UNDERSTANDING JUDICIAL REVIEW OF HOSPITALS' PHYSICIAN CREDENTIALING AND PEER REVIEW DECISIONS

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INTRODUCTION

A hospital’s organized medical staff plays a vital role in the hospital’s mission as a health care provider and also directly affects consumers of the hospital’s health care services. Two important functions of a medical staff are making credentialing decisions and conducting peer review. Credentialing decisions determine who is granted or retains staff membership and the level of practice privileges the staff member enjoys.1 Peer review is a broader concept involving review by medical staff members of the quality and effectiveness of services performed by other medical staff members.2 Although peer review in hospitals occurs in many contexts, the focus of this Article will be a hospital’s credentialing and peer review decisions resulting in the denial, limitation, suspension, revocation, or nonrenewal of a physician’s medical staff or clinical


privileges and the extent of judicial review of those decisions.

A physician seeking medical staff membership or clinical privileges goes through an application process. During this process, the hospital evaluates the physician's qualifications and background. Ultimately, privileges may be granted or denied. Furthermore, staff members with existing privileges are subject to regular reevaluation. When a hospital's medical staff, through peer review efforts or as a result of other information, becomes aware of health care quality concerns involving an individual staff member, it should investigate the concerns and take any necessary action. Possible actions include limitation, suspension, revocation, or nonrenewal of staff privileges. Such adverse actions involving staff privileges have a direct and potentially devastating impact on the staff member's practice. Frequently, the affected practitioner will exercise whatever administrative or judicial review options are available in an effort to overturn the decision. The issue then becomes the extent to which a court will review a hospital's decision adversely affecting staff privileges.

Part I of this Article identifies the problem and provides its historical background. Part II identifies the competing interests of physicians, hospitals, and the public in the credentialing and peer review processes that influence how courts deal with challenges to credentialing decisions. In Part III, the Article identifies and examines the various legal theories for judicial review of physician credentialing decisions including: constitutional due process, the rule of non-review, breach of contract, fiduciary duty, common law fairness, and statutory review. Finally, in Part IV, the Article concludes that due process review, rooted in constitutional principles in cases involving public hospitals and in contract in cases featuring private hospitals, provides an appropriate framework for judicial review. This due process review should be afforded to both initial applicants and staff members with existing privileges.

I. HOSPITAL MEDICAL STAFFS AND THE CREDENTIALING PROCESS

A. The Hospital-Physician Relationship and the Organization of Medical Staffs

1. Historical Development of the Hospital-Physician Relationship

Until the late nineteenth century, hospitals were usually charitable

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3. See generally JCAHO MANUAL, supra note 1, MS.5 to MS.5.11 at MS 7-10 (discussing application process and requirements). See also infra notes 73-83 and accompanying text for a discussion of the application process.

4. See JCAHO MANUAL, supra note 1, MS.5.4, MS.5.4.3 at MS-8 (discussing consideration of professional criteria).

5. See id. MS.5.11, at MS-10 ("Appointment or reappointment to the medical staff and the granting, renewal, or revision of clinical privileges are made for a period of no more than two years."). See also infra notes 84-86 and accompanying text for a discussion of the reappointment process.

6. See infra notes 86-88 and accompanying text for a discussion of possible adverse actions.

7. See infra notes 89-112 and accompanying text for a discussion of the impact of an adverse action.
institutions providing free health care to the poor.\textsuperscript{8} Most of these early hospitals lacked what has become known as self-governing, organized medical staffs.\textsuperscript{9} One authority described these pre-twentieth century hospitals as ""boarding houses . . . unworthy of the confidence and support of their communities.'\textsuperscript{10} According to Loyal Davis, they ""were conducted in a manner which brought discredit upon the medical profession."\textsuperscript{11} Prior to the beginning of the twentieth century, a physician performed most of his work outside of hospitals in the physician's office or private individuals' homes\textsuperscript{12} and thus, a physician's practice did not require access to a hospital. Paul Starr estimates that in the 1870s as few as two percent of American physicians had hospital privileges.\textsuperscript{13} Physicians even performed surgeries in homes, often in the kitchen.\textsuperscript{14} Both the public and physicians often held a dim view of hospitals.\textsuperscript{15} According to Paul Starr, ""before 1900 the hospital had no special advantages over the home, and the infections that periodically swept through hospital wards made physicians cautious about sending patients there."\textsuperscript{16}

However, with medical advances, particularly in the area of surgery, the demand for hospitals increased substantially.\textsuperscript{17} Services became more


\textsuperscript{9} See Jost, supra note 8, at 848-49 (noting that percentage of hospitals with organized staffs increased dramatically between 1918 and 1935); Milton I. Roemer & Jay W. Friedman, Doctors in Hospitals: Medical Staff Organization and Hospital Performance 34-36 (1971) (noting lack of systematic policy in early hospitals).


\textsuperscript{12} See Eleanor D. Kinney, Private Accreditation as a Substitute for Direct Government Regulation in Public Health Insurance Programs: When is it Appropriate?, 57 Law & Contemp. Probs. 47, 50 (Autumn 1994) (""Until the twentieth century, most health care was provided at home.""); Morris J. Vogel, The Transformation of the American Hospital, 1850-1920, in Health Care in America: Essays in Social History 105, 105-06 (Susan Reverby & David Rosner eds., 1979) (stating ""even the most difficult surgical procedures were preformed in the home, often in the kitchen").

\textsuperscript{13} Starr, supra note 8, at 162. See also, id. at 162 (stating 1907 survey in the Bronx and Manhattan revealed that only about ten percent of physicians had hospital privileges).

\textsuperscript{14} See Vogel, supra note 12, at 105 (stating ""even the most difficult surgical procedures were performed in the home, often in the kitchen").


\textsuperscript{16} Starr, supra note 8, at 157.

\textsuperscript{17} See Davis, supra note 11, at 62-63 (attributing expansion to growing volume of surgical
specialized as hospitals transformed themselves from asylums for the indigent into "citadels of healing."\textsuperscript{18} According to Paul Starr, "roughly between 1870 and 1910, hospitals moved from the periphery to the center of medical education and medical practice."\textsuperscript{19} Starr adds that these hospitals evolved "[f]rom refuges mainly for the homeless poor and insane . . . into doctors' workshops for all types and classes of patients."\textsuperscript{20} As part of the move away from their role as primarily charitable institutions, hospitals began to allow physicians to charge patients for services rendered in hospitals,\textsuperscript{21} thus hospital privileges became more important to physicians. With medical advances, "the conscientious physician became increasingly dependent on the diagnostic and therapeutic facilities which only a hospital could provide."\textsuperscript{22}

As this new demand for hospital services increased, the number of hospitals in the United States exploded, jumping from 178 in 1873, to 4359 in 1909, and to 6719 by 1930.\textsuperscript{23} In the face of this rapid expansion, the American College of Surgeons ("ACS") was organized in 1913 with a primary objective to standardize hospital care.\textsuperscript{24} Surgeons in particular believed that both hospitals and physicians performing surgeries should meet minimum standard requirements for safe equipment and safe performance of surgeries.\textsuperscript{25} Beginning in 1917, the ACS established the voluntary "Minimum Standard" for hospitals.\textsuperscript{26} In 1919, the
ACS established the Hospital Standardization Program ("HSP") to carry out its goal of hospital standardization by studying and monitoring hospitals and building on the Minimum Standard. The HSP was the predecessor of what is now known as the Joint Commission On Accreditation of Healthcare Organizations ("JCAHO"). The Minimum Standard stressed self-regulation through organized medical staffs. For instance, it required "[t]hat physicians and surgeons privileged to practice in the hospital be organized as a definite medical staff" and "[t]hat the medical staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital." From 1918 to 1935, largely in response to the ACS's standardization initiative, the percentage of hospitals with organized medical staffs increased from twenty percent to ninety percent of the hospitals surveyed by the HSP.

Prior to organized medical staffs and hospital standardization, some "open staff" hospitals allowed nearly any physician—regardless of qualifications—the privilege of admitting and caring for private paying patients in the hospital.
while many "closed staff" hospitals made staff appointments often based on "favoritism rather than skill." Standardization addressed this lack of standards by imposing requirements for membership on the medical staff and by encouraging "collective responsibility for standards among the 'open staff' itself." The Minimum Standard required:

That membership upon the medical staff be restricted to physicians and surgeons who are (a) graduates of medicine of approved medical schools, with the degree of Doctor of Medicine, in good standing, and legally licensed to practice in their respective states or provinces; (b) competent in their respective fields; and (c) worthy in character and in matters of professional ethics; . . . .

A central purpose of hospital standardization was to "prevent[ ] hospitals from being imposed upon by incompetent physicians," and, in turn, to protect the public. Early supporters of hospital standardization were motivated not only genuine concern for the quality of care provided to patients, but also the need to assure the public that hospitals were safe and worthy of the public's patronage. JCAHO has continued to emphasize the necessity for independent, self-governing medical staffs at hospitals. The medical staff has "overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body." JCAHO's Accreditation Manual for Hospitals contains a chapter with numerous standards governing medical staffs. The influence of JCAHO accreditation requirements, including those governing medical staffs, is considerable. Although JCAHO is a private nonprofit corporation and hospitals are not required to obtain JCAHO accreditation, the great majority of hospitals do seek and receive accreditation. JCAHO accreditation affords substantial advantages to hospitals including eligibility to receive Medicare payments and recognition under state licensing requirements. States, as part of their hospital staff"); cf. id. at 37 (noting appeals in 1912-1920 literature that medical staff appointments be merit based rather than based on social or political connections or no standards at all).

33. STEVENS, supra note 18, at 53.
34. Id. at 53. See also id. at 78, 116-17 (discussing impact of national rules on hospitals).
35. MACEachern, supra note 8, at iv (quoting Minimum Standard II).
36. Harris v. Thomas, 217 S.W. 1068, 1072 (Tex. Civ. App. 1920). In Harris, the hospital's standardization plan "contemplate[d] that the members of said staff shall meet at regular intervals, criticize their practice, and eliminate from their members such as may prove to be incompetent and unfit, the plan likewise contemplat[ed] finally specialized work as a basis for competency and fitness." Id. at 1072.
37. JCAHO MANUAL, supra note 1, MS.1, at MS-2.
38. Id. at MS-1 to MS-92.
39. See Jost, supra note 8, at 845 (stating that eighty percent of all acute care hospitals and "virtually all hospitals with more than twenty-five beds" are JCAH [now JCAHO] accredited).
licensure regulations, also require the organization of medical staffs and define the staff's role.\textsuperscript{41}

2. The Meaning of Medical Staff Membership

The medical staff consists of "fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital."\textsuperscript{42} Although this Article will refer primarily to physicians (both medical doctors and osteopathic doctors), hospital staffs, depending upon state law and the hospital's own bylaws, also may include dentists, podiatrists, psychologists, and other health care professionals.\textsuperscript{43}

\textsuperscript{41} See, e.g., ARIZ. ADMIN. CODE R9-10-214(A) (West, WESTLAW through Dec. 31, 1999) (requiring Arizona hospitals to have organized medical staff); FLA. ADMIN. CODE ANN. r. 59A-3.220(1) (West, WESTLAW through July 1, 2000) (mandating that each hospital have organized medical staff); KAN. ADMIN. REGS. § 28-34-6a(a) (West, WESTLAW through Jan. 1, 1999) (requiring hospitals to have organized medical staff); 12 Va. Admin. Code § 5-410-210 (West, WESTLAW through Aug. 14, 2000) (stating that each hospital must have organized medical staff "responsible to the [hospital] governing body" and whose bylaws are approved by the hospital's governing body).

\textsuperscript{42} Federal regulations require hospitals participating in Medicare and Medicaid to have organized medical staffs. See, e.g., 42 C.F.R. § 482.22 (1999) ("The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.").

\textsuperscript{43} JCAHO MANUAL, supra note 1, MS.1.1.1, at MS-2.

\textsuperscript{44} See id. MS.6.2, at MS-11 (defining "qualified physician" to include doctors of medicine and doctors of osteopathy).

\textsuperscript{44} See, e.g., Illinois Psychological Ass'n v. Falk, 638 F. Supp. 876, 880 (N.D. Ill. 1986) (noting psychologists were serving on medical staffs at several Chicago-area hospitals, but considering department of public health's interpretation of licensing requirement to exclude psychologists from medical staffs), aff'd, 818 F.2d 1337 (7th Cir. 1987); Clemons v. Fairview Med. Ctr., Inc., 449 So. 2d 788, 789-90 (Ala. 1984) (holding physical therapist might be member of medical staff entitled to protection under the bylaws); Lewisburg Cmty. Hosp., Inc. v. Alfredson, 805 S.W.2d 756, 760 (Tenn. 1991) (noting bylaws define "Medical Staff" as licensed physicians, dentists, and podiatrists); Ogrodowczyk v. Tennessee Bd. for Licensing Health Care Facilities, 886 S.W.2d 246, 251-52 (Tenn. Ct. App. 1994) (noting that under Tennessee law medical staff members must be graduates of approved programs of medicine, dentistry, osteopathy, podiatry, psychology, nurse midwifery, or optometry); 12 VA. ADMIN. CODE § 5-410-10 (West, WESTLAW through Aug. 14, 2000) (defining terms regarding hospital employees, their activities, and hospital facilities as used in this chapter of the Code). See also Cooper v. Forsyth County Hosp. Auth., Inc., 789 F.2d 278, 279 (4th Cir. 1986) (upholding bylaws restricting staff membership to physicians and dentists, thus excluding podiatrists); Wrable v. Cmty. Mem'l Hosp., 501 A.2d 187, 190 (N.J. Super. Ct. Law Div. 1985) (upholding denial of staff membership to psychiatric nurse), aff'd, 517 A.2d 470 (N.J. Super. Ct. App. Div. 1986); MD. CODE ANN., HEALTH-GEN. II § 19-351 (1996) (prohibiting hospitals from denying staff privileges to podiatrists, qualified dentists, and licensed psychologists on a class-wide basis).

Several jurisdictions either have prohibited chiropractors from staff membership or upheld hospital decisions to deny staff membership for chiropractors. See Petrocco v. Dover Gen. Hosp. & Med. Ctr., 642 A.2d 1016, 1021-27 (N.J. Super. Ct. App. Div. 1994) (rejecting chiropractor's claim that hospital's refusal to grant him staff privileges constituted violation of due process, defamation, and conspiratorial conduct); Cohn v. Wilkes Reg't Med. Ctr., 437 S.E.2d 889, 891-92 (N.C. Ct. App. 1994) (finding local statues governing hospitals and health services do not require hospitals to give staff privileges to chiropractors); Fort Hamilton-Hughes Memorial Hosp. Ctr. v. Southard, 466 N.E.2d 903, 905-06 (Ohio 1984) (finding that statute which protects doctors from discriminatory granting of staff membership but not chiropractors is not violation of equal protection); Boos v. Donnell, 421 P.2d 644,
Medical staff membership normally does not create an employment relationship with the hospital. Instead, it represents membership in an organization that affords certain rights and responsibilities. As one court explained:

Staff privileges serve to delimit a doctor's authority to practice in the hospital based upon the doctor's overall competence in his particular field(s) of practice. Staff privileges do not establish an employment contract with the hospital.... Rather, the use a doctor makes of his staff privileges depends upon some independent source. In the case of a physician or surgeon, that independent source is typically the operation of his private practice. In the case of a pathologist that source may be some independent contractual arrangement with the hospital....

A physician's relationship with a hospital based solely on staff membership and corresponding clinical privileges lacks the traditional elements of an employment relationship. Perhaps most significantly, the hospital does not direct or control the details of a physician's medical practice. Although the

647 (Okla. 1966) (finding hospital has no duty to grant hospital privileges to chiropractors); Samuel v. Curry County, 639 P.2d 687, 689 (Or. Ct. App. 1982) (concluding Oregon law does not require grant of hospital privileges to chiropractors because they are not licensed, practicing physicians); Ogrodowczyk, 886 S.W.2d at 252 (finding local rules precluded hospitals from granting medical staff privileges to chiropractors). See also FLA. ADMIN. CODE ANN. r. 59A-3.217(4)(h) (West, WESTLAW through July 1, 2000) (“nothing contained in the provisions of this section shall require a licensed facility to grant staff privileges to a chiropractor”).


46. Engelstad v. Virginia Mun. Hosp., 718 F.2d 262, 267 (8th Cir. 1983); accord, e.g., Draghi v. County of Cook, 991 F. Supp. 1055, 1058 (N.D. Ill. 1998) (finding that doctor's appointment to hospital staff does not create an employment contract), aff'd, 184 F.3d 689 (7th Cir. 1999).

47. In determining whether a particular relationship is an employment relationship, courts often have looked to the factors identified in the RESTATEMENT (SECOND) OF AGENCY § 220 (1958). See, e.g., Cmty. for Creative Non-Violence v. Reid, 490 U.S. 730, 751-52 & nn.18-30 (1989) (analyzing whether organization's agreement with artist to produce sculpture is "work made for hire" under Restatement principles); Cilecek v. Inova Health Sys. Servs., 115 F.3d 256, 262-63 (4th Cir. 1997) (citing Restatement to support notion that doctor under contract with hospital to provide emergency medical services is independent contractor). See also RESTATEMENT (SECOND) OF AGENCY § 2 (1958) (defining master, servant, and independent contractor).

hospital makes its facilities available to the physician and imposes certain professional standards; the physician is paid directly by individual patients or insurers and independently diagnoses, admits, and prescribes the course of treatment for his or her patients. Conversely, the hospital does not bill patients for the physician's services, pay the physician, provide retirement or insurance benefits for the physician, select the physician's patients, set the physician's schedule, or control or direct the manner in which the physician provides services.

The assumption that individual medical staff members act independently and therefore without undue interference from the hospital serves as the foundation for the concept of an organized medical staff. By definition, the medical staff consists of "licensed independent practitioners" who are authorized "to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges."

Viewing medical staff members as non-employees of the hospital is consistent with the historical development of modern American hospitals. Over time, hospitals offering charitable care without cost began to rely upon revenue
from private rooms used by patients admitted by private practitioners. These private rooms in many cases were available for patients of "almost any private physician," and "[t]here was no systematic policy in voluntary hospitals toward exercise of controls over the work of private physicians." Although policies and minimum standards were later imposed, the physician has continued to exercise significant autonomy over the care administered to individual patients at the hospital.

Of course, a physician who is a member of the medical staff also may be an employee of the hospital, but that employment relationship is created separately. Indeed, in recent years, with the increased pressures toward managed care and vertical consolidation in the healthcare industry, more and more physicians are becoming employees of hospitals. A physician who, in addition to staff membership, also has an employment relationship with the hospital obviously has an employment contract and employment law remedies.

Membership on a hospital medical staff affords important advantages. First, staff membership is a prerequisite for a physician to admit patients to the hospital and provide health care services in the hospital. Individual members of the medical staff are granted specific “clinical privileges” according to their

53. See STARR, supra note 8, at 166-67 (noting that hospital boards often expanded available positions for “feeders,” doctors who could fill their beds).
54. ROEMER & FRIEDMAN, supra note 9, at 34.
55. See ROSNER, supra note 21, at 118 (noting “the authority of lay trustees declined as physicians began to exert greater control over the day-to-day services provided their private patients”).
56. See RESTATEMENT (SECOND) OF AGENCY § 223 cmt. a (1958) (noting physician at hospital not normally servant of hospital but may be in some circumstances). See also, e.g., Mitchell v. Frank R. Howard Mem’l Hosp., 853 F.2d 762, 766-67 (9th Cir. 1988) (concluding radiologist under oral contract to provide all radiology services at hospital, to treat hospital patients, and who was paid by hospital could be employee for purposes of Title VII); Beverley v. Douglas, 591 F. Supp. 1321, 1327 (S.D.N.Y. 1984) (distinguishing full-time staff physicians from self-employed physicians with private practices); Albain v. Flower Hosp., 553 N.E.2d 1038, 1043 n.5 (Ohio 1990) (“[H]ospitals often employ full-time salaried physicians”), overruled on other grounds by Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46 (Ohio 1994).
58. See, e.g., Illinois Psychological Ass’n v. Falk, 638 F. Supp. 876, 877 (N.D. Ill. 1986) (“[O]nly persons on the medical staff may admit patients, order medical treatment, and vote on hospital policies”), aff’d, 818 F.2d 1337 (7th Cir. 1987); ARIZ. ADMIN. CODE R9-10-214(B) (West, WESTLAW through Dec. 31, 1999) (“Patients shall be admitted to the hospital by a member of the medical staff in accordance with medical staff bylaws, and shall be under the general care of a physician.”); ILL. ADMIN. CODE tit. 77, § 250.240(b)(1) (West, WESTLAW through Aug. 25, 2000) (providing all patients must be admitted by a member of medical staff with admitting privileges); id. § 250.330(a) (stating that medication and treatment at hospital require order of medical staff member). See also JCAHO MANUAL, supra note 1, MS.6,5.1, at MS-12 ("Management of a patient's general medical condition is the responsibility of a qualified physician member of the medical staff.").
license, education, training, experience, competence, health status, and judgment. These delineated privileges are authorization for "a practitioner to provide specific care services . . . within well-defined limits." Staff membership and clinical privileges are related but separate concepts. The grant of medical staff membership does not assure the grant of any particular requested clinical privileges. Different staff members are entitled to different clinical privileges; a member of a medical staff who is a radiologist may be granted clinical privileges in radiology but not, for example, in anesthesiology. A physician may have clinical privileges to conduct certain specified surgeries, but not other types of surgeries. Importantly, medical staff members who admit patients must be granted specific privileges to do so. Members of the medical staff are then charged to be "intricately involved in carrying out, and in providing leadership in, all patient care functions conducted by individuals with clinical privileges."

Second, medical staff membership gives the physician a voice in the operation of the hospital. This voice transcends the fundamental fact that

59. See JCAHO Manual, supra note 1, at MS-2 (defining "clinical privileges"); id. MS.1.1.2, at MS-2 ("All medical staff members have delineated clinical privileges that define the scope of patient care services they may provide independently in the hospital."). See also, e.g., ARIZ. ADMIN. CODE R9-10-214(D) (West, WESTLAW through Dec. 31, 1999) ("Clinical privileges of each medical staff member shall be delineated in writing.").

60. JCAHO Manual, supra note 1, at MS-2; id. MS.6.4, at MS-12. See also Bryant v. Glen Oaks Med. Ctr., 650 N.E.2d 622, 624 (Ill. App. Ct. 1995) (observing that bylaws defined "clinical privileges" as "the permission granted to a practitioner to render specific diagnostic, therapeutic, psychiatric, medical, dental, podiatric or surgical services").

61. See Garibaldi v. Applebaum, 653 N.E.2d 42, 44 (Ill. App. Ct. 1995) (distinguishing between staff privileges and clinical privileges); Dutta v. St. Francis Reg'l Med. Ctr., Inc., 867 P.2d 1057, 1061 (Kan. 1994) ("A grant of medical staff membership does not guarantee a companion grant of clinical privileges."); Bartley v. Eastern Maine Med. Ctr., 617 A.2d 1020, 1022-23 (Me. 1992) (establishing that staff privileges "signify[] that a doctor is qualified to practice at the hospital. . . . [but] [t]he right to exercise the privileges, however, is a separate matter."); David J. Behinfar, Exclusive Contracting Between Hospitals and Physicians and the Use of Economic Credentialing, 1 DEPAUL J. HEALTH CARE L. 71, 78 (1996) (describing staff privileges as minimum standards that may be supplemented by clinical privileges, which serve as a grant of right to perform services at the hospital). "Medical staff privileges" or simply "staff privileges" are sometimes equated with "staff membership." See, e.g., Garibaldi, 653 N.E.2d at 44 (comparing staff privileges with staff membership); Lewisburg Cnty. Hosp., Inc. v. Alfredson, 805 S.W.2d 756, 760 (Tenn. 1991) (describing medical staff privileges as flowing from staff membership). When equated with staff membership, staff privileges are distinct from clinical privileges. Cf JCAHO MANUAL, supra note 1, at MS-2 (defining "clinical privileges").

But see 42 U.S.C. § 11151(3) (1995) (defining "clinical privileges" to include membership on medical staff); Engelstad v. Virginia Mun. Hosp., 718 F.2d 262, 266-67 (8th Cir. 1983) (equating "clinical privileges" with "staff privileges"); Clemons v. Fairview Med. Ctr., Inc., 449 So. 2d 788, 789 (Ala. 1984) ("The terms 'medical staff privileges' and 'clinical privileges' refer simply to the right of an individual to treat patients at [the hospital]").


63. See JCAHO MANUAL, supra note 1, MS.6, at MS-11.

64. Id. at MS-11. Some professional personnel may have clinical privileges but are not members of the medical staff. See KAN. ADMIN. REGS. 28-34-6a(e)(5) (West, WESTLAW through Feb. 14, 1999) (requiring that hospital bylaws delineate "clinical privileges and duties of professional personnel" who work in "clinical capacity" but "who are not members of the medical staff").
individual staff members supervise, direct, and perform the actual health care services provided to patients. The medical staff is an organized, self-governing collective that develops and adopts its own bylaws, rules, and regulations.65 These staff strictures define the medical staff's role in the hospital. The bylaws establish, among other things: (1) a medical staff executive committee and define its functions; (2) "[f]air-hearing and appellate review mechanisms for medical staff members and other individuals holding clinical privileges"; (3) "[m]echanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership or clinical privileges"; (4) "the medical staff's organization, including categories of medical staff membership"; (5) "[a] mechanism designed to provide for effective communication among the medical staff, hospital administration, and governing body"; and (6) "[m]edical staff representation and participation in any hospital deliberation affecting the discharge of medical staff responsibilities."66 These provisions assure the medical staff the opportunity to participate in overall hospital operations.

A medical staff may have different categories of medical staff membership, each with different rights and privileges assigned to it. Both JCAHO standards and federal regulations require the identification of these categories and their corresponding qualifications and limitations in the medical staff bylaws.67 The bylaws use various terms to describe these categories including attending staff, active staff, associate staff, consulting staff, courtesy staff, resident staff, or honorary staff.68

B. The Credentialing Process—Becoming and Remaining a Member of the Medical Staff

The medical staff's ultimate purpose is to ensure and further the quality of patient care. The medical staff is "responsible to the governing body of the hospital for the quality of all health care provided to patients in the facility and for the ethical and professional practices of its members."69 The medical staff

65. See JCAHO MANUAL, supra note 1, MS.2, MS.2.1, at MS-3 (establishing that bylaws are adopted by the medical staff).
66. Id. MS.2.3 to MS.2.3.8, at MS-3 - MS-4.
67. See 42 C.F.R. § 482.22(c)(2) (1999) (requiring identification of staff membership categories for hospitals participating in Medicare and Medicaid); JCAHO MANUAL, supra note 1, MS.2.3.4, at MS-3 (requiring description of staff's organization).
69. FLA. ADMIN. CODE ANN. r. 59A-3.220(1) (West, WESTLAW through July 1, 2000). See also, e.g., ARIZ. ADMIN. CODE R9-10-214(A) (West, WESTLAW through Dec. 31, 1999) (requiring that hospitals have organized medical staff that answers to governing body for the quality of health care rendered to patients and for ethical conduct of its members); JCAHO MANUAL, supra note 1, MS.1, at MS-2 (staff has "overall responsibility for the quality of the professional services provided by individuals with clinical privileges").
shapes and implements admissions standards to the medical staff as well as requirements for clinical privileges.\textsuperscript{70} This credentialing process entails "obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization."\textsuperscript{71} Although the governing body of the hospital also participates in the credentialing process, the medical staff largely defines and controls the process.\textsuperscript{72} Under JCAHO standards, "[t]he mechanisms for appointment or reappointment and initial granting and renewal or revision of clinical privileges are approved and implemented by the medical staff and governing body."\textsuperscript{73} As part of this process, the clinical departments recommend professional criteria for clinical privileges to the medical staff.\textsuperscript{74} Ultimately the final decision to grant or deny staff membership or clinical privileges is made by the governing body of the hospital, but the governing body bases its decision on the recommendation of the medical staff.\textsuperscript{75} A hospital’s governing body, usually a board, typically includes lay people, often prominent community members, who likely readily defer to the medical staff’s recommendations. In short, the medical staff acts as a gatekeeper and, within certain parameters, effectively controls admission to its membership and grant of clinical privileges.

The medical staff's credentialing responsibility arises in several similar, yet factually distinct, contexts. First, the staff considers new applications for appointment to the medical staff from individuals who do not have current membership. In this initial application process the staff and the hospital consider

\textsuperscript{70} See JCAHO MANUAL, supra note 1, MS.5.1, at MS-7 (establishing that appointments and reappointments made by governing board are based on medical staff recommendations); id. MS.5.3.1, at MS-7 (establishing that mechanisms for appointment and grant of privileges are "approved and implemented by the medical staff and governing body"); id. MS.5.4.1, at MS-8 ("Each clinical department makes recommendations to the medical staff regarding professional criteria for clinical privileges.").

\textsuperscript{71} JCAHO MANUAL, supra note 1, at MS-7.

\textsuperscript{72} See, e.g., KAN. ADMIN. REGS. 28-34-6a(b) (West, WESTLAW through Jan. 1, 1999) ("The medical staff shall adopt bylaws which define the requirements for admission to staff membership and for the [d]elineation and retention of clinical and admitting privileges."); JCAHO MANUAL, supra note 1, at MS-7 ("The medical staff is responsible for a credentialing process.").

\textsuperscript{73} JCAHO MANUAL, supra note 1, MS.5.3, MS.5.3.1, at MS-7. See also, e.g., ILL. ADMIN. CODE tit. 77, § 250.310(a)(1) (West, WESTLAW through Aug. 25, 2000) (stating that medical staff must establish written procedure for consideration of applications for staff membership and clinical privileges).

\textsuperscript{74} See JCAHO MANUAL, supra note 1, MS.5.4.1, at MS-8 (requiring recommendations from departments).

\textsuperscript{75} See, e.g., ARIZ. ADMIN. CODE R9-10-214(D) (West, WESTLAW through Dec. 31, 1999) (stating that medical staff shall recommend to governing body "physicians and other licensed practitioners considered eligible for new and continued membership on the medical staff"); FLA. ADMIN. CODE ANN. r. 59A-3.220(2)(d) (West, WESTLAW through July 1, 2000) (requiring medical staffs to "review" all applications by licensed practitioners for new and continued membership on medical staff and to endorse qualified applicants to the governing authority); KAN. ADMIN. REGS. 28-34-6a(d) (West, WESTLAW through Jan. 1, 1999) (declaring governing body shall decide upon "each recommendation for appointment to the medical staff" and that application process is to be considered in accordance with medical staff's bylaws); JCAHO MANUAL, supra note 1, MS.5.1, at MS-7 (establishing that governing body makes appointments based on medical staff recommendations).
information about the applicant’s licensure, training, experience, competence, ability, professional ethics, reputation, and health status.76 Many jurisdictions address the application process by statute and require procedural due process,77 reasonableness standards and procedures,78 impose timeframes for consideration of applications,79 or impose other requirements on the hospital.80

Second, the staff considers reappointments to staff membership for individuals with current membership. Usually a staff member’s appointment is for a one or two year term.81 Near the end of the term, the staff member goes through a reappointment process to renew staff privileges. In this process the medical staff considers an individual physician’s “pattern of performance by analyzing claims filed against the physician, data dealing with utilization, quality, and risk, a review of clinical skills, adherence to hospital bylaws, policies and procedures, compliance with continuing education requirements, and mental and physical status.”82 This required, periodic assessment results in a regular, systematic review of the competence and qualifications of staff members.83 If a problem is identified, the hospital may take appropriate corrective measures.

Third, the medical staff considers action involving existing privileges any time problems are identified. The hospital and the medical staff have the responsibility to continuously review and monitor the professional performance of individual staff members and all medical services rendered at the hospital.84

76. See, e.g., COLO. REV. STAT. ANN. § 25-3-103.5(1) (1999) (listing factors hospital may consider); FLA. STAT. ANN. § 395.0191(4) (West Supp. 2000) (listing factors hospital may consider). The hospital has discretion to determine the specific information required. See JCAHO MANUAL, supra note 1, at MS-7 (allowing individual organization to determine information required for decision making).


79. See D.C. CODE ANN. § 32-1307 (f) (1998); GA. CODE ANN. § 31-7-7 (Michie 1996) (setting forth application process requirements for government-owned hospitals); VA. CODE ANN. § 32.1-134.1 (Michie 1997) (requiring application review within sixty days).

80. See, e.g., VA. CODE ANN. § 32.1-134.1 (Michie 1997) (providing that reasons for denial must be in writing and provided to physician).

81. See, e.g., Adkins v. Sarah Bush Lincoln Health Ctr., 544 N.E.2d 733, 736 (Ill. 1989) (involving annual appointments); Ray v. St. John’s Health Care Corp., 582 N.E.2d 464, 467 (Ind. Ct. App. 1991) (involving two year appointments); Ritter v. Bd. of Comm’rs, 637 P.2d 940, 944 (Wash. 1981) (involving annual appointments); MD. CODE ANN., HEALTH-GEN. II § 19-319(e)(2)(iii) (Supp. 1999) (requiring reappointment process at least every two years); JCAHO MANUAL, supra note 1, MS.5.11 at MS-10 (“Appointment or reappointment to the medical staff and the granting, renewal, or revision of clinical privileges are made for a period of no more than two years.”).


83. See JCAHO MANUAL, supra note 1, MS.5.12 to MS.5.12.3, at MS-10 (“Appraisal for reappointment to the medical staff or renewal or revision of clinical privileges is based on ongoing monitoring of information concerning the individual’s professional performance; judgment; and clinical or technical skills.”).

84. See, e.g., FLA. STAT. ANN. § 395.0193(2), (3) (West, WESTLAW through Dec. 31, 1999) (describing peer review procedures); KAN. ADMIN. REGS. 28-34-6a(e)(10) (West, WESTLAW
They fulfill this responsibility through ongoing utilization review and quality assurance mechanisms whereby the medical staff, through its committees or departments, reviews outcomes and specific cases to determine appropriateness of patient care.\textsuperscript{85} If the quality of care provided by an individual staff member is questioned, the medical staff is required to investigate and take appropriate action which might include a recommendation that staff membership or clinical privileges be limited, revised, suspended, revoked, or not renewed.\textsuperscript{86} The right of a hospital, upon recommendation of its medical staff, to take immediate action in the interest of patient safety and welfare is universally recognized. JCAHO standards require medical staff bylaws to include "[m]echanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership or clinical privileges."\textsuperscript{87} State hospital licensing laws and regulations often specifically authorize hospitals to take immediate action when patient safety is jeopardized.\textsuperscript{88}

II. THE PROBLEM: BALANCING COMPETING INTERESTS OF PHYSICIANS, HOSPITALS, AND THE PUBLIC

A. The Physician's Interest

A physician has an interest in being able to pursue his or her profession.\textsuperscript{89} For the great majority of physicians, this interest requires access to hospital

\textsuperscript{85} See JCAHO MANUAL, \textit{supra} note 1, at MS-49 (stating that "[m]embers of the medical staff are involved in activities to measure, assess, and improve performance on an organizationwide basis" including "measurement of outcomes and of processes."); 1 Tom Curtis, \textit{The Medical Staff}, \textit{TREATISE ON HEALTH CARE LAW} § 6.04[1] (Michael G. MacDonald et al., eds. 1999).

\textsuperscript{86} See, e.g., FLA. STAT. ANN. § 395.0193(3) (West 1999) (describing discipline procedure); MISS. CODE ANN. § 73-25-93(1) (1999) (authorizing hospital to suspend, deny, revoke or limit privileges if warranted).

\textsuperscript{87} JCAHO MANUAL, \textit{supra} note 1, MS.2.3.3, at MS-3.

\textsuperscript{88} See, e.g., CAL. BUS. & PROF. CODE § 809.5(a) (West 1990 & Supp. 2000) (citing grounds for immediate suspension); FLA. STAT. ANN. § 395.0193(3) (West 1999) (listing grounds for disciplinary measures); 59 FLA. ADMIN. CODE ANN. r. 59A-3.217(5) (West WESTLAW through July 1, 2000) (stating that governing body has power to decline any staff member for "good cause" which includes but is not limited to "incompetence, negligence," substance abuse, "mental or physical impairment" that may negatively affect patient care, and "behavior disruptive to hospital environment"); 210 ILL. COMP. STAT. ANN. 85/10.4 (b)(2)(C)(1) (West Supp. 2000) (allowing suspension without hearing if staff member presents "immediate danger" to others).

\textsuperscript{89} Cf. Sheree Lynn McCall, \textit{A Hospital's Liability for Denying, Suspending and Granting Staff Privileges}, 32 BAYLOR L. REV. 175, 175 (1980) ("A physician's livelihood is dependent on acquiring and maintaining hospital staff privileges. This access to hospital facilities is necessary for most physicians to adequately treat and care for patients, to maintain their medical practice, and to pursue their medical career.")
facilities. That access requires staff membership and appropriate clinical privileges which are granted only by hospitals. In many areas, there may be only one hospital in a community, county, or region. Where there are no competing hospitals, denial or revocation of privileges may effectively prohibit the physician from participating in his or her profession in that community.

Even with the existence of competing hospitals, the negative implications of a denial or revocation of privileges remain because an adverse decision can have enormous consequences for the physician both at the hospital taking the adverse action and at other hospitals. Hospitals in the initial application and reapplication process require the physician to disclose any adverse actions taken involving the physician's professional license or privileges at any hospital. Hospitals often contact other hospitals where applicants have previously practiced to verify the information provided by the physician. Denial or revocation of privileges at another hospital alone may prevent the grant of privileges at a different hospital.

90. See Silver v. Castle Mem'l Hosp., 497 P.2d 564, 571 (Haw. 1972) ("The doctor has an interest in being able to pursue his profession which requires that the necessary facilities be available to him."); Burkhart v. Cmty. Med. Ctr., 432 S.W.2d 433, 436 (Ky. 1968) (discussing the rights of physicians to staff membership in hospital); 1 BARRY R. FURROW, ET AL., HEALTH LAW § 7-1 at 449 (1995) (stating access to hospitals is essential for a doctor to be successful practicing medicine); Note, The Physician's Right to Hospital Staff Membership: The Public-Private Dichotomy, 1966 WASH. U. L.Q. 485, 510-11 (noting for doctor to be successful, he/she must have access to hospitals).

91. See Holmes v. Hoemako Hosp., 573 P.2d 477, 480 (Ariz. 1977) (Struckmeyer, V.C.J., dissenting) (noting doctor was the only doctor in community and hospital was the only hospital serving that community); Lawler v. Eugene Wuesthoff Mem'l Hosp., 497 So. 2d 1261, 1264 (Fla. Dist. Ct. App. 1986) (stating loss of privileges "is a serious disadvantage to his or her ability to continue to practice in the community); Greisman v. Newcomb Hosp., 192 A.2d 817, 821 (N.J. 1963) (observing that only hospital in metropolitan area had virtual monopoly); Kelly v. St. Vincent Hosp., 692 P.2d 1350, 1353 (N.M. Ct. App. 1984) (noting that because many towns are isolated with only one hospital, a staffing decision can essentially deny a doctor opportunity to practice medicine); Ritter v. Bd. of Comm'rs of Adams County Pub. Hosp. Dist. No. 1, 637 P.2d 940, 949 (Wash. 1981) (Dore, J., dissenting) (noting physician's predicament in one-hospital town).

92. See JCAHO MANUAL, supra note 1, MS.5.5, at MS-8; Chester A. Groseclose, Jr., Hospital Privilege Cases: Braving the Dismal Swamp, 26 S.D. L. REV. 1, 1 (1981) (noting that hospital staff bylaws require such disclosures). For examples of bylaws requiring such disclosures see JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, GUIDELINES FOR THE FORMULATION OF MEDICAL STAFF BYLAWS 1971 at 10 (1977) [hereinafter "JCAH GUIDELINES FOR BYLAWS"]. See also, e.g., Bylaws of the Yale-New Haven Hosp., Inc. for the Medical Staff art. V, § B(3) (Sept. 8, 1999) [http://www.ynhh.com/med_prof/bylaws/contents.html] [hereinafter "Yale-New Haven Hosp. Bylaws"]; Presbyterian Hosp. Medical Staff By-Laws 1995 art. III, § 4(1) (revised Jan. 18, 1995) [http://cpmcnet.columbia.edu/dep/assurance/phby0000.html] [hereinafter "Presbyterian Hosp. Bylaws"]; The Hospital Council of Western Pennsylvania, Model Medical Staff Bylaws 4.2.2 (visited October 21, 2000) [http://www.hcwp.org/meddirfm/bylaws.htm] [hereinafter "HCWP Model Bylaws"]; The University of Texas Medical Branch, Bylaws and Rules and Regulations of the Medical Staff: The University of Texas Medical Branch at Galveston §§ 2.3.5, 2.3.6.6 Art. IV (rev. Feb. 17, 1999) [http://www.utmb.edu/policy/bylaws] [hereinafter "UTMB Bylaws"].

93. See Barbara A. Blackmond, Current Issues—The National Practitioner Data Bank and Hospital Peer Review, 7 HEALTH LAW. 1, 6 (1993).

94. See Mateo-Woodburn v. Fresno Cmty. Hosp., 270 Cal. Rptr. 894, 903 (Cal. Ct. App. 1990) (stating adverse action based on professional inadequacy or misconduct severely impairs ability to
Hospitals also check with state licensing officials, the National Federation of State Medical Boards Physician Disciplinary Data Bank, and the National Practitioner Data Bank. The Department of Health and Human Services established the National Practitioner Data Bank (hereinafter the "Data Bank") as required by the Health Care Quality Improvement Act (hereinafter "HCQIA" or the "Act"). The Act, passed in 1986, established a national reporting system to help prevent incompetent physicians from moving from state to state without discovery. To encourage reporting to the Data Bank, HCQIA provides hospitals which comply with its requirements qualified immunity from damages resulting from the hospital's professional review actions. Under HCQIA, a health care entity is required to report to the appropriate state board of medical examiners any "professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days." The Act become staff member at another hospital); State ex rel Bronaugh v. City of Parkersburg, 136 S.E.2d 783, 788 (W. Va. 1964) (observing that public hospital's denial of privileges without a hearing was based on denial of privileges at another hospital).

95. JCAHO MANUAL, supra note 1, MS.5.4.3.2, at MS-8.

96. See 45 C.F.R. § 60.1 (1999) (noting establishment of data bank on physician, dentist and healthcare providers for competency and conduct).


and its implementing regulations provide that "[t]he term 'adversely affecting' includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity."\(^{101}\)

HCQIA, as well as the accompanying regulatory framework, requires the state board to report the information it receives to the Data Bank.\(^{102}\) In addition to the professional review action information obtained indirectly from hospitals, the Data Bank also collects information about medical malpractice payments on behalf of physicians and actions taken by boards of medical examiners concerning a physician's license.\(^{103}\) Although the information provided to the Data Bank is confidential, hospitals and others have access to the information under certain circumstances.\(^{104}\) To enjoy the immunities extended by HCQIA, federal law requires hospitals to check with the Data Bank when a physician applies for staff or clinical privileges and every two years for physicians already on staff.\(^{105}\) In addition to the strong encouragement of HCQIA, state laws require hospitals to report adverse actions involving a physician's privileges.\(^{106}\) Failure to comply with these state law requirements may result in fines or loss of the hospital's license.\(^{107}\)

As a result of hospital practices, HCQIA, and state law, adverse action affecting a physician's staff membership or clinical privileges seriously affects a physician's ability to practice at any hospital.\(^{108}\) In one case, at the invitation of a

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102. See 42 U.S.C. §§ 11133(b), 11134(a) (1995); 45 C.F.R. §§ 60.4, 60.5(c), 60.9(b) (1999) (requiring reporting by board of medical examiners).
106. See, e.g., GA. CODE ANN. § 31-7-8(a) (1996) (requiring hospital administrator to submit written report to licensing board concerning denial, restriction or revocation of staff privileges); MASS. GEN. LAWS ANN. ch. 111, § 53B (West Supp. 2000) (requiring report of disciplinary hearing filed with board of registration of medicine within thirty days); UTAH CODE ANN. § 58-13-5(3) (1998) (requiring report of adverse action filed with Utah Medical Association within sixty days of event); University of S. Cal. v. Superior Court, 53 Cal. Rptr. 2d 260, 264 n.6 (Cal. Ct. App. 1996) (requiring report of denial of staff privileges to Medical Board).
107. See GA. CODE ANN. § 31-7-8(f) (1996) (stating non-compliance may result in loss of permit to operate); MASS. GEN. LAWS ANN. ch. 111, § 53B (West Supp. 2000) (stating non-compliance may result in fine not in excess of $10,000).
108. One court concluded that "[f]inding gainful employment in the hospital setting after a poor review is unlikely as a result of the provisions of the Health Care Quality Improvement Act of 1986, 42
community hospital, a physician left his large city practice after ten years and began a practice at the community hospital. After eight years of staff privileges at the hospital, the physician's privileges were summarily suspended. The consequences to his practice were devastating:

The findings of fact show that immediately after his suspension [he] lost 25 percent of his patients, necessitating staff lay-offs at his clinic. Additionally, [he] lost his courtesy privileges at Odessa Hospital, and his application for staff privileges at Moses Lake Good Samaritan Hospital was put on hold until they received additional information on the Adams County suspension. [His] subsequent attempts to enroll in the United States Navy and the United States Air Force Physician Corps were similarly rebuffed for the same reason. In short, the summary suspension effectively deprived [him] of the pursuit of his medical practice. He was forced to take a low paying employment as a resident in training at the University of Southern California Medical School.

Because the effect upon a physician is so significant, physicians have an interest in ensuring fairness in the credentialing and peer review process.

B. The Hospital's Interest

1. Patient Welfare

The hospital also has an important interest in the credentialing process. Perhaps foremost, the hospital is concerned about the quality of health care services provided in its facilities. This concern may have several motivations: (1) a genuine desire to fulfill the hospital's fundamental mission; (2) a desire to maintain and enhance the hospital's reputation in the community and among physicians, prospective patients, and the hospital's peers; (3) discharge of a hospital's legally imposed duty; (4) fear of liability to injured plaintiffs; and (5) the hospital's economic viability and ability to attract patients. As noted

U.S.C. §§ 11101-52 (1986), which requires that doctors who have been denied privileges be reported to a national service.” Cooper v. Delaware Valley Med. Ctr., 654 A.2d 547, 551 (Pa. 1995). See also Janes v. Centegra Health Sys., 721 N.E.2d 702, 707-08 (Ill. Ct. App. 1999) (noting pathologist's argument that report of a "for cause" revocation of his clinical privileges to the National Practitioner Data Bank would "directly injure his ability to gain future employment as a pathologist anywhere in the country"); Jacqueline Oliverio, Note, Hospital Liability for Defamation of Character During the Peer Review Process: Sticks and Stones May Break My Bones, but Words May Cost Me My Job, 92 W. VA. L. REV. 739, 740 (1990) (noting that denial of privileges based on poor performance can have devastating effects on a physician's career).

110. Id. at 942-43.
111. Id. at 952-53 (Dore, J., dissenting).
112. Based on this interest, California courts have recognized "[a] physician's right to pursue his livelihood free from arbitrary exclusionary practices.” Webman v. Little Co. of Mary Hosp., 46 Cal. Rptr. 2d 90, 95 (Cal. Ct. App. 1995) (alteration in original) (citing Rhee v. El Camino Hosp. Dist., 247 Cal. Rptr. 244 (Cal. Ct. App. 1988)).
113. See Rao v. Bd. of County Comm'rs, 497 P.2d 591, 592-93 (Wash. 1972) (discussing
later, concern for the quality of health care and ultimately patient welfare, has resulted in great deference by courts to hospital credentialing decisions.

2. Hospital Liability

The hospital's interest in avoiding legal exposure resulting from improper screening or monitoring of medical staff members or, less directly, from improper care provided by medical staff members at the hospital has become increasingly important. Formerly, most hospitals enjoyed immunity from tort liability under the widely-accepted doctrines of charitable immunity or governmental immunity. By the 1940s, however, courts began to explicitly reject the charitable immunity doctrine, rendering hospitals liable for their own negligent acts and the negligent acts of their employees. While a new development in many jurisdictions, allowing liability under these circumstances was by no means a radical move. Charitable immunity was, after all, an exception to the general rule that entities are liable for their own actions and the acts of their employees committed within the scope of the employees' employment.

The protection of governmental immunity is applicable, if at all, only to federal, state, county, or municipal hospitals. This immunity persists, but, as

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applicant's requirement of providing references is in interest of providing quality care and noting hospital's "economic success depends in large degree upon its good reputation").

114. See infra notes 542-48 and accompanying text for a discussion of the deference courts afford credentialing decisions.

115. Charitable immunity was first adopted in the United States in McDonald v. Massachusetts General Hospital, 120 Mass. 432 (1876), which relied on earlier English cases of dubious authority. See Bing v. Thunig, 143 N.E.2d 3, 5 (N.Y. 1957) (citing McDonald for doctrine of charitable immunity); Pierce v. Yakima Valley Mem'’l Hosp. Ass’n, 260 P.2d 765, 768 (Wash. 1953) (stating that McDonald court relied on English authority as sole basis for its holding). Other American courts followed McDonald's lead. See, e.g., Perry v. House of Refuge, 63 Md. 20, 26-28 (Md. 1885) (discussing charitable immunity); Richardson v. Carbon Hill Coal Co., 32 P. 1012, 1013 (Wash. 1893) (same); Downs v. Harper Hosp., 60 N.W. 42, 43 (Mich. 1894) (same); Lindler v. Columbia Hosp., 81 S.E. 512, 512 (S.C. 1914) (same); Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (same).


117. See, e.g., President of Georgetown College v. Hughes, 130 F.2d 810, 827 (D.C. Cir. 1942) (rejecting charitable immunity doctrine); Silva v. Providence Hosp., 97 P.2d 798, 802 (Cal. 1939) (declining to follow charitable immunity doctrine); Parker v. Port Huron Hosp., 105 N.W.2d 1, 14-15 (Mich. 1960) (adopting new rule of no charitable immunity for hospitals); Bing, 143 N.E.2d at 8-9 (finding nonliability "out of tune" with modern life); Pierce, 260 P.2d at 774 (abrogating nonliability doctrine). Even before abrogating the doctrine, courts had begun to impose numerous exceptions to charitable immunity, prompting one court to observe, "in this state, as elsewhere, the immunity rule has been 'devoured' with exceptions." Pierce, 260 P.2d at 772. See generally John D. Hodson, Annotation, Liability of Hospital or Sanitarium for Negligence of Physician or Surgeon, 51 A.L.R. 4th 235 (1987) for a discussion of cases holding hospitals liable for acts of their agents.

118. See, e.g., Pierce, 260 P.2d at 768 (noting "[t]he 'rule' is that one is liable for his negligent or tortious conduct. The 'rule' is that charity is no defense to tort. The immunity from suit granted charitable institutions, in actions involving tortious conduct, is an exception to these rules.") (citations omitted).

with charitable immunity, the doctrine has substantially eroded. Courts, however, did not stop with the abrogation or limitation of immunities. Courts increasingly hold hospitals liable for the malpractice of medical staff members—non-employees of the hospital—in various factual contexts and under various theories. A growing number of courts hold hospitals liable for the negligence of emergency room physicians even if those physicians are otherwise independent contractors and not hospital employees. These courts have sometimes relied upon theories of “ostensible” or “apparent” agency, or “agency by estoppel” to bring the cases within the general rule of respondeat superior liability for acts of an agent.

Some courts have imposed a more sweeping rule under a “nondelegable duty” theory. Under this theory, where a hospital has a duty imposed by law or otherwise to provide physicians for emergency room care, the hospital is responsible for the quality of care provided by those physicians regardless of whether the physicians are the hospital’s agents (employees) or not (independent contractors). This approach removes the necessity to prove actual or apparent authority. In Jackson v. Power, for example, the Alaska Supreme Court found that there was a genuine issue of fact whether the plaintiff agencies are statutorily immune from tort liability ‘[e]xcept as otherwise provided”’ and defining governmental agency as “the state, political subdivisions, and municipal corporations”) (alteration in original); Salcedo v. El Paso Hosp. Dist., 659 S.W.2d 30, 31 (Tex. 1983) (noting “[t]he El Paso Hospital District is a political subdivision of the State of Texas. As such, it is not liable for damages unless the negligent or wrongful act alleged falls within the statutory waiver of immunity.”).

120. See Salcedo, 659 S.W.2d at 30 (finding statutory waiver applicable); Condemarin v. University Hosp., 775 P.2d 348, 364 (Utah 1989) (finding portions of governmental immunity act unconstitutional). See FURROW, supra note 116, at § 7-1, at 450-51 (discussing governmental immunity).

121. See infra notes 125-47 and accompanying text for a discussion of the various contexts in which courts have held hospitals liable for medical staff members’ malpractice.

122. See Daniel L. Icenogle, Annotation, Hospital Liability as to Diagnosis and Care of Patients in Emergency Room, 58 A.L.R.5TH 613 (1998) (discussing hospital liability).


reasonably believed that the physician at issue was the hospital's employee. But, the court adopted the nondelegable duty theory and held the hospital vicariously liable as a matter of law for any malpractice committed by the emergency room attending physician, regardless of the physician's employment status. Martin C. McWilliams and Hamilton E. Russell, III, have noted:

Although nondelegability of medical care has not swept the field, the determination of some courts that hospitals are, even under limited circumstances, subject to traditional nondelegable duty reflects changing perceptions of public policy at the most potent level. As the Ohio Supreme Court observed in [Albian v. Flower Hospital], the movement is "toward imposing strict liability on hospitals" for medical care of patients.

Courts have also imposed liability on hospitals based on the acts of hospital non-employee medical staff members outside of the emergency room context. Some courts have based this expanded liability on the apparent authority doctrine. Hospital liability has also expanded dramatically under the "corporate liability" doctrine. A landmark case adopting this doctrine is Darling v. Charleston Community Memorial Hospital. In Darling, an eighteen year old broke his leg in a college football game and was taken to the defendant hospital emergency room. The plaintiff was treated by a physician on emergency call and admitted to the hospital where he remained for several days until he was transferred to another hospital. Ultimately his leg below the knee had to be amputated.

Plaintiff brought an action against the physician and the defendant hospital alleging that the hospital committed negligence by allowing the physician to do orthopedic work, not requiring the physician to review operative procedures, failing to adequately supervise the plaintiff's treatment, and not requiring a consultation. The defendant hospital argued that as a corporation it could not

126. Id. at 1381-82.
127. Id. at 1385.
128. McWilliams & Russell, supra note 123, at 457 (quoting Albian v. Flower Hosp., 553 N.E.2d 1038, 1046 (Ohio 1990)). See also Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 54 (Ohio 1994) (Moyer, C.J., dissenting) (accusing majority of making "a hospital the virtual insurer of its independent physicians"); id. at 56 (Wright, J.J., dissenting) (claiming that "[f]rom this day on no malpractice action evolving out of an incident within a hospital will be brought without joining the medical facility as a co-defendant").
130. 211 N.E.2d 253 (Ill. 1965).
131. Darling, 211 N.E.2d at 255.
132. Id. at 255-56.
133. Id. at 256.
134. Id.
practice medicine and could not control the doctor's treatment of the plaintiff. The court rejected this argument holding that a hospital assumes certain responsibilities for patient care:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment.

Numerous courts have followed Darling and adopted this "corporate negligence" or "corporate liability" theory, and imposed liability on hospitals for injuries resulting from the negligence of physicians on hospital medical staffs in some circumstances. In Thompson v. Nason Hospital, the Pennsylvania Supreme Court characterized the theory as imposing liability if a hospital "fails to uphold the proper standard of care owed its patient," and the court identified four distinct duties mandated by the standard of care:

(1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.

Notwithstanding the duties identified in Thompson, several courts have

135. Id.
136. Darling, 211 N.E.2d at 257 (quoting Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957)). One commentary accurately notes that while Darling is widely credited with taking the first step toward adopting corporate liability, its principal focus was actually the malpractice of the hospital nursing staff rather than the hospital's responsibility for the malpractice of the attending physician. See Abraham & Weiler, supra note 129, at 390 n.34 (noting that principle focus of Darling was negligence of hospital staff in failing to monitor and report on deteriorating condition of surgical patient).
139. Thompson, 591 A.2d at 707-08 (citations omitted).
only discussed the theory in the context of the selection and retention of medical staff members.\textsuperscript{140} Courts adopting the corporate liability theory emphasize that they are imposing liability on the hospital for the hospital's own negligence—not the negligence of its non-employee medical staff.\textsuperscript{141} Nonetheless, most of the cases necessarily require proof of an underlying negligent act by a physician or other staff member whose treatment (or lack thereof) directly contributed to the plaintiff's injury.\textsuperscript{142} The dissent in \textit{Thompson} criticized the corporate liability theory as merely a search for deep pockets and an attempt to hold hospitals "liable as guarantors of the quality of care afforded by independent staff members."\textsuperscript{143}

Professors Kenneth S. Abraham and Paul C. Weiler argue for even greater legal liability for hospitals.\textsuperscript{144} They propose a move toward an "enterprise medical liability" system under which hospitals "would be the exclusive bearers of medical liability for all malpractice claims brought by hospitalized patients—regardless of the provider's status as employee, independent contractor, or holder of admitting privileges, and regardless of the site of the provider's malpractice."\textsuperscript{145} A hospital's potential liability is real. As one court summarized:

Hospital governing body members have fiduciary duties as directors and under certain circumstances have exposure to personal liability. A hospital itself may be responsible for negligently failing to ensure the competency of the medical staff . . . by appropriately overseeing the peer review process. Hospital assets are on the line, and the hospital's governing body must remain empowered to render a final medical practice decision which could affect those assets.\textsuperscript{146}

As the Arizona Supreme Court noted, "[i]f a patient is injured while in a hospital, regardless of who is at fault, the hospital will almost always be joined as a codefendant."\textsuperscript{147}

\textsuperscript{140} See \textit{Insinga}, 543 So. 2d at 213-14 (finding duty to "select and retain" competent staff); \textit{Strubhart}, 903 P.2d at 276-78 (discussing selection and retention of hospital staff); \textit{Rodrigues}, 623 A.2d at 462-63 (discussing selection and review of staff privileges).

\textsuperscript{141} See, e.g., \textit{Insinga}, 543 So. 2d at 214 (imposing duty on hospital to select and retain competent physicians: "[T]he hospital will only be responsible for the negligence of an independent physician when it has failed to exercise due care in the selection and retention of that physician on its staff").

\textsuperscript{142} See, e.g., \textit{Humana Med. Corp. v. Traffanstedt}, 597 So. 2d 667, 669 (Ala. 1992) (requiring implicitly some proof staff member was negligent); \textit{Johnson v. Misericordia Cmty. Hosp.}, 301 N.W.2d 156, 163-64 (Wis. 1981) (discussing concepts of negligence and duty).

\textsuperscript{143} \textit{Thompson}, 591 A.2d at 709 (Flaherty, J., dissenting).

\textsuperscript{144} Abraham & Paul C. Weiler, \textit{supra} note 129, at 393.

\textsuperscript{145} \textit{Id.}


\textsuperscript{147} Holmes v. Hoemako Hosp., 573 P.2d 477, 479 (Ariz. 1977). President Clinton's proposal that hospitals be required to report medical errors that result in death or serious harm has heightened concerns of increased legal liability for hospitals. See Julie Marquis & Alissa J. Rubin, \textit{National Perspective Health Hospitals, Doctors Fear Fallout for Call for Error Reporting}, L.A. TIMES, Feb. 23, 2000, at A-5. ("Hospital and physician organizations voiced strong concerns . . . about President Clinton's proposal for mandatory reporting of serious or deadly medical errors, saying it could lead to
The current trend imposing greater liability upon hospitals for their credentialing decisions and the care provided by their medical staff members results in added pressure on hospitals to make conservative staff credentialing decisions. Hospitals, as a preventative measure, may turn away candidates with even minor blemishes on their records or in cases where any doubt exists.

3. Economic Credentialing

In addition to quality of care and concerns about potential liability, profitability and economic considerations have also affected credentialing decisions in recent years. According to the definition of the American Medical Association, "the use of economic criteria unrelated to the quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges" constitutes "economic credentialing." For instance, a hospital may engage in economic credentialing when it decides to enter into exclusive contracts with physician groups to reduce costs. As part of these exclusive dealings, the hospital may deny privileges to other physicians practicing that specialty without regard to those physicians' competence or abilities. Furthermore, an economically-minded hospital might refuse to renew the privileges of a physician who primarily practices in other competing hospitals and does not admit a certain volume of patients to the refusing hospital. The denial of privileges because the physician has an unfavorable patient mix of private paying patients, patients on Medicare and Medicaid, and charity patients represents another example of this type of credentialing.

Despite the American Medical Association's strong opposition to economic credentialing, hospitals who operate under substantial economic pressures...
have a strong incentive to consider economic factors at all levels of their operations including credentialing decisions. Some reports have suggested widespread use of economic credentialing. Some jurisdictions permit economic credentialing in at least some circumstances. For example, Indiana, by statute, allows consideration of “efficient and effective utilization of hospital resources” in credentialing decisions. On the other hand, Illinois, to some extent, has disapproved economic credentialing. An Illinois statute states that: “[t]he Illinois General Assembly finds: (1) That the citizens of Illinois are not served by the inappropriate use of economic criteria in determining an individual’s qualifications for initial or continuing medical staff membership or privileges. . . .” Significantly, however, the Illinois statute only addresses “inappropriate use” of economic criteria and not any use of economic criteria and does not flatly prohibit economic credentialing. Regardless of these legal reactions, hospitals experience economic pressures and clearly want to control the cost of health care. Economic credentialing is one way to achieve this goal of cost containment. One commentator, Brian Dahl, explains:

AMA . . . strongly opposes the practice of economic credentialing . . .”); Orie, supra note 150, at 442 (“The AMA and other medical organizations are vehemently opposed to economic credentialing.”). The AMA’s vigorous opposition continues apace. In a December 11, 1999 letter, AMA Executive Vice President E. Ratcliffe Anderson “asked the Inspector General’s Office of the Department of Health and Human Services to declare hospital ‘exclusive credentialing’ arrangements a violation of federal fraud laws.” Thom Wilder, AMA Calls ‘Exclusive Credentialing’ By Hospitals a Fraud Violation, 9 BNA’s HEALTH LAW REPORTER 344 (Mar. 9, 2000). In the letter, Anderson stated that “economic credentialing is a troubling phenomenon.” Id.

152. See Richard A. Feidstein, Economic Credentialing and Exclusive Contracts, 9 HEALTH LAW 1, 1 (1996) (stating that hospitals “face increasing pressure to cut costs and increase efficiencies,” and therefore “increasingly make credentialing decisions on economic grounds”); Orie, supra, note 150, at 438 (“The terms ‘cost efficiency’ and ‘cost containment,’ frequently touted by hospitals, are merely euphemisms for economic credentialing. . . . As hospitals consolidate, they are forced to focus even more on financial considerations, rather than patient outcome.”); id. at 448 (“Increasingly, hospitals are looking to economic credentialing to mitigate the financial pressures imposed by governmental and insurance company payors.”); Howard Larkin & Brian McCormick, The Many Faces of Economic Credentialing, 35 AM. MED. NEWS 3 (July 20, 1992).

153. See Brian A. Dahl, Economic Credentialing: The Propriety of Managing Physician Costs Through Privileging, 44 J. HEALTHCARE MGMT. 302, 302 (1999) (economic credentialing “is becoming increasingly prevalent”); Larkin & McCormick, supra note 152, at 3 (“It’s unclear how widespread economic credentialing is, but many signs point to increasing prevalence.”)


156. 210 ILL. COMP. STAT. ANN. 85/2(b) (West Supp. 2000). See also 210 ILL. COMP. STAT. ANN. 85/10.4(b)(1)(E), (b)(2)(B), (b)(3) (West Supp. 2000) (requiring written explanation to applicant whose privileges are denied or limited, and reporting to Hospital Licensing Board credentialing decisions based substantially on economic factors to study effects such decisions have on access to care and availability of physician services).
With the advent of cost-containment pressures brought on by diagnostic related groups (DRGs), capitated payments, and other financial risk-shifting payment schemes, hospital executives have found it increasingly necessary to exert control over physicians' use of hospital services. Although hospital executives exert no direct control over physicians' use of hospital services, hospital governing boards do exercise ultimate control over physician privileges. By tying economic considerations to a physician's privileges, the hospital's administrative staff can indirectly exert tremendous influence over service use.\textsuperscript{157}

In short, quality of care, potential legal liability, and economic factors all affect a hospital's credentialing decisions and must be considered in determining the appropriate scope of judicial review of credentialing decisions.

\section*{C. The Public's Interest}

In addition to the sometimes conflicting interests of the physician and the hospital, the public's interests in physician credentialing influence judicial decision making. Above all, concern for patient health and safety properly influences court reaction to credentialing challenges.\textsuperscript{158} This concern for public safety has resulted in a high level of deference to hospital staffing decisions. The Fifth Circuit explained:

Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance.\textsuperscript{159}

Other facets of the public's interest in health and safety include the need for widespread availability of quality health care services\textsuperscript{160} and the opportunity to choose a physician. In the words of one court, "[b]oth doctors and their..."
patients can suffer if otherwise qualified doctors are wrongly denied staff privileges.\textsuperscript{162}

Congress and individual states have recognized the public's obvious interest in quality health care. As a result, they have enacted legislation to encourage "peer review" of physicians.\textsuperscript{163} "Peer review" is described as "a process by which members of a hospital's medical staff review the qualifications, medical outcomes and professional conduct of other physician members and medical staff applicants to determine whether the reviewed physicians may practice in the hospital and, if so, to determine the parameters of their practice."\textsuperscript{164}

Congress, in enacting the Health Care Quality Improvement Act expressly found that effective professional peer review would improve the quality of medical care by discouraging medical malpractice and exposing incompetent physicians.\textsuperscript{165} To this end, Congress extended qualified immunity to physicians engaged in peer review to encourage their participation in the process.\textsuperscript{166} States also encourage peer review as a matter of public policy.\textsuperscript{167} For example, the Illinois Hospital Licensing Act states: "Because the candid and conscientious evaluation of clinical practices is essential to the provision of adequate hospital care, it is the policy of this State to encourage peer review by health care providers."\textsuperscript{168}


\textsuperscript{163} See infra notes 165-68 and accompanying text for a discussion of legislation encouraging peer review of physicians.

\textsuperscript{164} Scheutzow, supra note 2, at 7. The credentialing process is only one facet of the broader concept of peer review which also encompasses utilization review, infections review, and the review of specific hospital functions. Arthur F. Southwick & Debra A. Slee, Quality Assurance in Health Care, 5 J. LEGAL MED. 343, 344 (1984).

\textsuperscript{165} 42 U.S.C. § 11101(3) (1995) (suggesting that "professional peer review" can help solve the national problem of medical malpractice).

\textsuperscript{166} Id. at § 11111

\textsuperscript{167} See infra note 168 and accompanying text for example of a state statute encouraging peer review as a matter of public policy.

III. LEGAL THEORIES FOR JUDICIAL REVIEW OF CREDENTIALING AND PEER REVIEW DETERMINATIONS

A. The Public/Private Dichotomy

1. Constitutional Review of Public Hospital Actions

In an effort to appropriately accommodate the physician’s, hospital’s, and public’s competing interests, courts have developed various theories and approaches applicable to claims seeking judicial review of hospital credentialing and peer review decisions. The distinction between public and private hospitals provided the basis for the first approach that emerged in the early cases. A “public” hospital is a hospital owned, sponsored, or managed by a governmental entity—whether a federal veteran’s hospital, a state university hospital, or a local community hospital. In the words of several early decisions, public hospitals, like other public corporations, “are the instrumentalities of the state, founded and owned by it in the public interest, supported by public funds, and governed by managers deriving their authority from the state.” A “private” hospital, on the other hand, “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.”

A public hospital, as an extension of the state, is subject to the limitations imposed by the United States Constitution—in particular, due process and equal protection requirements. Several early decisions applied this constitutional approach holding that public hospitals could not arbitrarily or unreasonably exclude physicians from practicing in them. Actions of private hospitals, on

170. Id. at 555. Accord Shulman v. Washington Hosp. Ctr., 222 F. Supp. 59, 61 (D.D.C. 1963) (stating that public hospitals are supported by government funds and are managed by the government); Edson v. Griffin Hosp., 144 A.2d 341, 343 (Conn. Super. Ct. 1958) (noting that city hospitals are public institutions, owned by public and devoted to public); Hughes v. Good Samaritan Hosp., 158 S.W.2d 159, 161 (Ky. 1942) (citing Van Campen as authority for proposition that public hospitals are publicly funded and operated); Levin v. Sinai Hosp., Inc., 46 A.2d 298, 300 (Md. 1946) (noting that public corporations are funded and maintained by government).
172. See, e.g., Yashon v. Hunt, 825 F.2d 1016, 1022 (6th Cir. 1987) (considering procedural due process violations); Sosa v. Bd. of Managers, 437 F.2d 173, 174 (5th Cir. 1971) (considering Fourteenth Amendment violations); Campbell v. St. Mary’s Hosp., 252 N.W.2d 581, 585 (Minn. 1977) (“It is of course elementary that the due process provisions of the Fourteenth Amendment and MINN. CONST. art. 1, § 7, apply only if the actions to terminate plaintiff’s surgical privileges were done under color of state law.”); Ritter v. Bd. of Comm’rs, 637 P.2d 940, 944-45 (Wash. 1981) (considering due process violations); cf. Hayman v. City of Galveston, 273 U.S. 414, 416-17 (1927) (questioning but assuming that public hospital’s actions were limited by Fourteenth Amendment and finding regulation excluding osteopath was not arbitrary nor unreasonable); Newton v. Bd. of Comm’rs, 282 P. 1068, 1070 (Colo. 1929) (following Hayman).
173. See Findlay v. Bd. of Supervisors, 230 P.2d 526, 530 (Ariz. 1951) (holding that public hospital could not terminate physician privileges based on unconstitutional resolution); Ware v. Benedikt, 280
the other hand, are not subject to constitutional scrutiny.\textsuperscript{174}

This disparate treatment of public and private actors by the courts is well entrenched in our constitutional jurisprudence. In 1819, Justice Story in \textit{Trustees of Dartmouth College v. Woodward},\textsuperscript{175} explained the distinction between public and private corporations and illustrated his point by contrasting a hospital operated as a public corporation and a hospital operated as a private corporation.\textsuperscript{176} True to the express language of the Fourteenth Amendment,\textsuperscript{177} the United States Supreme Court has repeatedly held that the constitutional protections of the Fourteenth Amendment apply only to state action.\textsuperscript{178} Justice Rehnquist stated in \textit{Jackson v. Metropolitan Edison Co.}\textsuperscript{179}:

In 1883, this Court in the \textit{Civil Rights Cases}, 109 U.S. 3, affirmed the essential dichotomy set forth in that Amendment between deprivation by the State, subject to scrutiny under its provisions, and private conduct, "however discriminatory or wrongful," against which the Fourteenth Amendment offers no shield.\textsuperscript{180}

In \textit{Edmonson v. Leesville Concrete Co.},\textsuperscript{181} Justice Kennedy explained:

The Constitution structures the National Government, confines its actions, and, in regard to certain individual liberties and other specified matters, confines the actions of the States. With a few exceptions... constitutional guarantees of individual liberty and equal protection do not apply to the actions of private entities. This fundamental limitation on the scope of constitutional guarantees "preserves an area of


\textsuperscript{175} 17 U.S. (4 Wheat.) 518 (1819).

\textsuperscript{176} \textit{Id.} at 668-69.

\textsuperscript{177} "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

\textsuperscript{178} See \textit{infra} notes 178-83 and accompanying text for examples of Supreme Court's adherence to the holding that the 14th Amendment applies only to state action.

\textsuperscript{179} 419 U.S. 345 (1974).

\textsuperscript{180} \textit{Jackson}, 419 U.S. at 349 (citing Shelley v. Kramer, 334 U.S. (1949)).

individual freedom by limiting the reach of federal law.

Justice Kennedy continued: "One great object of the Constitution is to permit citizens to structure their private relations as they choose subject only to the constraints of statutory or decisional law."

Because many courts treat private hospitals with greater deference, a major issue for several decades was the determination of whether a hospital should be treated as a public or private entity. Plaintiff physicians alleged constitutional protections in connection with actions of nonprofit privately owned and operated hospitals on the theory that such hospitals should be treated as public or "quasi-public" hospitals. They argued that a hospital's charitable work for the public, the receipt of donations from the government, receipt of payments for services rendered from federal, state, or local governments, liability exemptions, tax exemptions, and state licensing and regulation should result in a finding that such hospitals were public.


183. Edmonson, 500 U.S. at 619 (citations omitted).

184. One commentary describing the state of the law at the time of its writing noted: "Since most courts are unyielding in their application of the sound discretion rule, often the only question in these cases is whether the hospital is public or private." Note, The Physician's Right to Hospital Staff Membership: The Public-Private Dichotomy, 1966 WASH. U. L.Q. 485, 492 n.29 (1966).

185. See, e.g., Pariser v. Christian Health Care Sys., Inc., 816 F.2d 1248, 1252 (8th Cir. 1987) (noting plaintiff alleged private hospital's actions constituted state action); Babcock v. St. Francis Med. Ctr., 543 N.W.2d 749, 759 (Neb. Ct. App. 1996) (reciting plaintiff's argument that private hospital "was a public or quasi-public entity and thus that its actions were state actions"); Mahmoodian v. United Hosp. Ctr., Inc., 404 S.E.2d 750, 752 n.2 (W. Va. 1991) (noting plaintiff argued that private hospital was "state actor").

186. See, e.g., Levin v. Sinai Hosp., Inc., 46 A.2d 298, 300-01 (Md. 1946) (holding hospital was private corporation even though "engaged in charitable work" and "operated solely for the benefit of the public"); Van Campen v. Olean Gen. Hosp., 205 N.Y.S. 554, 556 (N.Y. App. Div. 1924) ("That they are engaged in charitable work for the benefit of the public, and thereby affected with a-public interest, does not make them public corporations."). aff'd, 147 N.E. 219 (N.Y. 1925).


188. See, e.g., Babcock, 543 N.W.2d at 759 (noting receipt of Medicaid and Medicare funds); Van Campen, 205 N.Y.S. at 556 ("The fact that they may receive a donation from the government to enable them to carry on their work, or funds from a city or county to care for sick, disabled indigent persons, does not affect their character as private institutions."); Mahmoodian, 404 S.E.2d at 752 n.2 (noting receipt of "funds from governmental sources").

189. See Van Campen, 205 N.Y.S. at 556 (holding exemption from liability for negligence to patients did not affect status). With the widespread abrogation of charitable immunity, this justification has disappeared. See supra notes 115-18 and accompanying text for a discussion of the abrogation of charitable immunity.

190. See, e.g., Pariser, 816 F.2d at 1252 (holding enjoyment of tax benefits did not amount to state action); Babcock, 543 N.W.2d at 759 (holding use of tax-free bonds and tax exemption, among other factors, insufficient to establish state action); Van Campen, 205 N.Y.S. at 556 (holding tax exemption did not affect status).

191. See, e.g., Pariser, 816 F.2d at 1252 (holding subjection to pervasive governmental regulation insufficient to establish state action); Mahmoodian, 404 S.E.2d at 752 n.2 (holding subjection to governmental regulation insufficient).
public rather than private. The law now appears well-settled that an otherwise private hospital’s actions are not state action merely by virtue of the above factors.\textsuperscript{192}

\textsuperscript{192} See, e.g., Pariser, 816 F.2d at 1252 (holding list of government-related factors did not make a private hospital into a public one); Mendez v. Belton, 739 F.2d 15, 17-18 (1st Cir. 1984) (finding panoply of factors did not change hospital’s status from private to public); Loh-Seng Yo v. Cibola Gen. Hosp., 706 F.2d 306, 308 (10th Cir. 1983) (holding plaintiff’s cause of action properly dismissed because he had failed to prove that government funding of private hospital changed its private status); Hodge v. Paoli Mem’l Hosp., 576 F.2d 563, 564 (3d Cir. 1978) (affirming lower court’s dismissal of case because list of government-related factors did not make private hospital into a state actor); Schlein v. Milford Hosp., Inc., 561 F.2d 427, 428-29 (2d Cir. 1977) (stating that although private hospital had substantial ties to state, it remained private); Madry v. Sorel, 558 F.2d 303, 305 (5th Cir. 1977) (holding that private hospital’s use of state land and money did not make it state actor); Briscoe v. Bock, 540 F.2d 392, 395-96 (8th Cir. 1976) (holding that government involvement in private hospital did not make it state actor); Watkins v. Mercy Med. Ctr., 520 F.2d 894, 896 (9th Cir. 1975) (dismissing plaintiff’s case because he had failed to show state involvement in actions of private hospital named as defendant); Jackson v. Norton-Children’s Hosps., Inc., 487 F.2d 502, 502-03 (6th Cir. 1973) (affirming lower court dismissal of case against private hospital because hospital was private corporation); Doe v. Bellin Mem’l Hosp., 479 F.2d 756, 761-62 (7th Cir. 1973) (deciding plaintiff had no cause of action against private hospital because hospital was not acting under color of state law); Ward v. St. Anthony Hosp., 476 F.2d 671, 674 (10th Cir. 1973) (stating private hospital’s receipt of federal funds did not make it state actor); Canady v. Providence Hosp., 903 F. Supp. 125, 126-27 (D.D.C. 1995) (noting private hospital’s receipt of federal funds did not make it subject to federal constitutional law), aff’d, 132 F.3d 1480 (D.C. Cir. 1997); Brandt v. St. Vincent Infirmary, 701 S.W.2d 103, 105-06 (Ark. 1985) (holding private hospital’s actions not governed by 14th Amendment even though hospital received government funds); Bello v. South Shore Hosp., 429 N.E.2d 1011, 1014 (Mass. 1981) (holding private hospital’s actions not performed under color of state law); Babcock v. St. Francis Med. Ctr., 543 N.W.2d 749, 759 (Neb. Ct. App. 1996) (holding array of factors did not support determination that private hospital was public institution); Mahmoodian v. United Hosp. Ctr., Inc., 404 S.E.2d 750, 752 n.2 (W. Va. 1991) (noting private hospital not state actor or subject to due process requirements); Fletcher v. Eagle River Mem’l Hosp., Inc., 456 N.W.2d 788, 797 (Wis. 1990) (stating plaintiff’s claim of private hospital’s receipt of government funds did not make it state actor). For early cases, see, for example, Edson v. Griffin Hosp., 144 A.2d 341, 343-44 (Conn. Super. Ct. 1958) (stating private hospital’s receipt of state aid did not make hospital public); West Coast Hosp. Ass’n v. Hoare, 64 So. 2d 293, 296-97 (Fla. 1953) (stating private hospital was private corporation despite government involvement in some hospital affairs); Levin v. Sinai Hosp., Inc., 46 A.2d 298, 300-01 (Md. 1946) (stating private hospital not public even though it performed charitable work and was opened for use by public); Van Campen v. Oleaen Gen. Hosp., 205 N.Y.S. 554, 556 (N.Y. App. Div. 1924) (noting government contributions to private hospital did not change hospital’s status to public), aff’d, 147 N.E. 219 (N.Y. 1925).


A few courts, however, have viewed these factors as supporting a third classification of hospitals—"quasi-public" hospitals. Based on this finding, those courts have justified greater judicial review and have treated quasi-public hospitals much the same as public hospitals. See Kiesters v. Humana Hosp. Alaska, Inc., 843 P.2d 1219, 1223 n.2 (Alaska 1992) (reiterating that private hospital
2. Nonreview of Private Hospital Actions

Under the traditional view, private hospitals' credentialing decisions generally are subject to limited or no judicial review. Some courts have referred to this rule as the "rule of nonreview." In its broadest articulation the rule is:

[A] private hospital has a right to exclude any physician from practicing 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 practicing in the hospital, is not subject to judicial review. The decision of the hospital authorities in such matters is final.

The doctrine of nonreview developed in a string of early cases and persists in some form in numerous jurisdictions.

Although referred to as a rule of nonreview, this characterization and its seemingly unambiguous quality are misleading. The rule is not a complete bar to review of credentialing decisions and never was considered a complete bar; classified as quasi-public when it received government money); Storrs v. Lutheran Hosps. & Homes Soc'y, Inc., 609 P.2d 24, 28 (Alaska 1980) (holding private hospital "quasi-public" and must afford due process); Brandt v. St. Vincent Infirmary, 701 S.W.2d 103, 107-08 (Ark. 1985) (Dudley, J., concurring) (stating private hospital quasi-public and, therefore, required to afford doctors due process); Silver v. Castle Mem'l Hosp., 497 P.2d 564, 570 (Haw. 1972) (noting receipt of government funds demanded private hospital comply with due process standards); cf. Allison v. Centre Cmty. Hosp., 604 A.2d 294, 297 (Pa. Commw. Ct. 1992) (discussing quasi-public hospital category, but holding that all hospitals should be treated same).

193. See infra notes 194-238 and accompanying text for a discussion of "rule of nonreview."


instead, the rule is a doctrine of limited review.\textsuperscript{197} The seeds for the doctrine can be seen in an English case dating back to 1687, where, in a single sentence decision, the court held: "[a] mandamus to restore a surgeon to an [sic] hospital was denied; because it is not in the power of the Court, nor is it a publick [sic] office."\textsuperscript{198} In the United States, beginning in the late nineteenth century and continuing into the early twentieth century, courts held that a hospital whose business was conducted by a private corporation could impose restrictions which had the effect of excluding certain physicians.\textsuperscript{199} The courts came to this result by applying the general corporate law doctrine that if the hospital board acted within its legitimate corporate powers and not in violation of its bylaws, the court would not interfere.\textsuperscript{200} One early court also held that a complaining physician had no interest in the charitable trust operating a hospital and therefore had no standing to challenge the board's actions.\textsuperscript{201}

Two other cases reflecting early application of the doctrine of nonreview are \textit{Harris v. Thomas}\textsuperscript{202} and \textit{State ex rel. Wolf v. La Crosse Lutheran Hospital Ass'n.}\textsuperscript{203} In \textit{Harris}, the Texas Court of Civil Appeals considered a challenge by an osteopathic doctor who was excluded from practicing in a local hospital.\textsuperscript{204} As part of the American College of Surgeons' effort to standardize hospitals, the defendant organized its medical staff and imposed requirements for membership which excluded the plaintiff because he was an osteopath.\textsuperscript{205} The court held that a voluntary association may determine qualifications for its membership.\textsuperscript{206} In the court's view, membership was a privilege, and the court would not interfere with the association's decision making unless the association's rules were "against good morals or violate[d] the laws of the state."\textsuperscript{207} The court concluded, "[w]e believe it to be the right of the sanitarium to refuse business relation with appellant, if it sees proper to do so."\textsuperscript{208}

\begin{itemize}
\item \textsuperscript{197} See \textit{infra} notes 194-282 for a discussion of the history of the rule of nonreview and its limitations.
\item \textsuperscript{198} Anonymous, 90 Eng. Rep. 331 (K.B. 1687).
\item \textsuperscript{199} See, e.g., \textit{People ex rel. Replogle v. Julia F. Burnham Hosp.}, 71 Ill. App. 246, 249-50 (1897) (finding fully within hospital's power to adopt bylaws that are reasonable and consistent with general purposes of the corporation); Harris v. Thomas, 217 S.W. 1068, 1076-77 (Tex. Civ. App. 1920) (arguing that courts of equity generally will not interfere with decisions of voluntary associations); cf. Hayman v. City of Galveston, 273 U.S. 414, 417 (1927) (involving public hospital and allowing regulation excluding osteopath where regulation was not arbitrary or unreasonable).
\item \textsuperscript{201} \textit{Replogle}, 71 Ill. App. at 250.
\item \textsuperscript{202} 217 S.W. 1068 (Tex. Civ. App. 1920).
\item \textsuperscript{203} 193 N.W. 994 (Wis. 1923).
\item \textsuperscript{204} \textit{Harris}, 217 S.W. at 1069-70.
\item \textsuperscript{205} \textit{Id.} at 1074.
\item \textsuperscript{206} \textit{Id.} at 1076-77.
\item \textsuperscript{207} \textit{Id.} at 1077.
\item \textsuperscript{208} \textit{Id.} at 1078.
\end{itemize}
In *State ex rel. Wolf*, a hospital board without notice, hearing, or explanation, terminated a group of physicians’ hospital privileges. The physicians, who were until that time members of the medical staff, alleged that the hospital’s actions were inconsistent with the hospital’s medical staff bylaws. Refusing to order a writ of mandamus requiring reinstatement of the physicians’ privileges, the Wisconsin Supreme Court held that the hospital was a private corporation and its board had the power to exclude physicians from practicing in the hospital. The court’s holding, however, was not a general pronouncement of no review but instead was based on the requirements of mandamus. The court held out the possibility that if there were a breach of contract claim, such a claim might proceed in an action for damages or specific performance.

Perhaps the leading early case establishing the nonreview rule is *Van Campen v. Olean General Hospital*. In *Van Campen*, a private hospital terminated a physician’s staff privileges based on what the trial court found to be petty differences between the hospital management and the physician. The New York court reversed the grant of an injunction in favor of the physician and found that the physician was entitled to neither notice nor a hearing. The court disagreed with the lower court’s determination that the hospital was a public corporation. The fact that the hospital engaged in charitable work for the public, received donations and payments from the government in some cases, enjoyed protection from liability, and possessed a tax exemption, did not convert the hospital into a public corporation. The court then held that it should not interfere with the internal decisions of a private corporation short of illegal or improper conduct by the board jeopardizing the corporation’s property.

Another early case applying the nonreview rule is *Strauss v. Marlboro County General Hospital*. In *Strauss*, the South Carolina Supreme Court in a brief opinion affirmed the dismissal of a claim challenging rules that excluded a physician from practicing surgery in the hospital. The court held that the

209. 193 N.W. 994 (Wis. 1923).
211. *Id.* at 995-96.
212. *Id.* at 996. *See also* Johnson v. City of Ripon, 47 N.W.2d 328, 329-30 (Wis. 1951) (contrasting private hospital with public hospital and acknowledging *Wolf*’s holding that private hospitals have right to exclude physicians).
216. *Id.* at 558.
217. *Id.* at 555.
218. *Id.* at 556.
220. 194 S.E. 65 (S.C. 1937).
221. *Strauss*, 194 S.E. at 65.
hospital was a private corporation. The court's conclusion that the hospital was a private institution was dispositive because the parties conceded that if the hospital was private, the action would fail.

Other cases followed the Van Campen court. In Hughes v. Good Samaritan Hospital, a hospital barred a physician from performing surgeries. The Kentucky Court of Appeals held that the hospital was a private institution and, in the exercise of its reasonable discretion, had the right to exclude physicians from practicing in it. The court did note that the hospital had not acted for an arbitrary or capricious reason.

Similarly, in Levin v. Sinai Hospital of Baltimore City, the Maryland Court of Appeals focused on the public/private hospital distinction in affirming the dismissal of a physician's claim against a hospital for limiting his privileges. The court noted that the hospital's board had both the power to appoint and remove members of the medical staff and proclaimed that "[i]t has never been the policy of the State of Maryland to interfere with the power of the governing body of a private hospital to select its own medical staff."

In Natale v. Sisters of Mercy of Council Bluffs, the Iowa Supreme Court denied relief to a physician who had been a member of a private hospital medical staff for ten years but was expelled from the staff the day after he was divorced. The divorce trial was reported in "daily news articles under lurid head lines [sic], and also in radio broadcasts." The physician was removed from the staff because of the "scandalous divorce case," with no charges against him, no notice, no opportunity to appear or defend himself, and no hearing. In fact, he was not even given notice of his expulsion from the staff and discovered it from a lawyer friend. Even given these facts, the court held that the hospital was a private hospital entitled to conduct its affairs as it saw fit. The court also disregarded provisions of the medical staff bylaws affording procedural rights for expulsion from the staff, finding the bylaws were bylaws of

222. Id.
223. Id.
225. 158 S.W.2d 159 (Ky. 1942).
226. Hughes, 158 S.W.2d at 160.
227. Id. at 161-62.
228. Id. at 162.
229. 46 A.2d 298 (Md. 1946).
230. Levin, 46 A.2d at 300-01.
231. Id. at 303, 301.
232. 52 N.W.2d 701 (Iowa 1952).
233. Natale, 52 N.W.2d at 704.
234. Id. at 706.
235. Id. at 707.
236. Id.
237. Id. at 709.
the staff—not binding on the board. 238

3. Limitations to the Rule of Nonreview

But even these early cases recognized limits to the rule of nonreview. Van Campen noted that a court would intervene in a private hospital’s internal decisions “[t]o protect the property of a corporation . . . but only when corporate powers have been illegally or unconscientiously executed by the board of directors.” 239 State ex rel. Wolf pointed to the possibility of a breach of contract action for damages or specific performance. 240 Levin reaffirmed a court’s power to grant injunctive relief to a physician who was excluded from a hospital in violation of rights assured in the hospital’s own corporate bylaws and constitution. 241 Natale qualified its holding 242 by stating that the private hospital could act as it saw fit, “as long as its acts or omissions were not fraudulent, illegal, ultra vires, intentionally, negligently, or otherwise wrongfully injurious to another. In which event it would be liable as any other private corporation, so offending.” 243

A case falling within the parameters of the limitation to the rule of nonreview recognized in these cases is Stevens v. Emergency Hospital of Easton, Inc. 244 Stevens, after several years of practicing in the hospital, was denied the right to practice in the hospital. 245 Under the hospital’s constitution, the medical staff included the practitioners of medicine in good standing in the county where the hospital was located, and the hospital’s bylaws added some additional qualifications, all of which Stevens satisfied. 246 Several years after the founding of the hospital, a group of physicians attempted to amend the hospital’s constitution and bylaws in a manner that would allow them to exclude Stevens. 247 The court held that the amendments were ineffective because of a failure to follow the required notice procedures, and the court therefore enjoined the hospital from interfering with Steven’s right to practice at the

238. Natale, 52 N.W.2d at 709. See infra notes 414-25 and accompanying text for a discussion of the distinction between hospital bylaws and medical staff bylaws. For other early courts following the rule of nonreview see, e.g. Shulman v. Washington Hosp. Ctr., 222 F. Supp. 59, 63 (D.D.C. 1963) (embracing the rule of nonreview); Edson v. Griffin Hosp., 144 A.2d 341, 345 (Conn. Super. Ct. 1958) (recognizing general rule that hospitals, like corporations, have right to regulate affairs without interference); West Coast Hosp. Ass’n v. Hoare, 64 So. 2d 293, 297 (Fla. 1953) (determining non-profit corporation has right to manage own affairs).


240. State ex rel. Wolf, 193 N.W. 994, 996 (Wis. 1923).


242. Natale, 52 N.W.2d at 709.

243. Id.

244. 121 A. 475 (Md. 1923).

245. Stevens, 121 A. at 476.

246. Id. at 475-76.

247. Id. at 476-77.
As the law in this area developed, the limitation to the rule of nonreview became increasingly clear. Early cases like *Van Campen*, *Levin*, and *Natale* made no distinction between denial of an initial application for privileges by one not already on the medical staff (sometimes referred to as "exclusion") and revocation, limitation, or failure to renew privileges for existing medical staff members (sometimes referred to as "expulsion"). Each of those cases involved revocation or limitation of previously existing privileges. Later courts, however, have adopted what some courts have characterized as an "exception" to the general rule of nonreview applicable to cases involving limitation of existing staff membership or privileges. This refinement of the rule allows limited judicial review of a decision to revoke, suspend, restrict, or refuse to renew staff membership or clinical privileges in order to ensure that the hospital complied with the procedures set forth in its medical staff bylaws, and to determine whether the process afforded by the bylaws themselves afforded fair process. Under this approach, a private hospital's decision to deny staff membership to a new physician applying for staff membership is not subject to

248. *Id.* at 478-79. See also *Emergency Hosp. v. Stevens*, 126 A. 101, 103 (Md. 1924) (discussing injunction).


252. In *Glass v. Doctors Hospital Inc.*, 131 A.2d 254 (Md. 1957), the Maryland Supreme Court viewed refusal to renew privileges as an exclusion case rather than a dismissal case. *Id.* at 263. Consequently, the medical staff bylaws notice and hearing requirements, necessary for dismissal, did not apply. *Id.* The court held that the physician "was merely notified that his year to year privileges would not be renewed when they expired. In such case no notice, other than that given him, and no hearing are required." *Id.*


judicial review, but a decision affecting a physician's existing hospital staff membership or clinical privileges is subject to limited judicial review. This evolution of the rule is better viewed as resulting in two separate and distinct rules rather than a general rule and its exception. Characterization as a general rule and its exception is misleading because the exception—far from being the unusual or rare case—applies frequently.256

Permitting limited judicial review in cases involving a physician's existing staff or clinical privileges may be no more than application of the limitation intimated in the early cases. A physician who enjoys a preexisting relationship with the hospital and is a member of the hospital's medical staff may have certain contractual or other rights afforded by the hospital's and medical staff's internal rules which the courts will enforce.257 In Van Campen, the court relied in part upon the fact that no provision in the bylaws required a hearing prior to removal or suspension,258 possibly implying a different result if the bylaws did require such a hearing.259 Levin recognized: "In Maryland a court of equity may properly grant injunctive relief to protect a physician in his right to treat his own patients in a hospital where its constitution and by-laws accord him that right . . . ."260 In a 1963 case, Shulman v. Washington Hospital Center, 261 a federal district court, in dicta, also recognized the potential for review "in a case in which there is a failure to conform to procedural requirements set forth in [a hospital's] constitution, by-laws, or rules and regulations."262

The facts in these early cases, however, did not present the issue of whether the hospitals had violated their own medical staff bylaws, and the rule of nonreview prevailed. If that issue had been presented, the dicta implies a possibly different outcome. One problem with this suggestion is the distinction between a hospital's own corporate bylaws and the bylaws of its medical staff. Many courts consider a hospital's medical staff to be a separate, self-governing, legal entity, distinct from the hospital,263 and the hospital and the medical staff
have separate bylaws. It is unclear whether the bylaws referred to in Van Campen, Levin, and Shulman would have included the medical staff bylaws. Furthermore, the court in Natale held that the hospital medical staff was distinct from the hospital board and that the hospital board was not bound by the provisions of the medical staff bylaws.

Regardless of what the early decisions may have meant, recent decisions still applying the public/private hospital distinction generally do not review challenges to initial applications, but they do allow limited review of actions affecting existing privileges. At least one court refuses to review decisions affecting even existing privileges to determine compliance with bylaws.

Significantly, however, the limited review afforded by the rule does not foreclose statutory claims for otherwise improper conduct. For example, although a court may refuse to consider the merits of a credentialing decision, it will consider whether a decision violated a physician's civil rights or antitrust laws.

Vigorously adhering to the rule of nonreview, the Michigan Court of Appeals, in Long v. Chelsea Community Hospital explained:

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267. Natale v. Sisters of Mercy, 52 N.W.2d 701, 709 (Iowa 1952). See infra notes 413-47 and accompanying text for a discussion of the distinction between the hospital and medical staff and whether the medical staff bylaws should be binding on the hospital.


270. See Samuel, 201 F.3d at 834-35 (6th Cir. 2000) (considering discrimination and antitrust claims but finding no jurisdiction to consider tortious interference with contract claim); Menkowitz v. Pottstown Mem'l Med. Ctr., 154 F.3d 113, 121 (3d Cir. 1998) (stating physician may state claim under Americans with Disabilities Act); Muzquiz v. W.A. Foote Mem'l Hosp., Inc., 70 F.3d 422, 428-30 (6th Cir. 1995) (applying Michigan law and rejecting breach of contract claim but considering separately and rejecting on facts Title VII and antitrust theories); Ponca City Hosp. Inc. v. Murphree, 545 F.2d 738, 742 (Okla. 1976) (supporting judicial review of claims of race, sex, or age discrimination). Antitrust claims are often alleged in staff privileging cases, but they are rarely successful. See Furrow, supra note 116, at §§ 10-16, at 623 & nn.5-7, §§ 10-25 for a good general discussion of antitrust claims.

We decline to articulate a broad principle that a private hospital’s staffing decisions may never be judicially reviewed. Private hospitals do not have carte blanche to violate the public policy of our state as contained in its laws. Had plaintiff in this case asserted that defendants violated state or federal law, we may have chosen to review his claim.272

The Pennsylvania courts have held that the substance of a private hospital’s staffing decisions are not subject to judicial review where the remedy sought is an injunction to have the decision changed, but review is appropriate where the plaintiff seeks only damages under legitimate contract and tort theories.273 The rule of nonreview, then, is a misnomer and is instead a rule of limited review.

4. Movement Away from the Public/Private Distinction

Some commentators and courts have urged abandonment of the public/private distinction and its replacement with the equivalent of constitutional due process requirements on all hospitals, public and private.274 One commentator refers to the public/private distinction as “largely fictional” and “more historical than real.”275 Another commentator argues that the distinction between public and private hospitals “is slight” and does “not justify different judicial approaches.”276 She contends that, although private hospitals’ actions may not be state action in the constitutional sense, their actions should be subject to review on state common law grounds as a result of private hospital’s exercise of “quasi-governmental authority.”277 These commentators

272. Long, 557 N.W.2d at 161-62.
274. See Groseclose, supra note 92, at 14 (“A persuasive argument is thereby provided that the distinction between public and private hospitals is abolished and a physician cannot be denied access to either a public or private hospital without constitutional due process.”); Karen G. Seimetz, Note, Medical Staff Membership Decisions: Judicial Intervention, 1985 U. ILL. L. REV. 473, 483-84 (finding little difference between public and private hospitals and arguing impact of unfair staffing decision the same). See also Kiester v. Humana Hosp. Alaska, Inc., 843 P.2d 1219, 1223 n.2 (Alaska 1992) (noting trend affording judicial review so that no hospital, public or private, adopts rule that exclude arbitrary or capriciously); Storrs v. Lutheran Hosps. & Homes Soc’y, Inc., 609 P.2d 24, 28 (Alaska 1980) (holding private hospital “quasi-public” and must afford due process because it was only hospital serving community and enjoyed significant government funding); Brandt v. St. Vincent Infirmary, 701 S.W.2d 103, 107 (Ark. 1985) (Dudley, J., concurring) (arguing private hospital should be considered “quasi-public”); Mahmoodian v. United Hosp. Ctr., Inc., 404 S.E.2d 750, 752 (W. Va. 1991) (finding public/private dichotomy distracting from more significant issues; noting scope of judicial review essentially the same for both private and public hospitals); cf. Silver v. Castle Mem’l Hosp., 497 P.2d 564, 570 (Haw. 1972) (stating if fiduciary trust view accepted, public/private/quasi-public distinction “becomes meaningless”).
275. Groseclose, supra note 92, at 3-4.
276. Seimetz, supra note 274, at 483-84.
277. Id. at 501.
focus on the consequences adverse actions have on physicians, patients, and the public, an effect unchanged by the hospital’s status as public or private.

Of course, a focus on the immediate effect ignores the state action requirement of the Constitution. Whether a lawyer, a teacher, a secretary, or any employee’s employment is terminated by a state agency or a private entity, the result to the former employee is the same—she or he has lost a job. Indeed, the private corporation may have acted without due process or arbitrarily, but, as the Supreme Court has held, the Constitution does not provide a remedy for every private wrong. Courts should not rush past fundamental constitutional requirements to obtain a result.

But the absence of a constitutional remedy does not mean there is no other basis for a remedy, and in fact many courts have moved away from the public/private hospital dichotomy. Some courts rely on a contract theory. Other courts use common law and public policy theories to impose more extensive judicial review. Still other courts look to state statutes that impose new limits on hospitals’ staffing decisions and define the scope of judicial review.

B. Breach of Contract—It’s in the Bylaws

1. Medical Staff Bylaws are a Contract Under Majority Rule

Courts increasingly have relied on a contract theory to allow limited judicial review of hospital credentialing and peer review decisions. Under this view, medical staff bylaws constitute a contract between a physician who enjoys medical staff privileges and the hospital. If the hospital takes action affecting the physician’s privileges without following the procedures or requirements outlined by the bylaws, the hospital has breached its contract. This theory is often cited as the basis for reviewing private hospitals’ actions affecting existing privileges. In the view of some courts, the theory is limited by the

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279. See infra Part III.A.4 for a discussion of courts rejecting public/private distinction.

280. See infra Part III.B for a discussion of courts using a contract theory to reject the public/private distinction.

281. See infra Part III.C for a discussion of courts’ use of common law and public policy theories to impose more extensive judicial review.

282. See infra Part III.D for a discussion of courts’ use of state statutes to define the scope of judicial review.

283. See infra Part III.B.1 for a discussion of view that medical staff bylaws constitute a contract between a physician and the hospital.

284. See infra Part III.B.1 for a discussion of courts’ view that bylaws create an enforceable contract between a physician and a hospital.

exclusion/expulsion distinction noted above,286 and therefore, may not assist a physician without a current relationship with the hospital who is applying for privileges. In the view of these courts, until the physician becomes a member of the medical staff, he or she has no contractual relationship with the hospital and no contract rights under the bylaws.287

A large majority of courts that have considered the question have held that a hospital’s medical staff bylaws are a binding contract between the hospital and its medical staff members.288 Some courts have taken a more limited position bylaws).

286. See supra note 256 and accompanying text for a discussion of the exclusion/expulsion distinction.

287. See Bello v. South Shore Hosp., 429 N.E.2d 1011, 1016 (Mass. 1981) (stating physician applicant had no standing to challenge compliance with bylaws); Groseclose, supra note 92, at 25-26 & n.169 (discussing nature of physician’s relationship with hospital). But see infra note 346-64 and accompanying text for argument that applicants should have contractual rights.

and find that the medical staff bylaws alone are not a contract, but, in the context of the entire relationship between the physicians and the hospital, they are enforceable as part of a larger contractual relationship. A minority of courts have declared that medical staff bylaws are not an enforceable contract. Like contractual due process rights; Brinton v. IHC Hosps., Inc., 973 P.2d 956, 966 (Utah 1998) (discussing contractual obligations under bylaws); Rees v. Intermountain Health Care, Inc., 808 P.2d 1069, 1076-77 (Utah 1991) (stating bylaws are “in essence, a contract between the hospital and physician”); Houston v. Intermountain Health Care, Inc., 933 P.2d 403, 408 (Utah Ct. App. 1997) (agreeing bylaws create contract between hospital and physician); Mahmoodian v. United Hosp. Ctr., Inc., 404 S.E.2d 750, 755 (W. Va. 1991) (under breach of contract principles, hospital must follow medical staff bylaws); Bass v. Ambrosius, 520 N.W.2d 625, 627-29 (Wis. Ct. App. 1994) (discussing how bylaws create contract).

See also Clemons v. Fairview Med. Ctr., Inc., 449 So. 2d 788, 790 (Ala. 1984) (breach of contract claim based on violation of medical staff bylaws upheld); Balkissoon v. Capitol Hill Hosp., 558 A.2d 304, 308 (D.C. Cir. 1989) (bylaws may create contractual rights); Clough v. Adventist Health Sys., Inc., 780 P.2d 627, 632 (N.M. 1989) (accepting district court’s holding and parties’ assumption that bylaws created implied contract). Several courts have faced the issue but have not decided it. See Even v. Longmont United Hosp. Ass’n, 629 P.2d 1100, 1103 ( Colo. Ct. App. 1981) (assuming arguendo that bylaws were contract); Duby v. Jordan Hosp., 341 N.E.2d 876, 879 (Mass. 1976) (assuming without deciding that bylaws give rise to contract); Wong v. Stripling, 700 So. 2d 296, 300-02 (Miss. 1997) (dissing breach of contract claim based on violation of bylaws on collateral estoppel grounds); Gelbard v. Genesee Hosp., 664 N.E.2d 1240, 1242 (N.Y. 1996) (expressing that question would not be reached until plaintiff exhausted administrative remedies); Bouquet v. St. Elizabeth Corp., 538 N.E.2d 113, 115-16 (Ohio 1989) (assuming without deciding that bylaws binding contract); Panca City Hosp., Inc. v. Murphee, 545 P.2d 738, 742 (Okla. 1976) (acknowledging the “bylaws create contract” issue but failing to address it because plaintiff brought suit in equity seeking injunction); Medical Ctr. Hosps. v. Terzis, 367 S.E.2d 728, 729 (Va. 1988) (assuming but expressly not deciding the issue of whether bylaws constitute contracts).


the Iowa Supreme Court in *Natale v. Sisters of Mercy of Council Bluffs*, 291 a few courts have distinguished between the hospital's own bylaws and the medical staff's bylaws, holding the former contractually binding on the hospital but not the latter. 292

Two early cases adopting the view that medical staff bylaws give rise to a contractual relationship are *Joseph v. Passaic Hospital Association* 293 and *Berberian v. Lancaster Osteopathic Hospital Association Inc.* 294 In *Joseph*, a hospital refused to reappoint a physician to the medical staff and refused to afford him a hearing. 295 The physician complained that the hospital acted in violation of its medical staff bylaws by failing to provide him a hearing and by acting with malice. 296 The court, without analysis on the contract issue, concluded that the physician stated a cause of action "arising out of a breach of a contract between plaintiff and the hospital set out in its constitution and the by-laws of the medical staff." 297 In *Berberian*, a physician's medical staff privileges were terminated without notice and without opportunity for a hearing, both allegedly in violation of the medical staff bylaws. 298 The Pennsylvania Supreme Court held:

While there can be no doubt that the board of directors of the hospital has authority to deprive a physician of the privileges of the staff, it is equally clear that the board has agreed to follow certain specified procedures before determining whether to exercise its authority in a matter of a staff member's expulsion from the hospital . . . . When the board of directors approved the staff by-laws, they became an integral part of the contractual relation between the hospital and the members of its staff. 299

291. 52 N.W.2d 701 (Iowa 1952).
296. Id. at 698.
297. Id. at 700.
299. Id. at 458-59. *See also* id. at 459 (physician and hospital had "entered into a contract
This majority view is consistent with general corporate law which holds that corporate bylaws are contracts between the corporation and its shareholders.300 Courts finding the existence of a contract have been influenced by concern that if the bylaws were not enforceable, they would be rendered essentially meaningless.301 One court, borrowing from Shakespeare, stated that failure to find bylaws enforceable in contract would render them merely hortatory—"much 'sound and fury, signifying nothing.'"302 On the other hand, those courts questioning whether the bylaws are a contract usually resort to the traditional elements for an enforceable contract and find one or more elements missing.303

2. Defining a Contract

A contract broadly defined is "a promise or a set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty."304 Professor Joseph M. Perillo, in Corbin on Contracts, prefers the Uniform Commercial Code's definition of a contract: "the total legal obligation which results from the bargain of the parties in fact as found in their language or by implication from other circumstances, as affected by rules of law."305 Neither definition, however, identifies the facts necessary for

whereof the provisions of the staff by-laws, as approved by the hospital's board of directors, constitute the legally binding terms"). But see id. at 461 (Bell, J., dissenting) (stating that staff bylaws not binding on board).


301. See infra note 302 and accompanying text for a discussion of the reasoning of courts that have found bylaws rendered meaningless if not enforceable.

302. Bass v. Ambrosius, 520 N.W. 625, 627 (Wis. Ct. App. 1994) (quoting Willaim Shakespeare, Macbeth, act V, scene v, lines 27-28). See also Lewisburg Cmty. Hosp. v. Alfredson, 805 S.W.2d 756, 759 (Tenn. 1991) (stating that "to suggest that the hospital has no legal duty to follow its own bylaws would be to reduce the bylaws to meaningless mouthing of words"); Bouquett v. St. Elizabeth Corp., 538 N.E.2d 113, 115 (Ohio 1989) (stating "cases holding that a hospital is bound by its staff bylaws base their decisions on the reasoning that if the hospital is not bound by the bylaws, then essentially the bylaws would be meaningless") (quoting Munoz v. Flower Hosp., 507 N.E.2d 360, 364 (Ohio Ct. App. 1985)).


304. RESTATEMENT (SECOND) OF CONTRACTS § 1 (1981); accord, e.g., Cook v. Cook, 691 P.2d 664, 667 (Ariz. 1984) (stating "sine qua non of any contract is the exchange of promises"); Atwood v. Western Constr., Inc., 923 P.2d 479, 483 (Idaho Ct. App. 1996) (defining contract as "a promise or set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty"); Cederstrand v. Lutheran Bhd., 117 N.W.2d 213, 219 (Minn. 1962) (stating "a contract is a legally enforceable promise"); Fitzpatrick v. Vermont State Treasurer, 475 A.2d 1074, 1077 (Vt. 1984) (defining special contract as "one with peculiar provisions or stipulations not found in the ordinary contract relating to the same subject matter, and which, if omitted, the law will not supply") (citations omitted).

a court to find enforceable rights and duties, and both obviously call for legal conclusions about what the law will enforce.

Speaking very generally, the typical contract requires: (1) parties with capacity to contract, (2) proper subject matter, (3) consideration, (4) a bargain, and (5) manifestation of mutual assent. The manifestation of mutual assent may be demonstrated by an offer and acceptance. The ultimate goal of the law of contracts is “the realization of reasonable expectations that have been induced by the making of a promise.”

Concerning the requirement of parties with the capacity to contract, the possible parties to the alleged contract are the hospital, the hospital’s medical staff, or both, on one side, and the physician on the other. Beyond question, the physician as an individual and the hospital as a business entity have capacity to enter contracts. The medical staff, too, as an unincorporated organization or association of physicians is capable of forming a contract with its individual

306. The authorities are quick to point out that not all enforceable contracts satisfy these requirements. For example, the RESTATEMENT (SECOND) ON CONTRACTS recognizes a special category of contracts, “formal contracts,” that may be formed without a bargain, manifestation of assent, or consideration. RESTATEMENT (SECOND) OF CONTRACTS §§ 6, 17 & cmt. a (1981). Even some “atypical” “informal” contracts are binding even though they are not part of a bargain. See id. § 17 cmt. e.


The RESTATEMENT (SECOND) OF CONTRACTS and other authorities specifically reject the requirement of “mutuality of obligation.” See RESTATEMENT (SECOND) OF CONTRACTS § 79(c) & cmt. f (1981) (concluding that if requirement of consideration met, no need for mutuality of obligation); 2 JOSEPH M. PERILLO & HELEN HADJYANNAKIS BENDER, CORBIN ON CONTRACTS § 6.1, at 197 (rev. ed. 1995) (stating “requirement of mutuality of obligation is now widely discredited”).


309. 1 PERILLO, supra note 305, § 1.1, at 2.
members. Concerning the second requirement, the medical staff bylaws do address a lawful and proper subject matter. They identify the medical staff's purpose; set standards and procedures for admission and reappointment to the medical staff; define rights of various categories of medical staff membership; create an organizational structure; assign responsibilities within the structure; and establish procedures for corrective action, hearings, and appellate review. The subject matter is not only proper but mandated by state law.

3. The Problem of Consideration

a. Consideration in the Bylaws Themselves

The other three elements—consideration, bargain, and mutual assent—have caused some difficulty in the context of medical staff bylaws. The most frequently identified ground for finding no contract is a perceived lack of consideration. A few courts reason that, because the hospital is required by state law to adopt medical staff bylaws and, in some instances, even to have a particular minimum content, the rights provided for in the bylaws cannot legally constitute valid consideration. As one court explained:

The bylaws cannot be considered a contract per se because there is no mutual exchange of consideration which brought them into existence. The Hospital had the previous obligation to create those bylaws and to develop a procedure for reviewing a doctor's competency. Consequently, because the hospital had the legal duty to develop the bylaws and the procedures therein independently of its association with [the physician], no consideration could have been given for their creation, and . . . without consideration, there cannot be a contract.

310. See RESTATEMENT (SECOND) OF CONTRACTS § 11 illus. 1 (1981) (illustrating the following example: "A becomes a member of an unincorporated society, and by so doing promises to pay dues to the society. He is bound by a contract."). See also infra notes 414-25 and accompanying text for a discussion of the nature of the medical staff as an entity.


313. See infra note 315-21 and accompanying text for a discussion of the view that bylaws cannot constitute valid consideration.

The Connecticut Supreme Court, in *Gianetti v. Norwalk Hospital*, went a step further noting that the hospital not only had a legal duty to adopt the bylaws but also had a legal duty to abide by them. According to the court, “[i]f the department of health had not intended that the hospital abide by its medical staff bylaws, then the requirement that it enact such bylaws would be superfluous.” The court concluded that a hospital’s agreement to abide by the bylaws could not per se constitute valid consideration.

Not only does state law require medical staff bylaws, but the hospital accrediting body, the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”), also requires medical staff bylaws and to some extent defines their content. Similarly, federal regulations governing hospitals participating in Medicare and Medicaid require adoption and enforcement of medical staff bylaws. A promise to do that which one already has a preexisting legal duty to do is not consideration. Therefore, because the hospital had a preexisting legal duty to adopt and follow its medical staff bylaws, the physician received no additional benefit from the hospital’s assurances or promises in the bylaws.

Consider the irony: a physician attempting to enforce the provisions of the bylaws in a contract action (whether through damages or injunctive relief) is barred because the provisions the physician is trying to enforce did not confer any added benefit to the physician. The physician cannot enforce the provisions because they were already required by law. This result turns contract law on its head because the person who allegedly received no benefit cannot enforce the agreement against the party who received benefit but purportedly gave nothing. Unfortunately, the physician has no claim under the state statutes requiring the bylaws either because the hospital did in fact have bylaws and, moreover, the statutes are regulatory in nature and typically do not confer private causes of action.

A fuller understanding of the preexisting legal duty contract doctrine suggests a different outcome. The purpose of this doctrine is to prevent the enforcement of promises “obtained by an express or implied threat to withhold performance of a legal duty,” because such promises do “not have the
presumptive social utility normally found in a bargain."\textsuperscript{323} These concerns are not served by refusing to enforce the bylaws in a contract action. The doctrine as set forth in the Restatement (Second) of Contracts is:

Performance of a legal duty owed to a promisor which is neither doubtful nor the subject of honest dispute is not consideration; but a similar performance is consideration if it differs from what was required by the duty in a way which reflects more than a pretense of bargain.\textsuperscript{324}

Although state law, JCAHO standards, and federal regulations may require adoption of medical staff bylaws, their precise form and content are left largely to the hospital and its medical staff.\textsuperscript{325} For example, Arizona state regulations merely require the medical staff to adopt bylaws and delineate in the bylaws eligibility requirements for medical staff membership and "state the type, purpose, composition and organization of standing committees."\textsuperscript{326}

The hospital and its medical staff, by their choice of particular procedures and methods to satisfy these legal requirements, exercise their discretion. Many of the specific provisions in the bylaws admittedly satisfy the legal requirements, but their specific details are not required. Hence, the promises may differ from what was required by the duty thereby constituting consideration. Nothing in these regulations prevents hospitals from agreeing to create rights enforceable in favor of physicians.\textsuperscript{327} Therefore, bylaws which exceed the minimum standards required under state law satisfy the consideration requirement.\textsuperscript{328}

\textit{b. Consideration Beyond Promises in the Bylaws}

Some courts look beyond the bylaws themselves to find consideration from the hospital to the physician. This approach considers all the circumstances of

\textsuperscript{323} RESTATEMENT (SECOND) OF CONTRACTS § 73 cmt. a, at 180 (1981).
\textsuperscript{324} Id. § 73.
\textsuperscript{325} See Bass v. Ambrosius, 520 N.W.2d 625, 628 n.8 (Wis. Ct. App. 1994) (explaining that statute fails to specify any particular procedure).
\textsuperscript{326} ARIZ. ADMIN. CODE R9-10-214 (West, WESTLAW through Dec. 31, 1999). See also CONN. AGENCIES REGS. § 19-13-D3(b)(c) (West, WESTLAW through June 27, 2000) (establishing that "governing board" will manage hospital, adopt bylaws, annually designate medical staff, select hospital administrator, and create "joint conference committees"); CONN. AGENCIES REGS. § 19-13-D3(c) (West, WESTLAW through Aug. 10, 1999) (outlining structure of medical staff and requiring medical staff bylaws include procedures for administration of privileges awarded to medical staff members); ILL. ADMIN. CODE tit. 77, § 250.310 (West, WESTLAW through Aug. 25, 2000) (mandating medical staff organize according to "bylaws, rules and regulations approved by governing Board"); KAN. ADMIN. REGS. 28-34-6a(e) (West, WESTLAW through Jan. 1, 1999) (ordering medical staff to adopt bylaws, rules, and regulations to be approved by the governing board, which must delineate "the organizational structure of the medical staff," peer review procedures, and structure and purpose of standing committee). For federal Medicare and Medicaid participants, the requirements are identified in 42 C.F.R. § 482.22(c) (1998).
\textsuperscript{327} State hospital licensing requirements are regulatory in nature and typically do not create private causes of action.
the hospital/physician relationship to determine whether a contract exists which includes rights under the bylaws. 329 Viewed in this way, when a hospital asks a physician to agree in writing to be bound by the bylaws, the physician agrees, and the hospital extends privileges to the physician, an exchange of promises occurs. 330 When a physician requests privileges and a hospital extends the requested privileges, each party receives a benefit which exceeds the hospital's preexisting duty to adopt bylaws. 331 After all, the hospital has no duty to extend privileges to a particular physician. 332 With the extension of privileges, the physician is entitled to treat patients at the hospital and utilize hospital facilities; the hospital, on the other hand, receives the opportunity to provide services to the physician's patients. 333 The rights in the bylaws are then part of the hospital's commitment to the physician. 334 In the end, the consideration received by the physician to support the contract is the grant of staff privileges. 335

c. The Physician's Consideration

In Do Hospital Medical Staff Bylaws Create a Contract, 336 authors John Hulston, Donald Jones, and Timothy Gammon take a different view of consideration and argue that the physician provides no consideration to make


330. See Gianetti, 557 A.2d at 1254 (stating that after extending privileges, hospital has "done something it was not already bound to do"); Virmani, 488 S.E.2d at 288 (holding bylaws integral part of contract).

331. See Gianetti, 557 A.2d at 1254 (stating that extension of privileges equates to additional consideration); Virmani, 488 S.E.2d at 288 (finding mutual assent to include bylaws as part of contract).

332. See Gianetti, 557 A.2d at 1254 (finding no duty to extend privileges); Virmani, 488 S.E.2d at 288 (stating offer to practice medicine by hospital exceeds statutory duty).

333. See Virmani, 488 S.E.2d at 288 (noting that "the hospital receives the benefit of providing care to the physician's patients").

334. See id. at 288 (holding that "valid and enforceable contract existed . . . and . . . the Bylaws were an integral part of that contract").

335. See Gianetti, 557 A.2d at 1254-55 (finding consideration in privilege to practice medicine in hospital). See also Owens v. New Britain Gen. Hosp., 643 A.2d 233, 239-40 & n.25 (Conn. 1994) (recognizing Gianetti's holding that extension of medical staff privileges in return for agreement to abide by bylaws constituted valid consideration); Virmani, 488 S.E.2d at 287-88 (finding contract exists where parties agree to staff privileges). In Robles v. Humana Hosp. Cartersville, 785 F. Supp. 989 (N.D. Ga. 1992), the Northern District of Georgia acknowledged but rejected this possible basis for consideration by stating: "This mutually beneficial relationship, however, goes to the arrangement between the two parties, not to whether the bylaws, per se, are a contract as Plaintiff claims. Whether the bylaws per se constitute a contract is a wholly different question." Robles, 785 F. Supp. at 1001 n.10. The rationale behind this statement is obscure. Perhaps, the court merely echoes Gianetti where the court held that bylaws alone did not constitute a contract. See Gianetti, 557 A.2d at 1254. But Gianetti, which Robles relied upon, agreed that in the context of the totality of the hospital/physician relationship the bylaws were enforceable as part of the whole contractual relationship, a conclusion Robles does not consider. See id. at 1255.

the bylaws a binding contract:

What consideration can a . . . physician claim to have given, or undertaken, to make any statement in the bylaws binding as a contract? Nothing. Normally, the physician does not agree to provide a service for the hospital, does not agree to give the hospital any certain number of patients and has no contractual commitments to the hospital. Physicians should not be able to claim the hospital has any commitment to them . . . .337

To the extent that this view focuses on the lack of "mutuality of obligation"338 as a requirement distinct from consideration,339 the approach is misguided. According to the Restatement (Second) of Contracts, "[i]f the requirement of consideration is met, there is no additional requirement of . . . mutuality of obligation."340 It is true, however, that an illusory promise—a promise, the performance of which is entirely optional upon the promisor—is not consideration.341 But even an illusory promise may become valid consideration when it is actually performed.342 The employment law context provides a close analogy. Where an employer promises "job security through restrictions on the power to terminate the employment, the employee's services provide consideration for a unilateral contract."343 Since the bylaws restrict the hospital's power to limit privileges, once the physician admits a patient to the hospital, treats patients at the hospital, or otherwise uses the hospital's facilities,

337. Id. at 354.


341. See RESTATEMENT (SECOND) OF CONTRACTS § 77 cmt. a (1981). See also id. § 2 cmt. e (explaining illusory promises).

342. See 1 PERILLO, supra note 305, § 1.17 at 49 (stating performance of illusory promise equates to consideration).

the physician provides consideration through actual performance.

However, even without actual utilization of the hospital, the physician already has provided consideration. A physician is bound by any promises in the bylaws even if the physician is not required to maintain a practice at the hospital, refer any patients to the hospital, or continue an existing practice at the hospital. Normally, a physician at the application stage must agree to be bound by the terms of the medical staff bylaws as a condition for staff membership—regardless of whether the physician actually admits a single patient to the hospital or uses its facilities. Consideration exists because the bylaws require the physician to act in a specific way and forego certain rights.

The very fact that hospitals uniformly require physicians to agree in writing “to abide by the medical staff bylaws” and to “be bound by the terms thereof” is a clear indication the hospitals believe the bylaws contain promises or performance of the physicians. These promises typically include: (1) grant

344. See Terre Haute Reg’l Hosp., Inc. v. El-Issa, 470 N.E.2d 1371, 1377 (Ind. Ct. App. 1984) (stating “the doctrine of mutuality of obligation does not require that every duty within an agreement be based upon a corresponding obligation”).

345. See, e.g., Webman v. Little Co. of Mary Hosp., 46 Cal. Rptr. 2d 90, 96 (Cal. Ct. App. 1995) (stating that applicants, by signing application, agree to abide by bylaws); Gianetti v. Norwalk Hosp., 557 A.2d 1249, 1250 (Conn. 1989) (stating physician agreed in writing to abide by bylaws); Babcock v. St. Francis Med. Ctr., 543 N.W.2d 749, 760 (Neb. Ct. App. 1996) (stating bylaws require all applicants agree to be bound by them); Virmani v. Presbyterian Health Servs. Corp., 488 S.E.2d 284, 288 (N.C. Ct. App. 1997) (stating that under bylaws provision, physician agreed to be bound by them); Rees v. Intermountain Health Care, Inc., 808 P.2d 1069, 1076 (Utah 1991) (finding “[h]ospitals generally will not grant a doctor privileges at the hospital until the doctor agrees to abide by the bylaws of the hospital.”); Bass v. Ambrosius, 520 N.W.2d 625, 628 (Wis. Ct. App. 1994) (observing that physician must agree to bylaws in signed application). See also Sullivan v. Baptist Mem'l Hosp.—Golden Triangle, Inc., 722 So. 2d 675, 677 (Miss. 1998) (stating that in reappointment application physicians agreed to be bound by bylaws). JCAH's Guidelines for the Formulation of Medical Staff Bylaws 1971 includes a bylaws provision requiring that “[e]very application for staff appointment shall be signed by the applicant and shall contain the applicant’s specific acknowledgment of every medical staff member’s obligations... to abide by the medical staff bylaws, rules and regulations... .” JCAH GUIDELINES FOR BYLAWS, supra note 92, at 8. The guidelines also provided for a provision stating that:

The application form shall include a statement that the applicant has received and read the bylaws of the hospital governing body and the bylaws, rules and regulations of the medical staff and that he agrees to be bound by the terms thereof if he is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he is granted membership and/or clinical privileges in all matters relating to consideration of his application.

Id. at 12 (non-departmental hospitals); accord, e.g., HCWP Model Bylaws, supra note 92, at 4.4-9(c)(1); UTMB Bylaws, supra note 92, at § 2.3.1. State law may also require medical staff members to agree to be bound by the bylaws. See, e.g., Mo. STAT. ANN. §§ 205.195(1), 206.105(1) (1996) (requiring every physician, podiatrist, and dentist applying for staff membership to “give specifically” his or her “willingness to abide by the bylaws of the board and the staff in all respects... .”)

346. JCAH GUIDELINES FOR BYLAWS, supra note 92, at 8.

347. Id. at 12; accord HCWP Model Bylaws, supra note 92, at 4.4-9(c)(1); UTMB Bylaws, supra note 92, at § 2.3.1.

of broad releases and immunities from liability (with specified limitations) to the
goal, its medical staff, and others, in connection with evaluation of the
application or reapplication and as part of other peer review activities;\(^\text{349}\) (2)
agreement to attend medical staff meetings;\(^\text{350}\) (3) authorization for the hospital
to consult with other medical staffs with which the applicant has been associated,
and consent to inspection of records and documents necessary for the
evaluation;\(^\text{351}\) (4) a physician against whom adverse recommendation or decision
has been rendered waives rights to a hearing or appellate review by failing to
request them within the time limits identified in the bylaw;\(^\text{352}\) (5) a physician may
waive issues not raised during the original hearing;\(^\text{353}\) (6) the applicant has the
burden of producing information for evaluation of the application and resolving
doubts about qualifications;\(^\text{354}\) (7) the applicant has the burden of establishing his
or her qualifications and competency for the clinical privileges requested;\(^\text{355}\) (8)
agreement to “strictly abide by the Principles of Medical Ethics of the American
Medical Association”;\(^\text{356}\) and (9) participate in the hospital’s quality assurance
programs.\(^\text{357}\) These promises alone are consideration to support a contract.\(^\text{358}\)

Under this analysis, contract rights extend to applicants seeking staff
membership as well as to those physicians who already have existing privileges.
When, as part of the application process, the applicant agrees “to be bound by
the terms [of the bylaws] without regard to whether or not he is granted
membership and/or clinical privileges in all matters relating to consideration of
his application,”\(^\text{359}\) he or she has given consideration.

d. Consideration Not Bargained For

The lack of any bargaining or negotiation between a hospital and a
physician over the terms in the bylaws also influences courts that refuse to

\(^\text{349}\) See JCAH GUIDELINES FOR BYLAWS, supra note 92, at 11 (discussing importance of
immunity from liability).
\(^\text{350}\) See id. at 8, 47 (mandating attendance of staff meetings).
\(^\text{351}\) See id. at 11 (authorizing background checks).
\(^\text{352}\) See id. at 22 (requiring compliance with hearing or review procedures).
\(^\text{353}\) See id. at 28 (failing to raise issues at original hearing equates to a waiver).
\(^\text{354}\) See JCAH GUIDELINES FOR BYLAWS, supra note 92, at 11 (explaining applicant's burden).
\(^\text{355}\) See id. at 15 (explaining applicant must evidence his qualifications).
\(^\text{356}\) Id. at 7.
1984) (noting physician's requirement to “participate in the operation of the Medical and Dental
Staff” by, inter alia, participating in quality assurance programs).
\(^\text{358}\) See also id. (stating bylaws required physician to attend various meetings, serve on
committee and in staff positions, participate in quality assurance programs, participate in on-call
(noting physician's consideration and duties under bylaws). For examples of bylaws, see Presbyterian
Hosp. Bylaws, supra note 92; Yale-New Haven Hosp. Bylaws, supra note 92; HCWP Model Bylaws,
supra note 92; UTMB Bylaws, supra note 92; OHSU Bylaws, supra note 311.
\(^\text{359}\) JCAH GUIDELINES FOR BYLAWS, supra note 92, at 12. See also JCAHO MANUAL, supra
note 1, at MS-32 (“applicant... is informed of existing bylaws, rules and regulations, and policies
regarding the application process and agrees, in writing, that he or she will be bound by them”).
recognize the bylaws as a contract.\textsuperscript{360} They reason that the bylaws are not a contract is because a physician has no input in the bylaws and no power to change their terms.\textsuperscript{361} Under the Restatement (Second) of Contracts, consideration is a performance or a return promise which "must be bargained for."\textsuperscript{362} This bargaining requirement, however, does not require that the parties engage in actual negotiations over the terms. If that were true, any form contract would be invalid.\textsuperscript{363} It should be sufficient that the hospital makes promises in the bylaws and promises to consider a physician's application in exchange for the physician's promise to be bound by the bylaws. This exchange of promises is then bargained for and satisfies the consideration requirement; one promise is the inducement for the other.\textsuperscript{364} If the physician refuses to be bound, the hospital refuses to extend privileges. Likewise, if the physician disagrees with the provisions in the bylaws, the physician can walk away and not pursue staff membership there.

Furthermore, the physician who is a member of the medical staff (as contrasted with an initial applicant) actually does have the opportunity to influence the content of the medical staff bylaws. Members of the medical staff compile and adopt the bylaws.\textsuperscript{365} Thus, individual physicians have the opportunity to vote for or against the bylaws or any changes to them. Although the hospital governing board must approve the bylaws,\textsuperscript{366} it does not unilaterally

\textsuperscript{360} See supra Part III.B.4.a for additional discussion of the reasoning of courts that have refused to recognize bylaws as contracts.

\textsuperscript{361} See Robles v. Humana Hosp. Cartersville, 785 F. Supp. 989, 1002 (N.D. Ga. 1992) (reasoning plaintiff had no input into or power to change bylaws); Gianetti v. Norwalk Hosp., 557 A.2d 1249, 1254 (Conn. 1989) (finding plaintiff made no claim he had input into bylaws); Zipper v. Health Midwest, 978 S.W.2d 398, 416 (Mo. Ct. App. 1998) (stating no bargained for exchange because doctor did not have input or power to change bylaws).


\textsuperscript{363} In the area of insurance for example, insurance policies are considered to be contracts notwithstanding the lack of bargaining power or negotiation over specific terms in the policy. See Tackett v. State Farm Fire & Cas. Ins. Co., 653 A.2d 254, 264 (Del. 1995) (agreeing with jurisdictions that insurance disputes are subject to constructual analysis); Collier v. MD—Individual Practice Ass'n, 607 A.2d 537, 539 (Md. 1992) (stating in Maryland, insurance policies are construed like contracts); Dairyland Ins. Co. v. Douthat, 449 S.E.2d 799, 801 (Va. 1994) (observing that insurance policies are contracts to be construed under general contract principles).

\textsuperscript{364} RESTATEMENT (SECOND) OF CONTRACTS § 71 cmt. b (1981).

\textsuperscript{365} See JCAHO MANUAL, supra note 1, MS.2, at MS.3 ("Each medical staff develops and adopts bylaws and rules and regulations to establish a framework for self-governance of medical staff activities and accountability to the governing body."); MACEACHERN, supra note 8, at 165 (stating bylaws compiled by committee, then adopted by whole staff). See also, e.g., Mo. ANN. STAT. §§ 205.195 (2), 206.105 (2) (West 1996) (providing for professional staff to initiate and adopt bylaws and rules); ARIZ. ADMIN. CODE R9-10-214 (D) (West, WESTLAW through Aug. 31, 1999) (stating that medical staff shall adopt bylaws); KAN. ADMIN. REGS. 28-34-6a(b) (West, WESTLAW through Jan. 1, 1999) (same).

\textsuperscript{366} For examples of statutes requiring bylaws to be adopting by a governing body, see, FLA. ADMIN. CODE ANN. r. 59A-3.220(1) (West, WESTLAW through Aug. 1, 2000) (stating that medical staff bylaws must be "approved by the governing body"); ILL. ADMIN. CODE tit. 77, § 250.310(a) (West, WESTLAW through Aug. 25, 2000) (requiring governing body approve medical staff bylaws). See also 42 C.F.R. § 482.22(c)(1) (1999); JCAHO MANUAL, supra note 1, MS.2.1, at MS.3.
impose the medical staff bylaws on the medical staff because both the hospital and the medical staff must approve any changes to them.367

In *Saint John's Hospital Medical Staff v. Saint John Regional Medical Center, Inc.*,368 a hospital medical staff brought an action against a hospital to obtain a declaration invalidating unilaterally imposed medical staff bylaws.369 Upon construction of the hospital in 1947, the hospital proposed medical staff bylaws based on an existing model.370 Both the medical staff and the hospital adopted the proposed bylaws.371 Under the adopted bylaws, any amendments required medical staff approval by a two-thirds majority vote.372 In 1972, the hospital attempted to make changes to the bylaws, but the medical staff refused.373 Thereafter, the hospital unilaterally adopted new medical staff bylaws.374 The Supreme Court of South Dakota held that the unilaterally-adopted bylaws were “null and void,” and it concluded that any changes had to be approved by the medical staff in compliance with the two-thirds majority requirement in the original bylaws.375

Some authorities appear to suggest that a hospital may unilaterally change the medical staff bylaws,376 but these authorities must be considered in context and reviewed critically. Some of the cases may be referring to the hospital broadly, grouping together the actions of both the hospital board and the medical staff.377 Some cases fail to distinguish hospital bylaws from medical staff bylaws,378 merely cite unanalyzed arguments by litigants,379 or are factually suspect in view of state law and accreditation requirements.380 Ultimately, the

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367. See JCAHO MANUAL, supra note 1, M.S.2.1, at MS-3 for requirements necessary to adopt bylaws, rules, and regulations.
368. 245 N.W.2d 472 (S.D. 1976).
369. St. John’s, 245 N.W.2d at 473.
370. Id.
371. Id.
372. Id.
373. Id. at 473-74.
374. St. John’s, 245 N.W.2d at 474.
375. Id. at 475.
376. See, e.g., Groseclose, supra note 92, at 27-28 (“The authority to adopt bylaws, like the authority for a corporation to come into existence, is statutory. Typically, that authority is unilaterally vested in the governing board. Hence the terms of the contract will be what one party says they are.”).
380. See Zipper v. Health Midwest, 978 S.W.2d 398, 416-17 (Mo. Ct. App. 1998) (finding that hospital “had the right to unilaterally change the procedures set forth in the bylaws without consultation with anyone on the medical staff and to impose those bylaws on its medical staff”). The court cited no bylaw provisions supporting this conclusion. Possibly, the court referred to the hospital’s own corporate bylaws rather than the medical staff bylaws. However, the court cited and relied on cases involving medical staff bylaws. See id. at 416 (citing Gianetti, 557 A.2d at 1256;
bylaws are not unilaterally imposed because of both the medical staff’s participation and the physician’s choice to reject medical staff bylaws altogether by leaving the medical staff or declining to join.381

e. Estoppel as a Consideration Substitute

The bylaws also should be enforceable in the absence of consideration under a theory of promissory estoppel. This theory may be invoked to enforce gratuitous promises which are not supported by consideration but which otherwise would constitute a contract.382 The reliance element of promissory estoppel may be viewed as supplying the necessary consideration383 or as a consideration “substitute.”384

The touchstones of promissory estoppel are reliance by the promisee and resulting hardship. The elements of promissory estoppel are often identified as: (1) a promise; (2) reliance by the promisee; (3) the reliance must be of a definite and substantial character; (4) the promisor should reasonably have anticipated the reliance; and (5) enforcement of the promise is necessary to avoid injustice.385

The staff bylaws set forth appointment procedures, rights to notice of charges and proposed action, hearings, opportunity to present evidence, opportunity for appeal, and other rights.386 These affirmatively stated rights

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Balkissoon v. Capitol Hill Hosp., 558 A.2d 304 (D.C. Cir. 1989); Todd v. Physicians & Surgeons Cmty. Hosp., Inc., 302 S.E.2d 378 (Ga. Ct. App. 1983)). If the court is referring to the medical staff bylaws, its statement is highly suspect in view of Missouri law requiring that “[t]he professional staff of the hospital . . . shall initiate and, with the approval of the board, adopt bylaws,” Mo. ANN. STAT. §§ 205.195(2), 206.105(2) (1996), and JCAHO standards requiring the medical staff itself to adopt both the bylaws and any amendments to them. JCAHO MANUAL, supra note 1, MS.2, MS.2.1, at MS-3.

381. See Virmani v. Presbyterian Health Servs. Corp., 488 S.E.2d 284, 288 n.5 (N.C. Ct. App. 1997) (noting that bylaws were not unilateral because staff was involved in formulating and recommending them).

382. See 4 WILLISTON & LORD, supra note 307, § 8:4, at 41 (stating that under promissory estoppel, courts in effect form contract despite absence of consideration).


386. See JCAH, GUIDELINES FOR BYLAWS, supra note 92, at 21-30 for an outline of hearing and appellate review procedures and JCAHO MANUAL, supra note 1, MS.2.3.2, at MS-3, MS.5.2, at MS-7 for a discussion of fair hearing and appellate review. For examples of cases discussing these provisions
should be construed as promises by the hospital to the physician. After all, a reasonable physician would believe that such statements were commitments by the hospital to the physician. For example, if the bylaws state that "when any practitioner receives notice of a recommendation . . . that will adversely affect his appointment to or status as a member of the medical staff . . . he shall be entitled to a hearing before an ad hoc committee of the medical staff" and that "[a]ll hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all rights to which he is entitled," the physician may reasonably understand that the hospital is making a promise, and the physician may be expected to reasonably rely upon such a promise.

The reliance is the physician's acceptance of privileges and subsequent activities as a staff member while foregoing other options. The hospital's promises of fair procedure and staff organization induce the physician to follow through with or submit his or her initial application or application for reappointment. If privileges are granted, the physician, in reliance upon those privileges, may establish a practice in the area. In a similar context, courts have discussed the reliance necessary to enforce procedural protections in employee handbooks and have held that "[o]nce an employee is aware of a policy, and his sense of job security is enhanced thereby, he need take no action in reliance on the promise except to remain on the job." Finally, the potential hardship to the physician in this situation is obvious; loss of privileges may result in loss of a physician's practice and jeopardize a physician's ability to practice elsewhere.

4. Mutual Assent and Intent to Be Bound

A few courts have wrestled with the issue of whether the physician and hospital intended to be bound by the bylaws. Without question, the physician


387. See supra at notes 344-59 for a discussion of the specific promises in the staff bylaws.

388. JCAH GUIDELINES FOR BYLAW, supra note 92, at 21.


390. See supra notes 89-112 and accompanying text for a discussion of the negative effect of the loss of privileges.

agrees, usually in writing, to be bound by the medical staff bylaws as a condition of staff membership. Whether the hospital has a corresponding intent to be bound is a closer question. In one case, *Garibaldi v. Applebaum,* the medical staff bylaws included a provision disclaiming the creation of contractual rights. The Illinois Appellate Court considered and rejected an argument that bylaws did not create contractual rights because the bylaws stated that “these bylaws do not purport to be a contract between the Medical Staff or any of its individual members.” Even when faced with the express provision, the court held that the bylaws created contractual rights. It held that the disclaimer was against public policy and therefore unenforceable.

Furthermore, often the medical staff bylaws contain language that the bylaws “shall when adopted and approved be equally binding on the Board of Trustees and the Staff,” or that the hospital “shall be guided and governed by rules and regulations consistent with these Bylaws.” JCAHO, the hospitals’ accrediting entity, recognizes the true essence of medical staff bylaws arising from their creation of “a system of mutual rights and responsibilities between members of the medical staff and the hospital.” JCAHO’s standards also note that the bylaws are intended to “create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.” In view of these requirements, state statutory mandates for the adoption of bylaws, and the accepted purposes for bylaws, courts should hold that bylaws are intended and understood to be binding on both parties.

5. Employee Handbook Analogy

Employee manuals or handbooks are sometimes considered analogous to medical staff bylaws. Traditionally, courts refused to find contract rights in

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parent corporation is bound by medical staff bylaws).

392. See *supra* notes 344-45 and accompanying text for a discussion of requirement that physician agrees to be bound by bylaws.


394. *Garibaldi,* 704 N.E.2d at 704.

395. *Id.* (quoting *Garibaldi v. Applebaum,* 653 N.E.2d 42 (Ill. App. Ct. 1995)).

396. *Id.* at 705.

397. *Id.* The Illinois Supreme Court reversed *Garibaldi* in part but expressly did not decide the question of whether the hospital’s bylaws were a contract. Garibaldi v. Applebaum, Nos. 86952, 87120, 2000 WL 1599464, at *4 (Ill. Oct. 26, 2000).


400. JCAHO MANUAL, *supra* note 1, at MS-2 to MS-3 (emphasis added).

401. *Id.* at MS.2.2, at MS-3.

402. *See Janda v. Madera Cmty. Hosp.,* 16 F. Supp. 2d 1181, 1188-89 (E.D. Cal. 1998) (comparing assurances in bylaws with employer rules and policies and citing employee handbook cases); *Tredrea v. Anesthesia & Analgesia, P.C.,* 584 N.W.2d 276, 285 (Iowa 1998) (citing “analogous cases involving employee handbooks” in deciding whether bylaws were a contract); *Bass,* 520 N.W.2d at 627 (comparing bylaws with employee handbook); Hulston, et al., *supra* note 290, at 354.
employee manuals for many of the same reasons some courts now refuse to recognize the bylaws as a contract. First, they argued that no consideration exists, and second, they pointed to an absence of mutuality of obligation. In recent years, however, a large majority of courts have held that employee manuals may create an implied contract. These courts usually rely on the theory of unilateral contract or promissory estoppel to resolve the consideration problem. The Illinois Supreme Court identified three requirements for enforcement of an employee manual in a contract action:

First, the language of the policy statement must contain a promise clear enough that an employee would reasonably believe that an offer has been made. Second, the statement must be disseminated to the employee in such a manner that the employee is aware of its contents and reasonably believes it to be an offer. Third, the employee must accept the offer by commencing or continuing to work after learning of the policy statement. When these conditions are present, then the employee’s continued work constitutes consideration for the promises contained in the statement, and under traditional principles a valid contract is formed.

Based on this analysis, courts should find that medical staff bylaws create a valid contract. First, the bylaws state the promises and commitments directly and clearly. Second, a physician receives copies of the bylaws and is asked to become acquainted with them. Third, the physician agrees to be bound by the bylaws and accepts appointment to the medical staff if the application is

403. See infra notes 408-16 and accompanying text for a discussion of courts that have found contract rights in employee manuals.

404. See 2 Mark A. Rothstein, et al., Employment Law § 9.3, at 239 (1994) (noting that some courts held that statements made in employment handbooks did not create contractual obligations because of lack of consideration).

405. See id. at 526 (concluding that approximately three-quarters of the states hold promises in manuals binding).

406. See id. (stating “courts have addressed the consideration and mutuality of obligation obstacles either by viewing employment manuals as unilateral contracts or by applying the doctrine of promissory estoppel”).


408. For example, according to the JCAH GUIDELINES FOR BYLAWS, supra note 92, the bylaws state that recommendations for reappointment “shall be based upon” a number of listed factors, id. at 14; redetermination of clinical privileges “shall be based upon” a number of listed factors, id. at 15; a physician facing adverse action “shall be entitled to a hearing” and potentially an appellate review, id. at 21; and “[a]ll hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all rights to which he is entitled,” id. at 21.

409. See JCAHO Manual, supra note 1, MS.5.1.1, at MS-7 (stating that applicant “is oriented” to bylaws and agrees to be bound by them); id. MS.2.4.2, at MS-4 (requiring that if significant changes are made to bylaws, individuals are provided with revised text); id. at MS-32 (stating that applicant for appointment or reappointment “is informed of existing bylaws”). See also, Kiester v. Humana Hosp. Alaska, Inc., 843 P.2d 1219, 1221 (Alaska 1992) (noting physician received bylaws as part of application); Virmani v. Presbyterian Health Servs. Corp., 488 S.E.2d 284, 286 (N.C. Ct. App. 1997) (noting plaintiff received copy of bylaws upon his application for privileges).
In Thompson v. Saint Regis Paper Co., the Washington Supreme Court held that "[o]nce an employer announces a specific policy or practice, especially in light of the fact that he expects employees to abide by the same, the employer may not treat its promises as illusory." The hospital, through bylaws, announces specific policy and practices and requires physicians to comply. The hospital should not be allowed to treat its commitments as illusory.

6. Hospital Bylaws versus Medical Staff Bylaws

As noted earlier, a few courts have distinguished between the hospital's own bylaws and the medical staff's bylaws, holding the former contractually binding on the hospital but not the latter. Under this view, the medical staff is an unincorporated association separate from the hospital itself. Accordingly, it follows that the hospital as a separate party is not bound by the medical staff bylaws. The bylaws would be an agreement between the medical staff collectively and individual physicians. This position, however, ignores the realities of the hospital-medical staff relationship and the essence of the medical staff bylaws.

The symbiotic relationship between the hospital and its medical staff is

410. See supra notes 344-45 and accompanying text for a discussion of the requirement that physician agree to be bound by bylaws.


412. Thompson, 685 P.2d at 1088.


416. See Manczur, 183 N.Y.S. 2d at 961-62 (finding medical staff bylaws not binding on hospital board).
The hospital establishes and sponsors its medical staff.\textsuperscript{417} The hospital is required by law and for accreditation purposes to have an organized medical staff which is governed by bylaws.\textsuperscript{418} This medical staff is a "collaborating organization" responsible to the hospital's governing board.\textsuperscript{419} Although the medical staff adopts its own bylaws, the bylaws are not effective until approved by the hospital's board.\textsuperscript{420} The medical staff carries out duties delegated to it by the hospital's board.\textsuperscript{421}

Under JCAHO's standards, the medical staff bylaws intentionally "create a system of mutual rights and responsibilities between members of the medical staff and the hospital."\textsuperscript{422} In some cases, the hospital's own bylaws directly incorporate the limitations and rights afforded by the medical staff bylaws.\textsuperscript{423} Although separate from the hospital governing board, the medical staff should be considered an arm of the hospital in the context of rights afforded to individual physicians under the medical staff bylaws.\textsuperscript{424} Indeed many courts

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417. See JCAHO MANUAL, supra note 1, GO.2.2.1, at GO-4 ("The medical staff has the right to representation (through attendance an voice) by one or more medical staff members selected by the medical staff, at governing body meeting."). See also supra notes 27-31, 236-41 and accompanying text for an analysis of legal requirements mandating creation of an organized medical staff.

418. See also supra notes 27-31 and accompanying text for an analysis of legal requirements mandating creation of an organized medical staff.

419. See JCAHO MANUAL, supra note 1, MS.1, at MS-2 (medical staff accountable to hospital's governing body for quality of services provided by those with clinical privileges); MACEACHERN, supra note 8, at 143.

420. According to one authority: "Although few governing bodies use this power to impose bylaws on medical staffs, the hospital administration nevertheless tends to have significant power to influence the form of the bylaws that will be adopted by the medical staff." Glen A. Reed & Robert W. Miller, The Hospital Medical Staff: Due Care with Due Process, in REPRESENTING HEALTH CARE FACILITIES 25, 37 (Matthew M. Strickler & Frederic L. Ballard, Jr. eds., 1981). Some courts hold that upon approval or ratification by the hospital board the medical staff bylaws become binding upon the hospital. See Hager v. Venice Hosp., Inc., 944 F. Supp. 1530, 1534 (M.D. Fla. 1996) (stating hospital bylaws, when approved and adopted by governing board, become binding and enforceable contract between hospital and physicians comprising medical staff), aff'd, 132 F.3d 1461 (11th Cir. 1997); Lawler v. Eugene Wuesthoff Mem'l Hosp. Ass'n, 497 So. 2d 1261, 1264 (Fla. Dist. Ct. App. 1986) (same); Joseph v. Passaic Hosp. Ass'n, 141 A.2d 18, 23 (N.J. 1958) (same). In Islami v. Covenant Med. Ctr., Inc., 822 F. Supp. 1361 (N.D. Iowa 1992), the hospital argued that although the hospital's board of directors might be bound under the bylaws, the hospital was not. Id. at 1371. The court rejected that argument, finding no distinction between the hospital and its board. Id. at 1371. Cf. Munoz v. Flower Hosp., 507 N.E.2d 360, 364 n.2 (Ohio Ct. App. 1985) (concluding hospital acts through and is represented by its board).


422. JCAHO MANUAL, supra note 1, MS-3 (emphasis added).

423. See Gonzalez v. San Jacinto Methodist Hosp., 880 S.W.2d 436, 438-39 & nn.2-3 (Tex. Ct. App. 1994) (stating hospital bylaws set forth specific rights and duties for each physician). See also JCAHO MANUAL, supra note 1, M.S.2.4.1, at MS-4 (stating medical staff bylaws and governing body's bylaws must not conflict). Some courts hold that upon approval or ratification by the hospital board the medical staff bylaws become binding upon the hospital. See, e.g., Joseph v. Passaic Hosp. Ass'n, 141 A.2d 18, 23 (N.J. 1958) (noting that, upon ratification by board of governors of hospital, bylaws "became a constituent part of the Association's elemental law").

424. In a closely related context, the courts are split on the question of whether a hospital can
make no distinction between hospital and medical staff bylaws and, instead, use the labels interchangeably or consistently refer to "hospital bylaws" when they mean the hospital's medical staff bylaws.\textsuperscript{425}

7. Consequences of Enforcing Bylaws in a Contract

Courts should hold that medical staff bylaws form a binding contract between the hospital and individual members of its medical staff. To the extent that the bylaws provide rights specific to applicants, applicants too should have enforceable contractual rights.\textsuperscript{426} This conclusion is supported by application of contract law principles and sound policy.\textsuperscript{427} The hospital and physician exchange promises with the intent to be bound.\textsuperscript{428} This contract approach provides a reasonable vehicle for limited judicial review of credentialing and peer review decisions.\textsuperscript{429}

Some courts that determined the bylaws are not a contract still enforce them in an action for injunctive relief.\textsuperscript{430} In Robles v. Humana Hospital
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Cartersville, for example, the Northern District of Georgia reasoned that recognition of a contract would create a damage claim that would be contrary to the state's policy of allowing hospitals to choose their medical staffs. But state law requirements mandating the development of bylaws and procedures to protect staff members justified judicial enforcement of the bylaws in an action for injunctive relief. The district court's concern about exposing hospitals to damage claims can be addressed by qualified immunity under federal and state laws and specific provisions in the bylaws themselves. In particular, under the federal Health Care Quality Improvement Act, hospitals which comply with certain requirements enjoy immunity from damages for their peer review actions. This immunity covers damage claims for breach of contract, including alleged breach of the bylaws. If the immunity provisions do not apply because of the presence of such factors as bad faith, damage claims may be warranted.
and necessary to make the physician whole.

A finding that the bylaws are an enforceable contract is not a one way street favoring physicians—hospitals too stand to benefit, particularly from waiver and immunity provisions.\textsuperscript{440} In \textit{Brinton v. IHC Hospitals, Inc.}, \textsuperscript{441} the Utah Supreme Court held that the express waiver provision of the bylaws bound a physician who therefore had a duty "to take affirmative steps to raise issues in a timely fashion."\textsuperscript{442} The physician was "contractually bound to raise any objections during the [peer review] process or relinquish them as waived."\textsuperscript{443} Accordingly, alleged procedural violations which the physician failed to raise in his peer review hearings and before the hospital board could not support a cause of action.\textsuperscript{444}

In \textit{Everett v. Saint Ansgar Hospital}, \textsuperscript{445} the Eighth Circuit enforced an immunity provision and held that a physician's breach of contract claim for suspension and revocation of his privileges was waived.\textsuperscript{446} It held:

Even if there was such a violation, however, [the physician] waived his right to sue for a breach of the contract. When he applied for hospital privileges, [the physician] specifically acknowledged that with respect to actions taken for the purpose of achieving and maintaining an acceptable level of patient care "there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act ... [S]uch immunity shall apply to all acts ... performed or made in connection with this ... health care institution['s] activities related ... to ... corrective action."\textsuperscript{447}

\section*{C. Common Law Review: Fiduciary Duty and Fairness}

1. New Jersey's Fiduciary Duty Theory

A number of courts have rejected both the public/private distinction and

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\item good faith requirement.
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\textsuperscript{440} For a critical and cryptic view, see Groseclose, \textit{supra} note 90, at 28 ("The so-called contract can actually be a vehicle for oppression rather than a meaningful judicial remedy.").

\textsuperscript{441} 973 P.2d 956 (Utah 1998).

\textsuperscript{442} \textit{Brinton}, 973 P.2d at 965.


\textsuperscript{444} \textit{Brinton}, 973 P.2d at 966.

\textsuperscript{445} 974 F.2d 77 (8th Cir. 1992).

\textsuperscript{446} \textit{Everett}, 974 F.2d at 80.

breach of contract analysis in favor of allowing judicial review of credentialing and peer review decisions based on public policy grounds. These courts recognize a hospital's fiduciary duty, benefiting the public, to make reasonable peer review and credentialing decisions. The New Jersey Supreme Court first recognized this theory in Greisman v. Newcomb Hospital, which serves as the foundation for one public policy theory alternative.

In Greisman, the plaintiff, a graduate of a school of osteopathy, applied for staff privileges at a private hospital. The hospital refused to accept plaintiff's application for admission to the staff because the bylaws required staff members to be graduates of an American Medical Association approved medical school, and this requirement excluded all schools of osteopathy. The hospital first argued that as a purely private hospital its staffing decisions were not subject to judicial review. The court rejected this argument. It questioned the private nature of hospitals generally and the defendant hospital in particular:

[Private hospitals] are private in the sense that they are nongovernmental but they are hardly private in other senses. [The defendant hospital] is a nonprofit organization dedicated by its certificate of incorporation to the vital public use of serving the sick and injured, its funds are in good measure received from public sources and through public solicitation, and its tax benefits are received because of its nonprofit and nonprivate aspects. It 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 alleged private nature.

The court compared hospitals to other private businesses that have special common law duties. For example, private innkeepers and common carriers have a duty to serve "all comers on reasonable terms," and private railroad companies "hold their property 'as a quasi-public trust.'" The court also relied on its own earlier precedent striking down a private, nonprofit county medical society's arbitrary membership requirement. The court found that the hospital was dedicated to serve the public and was the only hospital in the area. "[H]ospitals are operated not for private ends but for the benefit of the public, and... their existence is for the purpose of faithfully furnishing facilities to the members of the medical profession in aid of their service to the public." The court concluded that the hospital's power to pass on staff membership applications is a fiduciary power held in trust which must be exercised

449. Greisman, 192 A.2d at 818.
450. Id. at 819.
451. Id. at 820.
452. Id. at 821 (citations omitted).
453. Id. (internal citation omitted).
454. Greisman, 192 A.2d at 821.
455. Id. at 821-22.
456. Id. at 822-23 (citing Falcone v. Middlesex County Med. Soc'y, 170 A.2d 791 (N.J. 1961)).
457. Id. at 825.
reasonably for the public good. 458

Under this public policy approach, the judicial inquiry may be more probing than merely ensuring the hospital’s compliance with procedures in the bylaws. Instead, the court asks whether the hospital has acted in accordance with its fiduciary duty, and “a court should not hesitate in promoting natural justice to fill any gaps” in “self-serving” bylaws. 459 Indeed in Greisman, the issue was not whether the hospital complied with its bylaws, but whether the bylaws themselves were reasonable. 460 The result of the holding in Greisman, and cases like it, has been the imposition of an arbitrary, capricious, or unreasonable standard on all hospitals, whether public or private, in connection with their credentialing and peer review decisions. 461 In the words of one court: “The better rule provides that such review be available as to whether the doctor excluded was afforded procedural due process, and as to whether an abuse of discretion by the hospital board occurred, resulting in an arbitrary, capricious or unreasonable exclusion.” 462 Several states have followed Greisman’s lead. 463

458. Id.


460. Greisman v. Newcomb Hosp., 192 A.2d 817, 824 (N.J. 1963) (stating “our proper concern here is whether the hospital had the right to exclude consideration of the plaintiff, solely because he was a doctor of osteopathy”).

461. See, e.g., Sokol v. Akron Gen. Med. Ctr., 173 F.3d 1026, 1030 (6th Cir. 1999) (applying Ohio law and stating “hospitals must provide ‘procedural due process ... in adopting and applying reasonable, non-discriminatory criteria for the privilege of practicing’”); Bricker v. Seton Speare Mem’l Hosp., 281 A.2d 589, 592 (N.H. 1971) (recognizing rules will be reviewed by court and “set aside if arbitrary, capricious or unreasonable”) (citations omitted); Bouquet v. St. Elizabeth Corp., 538 N.E.2d 113, 114 (Ohio 1989) (finding decisions of hospital will be set aside if “arbitrary, capricious or unreasonable”); Nashville Mem’l Hosp., Inc. v. Binkley, 534 S.W.2d 318, 320 (Tenn. 1976) (stating “duly licensed physician ... cannot be deprived of [the right to practice] by rules, regulations, or actions of the hospital’s governing authority that are unreasonable, capricious or discriminatory”).


Although *Greisman* involved a physician applying for admission to the medical staff, its holding also has been applied to cases involving the revocation or limitation of privileges.  

These courts suggest that a hospital's credentialing decisions result from the exercise of "fiduciary powers," powers held "in trust," and that the hospital "occupies a fiduciary trust relationship between itself, its staff and the public it seeks to serve." A fiduciary relationship, however, should not be found to exist between the hospital, its physicians, as well as the public. The Restatement (Second) of Torts defines a fiduciary relationship as a relationship "between two persons when one of them is under a duty to act for or to give advice for the benefit of another upon matters within the scope of the relation." A fiduciary relationship in the hospital credentialing context does not fit well with the traditional categories of fiduciaries. One authority identified the following typical fiduciary categories:

An attorney is a fiduciary for a client, a corporate director or officer for the corporation or its shareholders, a promoter for the corporation, an agent for the principal, a guardian for the ward, joint venturers for one another, a partner for the other partners, a bailee for the bailor, a securities broker for a customer, a member of a creditor's committee for the creditors, and, in class action lawsuits, the representative of a class for its members. According to some authorities, a physician or a psychiatrist may be a fiduciary for a patient, an employee for his employer, a stockholder for the other stockholders in a closely held corporation, and a priest for a penitent.

The courts should not find a fiduciary relationship between a hospital and a physician excluded or expelled from the hospital's medical staff. The hospital, in agreement with *Greisman* reasoning and noting private hospital not immune from public supervision because of its private nature; Woodard v. Porter Hosp., Inc., 217 A.2d 37, 40 (Vt. 1966) (citing *Greisman* and holding courts will intervene when hospital's decision is "unreasonable, arbitrary, capricious or discriminatory"); cf. Owens v. New Britian Gen. Hosp., 643 A.2d 233, 240 (Conn. 1994) (citing *Greisman* and agreeing that hospital's powers held in trust); Balkissoon v. Capital Hill Hosp., 558 A.2d 304, 308 (D.C. Cir. 1989) (noting public's substantial interest and holding duty to comply with bylaws independent of contractual right); Nashville Mem'l Hosp., Inc. v. Binkley, 534 S.W.2d 318, 320 (Tenn. 1976) (citing *Greisman*).


464. See, e.g., *Sokol*, 173 F.3d at 1029 (concerning limitation of privileges); *Hawkins*, 540 P.2d at 346 (involving termination of privileges); *Silver*, 497 P.2d at 566 (involving failure to renew temporary privileges); *Bricker*, 281 A.2d at 591 (concerning denial of reappointment).


466. *Silver*, 497 P.2d at 570.

467. Restatement (Second) of Torts § 874 cmt. a. (1979); accord Restatement (Second) of Trusts § 2 cmt. b (1959) (discussing circumstances constituting fiduciary relationship).

its staffing decisions, acts in its own interests and does not purport to act primarily in the interest of the applicant. Indeed, the physician is the subject of the hospital's scrutiny during the process.

A closer question is whether a fiduciary relationship might exist between a hospital and the public. In short, does the hospital in making credentialing decisions consider primarily its own interests or the interests of the public? In one sense, the public does rely upon hospitals to make staffing decisions and to police the quality of their staff membership. But the public does not entrust hospitals with any confidential information or property, nor does the hospital make decisions on behalf of the public. A hospital's credentialing decisions are made based on the interests of the hospital itself. This self interest is particularly strong in the actions of private for-profit hospitals who, like other for-profit businesses, presumably have their own economic interests foremost in mind. Of course, the hospital's own interests often coincide with the public's interests. But hospital provision of health care services, although unquestionably important to the public, does not make private hospitals fiduciaries to the public. As flexible as the theory of fiduciary duties is, it should not stretch to cover a private hospital's relationship with the general public or physicians applying for privileges.

Assuming a hospital has fiduciary duties to the public, those duties are not implicated by exclusion of a physician from a hospital's medical staff. Any fiduciary duty does not require that a hospital accept into its membership every qualified physician. Exclusion of a physician does not make the existing medical staff less safe or endanger the public. The hospital has not misused any property of the public or any confidential information entrusted to it by the public. The public has not been misled or deceived. Even if the public is wronged, any liability for the breach would be to the public—not to an offended physician to whom no duty was owed.

2. California's Common Law Fair Procedure Theory

The California courts, building on their own precedents and citing Greisman

469. See BLACK'S LAW DICTIONARY 625 (6th ed. 1990) (defining fiduciary as: "A person having duty, created by his undertaking, to act primarily for another's benefit in matters connected with such undertaking").

470. See RESTATEMENT (SECOND) OF TORTS § 874 cmt. a. (1979) (finding fiduciary relationship imposes duty to act for benefit of another); accord RESTATEMENT (SECOND) OF TRUSTS § 2 cmt. b (1959) (stating "a person in a fiduciary relationship to another is under a duty to act for the benefit of the other").

471. The fact that states have their own professional licensing requirements for physicians suggests that the public is acting independently to protect its own interests.

472. A grocery store provides a vital service to the public but does not thereby become a fiduciary.

473. Arguably, denial of the services of a qualified physician or denial of the opportunity to select a particular physician is some harm.

474. Cf. RESTATEMENT (SECOND) OF TORTS § 874 & cmt. b (finding fiduciary may be liable to beneficiary for breach).
and its progeny, also have rejected the public/private hospital distinction and a contractual approach, and allow review of hospital credentialing decisions based on the “common law right of fair procedure.” The California Supreme Court in *Anton v. San Antonio Community Hospital* stated the rule “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.” Other California decisions have made clear that the right afforded is not constitutional due process, but a common law right of fair procedure, though the distinction is of little consequence. The right of fair procedure is flexible, but at a minimum


477. 567 P.2d 1162 (Cal. 1977) [Anton II].


479. See, e.g., *Gaenslen*, 232 Cal. Rptr. at 241-42 (discussing distinction between due process and fair procedures); *Anton I*, 183 Cal. Rptr. at 432 & n.4 (noting proper term for review is “fair procedure” because decision based on common law and not constitutional privileges). The distinction is one of origin and does not indicate the extent of protection provided. See *Goodstein*, 78 Cal. Rptr.
it requires “adequate notice of charges, a reasonable opportunity to respond, and an impartial tribunal” if a hearing is required. Moreover, review is not limited to procedural fairness; it also allows scrutiny of substantive requirements to determine whether a requirement is “irrational, unlawful or contrary to established public policy.”

Although the California courts partially erased the public/private hospital distinction by applying procedural due process to public hospitals and common law fair procedure to private hospitals—in substance the same standard—the distinction remained significant as a result of legislation overruling in part the 1977 Anton v. San Antonio Community Hospital decision. The Anton decision required courts to exercise their “independent judgment” in reviewing the factual basis for a hospital board’s decision. In 1978, the legislature amended California’s mandamus statute, which is the mechanism for seeking injunctive relief from hospital decisions, to specifically limit the courts’ scope of review of private hospital board decisions to a substantial evidence standard. This alteration in the mandamus proceedings is significant not only for a claim for injunctive relief, but also for damage claims since a physician cannot seek damages until after a successful mandamus action. Under the substantial evidence standard, the courts “review the administrative record to determine whether its findings are supported by substantial evidence in the light of the whole record,” and will uphold the findings “unless [they] are so lacking in evidentiary support as to render them unreasonable.” While substantial evidence is the standard of review for factual findings, the courts continue to

2d at 583 (identifying “fairness” as essence of both rights); Anton I, 183 Cal. Rptr. at 433 (finding “little distinction”); Applebaum v. Bd. of Dirs., 163 Cal. Rptr. 831, 836 (Cal. Ct. App. 1980) (identifying “fairness” as “essence of both rights”).


481. Miller v Eisenhower Med. Ctr., 614 P.2d 258, 265 (Cal. 1980) (Mosk, J., dissenting); accord, e.g., Goodstein, 78 Cal. Rptr. 2d at 582 (discussing whether hospital policy is “substantially irrational, unlawful or contrary to established public policy or procedurally unfair”) (citation omitted).

482. See Miller, 614 P.2d at 271-72 (Mosk, J., dissenting) (discussing standards); Anton II, 567 P.2d at 1168 & n.12 (discussing similarities in standards).

483. 567 P.2d 1161 (Cal. 1977).

484. Anton II, 567 P.2d at 1172.


486. See CAL. CIV. PRO. CODE § 1094.5(d) (West Supp. 2000) (adopting “substantial evidence” standard). See also Anton I, 183 Cal. Rptr. at 426-27 (citing Section 1094.5(d)).


conduct an independent review to determine whether fair procedure was afforded. The public/private hospital distinction appears to have receded again with a 1992 amendment to section 1094.5(d), applying the substantial evidence standard to decisions of both private and municipal hospitals.

Under California law, a physician whose privileges are denied or withdrawn, before bringing a damage action, must first exhaust the hospital's administrative process in addition to prevailing in a mandamus action to overturn the hospital decision.

3. Other Courts' Public Policy Review

Many courts that continue to adhere to the public/private distinction and rely on a breach of contract theory also engage to some degree in a common law public policy judicial review. West Virginia's highest court, expressly relying on breach of contract principles, sets forth this approach:

... the decision of a private hospital to revoke, suspend, restrict or to refuse to renew the staff appointment or clinical privileges of a medical staff member is subject to limited judicial review to ensure that there was substantial compliance with the hospital's medical staff bylaws governing such a decision, as well as to ensure that the medical staff bylaws afford basic notice and fair hearing procedures, including an impartial tribunal.

These courts look beyond merely whether the bylaws were followed; they also consider whether the bylaws themselves afford due process. The West


490. In its current codification, section 1094.5(d) states:

(d) Notwithstanding subdivision (c), in cases arising from private hospital boards or boards of directors of districts organized pursuant to The Local Hospital District Law, Division 23 (commencing with Section 32000) of the Health and Safety Code or governing bodies of municipal hospitals formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of the Government Code, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record. However, in all cases in which the petition alleges discriminatory actions prohibited by Section 1316 of the Health and Safety Code, and the plaintiff makes a preliminary showing of substantial evidence in support of that allegation, the court shall exercise its independent judgment on the evidence and abuse of discretion shall be established if the court determines that the findings are not supported by the weight of the evidence.


493. See, e.g., Mahmoodian, 404 S.E.2d at 755 (court will review to ensure bylaws afford notice
Virginia court continued, "there are basic, common-law procedural protections which must be accorded a medical staff member by a private hospital in a disciplinary proceeding which could seriously affect his or her ability to practice medicine." In addition, the Illinois Supreme Court explained: "A court, however, will be justified in reviewing a private hospital's actions even where the bylaws are followed if actual unfairness . . . is demonstrated in the record."

D. State Statutes Define the Scope of Judicial Review

In addition to judicial review based on theories of constitutional due process, contractual rights, or common law fair procedure, state legislatures have addressed the scope of judicial review of hospital peer review decisions. State statutes vary widely, but they generally function in four ways.

1. Statutes Granting Immunity from Damages

Nearly all states have statutes which grant immunity from damages to individuals and entities involved in peer review proceedings in certain circumstances. These provisions provide a qualified immunity from damages for actions taken in good faith, without malice, or under some other standard. An example of such an immunity statute is the Florida statute which provides:

There shall be no monetary liability on the part of, and no cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, or employees; a committee of a hospital; or any other person, for any action taken without intentional fraud in carrying out the provisions of this section [i.e. peer review].

These immunity statutes are not uniform. Some apply to individuals involved in the peer review process but not to hospitals. Among those statutes which do apply to hospitals, the standards differ. The statutes either adopt an

and fair hearing procedures).

494. Id. at 756.
absolute immunity from damages standard, a "good faith" standard, a "without malice" standard, or some other standard. Courts have applied these various immunity statutes to dismiss damage claims brought by physicians in numerous cases.

2. Statutes Requiring Specific Admissions Criteria, Peer Review Standards, or Due Process Requirements

Some statutes require hospitals to adopt specific admissions criteria, peer review standards, and procedural due process rights either in bylaws or other hospital regulations. These statutory requirements in some instances are detailed and in others instances general and brief. These requirements may

499. See ARIZ. REV. STAT. ANN. § 36-445.02(B) (West 1993) ("No hospital . . . may be liable in damages to any person who is denied the privilege to practice in a hospital or center whose privileges are suspended, limited, or revoked.").


501. See, e.g., GA. CODE ANN. §§ 31-7-131(2)(K), 31-7-132(a) (West 1996) (adopting "without malice" standard). Other states that have adopted the "without malice" standard include Louisiana (LA. REV. STAT. ANN. §§ 13:3715.3(C) (West Supp. 2000)), Mississippi (MISS. CODE ANN. § 73-25-93(2) (West 1999)), and North Dakota (N.D. CENT. CODE § 23-34-06(2) (Supp. 1999)).


506. The Texas statute, for example, states:

(c) The process for considering applications for medical staff membership or privileges or the renewal, modification or revocation of medical staff membership and privileges must
provide the legal basis for challenges to hospital action and conversely limit a court’s review.507

New York is an example of a state which has adopted such a statute. New York for many years followed the traditional rule of nonreview of private hospital staffing decisions announced in Van Campen v. Olean General Hospital,508 holding that “[d]enial of staff privileges, for whatever reason or for no reason at all, constituted no legal wrong.”509 In 1972, however, the legislature modified the common law by enacting section 2801-b of the Public Health Law which states in relevant part:

It shall be an improper practice for the governing body of a hospital to refuse to act upon an application for staff membership or professional privileges or to deny or withhold from a physician . . . staff membership or professional privileges in a hospital, or to exclude or expel a physician . . . from staff membership in a hospital or curtail, terminate or diminish in any way a physician’s . . . professional privileges in a hospital, without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant.510

A physician alleging violations of this provision, after exhausting the administrative remedies outlined in the statute, may seek an injunction to enforce the provision.511
Similarly, Florida initially distinguished between public and private hospitals and followed the rule of nonreview.\textsuperscript{512} The Florida legislature in 1975, however, enacted a statute imposing duties on hospitals in connection with their staff membership and peer review decisions.\textsuperscript{513} The statute in effect eliminates the public/private hospital distinction as it related to protecting staff privileges and sets forth valid criteria for evaluation of membership application and for limiting existing privileges.\textsuperscript{514} These statutory provisions provide the basis for claims by physicians for injunctive relief and potential damages.\textsuperscript{515}

3. Statutes Specifically Addressing the Process for Judicial Review and Standards to Be Applied


512. See West Coast Hosp. Ass'n v. Hoare, 64 So. 2d 293, 299 ( Fla. 1953) (holding rules and regulations applied to public hospitals not applicable to private hospitals).

513. FLA. STAT. ANN. §§ 395.0191, 395.0193 (West Supp. 2000). See also Lake Hosp. & Clinic, Inc. v. Silversmith, 551 So. 2d 538, 544 (Fla. Dist. Ct. App. 1989) (recognizing that adoption of §395.065(2) made private hospitals accountable for regulation of staff privileges). The state also has promulgated corresponding regulations governing hospital staff membership decisions and peer review. See FLA. ADMIN. CODE ANN. r. 59A-3.201 (West, WESTLAW through July 1, 2000) (defining terms used in various state administrative regulations concerning management of hospital, organizational structure of medical staff, and peer review procedures); id. at § 3.220 (requiring hospitals to have organized medical staff and bylaws, as well as rules and regulations that govern selection and retention of medical staff).


515. See Fernandez v. Coral Gables Hosp., Inc., 720 So. 2d 1161, 1162-63 (Fla. Dist. Ct. App. 1998) (discussing statute allows for injunctive relief); Silversmith, 551 So. 2d at 544 (stating statute, not constitutional due process, provides basis for physician's claim); Lawler, 497 So. 2d at 1264-65 (incorporating statute and explaining hospitals immune from liability as long as decisions conform with statute and not malicious); Dam v. Heart of Fla. Hosp., Inc., 536 So. 2d 1177, 1178 (Fla. Dist. Ct. App. 1989) (statute provides procedure for terminating privileges); Carida, 427 So. 2d at 806 & n.6 (interpreting statute and concluding inadequate notice of termination would violate statute); cf. Noble v. Martin Mem'l Hosp. Ass'n, 710 So. 2d 567, 569 (Fla. Dist. Ct. App. 1997) (dismissing damage claims based on failure to allege “intentional fraud” as required by statute).

516. See ARIZ. REV. STAT. ANN. § 36-445.02(B) (West 1993) (stating judicial review limited to record with injunction as only remedy); CAL. CIV. PRO. CODE § 1094.5(a), (d), (h) (West Supp. 2000) (providing for judicial review); COLO. REV. STAT. §§ 12-36.5-106 (10) (1999) (declaring administrative action may be reviewed by a court of appeals); D.C. CODE §32-1309(c) (Michie Supp. 2000) (stating aggrieved party may bring action in superior court); N.Y. PUB. HEALTH § 2801-c (West 1993)
requires a hospital to provide a physician, in writing, the reasons for denial or termination of privileges. The statute also identifies several impermissible reasons for a denial or termination of privileges. If a hospital violates the statute's requirements, a physician has the right to seek an injunction prohibiting any further violation from the circuit court. An Arizona statute specifically allows "an action for injunctive relief seeking to correct [a hospital's] erroneous decision or procedure." The Arizona statute also determines the court's standard of review: "If the record shows that the denial, revocation, limitation or suspension of membership or privileges is supported by substantial evidence, no injunction shall issue."

The California mandamus statute provides for review of hospital credentialing decisions in the reviewable category of "any final administrative order or decision," and it specifically adopts an abuse of discretion standard for review of hospital decisions. Abuse of discretion is shown if "the findings are not supported by substantial evidence in the light of the whole record." The California statute further identifies the standard necessary to stay the hospital decision while the action is pending. A District of Columbia statute lists a number of factors which may not support an adverse credentialing determination, but it does permit an action in the District's Superior Court to enjoin violations of the statute. Moreover, in a challenge to the hospital's determination, the hospital has the burden to establish that it did not rely on an improper factor. The Colorado and New York statutes specifically permit judicial review following consideration by special administrative boards.

4. Statutes Creating Administrative Review

Finally, a statute may create an administrative review board to hear the merits of a physician's claim prior to any court action. Both New York and Colorado have taken this approach. The New York statute permits a court to order injunctive relief against a hospital in accordance with the process identified

(providing injunction relief by the courts); VA. CODE ANN. § 32.1-134.1 (Michie 1997) (outlining right to injunctive relief by court); cf. FLA. STAT. ANN. §§ 395.0191 (9), 395.0193 (9) (West Supp. 2000) (providing attorney's fees).

517. VA. CODE ANN. § 32.1-134.1 (Michie 1997).
518. Id.
519. Id.
520. ARIZ. REV. STAT. ANN. § 36-445.02(B) (West 1993).
521. Id.
522. CAL. CIV. PRO. CODE § 1094.5(a) (West Supp. 2000).
523. Id. § 1094.5(d).
524. Id. § 1094.5(b).
525. D.C. CODE §§ 32-1307(b), 1390(c) (Michie 1998).
526. Id. § 32-1307(c) (Michie 1998).
527. COLO. REV. STAT. § 12-36.5-106 (10)(a), (b) (1999); N.Y. PUB. HEALTH § 2801-c (West 1993).
528. COLO. REV. STAT. § 12-36.5-106 (1999); N.Y. PUB. HEALTH § 2801-c (West 1993).
in the statute. First, an aggrieved physician must submit a complaint to the
New York Public Health Council ("PHC") who investigates the complaint. After its investigation, the PHC may direct the hospital to reconsider its decision or announce its own finding that the complaint lacks merit. Following the PHC review, the physician may then commence a court action for injunctive relief or damages. The statutory scheme permits the PHC, a body with expertise in the health care field, to consider the merits of the hospital’s action before any judicial involvement. This body plays an important mediation role by offering both the physician and the hospital a qualified independent opinion based on the facts. The New York Court of Appeals has observed that “[u]nder the conciliating professional influence of the PHC—an impartial third party with vast experience and unparalleled expertise in these cases—disputes between physician and hospital may be resolved expeditiously avoiding costly and protracted litigation.” The PHC also plays a fact finding role which will assist in any future litigation on the matter. Under the statute, the PHC’s findings of fact are prima facie—though not conclusive—evidence of the facts found in any subsequent judicial proceeding.

Similarly, Colorado, by statute, has established the Committee on Anticompetitive Conduct (the “Committee”) which reviews claims of unreasonable anticompetitive conduct made by physicians in connection with their privileges or staff membership. The Committee consists of five members, four of whom must be licensed to practice medicine and actively practicing medicine. The statute provides, in relevant part:

Any physician who is the subject of a final action by a governing board, which action results in the denial, termination, or restriction of privileges at or membership in or participation in an organization, and who believes that such action resulted from unreasonable anticompetitive conduct shall have, as his sole and exclusive remedy,

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529. N.Y. PUB. HEALTH § 2801-b(2) (West 1993).
531. N.Y. PUB. HEALTH § 2801-b(3) (West 1993). See also Gelbard, 664 N.E.2d at 1242 (discussing and explaining requirements of statute).
532. N.Y. PUB. HEALTH § 2801-c (West 1993). See also Gelbard, 664 N.E.2d at 1243 (plaintiff may bring action for injunctive relief to restore privileges only after PHC review but noting, without elaborating, that some claims may not be subject to requirement of PHC review).
533. Gelbard, 664 N.E.2d at 1243.
534. N.Y. PUB. HEALTH § 2801-c (West 1993).
535. Id. See also Gelbard, 664 N.E.2d at 1242 (“PHC’s determination serves as prima facie evidence of the facts found therein” but “findings are accorded only presumptive, not conclusive, effect.”).
536. COLO. REV. STAT. § 12-36.5-106 (1999).
537. Id. The fifth member must be a licensed attorney with experience in antitrust law. Id. § 12-36.5-106(2).
direct review of the record by the committee. Such review shall be limited to the sole issue of whether such final board action resulted from unreasonable anticompetitive conduct. Failure to exhaust this administrative remedy before the committee shall preclude the right of de novo review on the merits of the issue of unreasonable anticompetitive conduct.538

The procedure before the Committee is noted in the statute. Ultimately, the Committee may (1) set aside or modify the hospital's action, (2) dismiss the complaint, or (3) remand the case to the hospital board for further review.539 Following the Committee's review, the action of the Committee may be reviewed by the state's court of appeals, or the action of the hospital may be reviewed de novo on the merits in a district court.540 Claims not alleging anticompetitive conduct may be raised directly with the court.541

E. Substantial Compliance with the Bylaws and Abuse of Discretion

If a court decides that review is appropriate, it must determine what level of review it will allow. Courts overwhelmingly agree that a hospital's determination is entitled to great deference.542 Hospitals exercise their expertise in making staffing decisions.543 Courts, therefore, are and should be reluctant to second guess those decisions.

Courts that review hospital decisions for compliance with the bylaws almost uniformly apply a substantial compliance standard.544 Some courts limit review

538. Id. § 12-36.5-106(7).
539. Id. § 12-36.5-106(9)(k)-(m).
541. COLO. REV. STAT. § 12-36.5-106(8) (1999). Claims of anticompetitive conduct that do not result from professional review committee activity also may be raised directly in a court. See Ryals v. St. Mary-Corwin Reg'l Med. Ctr., No. 99SC137, 2000 WL 1335873, at *1 (Colo. Sept. 18, 2000) (holding Committee on Anticompetitive Conduct did not have jurisdiction over claims where denial of privileges was business decision not involving physician's qualifications or conduct).
543. See Kiester, 843 P.2d at 1223 (referring to "a hospital's recognized expertise regarding evaluation of medical qualifications"); Owens, 643 A.2d at 241 (noting that determinations of professional competence "should be left to the expertise of the hospital's staff and administration").
to compliance with procedural requirements in the bylaws but will not consider
the merits of any underlying medical decision. Under this approach, the court
will only consider, for example, whether the physician received appropriate
notice, had an opportunity to respond to the charges, and whether the process
was otherwise fair. Other courts will review the basis for the hospital’s
decision under either an abuse of discretion, substantial evidence, or arbitrary
and capricious standard. This limited review of the substantive evidence is
viewed by some as merely an integral part of the procedural review because
“such examination is in recognition that an inherent element of fair hearing
procedures is that there be sufficient evidence to support the hospital’s
decision.”

CONCLUSION

Judicial review of credentialing decisions presents difficult questions for
physicians, hospitals, and the courts. The courts, using various theories, attempt
to balance the competing interests of the physician, hospital, and public. The
seeming complexity and variety of approaches found in the cases—characterized
by one commentator as a “dismal swamp”—at times is daunting. Nonetheless,

1996) (same); Brinton v. IHC Hosps., Inc., 973 P.2d 956, 964-65 (Utah 1998) (same); Mahmoodian, 404
Ct. 1980) (requiring strict compliance to bylaws).

545. See Brinton, 973 P.2d at 964 (allowing procedural fairness to be questioned, but refusing to
evaluate medical judgment of hospital).

546. See Kiester, 843 P.2d at 1223 (stating “courts are equipped to determine whether a hospital
governing body has followed its bylaws and whether a decision regarding an application for privileges
was made in accordance with basic principles of fairness and due process”); Owens, 643 A.2d at 241
(limiting review to considerations of basic notice and fair hearing procedures).

547. See CAL. CODE CIV. PRO. § 1094.5(d) (West Supp. 2000) (establishing abuse of discretion
standards; findings not supported by substantial evidence); Sokol v. Akron Gen. Med. Ctr., 173 F.3d
1026, 1030 (6th Cir. 1999) (reviewing for arbitrariness, abuse of discretion, supported by any
evidence); Kiester, 843 P.2d at 1223 (ensuring standards set by hospital not arbitrary and capricious);
and capricious); Oskooi v. Fountain Valley Reg’l Hosp. & Med. Ctr., 49 Cal. Rptr. 2d 769, 774 (Cal.
1975) (stating claim if decision is arbitrary, capricious, and unreasonable); Dworkin v. St. Francis
Hosp., Inc., 517 A.2d 302, 305-06 (Del. Super. Ct. 1986) (confining court’s role to determination of
whether review committee decision was arbitrary or capricious); Babcock, 543 N.W.2d at 760
(sufficient evidence, not arbitrary or capricious); Nanvati v. Burdette Tomlin Mem’l Hosp., 526 A.2d
697, 702 (N.J. 1987) (passing judicial review when decision supported by sufficient reliable evidence);
decision supported by credible evidence, not arbitrary or capricious); Bouquett v. St. Elizabeth Corp.,
538 N.E.2d 113, 114 (Ohio 1989) (refraining from interfering unless decision was arbitrary, capricious,
unreasonable, i.e., an abuse of discretion); Mahmoodian, 404 S.E.2d at 762 (applying substantial
evidence standard).

548. Babcock, 543 N.W.2d at 760.

549. See supra notes 89-168 and accompanying text for a discussion of these competing interests.

the outcomes of the cases are more uniform than one might expect.551 In the final analysis, regardless of the underlying theory, most courts review decisions expelling physicians from medical staffs or limiting their privileges to ensure that the physician was afforded what amounts to procedural due process. That due process review for decisions of public hospitals is grounded, at least as a minimum, on constitutional protections.552 For private hospitals, the due process review is based on contract (the bylaws), fiduciary duty, common law fairness, or statute.553

In contrast to decisions affecting existing privileges, the courts are sharply split on the question of review of private hospital decisions excluding physicians from medical staffs.554 Many courts follow the rule of nonreview, but many other courts allow review under fiduciary duty, common law fairness, or statutory theories.555 Courts are uniformly reluctant to delve into the substantive merits of a physician's claim.556 However, many courts do venture beyond purely procedural issues and will consider whether the decision was based on substantial evidence or was not arbitrary or capricious.557

Most courts will permit injunctive relief to an aggrieved physician.558 Claims for damages, however, are difficult to maintain and rarely successful. Federal and state immunity statutes, coupled with the considerable deference courts give hospital staffing decisions,559 set a very high, and in most cases insurmountable, standard. The courts are correct in exercising caution when reviewing hospital staffing determination. They should avoid creating a situation where they are required to make determinations concerning the appropriateness of care or a particular physician's abilities. Hospitals generally, and private hospitals in particular, should be afforded great deference in their internal staffing decisions. Private hospitals, like other private entities, should be permitted to decide who meets their particular standards and needs without judicial second guessing or, as one judge put it, "Monday-morning quarterbacking."560 Our jurisprudence and governmental system demand respect for the diversity and autonomy of private entities. Judicial intrusion on

551. See generally supra Part III for a discussion of the various theories of review.

552. See supra note 173 and accompanying text for a discussion judicial review of public hospital actions.

553. See generally supra Part III for a discussion of these various theories of review.

554. See supra notes 270, 288 and accompanying text discussing review of decisions excluding physicians.

555. See supra notes 448-548 and accompanying text for a discussion of these theories.

556. See supra notes 159-60, 542-48 and accompanying text for a discussion of the deference courts afford hospital decisions.

557. See supra note 547 and accompanying text for a discussion of standard of review.


559. See supra notes 159-60, 542-48 and accompanying text discussing deference courts afford hospital decisions.

common law or public policy grounds without statutory guidance should be minimized. A court may decide a case and never consider the matter again, but a hospital, its staff, and its patients must live with the consequences. Reinstating a physician or merely discouraging a hospital from taking action against a physician because of fear of lengthy and difficult legal proceedings have long-term consequences for both the hospital and the public. Most importantly, public safety may be compromised.

Courts should find that the hospital and medical staff bylaws are contractually binding in favor of both applicants and medical staff members. The elements of a contract are satisfied, and contract law provides a valid, principled basis for judicial review of credentialing and peer review decisions. Specific statutory provisions also provide a valid basis for judicial review and in some jurisdictions provide a helpful mechanism for administrative review and dispute resolution prior to judicial review. Under these theories, a court can and should determine whether fair procedures were provided to a physician including: notice of the proposed action, notice of the grounds for the proposed action, notice of rights afforded by the bylaws and other regulations, notice of hearings which the physician is entitled to attend, adequate opportunity to prepare a response, opportunity to respond, opportunity to present evidence, a hearing before an unbiased panel, opportunity for appeal, and notice of right to appeal. The court’s review should also include consideration of whether the hospital’s decision was based on a proper purpose as defined by the bylaws or state law. If the procedures in the bylaws were followed, the hospital’s decision should only be overturned if the court finds that the hospital acted arbitrarily and capriciously and contrary to the substantive standards imposed by the bylaws or state law.

561. See supra notes 379-416 and accompanying text discussing contract theory.