee's acts and the state such that the committee's conduct is fairly attributable to the state.[280] That nexus exists when the state exercises coercive power or has provided such significant encouragement, either overt or covert, that the choice must be deemed to be that of the state.[281] The actions of the state in *Goss* did not meet this standard, and thus the peer review committee did not act under the color of state law.[282]

---

272. *See infra* notes 281 & 313 and accompanying text.

273. *See infra* notes 286, 290, 304-08, 314-18, 330-32 and accompanying text.

274. *See infra* notes 309-12, 319-27 and accompanying text.

275. *See Civil Rights Cases*, 109 U.S. 3, 11-14 (1883); Shelley v. Kramer, 334 U.S. 1, 13-23 (1948); Burton v. Wilmington Parking Auth., 365 U.S. 715, 721-26 (1961); Moose Lodge No. 107 v. Irvis, 407 U.S. 163, 171-79 (1972).

276. 789 F.2d 353 (5th Cir. 1986).

277. *Id.* at 354.

278. *Id.* at 356.

279. 457 U.S. 830 (1982).

280. 789 F.2d at 356 (quoting Rendell-Baker v. Kohn, 457 U.S. 830, 838 (1982)).

281. *Id.* (quoting Blum v. Yaretsky, 457 U.S. 991, 1004 (1982)).

282. *Id.*

Patrick raises an interesting question regarding a claimant's ability to bring a section 1983 action. After *Patrick*, states will want to actively supervise medical peer review activities in order to qualify for immunity under the *Patrick* interpretation of the state action doctrine. The question will then be whether that active supervision creates a sufficiently close nexus between the state and the medical peer review committee to qualify under a section 1983 claim. Note that not even the HCQIA provides for medical peer review immunity under a section 1983 claim.[283]

States generally do not appoint members of the credentials committee. In addition, states do not exercise any oversight over the committee apart from the general review of all hospital activities for accreditation purposes.[284] The mere existence of state regulation does not transform the regulated activity into state action for purposes of section 1983.[285]

Hospitals which receive public funds for construction, operation or reimbursement for services have been challenged under the "state action" requirement. The Fifth Circuit, in *Jatoi v. Hurst-Euless-Bedford Hospital Authority*,[286] dealt with such a challenge. The plaintiff physician, who was denied hospital privileges, alleged that the "state action" requirement of section 1983 was satisfied by involvement of a hospital authority.[287] The hospital authority at issue was a public corporation created by statute to serve a public purpose, but it did not have direct input into the hospital's routine operations.[288] The court chose to overturn the district court's decision to follow *Madry v. Sorel*[289] and instead found state action under the Supreme Court's standard set forth in *Burton v. Wilmington Parking Authority*.[290]

---

283. 42 U.S.C. § 11111(a)(1) (1986) provides that under certain circumstances, one who participates in a medical peer review activity shall not be liable under the law of the United States or of any state. However, "[t]he preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons."

284. For example, the Texas Medical Practice Act only provides for members of the Texas State Board of Medical Examiners to be appointed by the State. TEX. REV. CIV. STAT. ANN. art. 4495b § 2.03 (Vernon Supp. 1988).

285. Quinn v. Kent Gen. Hosp., Inc., 617 F. Supp. 1226, 1234 (D.C. Del. 1985).

286. 807 F.2d 1214 (5th Cir. 1987).

287. *Id.* at 1217.

288. *Id.* at 1220.

289. 558 F.2d 303 (5th Cir. 1977), *cert. denied*, 434 U.S. 1086 (1978), *reh'g denied*, 435 U.S. 982 (1978). A doctor whose staff privileges were "permanently suspended" by the hospital alleged that he had been denied due process of law when he was discharged without notice or hearing. The Fifth Circuit held that the fact that a private, nonprofit, tax-exempt hospital received support from the local and federal government did not render the hospital's actions "state action."

290. 365 U.S. 715 (1961).

In *Burton*, the City of Wilmington created the Parking Authority to provide public parking facilities, and the city used public bonds to finance construction of a parking garage.[291] The Authority entered into a long-term lease with a restaurant that adopted a racially discriminatory policy.[292] The Supreme Court held that the discriminatory policy was "under color of state law" because the restaurant was part of a public building devoted to a public service.[293] The Court found that the state, through the Authority, was indirectly involved in the restaurant's operation, and it enjoyed a mutually beneficial relationship with the restaurant.[294] According to the Court, this relationship made the state a joint participant in the discriminatory activity.[295]

Following *Burton* the Supreme Court continued to develop the concept of state action in cases involving private facilities. In *Rendell-Baker v. Kohn*,[296] former teachers and a vocational counselor at a nonprofit, privately operated school brought a civil rights action against the school.[297] Plaintiffs alleged a violation of their constitutional rights to free speech and due process in connection with their employment discharge.[298] The *Kohn* court held that the plaintiffs employed by the private facility failed to establish state action.[299]

In another private facility case, *Blum v. Yaretsky*,[300] residents at a private nursing home sued, alleging that they had not been afforded adequate notice of their transfer to a lower level of nursing care and that this lack of notice violated their fourteenth amendment rights.[301] As in *Kohn*, the *Blum* court held that plaintiffs failed to establish "state action."[302]

The Fifth Circuit, in *Jatoi*, distinguished *Kohn* and *Blum*.[303] The defendants in *Kohn* and *Blum* operated private facilities that received some public funds, whereas the hospital in *Jatoi* was publicly owned and entirely constructed with public funds.[304] In *Kohn* and *Blum*, the

---

291. *Id.* at 717-18.
292. *Id.* at 719-20.
293. *Id.* at 724.
294. *Id.*
295. *Id.* at 725.
296. 457 U.S. 830 (1982).
297. *Id.* at 833.
298. *Id.* at 834-35.
299. *Id.* at 837.
300. 457 U.S. 991 (1982).
301. *Id.* at 993.
302. *Id.* at 1012.
303. Jatoi v. Hurst-Euless-Bedford Hosp. Auth., 807 F.2d 1214, 1221 (5th Cir. 1987).
304. *Id.*

state did not benefit financially from the private operation of the facility.[305] Conversely, in *Jatoi*, repayment of the bonds used to construct the hospital was directly linked to operation of the hospital.[306] Like the Wilmington Parking Authority in *Burton*, the hospital authority in *Jatoi* was a public corporation created by statute to serve a public purpose.[307] The public attributes of the hospital authority created the necessary state action nexus between the authority and the state.[308]

In *Jackson v. Metropolitan Edison Co.*,[309] the Supreme Court found that the acts of a privately owned, but state regulated utility, did not constitute state action.[310] The *Jackson* plaintiff sued the utility company under section 1983 for disconnecting her electricity service without notice and opportunity for a hearing.[311] Although the state heavily regulated the utility, the Supreme Court held that the mere fact that a business is subject to state regulation does not by itself convert its action into that of the state.[312] The inquiry must be whether there is a sufficiently close nexus between the state and the challenged action of the regulated entity so that the entity's action may be fairly treated as that of the state itself.[313]

Following *Jackson*, courts in the Third Circuit have declined to find state action by private hospitals.[314] In *Hodge v. Paoli Memorial Hospital*,[315] a physician who was denied hospital staff privileges brought suit under section 1983, arguing that the hospital's receipt of federal funds and state benefits made the termination of his privileges

---

305. *Id.*
306. *Id.*
307. *Id.*
308. *Id.*
309. 419 U.S. 345 (1974).
310. *Id.* at 358.
311. *Id.* at 347.
312. *Id.* at 350.
313. *Id.* at 351.
314. *See, e.g.*, Quinn v. Kent Gen. Hosp., Inc., 617 F. Supp. 1226 (D.C. Del. 1985). A physician brought civil rights and antitrust claims against a private hospital for the hospital's refusal to admit him to its medical staff. The plaintiff asserted that the hospital's decision to deny him staff privileges constituted state action because the hospital was a public entity. *Id.* at 1233. The court held that the private hospital's refusal to admit the physician did not constitute state action for purposes of a § 1983 claim. *Id.* at 1235. The court reached this result even though the hospital was dedicated to public use, was subject to state regulation, received tax benefits associated with its public function, received funding from public sources, had a monopoly on hospital facilities in the area, and complied with federal regulations governing conditions under which hospitals receive federal aid. *Id.* at 1234.
315. 576 F.2d 563 (3d Cir. 1978).

state action.[316] The Third Circuit disagreed, stating that the receipt of federal construction funds and medicare and medicaid funds did not constitute state action under section 1983.[317] In addition, the Court held that state licensing requirements for nonprofit hospitals do not constitute state action.[318]

The Tenth Circuit Court of Appeals recently considered the state action question in *Tarabishi v. McAlester Regional Hospital.*[319] The physician in *Tarabishi* brought an action under section 1983 after the defendant hospital revoked his staff privileges.[320] The court cited *Kohn,*[321] and *Lugar v. Edmonson Oil Co.,*[322] in analyzing what actions may be "fairly attributable to the state," and employed a two part test.[323] First, the exercise of some state created right, privilege or rule of conduct must cause the deprivation.[324] Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor.[325] The court noted that the defendant hospital was a public trust created under state laws, and its trustees were public officers acting on behalf of the state.[326] The court thus held that the actions of the trustees who terminated the physician's privileges were actions "fairly attributable to the state."[327]

The Sixth Circuit considered the possibility of a similar section 1983 action in *Sarin v. Samaritan Health Center.*[328] The *Sarin*

---

316. *Id.* at 563-64.

317. *Id.* at 564.

318. *Id. See also* Holton v. Crozier-Chester Med. Center, 419 F. Supp. 334 (E.D. Pa. 1976), *vacated on other grounds,* 560 F.2d 575 (3d Cir. 1977); Sament v. Hahnemann Med. College & Hosp., 413 F. Supp. 434 (E.D. Pa. 1976); Acosta v. Tyrone Hosp., 410 F. Supp. 1275 (W.D. Pa. 1976); Allen v. Sisters of St. Joseph, 361 F. Supp. 1212 (N.D. Tex. 1973) (plaintiffs failed to demonstrate requisite state action to maintain cause of action under federal civil rights statute providing for liability for deprivation of rights under color of state law).

319. 827 F.2d 648 (10th Cir. 1987).

320. *Id.* at 650.

321. 457 U.S. 830 (1982).

322. 457 U.S. 922 (1982). A debtor brought action under § 1983 claim against corporate creditor alleging that by attaching his property before judgment, defendants acted jointly with the state to deprive him of his property without due process of law. The Supreme Court held that the debtor was deprived of property through state action; because the corporation acted under color of state law, the § 1983 claim was valid).

323. Tarabishi v. McAlester Regional Hosp., 827 F.2d 648, 651-52 (10th Cir. 1982) (quoting Lugar v. Edmondson Oil Co., 457 U.S. 922, 937 (1982)).

324. *Id.*

325. *Id.*

326. *Id.* at 652.

327. *Id.*

328. 813 F.2d 755 (6th Cir. 1987).

plaintiff, a physician whose medical privileges had been restricted, sought relief from the hospital under section 1983.[329] Plaintiff claimed state action based on the hospital's receipt of funds from Medicare and Medicaid and state regulation.[330] Citing an earlier Sixth Circuit case with similar facts,[331] the *Sarin* court held that state licensing and regulation of the defendant hospital and its receipt of federal funds did not establish state action.[332] This is the prevailing view among the circuit courts.

V. SUBJECT MATTER JURISDICTION OF THE COURT

The Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several states."[333] It also prohibits "monopoliz[ing] any part of the trade or commerce among the several states."[334] In pleading a cause of action under sections 1 and 2 of the Sherman Act, the plaintiff must adequately allege the jurisdictional requirement of state commerce.[335]

Although *Patrick* did not raise the issue of subject matter jurisdiction, courts summarily dismiss claims in which the plaintiff fails to allege a sufficient interstate commerce nexus.[336] However, courts should not dismiss a complaint unless it appears beyond doubt that the plaintiff can prove "no set of facts in support of his claim which would entitle him to relief."[337] Plaintiffs must demonstrate a nexus between the defendants' activity and interstate commerce.[338]

---

329. *Id.* at 757.

330. *Id.* at 759.

331. *Id.* (citing Crowder v. Conlan, 740 F.2d 447 (6th Cir. 1984)). A hospital restricted a physician's staff privileges. The hospital received a large percentage of its revenues from government sources, including Medicare and Medicaid. In addition, the state extensively regulated the hospital. The county owned the hospital, and two local government officials sat on the hospital board. Despite these facts, the Crowder court did not find a sufficient nexus between the state and the hospital to warrant a finding of state action. *Id.*

332. *Id.*

333. 15 U.S.C. § 1 (1982).

334. *Id.* § 2.

335. *See* McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232, 241-42 (1980).

336. *See* Hayden v. Bracy, 744 F.2d 1338, 1342-43 (8th Cir. 1984); Furlong v. Long Island College Hosp., 710 F.2d 922, 926-28 (2d Cir. 1983); Capili v. Shott, 620 F.2d 438, 439 (4th Cir. 1980) (per curiam); Wolf v. Jane Phillips Episcopal-Memorial Med. Ctr., 513 F.2d 684, 687-88 (10th Cir. 1975).

337. Conley v. Gibson, 355 U.S. 41, 45-46 (1957).

338. *McLain*, 444 U.S. at 246. *See also* Bunker Ramo Corp. v. United Business Forms, Inc., 713 F.2d 1272, 1281-82 (7th Cir. 1983); Williams v. St. Joseph Hosp., 629 F.2d 448, 453-54 (7th Cir. 1980) (analytical focus is on the nexus between interstate commerce and the challenged activity).

The Sixth Circuit Court of Appeals in *Stone v. William Beaumont Hospital*[339] dealt with the staff privileges issue and Sherman Act jurisdiction. In *Stone*, a doctor alleged that denial of his application for staff privileges at a Detroit area hospital constituted a violation of the Sherman Act.[340] The court of appeals, relying on the Supreme Court's opinion in *McLain v. Real Estate Board of New Orleans*,[341] found that the doctor had failed to establish a sufficient nexus with interstate commerce.[342] Since the hospital in *Stone* operated only locally, the Sixth Circuit held that the plaintiff must allege sufficient facts to support an inference that defendant's activities can reasonably be expected to have a "not insubstantial effect" on interstate commerce.[343]

The Seventh Circuit Court of Appeals, in *Williams v. St. Joseph Hospital*,[344] set forth the general rule that medical practice per se is a local activity.[345] To bring a medical practice within reach of the Sherman Act, a plaintiff must show a substantial and adverse effect upon interstate commerce.[346] The impact of defendants' professional activities upon interstate commerce in medical supplies is a question of fact.[347] Although the actual impact of a defendant's activities on interstate commerce may be small, plaintiffs nonetheless must be able to demonstrate a substantial effect on interstate commerce as a matter of "practical economics."[348]

The Fifth Circuit Court of Appeals, in *Feminist Women's Center, Inc. v. Mohammad*,[349] upheld the substantial interstate commerce effect test, as did the Sixth Circuit in *Sarin v. Samaritan Health*

---

339. 782 F.2d 609 (6th Cir. 1986).

340. *Id.* at 611. The gravamen of Stone's complaint was that defendants illegally excluded him from using a local hospital two or three times a month.

341. *Id.* at 613 (quoting *McLain*, 444 U.S. at 242).

342. *Stone*, 782 F.2d at 613.

343. *Id.* (quoting Furlong v. Long Island College Hosp., 710 F.2d 922, 926 (2d Cir. 1983)).

344. 629 F.2d 448 (7th Cir. 1980).

345. *Id.* at 454.

346. *Id.* (citing Polhemus v. American Med. Ass'n, 145 F.2d 357, 359 (10th Cir. 1944)).

347. *Id.*

348. *Id.* (citing McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232 (1980). In Justice Burger's words, "To establish federal jurisdiction in this case there remains only the requirement that respondents' activities which allegedly have been infected by a price-fixing conspiracy, be shown 'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved.").

349. 586 F.2d 530, 540-41 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979). A center which maintained an abortion clinic brought an action against a physician, alleging federal and state antitrust violations. The court held that travel of patients from other states to use the clinic's services brought case within the jurisdictional scope of the Sherman Act.

Center.[350] In *Sarin*, the court further refined the concept of a physician's impact on interstate commerce. The *Sarin* court held that a physician must show that a hospital's denial of hospital privileges has more than a de minimis effect on interstate commerce.[351]

In *Hospital Building Co. v. Rex Hospital Trustees*,[352] the Supreme Court stated that an effect can be "substantial" under the Sherman Act even if its interstate commerce impact falls far short of either affecting market price or causing enterprise to fold.[353] The Court then outlined what a plaintiff should allege in the complaint in order to establish that the defendant's conduct had a "substantial effect" on interstate commerce.[354] It is sufficient if a plaintiff alleges that defendant's activities will place "unreasonable burdens on the free and uninterrupted flow of interstate commerce."[355] A plaintiff need not allege that the defendant had the "purposeful goal of affecting interstate commerce" or that "the conspiracy threaten[s] the demise of out-of-state businesses."[356] Further, a plaintiff does not allege that the conspiracy affects market prices.[357]

Since *Hospital Building Co.* and *McLain*, lower federal courts have embarked upon an expanded interpretation of the Sherman Act's jurisdictional interstate commerce requirement. *Cardio-Medical Association v. Crozer-Chester Medical Center*[358] is an example of this trend toward an expanded interpretation of Sherman Act jurisdiction. In *Cardio-Medical*, four cardiologists claimed that their denial of specialized staff privileges, preventing them from using advanced equipment at the defendant hospital, violated the Sherman Act.[359] Plaintiffs alleged that twelve to fifteen percent of their patients generated large annual revenues.[360] They also alleged large purchases of

---

350. 813 F.2d 755, 758 (6th Cir. 1987).

351. *Id.* Dr. Sarin, whose hospital privileges were revoked, was shown to have been performing, on the average, less than one operation per week at the Samaritan Health Center.

352. 425. U.S. 738 (1976).

353. *Id.* at 745.

354. *Id.* at 746.

355. *Id.* (quoting United States v. Employing Plasterers Ass'n, 347 U.S. 186, 189 (1954)).

356. *See* Tiger v. Browning-Ferris Indus., Inc., 560 F.2d 818, 826 (7th Cir. 1977), *cert. denied*, 434 U.S. 1034 (1978) (plaintiff alleged that defendant attempted to monopolize waste collection service in parts of both Indiana and Kentucky in violation of the Sherman Act § 2. At issue was whether certain facts were sufficient to satisfy the "substantial effect" test at the pleading stage of the proceeding).

357. 560 F.2d at 826.

358. 721 F.2d 68 (3d Cir. 1983).

359. *Id.* at 71.

360. *Id.* at 76.

out-of-state medications.[361] The court held that interferences with interstate travel of patients, interstate payment of fees, and interstate purchases of medical supplies demonstrated an effect on interstate commerce.[362] The court concluded that the pleadings were adequate to meet the jurisdictional requirements of the Sherman Act.[363]

Federal courts have relied upon the broad language of *Cardio-Medical* to find that various factors may satisfy the Act's jurisdictional requirement in the hospital context. These factors include the following: treatment of out-of-state patients; receipt of Medicare, Medicaid, and out-of-state insurance funds; and purchase of medicine, equipment, and medical supplies from out-of-state purveyors by the plaintiff doctor or the defendant hospital.[364] Hospital credentials committees should consider these Sherman Act jurisdictional factors before making a decision that is likely to lead to litigation. Although federal courts require a sufficient relationship with interstate commerce before jurisdiction exists, the present trend is to make the jurisdictional requirement easy to satisfy.

VI. Good Faith Decisions by the Medical Peer Review Committee

The majority of states have statutes granting peer review immunity for decisions made in "good faith." Good faith is an abstract quality encompassing an honest belief, absence of malice, and absence of design to defraud or to seek an unconscionable advantage.[365] States impose the good faith requirement in various ways. For example, the Illinois Medical Practice Act provides immunity from civil liability for medical review committee members unless their conduct is willful and wanton.[366] Accordingly, an Illinois appeals court recently required a plaintiff doctor who was denied staff privileges to show that the defendant medical review committee members acted willfully and wantonly.[367] Additionally, the court held that a proper charge of willful

---

361. *Id.*

362. *Id.*

363. *Id.*

364. *See* Marrese v. Interqual, Inc., 748 F.2d 373, 382 (7th Cir. 1984) (includes extension listing of similar cases involving denial or revocation of physician clinical privileges at hospitals); *see also* Crowder v. Conlan, 740 F.2d 447 (6th Cir. 1984) (receipt of federal funds from Medicare and Medicaid not adequate to establish an effect on interstate commerce).

365. *See* Efron v. Kalmanovitz, 249 Cal. App. 2d 187, 57 Cal. Rptr. 248, 251 (1967); Doyle v. Gordon 158 N.Y.S.2d 248, 249, 260 (1914).

366. Ill. Rev. Stat. ch. 111, ¶ 4406 (1983).

367. *See* Adkins v. Sarah Bush Lincoln Health Center, 158 Ill. App. 3d 982, 511 N.E.2d 1267 (Ill. App. 4th Dist. 1987).

and malicious committee conduct must include a charge that the individual defendant voted for the action with the requisite mental state.[368]

Minnesota has gone one step further in dealing with good faith in the peer review committee. The Minnesota peer review statute grants immunity to peer review members unless they act with "malice."[369] Thus, in *Campbell v. St. Mary's Hospital*,[370] the Supreme Court of Minnesota held that the plaintiff's causes of action against hospital peer review members for interference with business relationships, defamation, and conspiracy could not stand in the absence of legal malice.[371]

The strong language of Florida's medical peer review statute[372] evidences the state's policy of encouraging peer review activities.[373] The Florida statute protects peer review members who act "without intentional fraud."[374] In addition, the statute prohibits the discovery or introduction into evidence of peer review records in any civil action against a peer review member.[375]

The HCQIA adds further definition to the "good faith" requirement.[376] In requires a "reasonable belief" that the action was in furtherance of quality health care[377] and a reasonable effort to obtain the pertinent facts.[378] The HCQIA also requires a reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts.[379]

Other states choose to deal with good faith from a perspective more akin to that of due process. The Wisconsin peer review statute, for example, provides that persons who act in good faith while participating in the peer review process are not liable for any civil damages for their peer review actions.[380] To determine whether a member acted in good faith, the statute requires the court to consider several factors. These include whether the member sought to prevent the health facility from examining peer review records, presenting witnesses, estab-

---

368. *Id.* at 988, 511 N.E.2d at 1272.
369. 1987 MINN. LAWS § 145.63.
370. 312 Minn. 379, 252 N.W.2d 581 (1977).
371. *Id.* at 389, 252 N.W.2d at 587.
372. FLA. STAT. § 766.101.
373. *See* Holly v. Auld, 450 So. 2d 217 (Fla. 1984).
374. FLA. STAT. § 766.101(3)(a).
375. *Id.* § 766.101(5).
376. 42 U.S.C. § 11112 (1986).
377. *Id.* § 11112(a)(2).
378. *Id.*
379. *Id.* § 11112(a)(4).
380. 1982 Wis. Laws 146.37 (2).

lishing pertinent facts, cross-examining adverse witnesses or receiving a copy of the review committee's final recommendation.[381]

While this type of peer review statute may provide some immunity absent a showing of bad faith, it does little to define bad faith. Instead, it focuses on the committee satisfying due process-type procedural requirements. Thus, an aggrieved party accorded due process could not sue members of the reviewing organization despite any bad faith conduct on their part. It is unlikely that any legislative body would have intended such a result. Nevertheless, under a liberal interpretation of a Wisconsin-type peer review statute, due process in the peer review process would suffice for "good faith" action by the committee.

In *Carida v. Holy Cross Hospital, Inc.*,[382] a Florida court sought to reconcile the "good faith, without malice" statutory standard[383] with a due process complaint of arbitrary and capricious peer review decisionmaking.[384] The *Carida* court chose to limit "liability" as restricted in the statute to those damages proximately resulting from a tort.[385] The court was careful, however, not to foreclose the plaintiff's due process rights.[386]

The *Carida* court sought to protect peer review members from civil liability according to the statutory mandate while at the same time protecting the procedural due process right of a peer review applicant. Likewise, the HCQIA and the *Patrick* decision should stimulate state legislatures to examine these dual protections in light of reconsidering their medical peer review immunity statutes and the

---

381. *Id.*

382. 427 So. 2d 803 (Fla. 4th D.C.A. 1983).

383. FLA STAT. § 395.0653(3) (1981) provides in pertinent part that "[t]here shall be no liability on the part of, and no cause of action of any nature shall arise against, any hospital . . . for any action taken in good faith and without malice (in conducting peer review pursuant to Florida law)."

384. *Carida*, 427 So. 2d at 803.

385. *Id.* at 806 n.6.

386. *Id.* The court stated:

> Were we to construe this subsection 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 without malice, then any determinative hearing could be notwithstanding the physician's substantial inability to prepare therefor. Similarly, any arbitrary and capricious, but not malicious action taken upon an application for reappointment would go totally unanswered.

Id. at 806 n.6.

The court relied upon Article I, § 21 of the Florida Constitution which provides: "The courts shall be open to every person for redress of any injury . . . ."

qualifying requirements of the medical peer review committee. At least two states are already considering changes in their medical practice acts.[387]

VII. DUE PROCESS FOR THE AGGRIEVED PHYSICIAN[388]

The modern view of procedural due process is typified in *Bowens v. North Carolina Department of Human Resources*.[389] The *Bowens* plaintiff, a dentist and Medicaid provider, was denied continuing participation in the Medicaid program.[390] Plaintiff brought suit against the North Carolina Department of Human Resources for violating his fourteenth amendment due process rights.[391] In various Supreme Court procedural due process cases, the Court reiterated that at minimum, due process usually requires adequate notice of charges and fair opportunity to meet them.[392] In addition, the particulars of notice and hearing must be tailored to the capacities and circumstances of those who are to be heard.[393] Finding that the state agency had afforded plaintiff adequate notice and opportunity for hearing, the court affirmed the lower court's summary judgment for the agency.[394]

The federal district court in *Jerico v. Coffeyville Memorial Hospital*[395] applied the due process concept in the area of medical peer review.[396] The *Jerico* court held that an anesthesiologist who was demoted without a hearing in violation of the hospital's bylaws was

---

387. California, anticipating the Supreme Court's decision in *Patrick v. Burget*, actually started drafting and refining SB 2565 a year ago. Closely modeled on the federal HCQIA, the bill also would grant M.D.s who participate in peer review limited immunity from antitrust liability as long as certain, fair procedures are followed. Washington state, in the wake of *Patrick*, is drafting newly remodeled medical peer review statutes.

388. Due process of law first entered into American jurisprudence in the fifth amendment to the United States Constitution which provides that "nor [shall any person] be deprived of life, liberty, or property, without due process of law . . . ." U.S. CONST. amend. V. This phrase was made applicable to the states with the adoption of the fourteenth amendment, § 1, which states that "[n]or shall any State deprive any person of life, liberty or property, without due process of law." U.S. CONST. amend. XIV. "Due process" does not have a fixed meaning but expands with jurisprudential attitudes of fundamental fairness. Palko v. State, 302 U.S. 319 (1937).

389. 710 F.2d 1015 (4th Cir. 1983).

390. *Id.* at 1017.

391. *Id.*

392. *Id.* at 1019. *See also* Mathews v. Eldridge, 424 U.S. 319 (1976); Goldberg v. Kelly, 397 U.S. 254, 268-69 (1970).

393. *Id.*

394. *Id.* at 1021.

395. 628 F. Supp. 329 (D. Kan. 1985).

396. *Id.*

entitled to bring suit against a city-owned hospital.[397] Even though the physician was not denied privileges, the change of status occurred in a way contrary to the bylaws which the medical staff had adopted.[398]

In *Marrese v. Interqual, Inc.*,[399] the Seventh Circuit held that a physician denied continuing hospital privileges was entitled to a hearing and a review before the hospital peer review committee.[400] The court noted that plaintiff was also entitled to judicial review of the hospital's decision.[401] The court held that in light of the hospital's fair hearing procedures and the availability of judicial review of the hospital's decision, the plaintiff had a more than adequate forum to challenge the defendants' conduct.[402]

In *Ramirez v. Ahn*,[403] the Fifth Circuit considered the procedural due process claim of an obstetrician whose medical license was revoked by the Texas State Board of Medical Examiners.[404] The court explained that the due process clause requires procedure at a level appropriate to the nature of the case.[405] According to the court, the level of procedural due process required of an administrative body is determined by balancing the individual's property interest against the government's interest in efficient administration.[406] The court determined that the state license revocation hearing need not be ideal for the obstetrician to receive constitutionally required procedural due process.[407]

Having established that physicians denied hospital privileges are entitled to procedural due process, the next issue is to determine the process due.[408] The standard of procedural due process is an opportunity to be heard "at a meaningful time and in a meaningful manner."[409] Many states have addressed the issue of fair hearing and notice. Texas, for example, in its Medical Practice Act sets forth guidelines for both

---

397. *Id.* at 333.
398. *Id.*
399. 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).
400. *Id.* at 393.
401. *Id.*
402. *Id.*
403. 843 F.2d 864 (5th Cir. 1988), *cert. denied*, 109 S. Ct. 1545 (1989).
404. *Id.*
405. *Id.* at 868; *see also* Mullane v. Central Hanover Bank & Trust Co., 339 U.S. 306, 313 (1950).
406. 843 F.2d at 868.
407. *Id.* at 869.
408. Morrissey v. Brewer, 408 U.S. 471, 481 (1972).
409. Armstrong v. Manzo, 380 U.S. 545, 552 (1965).

"notice" and "hearing" in medical license suspension or revocation cases.[410]

The HCQIA discusses standards for professional review actions.[411] The HCQIA prescribes a number of notice procedures that health care facilities must meet.[412] The physicians must be given notice stating that a professional review action against the physician has been proposed[413] and the reasons for the proposed action.[414] In addition, the physician must be notified of the thirty day time limit to request a hearing on the proposed action.[415]

A physician's hearing rights include the right to call, examine, and cross-examine witnesses,[416] to present relevant evidence,[417] and to submit a written statement at the close of the hearing.[418] Upon completion of the hearing, the physician involved has the right to receive the written recommendation of the arbitrator, officer or panel, including a statement of the basis for the recommendations.[419] In addition, the physician has the right to receive a written decision of the health care entity, including a statement of the basis of the decision.[420] A professional review action is presumed to meet the preceding standards unless the presumption is rebutted by a preponderance of the evidence.[421]

---

410. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.01(h) (Vernon 1988).

411. 42 U.S.C. § 11112(b).

412. *Id.*

413. *Id.* § 11112(b)(1)(A)(i).

414. *Id.* § 11112(b)(1)(A)(ii).

415. *Id.* § 11112(b)(1)(B)(i). If a hearing is requested on a timely basis, the hearing shall be held in several different ways, as determined by the health care entity. *Id.* § 11112(b)(3)(A). The hearing shall be held before an arbitrator who is mutually acceptable to the physician and the health care entity. *Id.* § 11112(b)(3)(A)(i). The hearing may also be held before a hearing officer appointed by the entity who is not in direct economic competition with the physician involved or before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physicians involved. *Id.* § 11112(b)(3)(A)(ii) and *id.* § 11112(b)(3)(A)(iii). The right to the hearing may be forfeited if the physician fails, without good cause, to appear. *Id.* § 11112(b)(3)(B). During the hearing, the physician has the right to representation by an attorney. *Id.* § 11112(b)(3)(C)(i). The physician also has the right to have a record made of the proceedings and the right to receive a copy of the record. *Id.* § 11112(b)(3)(C)(ii).

416. *Id.* § 11112(b)(3)(C)(iii).

417. *Id.* § 11112(b)(3)(C)(iv) (hearing officer determines the relevancy of the evidence regardless of its admissibility in a court of law).

418. *Id.* § 11112(b)(3)(C)(v).

419. *Id.* § 11112(b)(3)(D)(i).

420. *Id.* § 11112(b)(3)(D)(ii).

421. *Id.* § 11112(a).

Hearings conducted by hospital medical peer review committees which involve negative decisions about physicians' privileges should be attended by counsel to insure that the proper procedures are followed according to hospital bylaws. If the bylaws are lacking in the procedural due process area, then counsel should assist in amending them. Guidelines are now clearly delineated in the HCQIA. Without them, members of the medical peer review committee may find their presumed immunity nonexistent.

VIII. CONCLUSION

Whether medical peer review immunity exists after *Patrick* is an open issue. Since physicians are reluctant to rely on an untested immunity law, they hesitate to serve on professional peer review committees at a time when governmental regulatory agencies are demanding more rigorous quality assurance. Generally, doctors agree that medical peer review is a worthwhile and necessary activity. In the wake of *Patrick*, however, fewer physicians are willing to serve on peer review boards without some assurance of immunity for their good faith peer review action.

Statutory relief is the obvious first step. State medical associations are likely to begin working with their legislators in an attempt to refine the present medical peer review immunity statutes. In addition, the AMA should work with Congress to strengthen the weak parts in the HCQIA.

The AMA and the JCAH have taken a conciliatory position toward *Patrick* in an attempt to dissuade physicians from avoiding peer review activities. The AMA general counsel has said "that while the decision was disappointing, physicians should be told that there is no significant risk of antitrust liability for peer review done in good faith."[422] Other prominent legal experts believe that the new federal law greatly protects physicians who engage in proper peer review procedures from the threat of antitrust suits.[423] The JCAH Vice President of Education urged physicians not to give up on the law and abandon peer review activities: "They must understand that *Patrick* and HCQIA both stand for the principles that MD's must be 'crystal clean about keeping economics out' of peer review and that they must strictly follow due process rules."[424] An AMA attorney reported that no cases had been

---

422. O'Brien, *Supreme Court Reverses* Patrick, AMERICAN MEDICAL NEWS, May 27, 1988, at 18.

423. *Id.*

424. *Id.*

found in which physicians had successfully sued other physicians in the context of good faith peer review following proper procedures.[425]

Obvious deficiencies are likely to be found in most states' medical peer review statutes under the *Patrick* standards. Hospitals which operate in large metropolitan areas in close proximity to other similar hospitals may feel protected from application of the Sherman Act. However, hospitals in smaller communities should reevaluate their monopoly position and its impact on medical practitioners whose privileges are denied or revoked.

The Eleventh Circuit determined that judicial review may, under certain circumstances, qualify for active state supervision.[426] This holding is likely to guide state legislatures in undertaking to remedy the lack of medical review immunity found by the *Patrick* Court.

Section 1983 claims after *Patrick* will probably increase due to states' increased "active supervision" of medical peer review committees under the state action doctrine. As state legislatures create active supervision of regulatory medical boards, a sufficient nexus to qualify for a section 1983 claim may be created.

A paradox exists in the courts' diverse attitudes toward subject matter jurisdiction and the state action doctrine in civil rights actions. The modern trend in pleading jurisdiction is for courts to allow any out-of-state patient traffic, purchasing of medical supplies or receipt of federal funds to meet the jurisdictional "substantially affecting" interstate commerce test. Yet, courts find virtually the same factors to be an insufficient nexus between hospital peer review committees and the state to properly plead state action.

Bad faith decisions by members of the professional review committee have never been protected. However, complex litigation procedural schemes may overwhelm committee decisions made in good faith. For example, the Ninth Circuit noted that the peer review process in *Patrick* involved shabby, unprincipled, and unprofessional conduct.[427] Yet the Supreme Court did not ostensibly decide *Patrick* on the basis of the committee's bad faith.[428]

Following *Patrick*, physicians are acutely aware that even good faith decisions do not protect them from potential litigation. Due process, after *Patrick*, because of the adverse impact of peer review decisions on a physician's career should become more closely defined. Accordingly, due process should at least provide a physician the right to have an attorney present during peer review hearings.

---

425. *Id.* Case review in this article reveals that this statement should be viewed with caution.

426. Bolt v. Halifax Hosp. Med. Ctr., 851 F.2d 1273 (11th Cir. 1988).

427. Patrick v. Burget, 800 F.2d 1498, 1509 (9th Cir. 1986).

428. Patrick v. Burget, 486 U.S. 94 (1988).

Doctors have reacted ambivalently to the *Patrick* decision. On the one hand, they want the advice and protection of an attorney during the quasi-legal process of professional peer review. However, doctors are reluctant to create in the committee room an adversarial environment which an attorney's presence might cause. Lawyers are simultaneously attempting to define more closely how to quantitatively measure the quality of medical care. With one mighty stroke of the pen, the Supreme Court of the United States has created a system whereby doctors are spending an inordinate amount of time worrying about how to practice law and lawyers are busily trying to determine how to practice medicine.