ALASKA'S "QUASI-PUBLIC" HOSPITALS: THE IMPLICATIONS OF *STORRS*

I. INTRODUCTION

In *Storrs v. Lutheran Hospitals and Homes Society of America, Inc.*,[1] the Alaska Supreme Court created a new legal entity: the "quasi-public" Alaska hospital. Dr. Storrs alleged that his suspension from the medical staff of Fairbanks Memorial Hospital, a private, nonprofit hospital, violated due process.[2] The hospital agreed that Storrs was entitled to procedural due process but argued that he had received it.[3] Since the hospital did not contest whether it was necessary for the hospital to conform to "due process," the court concluded, without elaboration, that due process was required:

> Although Fairbanks Memorial Hospital is not a public hospital, we hold that it is a quasi-public hospital because it is the only hospital serving the community, the construction of the hospital was funded in significant part by state and federal grants, and over twenty-five per cent of the funds received for hospital services comes from governmental sources. Consequently, we hold that the hospital cannot violate due process standards in denying staff privileges.[4]

In support of its holding, the court cited decisions from other jurisdictions without discussing the reasoning in those decisions.[5]

With the *Storrs* decision, Alaska joined those states which have abandoned the traditional rule of nonreview of internal private hospital decisions regarding physician's privileges in favor of a "common law due process" review.[6] This note considers the implications of

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1. 609 P.2d 24 (Alaska 1980), *appeal after remand,* 661 P.2d 632 (Alaska 1983).

2. 609 P.2d at 27. Storrs also alleged that the hospital had failed to follow its bylaws. The court agreed and held that the hospital bylaws would be enforced as if they were a contract. *Id.* at 30. *See infra* note 202.

3. 609 P.2d at 28. The appellee hospital argued that it was either private or quasi-public and that, whichever legal definition the court adopted, the hospital had not violated Storrs's rights. Brief for Fairbanks Memorial Hospital at 10-19 (No. 4564, filed Aug. 22, 1979), Storrs v. Lutheran Hosps. & Homes Soc'y of Am., Inc., 609 P.2d 24 (Alaska 1980), *appeal after remand,* 661 P.2d 632 (Alaska 1983).

4. *Storrs,* 609 P.2d at 28.

5. *Id.* (citing Peterson v. Tucson Gen. Hosp., Inc., 114 Ariz. 66, 559 P.2d 186 (Ct. App. 1976); Anton v. San Antonio Community Hosp., 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564 (1972), *cert. denied,* 409 U.S. 1048 (1972); Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963)).

6. *See* Groseclose, *Hospital Privilege Cases: Braving the Dismal Swamp,* 26

Storrs for Alaska courts, hospitals, and physicians. As background, the note briefly discusses why *constitutional* due process cannot be invoked to challenge decisions made by "quasi-public" hospitals[7] and explores the reasoning underlying the traditional "rule of nonreview."[8] Attention is then given to the reasoning used by other jurisdictions, especially those relied upon by the Alaska Supreme Court in *Storrs,* to support the extension of common law due process review to private hospitals. Specific "due process" requirements and the standard of judicial review applied in other jurisdictions are considered. Finally, the note suggests policy concerns which Alaska courts should consider in further developing common law due process requirements for hospitals.

II. COMMON LAW, NOT CONSTITUTIONAL LAW

Court intervention in the medical staff decisions of private hospitals is permitted by common law principles and is not required by the Constitution. The cases relied upon in *Storrs* to justify due process review of "quasi-public" hospitals are *not* constitutional due process cases. They rest on common law foundations.[9] The distinction between common law due process and constitutional due process is important because, under common law, state action by the hospital is not a prerequisite to due process review.[10] Additionally, the particular demands of common law due process can develop independently of federal constitutional requirements.[11]

S.D.L. REV. 1, 3 (1981); McMahon, *Judicial Review of Internal Policy Decisions of Private Nonprofit Hospitals: A Common Law Approach,* 3 AM. J.L. & MED. 149 (1977). Neither counsel for the parties nor the Alaska court identified the possible statutory basis for appellate review of private hospital decisions found in ALASKA STATUTE section 18.23.030(c) (1981). *See infra* text accompanying note 210.

7. *Infra* notes 9-26 and accompanying text.

8. *Infra* notes 27-39 and accompanying text.

9. *See* Groseclose, *supra* note 6, at 3; McMahon, *supra* note 6.

10. *See* Kiracofe v. Reid Memorial Hosp., 461 N.E.2d 1134 (Ind. Ct. App. 1984) (The court refused to conduct a constitutional due process review because there was no state action, but the concurring opinion distinguished constitutional from common law due process and advocated adopting a common law due process review.).

11. Substantive due process is especially likely to differ between common law and constitutional standards. At least one commentator, McMahon, *supra* note 6, at 175, has suggested that the common law can adopt a much more demanding requirement of reasonableness for hospitals than constitutional due process would require. *See infra* notes 174-77 and accompanying text. *See, e.g.,* Applebaum v. Board of Directors, 104 Cal. App. 3d 648, 657, 163 Cal. Rptr. 831, 836 (1980) (noting the distinction between the common law requirement of fair procedure and the constitutional demand of due process); Garrow v. Elizabeth Gen. Hosp. & Dispensary, 79 N.J. 549, 563, 401 A.2d 533, 540 (1979) (noting that in the absence of state action "constitutional due process may not be invoked" and that courts should look to "fundamental fairness" and certain practical considerations).

Before 1974, many courts found sufficient state action on the part of the hospital to justify constitutional due process review when there were factors indicating some relationship between the hospital and the state, including the hospital's receipt of government funds, especially Hill-Burton funds for facility construction, government regulation, state licensure, monopoly status, a public purpose or function, and appointment by public officials of hospital board members.[12] Courts were much less likely to find the state action necessary to justify constitutional due process review after the Supreme Court's 1974 decision in *Jackson v. Metropolitan Edison,*[13] which rejected the claim that a customer must be afforded constitutional due process before a private electricity company can terminate power.[14] The Court in *Jackson* clarified the nature of the relationship that must exist between the state and a private party in order to find that the private party has engaged in state action: "[T]he inquiry must be whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself."[15] Among other considerations, the Court found that monopoly status[16] and provision of an "essential public service"[17] do not transform the actions of a private utility into state action. Since 1974, the federal courts of appeals have generally refused to find state action in medical staff decisions of private hospitals, concluding that the nexus between the hospital and state is not sufficient to meet the *Jackson* test.[18] The Ninth Circuit has decided

12. Annot., 42 A.L.R. FED. 463 (1979).

13. 419 U.S. 345 (1974). *Jackson* relied upon Moose Lodge No. 107 v. Irvis, 407 U.S. 163 (1972), in which the Court found that state action was not involved in the refusal of a private club to serve the black guest of a white member, even though the club was licensed by the state to serve alcoholic drinks.

14. 419 U.S. at 358-59.

15. *Id.* at 351. In contrast to *Jackson,* Burton v. Wilmington Parking Auth., 365 U.S. 715 (1961) (state action involved in the decision to segregate privately run restaurant which was located in a city owned and operated building), arguably marks the limit of the Court's willingness to find state action. In *Burton* the Court held that "the State has so far insinuated itself into a position of interdependence . . . that it must be recognized as a joint participant in the challenged activity." 365 U.S. at 725. *See Jackson,* 419 U.S. at 357-58.

16. 419 U.S. at 351, 352.

17. *Id.* at 353.

18. *See, e.g.,* Lubin v. Crittenden Hosp. Ass'n, 713 F.2d 414 (8th Cir. 1983), *cert. denied,* 104 S. Ct. 1282 (1984); Loh-Seng Yo v. Cibola Gen. Hosp., 706 F.2d 306 (10th Cir. 1983); Modaber v. Culpeper Memorial Hosp., 674 F.2d 1023 (4th Cir. 1982); Musso v. Suriano, 586 F.2d 59 (7th Cir. 1978), *cert. denied,* 440 U.S. 971 (1979); Nadry v. Sorel, 558 F.2d 303, 305-06 (5th Cir. 1977), *cert. denied,* 434 U.S. 1086 (1978). Recent Supreme Court cases further support this result. *See* Blum v. Yaretsky, 457 U.S. 991 (1982) (activity of heavily regulated nursing home, receiving Medicaid and Medicare, was not state action); Rendell-Baker v. Kohn, 457 U.S. 830 (1982)

that pervasive regulation[19] and receipt of Hill-Burton construction funds,[20] even when combined with tax exemptions[21] and the presence of board members appointed by public authorities,[22] do not make a private hospital's activities "state action" for purposes of constitutional challenge.

The Alaska Supreme Court has not clearly recognized and maintained the important distinction between constitutional and common law due process. In *Storrs,* the facts that Fairbanks Memorial Hospital was the only hospital in the area and was built, in part, with government funds would not have been sufficient to justify fourteenth amendment due process scrutiny. Yet, in the few cases applying *Storrs,*[23] the Alaska Supreme Court has not seemed aware that it is developing common law, not applying constitutional law. For instance, in *Eidelson v. Archer* the court incorrectly suggested that if the hospital were quasi-public it "should be held to the constitutional due process standard."[24] The court has also relied, without clarifying its reasons for reliance, on both common law and constitutional due process cases.[25] Given the potential for confusion of the two doctrines, the Alaska court would be well-advised to drop the term "due process," as the California courts have done, and speak instead in

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(private school for maladjusted high school students, which received most of its students from references from city committees and at least 90% of its funds from public sources, was found not to be engaged in state action when it dismissed a teacher).

For an interesting comparison of pre- and post-*Jackson* decisions on whether state action is involved in hospital decisions concerning physician privileges, *compare* Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959, 967 (4th Cir. 1963), *cert. denied,* 376 U.S. 938 (1964) (using the *Burton* test, discussed *supra* note 15, the court found sufficient elements of a joint enterprise, based upon acceptance of Hill-Burton funds by hospitals, to constitute state action) *with Modaber,* 674 F.2d at 1026 ("But the mere fact that the hospitals implement a governmental program does not establish the nexus which *Jackson* requires.").

19. Chrisman v. Sisters of St. Joseph of Peace, 506 F.2d 308, 313-14 (9th Cir. 1974); *accord Jackson,* 419 U.S. at 350 (pervasive regulation does not make a private utility public).

20. *Chrisman,* 506 F.2d at 314.

21. Watkins v. Mercy Medical Center, 520 F.2d 894, 896 (9th Cir. 1975); Ascherman v. Presbyterian Hosp. of Pacific Medical Center, 507 F.2d 1103, 1105 (9th Cir. 1974).

22. Aasum v. Good Samaritan Hosp., 542 F.2d 792, 795 (9th Cir. 1976).

23. In McMillan v. Anchorage Community Hosp., 646 P.2d 857, 863 (Alaska 1982), the court reviewed a summary suspension for due process violations because the parties had stipulated to abide by that standard. Eidelson v. Archer, 645 P.2d 171, 181 (Alaska 1982), was not a due process case; however, the court's analysis of the reasons for applying the exhaustion of remedies doctrine to appeals from private hospital proceedings emphasizes factors important in a due process analysis and suggests how the court might approach a due process analysis.

24. 645 P.2d 171, 175 n.13, 181 (Alaska 1982).

25. While constitutional due process cases may provide helpful reasoning, they may also be ignored. *See infra* text accompanying notes 98-103.

terms of actions which are "substantially rational and procedurally fair."[26]

III. THE TRADITIONAL RULE OF NONREVIEW

Traditionally, courts have refused to review the internal decisions of private entities such as hospitals. *Shulman v. Washington Hospital Center*[27] provides a clear statement of the traditional rule of nonreview. In addressing the question "whether a private hospital has power to appoint and remove members of its medical staff at will, and whether it has authority to exclude in its discretion members of the medical profession from practising in the hospital," the court concluded:

> The rule is well established that a private hospital has a right to exclude any physician from practising therein. The action of hospital authorities in refusing to appoint a physician or surgeon to its medical staff, or declining to renew an appointment that has expired, or excluding any physician or surgeon from practising in the hospital, is not subject to judicial review. The decision of the hospital authorities in such matters is final.
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> The only possible exception is in a case in which there is a failure to conform to procedural requirements set forth in its constitution, by-laws, or rules and regulations. In that event the extent of judicial review is to require compliance with the prescribed procedure.[28]

The *Shulman* court began its review of the reasons supporting this widely accepted position[29] by drawing a clear distinction between public and private hospitals, based on ownership and control.

> A public hospital, as its very name implies, is one owned, maintained and operated by a governmental unit, such as a municipality, or county, and supported by governmental funds. . . . A private hospital is one that is owned, maintained and operated by a corporation or an individual without any participation on the part of any governmental agency in its control.[30]

In *Shulman,* the court reasoned that, because the hospital was a private corporation, the hospital board had the duty and power to

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26. Ascherman v. St. Francis Memorial Hosp. (*Ascherman II*), 45 Cal. App. 3d 507, 511-12, 119 Cal. Rptr. 507, 509 (1975). On this point, *Ascherman II* follows Pinsker v. Pacific Coast Soc'y of Orthodontists, 12 Cal. 3d 541, 550 n.7, 526 P.2d 253, 259 n.7, 116 Cal. Rptr. 245, 251 n.7 (1974).

27. 222 F. Supp. 59 (D.D.C. 1963).

28. *Id.* at 63.

29. For recent decisions following the reasoning in *Shulman,* see, for example, Knapp v. Palos Community Hosp., 125 Ill. App. 3d 244, ____, 465 N.E.2d 554, 563 (1984); Jain v. Northwest Community Hosp., 67 Ill. App. 3d 420, 424, 385 N.E.2d 108, 112 (1978); Hoffman v. Garden City Hospital-Osteopathic, 115 Mich. App. 773, 778-79, 321 N.W.2d 810, 813 (1982).

30. 222 F. Supp. at 61 (citing Levin v. Sinai Hosp., 186 Md. 174, 178, 46 A.2d 298, 300 (1946)). This distinction has substantial historical legitimacy. In Trustees of

manage the hospital[31] and that courts should not interfere because they are "not equipped to review the action of hospital authorities in selecting or refusing to appoint members of medical staffs, declining to renew appointments previously made, or excluding physicians or surgeons from hospital facilities."[32] The *Shulman* court rejected the idea that a private hospital is subject to judicial review because it receives public funds to care for the sick or to construct buildings.[33] According to the rule of nonreview, acts of the hospital board can be challenged as outside of corporate powers, as a violation of state statutes and regulations, or as a deviation from the corporate bylaws.[34] Otherwise, the judgments of private hospitals are immune from judicial review.[35]

Dartmouth College v. Woodward, 17 U.S. (4 Wheat.) 518, 668-69 (1819), Justice Story, concurring, insisted upon a clear division between corporations:

> Another division of corporations is into public and private . . . . [P]ublic corporations are such only as are founded by the government for public purposes, where the whole interests belong also to the government. If, therefore, the foundation be private, though under the charter of the government, the corporation is private, however extensive the uses may be to which it is devoted, either by the bounty of the founder, or the nature and objects of the institution.

Both Chief Justice Marshall, writing for the majority, *id.* at 634-35, and Justice Story, concurring, *id.* at 668, identified the nonprofit hospital as a private corporation, despite its public function.

31. 222 F. Supp. at 62 (citing Edson v. Griffin Hosp., 21 Conn. Supp. 55, 57-58, 144 A.2d 341, 344-45 (1958) ("The test [for identifying a private hospital] is whether, under the charter or corporate powers granted, they have the right to elect their own officers and directors, with the power to manage their own affairs.")); *see also* Van Campen v. Olean Gen. Hosp., 210 A.D. 204, 209, 205 N.Y.S. 554, 557-58 (1924), *aff'd mem.*, 239 N.Y. 615, 147 N.E. 219 (1925) ("[C]ourts have nothing to do with the internal management of corporations in the absence of fraud or bad faith, if kept within corporate powers."); Khoury v. Community Memorial Hosp., 203 Va. 236, 244, 123 S.E.2d 533, 538 (1962) (the "hospital falls squarely within the time honored definition of a private corporation").

32. 222 F. Supp. at 64; *see also Knapp,* 125 Ill. App. 3d at ____, 465 N.E.2d at 563 (recent restatement of a court's "unwillingness to substitute its judgment for that of private hospital authorities"). Other courts have emphasized different reasons for deference to the private hospital board. *See* Mauer v. Highland Park Hosp. Found., 90 Ill. App. 2d 409, 415, 232 N.E.2d 776, 779 (1967) (hospital's potential liability for malpractice of physician imprudently admitted to staff argues for court deference to the hospital board).

33. *Shulman,* 222 F. Supp. at 61; *see, e.g., Edson,* 21 Conn. Supp. at 58, 144 A.2d at 343; *Khoury,* 203 Va. at 244-45, 123 S.E.2d at 538; *see also Trustees of Dartmouth College,* 17 U.S. (4 Wheat.) at 567, discussed *supra* note 30.

34. *Shulman,* 222 F. Supp. at 61, 63-64. *Shulman* did not explicitly refer to court review of alleged ultra vires acts or of violations of state law by the hospital. Cases it relied upon did. *See* cases cited *supra* note 31. Today some courts that follow the rule of nonreview "also make an exception where conspiracy to injure the physician in his profession is alleged." *Jain,* 67 Ill. App. 3d at 425, 385 N.E.2d at 112.

35. *Shulman,* 222 F. Supp. at 64.

The *Shulman* court was "not unmindful of the fact that . . . occasional injustice may result" from refusal to review.[36] The court, however, viewed its role as limited: "The Courts . . . do not sit to remedy every ill caused by the frailties of mankind. Their function is but to vindicate legal rights and redress legal wrongs."[37] Implicit in this statement is the suggestion that it is a legislative function, not a judicial one, to create substantial new legal rights.

In summary, the stance of courts that support the rule of nonreview is based upon the following: 1) recognition of a clear distinction between public and private corporations and a corollary limitation on the grounds for challenging medical staff decisions of private hospitals to violations of state law or of the hospital's bylaws; 2) deference to the hospital board because of the inability of courts to oversee hospital management decisions and the impropriety of judicial interference in the decisions of private corporations; and 3) the view that the proper role of the courts is limited to redressing legal wrongs.

Shulman was decided a few months after the New Jersey Supreme Court rejected the rule of nonreview in *Greisman v. Newcomb Hospital.*[38] The *Shulman* court explicitly rejected the "public utility" or "common carrier" reasoning which the *Greisman* court relied upon to extend common law court review to private hospitals.[39]

IV. COMMON LAW DUE PROCESS

Since the *Greisman* decision in 1963, at least eleven jurisdictions[40] have indicated a willingness to review private hospital medical staff

36. *Id.*

37. *Id.*

38. 40 N.J. 389, 192 A.2d 817 (1963).

39. In rejecting the *Greisman* court's reasoning, the court in *Shulman* stated that "[a] private hospital is not a public utility in the legal sense of that term. Neither is the operation of the hospital a public calling, such as that of a common carrier, light or power companies, or a telephone company." 222 F. Supp. at 62. The *Shulman* court declined to follow the substantive law relating to common law regulation of common carriers, specifically noting that it would be inappropriate to regulate the rates or patient admissions policies of private hospitals. *Id.* The *Shulman* court noted that "New Jersey seems to stand alone in apparently adopting a different rule." *Id.* at 64. The *Shulman* court, however, read more into the *Greisman* court's use of the common law of common carriers than is justified. *See infra* text accompanying notes 55-57.

40. For states which have judicially abandoned the rule of nonreview, see, for example, *Storrs,* 609 P.2d 24; Peterson v. Tucson Gen. Hosp., 114 Ariz. 66, 559 P.2d 186 (Ct. App. 1976); Ascherman v. St. Francis Memorial Hosp., 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975); Hawkins v. Kinsie, 540 P.2d 345 (Colo. App. 1975); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564, *cert. denied,* 409 U.S. 1048 (1972); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589, *cert. denied,* 404 U.S. 995 (1971); Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d

decisions. The traditional rule of nonreview, however, continues to be the majority position.[41] Several courts have recently declined an invitation to change their position from the traditional rule.[42]

A. A Common Law Break With Tradition—*Greisman*

In *Greisman v. Newcomb Hospital,* the Supreme Court of New Jersey broke completely from the well-established rule of nonreview.[43] The court was asked to review a hospital bylaw which effectively prevented consideration of an osteopath, licensed as a physician by the state, for membership on the medical staff. The medical staff bylaw required an applicant to be a graduate of an American Medical Association approved medical school and a member of the County Medical Society.[44] The traditional rule of nonreview generally would not allow court review of the *substance* of a bylaw,[45] but the court found compelling reasons for rejecting the traditional rule.

Newcomb Hospital was a private, nonprofit hospital which received some public funds and tax benefits. The hospital's argument that its decisions were not subject to judicial review was rejected by the court:

> [The hospital] constitutes a virtual monopoly in the area in which it functions and it is in no position to claim immunity from public supervision and control because of its allegedly private nature. Indeed, in the development of the law, activities much less public than the hospital activities of Newcomb, have been subjected to judicial

246, 250 N.E.2d 892 (1969); Woodward v. Porter Hosp., 125 Vt. 419, 217 A.2d 37 (1966); Rao v. Auburn Gen. Hosp., 10 Wash. App. 361, 517 P.2d 240 (1973). Two courts have interpreted state statutes as rejecting the rule of nonreview. *See* Carida v. Holy Cross Hosp., 427 So. 2d 803, 805 (Fla. Dist. Ct. App. 1983); Fritz v. Huntington Hosp., 39 N.Y.2d 339, 345, 348 N.E.2d 547, 552, 384 N.Y.S.2d 92, 96 (1976).

41. *See* Hoffman v. Garden City Hospital-Osteopathic, 115 Mich. App. 773, 778, 321 N.E.2d 810, 813 (1982).

42. *See supra* note 29.

43. The New Jersey court was aware that it was going against the weight of case law in abandoning the rule of nonreview. 40 N.J. at 395-96, 192 A.2d at 820-21.

44. *Id.* at 392, 192 A.2d at 819. Osteopaths are not graduates of American Medical Association approved schools and are often not eligible for membership in local medical societies.

45. One possible basis for review of the *substance* of a bylaw which is consistent with the rule of nonreview was suggested in Hamilton County Hosp. v. Andrews, 227 Ind. 217, 84 N.E.2d 469, *cert. denied,* 338 U.S. 831 (1949). The court struck down a bylaw, much like the one at issue in *Greisman,* because it effectively delegated to the medical staff and the County Medical Society the "power to determine what physicians may use its facilities." *Id.* at 225-26, 84 N.E.2d at 472. The court found that the board had a nondelegable duty to make such decisions. *Id.* This decision has not been widely followed and was not considered by the *Greisman* court.

(as well as legislative) supervision and control to the extent necessary to satisfy the felt needs of the times.[46]

The New Jersey Supreme Court decided that "the felt needs of the times" required a blurring of the previously clear distinction between public, governmentally owned and operated hospitals and private, nonprofit hospitals. In support of its position the court cited[47] a concurrence by Justice Douglas in a 1963 Supreme Court decision, *Lombard v. Louisiana.*[48] *Lombard* reversed the criminal mischief conviction of three black students and one white student for refusing to comply with a request to leave a racially segregated refreshment counter.[49] The Fifth Circuit had affirmed the conviction "on the ground that the decision to segregate this restaurant was a private choice, uninfluenced by the officers of the State."[50] The majority of the Supreme Court had no difficulty in finding the required state action in the behavior of city officials.[51] Justice Douglas found the required state action in the use of the judiciary to enforce private discriminatory behavior.[52] He used the example of the judicial creation of common law "rules governing innkeepers and carriers" to illustrate the need for courts to act even in the absence of legislation.[53] For Justice Douglas, the real significance of such common law regulation was that it was a "response to the felt needs of the times that spawned it."[54]

In *Greisman,* the New Jersey court adopted Douglas's expansive view of the common law powers of the courts, illustrated by the courts' traditional common law regulation of innkeepers and common carriers.[55] The *Greisman* court did *not* rely *substantively* on cases regulating common carriers; it only relied on these cases to justify judicial

46. 40 N.J. at 396, 192 A.2d at 821.

47. *Id.*

48. 373 U.S. 267 (1963) (Douglas, J., concurring).

49. *Id.* at 269.

50. *Id.* at 274.

51. *Id.* at 273.

52. *Id.* at 278 (Douglas, J., concurring).

53. *Id.* at 276 (Douglas, J., concurring); *see also* McMahon, *supra* note 6, at 167-71. For the *Shulman* court's reasons for rejecting the common carrier tradition as applied to private hospitals, see *supra* note 39.

54. 373 U.S. at 279 (Douglas, J., concurring). Justice Douglas, in fact, recognized that the common law regulation of common carriers had never been extended to private restaurants. He was not advocating the extension of established precedent; rather, he was illustrating an expansive exercise of judicial common law powers.

> The substance of the old common-law rules has no direct bearing on the decision required in this case. Restaurateurs and owners of other places of amusement and resort have never been subjected to the same duties as innkeepers and common carriers. But what is important is that this whole body of law was a response to the felt needs of the times that spawned it.

55. 40 N.J. at 397, 192 A.2d at 821.

intervention.[56] Cases in other jurisdictions that have followed *Greisman* in rejecting the rule of nonreview have rarely mentioned the common carrier aspect of the decision. The substantive law relied upon in *Greisman* was the law placing a high duty of care on fiduciaries: "[W]hile the managing officials may have discretionary powers in the selection of the medical staff, those powers are deeply imbedded in public aspects, and are rightly viewed . . . as fiduciary powers to be exercised reasonably and for the public good."[57] The New Jersey court found that the powers of certain private hospital boards, "particularly those relating to the selection of staff members, are powers in trust."[58] The court felt that it would be "remiss" if it failed to strike down a bylaw which could not be justified by "sound hospital standards" and "was not in furtherance of the common good."[59]

The contrast between *Greisman* and the *Shulman* court's adherence to the rule of nonreview is clear. In *Greisman:* 1) the line between public and private was blurred by emphasizing that private acts bearing on the common good are subject to regulation; 2) the court was confident in its ability to determine whether private hospitals have exercised their judgment in a "reasonable and constructive manner;" and 3) the court had an expansive view of its role and was willing to adjust the character of judicial review to the "felt needs of the times."

B. Judicial Development of Common Law Due Process Requirements for Private Hospitals

All state courts that have rejected the rule of nonreview and have subjected certain private hospitals to judicial review did so by following, to varying degrees, the fiduciary duty reasoning of *Greisman.*[60] State court decisions, including the ones relied upon in *Storrs,* have differed, however, on which hospitals have such a duty, to whom this duty is owed, and what specifically this duty requires. In other words, even among jurisdictions that agree review is appropriate, there is no consensus regarding which hospitals are subject to judicial review and the nature of that review. The following discussion considers various approaches to these questions and their potential application in Alaska.

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56. The *Shulman* court misunderstood the use of analogies to the common law of common carriers and public utilities by the *Greisman* court. *See supra* note 39.

57. 40 N.J. at 402, 192 A.2d at 824. *Greisman* heavily relied upon Falcone v. Middlesex County Medical Soc'y, 34 N.J. 582, 170 A.2d 791 (1961) (holding that a private medical professional association was subject to judicial review because of its fiduciary duty to the public).

58. 40 N.J. at 404, 192 A.2d at 825.

59. *Id.*

60. *See supra* note 40 for a list of cases in which courts have abandoned the rule of nonreview.

1. *Which hospitals are subject to common law due process review?* The *Greisman* rationale for judicial review is that certain private hospitals owe a fiduciary duty to the public because of their public function and because they receive public funds and have a monopoly on an essential service.

Storrs could be read as extending judicial review only to those private, nonprofit hospitals that have a monopoly and receive public funds, as was the case in *Greisman.*[61] Other cases cited in *Storrs,* however, go further.[62] In *Silver v. Castle Memorial Hospital,*[63] the Hawaii Supreme Court noted a tension, which is apparent in *Greisman,*[64] between the broad language identifying a hospital's fiduciary duty to the public and the limitation of judicial review to those hospitals that receive public funds and possess a virtual monopoly:

> [I]f the proposition that *any* hospital occupies a fiduciary trust relationship between itself, its staff and the public it seeks to serve is accepted, then the rationale for any distinction between public, 'quasi-public,' and truly private breaks down and becomes meaningless, especially if the hospital's patients are considered to be of primary concern.[65]

The Hawaii court did not have to decide whether to extend judicial review to *all* private hospitals because the appellee hospital had received state and federal funds. The court, therefore, limited its

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61. Since *Greisman* was decided, the New Jersey court has expanded the class of the hospitals it reviews to include all nonprofit, private hospitals "serving the public generally." Garrow v. Elizabeth Gen. Hosp. & Dispensary, 79 N.J. 549, 557, 401 A.2d 533, 537 (1979) ("A non-profit private hospital serving the public generally is a quasi-public institution whose obligation to serve the public is the linchpin of its public trust and the fiduciary relationship which arises out of the management of that trust.").

62. *See* cases cited in 609 P.2d at 28, noted *supra* note 5.

63. 53 Hawaii 475, 497 P.2d 564, *cert. denied,* 409 U.S. 1048 (1972) (involving a hospital's failure to renew a physician's staff privileges).

64. In *Silver,* after quoting extensively from *Greisman* and citing a subsequent New Jersey decision, the court referred to the tension between the breadth of the idea of the fiduciary duty hospitals have to the public, on the one hand, and a holding limiting judicial review to hospitals with particular characteristics, on the other. Therefore, the implication that the Hawaii court was referring to a tension in *Greisman* is quite strong. *See Silver,* 53 Hawaii at 482, 497 P.2d at 569-70.

65. *Id.* at 482, 497 P.2d at 570 (emphasis added). The Hawaii court most clearly identified and labeled as "quasi-public" those private hospitals which are "constructed with public funds," are "presently receiving public benefits" or have been "sufficiently incorporated into a governmental plan for providing hospital facilities to the public." *Id.* at 481-82, 497 P.2d at 569. The court in Peterson v. Tucson Gen. Hosp., 114 Ariz. 66, 69, 559 P.2d 186, 189 (Ct. App. 1976), viewed application of this definition of a hospital as "quasi-public" as an alternative approach to the fiduciary duty reasoning of *Greisman.* It seems clear from the *Silver* court's heavy reliance on *Greisman* and its reference to subsequent New Jersey decisions that the court was basing its definition of quasi-public on *Greisman* and that use of the label "quasi-public" does not rise to the level of an alternative approach. *Silver,* 53 Hawaii at 481-82, 497 P.2d at 568-69.

holding to hospitals with "more than nominal governmental involvement in the form of funding."[66] In contrast, California has gone further than either New Jersey or Hawaii, extending judicial review to all private hospitals.[67]

In *Storrs,* the Alaska Supreme Court[68] cited the California Supreme Court's decision in *Anton v. San Antonio Community Hospital*[69] as support for the extension of due process protection in Alaska. *Anton* did not, in fact, directly address the rationale underlying the extension of common law due process;[70] rather, it assumed the reasoning of several earlier California cases. In *Ascherman v. San Francisco Medical Society* (*Ascherman I*), a California court of appeals adopted the now familiar fiduciary duty argument[71] and remanded the case for further proceedings. During the same year the Supreme Court of California held in *Pinsker v. Pacific Coast Society of Orthodontists*[72] that a professional association's fiduciary obligation to the public justified judicial review whenever the association's decisions "would effectively impair the applicant's right 'to fully practice his profession.' "[73] When *Ascherman v. St. Francis Memorial Hospital* (*Ascherman II*) came before it in the following year, the court of appeals decided that the hospital's fiduciary duty arose for the same reason.[74] Consequently, the court struck down a hospital bylaw that permitted summary rejection of Dr. Ascherman's application for medical staff membership solely because of his failure to include three letters of recommendation from active members of the medical staff.[75]

The court's discussion of the facts of *Ascherman II* indicates its willingness to set a very low threshold for a finding that the challenged

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66. *Silver,* 53 Hawaii at 483, 497 P.2d at 570.

67. Anton v. San Antonio Community Hosp., 19 Cal. 3d 802, 815, 567 P.2d 1162, 1168, 140 Cal. Rptr. 442, 448 (1977).

> Our decision in *Pinsker v. Pacific Coast Society of Orthodontists* . . . referring to a long and well-established line of cases of similar purport, made it clear that a physician may neither be refused admission to, nor expelled from the staff of a hospital, *whether public or private,* in the absence of a procedure comporting with the minimum common law requirements of procedural due process.

Id. (emphasis in original).

68. 609 P.2d at 28.

69. 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977).

70. The lower court opinion did address the issue. Anton v. San Antonio Community Hosp., 55 Cal. App. 3d 212, 127 Cal. Rptr. 394, 398 (1976), *vacated,* 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977).

71. 39 Cal. App. 3d 623, 631, 114 Cal. Rptr. 681, 685 (1974).

72. 12 Cal. 3d 541, 526 P.2d 253, 116 Cal. Rptr. 245 (1974).

73. *Id.* at 554, 526 P.2d at 262, 116 Cal. Rptr. at 254 (*quoting* Wyatt v. Tahoe Forest Hosp. Dist., 174 Cal. App. 2d 709, 715, 345 P.2d 93, 97 (1959)).

74. 45 Cal. App. 3d 507, 511, 119 Cal. Rptr. 507, 509 (1975).

75. *Id.* at 508-09, 119 Cal. Rptr. at 507-08. The defendants, facts, and the cause of action changed considerably between *Ascherman I* and *Ascherman II.*

action impairs a physician's right to "fully" practice his profession. At the time of *Ascherman II,* Dr. Ascherman was on the medical staff of four hospitals, including another in the same area as St. Francis Memorial Hospital.[76] His annual income was between $80,000 and $90,000, and he made no showing of injury to his practice.[77] "[H]is purpose in making the application was to find a hospital a little closer to his home office in order to make life a bit easier for himself."[78]

The fiduciary duty justifying judicial review in *Greisman* arose from the hospital's monopoly position and public support; the nature of the hospital was critical. In contrast, in *Ascherman II* the California court found that the fiduciary obligations of hospitals arise from the impact of hospital decisions on physicians. In the court's view, the hospital's decision affected a fundamental property right, even though the decision was no more than an inconvenience to the physician.[79] California, therefore, has extended judicial review to all private hospitals and has broadened the justification for review to include the protection of the physician's right to "fully" practice his profession.

Which Alaska Hospitals Are Subject to Common Law Due Process Review? By its unexplained reliance on the reasoning in cases from different jurisdictions,[80] which employed quite different threshold criteria for subjecting private hospital staff decisions to judicial review, the Alaska Supreme Court introduced a significant element of legal uncertainty into the task of identifying which hospitals may be treated as quasi-public. It is not clear whether Alaska will treat *all* private hospitals as quasi-public, following the California view, or whether review will occur only if the hospital has a "virtual monopoly"[81] or is

76. *Id.*

77. *Id.*

78. *Id.* at 509, 119 Cal. Rptr. at 508.

79. The importance of the physician's right to practice as *the* reason for the hospital's fiduciary duty is also clear in *Anton,* 19 Cal. 3d at 824-25, 567 P.2d at 1174-75, 140 Cal. Rptr. at 454-55, cited by the Alaska court in *Storrs,* 609 P.2d at 28. Other courts also emphasize the importance of the physician's right to practice, though none gives the physician's interests the independent significance that California does. *See, e.g.,* Holmes v. Hoemako Hosp., 117 Ariz. 403, 405, 573 P.2d 477, 479 (1977). *But cf.* Hayman v. City of Galveston, 273 U.S. 414 (1927) (holding that a physician did not have a fundamental right to practice in a public hospital). California distinguished *Hayman* from its holding in *Ascherman I.* 39 Cal. App. 3d at 645, 114 Cal. Rptr. at 695.

80. *Storrs,* 609 P.2d at 28. *See supra* note 5.

81. *Greisman,* 40 N.J. at 396, 192 A.2d at 821. *But see supra* note 61. *See also* the dissents in Miller v. Eisenhower Medical Center, 27 Cal. 3d 614, 636-37, 614 P.2d 258, 272, 166 Cal. Rptr. 827, 840 (1980) (Mosk, J., dissenting), and Ezekial v. Winkley, 20 Cal. 3d 267, 280-81, 572 P.2d 32, 41, 142 Cal. Rptr. 418, 427 (1977) (Mosk, J., dissenting), for the argument by a California justice that "monopoly control"

receiving more than "nominal" governmental support.[82]

In the meantime, private hospital boards in Alaska have no way of knowing with confidence which hospitals will be classified as quasi-public and subjected to a common law due process judicial review. The likely result of this uncertainty will be that hospitals will agree to a due process judicial review, as the hospital did in *McMillan v. Anchorage Community Hospital.*[83] In *McMillan,* the hospital's summary suspension of a physician was initially challenged as a violation of the due process rights recognized in *Storrs,* a challenge which required the plaintiff physician to prove that the hospital was quasi-public.[84] When faced with requests to provide "hospital books and records that would indicate the percentage of funding, such as grants, revenue sharing and welfare payments, received from public sources," the hospital abandoned its initial claim that "it was a private hospital whose staffing decisions were not subject to judicial review."[85] Thus, in the absence of clear judicial criteria, the onerous task of providing evidence to refute a claim of quasi-public status may induce hospitals to stipulate to a due process review, thereby foregoing a determination on the merits of the actual appropriateness of the action.

In a footnote in *McMillan,* the Alaska court considered whether the Anchorage Community Hospital would be "quasi-public."[86] A comparison of this footnote with the holding in *Storrs*[87] suggests that the court will not strictly apply the criteria mentioned in *Storrs* in determining whether a hospital is quasi-public. In *Storrs,* the court held that the hospital was quasi-public because it was the only one in the community, it had been constructed in part with government grants, and it received over twenty-five percent of its payments for hospital services from government sources.[88] In contrast, in *McMillan* the court noted that the Anchorage Community Hospital was not the only hospital in the area and that the building in which McMillan worked was not constructed with public funds; yet, the court suggested that the hospital might have "sufficient public funding contacts" to be considered quasi-public.[89] The clear implication is that the criteria of a monopoly on hospital services and of public funding for construction

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should be the "one exception that may justify interference with operations of a private hospital." *Miller,* 27 Cal. 3d at 637, 614 P.2d at 272, 166 Cal. Rptr. at 840.

82. *Silver,* 53 Hawaii at 483, 497 P.2d at 570, discussed *supra* text accompanying notes 63-66.

83. 646 P.2d 857 (Alaska 1982).

84. *Id.* at 860-61 n.4.

85. *Id.*

86. *Id.*

87. 609 P.2d at 28, *quoted supra* text accompanying note 4.

88. *Id.*; *see also McMillan,* 646 P.2d at 860 n.4.

89. 646 P.2d at 860-61 n.4.

are not essential for the determination that a hospital is quasi-public. This language also suggests that in determining quasi-public status the Alaska Supreme Court is likely to adopt the *Silver* standard of "more than nominal governmental involvement in the form of funding."[90]

2. *What Is Required of Quasi-Public Hospitals by Common Law Due Process?* If the Alaska Supreme Court follows the example of other jurisdictions, it will extend common law due process protections not only to suspensions and removals of physicians from the medical staff of quasi-public hospitals,[91] but also to initial denials of applications,[92] to denials of reapplications,[93] and to reductions in privileges.[94] The court will be concerned with both procedural and substantive common law due process.[95]

Despite basic areas of agreement, courts often have fundamentally different approaches to judicial review, different standards of review, and different requirements for what hospitals must do in the name of fair procedure and substantive rationality. Alaska Supreme Court cases only hint at how Alaska courts should approach judicial review of quasi-public hospitals. Reliance on constitutional due process cases, administrative law, and a balancing of interests approach are apparent in the few cases currently available. The following sections identify and discuss different standards and approaches to judicial review of quasi-public hospitals, focusing on their potential utility to Alaska courts as they develop the details of common law due process review in Alaska.

a. Constitutional Due Process as Precedent? In *McMillan* the Alaska Supreme Court conducted a due process review because the parties stipulated that they would abide by that standard.[96] The stipu-

90. *Silver,* 53 Hawaii at 483, 497 P.2d at 570.

91. *Storrs,* 609 P.2d at 28, addressed suspensions and removals.

92. *See, e.g., Ascherman II,* 45 Cal. App. 3d at 511-12, 119 Cal. Rptr. at 509; *Silver,* 53 Hawaii at 484, 497 P.2d at 571; *Greisman,* 40 N.J. at 404, 192 A.2d at 825.

93. *See, e.g., Peterson,* 114 Ariz. 66, 559 P.2d 186; *Anton,* 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442.

94. *See, e.g.,* Applebaum v. Board of Directors, 104 Cal. App. 3d 648, 658, 163 Cal. Rptr. 831, 837 (1980).

95. Every jurisdiction that does one, does both. *See, e.g.,* Holmes v. Hoemako Hosp., 117 Ariz. 403, 404, 573 P.2d 477, 478 (1977); *Ascherman II,* 45 Cal. App. 3d at 511-12, 119 Cal. Rptr. at 509; *Pinsker,* 12 Cal. 3d at 550, 526 P.2d at 259-60, 116 Cal. Rptr. at 251-52 ("[W]henever a private association is legally required to refrain from arbitrary action, the asssociation's action must be both substantively rational and procedurally fair."). The due process review by stipulation in *McMillan,* 646 P.2d at 861-66, included both procedural and substantive considerations.

96. 646 P.2d at 863.

lation did not distinguish common law from constitutional due process.[97] After noting that *Storrs* required adherence to due process, the court followed constitutional due process precedent.[98] For reasons already discussed,[99] constitutional due process cases are not controlling in this context. Instead, the policy concerns and the reasoning embodied in constitutional due process precedent can be followed when Alaska courts find them compelling or rejected when the courts find them inappropriate.[100] A common law due process review gives Alaska courts the discretion[101] to determine whether the constitutional requirements placed on public hospitals are fair[102] and reasonable[103] for private hospitals. The application of common law, rather than constitutional law, to private hospitals permits courts to acknowledge and make allowances for the special contributions and characteristics of private hospitals.

b. An Administrative Law Approach. Most jurisdictions have not specifically addressed the relevance of administrative law to judicial review of decisions by private hospitals. In *Storrs,* the Alaska Supreme Court suggested that if public statutes and ordinances existed which delineated the scope of administrative appeal of public hospital decisions, it would apply them to quasi-public hospitals as well.[104] The *Storrs* court found no relevant statutory guidance[105] and turned

97. *Id.*

98. *Id.* Specifically, the court relied on Nichols v. Eckert, 504 P.2d 1359 (Alaska 1973) (due process applied to mid-year dismissal of non-tenured public school teachers) and Pennsylvania *ex rel.* Rafferty v. Philadelphia Psychiatric Center, 356 F. Supp. 500 (E.D. Pa. 1973) (termination of a nurse by a state-supported psychiatric center without a hearing violated due process).

99. *Supra* notes 10-26 and accompanying text.

100. In so far as the fourteenth amendment requires only those procedural protections appropriate for the circumstances, *McMillan,* 646 P.2d at 863-64, and determines reasonableness by balancing the interests of the parties, courts using the common law approach may adopt standards developed in constitutional law cases because they make good sense. *See infra* notes 136 & 187 and accompanying text.

101. *See* McMahon, *supra* note 6, at 173-80.

102. *See infra* notes 153-71 and accompanying text for a discussion of the specific requirements of common law procedural due process.

103. *See infra* notes 172-89 and accompanying text for a discussion of substantive common law due process requirements.

104. 609 P.2d at 29. The court viewed the absence of rules defining the scope of review of administrative proceedings for public hospitals as requiring it to follow instead the hospital bylaws and a stipulation between the parties. The implication is that the court would have applied rules written for public hospital proceedings to quasi-public hospitals if such rules existed.

105. Chapter 8 of the Alaska Administrative Procedures Act on "Administrative Adjudication," ALASKA STAT. §§ 44.62.330-.630 (1984), specifically lists, in section 44.62.330(a), the agencies whose decisions are subject to judicial review. The governing boards of hospitals are not included. In general, the Administrative Procedures Act provides for extensive administrative hearing procedures, including the

instead to the hospital's bylaws and a stipulation by the parties.[106] Whether Alaska courts should turn to administrative law standards and doctrines for guidance and whether any future legislation prescribing administrative procedures for public hospitals should be applied to quasi-public hospitals[107] are open questions.

Among jurisdictions which have directly addressed the role of administrative law in judicial review of hospital staff decisions, New Jersey and California provide an instructive contrast. The New Jersey Supreme Court at one time applied administrative law to quasi-public hospital proceedings,[108] but later in *Garrow v. Elizabeth General Hospital & Dispensary* rejected that position: "The proper standard upon review is not identical with that customarily applied to administrative agencies, that is, substantial competent credible evidence . . . . This is not warranted nor possible in view of the nature of the hearing."[109]

The *Garrow* court decided that the exhaustion of remedies doctrine, which requires that administrative remedies be exhausted before courts will act, "would seem as a matter of principle to be equally applicable to appointment procedures before a hospital board."[110] The court went on to suggest that other aspects of typical governmental administrative proceedings would not be appropriate for either public or private hospitals. Recognizing that all hospitals must rely on "the voluntary cooperation of other comparable institutions and members of the medical profession, including those on the hospital's staff,"[111] the court felt that hospitals could not properly investigate a physician if full "adherence to the rules of evidence" was required or if the hospital had to conduct a "trial-type hearing."[112] Since much of the evidence used to make medical staff decisions "will consist of letters, reports and medical records,"[113] the court allowed the hospital

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power to subpoena, § 44.62.430, and to call and cross-examine witnesses, § 44.62.460(b), which some courts have rejected as inappropriate for hospital medical staff decisions. *See, e.g., Silver,* 53 Hawaii at 485, 497 P.2d at 571; *Garrow,* 79 N.J. at 564-65, 401 A.2d at 537.

106. *Storrs,* 609 P.2d at 29.

107. In recent years, the legislature has been primarily concerned with protecting and encouraging participation in peer review in hospitals. *See infra* notes 207-10 and accompanying text. All licensed hospitals are already required to have bylaws which include specified elements. ALASKA ADMIN. CODE tit. 7, § 12.110 (Jan. 1984).

108. Guerrero v. Burlington County Memorial Hosp., 70 N.J. 344, 356, 360 A.2d 334, 340 (1976).

109. 79 N.J. 549, 565, 401 A.2d 533, 541 (1979).

110. *Id.* at 558, 401 A.2d at 538. *But cf.* Berman v. Valley Hosp., 196 N.J. Super. 359, ____, 482 A.2d 944, 949 (1984) (while noting the possible applicability of the exhaustion of remedies doctrine to the case before it, the court decided that there were other compelling reasons for deciding the case on the merits at that time).

111. 79 N.J. at 565, 401 A.2d at 541.

112. *Id.*

113. *Id.*

great latitude, insisting simply that "[i]ts conclusions must be founded on reasonable and sensible grounds."[114]

The *Garrow* court also recognized basic differences between private hospitals and public agencies which would make application of administrative law to *private* hospitals particularly inappropriate.

> Although processing and determination of an application by a hospital have many characteristics similar to licensing by an administrative agency, certain basic differences do exist. . . . [Nonprofit, private hospitals] have not been created by government and their boards have not been endowed with the powers usually vested in administrative agencies by legislative enactments. Administrative agencies frequently have broad investigatory authority supportable by the power to issue subpoenas and obtain sanctions for their enforcement. They have the authority to promulgate rules and regulations which fill in legislative interstices and have a legislative effect.[115]

The New Jersey court rejected wholesale application of administrative law to hospitals and adopted a selective attitude toward application of administrative law doctrines. This selective attitude is sensitive to policy concerns[116] and to the distinctive features of private hospitals.[117]

California's judicial approach to private hospital decisions is unusual in explicitly applying the state statute that provides for judicial review of administrative agencies[118] to private hospitals,[119] and in requiring courts to exercise their "independent judgment" in evaluating the facts if the hospital's decision affects fundamental, vested rights (the trial de novo rule).[120]

In *Anton v. San Antonio Community Hospital,* the California Supreme Court decided to apply administrative law to nongovernmen-

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114. *Id.*

115. *Id.*

116. The *Garrow* court decided that the exhaustion of remedies doctrine was, as a matter of principle, applicable. *See supra* note 110 and accompanying text. In a recent decision, the superior court noted that the supreme court had not indicated that the exhaustion of remedies doctrine was "absolute" as applied to private hospitals. The superior court then listed a series of policy and equity considerations which weighed against the application of the exhaustion of remedies doctrine in the case before it and concluded that "the issues are primarily legal and the public interest calls for resolution of this seven year old controversy." *Berman,* 196 N.J. Super. at ____, 482 A.2d at 949.

117. *See supra* note 115 and accompanying text. A Colorado court has also refused to engage in review of a private hospital's decisions as if it were a public agency. Even v. Longmont United Hosp. Ass'n, 629 P.2d 1100, 1103 (Colo. Ct. App. 1981) (finding that a Colorado statute governing judicial review of an "inferior tribunal" was not applicable because "[a] private hospital board is not a public agency . . . and, therefore, is not an 'inferior tribunal' within the scope of C.R.C.P. 106(a)(4)").

118. CAL. CIV. PROC. CODE § 1094.5 (West 1980).

119. *Anton,* 19 Cal. 3d at 815-16, 567 P.2d at 1168-69, 140 Cal. Rptr. at 448-49.

120. *Id.* at 822, 567 P.2d at 1173, 140 Cal. Rptr. at 453. Independent judgment review is discussed *infra* notes 142-46 and accompanying text.

tal agencies based upon a close reading of section 1094.5 of the California Code of Civil Procedure.[121] The court determined that the terms of the statute encompassed private hospitals and other nongovernmental agencies if such agencies were required by law to conduct a hearing and take evidence and had "discretion in the determination of facts."[122] Since California case law required private hospitals to follow these procedures,[123] section 1094.5 was found to be applicable.[124]

In addition to its statutory rationale, the California court referred to a "compelling practical consideration" justifying the application of state administrative law to private hospitals.[125] Because public hospitals are required to hold hearings which are reviewed in accordance with section 1094.5, the court believed "[i]t would be incongruous . . . to hold that the decisions of *private* hospital boards, which are required . . . to be based upon a hearing of substantially identical scope and purport, were to be subject to some different form of review."[126] The court emphasized this point by taking judicial notice that both public and private hospitals are accredited by the Joint Commission on Accreditation of Hospitals (JCAH), which holds them to the same standards.[127] In effect, the court adopted a policy of judicial support of efforts, such as those of the JCAH,[128] to standardize all hospitals, public and private, and then used that policy as a "compelling practical consideration" for extending California administrative law to private hospitals. The California Supreme Court's standardizing approach clearly differs from the New Jersey Supreme Court's approach,

121. *Id.* at 814-19, 567 P.2d at 1169-70, 140 Cal. Rptr. at 447-50.

122. *Id.* at 814-15, 567 P.2d at 1167-68, 140 Cal. Rptr. at 447-48. The court acknowledged that it had been "widely assumed that mandate review via Section 1094.5 is available only with respect to administrative decisions by *governmental* agencies." *Id.* at 815-16, 567 P.2d at 1169, 140 Cal. Rptr. at 449 (emphasis in original).

123. *Id.* at 815, 567 P.2d at 1168, 140 Cal. Rptr. at 448; *see also Ascherman II,* 45 Cal. App. 3d 507, 119 Cal. Rptr. 507.

124. The court noted that the legislature enacted section 1094.5 on the basis of a judicial report which was directed exclusively at state licensing and disciplinary agencies. This did not prevent the court from finding a broader legislative intent, however. *Anton,* 19 Cal. 3d at 817-18, 567 P.2d at 1170, 140 Cal. Rtpr. at 450.

125. *Id.* at 818, 567 P.2d at 1170, 140 Cal. Rptr. at 450.

126. *Id.* (emphasis in original).

127. *Id.* at 818-19, 567 P.2d at 1171-72, 140 Cal. Rptr. at 451-52.

128. The JCAH has been subjected to antitrust attack and other criticism for its tendency to over-standardize hospitals. *See* Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective* (pt. 2), 9 AM. J.L. & MED. 263, 323-24 (1983); Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest,* 24 B.C.L. REV. 835, 875-79 (1983); *see also* Wilk v. American Medical Ass'n, 719 F.2d 207 (7th Cir. 1983), *cert. denied,* 104 S. Ct. 2398 (1984) (chiropractors challenged the JCAH and the AMA, among others, on antitrust grounds).

which recognizes basic differences between public and private agencies and selectively applies principles drawn from administrative law to quasi-public hospitals.[129]

The year after *Anton* was decided, the California legislature amended section 1094.5 of the California Code of Civil Procedure by adding a new subsection directing the courts to apply a substantial evidence standard to review of *private* hospital board decisions.[130] In cases involving fundamental, vested interests, the new statutory standard is different from the independent judgment standard which *Anton* applied to review of decisions of both private and public hospitals.[131] The new subsection suggests that the California legislature was not convinced of the wisdom of the judicial policy, expressed in *Anton,* of standardizing judicial treatment of public and private hospitals.

Unlike California, Alaska does not have administrative statutes which can be interpreted as extending to judicial review of hospitals.[132] While administrative law includes doctrines, such as the exhaustion of remedies doctrine,[133] to which courts and hospitals may wisely turn in formulating fair procedures, administrative law should not play a determinative role in court review of hospital board decisions.

c. The Standard of Review and Burden of Proof. Three different standards of judicial review of private hospital board decisions can be identified in decisions relied upon by the Alaska Supreme Court in *Storrs.*

The most deferential standard of review of quasi-public hospital decisions is the sufficient evidence standard which has been adopted in New Jersey and several other jurisdictions.[134] It requires "sufficient reliable evidence . . . to justify the result."[135] Federal courts use a

129. *See supra* notes 109-17 and accompanying text.

130. CAL. CIV. PROC. CODE § 1094.5(d) (West 1980) (adopted in 1978).

131. For further discussion of the independent judgment standard, see *infra* notes 142-45 and accompanying text.

132. *See supra* note 105.

133. Alaska applies the exhaustion of remedies doctrine to all private hospitals. *Eidelson,* 645 P.2d at 179; *accord* Westlake Community Hosp. v. Superior Court, 17 Cal. 3d 465, 474-75, 551 P.2d 410, 416, 131 Cal. Rptr. 90, 95 (1976) (requiring exhaustion of internal remedies whether the plaintiff seeks reinstatement to privileges or tort damages); *Garrow,* 79 N.J. at 558, 401 A.2d at 538.

134. *See Holmes,* 117 Ariz. at 405, 573 P.2d at 479; Even v. Longmont, 629 P.2d at 1103; *Garrow,* 79 N.J. at 565, 401 A.2d at 541; *Berman,* 196 N.J. Super. at ____, 482 A.2d at 949; Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d 246, 251, 250 N.E.2d 892, 896 (1969); Huffaker v. Bailey, 273 Or. 273, 280, 540 P.2d 1398, 1401 (1975) ("As long as the denial was made in good faith and supported by an adequate factual basis, we are not disposed to invalidate it.").

135. *Garrow,* 79 N.J. at 565, 401 A.2d at 541; *see also Berman,* 196 N.J. Super. at ___, 482 A.2d at 949.

similar standard in constitutional due process review of public hospital decisions.[136] Frequently, though not always, courts which have adopted this standard of review describe their task as determining whether the hospital's decision was "arbitrary or capricious."[137]

A second standard of review, illustrated by *Silver,* is the substantial evidence standard, which requires that "[t]he basis for the decision must come from substantial evidence which was produced at the hearing."[138] This standard of review is typical in court review of administrative proceedings[139] and is the statutorily mandated standard for review of private hospital decisions in California.[140] Once followed in New Jersey, this standard was rejected in favor of the "sufficient evidence" standard in 1979.[141]

The third standard of review, unique to California, is the independent judgment review which, under *Anton,* extends beyond public agencies to private hospitals when the hospital's decision affects a physician's vested and fundamental interests.[142] *Anton* required a

136. *See* Laje v. R.E. Thomason Gen. Hosp., 564 F.2d 1159, 1162 (5th Cir.1977); Woodbury v. McKinnon, 447 F.2d 839, 842 (5th Cir. 1971) ("The decision resulting from the hearing must be untainted by irrelevant considerations and supported by sufficient evidence to free it from arbitrariness, capriciousness or unreasonableness.").

137. *Holmes,* 117 Ariz. at 405, 573 P.2d at 478-79; *see also* cases cited *supra* notes 134, 136. The "arbitrary or capricious" terminology is not used exclusively in jurisdictions following the "sufficient evidence" standard of review. For instance, the Arizona Court of Appeals in *Peterson,* 114 Ariz. at 71, 559 P.2d at 191, required *substantial* evidence to support the board's decision. The "arbitrary and capricious" standard of review suggested by the Arizona Supreme Court in *Holmes* is arguably in conflict with the substantial evidence standard in *Peterson.* Another example of this hybrid standard is found in *Silver* where the Hawaii Supreme Court said that its review was intended to discover abuses of discretion by the hospital "resulting in an arbitrary, capricious or unreasonable exclusion," 53 Hawaii at 479-80, 497 P.2d at 568, while also insisting that the hospital board's decision be based on "substantial evidence," *id.* at 485, 497 P.2d at 572.

138. 53 Hawaii at 485, 497 P.2d at 572; *see also Peterson,* 114 Ariz. at 71, 559 P.2d at 191. See discussion *supra* note 137.

139. *See* 5 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 29:5 (2d ed. 1984).

140. CAL. CIV. PROC. CODE § 1094.5(d) (West 1980). This statutory standard conflicts with the standard adopted in *Anton. See supra* notes 130-31 and accompanying text.

141. See discussion *supra* notes 108-09 and accompanying text.

142. If a physician's hospital privileges are revoked or suspended or if a routine reapplication is denied, a fundamental, vested right is at issue. *Anton,* 19 Cal. 3d at 824-25, 567 P.2d at 1175, 140 Cal. Rptr. at 455. Denials of initial applications do not involve a vested right and are evaluated under the substantial evidence rule. Unterthiner v. Desert Hosp. Dist., 33 Cal. 3d 285, 298, 656 P.2d 554, 562-63, 188 Cal. Rptr. 590, 598-99 (1983), *cert. denied,* 104 S. Ct. 973 (1984).

In jurisdictions following the sufficient evidence standard, appeals courts have rejected lower court decisions when the lower court exercised its independent judgment in arriving at its decision. *See, e.g., Laje,* 564 F.2d at 1162; *Berman,* 196 N.J. Super. at ____, 482 A.2d at 950.

court to conduct a de novo proceeding, reweigh the evidence, and make an independent judgment based upon all of the evidence.[143] California's de novo review requirement was initially based upon the state constitutional provision on the separation of powers[144] and requires courts to make an independent judgment when an administrative agency's actions affect "constitutional rights of liberty and property."[145] The conflict in California between the statutorily mandated substantial evidence standard and the constitutionally based independent judgment standard has not been resolved.

The Alaska Supreme Court has rejected the rationale underlying the independent judgment rule, holding that neither due process nor state law requires courts to conduct de novo proceedings when administrative decisions are appealed.[146] Therefore, it is unlikely that private hospitals in Alaska will be subjected to an independent judgment review. It is unclear which of the two other standards the Alaska Supreme Court will adopt.

Frequently, courts reviewing private hospital staff decisions have not clearly stated the parties' respective burdens of proof at each stage of the proceeding. Generally, the plaintiff physician appears to carry the burden of proof, but the hospital is expected to present evidence supporting its decision.[147] In *Holmes v. Hoemako Hospital,* the Arizona Supreme Court found that the physician had the initial burden of

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143. The specific requirements of California's independent judgment rule are well described by Justice Clark, dissenting, in *Anton,* 19 Cal. 3d at 831, 567 P.2d at 1179, 140 Cal. Rptr. at 459. When a court is required to exercise its independent judgment, abuse of discretion is "established if the court determines that the findings are not supported by the weight of the evidence." CAL. CIV. PROC. CODE § 1094.5(c) (West 1980).

144. For a list of authorities which oppose this interpretation of California's constitution, see Justice Clark, dissenting, in *Anton,* 19 Cal. 3d at 833-34, 567 P.2d at 1181, 140 Cal. Rptr. at 461 ("Interestingly, while every state vests judicial power in the courts, none has felt compelled to adopt California's trial de novo rule.").

145. Drummey v. State Bd. of Funeral Directors & Embalmers, 13 Cal. 2d 75, 85, 87 P.2d 848, 854 (1939), (*quoting* St. Joseph Stock Yards Co. v. United States, 298 U.S. 38, 52 (1936)). For recent confirming opinions, see *Anton,* 19 Cal. 3d at 821, 567 P.2d at 1172, 140 Cal. Rptr. at 452-53; Bixby v. Pierno, 4 Cal. 3d 130, 138, 481 P.2d 242, 247-48, 93 Cal. Rptr. 234, 239 (1971). California's independent judgment rule derives from a federal constitutional perspective that has been largely abandoned by federal courts. *Bixby,* 4 Cal. 3d at 138 n.4, 481 P.2d at 247 n.4, 93 Cal. Rptr. at 239 n.4; *see also* Williams, *Fifty Years of the Law of the Federal Administrative Agencies — And Beyond,* 29 FED. B.J. 267, 269-70 (1970). The Alaska Supreme Court has rejected the earlier federal constitutional reasoning. *See infra* note 146 and accompanying text.

146. Keiner v. City of Anchorage, 378 P.2d 406, 408-10 (1963).

147. *See, e.g., Berman,* 196 N.J. Super. at __, 482 A.2d at 949 ("Plaintiffs had a heavy burden in the trial court for the judge was obliged to uphold the resolution if the record contained sufficient reliable evidence . . . to justify the adoption of the resolution.").

presenting to the court a record of what transpired in the hospital proceedings.[148] In *Anton,* the California Supreme Court accepted a bylaw procedure that appeared to place the burden of producing evidence on the physician but added that the bylaws clearly contemplated that the hospital would come forward to show that its record supported its decision.[149] In *Silver,* the Hawaii Supreme Court required the hospital to make a written report with findings supporting the hospital's decision.[150] In practical terms, regardless of who has the burden of proof, the interests of both physicians and hospitals require that hospital proceedings are accurately and fully recorded so that a court will have a reliable record to review.

d. Balancing the Interests. Most jurisdictions that conduct a judicial review of private hospital staff decisions determine the requirements of common law due process by balancing the interests of those involved. The New Jersey Supreme Court clearly stated this position in *Garrow:* "Judicial review of the hospital board's action should properly focus on the reasonableness of the action taken in relation to the several interests of the public, the applicant, and the hospital."[151] Alaska has, in fact, used a balancing of interests approach, though it has done so by following decisions based on constitutional due process.[152]

The balancing of interests approach is based on the view that quasi-public hospitals have fiduciary duties to physicians and the public which are enforceable by the courts. Logically, the specific requirements placed on hospitals by common law due process should depend on what will best serve the interests the court has determined it should protect. The court's concerns are both procedural and substantive.

Procedural Balancing of Interests. If the parties have followed the procedures established in the medical staff bylaws,[153] a court's pro-

148. 117 Ariz. 403, 405, 573 P.2d 477, 479 (1977).

149. *Anton,* 19 Cal. 3d at 829-30, 567 P.2d at 1178, 140 Cal. Rptr. at 458 (upholding a hospital bylaw specifying burden of production of evidence).

150. *Silver,* 53 Hawaii at 485, 497 P.2d at 572. An obvious corollary is that the hospital is required to make a record. Davis v. Morristown Memorial Hosp., 106 N.J. Super. 33, 43-44, 254 A.2d 125, 131 (1969). A complete and accurate record maximizes the chances that the case will be resolved on summary judgment.

151. 79 N.J. at 565, 401 A.2d at 541; *see also Silver,* 53 Hawaii at 484, 497 P.2d at 571.

152. *See McMillan,* 646 P.2d 857, 864 (*following* Pennsylvania *ex rel.* Rafferty v. Philadelphia Psychiatric Center, 356 F. Supp. 510 (E.D. Pa. 1973)); *Storrs,* 609 P.2d at 31 (*following* Citta v. Delaware Valley Hosp., 313 F. Supp. 301, 307-09 (E.D. Pa. 1970)).

153. It is clear that in Alaska recourse to the courts will be available only after the hospital's own internal bylaw procedures have been exhausted. *Eidelson,* 645 P.2d at 177. This is required by the determination in *Storrs,* 609 P.2d at 30, that the medical

cedural review is generally limited to determining whether those procedures provide for "fair and thorough consideration."[154] In the case of a medical staff member who is being terminated or suspended, courts agree that the hospital must provide a hearing and the physician must receive sufficient notification of the hearing, the "charges," and the evidence against him so that he is able to prepare a "defense."[155] The staff member must have an opportunity to respond.[156] If the hospital is considering denial of an initial application, the prospective staff member must be notified and informed of the reasons so that he may request a hearing and prepare a response.[157] The procedural protections afforded to the initial applicant by common law due process are especially important because, unlike the established staff member facing suspension or termination, the initial applicant may

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staff bylaws will be treated as a contract and is further supported by the logic of the exhaustion of remedies doctrine.

Deference to the hospital's bylaws is also reasonable because of the flexible nature of common law procedural due process. As the California Supreme Court said in *Anton*:

> The common law requirement of a fair procedure does not compel formal proceedings with all the embellishments of a court trial . . . nor adherence to a single mode of process. It may be satisfied by any one of a variety of procedures which afford a fair opportunity for an [affected party] to present his position. As such, this court should not attempt to fix a rigid procedure that must invariably be observed. Instead, the associations themselves should retain the initial and primary responsibility for devising a method which provides an [affected party] adequate notice of the "charges" against him and a reasonable opportunity to respond. In drafting such procedure . . . the organization should consider the nature of the tendered issue and should fashion its procedure to insure a *fair* opportunity for an [affected party] to present his position. Although the association retains discretion in formalizing such procedures, the courts remain available to afford relief in the event of the abuse of such discretion.

19 Cal. 3d at 829, 567 P.2d at 1178, 140 Cal. Rptr. at 458 (quoting from Pinsker v. Pacific Coast Soc'y of Orthodontists, 12 Cal. 3d 541, 555-56, 526 P.2d 253, 263, 116 Cal. Rptr. 245, 255 (1974)) (footnote omitted) (emphasis in original).

154. *Silver,* 53 Hawaii at 484, 497 P.2d at 571. Other courts state this requirement in terms of the hospital providing procedures which "fully inform" the decisionmakers. *See, e.g.,* Sussman v. Overlook Hosp. Ass'n, 95 N.J. Super. 418, 425, 231 A.2d 389, 393 (1967).

155. *See, e.g., Peterson,* 114 Ariz. at 70, 559 P.2d at 190; *Pinsker,* 12 Cal. 3d at 555, 526 P.2d at 263, 116 Cal. Rptr. at 255; *Silver,* 53 Hawaii at 484-85, 497 P.2d at 571; *Garrow,* 79 N.J. at 564, 401 A.2d at 541.

156. *See* cases cited *supra* note 155. In *Storrs,* 609 P.2d at 30-31, and *McMillan,* 646 P.2d at 866, the court determined that a summary suspension prior to a hearing was acceptable if the physician's conduct posed a realistic or recognizable threat to patient care.

157. *Silver,* 53 Hawaii at 484, 497 P.2d at 571; *Garrow,* 79 N.J. at 564, 401 A.2d at 541.

not be protected by a contractual remedy since he is not yet a party to any contract or bound by the bylaws.[158]

Two disputed areas of procedural review are whether the medical staff member has the right to counsel when he appears before various hospital review tribunals[159] and what degree of impartiality is required of the members of those tribunals.

The New Jersey Supreme Court has recognized a physician's right to counsel, although counsel's "role will be subject to the reasonable rules laid down by the Hospital's board of trustees . . . and management and control of the hearings will rest with the person or persons in charge."[160] Hawaii[161] and California[162] have held that minimum due process generally does not require the presence of counsel. The Hawaii Supreme Court, however, added that counsel may be required if "the hospital's attorney is used in the proceedings or the extreme nature of the charges involved [indicates] that representation by an attorney would be advantageous."[163] The question of a physician's right to counsel in hospital proceedings has not been addressed by the Alaska Supreme Court.[164]

In *Storrs,* the Alaska Supreme Court decided that due process requires that quasi-public hospitals provide an impartial decisionmaking tribunal.[165] In *Eidelson v. Archer,* the court adopted a constitutional standard for evaluating partiality, requiring that the plaintiff

158. *See* Note, *Hospital Staff Privileges: The Need for Legislation,* 17 STAN. L. REV. 900, 910 (1965); *see, e.g.,* Jain v. Northwest Community Hosp., 67 Ill. App. 3d 420, 425, 385 N.E.2d 108, 112 (1978) (refusing to order the hospital to consider an initial application for medical staff membership and limiting court enforcement of medical staff bylaws to situations in which "a physician's existing staff privileges are revoked or reduced").

159. *See* Ludlam, *Physician-Hospital Relations: The Role of Staff Privileges,* 35 LAW & CONTEMP. PROBS. 879, 889-90 (1970).

160. *Garrow,* 79 N.J. at 566-67, 401 A.2d at 542. On this point, the New Jersey court overruled a decision made in an earlier appellate division case, *Sussman,* 95 N.J. Super. 418, 231 A.2d 389, which made the presence of counsel a matter of discretion for the hospital board.

161. *Silver,* 53 Hawaii at 485, 497 P.2d at 571.

162. *Anton,* 19 Cal. 3d at 827, 567 P.2d at 1176-77, 140 Cal. Rptr. at 456-57 (upholding as not offensive to minimal due process a hospital bylaw allowing counsel to be present only at the hospital committee's discretion and only where both sides are represented by counsel).

163. *Silver,* 53 Hawaii at 485, 497 P.2d at 572.

164. In *McMillan,* 646 P.2d at 859, and *Storrs,* 609 P.2d at 26, counsel were present at the hospital proceedings. The fact that Alaska now requires hospitals to report suspensions or revocations of hospital privileges, along with the circumstances involved, to the State Medical Board, ALASKA STAT. § 18.20.076 (Supp. 1984), may tilt the balance in favor of allowing counsel, because the implications of an unfavorable decision to the physician extend beyond the hospital.

165. *Storrs,* 609 P.2d at 28 n.12. In *Storrs,* the Alaska court, based on constitutional precedent, stated that when "the functions of investigating, prosecuting, and

physician present "evidence of actual bias on the part of the individual members of the board."[166] This constitutional standard may be the most appropriate standard for common law due process review;[167] Alaska courts, however, are not bound by constitutional precedent when reviewing the impartiality of quasi-public hospital proceedings. The flexibility of the common law due process approach allows Alaska courts to take into account the difficulty of assembling an impartial tribunal in small hospitals. More generally, the courts can consider the importance of allowing private hospitals to make decisions based on internal peer review committee evaluations, even when the committees are composed of staff members whose personal knowledge of the challenged physician makes impartiality difficult.[168]

Alaska's "actual bias" standard differs from the standard adopted by a California court of appeals in *Applebaum v. Board of Directors.*[169] "[C]ompletely apart from any question of actual bias on the part of the physicians involved and from the merits of the charges," the California court found that unacceptable partiality existed "by virtue of a practical probability of unfairness."[170] Given the close working relationships of the parties in the hospital, "a realistic appraisal of psychological tendencies and human weakness compels the conclusion that

judging have been combined in the same person, due process has been violated." *Id. But see* Withrow v. Larkin, 421 U.S. 35, 46-55 (1975) (holding that the combination of adjudicative and investigative functions in an administrative office was not inherently objectionable to due process); Arnett v. Kennedy, 416 U.S. 134 (1974) (holding that there is no constitutional requirement that the decisionmaker be an uninvolved person when a property interest protected by due process is at issue).

166. *Eidelson,* 645 P.2d at 183 (citing Robbins v. Ong, 452 F. Supp. 110, 116 (S.D. Ga. 1978)). In *Eidelson,* 645 P.2d at 181-83, the court's actual holding was that an impartial tribunal was necessary if the courts were to enforce the exhaustion of remedies doctrine in hospital proceedings. However, the court's discussion is clearly based upon what the court believed due process would require.

167. Applebaum v. Board of Directors, 104 Cal. App. 3d 648, 657, 163 Cal. Rptr. 831, 836 (1980).

168. Alaska courts should take into consideration legislative support and reinforcement of hospital peer review. See discussion *infra* notes 207-09 and accompanying text. The constitutional due process standard can recognize the importance of allowing official bodies and people with special qualifications to make decisions even when the risk of bias is clear. *See, e.g.,* Simard v. Board of Educ., 473 F.2d 988, 993 (2d Cir. 1973). In *Simard,* the teacher whose contract had been terminated alleged due process violations because several of the board members who made the decision were biased from having previously engaged in acrimonious collective bargaining negotiations with the teacher. The court observed that if it found unconstitutional bias in such circumstances, significant decisions would be "surrendered to a body less familiar with relevant considerations and not responsible under state and local law for making these decisions." The court did "not believe that due process, varying as it does with different factual contexts, requires so much in this case, absent a showing of actual, rather than potential bias." *Id.*

169. 104 Cal. App. 3d 648, 658, 163 Cal. Rptr. 831, 836 (1980).

170. *Id.* at 659, 163 Cal. Rptr. at 837-38.

the risk of prejudgment or bias was too high to maintain the guarantee of fair procedure."[171] This demanding, psychological standard for judging partiality raises serious questions about when internal peer review can be the basis for hospital decisionmaking in California. In contrast, Alaska's actual bias standard avoids in-depth judicial inquiry into the psychological complexities of medical staff relations and does not equate familiarity with the facts with prejudgment.

Substantive Balancing of Interests. Courts engaged in common law due process review of hospital medical staff decisions will require that the hospital reach its decision "by the application of a reasonable standard, i.e., one that comports with the legitimate goals of the hospital and the rights of the individual and the public."[172] This standard is also used in constitutional due process cases.[173] One commentator has argued, however, that a "reasonable standard" under constitutional due process analysis is less searching than under the common law due process inquiry developed by some state courts.[174] Since hospital medical staff decisions almost never concern a "fundamental right" or a "suspect classification," courts applying constitutional due process "will look only to see that the policy is somehow 'rationally related' to any permissible objective, and the plaintiff generally will lose."[175] While it is possible to disagree with the assessment that constitutional law has prescribed a low due process standard,[176] courts engaged in

171. *Id.* at 660, 163 Cal. Rptr. at 838. The court relied on Withrow v. Larkin, 421 U.S. 35, 46-55 (1975), in which the United States Supreme Court held that, although due process could tolerate many forms of administrative hearings combining adjudicative and investigative functions, due process would be compromised if the risk of bias were too high.

172. *Peterson,* 114 Ariz. at 71, 559 P.2d at 191. The *Greisman* language is also frequently cited by courts:

> While reasonable and constructive exercises of judgment should be honored, courts would indeed be remiss if they declined to intervene where, as here, the powers were invoked at the threshold to preclude an application for staff membership, not because of any lack of individual merit, but for a reason unrelated to sound hospital standards and not in furtherance of the common good.

40 N.J. at 404, 192 A.2d at 825.

173. *See, e.g.,* Laje v. R.E. Thomason Gen. Hosp., 564 F.2d 1159, 1162 (5th Cir. 1977); Woodbury v. McKinnon, 447 F.2d 839, 845 (5th Cir. 1971).

174. McMahon, *supra* note 6, at 175-80.

175. *Id.* at 176. *See supra* note 136 and accompanying text for a brief discussion of the related question of the evidence requirement in constitutional cases.

176. One could make an argument against McMahon's position based on the dissent in *Ascherman II,* 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975) (Kane, J., dissenting). The majority struck down a private hospital bylaw requiring that an applicant obtain three letters of recommendation from members of the current staff. *See* discussion *supra* text accompanying notes 74-78. Justice Kane, in dissent, argued that the court should adopt a more flexible common law approach:

common law due process review clearly can demand that hospitals be more than minimally rational in their decisions.[177]

Common law substantive due process analysis balances the interests of the parties; therefore, it is not surprising that a court's willingness to strike down medical staff bylaws or other substantive criteria used in hospital decisions or to overturn hospital decisions as unreasonable will depend upon the court's evaluation of the relative importance of the parties' interests.

Because California law places a uniquely strong emphasis on the physician's right to practice[178] and applies demanding public hospital statutory standards of staff selection to private hospitals,[179] California courts are less likely than courts in other jurisdictions to defer to hospital decisions. For instance, in *Miller v. Eisenhower Medical Center,* the California Supreme Court narrowly interpreted a bylaw requiring that a new applicant applying for medical staff membership demonstrate the ability to work with others:

> [The bylaws] demand a showing in cases of rejection . . . that an applicant's inability to "work with others" in the hospital setting is such as to present a real and substantial danger that patients treated by him might receive other than a "high quality of medical care" at the facility if he were admitted to membership.[180]

> Bearing in mind that we are dealing with common law—not constitutional—standards . . . we should not allow our decision to be formulated by "due process" considerations which are not only inapplicable . . . but, in my opinion, inappropriate to the situation and the parties at bench.

Id. at 512, 119 Cal. Rptr. at 512 (citations omitted). Justice Kane clearly thought that the majority had been unduly influenced by a high constitutional due process standard. It may be more accurate to say that the majority and the dissent simply disagreed about the appropriate common law standard. The majority uses the language of due process, but applies it, as McMahon suggests, with common law flexibility to raise the standard above the constitutional standard of minimum rationality. The dissent argues that common law should be more deferential to hospital board judgments.

177. McMahon, *supra* note 6, at 175-80.

178. *See Ascherman II,* 45 Cal. App. 3d at 511, 119 Cal. Rptr. at 509; *see supra* text accompanying notes 72-79.

179. *Ascherman II,* 45 Cal. App. 3d at 511, 119 Cal. Rptr. at 509, and *Anton,* 19 Cal. 3d at 815, 567 P.2d at 1168, 140 Cal. Rptr. at 448, make it clear that the same standards will be applied to public and private hospitals. For an example of a demanding standard of staff selection applied to a public hospital, see Rosner v. Eden Township Hosp. Dist., 58 Cal. 2d 592, 375 P.2d 431, 25 Cal. Rptr. 551 (1962), discussed *infra* note 180.

180. 27 Cal. 3d 614, 628-29, 614 P.2d 258, 266-67, 166 Cal. Rptr. 826, 834-35 (1980). The court relied upon earlier *public* hospital precedent which dramatically limited the board's choice of criteria to those which were explicitly statutory and fell above a high standard of impermissible vagueness. Rosner v. Eden Township Hosp. Dist., 58 Cal. 2d 592, 375 P.2d 431, 25 Cal. Rptr. 551 (1962). For a criticism of Rosner v. Eden Township, see Note, *supra* note 158, at 913-17 (1965). See also the dissent in *Miller,* in which Justice Mosk argued that the hospital's bylaw was not impermissibly vague, given the realities of hospitals, and that private hospitals should

The *Miller* court rejected decisions from other jurisdictions which sustained the hospital board's judgment that "a physician's ability to 'work with others' in the hospital setting has an inherent effect on the level of patient care."[181]

Other jurisdictions give relatively more consideration to the interests of hospitals.[182] For instance, in *Huffaker v. Bailey,*[183] the Oregon Supreme Court deferred to a hospital board's judgment on the importance of a medical staff applicant's ability to work with others. In *Huffaker,* despite evidence that the applicant physician was medically competent, the hospital rejected his request for staff membership based on evidence that the physician did not work well with others.[184] In evaluating the hospital's interest in excluding the physician, the court was impressed with the hospital board's responsibility for providing high quality care[185] and with the hospital's potential tort liability for medical staff negligence.[186] For the *Huffaker* court these factors weighed heavily in favor of judicial deference to hospital board decisions, especially to decisions about which substantive criteria are important in determining medical staff membership.[187]

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have more "freedom from external intervention" than public hospitals. 27 Cal. 3d at 636, 614 P.2d at 272, 166 Cal. Rptr. at 840.

181. 27 Cal. 3d at 629, 614 P.2d at 267, 166 Cal. Rptr. at 835, (rejecting Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398 (1975)).

182. For cases rejecting California decisions that do not sufficiently protect hospitals, see, for example, *Peterson,* 114 Ariz. at 72, 559 P.2d at 192, in which the Arizona court considered and rejected Wyatt v. Tahoe Forest Hosp. Dist., 174 Cal. App. 2d 709, 345 P.2d 93 (1959) (in which the court limited hospital consideration of a physician's past conduct in determining whether he will be given staff privileges). For another case rejecting a California decision, see *Holmes,* 117 Ariz. at 406, 573 P.2d at 480, which rejected Rosner v. Peninsula Hosp. Dist., 224 Cal. App. 2d 115, 36 Cal. Rptr. 332 (1964) (court refused to allow the hospital to deny staff privileges on the basis that the physician had no malpractice insurance) (later legislatively overruled by CAL. HEALTH & SAFETY CODE § 1319 (West 1980)). *See also infra* note 187.

183. 273 Or. 273, 540 P.2d 1398 (1975). The court did not formally decide that private hospital board decisions were subject to common law due process in Oregon. The court assumed, for the purposes of the case, the plaintiff's own common law legal argument and held against the plaintiff anyway. *Id.* at 275, 540 P.2d at 1399.

184. *Id.* at 280, 540 P.2d at 1401.

185. *Id.* at 280-81, 540 P.2d at 1401-02. To support its point, the court quoted at length from *Shulman,* discussed *supra* notes 27-37 and accompanying text.

186. *Huffaker,* 273 Or. at 181-82, 540 P.2d at 1402; *see also infra* note 224.

187. 273 Or. at 276-77, 540 P.2d at 1399-1400. The *Huffaker* court noted and rejected California's approach. *Id.* at 276, 540 P.2d at 1399. The court found compelling the reasoning of a frequently cited constitutional due process case, Sosa v. Board of Managers, 437 F.2d 173, 176-77 (5th Cir. 1971):

> Admittedly, standards such as "character qualifications and standing" are very general, but this court recognizes that in the area of personal fitness for medical staff privileges precise standards are difficult if not impossible to articulate. . . . The subjectives of selection simply cannot be minutely codified. The governing board of a hospital must therefore be given great latitude in prescribing the necessary qualifications for potential applicants. . . .

The Alaska Supreme Court has used the balancing of interest approach in deciding cases involving the decisions of private hospital boards.[188] It is not yet clear, however, how the court will eventually strike the balance between the relative interests of the physician, the hospital, and the public.[189] The important point is that common law due process requires Alaska courts to determine the most appropriate level of substantive review based on careful evaluation of competing interests and policy considerations.

e. Summary of What Common Law Due Process Requires. What specifically does common law due process require of hospitals? The answer is not yet provided by Alaska case law because the Alaska courts have not had the opportunity to address many of the specific issues raised by the decision to conduct a due process review of private hospital board decisions. Alaska courts may turn to constitutional[190] or administrative law[191] for helpful insights into what, specifically, common law due process should require. Since they are developing common law, however, Alaska courts are free to tailor due process requirements to their assessment of the current circumstances and relative interests of hospitals, physicians, and the public.

Three different standards of judicial review of the evidentiary bases for hospital decisions can be identified in the case law — the sufficient evidence test, the substantial evidence test, and the independent judgment rule.[192] While it is not clear which standard Alaska will adopt, it is clear that it is in the interests of both hospitals and physicians to keep complete and accurate records of the hearings so that the court will have a record to review.[193]

Consideration of cases from other states indicates basic agreement about the fundamental requirements of procedural due process — notice, a hearing, and a chance to respond.[194] Courts differ over

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> In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere. Courts must not attempt to take on the escutcheon of Caduceus.

Cited in *Huffaker,* 273 Or. at 277, 540 P.2d at 1400.

188. *See supra* note 152 and accompanying text.

189. The conflicting cases of *Huffaker,* 273 Or. 273, 540 P.2d 1398, and *Miller,* 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 834, are both cited in *Eidelson,* 645 P.2d at 180, in support of the proposition that staff cooperation is important. There is no apparent recognition of the conflict between the two cases.

190. *See supra* notes 98-103 and accompanying text.

191. *See supra* notes 104-33 and accompanying text.

192. *See supra* notes 134-46 and accompanying text.

193. *See supra* notes 148-50 and accompanying text.

194. *See supra* notes 153-58 and accompanying text.

the secondary procedural issues of the necessity of counsel[195] and how to determine whether the decisionmakers were impartial.[196] Substantive due process poses more fundamental concerns.[197] By balancing the interests of the parties, some states conclude that the proper approach is to defer to the judgments of hospital boards unless they are clearly arbitrary and unreasonable; other states, most significantly California, require hospitals to meet a higher standard of reasonableness.

V. WHERE TO GO FROM HERE?

Private hospitals in Alaska and physicians who are considering legal action against hospitals based on claims of unfair or unreasonable treatment will find only hints in Alaska case law as to how courts will approach a common law due process review. Therefore, it is appropriate to ask where Alaska courts should go from here.

The initial step was taken in *Storrs* — at least some private hospitals are subject to some form of judicial review.[198] This initial step can be criticized as an unwarranted exercise of common law power in an area more appropriate for legislative attention.[199] But rather than challenge this initial step, this note suggests that Alaska courts exercise their common law power with more careful attention to the reasons for conducting a common law due process review than is evident in *Storrs*. Hospitals need to be able to plan; physicians need to know when a request for review is likely to be successful. The following discussion concentrates on two factors courts should consider when a common law due process challenge is presented: 1) the alternative of simply enforcing the bylaws and 2) the importance of consistency with legislative policy. Finally, a brief consideration of the "felt needs of

195. *See supra* notes 159-64 and accompanying text.

196. *See supra* notes 165-71 and accompanying text.

197. *See supra* notes 172-89 and accompanying text.

198. 609 P.2d at 28. Arguably the initial step was taken, unnoticed, by the legislature in 1976. *See infra* text accompanying note 210.

199. As suggested, *supra* text accompanying notes 36-37 & 60, differing attitudes toward the appropriate role of courts is one factor that distinguishes *Greisman* from *Shulman*. There is, however, statutory language implicitly recognizing appellate review of private hospital peer review proceedings in Alaska. ALASKA STAT. § 18.23.030(c) (1981), discussed *infra* text accompanying note 210. One could challenge the Alaska Supreme Court, however, on the basis that the due process review adopted in *Storrs* went well beyond whatever the legislature may have intended when it enacted ALASKA STATUTE section 18.23.030(c). It is unclear whether the court was unaware of the statute or simply chose not to refer to it. *See* Franco v. District Court, 641 P.2d 922, 928 (Colo. 1982) (construing the legislative intention behind similar statutory language in Colorado).

the times"[200] suggests current practical and policy considerations to which courts should be sensitive when balancing the interests of the parties involved in a hospital staff privilege decision.

A. Enforcing the Hospital's Medical Staff Bylaws

Alaska courts should not unnecessarily expand common law due process judicial review. Hospitals and physicians should be able to have a high degree of confidence that, if they follow their bylaws, courts will not upset the result.[201] Since the Alaska Supreme Court has decided that the medical staff bylaws will be treated as a contract,[202] the courts should be able to decide most cases simply by reference to the relevant bylaws. Deciding a case on the basis of the bylaws has the advantage of eliminating the need for a factually demanding threshold determination of whether the hospital is quasi-public and therefore subject to due process judicial review.[203] All hospitals — public, private nonprofit, and for-profit — would be subject to review for breach of their bylaws.[204] Because of standardized accrediting requirements, most medical staff bylaws provide for fair procedures and reasonable substantive criteria for making medical staff privilege decisions.[205] A hospital's awareness that courts will enforce the medical

200. Greisman v. Newcomb Hosp., 40 N.J. 389, 396, 192 A.2d 817, 821 (1963), discussed *supra* notes 46-54 and accompanying text.

201. This conclusion can be reached either upon the reasoning of *Shulman,* discussed *supra* text accompanying notes 31-35, or because common law due process can be highly deferential to bylaws, see *supra* note 153.

202. *Storrs,* 609 P.2d at 30. Treating the bylaws as a contract is, itself, a controversial decision. *See* Horty & Mulholland, *The Legal Status of the Hospital Medical Staff,* 22 ST. LOUIS U.L.J. 485, 496-98 (1978). Cases holding that the bylaws can be a contract include Terre Haute Regional Hosp. v. El-Issa, 470 N.E.2d 1371, 1376-77 (Ind. Ct. App. 1984); Anne Arundel Gen. Hosp. v. O'Brien, 49 Md. App. 362, 432 A.2d 483 (1981); Berberian v. Lancaster Osteopathic Hosp. Ass'n, 395 Pa. 257, 149 A.2d 456 (1959); St. John's Hosp. Medical Staff v. St. John Regional Medical Center, 90 S.D. 674, 245 N.W.2d 472 (1976). *Contra* Todd v. Physicians & Surgeons Community Hosp., 165 Ga. App. 656 (1983); Ponca City Hosp. v. Murphree, 545 P.2d 738, 742 (Okla. 1976); Weary v. Baylor Univ. Hosp., 360 S.W.2d 895 (Tex. Civ. App. 1962).

203. Also, if the court conducts a review on the authority of Alaska Statute section 18.23.030(c) (1981) (discussed *infra* text accompanying note 210), no initial determination that the hospital is quasi-public would be necessary in order to review the hospital's decision.

204. Alaska Administrative Code title 7, section 12.110(b) (Jan. 1984), requires that hospitals have medical staff bylaws which provide for "eligibility for medical staff membership, and recommending appointments to the governing body."

205. *See generally* W. ISELE, THE HOSPITAL MEDICAL STAFF 26-41 (1984). The forthcoming *Medical Staff* section of the 1985 ACCREDITATION MANUAL FOR HOSPITALS (soon to be published but presently available in unpublished manuscript form from the Joint Commission on the Accreditation of Hospitals) specifies professional criteria to be used as the basis for granting or continuing staff membership (Standard

staff bylaws as if they were a contract is likely to be a far more effective curb on unfair hospital practices than court enforcement of vaguely defined due process requirements. In each hospital medical staff case in which the Alaska Supreme Court has referred in any way to a due process review of hospitals, the same result could have been reached simply by enforcing the bylaws.[206] On the basis of these cases, the decision that hospitals are subject to a due process review appears to be an unnecessary and confusing extension of Alaska law. The courts should turn to a due process review only if simply enforcing the bylaws will lead to a result that is procedurally unfair or substantively unreasonable.

B. Legislative Policy Considerations

Alaska courts should approach judicial review of hospitals in a manner that complements legislative policy concerns. The Alaska legislature has been particularly concerned with fostering hospital peer review. In 1976, the legislature enacted a "shield law" which limits discovery of evidence and testimony gathered during peer review proceedings and protects participants from liability resulting from participation.[207] Other states have adopted similar legislation in recognition of the important part hospital peer review plays in identifying incompetent physicians.[208] In 1984, the Alaska legislature further recognized this important function of peer review by requiring that

I, Required Characteristic B.2) and requires the establishment of fair hearing and appeals procedures (Standard II, Required Characteristic D.2; Standard III, Required Characteristic E.2.g).

206. In *McMillan,* 646 P.2d at 862-63, the court undertook a due process review of a summary suspension, pursuant to a stipulation between the parties, after concluding that the bylaws supported the plaintiff's position. In *Eidelson,* 645 P.2d at 177-78, the court concluded that the plaintiff must exhaust the hospital's internal remedies before seeking court review, but did not do so on the basis of the hospital bylaw which required the aggrieved party to request a hearing or an appeal before seeking judicial review. Finally, in *Storrs,* 609 P.2d at 30, the court conducted a due process review of a summary suspension only to decide that the result reached by following the bylaws was appropriate.

207. *See generally* ALASKA STAT. §§ 18.23.010-.070 (1981). ALASKA STAT. § 18.23.010(a) provides:

> A person providing information to a review organization is not subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

ALASKA STAT. § 18.23.030(a) provides in part:

> [A]ll data and information acquired by a review organization . . . shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery.

208. *See, e.g., Franco,* 641 P.2d at 929 (construing shield legislation in Colorado). *See generally* Chayet & Reardon, *Trouble in the Medical Staff: A Practical Guide to*

hospitals report suspensions and revocations of privileges to the State Board of Medical Examiners.[209]

In *Storrs* and subsequent decisions, the Alaska Supreme Court has not mentioned the implied statutory recognition of appellate review of hospital peer review proceedings found in Alaska Statutes section 18.23.030(c). This section provides that "a person whose conduct or competence" has been subject to peer review may obtain "for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review committee."[210] Exactly what form of appellate review the legislature intended to allow by this language is unclear. The statute can be read as approving nothing more than judicial review of the record to see if the hospital adhered to its own bylaws; it does not necessarily imply a due process review. It is clear, however, that when Alaska courts conduct a judicial review of hospital decisions, based on common law due process or on some other cause of action, they should be attentive to the legislative concern that peer review be encouraged. The danger courts must guard against is a chilling of the efficacy of peer review by judicial imposition of time-consuming and costly formal requirements in the peer review process. Courts must strike a balance between formulating fair procedures and reasonable standards on one hand and protecting the flexibility necessary to ensure the vitality of hospital peer review on the other.

C. Balancing the Parties' Interests in Light of the "Felt Needs of the Times"

As the *Greisman* court recognized, common law due process review should be sensitive to the "felt needs of the times."[211] Since *Greisman* inaugurated the concept of common law due process review of private hospital staff decisions in 1963, the whole health care "industry" and hospital-physician relations in particular have undergone pervasive and fundamental changes.[212] When considering what

Hospital Initiated Quality Assurance, 7 AM. J.L. & MED. 301 (1981); Note, *The Legal Liability of Medical Peer Review Participants for Revocation of Hospital Staff Privileges,* 28 DRAKE L. REV. 692, 693 (1978-79); Comment, *Medical Peer Review Protection in the Health Care Industry,* 52 TEMP. L.Q. 552, 552 (1979).

209. ALASKA STAT. § 18.20.076 (Supp. 1984).

210. *Id.* § 18.23.030(c) (1981).

211. *Greisman,* 40 N.J. at 396, 192 A.2d at 821, quoted *supra* text accompanying note 46.

212. For a general historical and sociological sense of the changes in American medicine, see, P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 335-449 (1982). *See generally* MINNESOTA HOSPITAL ASSOCIATION, THE CHANGING ROLE OF THE HOSPITAL (1980); Owen, *Coping with Medicare Prospective Payment,* in HEALTH CARE INSTITUTIONS IN FLUX: CHANGING REIMBURSEMENT PATTERNS IN

should be expected of hospitals today, Alaska courts should rely on prior case law only after careful consideration of its continued relevance given the pressures hospitals face today and the current demands of policy and of the public.

The Public Interest. In 1963, public interest in how hospitals fulfilled their fiduciary duties was dominated by concern about an undersupply in physicians[213] and by a desire to expand the availability of

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THE 1980S 95, 100-01 (W. Greenberg & R. Southby eds. 1984) (discussing the importance of gaining control of the medical staff by hospital administrators in order to contain costs); Shortell, *Hospital Medical Staff Organization: Structure, Process, and Outcome,* in HOSPITAL ORGANIZATION AND MANAGEMENT 198 (J. Rakich & K. Darr 3d ed. 1983); Shortell, *Physician Involvement in Hospital Decision Making,* in THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT 73 (B. Gray ed. 1983) [hereinafter cited as Shortell, *Physician Involvement*] (discussing the desire of the public for more health care choices and the impact of the increased power of the hospital board and adminstration on changes in the structure of physician involvement in hospitals). One commentator identified the changes as follows:

> When combined with the increasing focus on economic competition, the structural changes already taking place will create major entrepreneurial opportunities in what has been, traditionally, a risk-averse industry. Physicians and hospital managers will face a changing strategic environment, one which will put the economic interests of the physician and hospitals into increased conflict. Changing economic opportunities will challenge hospitals and physicians to redefine the terms of their often troubled relationship, and seek mutual opportunities in an era of increasing scarcity of patients and income.

J. GOLDSMITH, CAN HOSPITALS SURVIVE? THE NEW COMPETITIVE HEALTH CARE MARKET xv (1981). Another commentator reflected on the changing relationship between the board and the medical staff:

> Until recent years, few boards exercised much influence on the organization or performance of the hospital's medical staff . . . . However, court decisions that more clearly define the board's obligations coupled with the growing realization that medical staff performance has great impact on the hospital's financial well-being as well as the quality of patient care are causing boards to take an increasingly active interest in medical staff matters. In the future, it is likely that more and more boards will begin to exercise their authority to influence the size, organization, and performance of their hospital's medical staff.

Prybil, *The Evolution of Hospital Governance,* in HEALTH MANAGEMENT FOR TOMORROW 76, 81 (S. Levey & T. McCarthy eds. 1980).

213. The baby boom generation was young in 1963 and its health care demands were insistent. The Health Professions Educational Assistance Act of 1963, Pub. L. No. 88-129, 77 Stat. 164 (codified as amended in scattered sections of 42 U.S.C. ch. 6A), and the Health Professions Educational Assistance Amendments of 1965, Pub. L. No. 89-290, 79 Stat. 1056 (codified as amended in scattered sections of 42 U.S.C. ch. 6A) were addressed to the perceived undersupply of physicians. *See* P. STARR, *supra* note 212, at 421 ("Between 1965 and 1980, federal aid succeeded in increasing the number of medical schools from 88 to 126 and raising the number of graduates from 7,409 to 15,135.").

health care to all who needed it.[214] Today public interest has changed in ways that raise basic questions about how to manage a hospital medical staff. The perceived physician shortage has disappeared in most places.[215] Consumers are concerned about containing medical care costs[216] and are demanding more choices and more control over the medical care they receive.[217]

A major political and policy response to these changed demands and circumstances has been to encourage competition[218] and to promote the development of new ways of providing health care.[219] Whether a particular decision by a hospital board serves the prevailing notion of the public interest will often be difficult to determine. Many commentators suggest that cost containment will require increased hospital control of physicians,[220] and that a hospital is best able to act in its own and the public's interests if it is not dominated by its medical staff.[221] Encouraging a desirable diversity in health care services will require that hospitals be permitted to make medical staff decisions

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214. P. STARR, *supra* note 212, at 367-74.

215. *See id.* at 421; SUMMARY REPORT OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMMITTEE 3 (1980) (estimating a surplus of 70,000 physicians by 1990).

216. Owen, *supra* note 212, at 95.

217. Shortell, *Physician Involvement, supra* note 212, at 93-94. One of the more interesting points of consumer attack on physician dominance of health alternatives is an attack on licensure. *See* Baron, *Licensure of Health Care Professionals: The Consumer's Case for Abolition,* 9 AM. J.L. & MED. 335 (1983). Consumers have also turned to courts. *See, e.g.,* Andrews v. Ballard, 498 F. Supp. 1038 (S.D. Tex. 1980) (class action by consumers successfully claiming that the Texas State Board of Medical Examiners had unconstitutionally infringed their right to choose acupuncture as a form of therapy by limiting its practice to licensed physicians, none of whom were qualified to do acupuncture).

218. The way for increased competition was cleared, in part, by antitrust scrutiny of hospitals by the Federal Trade Commission and by court decisions which ended the exemption that professionals had enjoyed from such scrutiny. *See* Havighurst, *The Doctors' Trust: Self-Regulation and the Law,* 2 HEALTH AFFAIRS 64, 67-68 (Fall 1983); Proger & Wentz, *Antitrust Primer,* in ANTITRUST IN THE HEALTH CARE FIELD 1, 2-6 (1979).

219. The development of health maintenance organizations has been especially significant. *See* P. FELDSTEIN, HEALTH CARE ECONOMICS 346-49 (2d ed. 1983). Federal support is apparent in the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. § 300e to 300e-11 (1982)) and the Health Maintenance Organization Act Amendments of 1976, Pub. L. No. 94-460, 90 Stat. 1945 (codified as amended at 42 U.S.C. § 300e-1 to 300e-11 (1982)).

220. *See* GOLDSMITH, *supra* note 212, at 162; R. SCHULZ & A. JOHNSON, MANAGEMENT OF HOSPITALS 252 (1983); Owen, *supra* note 212, at 100-01; Prybil, *supra* note 212, at 81. It is unclear how courts will review hospital board decisions made on the basis of a physician's willingness to cooperate with cost containment efforts.

221. *See* P. FELDSTEIN, *supra* note 219, at 219-23; *see also* Horty & Mulholland, *Legal Differences Between Investor-Owned and Nonprofit Health Care Institutions,* in THE NEW HEALTH CARE FOR PROFIT 17, 22 (B. Gray ed. 1983) ("In hospitals, per-

on the basis of a physician's willingness to provide a particular kind of service and, perhaps, on the basis of a compatible philosophy of medical practice.[222]

Substantive due process review is significantly more complex when, as now, the public interest is not well served simply by making a place on hospital medical staffs for all available competent physicians. Courts should take a deferential approach when faced with a questionable decision by a hospital governing board, especially if the decision was made in response to public demands for more cost effective and innovative choices in health care.

The Hospital's Interests. Hospitals have also been affected by the increased supply of physicians. Faced with more requests for medical staff privileges from medically competent physicians than they can accommodate, hospitals can, and sometimes must, make choices on some basis other than basic medical competence.[223] Courts should recognize that criteria other than those directly related to basic competence may embody valid hospital concerns which deserve judicial respect.

Perhaps the most obvious changes affecting hospitals since *Greisman* was decided in 1963 are the demise of the doctrine of charitable immunity,[224] the impact of Medicare and Medicaid, and the related

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haps more than other nonprofit institutions, it is essential that the board and management retain real control of the hospital.").

The antitrust laws provide one ground for court supervision of hospital medical staff decisions. When the medical staff exercises control over competition by controlling admission to the medical staff, antitrust questions are raised. One commentator has suggested that a solution to this antitrust problem is for the hospital governing board to make the medical staff decisions, with advice from the medical staff limited to the question of medical competence. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships,* 1984 DUKE L.J. 1072, 1093-98; *see also* Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom,* 70 CALIF. L. REV. 595, 648-50 (1982).

222. *Cf.* Marjorie Webster Junior College v. Middle States Ass'n of Colleges & Secondary Schools, 432 F.2d 650 (D.C. Cir.), *cert. denied,* 400 U.S. 965 (1970) (upholding a bylaw which excluded private schools from accreditation on the basis that accrediting organizations should be able to base their decisions on philosophical grounds).

223. *See, e.g.,* Berman v. Valley Hosp., 196 N.J. Super. 359, 482 A.2d 944 (1984) (upholding a hospital rule which denied applications for initial staff membership to well-established physicians because of overcrowding). Decisions such as Wyatt v. Tahoe Forest Hosp. Dist., 174 Cal. App. 2d 709, 715, 345 P.2d 93, 97 (1959), disapproving as vague a bylaw limiting staff membership to doctors who can provide the "best possible care," seem unwise in the current context.

224. An early and frequently cited case on hospital negligence is Darling v. Charleston Community Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied,* 383 U.S. 946 (1966). *See generally* W. ISELE, *supra* note 205, at 60-67 (1984) (overview of the expanding tort liability of hospitals related to medical staff incompetence); Southwick, *The Hospital Institution — Expanding Responsibilities Change Its Rela-*

massive movement of federal funds and regulations into health care.[225] More recent factors which have fundamentally altered the provision of hospital services include the federal government's switch from cost-based reimbursement to prospective payment for hospital services,[226] cost containment activities by private corporations and insurers,[227] and the growth of for-profit health care ventures[228] and multi-institutional health systems.[229] At the same time, hospital administration has become increasingly important and professionalized. Top hospital administrators, now often referred to as CEOs (chief executive officers), and hospital governing boards increasingly look to other corporations and industries for models of effective change and internal organizations.[230]

These changes have been characterized as "the coming of the corporation" to health care.[231] Reconsidering *Shulman* and other cases supporting the rule of nonreview,[232] one could argue that this transformation should be characterized as a return to the view of the private hospital as a truly private corporation. This characterization would give support to those jurisdictions which follow the traditional rule. Whatever the legal characterization of hospitals today, the courts must be responsive to underlying changes in the structure of health care.[233] Courts following *Greisman,* no more or less than courts following the traditional rule, must adjust the law to hospital problems which are being worked out under changing conditions.

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tionship with the Staff Physician, 9 CAL. W.L. REV. 429, 430 (1973) (implications of hospitals' tort liability for relationship to the medical staff).

225. *See generally* C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 25-50 (critically discussing efforts at cost containment through regulation); R. SCHULZ & A. JOHNSON, *supra* note 220, at 10-11; P. STARR, *supra* note 212, at 367-78; Rakich & Darr, *The Hospital as an Organization,* in HOSPITAL ORGANIZATION AND MANAGEMENT 24 (J. Rakich & K. Darr 3d ed. 1983).

226. *See* Owen, *supra* note 212, at 95-96.

227. *See* Samors & Sullivan, *Health Care Cost Containment through Private Sector Initiatives,* in MARKET REFORMS IN HEALTH CARE 144 (J. Meyer ed. 1983).

228. *See* Gray, *An Introduction to the New Health Care for Profit,* in THE NEW HEALTH CARE FOR PROFIT 1 (B. Gray ed. 1983).

229. *See* Katz, Mitchell & Markezin, *Introduction,* in AMBULATORY CARE AND REGIONALIZATION IN MULTI-INSTITUTIONAL HEALTH SYSTEMS 3 (G. Katz, A. Mitchell, & E. Markezin eds. 1982).

230. *See* THE CHANGING ROLE OF THE HOSPITAL, *supra* note 212, at 8 (1980); R. SCHULZ & A. JOHNSON, *supra* note 220, at 162; Prybil, *supra* note 212, at 76-89 (on the increasingly complicated "corporate role and responsibilities" of hospital governing boards).

231. P. STARR, *supra* note 212, at 420-49.

232. *Supra* notes 27-39 and accompanying text.

233. *See generally* Baydin & Sheldon, *Corporate Models in Health Care Delivery,* in HOSPITAL ORGANIZATION AND MANAGEMENT 86 (J. Rakich & K. Darr 3d ed 1983).

Within hospitals there is a clear recognition that internal cooperation is required to address changed circumstances.[234] Yet, it is equally clear that conflict will occur[235] as hospital governing boards exercise more control over the medical staff.[236] More than ever, hospitals need a predictable legal environment so they can plan for change. The ambiguous state of Alaska's due process review of hospitals makes planning more difficult than it needs to be. Courts must acknowledge the pressures hospitals face and use caution in applying case law developed to accommodate hospitals as they used to be and not as they are now.

The Physicians' Interests. Although alternative practices and options for physicians have also developed since *Greisman* was decided,[237] physicians continue to want and need hospital medical staff privileges. Today physicians can confront hospitals which are treating them unfairly with legal causes of action that did not exist when *Greisman* was decided. Antitrust actions by physicians are increasingly common and are successful often enough to make them a viable source of relief.[238] Alaska has recognized the tort of intentional interference with contractual relations,[239] which has been used in other jurisdictions to challenge hospital staff privilege decisions.[240] Asking the court to enforce the bylaws is also a significant protection today because the bylaws often reflect due process considerations.[241]

As long as the remedies available through these alternative causes of action include granting the injured physician staff privileges or, at least, fair consideration for privileges, an additional due process review is arguably superfluous. On the other hand, if an aggrieved physician

234. Internal cooperation is a major theme, even as hospital board-medical staff relations deteriorate. *See* Ewing, *Future of the Trustee,* in THE CHANGING ROLE OF THE HOSPITAL 11 (1980); W. ISELE, *supra* note 205, at 16-17. Shortell, *Physician Involvement, supra* note 212, at 84-99, argues that particular kinds of physician involvement in hospital administration may be a crucial aspect of efficient hospital management.

235. *E.g.,* St. John's Hosp. Medical Staff v. St. John Regional Medical Center, 90 S.D. 674, 245 N.W.2d 472 (1976) (the medical staff took a dispute with the governing board over bylaw amendments to court). *See generally* R. SCHULZ & A. JOHNSON, *supra* note 220, at 81; P. STARR, *supra* note 212, at 425-27.

236. The Joint Commission on Accreditation of Hospitals (JCAH) has recognized the inevitability of increased governing board control by eliminating its requirement that the medical staff "establish a framework of self-government." *Compare* JCAH, AMH/84 ACCREDITATION MANUAL FOR HOSPITALS 98 (1984) *with Medical Staff,* Standard II, forthcoming in JCAH, ACCREDITATION MANUAL FOR HOSPITALS (1985).

237. P. STARR, *supra* note 212, at 424-25.

238. *See, e.g.,* Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984). *See generally* Groseclose, *supra* note 6, at 28-35.

239. Long v. Newby, 488 P.2d 719, 722 (Alaska 1971).

240. *See* Annot., 7 A.L.R. 4TH 572 (1981); Groseclose, *supra* note 6, at 35.

241. *See supra* note 205 and accompanying text.

limits his complaint to violations of common law due process, judicial review may be an efficient means to insure that hospitals treat physicians fairly and reasonably.[242] If courts develop easily applied criteria for determining whether the physician's interests have been injured, both physicians and hospitals could benefit from early resolution of disputes on summary judgment in common law due process proceedings.

VI. CONCLUSION

The struggle to provide health care that meets the needs and demands of a diverse public at a reasonable cost has significance for everyone. With its decision in *Storrs,* the Alaska Supreme Court abandoned a sideline position of simply ensuring that hospitals and their medical staffs abide by the bylaws. Invoking due process doctrines of reasonableness and fairness, the court adopted a more active role, with greater willingness to change the rules and add new ones. It is difficult to criticize this role by labeling it as interventionism or to praise it wholeheartedly as increased sensitivity. Instead, this note has attempted to clarify the nature of the Alaska Supreme Court's engagement in the following ways: first, by establishing that court intervention is permitted on the basis of common law principles and is not required by the Constitution; second, by contrasting Alaska's position with the traditional and still prevalent rule of nonreview; third, by identifying and discussing specific, controverted issues raised by the often inconsistent case law relied upon in *Storrs,* which courts must address when asked to determine what common law due process requires of hospitals; and finally, by pointing to economic and social factors and policy concerns which courts should consider as they develop the common law obligations of private hospitals.

The task the Alaska Supreme Court has undertaken is inherently difficult. On one hand, the common law principles of reasonableness and fairness are intrinsically difficult to define and apply consistently, especially when the relationships which are the object of judicial concern are changing. On the other hand, the need for cost containment and the essentially contractual nature of the relationship between hospital and physician make consistency and the ability to plan important to everyone. The wisdom of the Alaska Supreme Court's decision to intervene in the decisionmaking processes of private hospitals will depend on its ability to develop a framework for judicial review which

242. The inefficiency associated with the alternative causes of action is related to the difficulties of putting together a case and conducting a trial on these more complex claims.

ensures consistent, fair results and is responsive to the "felt needs of the times."

M. Kathleen Kenyon