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THE ANTITRUST LAWS AND THE MEDICAL PEER REVIEW PROCESS

I. INTRODUCTION

A physician's access to a hospital is essential for that physician's practice of medicine. For a physician to admit patients to the hospital and to utilize the hospital's resources to provide treatment for his or her patients, the hospital must first grant the physician staff privileges.¹ Practicing physicians who obtain staff privileges are often organized, under the hospital's auspices, into self-governing medical staffs, which are responsible for performing numerous technical functions that are essential to the hospital's operation.² One of these functions may be to serve on a medical peer review panel. The medical peer review panel decides whether a physician should initially be granted staff privileges, and whether the staff privileges of a physician should be revoked for cause. As a result of an adverse peer review decision, a physician may seek to resort to the courts in an attempt to force the hospital to grant him staff privileges.³

The Supreme Court, in Summit Health Ltd. v. Pinhas,⁴ recognizes a federal cause of action by a physician who has either been denied medical staff privileges or had those privileges revoked, against the offending hospital and/or medical peer review committee where the physician alleges that the decision of the committee violated the Sherman Act.⁵ For a physician to successfully litigate an antitrust suit against a hospital for the denial of staff privileges under Section 1 of the Sherman Act, the physician must prove: (1) an effect on interstate commerce, thereby fulfilling the jurisdictional requirement, (2) a conspiracy or combination,⁶ and (3) a restraint of trade.⁷ Summit Health Ltd. resolved a split among the federal circuit courts regarding the necessary showing a physician must make to establish jurisdiction under

² Id.
³ Id. at 1076.
⁵ Id.
⁶ Circuit courts remain divided regarding whether physicians participating in the hospital review process should be characterized as a combination or a conspiracy, either among themselves or with the hospital. See infra note 29.
the antitrust laws. In *Summit Health Ltd.*, the Supreme Court held that a physician can surpass the jurisdictional threshold, and thus bring an antitrust suit in federal court against a hospital review committee for denying him staff privileges by liberally construing the jurisdictional requirement of the Sherman Act.

Prior to *Summit Health Ltd.*, the jurisdictional requirement was an obstacle to litigation that hospitals favored as a means of protecting the hospital's medical peer review decisions from antitrust challenges. This is no longer the case. In *Summit Health Ltd.*, the Court held that a plaintiff who alleges an illegal agreement that restrains trade and that is in violation of the Sherman Act need not allege or prove an actual effect on interstate commerce to support federal jurisdiction; nor is a specific purpose to restrain interstate commerce required.

The impact of the Supreme Court's liberal interpretation of the jurisdictional requirements of the Sherman Act is heightened by the fact that the jurisdictional defenses available to hospital peer review committees are otherwise greatly limited. The state action immunity doctrine is one available defense. It provides that if a state has a "clearly articulated policy" to replace competition with regulation, and the state "actively supervises" the regulation, then such suits may not be litigated in federal court. In *Patrick v. Burgert*, however, a hospital's ability to invoke the state action immunity doctrine as a defense was effectively eroded by the Supreme Court. In

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8. The fourth, seventh, eighth, and eleventh circuits held that peer review or credentialing does not affect interstate commerce, and the second, third, sixth, seventh, ninth, tenth and eleventh circuits held that peer review does affect interstate commerce. *Health Care Statute Immunizes Physicians Involved in Peer Review, Antitrust & Trade Reg. Rep. (BNA)* No. 58, at 265, 273 (Feb. 22, 1990). See infra text accompanying notes 40-74 (discussing the nature of the jurisdictional inquiry applied by the circuit courts prior to *Summit Health Ltd. v. Pinhas*).


10. *Id.* at 1854 (Scalia, J., dissenting).

11. *Id.* at 1847-49. The Court held that the interstate commerce requirement of antitrust jurisdiction was satisfied by an ophthalmologist's allegations that the hospital owner, hospital, and its medical staff conspired to exclude the ophthalmologist, who was a duly licensed and practicing physician and surgeon, from the market for ophthalmologist services in Los Angeles because he refused to follow unnecessarily costly surgical procedures. *Id.* The Court also held that ophthalmological services were regularly performed for out-of-state patients, that they generated revenues from out-of-state sources, and, if the conspiracy alleged was successful, as a matter of practical economics, a reduction in the provision of ophthalmological services in the Los Angeles market would occur. *Id.* at 1846-47.

12. See infra notes 75-99 and accompanying text.

13. See infra notes 81-83 and accompanying text.


15. See infra notes 94-99 and accompanying text.
addition, the Health Care Quality Improvement Act (HCQIA)\[^{16}\] provides another possible defense.\[^{17}\] A peer review committee may not rely, however, on the HCQIA to protect itself from the antitrust laws because the HCQIA offers only limited immunity, and the immunity it provides may be defeated if the adversely affected physician bringing the antitrust suit alleges "bad faith," e.g., that the peer review participants were not motivated by quality-of-care concerns.\[^{18}\]

Assuming that jurisdiction is established and that the physician is in a jurisdiction where the peer review committee is construed as a combination in restraint of trade, the federal courts must then evaluate the peer review decisions. Under the antitrust laws, the federal court examines the peer review decision to determine if it is an undue restraint on the competition of physicians.\[^{19}\] To make this determination, courts employ one of two analytical approaches: the per se rule or the rule of reason.\[^{20}\]

If hospital peer review committees' decisions to deny a physician staff privileges are judicially characterized as per se illegal restraints of trade, peer review committees may become less effective.\[^{21}\] For example, if a physician

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17. See infra notes 100-124 and accompanying text.
18. See 42 U.S.C. §§ 11111(a)(1), 11112(a) (1988) (requiring that the professional hold a reasonable belief that his or her actions are warranted by factual findings, incompetence, or misconduct and are in furtherance of quality health care).
20. To determine which of the two approaches to apply, courts will take a "quick look" at the restraint to determine if it is an unreasonable restraint or not. National Collegiate Athletic Ass'n v. Board of Regents of Univ. of Okla., 468 U.S. 85, 100-04 (1984); Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 18-23 (1979). If it is a restraint with which the courts have had judicial experience, they may automatically presume that the restraint unduly restrains competition. Arizona v. Maricopa City Medical Soc'y, 457 U.S. 332, 344 (1982); United States v. Topco Assoc., Inc., 405 U.S. 569, 607-08 (1972). As a result, they may conclude that it is illegal without analyzing the purpose or effect of the restraint. Id. If the restraint does not fit into this per se category, the courts will examine the purpose and probable effects of the restraint. National Collegiate Athletic Ass'n, 468 U.S. at 113-15. They will then weigh the anti-competitive effects, which the plaintiff has the burden to prove, with the pro-competitive effects, which the defendant has the burden to prove, and determine if, the restraint is unreasonable. Id.


21. See Clark C. Havighurst, Professional Peer Review and the Antitrust Laws, 36 CASE W. RES. L. REV. 1117, 1160-61 (1986) (citing 42 U.S.C. § 402(4)) (stating that one purpose of the Health Care Quality Improvement Act was to combat the threat of liability for money damages under the federal laws, including treble damage liability under federal antitrust law because this liability unreasonably discourages physicians from participating in effective professional peer review)).
knows his contribution to an adverse peer review decision will be a per se
violation of the antitrust laws that may subject him or her to treble damages,
then he or she will have a strong disincentive to participate as a member of a
peer review committee. In the alternative, federal courts employing the
rule of reason analysis decide cases based upon the merits of the peer review
process. In doing so, the federal courts examine not only the procedures
that hospitals utilized, but also, more importantly, the substantive content of
the peer review hearings. The result is that previously confidential materi-
als become publicly available. Thus, a participating physician’s comments in
a peer review process may expose him to liability, or at least make him a
candidate, for either defamation in a private suit by the affected physician, or
treble damages in an antitrust suit. Thus, whether the courts apply the per
se rule or the rule of reason, the effect is the same. Due to the potential
liabilities that participating physicians may incur, they will not want to par-
ticipate in peer review committees. As a result, the medical peer review pro-
cess as a viable hospital policy and as a method for physicians to police
themselves may cease to exist. If physicians decline to participate in the
medical peer review process due to the possible liabilities they may incur by
doing so, what may happen to the quality of patient care?

This Comment discusses how a physician may, in light of Summit Health
Ltd., establish an antitrust suit against a hospital peer review committee for
denying him or her staff privileges. Next, the Comment shows the extent to
which the hospital is left with an immunity defense to an antitrust suit under
either the state action doctrine after Patrick v. Burget or under the Health
Care Quality Improvement Act. The Comment then discusses the impact of
allowing antitrust violations to be brought in federal court upon the medical
peer review process. The Comment concludes with a discussion of the effect
that the availability of antitrust liability for peer review decisions is likely to
have on the quality of patient care, and recommends courses of action that
permit hospitals and physicians to retain the medical peer review process
while ensuring that their objectives are not defeated by the threat of an anti-
trust suit.

II. THE PEER REVIEW PROCESS AS A CONTRACT, COMBINATION, OR
CONSPIRACY

The medical peer review process imposes dual responsibilities on partici-
The physician becomes a peer evaluator for the hospital while remaining an individual provider of health care services in that hospital, in direct or indirect competition with those individuals he will review. As a result, concern arises that anti-competitive reasons may underlie the decision-making process to limit or deny another physician staff privileges.

Because of the possibility that the denial or termination of a physician's staff privileges may result from anti-competitive motives, courts are split regarding whether such committees may constitute a "contract, combination, or conspiracy" in restraint of trade. In *Copperweld Corp. v. Independence* (1984), the court held that a corporation may not conspire with itself because this "looks to the form of an enterprise's structure and ignores the reality" and cautioning that adopting a rule that penalized coordinated conduct simply because a corporation delegated certain responsibilities to autonomous units might well discourage corporations from creating divisions with their presumed benefits; *Nurse Midwifery Ass'n v. Hibbett* (1991), *cert. denied*, 112 S. Ct. 406 (1991) (holding that when competing physicians are making privilege recommendations concerning another competitor, sufficient anti-competitive concerns are raised to warrant a conclusion that the members of a medical staff are not acting as agents of the hospital for purposes of precluding a conspiracy among the staff members; the medical staff were acting as agents of the hospital); *Nanavati v. Burdette Tomlin Memorial Hosp.* (1988), *cert. denied*, 489 U.S. 1078 (1989) (holding that a medical staff is a group as a matter of law for actions it takes as a group); *Cooper v. Forsyth County Hosp. Auth.* (1986), *cert. denied*, 479 U.S. 972 (1986) (recognizing that making a peer review recommendation does not prove the existence of a conspiracy). *See also* Oksanen v. Page Memorial...
the Supreme Court held that an intracorporate agreement cannot constitute a conspiracy. Thus, because a peer review decision is usually based upon the medical staff's recommendation, and is ultimately made by the hospital's board of trustees, intracorporate immunity would likely apply. In other words, the hospital staff cannot be held to have conspired with their employer, the hospital board, within the meaning of Section 1 of the Sherman Act.

The application of intracorporate immunity to the medical peer review process has not been widely accepted. In Weiss v. York Hospital, the United States Court of Appeals for the Third Circuit held that a medical staff is a "combination" for antitrust purposes. In Weiss, the court reasoned that physicians on a medical staff who participated in a medical peer review proceeding were tantamount to a combination because of their status as independent entities capable of joint action. The court restricted the application of the Copperweld holding to instances in which employees did not have separate interests from their employers. For example, physicians who are salaried employees of the hospital may enjoy intracorporate immunity; whereas physicians who are in private practice may not.

Until the Supreme Court resolves this split among the circuits on the issue of conspiracy in restraint of trade, jurisdiction will be an important issue in litigation under the Sherman Act. In those jurisdictions where the medical

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31. Id. at 769.
32. Sharon A. Christie, Note, Denial of Hospital Admitting Privileges for Non-Physician Providers — A Per Se Antitrust Violation?, 60 NOTRE DAME L. REV. 724, 730 (1985) (referring to Copperweld Corp. v. Independence Tube Corp., 104 S. Ct. 2731, 2741 (1984)). In Copperweld, the Supreme Court held that officers or employees of the same firm do not provide the plurality of actors imperative for a section 1 Sherman Act conspiracy. Cooperweld, 104 S. Ct. at 2741. In addition, the Court held that a corporation does not violate section 1 of the Sherman Act by agreeing to pursue a course of action with a wholly-owned subsidiary. Id. at 731.
33. Id.
34. 745 F.2d 786, 815 (3d Cir. 1984).
35. Id.
36. Id.
37. Christie, supra note 32, at 731.
39. See cases cited supra note 29.
peer review committee can be construed as a "contract, combination or conspiracy" in restraint of trade, the test the Supreme Court recently announced in Summit Health Ltd. for establishing federal jurisdiction ensures these cases will be litigated in federal court under the antitrust laws.

III. THE INTERSTATE COMMERCE REQUIREMENT OF THE SHERMAN ACT AND THE PEER REVIEW PROCESS

The Sherman Act limits the reach of the federal antitrust laws to conduct that affects interstate commerce.\(^{40}\) Thus, plaintiff-physicians challenging staffing privileges decisions under the Act must first overcome this jurisdictional requirement.\(^{41}\) The circuit courts are divided regarding whether the jurisdictional requirement is surmountable.\(^{42}\) Courts have relied upon three analytical frameworks to decide if the decision to deny a physician staff privileges affects interstate commerce: 1) Does it affect the plaintiff’s activity in interstate commerce,\(^{43}\) 2) does it affect the defendant’s general business activity,\(^{44}\) or 3) does it affect the defendant’s specific activities related to the denial of staff privileges?\(^{45}\)

If the court focuses upon the effect the restraint will have on the plaintiff’s activity in interstate commerce, the jurisdictional requirement is more easily satisfied. The plaintiff-physician simply needs to show either that he treats patients who are covered by Medicare or Medicaid,\(^{46}\) that his patients travel across state lines to receive his treatment,\(^{47}\) or that he is reimbursed for his


\(^{41}\) Havighurst, supra note 1, at 1142.

\(^{42}\) In the following cases, the courts decided that physicians were unable to prove an effect on interstate commerce: Seglin v. Esau, 769 F.2d 1274, 1283-84 (7th Cir. 1985); Hayden v. Bracy, 744 F.2d 1338, 1342-43 (8th Cir. 1984); Furlong v. Long Island College Hosp., 710 F.2d 922, 925-26 (2d Cir. 1983); Cordova & Simponpietri Ins. Agency, Inc. v. Chase Manhattan Bank, 649 F.2d 36, 45 (1st Cir. 1981); Thompson v. Wise Gen. Hosp., 707 F. Supp. 849, 854-56 (W.D. Va. 1989), aff’d, 896 F.2d 547 (4th Cir. 1990); Cardio-Medical Assocs. v. Crozer-Chester Medical Ctr., 536 F. Supp. 1065, 1080-84 (E.D. Pa. 1982), rev’d, 721 F.2d 68 (3d Cir. 1983). Compare the following cases, in which the courts decided that physicians were able to prove an effect on interstate commerce: Shahawy v. Harrison, 875 F.2d 1529, 1535 (11th Cir. 1989); McElhinney v. Medical Protective Co., 549 F. Supp. 121 (E.D. Ky. 1982); Memorial Hosp. v. Shadur, 664 F.2d 1058, 1063 (7th Cir. 1981); Crane v. Intermountain Health Care, Inc., 637 F.2d 715, 725 (10th Cir. 1980).


\(^{45}\) Christie, supra note 32, at 732-33 n.47.


service by out of state insurance companies.\textsuperscript{48}

When focusing upon the effect that defendants' activities have on interstate commerce in order to establish federal jurisdiction, the courts are inconsistent in both their methodologies and their results.\textsuperscript{49} Summit Health Ltd. suggests that courts should increasingly construe the jurisdictional requirement in an expansive way so that the granting of jurisdiction will essentially be guaranteed.\textsuperscript{50}

Until 1980, the nature of this jurisdictional inquiry (with respect to restraints not targeted at the very flow of interstate commerce),\textsuperscript{51} was clear: Would the restraint at issue, if successful, substantially affect interstate commerce?\textsuperscript{52} In 1980, the Supreme Court, in McLain v. Real Estate Board of

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\item \textsuperscript{48} Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 744 (1976).
\item \textsuperscript{49} Summit Health Ltd. v. Pinhas, 111 S. Ct. 1842, 1849-50 (1991).
\item \textsuperscript{50} Id. at 1843. Pinhas, an ophthalmologist on the staff of Midway Medical Center, alleged that Midway Medical Center conspired to exclude Pinhas from the Los Angeles ophthalmologist services market by terminating his staff privileges via the peer review process, mainly because Pinhas refused to follow an unnecessarily costly surgical procedure used at Midway. \textit{Id.} The Court found that Midway's peer review proceedings obviously affected its entire staff, and that Pinhas need not make a particularized showing of the effect on interstate commerce caused by the alleged conspiracy. \textit{Id.} The Court held that Pinhas' allegations satisfied the Sherman Act's jurisdictional requirements, and that to be successful, Pinhas need not allege an actual effect on interstate commerce. \textit{Id.} at 1834-44. The Court reasoned that because the essence of any Section 1 violation is the illegal agreement itself, the proper analysis should focus upon the potential harm that would ensue if the conspiracy were successful, not upon actual consequences. \textit{Id.} As such, in \textit{Summit Health Ltd.}, the Court found that if the conspiracy alleged in the complaint were to be successful, then, as a matter of practical economics, there would be a reduction in the provision of ophthalmological services in the Los Angeles market. \textit{Id.}
\item \textsuperscript{51} K.A.G. & M.A.G., \textit{The Interstate Commerce Test for Jurisdiction in Sherman Act Cases and Its Substantive Applications}, 15 GA. L. REV. 714 (1981) [hereinafter \textit{Interstate Commerce Test}]. There are two ways a plaintiff can establish subject matter jurisdiction in federal court. One is the "in-commerce" theory. \textit{Id.} at 714. Under this theory, jurisdiction is proper where the plaintiff sufficiently alleges that the defendant's unlawful conduct occurred in interstate commerce. \textit{E.g.}, United States v. Shubert, 348 U.S. 222 (1955) (holding that a complaint alleging that defendants restrained business in interstate commerce stated a cause of action); United States v. Socony Vacuum Oil Co., 310 U.S. 150 (1949) (holding that a combination formed for the purpose and with the effect of fixing the price of a commodity in interstate commerce or foreign commerce is illegal per se under the Sherman Act); United States v. Yellow Cab Co., 332 U.S. 218 (1947) (holding that the complaint was sufficient because the transportation of passengers between railroad stations in Chicago was deemed a part of the stream of interstate commerce). Alternatively, under the "effect-on-commerce" theory, a plaintiff can establish jurisdiction by alleging that the defendant's unlawful conduct, although occurring in intrastate commerce, had a substantial effect on interstate commerce. See \textit{Interstate Commerce Test} at 714. It is the "effect-on-commerce" theory to establishing jurisdiction to which the above text is referencing.
\item \textsuperscript{52} Summit Health Ltd., 111 S. Ct. at 1849 (Scalia, J., dissenting); see \textit{Interstate Commerce Test}, supra note 51, at 716-17 (citing Hospital Bldg. Co. v. Rex Hosp. Trustees, 425 U.S. 738, 741, 744 (1976) (finding that a restraint of trade substantially affecting interstate com-
\end{itemize}
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New Orleans, Inc., 53 "appeared to shift the focus of the inquiry away from the effects of the restraint itself, asking instead whether the [defendant's] activities which allegedly have been infected by a price-fixing conspiracy . . . have a not insubstantial effect on the interstate commerce involved." 54 This language introduced the more expansive "infected activity" test, suggesting that courts should broadly construe the interstate commerce requirement. 55 After McLain, the courts were divided regarding whether the interstate commerce inquiry should focus on the defendant's general business activity or on the particular challenged conduct of the defendant. 56

The Third and Ninth Circuits have adopted a broad interpretation of McLain, holding that if the defendant's overall business activity affects interstate commerce, then jurisdiction under the Sherman Act exists. 57 Therefore, even "local" activity could fall within the reach of the Sherman Act if some aspect of the activity affects interstate commerce. 58 As such, the general business activities test merely requires the plaintiff-physician to show that the hospital's overall conduct affects interstate commerce. This is not a difficult factor to prove because hospitals generally purchase supplies...
from out-of-state companies or receive reimbursements from out-of-state insurance companies. 59

The First, Second, Sixth, Eighth, and Tenth Circuits have narrowly interpreted McLain, requiring "a showing that the challenged activity affects interstate commerce." 60 That is, a plaintiff-physician must show that the challenged hospital action significantly touches the flow of interstate commerce. 61 As such, this approach shifts the emphasis away from individual competitors (for example, the exclusion of a single physician from a single hospital) to the impact on competition and consumer welfare. 62

The difficulty with the "challenged conduct" test is that the circuit courts, asserting only that general allegations regarding the hospital's overall business activities would not be enough, have yet to establish what conduct is sufficient to guarantee jurisdiction. 63 Courts utilizing the "infected activities" test disagree regarding which activities of the defendants are "infected." For example, are they: 1) the activities of the entire hospital?; 64 or 2) only the activities of the eye surgery department?; 65 or 3) the entire practice of particular surgeons who use the hospital?; 66 or 4) the peer review process itself? 67 Other courts continued to maintain that the ultimate question is whether the unlawful conduct itself, if successful, would substantially effect interstate commerce, thus avoiding the dictum of McLain. 68

In Summit Health Ltd. v. Pinhas, the Supreme Court adopted yet another test by which federal jurisdiction under the Sherman Act may be determined and, as a result, definitively established that antitrust suits against the peer

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60. Christie, supra note 32, at 734 n.54.
61. Id.
62. Havighurst, supra note 1, at 1143.
66. See Shahawy v. Harrison, 778 F.2d 636, 641 (11th Cir. 1985) (finding "infected activity" where defendant physicians denied plaintiff cardiologist access to hospital cardiac catherization lab).
review process qualify for federal jurisdiction.\textsuperscript{69} In his dissenting opinion in Pinhas, Justice Scalia stated:

To determine Sherman Act jurisdiction, [the Court] looks neither to the effect on commerce of the restraint, nor to the effect on commerce of the defendants' infected activity, but rather, it seems, to the effect on commerce of the activity from which the plaintiff has been excluded . . . . \textsuperscript{70} The test of Sherman Act jurisdiction is whether the entire line of commerce from which [the plaintiff] has been excluded affects interstate commerce . . . . \textsuperscript{71} The jurisdictional question is simply whether that market affects interstate commerce, which of course it does.\textsuperscript{72}

In Summit Health Ltd. v. Pinhas, the Supreme Court, consistent with McLain, found that a plaintiff asserting a claim under Section 1 of the Sherman Act need not allege, nor prove, an actual effect on interstate commerce in order to support federal jurisdiction.\textsuperscript{73} The Court held that allegations that the hospital, doctors, and others entered into a conspiracy to exclude an ophthalmologist from the market for ophthalmological services in Los Angeles by revoking his staff privileges at the hospital established a sufficient nexus with interstate commerce to support federal jurisdiction.\textsuperscript{74} The proceedings affect the entire staff at Midway and thus affect the hospital's interstate commerce.\textsuperscript{75} The Supreme Court inferred that the denial of staff privileges would have an effect on the entire staff of the hospital, which in turn would affect interstate commerce.\textsuperscript{76} As such, Summit Health Ltd. v. Pinhas removed the jurisdictional issue as a viable barrier to federal court for the antitrust plaintiff physician.

\textbf{IV. THE STATE ACTION DOCTRINE IMMUNITY: A TRADITIONAL DEFENSE OF IMMUNITY FROM THE ANTITRUST LAWS FOR PEER REVIEW COMMITTEES, EFFECTIVELY ERODED BY THE SUPREME COURT'S DECISION IN PATRICK V. BURGET\textsuperscript{77}}

Most state statutes grant participants in the expert medical peer review

\textsuperscript{69} Summit Health Ltd., 111 S. Ct. at 1850 (Scalia, J., dissenting).
\textsuperscript{70} Id.
\textsuperscript{71} Id. at 1847-48.
\textsuperscript{72} Id. at 1848-49.
\textsuperscript{73} Id. at 1848.
\textsuperscript{74} Brown v. Our Lady of Lourdes Medical Ctr., 767 F. Supp. 618, 626-27 (1991) (citing Summit Health Ltd. v. Pinhas, 111 S. Ct. 1842, 1848 (1991), to support the inference that the denial of staff privileges for plaintiff doctor would effect the entire staff of the hospital, which, in turn, would effect interstate commerce).
\textsuperscript{75} 486 U.S. 94 (1988).
process immunity from civil liability. This legal protection provided by state law is called state action doctrine immunity. Many courts, in the interest of not proceeding to the issue of whether anti-competitive behavior occurred during the peer review decision-making process, simply grant the defendant peer review committees immunity based upon the state action doctrine. State action doctrine immunity was first established as a defense to antitrust violations by the Supreme Court in Parker v. Brown. Specifically, the Court held that the Sherman Act did not "restrain state action or official action directed by a state." The Court established a two-prong test in California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc. to determine if state action immunity from the antitrust laws should apply to the state regulation of the private parties. The challenging restraint must be: 1) "clearly articulated and affirmatively expressed as state policy, . . . [and (2)] the private anti-competitive conduct must be actively supervised by the state itself."

In 1985, the Supreme Court, in Southern Motor Carriers Rate Conference, Inc. v. United States, expanded immunity under the state action doctrine to include private parties. The Supreme Court accomplished this by applying the test developed in California Retail Liquor Dealer Ass'n v. Midcal Aluminum (the Midcal test) to private parties whose conduct was authorized, but not compelled, by state statutes. In Southern Motor, the Court stated that the "clear articulation" prong of the Midcal test is fulfilled if the state merely intends to displace competition with regulation through its stat-

77. Id.
78. See, e.g., Parker v. Brown, 317 U.S. 341 (1943) (holding that in the absence of Congressional legislation regulating the transactions affected by the state agricultural program, the state restrictions imposed on in-state sales between the producer and the processor who puts commodity into interstate commerce does not violate the Commerce Clause).
79. Id. at 352.
80. Id. at 351.
82. Id.
83. Id. at 105 (citing City of Lafayette v. Louisiana Power & Light, 435 U.S. 389, 410 (1978)).
86. Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 48-49 (1984) (holding that petitioners' collective ratemaking, although not compelled by the respective states, was immune from federal antitrust liability under the state action doctrine and that the Midcal test should be used to determine whether the private rate bureaus' collective ratemaking activities were protected under the federal antitrust laws).
utory scheme. Southern Motor had important implications for the protection of the peer review process because it raised the possibility that the state action doctrine immunity could extend to peer review committees as "private parties".

Following Southern Motor, courts have differed regarding whether the state action exemption to the antitrust law applies to private facilities as well as to members of peer review committees. The differences in outcome reflect differing analyses of the state statutes authorizing peer review. Specifically, the outcomes are based upon the court's interpretation of whether the state's statutes clearly articulate the restraint to be tantamount to a state policy, and whether the conduct was actively supervised by the state itself. If the state does not mandate peer review as a process to regulate physicians, in lieu of competition, and if the state does not supervise the peer review

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87. Id. at 64.
88. Id. at 58-59.
90. Id.
91. Those courts that have found that state action applies, have emphasized that the state statutory schemes have an articulated purpose of replacing competition with regulation and that such schemes provide for state administrative and judicial review of peer review activities. Those state courts that have denied application of the state action exemption have found that the peer review statute under scrutiny provided for a nonmandatory scheme of peer review precluding a finding of state action and either that such statutes did not articulate an intention to replace competition with regulation or that the particular scheme did not provide for active administrative and judicial supervision and review of the peer review process; see also Tambone v. Memorial Hosp., 825 F.2d 1132 (7th Cir. 1987) (holding that because Illinois statutes did not provide for any review by a state body of the medical staff's privilege decisions, the "active supervision" prong of the Midcal test had not been met and thus immunity for the peer review committee would not apply. As a result immunity from the antitrust laws could not be invoked when a physician was denied staff privileges and brought such a suit against the hospital peer review committee.); Quinn v. Kent Gen. Hosp., 617 F. Supp. 1226 (D. Del. 1985) (holding that the court could find no intent by the state to displace competition between physicians with regulation of the sort envisioned by the peer review process. Thus, the court found that the Midcal test was not met. Accordingly, immunity from the antitrust laws would not attach to a hospital peer review committee that refused a physician a position on the medical staff). Compare Marresse v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984), cert. denied, 472 U.S. 1027 (1985) (holding that members of the medical review committee were immune from antitrust liability, and satisfying the Midcal test. The state supervises the conduct of the peer review boards through the state medical boards which govern the licensing of both individual physicians and hospitals such that if hospitals do not maintain fair and adequate procedures for privilege termination decisions they risk loosing their licenses; furthermore state's statutes exhibit a clear policy of limiting a physician's access to staff privileges at hospitals.) with Posner v. Lankenau Hosp., 645 F. Supp. 1102 (E.D. Pa. 1986) (holding that the medical staff and the hospital were not immune from the antitrust laws).
process, at least by judicial review, then the state action immunity defense may not protect a hospital peer review committee from the antitrust laws for the alleged anti-competitive conduct.93

In Patrick v. Burget,94 the Supreme Court strictly construed the “active supervision” prong of the Midcal test, and held that the state-sponsored or affiliated body must have more than the power to review the anti-competitive conduct of the party claiming state action immunity.95 The state body must also have the power to strike down actions beyond the state policy.96 In effect, the Court required that the state body have an ultimate veto power over any hospital peer review decision for the state to qualify as actively supervising the activity.97 The Patrick decision did not hold that judicial review could never constitute sufficient “active supervision” under the Midcal test. In fact, Patrick is interpreted to sanction judicial review as adequate state supervision. Patrick does, however, require that the judicial review cover the procedural mechanisms employed in making the peer review decision as well as the merits of the substance of the adverse peer review decision.98 Ultimately, the Patrick decision has made it difficult for a hospital to invoke the state action doctrine to shield the peer review board’s privilege decisions from the antitrust laws.99

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93. See supra note 91 and accompanying text.
95. Id. at 101.
96. Id. “[N]o state actor in Oregon actively supervises hospital peer review decisions.” Id. at 105. Specifically, the court noted that the Oregon Health Division, the Oregon Board of Medical Examiners, and the judiciary did not have the “power to review a private peer review decision and overturn a decision that fails to accord with state policy . . . .” Id. at 102. The court did not indicate how extensive state or judicial review of the peer review process must be. It simply stated that “judicial review of privilege-termination decisions in Oregon, if such review exists at all, falls far short of satisfying the active supervision requirement.” Id. at 104.
98. See Bolt v. Halifax Hosp. Medical Ctr., 851 F.2d 1273, 1282 (11th Cir.), vacated, 861 F.2d 1233 (11th Cir. 1988), modified, 874 F.2d 755 (11th Cir. 1989) (en banc) (advocating judicial review of a state agency and noting that the court was uniquely or better suited “to divine, interpret and enforce legislative policy”). The judicial review of this case entailed review of both the procedures and the substance of the peer review procedures to determine the merits of the decision that the peer review committee had reached. Id. at 1282.
99. See Shahawy v. Harrison, 875 F.2d 1529 (11th Cir. 1989) (reversing district court’s grant of summary judgment on the grounds that the state action doctrine does not immunize the hospital board from plaintiff doctor’s antitrust claim).
V. THE PROTECTION A PEER REVIEW COMMITTEE MAY OBTAIN FROM THE ANTITRUST LAWS UNDER THE HEALTH CARE QUALITY IMPROVEMENT ACT

Undoubtedly, the jury verdict in Patrick was the primary impetus for medical professionals to testify before Congress for legal protection to enable them to continue to participate in peer review proceedings. In Patrick, the Supreme Court reinstated the jury’s $2.2 million award to a physician whose staff privileges were terminated. This award bankrupted a number of the doctors who served on the committee that had criticized the injured physician. As such, the Patrick decision had a chilling effect on the willingness of physicians to come forward and speak out regarding their concerns about a colleague’s capabilities. In addition, fewer hospitals took action against doctors they thought were incompetent due to the tremendous legal costs involved. Testimony of physicians before Congress disclosed that

100. Patrick v. Burget, 486 U.S. 94, 94 (1988). The Patrick case involved hospital peer review proceedings against Dr. Timothy Patrick, a surgeon in Astoria, Oregon. The defendant peer reviewers claimed that they recommended that Dr. Patrick’s hospital staff privileges be revoked because of serious questions about the quality of his patient care. Charity Scott, Justices Widen Sherman Act’s Application to Hospital Policy, THE NAT’L L. J., Sept. 1991, at 24 (citing Patrick v. Burget, 486 U.S. 94, 97 (1988)). Dr. Patrick countered that the defendants, who had previously offered to make him a partner in their private medical clinic, were not acting out of concern about his professional competence but rather out of a desire to eliminate him as a competitor in their community. Patrick, 486 U.S. at 97-98. The jury agreed with Dr. Patrick and awarded him $650,000 in damages. The trial court then trebled the award, and the Supreme Court upheld this decision on appeal.


103. Ron Wyden, The Physicians’ Peer Review Process Needs Protection, WASH. POST, Nov. 4, 1986, at A6; see Health Care Quality Improvement Act Hearings, supra note 101, at 3 (stating that doctors who are sufficiently fearful of the threat of litigation will not participate in meaningful peer review).

104. Leigh Page, Hard Times in States Afflict Underfunded Licensure Boards, AM. MED. NEWS, Mar. 2, 1992, at 10 (reporting that just a few legal challenges of board decisions by
instead of pursuing a course of legal action, the hospitals may opt for a "plea bargain." The hospital may ask the offending physician to leave, in exchange agreeing to keep quiet about the physician's incompetence. The doctor picks up and moves to a different state where the authorities who grant him privileges in the new territory have no knowledge of the physician's track record.

In response to widespread concerns, heightened by the Patrick decision, that potential legal liability would dissuade responsible physicians from participating in medical peer review, Congress found "an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." To encourage physicians to participate in rigorous peer review, Congress passed the Health Care Quality Improvement Act (HCQIA) with the express purpose of encouraging good faith peer review.

The HCQIA offers hospital peer review committees a limited amount of protection from the antitrust laws if certain requirements are met. First, the procedural safeguards of a hearing must be provided to the individual disciplined doctors can dry up already tenuous finances). One such challenge can easily cost a board $30,000. For this reason, boards often prefer not to formally discipline physicians. Informal actions, such as consent orders and stipulated agreements, make up 90% of board actions in some states.

105. Id. 106. Id.; Medical Malpractice Hearings, supra note 101, at 311-12 (1986) (stating that the standard practice is for physicians to try to negotiate surrendering their license to a state medical board in exchange for dropping charges to save their reputation and then to move their practice into another jurisdiction ). Representative Waxman noted the reasons why a hospital might prefer "plea bargaining" by giving a neutral recommendation in exchange for a "voluntary" resignation in order to get rid of incompetent physicians and pass them on to someone else. Id. See also Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540 Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary, 99th Cong., 2d Sess. 34 (1986) (stating that in many cases voluntary surrender of a license became part of a "plea bargain" arrangement whereby the boards could avoid costly due process hearings).

107. See supra note 106.


111. Id. § 11101(5).

112. Id. § 11111(a)(1). The Act also provides for a computerized system for keeping track of interstate movements of physicians who were denied staff privileges. Id. §§ 11137, 11151-52. The Act also prohibits physicians in direct economic competition with the physician being evaluated from participating in that physician's peer review. Id. § 11112.
who is the subject of the medical review. Second, the peer review committee must report their actions to the state’s Board of Medical Examiners who will report the same to the Secretary of the Department of Health and Human Services. In addition, the HCQIA requires that the medical peer review action must be taken:

1) in the reasonable belief that the action was in the furtherance of quality health care;
2) after a reasonable effort to obtain the facts of the matter;
3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of (3) above.

The HCQIA includes a rebuttable presumption that the hospital peer review committee complied with these requirements. Thus, if the hospital peer review process complies with the statutory requirements, it is considered a “qualified professional review,” and may enjoy a limited immunity from the antitrust laws. Specifically, the Act limits the remedies available

113. Id. § 11112(b). A health care entity is deemed to have met the adequate notice and hearing requirements if the following are met:
   1) The physician has been given notice of a proposed action and the reasons for the action;
   2) Not less than 30 days before a hearing, the physician is notified regarding the place, time and date of the hearing and is given a list of the witnesses expected to testify;
   3) The hearing is held before either an arbitrator who is mutually acceptable to the physician and the health care entity, or before a hearing officer, or before a panel of individuals who are not in direct economic competition with the physician;
   4) The physician has the right to be represented at the hearing by an attorney. He is entitled to have a record made of the proceedings and has the right to call, examine, and cross-examine witnesses. He can submit a written statement at the close of the hearing and upon completion of the hearing, the physician had the right to receive a written recommendation of the arbitrator, hearing officer or panel, and the written decision of the health care entity.

114. 42 U.S.C.A. § 11112(a), (b), implies that if a health care entity follows applicable state law or its own bylaws even if they provide fewer procedures, it will probably satisfy the “adequacy” requirement. Ila S. Rothchild, Major Omnibus Health Package Becomes Law, Health L. Vigil, Dec. 19, 1986, at 3.

115. Id. § 11112(a). Thus, immunity is only afforded to good faith peer review, and not in instances “[w]here the medical staff physicians are found to be pursuing their personal economic interests and are not acting solely on behalf of the hospital”. Henry S. Allen, Jr. & Jeffrey M. Teske, Note, Ninth Circuit Upholds Antitrust Violation in Hospital’s Exclusive Contracting for Anesthesia Services, J. Health & Hosp. L., Feb. 1989, at 1.


117. Initially, the House Committee on Energy and Commerce considered establishing a
to an aggrieved physician to injunctive or declaratory relief. However, a state may opt out of Section 11111(a) of the HCQIA, and thereby make money damages available. In addition, a defendant peer review committee that wins an antitrust suit may collect the cost of the suit, including attorney fees, if the claim or claimant's conduct during litigation was "frivolous, unreasonable, without foundation, or in bad faith." Importantly, though, the HCQIA will not shield physician peer review committees that engage in anti-competitive business practices. The HCQIA also does not grant its limited immunity to a peer review committee that conducts unfair proceedings or denies due process.

In sum, the HCQIA offers limited immunity to peer review committees, and introduces the federal government into the peer review process. The limited nature of this immunity is exemplified by the statistic that only one case to date has been decided in favor of the peer review committee under very broad protection from professional review lawsuits. Allen & Teske, supra note 115, at 2-3. However, there were concerns that such broad protection might be abused or serve as a shield for anti-competitive economic actions under the guise of quality controls. Id. References to the limited nature of the immunity were made repeatedly during the hearings and debates, evidently to quell strong criticisms of the grant of immunity in the first place. Charity Scott, supra note 26, at 327 n.53 (citing H.R. REP. No. 903, 99th Cong., 2d Sess. 3 (1986), reprinted in, 1986 U.S.C.C.A.N. 6384, 6385 ("limited, but essential immunity"); 132 CONG. REC. H9957 (daily ed., Oct. 14, 1986) (Rep. Waxman, noting "limited immunity"); 132 CONG. REC. H9962 (Rep. Madigan, "very limited immunity", "carefully drawn immunity"); 132 CONG. REC. H9963 (Rep. Tauke, "limited immunity").


119. 42 U.S.C. § 11111(c)(2)(B). Another limit to the protection from the antitrust laws provided for by the Health Care Quality Improvement Act is that it only applies to peer review activities that are concerned with physician discipline. Ronald F. Wright & Jack C. Smith, State Level Expert Review Committees — Are They Protected?, PUB. HEALTH REP., Jan.—Feb. 1990, at 22. It does not cover credentialing decisions or expert reviews such as maternal mortality reviews. Id.

120. 42 U.S.C. § 11113 (permitting payment of reasonable attorney's fees and costs in defense of suit).

121. See, e.g., Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810, 821-22 (11th Cir.), cert. denied, 495 U.S. 924 (1990) (holding peer review to be a pretext for anti-competitive exclusion); Boczar v. Manatee Hosps. & Health Sys., Inc., No. 88 Civ. 1867 (M.D. Fla. 1991) (finding the suspension of an obstetrician's staff privileges to be motivated by anti-competitive exclusion).

122. See, e.g., Miller v. Indiana Hosp., 843 F.2d 139, 144 (3d Cir.), cert. denied, 488 U.S. 870 (1988) (reversing grant of summary judgment in favor of a hospital where sufficient evidence existed, which, if proven, would show that the hospital's revocation of the physician's privileges was motivated by anti-competitive purposes, even though ostensibly for professional incompetence).
the HCQIA. In *Austin v. McNamara*, a hospital and physicians, suing under the antitrust laws, were successful in obtaining summary judgment by invoking immunity based upon the HCQIA.

### VI. THE FUTURE OF PEER REVIEW COMMITTEES

#### A. Background

The medical peer review process is primarily a quality control mechanism. It is the mechanism through which hospitals are able to ensure quality patient care. Medical peer review committees seek to ensure the quality of patient care through credentialing and peer review. Credentialing consists of investigating physicians to determine whether they should be appointed or reappointed to the hospital staff. Peer review is an ongoing process through which physicians' practices are monitored to identify the delivery of substandard or unacceptable patient care. As such, it is a process through which the medical profession polices itself.

The peer review process, however, is more than physician self-regulation. It is a device that benefits hospitals, physicians, and the public alike. The intended results of the peer review process are that: 1) hospitals hire and retain competent physicians; 2) physicians obtain medical and educational review of their work, and by being granted staff privileges, obtain access to operating facilities, sophisticated medical equipment and support personnel; and 3) the public secures access to the highest quality of medical services.


124. *Id.* at 938, 942.


127. *Id.*

128. *Id.*

129. *Id.* at 1025, 1032 (citing Haines, *Hospital Peer Review Systems: An Overview*, HEALTH MATRIX, Winter 1984-85, at 30 (detailing the history of peer review in hospitals)).


131. *Id.*

132. *Id.*
B. The Discoverability of Peer Review Committee Records

Most states require hospitals to have medical peer review committees.133 Review committees are also required by federal law as a prerequisite to receiving funding for certain programs.134 In addition, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), a nongovernmental organization consisting of private physicians and hospital representatives, requires hospitals to maintain a medical review system as a condition to accreditation.135 This requirement substantially affects hospital policy be-

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133. See, IIB, HOSPITAL LAW MANUAL (MEDICAL STAFF) §§ 1-2, at 7-9 (1987).

134. See, e.g., 42 U.S.C. §§ 1395 x(e), 1395 (k) (1982); HOSPITAL LAW MANUAL, supra note 133, §§ 1-3, at 9-10. These state and federal mandates, however, do not make the actions of the medical peer review committees automatically "state action." In Patrick v. Burget, 486 U.S. 94 (1988), the Supreme Court held the "state action" doctrine does not immunize peer review activities that are not reviewed by the state judiciary from the antitrust laws. Id. at 105. The Court also noted that the Health Care Quality Improvement Act expressly provides that "it does not change other 'immunities under law', § 11115(a), including the state action immunity, thus allowing states to immunize peer-review action that does not meet the federal standard." Id. at 105-6 n.8.

On the federal level, the immunity provided by § 11111(a)(1) of the Health Care Quality Improvement Act can be forfeited if the health care entity fails to report any disciplinary action taken against a physician resulting from a professional review action. Health Care Statute Immunizes Physicians Involved in Peer Review, ANTITRUST & TRADE REG. REP. (BNA), No. 58, at 265, 266 (Feb. 22, 1990); BARRY R. FURROW, HEALTH LAW 813 (2d ed. 1991) (citing Austin v. McNamara, 731 F. Supp. 934 (C.D. Ca. 1990)). The details of a professional review action that adversely affects the clinical privileges of a physician for more than thirty days must be reported to the board of medical examiners. Id. The defendants can qualify for immunity under the HCQIA [only] if they can demonstrate that: (1) the professional review actions complied with the standards set forth in 42 U.S.C. § 11112; (2) the results of the professional review actions were properly reported to the state authorities in compliance with 42 U.S.C. §§ 11131(c)(1), 11151(2); and (3) the professional review actions occurred on, or after November 14, 1986, the effective date of the HCQIA. Id.

The HCQIA, however, does not require all of the procedures of § 11112 be followed as a prerequisite for immunity. The Act also permits "such other procedures as are fair." 42 U.S.C. § 11112(a)(3). In fact, the Act explicitly provides that the failure to provide all the "adequate notice and hearing procedures" set forth in § 11112(b) "shall not, in itself, constitute failure to meet the standards" necessary to qualify for immunity. Jack Bierig, Peer Review after Patrick, J. HEALTH & HOSP. L., June 1988, at 135, 137 n.27.

Courts have correctly rejected the contention that the private nonprofit hospital's actions are state action, and are therefore subject to judicial review. Seimetz, supra note 130, at 485 noting that eight of the federal appellate circuits have held that private hospitals, despite their public nature, are not subject to the amendment's due process clause and citing Hodge v. Paoli Memorial Hosp., 576 F.2d 563 (3d Cir. 1978); Schlein v. Milford Hosp., 561 F.2d 427 (2d Cir. 1977); Madry v. Sorel, 558 F.2d 303 (5th Cir. 1977); Briscoe v. Bock, 540 F.2d 392 (8th Cir. 1976); Watkins v. Mercy Hosp. Medical Ctr., 520 F.2d 894 (9th Cir. 1975); Jackson v. Norton-Children's Hosp., 487 F.2d 502 (6th Cir. 1973); Doe v. Bellin Mem. Hosp., 479 F.2d 756 (7th Cir. 1973); Ward v. St. Anthony Hosp., 476 F.2d 671 (10th Cir. 1973).

135. Joint Commission on ACCREDITATION OF HEALTHCARE ORGANIZATIONS, AMH ACCREDITATION MANUAL FOR HOSPITALS 99 (1991) (Standard MS.1). "As part of the hospital's quality assurance program, the medical staff strives to assure the provision of quality
cause accreditation by the JCAHO in part qualifies the hospital to participate in Medicare, an important source of income.

The effectiveness of medical peer review depends upon participating physicians who act free of apprehension of legal liability. If a peer physician feels free to come forward when he or she becomes aware that another physician is performing substandard care, then he or she may protect present and future patients from the suspected physician. Considering the potential risks, early detection of an incompetent physician is critical to protect the unknowing public from harm. In this situation, physicians are uniquely situated and are possibly the only persons in a position to meaningfully evaluate the qualifications and performance of other practitioners. The theory behind peer review is that only someone with comparable training and experience is capable of judging another professional similarly situated.

If peer review decisions are going to be challenged in federal court under the antitrust laws, the records of the peer review proceedings, once confidential, may become discoverable and a matter of public record. What will be discoverable will likely depend upon the law of each jurisdiction. Under the Federal Rules of Evidence, federal courts look to state law when ruling on questions of privilege in diversity cases. For federal claims, the patient care through the monitoring and evaluation of the quality and appropriateness of patient care. See Robinson v. Magovern, 83 F.R.D. 79, 89 (W.D. Pa. 1979) (holding that state privilege does not protect documents in a Sherman Act claim); see also Memorial Hosp. v. Shadur, 664 F.2d 1058, 1063 (7th Cir. 1981) (the public interest in private enforcement of the federal antitrust law is too strong to permit the exclusion of relevant and possibly crucial evidence by application of the hospital's privilege).
HCQIA states that reported information will be confidential, but it does not provide any protection from discovery for peer review activities.\(^{142}\)

After the landmark Illinois decision of *Darling v. Charleston Community Hospital*,\(^{143}\) most states enacted confidentiality statutes.\(^{144}\) Such statutes are designed to protect the records and materials both produced and considered in the peer review proceeding from discovery in civil actions.\(^{145}\) In addition, many states enacted statutes to provide immunity from liability to committee members who participate in good faith in the peer review process.\(^{146}\) Thus, the governing state statute determines whether the materials of the peer review process will be publicly disclosed.\(^{147}\) Most states enacted statutes that restrict the discovery and admissibility of peer review materials in civil litigation,\(^{148}\) whereas other state statutes provide only limited

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\(^{142}\) 42 U.S.C. § 11137(b)(1). The Health Care Quality Improvement Act provides protection for documents required to be reported to the Secretary of Health and Human Services through the state's board on medical examiners. *Id.* Under the HCQIA, information reported by hospitals to the Secretary of Health and Human Services is considered confidential and can be disclosed only to the physician involved in the committee action, or to hospitals employing or extending privileges to a physician. *Id.* The HCQIA, however, does not protect reports remaining within the hospital, nor does it protect documents that may be disclosed under state law. *Id.*

\(^{143}\) 211 N.E.2d 253, 261 (Ill. 1965), cert. denied, 383 U.S. 946 (1966) (holding that a hospital, as a corporation, could be liable for negligence in the granting of privileges to physicians and establishing the principle that the hospital, independent of its agents or employees, owed a duty directly to patients to supervise the activities of medical staff physicians).


\(^{145}\) *Id.*

\(^{146}\) *Id.*

\(^{147}\) Creech, *supra* note 141, at 180 ("[T]he purpose of the [state] statutes is generally twofold: (1) to afford immunity from liability for committee members participating in good faith in the peer review process; and (2) to protect the proceedings of a medical review committee, the records and materials it produces and the materials it considers from discovery or from introduction as evidence at a trial.").

protection.\textsuperscript{149}

In addition, some state statutes are vague and uncertain as to the application and scope afforded such materials,\textsuperscript{150} and others provide only qualified

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{149} See, e.g., Neb. Rev. Stat. § 71-2048 (1990) (stating that peer review materials are not discoverable "unless (1) the privilege is waived by the [plaintiff] patient and (2) a court of record, after a hearing and for good cause, arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports or communications"); Or. Rev. Stat. § 41.675 (1991) (addressing only the admissibility or peer review materials and not the question of discovery).


\item\textsuperscript{150} Hicks, supra note 144, at 139-40 (stating that judicial construction has rendered privilege statutes unpredictable and arbitrary, and citing Cal. Evid. Code § 1157 (West Supp. 1992)). California has enacted a privilege statute with numerous exceptions in the event of litigation. Section 1157 provides an exemption to the prohibition on discovery and testimony for:

\begin{itemize}
\item statements made by any person in attendance at a meeting of any of those committees who is party to an action or proceeding the subject matter of which was reviewed at that meeting, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within policy limits.
\end{itemize}

Id. Section 1157(d) exempts certain medical and dental committees whose number of participants exceed ten percent of the society's membership. Hicks, supra note 144, at 139-40. By giving strict and broad interpretation to the statutory exceptions, and hence the scope of protection, decisions of the California courts have further increased the uncertainty that the statutory language itself creates. Compare Henry Mayo Newhall Memorial Hosp. v. Superior Court, 81 Cal. App. 3d 625 (Cal. Ct. App. 1978) (upholding strict enforcement of the privilege protection); Matchett v. Superior Court, 40 Cal. App. 3d 623 (Cal. Ct. App. 1974) (same) with Colo. Rev. Stat. Ann. § 12-36.5-101-203 (West 1990) and Fla. Stat. Ann. § 766.101 (West Supp. 1992). Colorado courts have arbitrarily interpreted the privilege statutes to foreclose the discovery of all medical records. See Franco v. District Court, 641 P.2d 922, 930-31 (Colo. 1982) (holding that in a suit filed for damages for wrongful suspension, the privilege statute barred a physician from discovering the basis upon which a hospital suspended his privileges); Posey v. District Court, 586 P.2d 36, 37-38 (Colo. 1978) (en banc) (stating that the court lacked knowledge of what the limitations of the privilege statute were and applying the privilege to all documents any committee might possess). An examination of several Florida cases reveals that the Florida peer review statute has been interpreted inconsistently. See Dade County Medical Ass'n v. Hlis, 372 So. 2d 117, 119-20 (Fla. Dist. Ct. App. 1979) (holding, in a suit in which neither a physician nor a hospital was a defendant, that an ethics committee was
As a result of these less explicit statutes, there is no uniformity of application. The effect upon litigants is an arbitrariness of application, granting to some substantial evidence while depriving others of material that their cases require for a fair adjudication, and that the statute may have intended that they should be able to obtain. The uncertainty of judicial statutory construction leaves medical professionals involved in the peer review process with doubt as to the confidentiality of their proceedings.

As a result, doctors’ concerns of confidentiality if they participate in a peer review decision, go beyond the threat of money damages. If a physician is candid in the review of another physician, he may rightfully be concerned about: 1) the loss of referrals, respect, and friends; 2) the possibility of retaliations for comments he contributed; 3) increased vulnerability to a tort law suit, such as defamation, for candor during the review process; and, finally; 4) a fear that a malpractice action may be brought against him, and that the material from the medical peer review process in which they participated will be used against him. Until state statutes articulate more pre-

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151. Ronald F. Wright & Jack C. Smith, *State Level Expert Review Committees — Are They Protected?*, PUB. HEALTH REP., Jan.—Feb. 1990, at 13, 19. Virginia, New Mexico, and the District of Columbia do not protect committee information from discovery at all if a litigant can convince a judge that there is “good cause” for them to obtain the information. *Id.*

152. Hicks, *supra* note 144, at 140.

153. *Id.*

154. *Id.*

155. *Id.*


157. *Id.*
VII. THE EFFECT ON THE QUALITY OF PATIENT CARE IF PEER REVIEW COMMITTEES ARE SUBJECT TO ANTITRUST LIABILITY

One of the first effects of an effective elimination of the medical peer review process resulting from the prospect of successful challenges to such decisions under the antitrust laws, is that the quality of patient care will be substantially diminished. Without the medical peer review process, the patient will be forced to rely upon successful malpractice suits to remove from hospitals those physicians providing deficient care. This alternative is unattractive. Furthermore, its social costs are high, and it is much less efficient than the peer review process. While a malpractice suit is litigated, the physician who is a party to the suit is permitted to practice medicine until the suit is successfully terminated. Such a result could lead to an increase in injury to patients subject to that physician's care.

In addition, malpractice suits are not a reliable alternative. According to a recent study analyzing retrospective reviews of physician malpractice claim records, the use of physicians' malpractice claims histories to target individuals for education or sanctions is problematic due to the modest predictive power of such claims histories. The study concluded that although physicians incurring large numbers of negligence claims in the past are more likely, on average, to incur large numbers in the future, predictions about individuals based on past claims experience are probably not accurate enough to identify most claim-prone physicians or to allow reliable judgments about an individual's propensity to practice negligently in the future.

The study points out that two theories dominate current thinking in medical quality improvement, each supported by different critical assumptions about the sources of poor-quality care. One theory posits that bad care arises from the persistent practices of a limited number of individuals who

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158. Hicks, supra note 144, at 141.
159. Morter, supra note 156, at 1138.
160. Id.
161. Id.
163. Id. at 2096.
164. Id. at 2093.
can be identified and removed from practice (a theory supported, in part, by the HCQIA's creation of the national data bank).\textsuperscript{165} Consistent with this perspective, the study cautions against the use of the newly established National Practitioner Data Bank.\textsuperscript{166} The Data Bank was founded on the premise that paid malpractice claims or adverse National Board of Medical Examiners reports can be used prospectively to identify practitioners who are likely to have future problems.\textsuperscript{167}

The second theory is that the clinical processes in which the physicians are involved may be to blame. This theory is dubbed "continuous quality improvement," and directs quality assurance efforts at the clinical processes rather than at the individual physicians.\textsuperscript{168} In this situation, information regarding a physician's malpractice claims history may reveal nothing about the competence of the individual physician, but rather may be a reflection of the quality of the facility at which the physician practices.\textsuperscript{169} As such, it is considered an ineffective source of data upon which potential patients may rely in selecting a physician.\textsuperscript{170} Finally, another potential problem of relying upon the existence of medical malpractice data to identify error-prone physicians is that malpractice claims both meritorious and otherwise, are relatively rare events.\textsuperscript{171} Many cases of physician negligence never result in malpractice claims.\textsuperscript{172}

The second effect on the quality of patient care that may ensue is that malpractice premiums will correspondingly increase, as both the number of antitrust lawsuits filed and the amounts of the damages awarded increase.\textsuperscript{173}

\textsuperscript{165} Id. at 2097.

\textsuperscript{166} Id.

\textsuperscript{167} John E. Rolph, supra note 162, at 2097 (1991).

\textsuperscript{168} Id. at 2093.

\textsuperscript{169} Richard L. Kravitz, et al. Malpractice Claims Data As a Quality Improvement Tool: Epidemiology of Error in Four Specialties, 226 JAMA 2087 (1991) (stating that many malpractice claims are filed in the absence of physician negligence).

\textsuperscript{170} Id.

\textsuperscript{171} Rolph, et al., supra note 162, at 2097. A study by Rand Corp. found that when classifying claims into eleven clinical error categories comprising three broad groups, the mean rate in the data base was 0.15 total claims per physician per year. \textit{Id.} The physicians included in the study were New Jersey physicians practicing obstetrics and gynecology, general surgery, anesthesiology, or radiology who were covered by the insurance carrier for any portion of 1977 through 1989. \textit{Id.} at 2096. The three broad categories were: (1) patient management problems, (2) technical performance, and (3) staff coordination problems. \textit{Id.}

\textsuperscript{172} Kravitz et al., supra note 169, at 2087.

\textsuperscript{173} Sen. Pete V. Domenici, Health Care Reform: Should Curbing Medical Malpractice Litigation Be Part of the Solution? Yes: A Prime Factor, A.B.A. J., Aug. 1992, at 42. ("By any measure, the current medical malpractice system is not good for our health care. It drives up costs dramatically and unnecessarily, making health insurance unaffordable for millions of Americans."); see Avoiding Litigation Begins in the Doctor's Office, AM. MED. NEWS, Oct. 21, 1991, at 19. The litigation explosion has had an effect on health care costs. "[P]atients, busi-
In turn, this increased cost of doing business will be transferred to the consumers of health care, most obviously in the form of more expensive medical care.174 This increase in cost may lead some consumers to forego medical services that they need and that they otherwise would be able to afford.175 An increase in the cost of insurance may also leave many consumers unable to continue to pay their health insurance premiums.176

The third effect may be that physicians begin practicing "defensive medicine" as they become sensitive to the threat of malpractice.177 Physicians may conduct more tests on any individual patient than are medically necessary as a defensive posture against the possibility of malpractice litigation.178 A study designed to identify potentially preventable sources of medical injury concluded that the use of marginally indicated tests to reduce the risk of negligent injury probably would not avert a large proportion of negligence claims, at least in the procedurally oriented specialties the study included.179 As a result of physicians practicing defensive medicine, the cost of medical care will increase and will have an adverse rippling effect upon members of the public.180

nesses and insurers — including the government — eventually must pick up most of the tab as liability insurance premiums rise. The costs of defensive medicine are passed along in the same way." Id.

174. Richard E. Leahy, Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines, 77 CAL. L. REV. 1483, 1485 (1989); see also Marrese v. Interqual, Inc., 748 F.2d 373, 394-95 (7th Cir. 1984), cert. denied, 472 U.S. 1027 (1985) (stating that allowing antitrust litigation would increase the cost of medical care to consumers, and that the physician plaintiff’s interests were adequately safeguarded by an evidentiary hearing within the hospital and a state court forum to challenge the peer review process).

175. Domenici, supra note 173, at 42.

176. Leahy, supra note 174, at 1485.

177. Domenici, supra note 173, at 42. "Physicians and other health providers, fearful of this unpredictable climate, practice defensive medicine by ordering unnecessary tests and performing unnecessary procedures. This adds billions to health care bills, with little or no benefits. With soaring costs, many Americans simply cannot afford health insurance." Id.

178. Id.; Victor Cohn, Why Patients Should Tremble, WASH. POST, Oct. 22, 1991, at Health Section 10 (stating that the medical malpractice laws foster unneeded procedures performed out of fear of possible lawsuits).

179. Kravitz et al., supra note 169, at 2091. This study was conducted by the Rand Corporation and was limited to the specialties of obstetrics and gynecology, general surgery, anesthesiology, and radiology.

180. Leahy, supra note 174, at 1485-86. See Avoiding Litigation Begins in the Doctor's Office, AM. MED. NEWS, Oct. 21, 1991, at 19. Discussing the effect of the litigation explosion on health care costs, this editorial stated: "As physicians have pointed out for years, patients, businesses and insurers—including the government—eventually must pick up most of the tab as liability insurance premiums rise. [And], [t]he costs of ‘defensive medicine’ are passed along in the same way." Id.
VIII. RECOMMENDATIONS TO PROTECT THE PEER REVIEW PROCESS FROM ANTITRUST LIABILITY

By liberally construing the jurisdictional requirement of the Sherman Act, the Supreme Court in *Summit Health Ltd. v. Pinhas*, makes it easier for a physician adversely affected by a peer review committee decision to bring an antitrust suit. Hospitals and physicians may decrease this likelihood by: 1) invoking the defense of the state action doctrine immunity; 2) invoking the limited immunity available under the HCQIA; 3) attempting to ensure that courts do not construe peer review committees themselves as a contract, combination, or conspiracy under Section 1 of the Sherman Act; 4) basing review decisions on pro-competitive justifications that may be successfully litigated under the antitrust law; and 5) providing physicians who participate in the peer review process indemnification from antitrust liability.

A. Ensuring That the Peer Review Committee Qualifies for State Action Immunity

Physicians and hospitals should work to amend hospital licensing laws and state regulations to meet the Supreme Court’s standard for absolute antitrust immunity, thus ensuring that the hospital peer review committee’s actions will pass the *Midcal* test. Thus, physicians and hospitals must lobby for state statutes that protect physicians participating in the peer review process by clearly articulating a policy to replace competition with regulation, and by providing that the state actively supervises the peer review process. Doctors should also be certain that, if this active supervision consists of state judicial review, such review covers both the substantive and the procedural aspects of the privilege decision, and also that the state review rises to a level of a “veto power” over the peer review decision.

The safest approach for a state to satisfy the active supervision prong of the state action doctrine is to enact a statute that requires: 1) reporting of adverse credentialing decisions to an administrative agency, and 2) court review of such decisions for compliance with standards specified in the stat-

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182. Jay D. Christensen, *Supreme Court Decides Patrick; Peer Review Alive and Well Despite Ruling*, HEALTH L. VIGIL, June 17, 1988, at 1, 4. “Professional liability insurance maintained by hospitals typically provides indemnity coverage for peer review participants acting in accordance with medical staff bylaws. Moreover, under appropriate circumstances, hospitals may enter into special indemnity arrangements to protect peer review participants after damage claims have been brought.” Id.
Unfortunately, the active supervision requirement contemplates that state officials may exercise this power. Therefore, there can be no assurance that the requirement is being met unless the administrative agency to which credentialing decisions are reported actually overturns such decisions from time to time. The disadvantage of this approach, however, is that a new layer of bureaucracy is created in order for a defendant to invoke state action immunity.

Should the state action immunity defense fail, hospital by-laws must articulate objective criteria and standards that further the hospital’s goals. This will enable the court to have a definite position against which it may measure the hospital’s findings in the peer review decision, rather than requiring the court to probe into the merits of a privilege decision. This will either avoid the discoverability of confidential material, or allow one to argue for a limit as to what information the peer review committee may consider discoverable. Thus, the integrity of the peer review process is preserved. A better approach, however, is to make sure the state statutes are broad enough to include information that the committee may continue to deem privileged and confidential. In sum, physicians and hospitals must act swiftly and wisely to save the medical peer review process. They need to insist that state statutes clearly afford them sufficient protection from the antitrust laws, so that courts will have no difficulties interpreting the scope of that protection.

B. Ensuring That the Peer Review Committees may Invoke Immunity Under the HCQIA

To support allegations of boycott, a complaining physician must “demonstrate that a conspiracy was entered into among parties with an independent economic stake in the matter.” Thus, hospitals should prohibit physicians in direct competition with physicians under review from participating in the peer review. In addition, it may be wise if the peer review process is

185. Id.
186. Id.
187. Seimetz, supra note 130, at 494.
188. Id. at 494-510.
189. See supra notes 107-124, and accompanying text.
190. Id.
191. Christensen, supra note 182, at 4; Oksanen v. Page Memorial Hosp., 945 F.2d 696, 706 (4th Cir. 1991), cert. denied, 112 S. Ct. 973 (1992) (noting that for purposes of Section 1 of the Sherman Act, members of a medical staff have the capacity to conspire among themselves since they are physicians who may have independent and competing interests. Every action taken by the staff, however, does not automatically satisfy the contract, combination, or conspiracy requirement of Section 1 liability. There must be proof of a conscious commitment to a common scheme designed to achieve an unlawful objective).
not dominated, as was the case in *Patrick*, by members of a single medical group or practice affiliation. These requirements, however, may pose insurmountable burdens for hospitals in some communities. For example, such requirements may mean that qualified physicians must be transported into small rural communities to participate in review panels at the hospital's expense. A solution for the small hospital staff that is unable to carry out the prescribed steps for due process requirements because it lacks impartial, unbiased, or noncompeting physicians, would be to amend the hospital by-laws to comply with the HCQIA.

C. Ensuring That the Peer Review Committee Is Not Capable of Being Characterized as a Contract, Combination, or Conspiracy under Section 1 of the Sherman Act

Peer review committees may be able to defeat an antitrust suit if the hospital's bylaws expressly provide that the committee's recommendations to the Hospital Board in no way preclude the Board from exercising its own judgment, even if it contravenes the committee's recommendation. If the Board retains ultimate responsibility for all such decisions, as in *Oksanen*, then the peer review committee will not be classified under the Sherman Act as a contract, combination, or conspiracy. As such, the antitrust suit could be defeated at the summary judgment stage.

D. Ensuring That Peer Review Decisions, if Subject to Antitrust Suits, are Based Upon the Record with Pro-Competitive Justifications

When peer review decisions proceed to trial, the restraint of trade element under the antitrust laws is viewed as a group boycott of the physicians and is analyzed under the rule of reason to determine whether the denial subsequently suppressed competition. Thus, in making the determination of staff privileges "relevant considerations include the reasons for denial." A hospital can thus build an adequate record explaining the reason for denial of the physician that the court could alone rely upon to uphold the decision as reasonable. Some pro-competitive reasons a hospital might advance for denial are: the practitioner's inadequate training, skill, or experience; failure

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193. See 42 U.S.C. § 11112(b) (allowing for the alternative use of a hearing officer or a panel).
195. *Id.* at 705-06.
197. *Id.*
to carry adequate malpractice insurance; and an inability or unwillingness to discharge staff membership responsibilities, for example, taking emergency call.\textsuperscript{198}

Thus, if antitrust claims go to trial on the merits, physicians and hospitals should argue that the denial of privileges must be analyzed under a competitive effects test. In this way, the competitive effects will withstand antitrust scrutiny if they are predominantly pro-competitive.\textsuperscript{199} In addition, the antitrust “rule of reason” analysis requires courts to balance the benefits of good faith peer review actions against the resulting harm to competition.\textsuperscript{200} In most market areas, it will be difficult or impossible to establish that a peer review action has harmed not solely a single competitor, but competition generally.\textsuperscript{201} Once again, however, there is a subset of hospitals, namely, those that are the only such facility in an area, as was the case in Patrick, where denial of privileges in that market could adversely affect competition.\textsuperscript{202} In addition, recall that the finding of competition depends on how the court defines the relevant market, as in Summit Health Ltd. v. Pinhas, where the denial of privileges to a single physician was found to suppress competition.\textsuperscript{203}

\textbf{E. Indemnification as Protection for Participating Physicians}

If physicians and hospitals do not wish to relinquish their autonomy over “credentialing” and peer review privilege decisions to the state, they may desire to agree among each other that in the event of an antitrust suit, the hospital will indemnify the staff physicians participating in the peer review.\textsuperscript{204}

\textbf{IX. CONCLUSION}

Supreme Court decisions such as Summit Health v. Pinhas and Patrick v. Burget increase the likelihood that medical peer review decisions will continue to be litigated in federal courts. At the same time, traditional defenses

\textsuperscript{198} \textit{Id.}
\textsuperscript{200} Christensen, \textit{ supra} note 182, at 4.
\textsuperscript{201} \textit{Id.}
\textsuperscript{202} Bierig, \textit{ supra} note 184, at 135.
\textsuperscript{203} 111 S. Ct. 1842 (1991).
\textsuperscript{204} Callahan, \textit{Patrick and the Medical Staff Credentialing Aftermath, Antitrust Health Care Chron.}, 10, 10-13 (1988). See Christensen, \textit{ supra} note 182, at 4. In California, professional liability insurance coverage maintained by hospitals typically provides indemnity coverage for peer review participants acting in accordance with medical staff bylaws. \textit{Id.} Moreover, under appropriate circumstances, hospitals may enter into special indemnity arrangements to protect peer review participants after damage claims have been brought. \textit{Id.}
such as the state action doctrine and the Health Care Quality Improvement Act may continue to offer peer review committees immunity from such suits. If these traditional defenses fail, peer review committees may still avoid antitrust liabilities. Peer review committees, aware of the potential for antitrust liability, must render their decisions affording the applying physician appropriate due process and must base their decisions upon a record that serves to promote pro-competitive efficiencies. In this manner, medical peer review committees can continue to promote the integrity of the process and can continue to serve the public interest by ensuring the increased quality of patient care.

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