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Health Professionals' Access to Hospitals: A Retrospective and Prospective Analysis

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NOTE

Health Professionals' Access to Hospitals: A Retrospective and Prospective Analysis

I. INTRODUCTION

The professional interdependence of the hospital institution and practicing physicians is a phenomenon of post-World War II society. This Note first examines the historical development of that interdependence and explores its erosion into a hospital-dominant mode. Next it examines the most important forces that influence and complicate the question of hospital privileges for the physician within the modern hospital: the interrelated pressures of intraprofessional restraints, pertinent government regulation, and medical technology. Then it sketches the internal procedures that have engendered and defined the relationship between physician and hospital, with special attention to the weaknesses within the procedures that have led to past litigation. Finally, this Note looks closely at significant emergent legal challenges in the area of the medical professional's hospital privileges and examines the health policy implications of the available alternatives. The Note concludes that the historical balance of power that has defined hospital access has been displaced. It proposes a diversification of institutional providers and a utilization of the newly-available autonomous health professionals.

II. HISTORICAL BACKGROUND

The symbiotic relationship between hospitals and physicians is the third major stage of their joint history. The first stage began in the mid-nineteenth century and lasted for approximately fifty years.[1] During that period wealthy individuals supported hospitals

1. *See generally* H. SIGERIST, *An Outline of the Development of the Hospital*, in HENRY E. SIGERIST ON THE SOCIOLOGY OF MEDICINE 319 (M. Roemer ed. 1960); A. SOMERS, HEALTH CARE IN TRANSITION: DIRECTIONS FOR THE FUTURE 27-38 (1971); Mechanic, *The Changing Structure of Medical Practice*, 32 LAW & CONTEMP. PROB. 707, 708 (1967); Saward, *Institutional Organization, Incentives, and Change*, in DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES 193 (J. Knowles ed. 1977); Vogel, *The Transforma-*

for the benefit of the indigent, insane, and criminal dependents of society, as well as for the protection of the middle and upper classes[2] from the medical and moral contagion of those "socially unfit" individuals.[3] Although a clear division arose in Europe between "generalists" and hospital-based "specialists,"[4] such specialization was neither feasible nor desirable in the professionally underserved and sparsely populated United States.[5] There were few hospitals, and only about twenty percent of physicians engaged in any hospital practice. The services rendered hospital patients by those few physicians were gratuitous. Hospital attendance, however, did expose the doctor to medical experience that enriched his professional knowledge and status and consequently enhanced the successful care and treatment he could offer to his private, paying patients. Thus, personal and professional advantage accompanied the performing of a benevolent and charitable duty.[6]

With the advent of asepsis and effective anesthesia at the close of the last century, medicine began to be more science than art.[7] Physicians could attempt more delicate and successful surgical procedures, and the era of predominantly home-based medical care began to draw to a close[8] since aseptic procedure was practically possible only in a hospital; "kitchen-table surgery" was on its way out.[9] As scientific knowledge expanded and as increasing urbanization isolated individuals from families that could care for them during medical crises,[10] the doctors serving traditional hospital populations gained the right to admit their private patients to

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tion of the American Hospital, 1850-1920, in HEALTH CARE IN AMERICA: ESSAYS IN SOCIAL HISTORY 105 (J. Reverby & D. Rosner eds. 1979).

2. Vogel, *supra* note 1, at 106.

3. *Id.* at 107-08.

4. Mechanic, *supra* note 1, at 708.

5. *See id.*

6. Vogel, *supra* note 1, at 109-10.

7. Saward, *supra* note 1, at 193.

8. Vogel, *supra* note 1, at 109-10. The great number of doctors who did not utilize hospital facilities viewed with alarm the increased dependence upon hospitals. As Vogel notes,

> By 1909 the Boston Medical Society was complaining about the "rising feeling" that surgery could be performed only in hospitals, "thus depriving all ordinary private physicians and surgeons of a class of cases." The [medical] society condemned the city's hospitals for "inculcating in the minds of the laity a lack of confidence in the abilities of the ordinary private practitioners."

Id.

9. *Id.* at 112.

10. *Id.* at 110-12.

the hospital when necessary.[11] This privilege of admission became the dominant pattern and has remained so, albeit for different reasons.[12]

The relationship between doctor and hospital entered its second stage in the first part of the twentieth century. The hospital served as a central institution devoted to service of the public and to the doctor's increased efficiency and convenience. It provided the doctor with a ready-made support staff of nurses, residents, and interns. It also bore the costs of acquiring the latest technological developments.[13] These latter innovations in medical care provided the impetus for the transformation of the traditional charitable hospital into its modern successor. As the costs of technology increased, wealthy patrons could no longer fund the institutions, and the main source of income to be tapped was the patients.[14] Thus, hospitals shifted toward greater economic self-maintenance, although still relying heavily upon charitable contributions and upon charitable immunity from taxes and liability.[15]

It is only slightly hyperbolic to suggest that, until the advent of the "wonder drugs" in the late 1930s and 1940s, the doctor had as much in common with the aboriginal witch doctor as with the scientist. Medicine as a profession was charismatic instead of curative. The traditional image of the family doctor as an available comforter and counselor is fairly realistic. In the first forty years of the century, physicians could prevent some disease through vaccination, inoculation, and other public health measures.[16] Although a

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11. *See* Mechanic, *supra* note 1, at 708.

12. *Id.*

13. Because hospitals had always been charities administered by philanthropic laymen, the old guard hospital establishment viewed with alarm the innovations of "newfangled" medicine. For example, George Ludlam, lay superintendent of New York Hospital and president of the American Hospital Association in 1906, deplored the difficulty of working with doctors trained in the scientific method: "Familiarity with these methods engenders a spirit of extravagance which permeates the whole establishment and which is exceedingly difficult to check or control." *Quoted in* Vogel, *supra* note 1, at 113. Massachusetts General Hospital, epitomizing the confrontation between the old charity hospital and the new scientific institution, asked the visiting staff to restrict the use of oxygen. *Id.* at 114.

14. *Id.*

15. Charitable immunity is an exception to general tort liability based upon the need to encourage and protect charitable institutions which shoulder economic and social burdens that would otherwise be borne by the government. The majority of American jurisdictions consistently recognized the immunity until 1942, when the District of Columbia abolished the doctrine. *See* President & Dirs. of Georgetown College v. Hughes, 130 F.2d 810 (D.C. Cir. 1942). Subsequently, more than half of the states have abolished the immunity. W. PROSSER, HANDBOOK OF THE LAW OF TORTS 996 & n.68 (4th ed. 1971).

16. "[T]herapeutic intervention was of only limited efficacy; much of medical practice

few diseases could be medically treated, most "cures" were effected surgically—still limited, however, by the threat of uncontrolled postoperative infection.

The discovery and use of antibiotics largely eliminated such threats. Science could not only prevent disease, but also control and even cure it. Federal and private monies began to pour into medical research.[17] The Hill-Burton Act[18] resulted in the building of hundreds of small hospitals with fewer than fifty beds in the postwar years.[19]

This explosion of hospitals helped fuel the trend toward specialization.[20] In 1940 the proportion of general practitioners to medical specialists was over three to one.[21] Thirty years later specialists exceeded general practitioners four to one.[22] Such a dramatic reversal evidences the third major stage in the hospital-physician relationship: that of the hospital-dependent physician.

Open recognition of the hospital's power was the underlying basis for the Illinois Supreme Court's decision in *Darling v. Charleston Community Memorial Hospital.*[23] In *Darling* a physician on call in the hospital's emergency room applied a cast to plaintiff's broken leg. Afterwards, plaintiff complained of severe pain and observed that his toes were "swollen and dark."[24] Two days later there was evidence of necrosis, but the physician did not institute an effective treatment. Approximately two weeks after his admission to the hospital, plaintiff was transferred to another hos-

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consisted of environmental manipulation." Vogel, *supra* note 1, at 106.

17. R. RUSHMER, NATIONAL PRIORITIES FOR HEALTH: PAST, PRESENT, AND PROJECTED 12-39 (1980). Rushmer traces the postwar emphasis on health care to the finding that 30% of draftees were rejected during World War II for health deficiencies and to the belief that medical problems could be controlled in much the same way that the Axis powers had been controlled, through "[c]ontinued collaboration between government and the private sector." *Id.* at 12.

18. Hospital Survey and Construction Act (Hill-Burton Act), ch. 958, 60 Stat. 1040 (1946) (current version at 42 U.S.C. §§ 291-291o (1976 & Supp. III 1979)). The Hill-Burton Act added Title VI to the Public Health Service Act, ch. 373, 58 Stat. 682 (1944).

19. Saward, *supra* note 1, at 195.

20. For a detailed discussion of the various factors in the trend toward specialization, see E. RAYACK, PROFESSIONAL POWER AND AMERICAN MEDICINE: THE ECONOMICS OF THE AMERICAN MEDICAL ASSOCIATION 204-39 (1967); Beeson, *The Natural History of Medical Subspecialties*, 93 ANNALS OF INTERNAL MED. 624 (1980); Strosberg, *Graduate Medical Education, Specialists, and Specialization—The Tangled Web*, 4 J. HEALTH POL., POL'Y & L. 559 (1980).

21. E. RAYACK, *supra* note 20, at 204.

22. M. ROEMER, COMPARATIVE NATIONAL POLICIES ON HEALTH CARE 60 (1977).

23. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

24. *Id.* at 328, 211 N.E.2d at 255.

pital where other physicians amputated the lower part of his leg. Plaintiff brought suit against both the original physician and the hospital for negligence but settled with the physician before trial. At trial a jury found for plaintiff against defendant hospital and awarded plaintiff $110,000. The Illinois Supreme Court subsequently affirmed the verdict.

The court rejected the hospital's argument that it was protected under a traditional charitable immunity doctrine,[25] and it prospectively abolished the rule limiting liability to the "amount of liability insurance that [charitable corporations] see fit to carry, [a limitation that] permits [such corporations] to determine whether or not they will be liable for their torts and the amount of that liability, if any."[26] The court cited with approval an earlier New York case[27] that described the nature of the modern hospital:

> 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. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employes [sic] will act on their own responsibility.[28]

Although two other jurisdictions had previously acknowledged hospital liability,[29] the *Darling* case is generally recognized as the landmark decision delineating the character of the modern hospital. No longer simply the "doctor's indispensable workshop, the hospital is also the principal center for development of quality measurements and controls. Its complex of internal and external audits and standards constitutes the nation's primary protection against unqualified or inappropriate medical practice."[30]

Recognition of a hospital's liability for quality of care to some extent displaced the traditional freedom of a physician to determine his own methods of patient care and affected the individual

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25. *Id.* at 337, 211 N.E.2d at 260.

26. *Id.*

27. *Id.* at 332, 211 N.E.2d at 257.

28. *Id.* (quoting Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957)).

29. *See* Goff v. Doctors Gen. Hosp., 166 Cal. App. 2d 314, 333 P.2d 29 (1958); Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

30. A. SOMERS, *supra* note 1, at 27.

physician's ease of access to hospital privileges. Until *Darling* both the quality of staff privileges extended to an individual physician and the complexity of procedures attempted by him often bore only a tenuous relationship to either an objective measure of the physician's competence or to the length and rigor of his training.[31] Rather, physicians made individual determinations concerning their own competence to undertake various medical procedures.[32] This entrepreneurial exuberance was contained only by the individual judgment of a physician and by the legal restraint imposed by malpractice liability. In response to *Darling,* however, hospitals undertook to safeguard themselves against liability, by adopting guidelines and regulations for different kinds and degrees of staff privileges. This represents a significant displacement of former strict intraprofessional regulation by physicians, since the guidelines and regulations mark a shift in emphasis toward protection of the hospital institution and away from the earlier freedom of access by almost any licensed physician.[33] Significantly, this erosion of the "third stage" of the hospital-physician relationship may signal the beginning of an historical "fourth stage" marked by an increasing dominance of the physician by the hospital.

III. Forces Affecting the Physician-Hospital Relationship

A variety of forces have contributed to the development of a symbiotic relationship between the hospital and the physician and to the rise of the hospital as the monolithic structure with which all health care providers must be affiliated in order to achieve legitimacy. This section of the Note examines several of the major forces affecting physicians' access to hospitals.

A. Intraprofessional Restraints

The medical profession has been internally regulated during most of its history.[34] The surgeon's guild followed the pattern of other craft guilds, with a rigid, prolonged apprenticeship that advanced the surgeon-craftsman from apprentice to journeyman to master.[35] The physician, however, was considered an academic and

31. *See* Mechanic, *supra* note 1, at 708.
32. *Id.*
33. *Id.*
34. H. Sigerist, *supra* note 1, at 308-18.
35. *Id.* at 311-12. To obtain the highest position, the surgeon was given a stringent examination by master-surgeons and sometimes by physicians. *Id.*

thus was not qualified to be a member of a guild.[36] The medical faculty of the university where he trained controlled the physician's entry into the profession.[37] If the physician wanted to move, he was required to present his credentials and recommendations to the medical faculty of his desired residence in order to receive the privilege to practice there.[38]

The American Medical Association (AMA)[39] is the modern counterpart of the guild or academic faculty and is synonymous with the medical establishment. The AMA's ethically-based desire to raise the quality of medicine coupled with its economically-based desire to restrict competition has, until very recently, exacerbated the chronic medical manpower shortage in American society.[40] The AMA's control over the supply of both physicians and hospitals, and over the quality of health care delivered, has affected the physician's ability to gain hospital access;[41] it has also

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36. *Id.* at 312.

37. The first medical school in western Europe (at Salerno) issued the following order in 1140 under the aegis of the Norman king, Roger:

> Who, from now on, wishes to practice medicine, has to present himself before our officials and examiners, in order to pass their judgment. Should he be bold enough to disregard this, he will be punished by imprisonment and confiscation of his entire property. In this way we are taking care that our subjects are not endangered by the inexperience of the physicians.
>
> Nobody dare practice medicine unless he has been found fit by the convention of the Salernitan masters.

Id.

38. *Id.* at 313-14.

39. The AMA's stated objective since its inception in 1847 has been the maintenance of a high quality of medical practice. Its primary objective during the last half of the nineteenth century was to ensure uniform standards through governmental licensing of all physicians. State medical societies, which are official offshoots of the AMA, control state as well as national health policy through lobbying and legislative proposals. Even though county medical societies are voluntary organizations, the state societies delegate rulemaking authority to the county societies. The latter are "crucial to a doctor because exclusion or expulsion gives rise to an adverse inference concerning professional fitness. Also, membership in a county society is often a prerequisite for eligibility for hospital staff privileges or membership in a specialty organization." Note, *Application of the Antitrust Laws to Anticompetitive Activities by Physicians*, 30 RUTGERS L. REV. 991, 999 (1977) (footnotes omitted).

40. *See* E. RAYACK, *supra* note 20, at 66-81, 94-101, 107-30; Blackstone, *The A.M.A. and the Osteopaths: A Study of the Power of Organized Medicine*, 22 ANTITRUST BULL. 405, 406-07 (1977). The medical manpower shortage may be alleviated within the next ten years, and, indeed, a surplus is predicted by 1990. *See* GRADUATE MEDICAL EDUCATION ADVISORY COMMITTEE, SUMMARY REPORT, 1 REPORT OF THE GRADUATE MEDICAL EDUCATION ADVISORY COMMITTEE TO THE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, 4 fig. 1, 23 (September 1980) [hereinafter cited as GMENAC SUMMARY REPORT].

41. *See* Blackstone, *supra* note 40, at 406. *But see* Hall & Lindsay, *Medical Schools: Producers of What? Sellers to Whom?*, J.L. & ECON. 55 (1980), for an argument that the AMA bas less infiuence on physician supply than has the normal market mechanism of

raised the specter of monopoly.

In 1904 the AMA created its Council on Medical Education, whose initial task was to inspect the nation's 161 medical schools. Of these schools, the Council found approximately one-half to be "acceptable."[42] The council's groundwork led to the Flexner Report, issued in 1910.[43] The result was the closing of substandard medical schools and a two-fifths reduction in the number of medical school graduates from 1904 to 1920.[44]

The more far-reaching effect of the establishment of the Council on Medical Education has been the AMA's power to accredit medical schools through the Council. The AMA soon began to condition state licensing of physicians—a prerequisite to medical practice—upon graduation from an AMA-accredited school.[45] Later, internship became a further requirement for licensure in most states, and the Council extended its duties to accreditation of internship programs.[46] Because hospitals needed interns[47] in order to attract other physicians to their staffs, the AMA thus wielded a powerful weapon. Unaccredited hospitals could not attract doctors; doctors could not practice medicine if they graduated from unaccredited medical schools or if they served unaccredited internships. Thus, the AMA controlled access to hospitals, albeit indirectly.[48]

Organized medicine has also had a profound impact upon the supply of physicians, which has a direct effect upon hospital access. If the number of physicians is restricted, more of the available physicians will be likely to gain hospital privileges. If the number of physicians increases, there will be, assuming a relatively constant number of staff positions, more doctors than existing hos-

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supply and demand.

42. *See* E. RAYACK, *supra* note 20, at 66.

43. *Id.* at 67. Abraham Flexner, a prominent medical educator in the early twentieth century, surveyed all medical schools in the United States and Canada for the Carnegie Foundation for the Advancement of Teaching. He published his findings as MEDICAL EDUCATION IN THE UNITED STATES AND CANADA in 1910. During the following decade, he assisted in the reorganization of the medical schools and the establishment of higher standards for medical education.

44. Even such a determined critic of organized medicine as Rayack can find no monopolistic intent by the AMA at that time, but rather a "socially justifiable desire to raise the deplorably low standards of medical training existing at the turn of the century." E. RAYACK, *supra* note 20, at 69-70.

45. *See* Blackstone, *supra* note 40, at 406.

46. *Id. See also* F. WILSON & D. NEUHAUSER, HEALTH SERVICES IN THE UNITED STATES 66 (rev. & enlarged 1st ed. 1976).

47. Until the mid-1960s, interns provided an extremely cheap labor source. *See* Blackstone, *supra* note 40, at 406.

48. *Id.*

pitals can accommodate. A good historical example of supply control took place during the economic depression of the 1930s, when physicians' incomes fell approximately forty percent between 1929 and 1932.[49] The medical hierarchy responded by calling for "professional birth control."[50] In the next seven years, medical schools accepted eighteen percent fewer students.[51] Except for the war years, 1941-1945, the low acceptance rate continued until very recently when governmental pressure led to an increased number of physicians. The effect of the medical hierarchy's restriction on the supply of physicians, coupled with the historical patterns of hospital privileges and an increase in hospital facilities, has been an ease of admission to a hospital staff. In recent years, however, countervailing hospital policies and overriding governmental regulation have reduced the singular importance of intraprofessional restraints.

B. Government Regulation: Licensing

A second significant influence on the ability of physicians to gain hospital access is the increasing role of the government in health care since World War II. Related to this intervention is a changing perception of health care from that of a group of related professions to that of a health "industry" requiring control and regulation.[52] The oldest form of governmental regulation of medicine is professional licensure, universally regarded as a valid exercise of the state police power.[53] The primary policy objective behind the process of licensing individual medical professionals and institutions is to insure public protection by establishing minimal standards of quality and integrity.[54] The primary problems

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49. *See* E. RAYACK, *supra* note 20, at 73.

50. *Editorial*, 99 J.A.M.A. 765 (1932), *quoted in* E. RAYACK, *supra* note 20, at 74.

51. *See* E. RAYACK, *supra* note 20, at 78; Blackstone, *supra* note 40, at 406-07.

52. COMMISSION ON THE COST OF MEDICAL CARE, REPORT OF THE TASK FORCE ON THE MARKETPLACE, 1 REPORT OF THE NATIONAL COMMISSION ON THE COST OF MEDICAL CARE (1976-77) 28 (AMA, 1978).

53. *See, e.g.*, McCoy v. Commonwealth Bd. of Med. Educ. & Licensure, 37 Pa. Commw. Ct. 530, 391 A.2d 723 (1978) (State has the right under the police power to regulate professions so long as the matter regulated affects the public interest).

54. Forgotson & Cook, *Innovations and Experiments in Uses of Health Manpower—The Effect of the Licensing Laws*, 32 LAW & CONTEMP. PROB. 731, 733 (1967); Vladeck, *The Design of Failure: Health Policy and the Structure of Federalism*, 4 J. OF HEALTH POL., POL'Y & L. 522, 528 (1979). *See generally* Carlson, *Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care*, 35 LAW & CONTEMP. PROB. 849 (1970).

arising from licensure are the preservation of the "status quo"[55] and the low quality endorsed by the statutes.[56] Moreover, in a time of increasing federal regulation of the health care industry, the lack of licensing uniformity among the various states often necessitates expensive adaptive procedures or results in a failure to implement the various federally-funded programs.[57]

Licensing laws often have been the *sine qua non* of hospital staff privileges: if one is not a licensed medical doctor, staff privileges are not available. Moreover, in contrast to the broad grant of discretion afforded medical doctors by the licensing laws, the state has restricted sharply the scope of licenses granted to other health professionals. Nurses,[58] midwives,[59] and, until recently, osteopaths,[60] have had limited licenses granted by the state. For these professionals the permitted practices are often unduly restrictive, or without reference to the realities of technical innovation or to the expanding scope of expertise possessed by them. As these other medical professionals become increasingly competitive with doctors, pressure grows to increase the scope of their licensed practices. One result is that the physicians' stranglehold on hospital privileges is slowly eroding.[61]

C. *Internal Procedures and Grounds for Exclusion*

Recent developments in the hospital staff privilege system have brought about important changes in physician-hospital rela-

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55. Forgotson & Cook, *supra* note 54, at 736. Forgotson and Cook point out that the licensure system alone is an insufficient regulatory device because once a physician is licensed, his position in the profession is virtually unchallengeable since the system is unable to effectively monitor his competence during the course of his career. *Id.* at 733.

56. Since the original enactment of most occupational licensure acts in substantially their present form shortly after the beginning of the twentieth century, vast social and scientific changes have taken place. Even though the substrate upon which licensure laws must act has changed, creating new problems and increased demand for health services, there have been no fundamental changes in licensure laws . . . .

Id. at 734.

57. Vladeck, *supra* note 54, at 528.

58. *See, e.g.*, TENN. CODE ANN. §§ 63-743, -748, -760 (1976 & Supp. 1980).

59. Almost all states now permit the practice of midwifery. *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 429.70-.90 (West Supp. 1979).

60. *See, e.g.*, TENN. CODE ANN. §§ 63-904 to -905 (1976) (no limitation on practice of osteopathic medicine). *See generally* Bloom, *The DOs' Growing Pains*, MED. WORLD NEWS, October 27, 1980, at 42. An osteopath practices osteopathy, a system of therapeutics based upon the theory that diseases are due chiefly to mechanical derangement, especially displacement of bones. *See* text accompanying note 147 *infra*.

61. *See* Part IV *infra*.

tions.[62] This section of the Note concentrates on the internal procedures by which hospitals add and maintain physicians on their staffs and on the bases for disallowing or discontinuing hospital privileges.

There is a new recognition that the hospital-reliant physician and the liability-shy hospital have potentially divergent interests—the physician being interested in maximizing his professional growth and livelihood through hospital affiliation, and the hospital being concerned with ensuring quality care to patients and shielding itself from liability and promoting its services in a competitive market. Thus, hospital staff privileges have value as adjuncts to governmental licensing laws[63] in promoting quality health care for the benefit of the public.[64] While licensure almost invariably involves a one-time imprimatur by the state,[65] the granting of staff privileges amounts to a continual recertification[66] both by a physician's peers[67] and by the potentially adversarial hospital board.[68] Furthermore, since boards grant hospital privileges on an institu-

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62. For perceptive discussions of hospital staff privileges for physicians, see Kessenick & Peer, *Physicians' Access to the Hospital: An Overview*, 14 U.S.F. L. REV. 43 (1979); Ludlam, *Physician-Hospital Relations: The Role of Staff Privileges*, 35 LAW & CONTEMP. PROB. 879 (1970); McCall, *A Hospital's Liability for Denying, Suspending and Granting Staff Privileges*, 32 BAYLOR L. REV. 175 (1980). *See generally* Annot., 37 A.L.R.3d 645 (1971). *See also* Forgotson & Cook, *supra* note 54, at 737-38; D. Steed, Legal Aspects of the Hospital-Staff Relationship (1979) (unpublished student paper on file with Vanderbilt Law Review).

63. *See, e.g.*, Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398 (1975) (hospital can set higher standard for admission to staff privileges than possession of a state license).

64. *See* Forgotson & Cook, *supra* note 54, at 737.

65. *See* Ludlam, *supra* note 62, at 896. Note that specialty board certification is also a "once and for all" testing procedure, although the procedure is undergoing modification through continuing medical education (CME) requirements.

66. Staff privileges are reviewed annually or biennially in most hospitals.

67. *See* Forgotson & Cook, *supra* note 54, at 737-38: "[S]ubprocesses [such] as utilization review, tissue committee review, medical audit, and professional activity surveys can be incorporated into the over-all process of supervision of staff privileges." *See also* Ludlam, *supra* note 62, at 896.

68. Although we start from the premise that the hospital's governing board has the ultimate responsibility for medical staff appointments and privileges, we must also assume that such a board made up of lay persons is not qualified to actually process an application involving issues of professional competency. Traditionally, the medical staff has heen treated as being self-governing in that it actually does all the work on the applications, and, except in very extraordinary circumstances, its recommendations are routinely approved by the governing board. Furthermore, the medical staff is exceedingly jealous of its prerogatives in this regard and should not be reversed except in extraordinary circumstances.

Ludlam, *supra* note 62, at 897. *See also* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, *Medical Staff*, ACCREDITATION MANUAL FOR HOSPITALS 93 (1981 ed.) [hereinafter cited as ACCREDITATION MANUAL]. *But see* Dimieri & Weiner, *The Public Interest and Governing Boards of Nonprofit Health Care Institutions*, 34 VAND. L. REV. 1029 (1981).

tion-by-institution basis, the procedure for evaluation is flexible and fairly expeditious. Difficulties too small for the governmental licensure mesh can be addressed and corrected efficiently on this parochial level. Similarly, the less formal and rigorous procedural standards of the hospital's evaluation processes result in a more efficient disposition of troublesome matters than is possible in the context of "quasi-penal" licensure violations.[69]

The "policing" mechanism of the hospital privilege system can deal with perceived "internal" problems such as ordinary incompetence in the performance of professional duties. The system can also restrict the breadth of a physician's activities if he lacks necessary skills, or it can suggest corrective measures if his educational or professional skills are obsolete or completely lacking. Finally, the hospital privilege system can deal effectively with skill diminution or incompetence resulting from age, illness, drug or alcohol abuse, and personality disorders.[70]

The hospital privilege system also has inherent weaknesses. Foremost is the hesitation of the errant physician's peers to discipline him. At the same time, however, physicians are reluctant to allow the integrity of the profession to be diminished by the errant physician.[71] Furthermore, the hesitancy to discipline is increasingly

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69. *See* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, MODEL BYLAWS (1977) [hereinafter cited as JCAH MODEL BYLAWS].

70. *See* Forgotson & Cook, *supra* note 54, at 737-38. The latest Hill-Burton regulations may severely undercut the advantages of the hospital privilege system. The original purpose of the Hill-Burton community service regulation was to prohibit racial discrimination and to prevent a "monopoly of government-funded hospitals by special interests." Note, *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 MD. L. REV. 316, 366 (1979). Under the latest revision of this regulation, 42 C.F.R. §§ 124.601-.607 (1979), this purpose has apparently been transformed to achieve the goal of complete access to hospital facilities and services by indigents (Medicaid recipients and others). The receipt of Hill-Burton funds by a hospital facility places the burden of indigent care upon that facility. *See* Note, *supra* at 366-67. While this regulation would seriously impair a hospital's efforts to contain costs, it would also demolish the rationale for hospital privileges. Under 42 C.F.R. § 124.603(d)(1), in order to comply with the community service regulation, a hospital cannot refuse admission to a person on the grounds that a physician with staff privileges at the particular hospital did not refer him.

One suggestion for assuring compliance is to "authoriz[e] the individual's physician, if licensed and otherwise qualified, to treat the patient at the facility even though the physician does not have staff privileges at the facility." 42 C.F.R. § 124.603(d)(1)(i) (1979). Since "otherwise qualified" remains undefined, disruption of hospital privilege procedure can only follow. This provision is in direct conflict with the accreditation and licensure requirements of most hospitals. In addition, the requirement increases the likelihood of hospital liability for the acts of physicians but without the guarantee of professional ability that the hospital privileges procedure affords. *See also* American Hosp. Ass'n v. Harris, 625 F.2d 1328, 1342-44 (7th Cir. 1980) (Pell, J., dissenting in part).

71. [T]he most important role of a medical staff is to improve the quality of prac-

counterbalanced by the hospital's necessity to shield itself from liability,[72] and by the existence of the Professional Standards Review Organizations (PSROs).[73]

A second problem concerns the ineffectiveness of staff privilege sanctions imposed on the incompetent or unstable physician who practices outside the hospital.[74] Unless his conduct is egregious, the "slightly" incompetent, unethical, or unstable physician may continue to practice free from licensing or other legal restraints but to the probable detriment of his patients' health.

Each hospital is a self-contained unit and "[c]linical privileges are hospital-specific. Thus, an individual may be a member of more than one hospital staff, yet have different practice privileges in each hospital. The possession of adequate professional qualifications based on training and experience does not in itself assure the granting of specific privileges."[75] Because of the potential for physician-hospital difficulties that may threaten the stability of the institution, staff membership is often predicated upon an agreement between the staff member and the hospital that the former will be "bound by the medical staff bylaws and the current hospital policies that apply to his activities as a medical staff member and that are consistent with the medical staff bylaws."[76] The Joint Commission on Accreditation of Hospitals (JCAH) mandates that medical staff bylaws include established procedures by which to resolve problems. The JCAH promulgated model bylaws in 1971 to aid

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tice of each individual physician, while the need to punish, by limiting or denying privileges, represents an ultimate failure for an individual, and perhaps for the entire staff system. The medical staff must assure itself that it has done everything reasonable to save the man before such steps are taken. Obviously, it cannot jeopardize the welfare of its own patients, but turning him out the door to commit the same errors on another group of patients in a new setting is not an adequate solution to the problem.

Ludlam, *supra* note 62, at 897.

72. *See* Goff v. Doctors' Gen. Hosp., 166 Cal. App. 2d 314, 333 P.2d 29 (1958); Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 166 N.Y.S.2d 3 (1957).

73. 42 U.S.C. § 1320c (1976). The 1972 amendments to the Social Security Act established the PSROs, which implemented a procedure for peer review aimed at promoting cost consciousness and assuring maintenance of quality in medical care. In essence, PSRO organizations in discrete geographical areas review the care provided to recipients of federal aid under Medicare and Medicaid. Funds for payment of such services are not disbursed to health care providers if the PSRO disapproves the care. *See* Blumstein, *Inflation and Quality: The Case of PSROs*, in HEALTH: A VICTIM OR CAUSE OF INFLATION? 245 (M. Zubkoff ed. 1976).

74. *See* note 71 *supra*.

75. ACCREDITATION MANUAL, *supra* note 68, at 96.

76. *Id.* at 93.

hospitals seeking to comply with its regulations.[77]

The status of the particular hospital—private, public, or quasi-public—determines whether and to what extent courts will be involved in the resolution of disputes concerning the conferral or denial of staff privileges.[78] In *Peterson v. Tucson General Hospital, Inc.*,[79] the court stated succinctly the differences among the three categories:

> The principal distinguishing feature of a private hospital is that it has the power to manage its own affairs and is not subject to the direct control of a governmental agency. The public hospital is an instrumentality of the state, founded and owned in the public interest, supported by public funds, and governed by those deriving their authority from the state. A "quasi public" status is achieved if what otherwise would be a truly private hospital was constructed with public funds, is presently receiving public benefits or has been sufficiently incorporated into a governmental plan for providing hospital facilities to the public.[80]

As a general rule, courts refuse to review a *private* hospital's action in denying staff privileges as long as the hospital complies with its own medical bylaws[81]—since staff exclusion is within the discretion of the hospital management[82]—and until the plaintiff has exhausted all internal hospital remedies.[83] The only staff privilege case to reach the United States Supreme Court is *Hayman v. City of Galveston*,[84] in which the Court held that a licensed physician has no constitutional right to practice in a public hospital. A *public* hospital, however, is "required to provide certain procedural and substantive due process rights to those physicians who are being excluded,"[85] since the hospital's actions are deemed state action and are thus subject to the proscriptions of the fifth and fourteenth amendments.[86] Exclusion of a physician from the staff of a

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77. JCAH MODEL BYLAWS, *supra* note 69.

78. For a discussion of these differentiations, see authorities cited in note 62 *supra*.

79. 114 Ariz. 66, 559 P.2d 186 (1976).

80. *Id.* at 69, 559 P.2d at 189 (citing Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564 (1972)).

81. *See, e.g.*, Shulman v. Washington Hosp. Center, 222 F. Supp. 59 (D. Colo. 1963); Storrs v. Lutheran Hosps. & Homes Soc'y of America, Inc., 609 P.2d 24 (Alaska 1980); Nagib v. St. Therese Hosp., Inc., 41 Ill. App. 3d 970, 355 N.E.2d 211 (1976).

82. *See* Peterson v. Tucson Gen. Hosp., Inc., 114 Ariz. 66, 71, 559 P.2d 186, 189 (1976).

83. For a cogent discussion of the present status of judicial review of staff privilege decisions by hospitals, see Kessenick & Peer, *supra* note 62 at 57-62.

84. 273 U.S. 414 (1927).

85. Kessenick & Peer, *supra* note 62, at 47. *See generally id.* at 47-57; McCall, *supra* note 62, at 182-201.

86. *See, e.g.*, Foster v. Mobile County Hosp. Bd., 398 F.2d 227 (5th Cir. 1968) (two black residents denied admission to hospital staff sued and won, proving violation of their fourteenth amendment rights and statutory rights under 42 U.S.C. § 1983).

public hospital cannot be arbitrary, capricious, or discriminatory; it must be based upon standards that are fair and rationally related to the reasonable ends of the hospital.[87]

Because of the serious effects of exclusionary action by hospitals, courts have increasingly extended due process protection to those excluded from a "quasi-public" hospital. The leading case extending such protection is *Greisman v. Newcomb Hospital*,[88] in which a hospital denied privileges to an osteopathic physician because he did not graduate from an AMA-approved school and did not belong to the county medical society. The court found that although the hospital was "non-governmental," it was not private because it functioned as a result of publicly solicited charitable donations. Dedicated to a public purpose, the hospital enjoyed tax benefits because of its nonprofit nature and was the only hospital serving an area with a population of more than 100,000.[89]

Several jurisdictions have consistently refused to recognize the public-private distinction and have mandated that all hospitals accord procedural and substantive due process to physicians excluded from staff privileges.[90] The courts have based the extension

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In the Fourth Circuit the receipt of Hill-Burton construction funds alone has been held sufficient to endow even a private hospital with enough state authority to make its actions take on the character of "state action." This position, however, is the minority view. *See* Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964) (racial discrimination against physicians and patients seeking access to hospitals unconstitutional). Although *Simkins* was justified by the federal sanction against racial discrimination in Hill-Burton recipient hospitals, the basis for the extension of *Simkins* in the Fourth Circuit is less apparent. *See, e.g.*, Sams v. Ohio Valley Gen. Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969) (denial of staff privileges to physicians on grounds that their offices and practices were located outside the county in which the Hill-Burton recipient hospital was located is denial of due process and equal protection). For a discussion of the relevant issues, see Cronin, *Private Hospitals that Receive Public Funds Under the Hill-Burton Program: The State Action Implications*, 12 NEW ENG. L. REV. 525 (1977). The majority of circuits, however, refuse to recognize "state action" on the receipt of Hill-Burton funds alone. *See, e.g.*, Hodge v. Paoli Memorial Hosp., 576 F.2d 563 (3d Cir. 1978); Schlein v. Milford Hosp., Inc., 561 F.2d 427 (2d Cir. 1977); Briscoe v. Bock, 540 F.2d 392 (8th Cir. 1976); Greco v. Orange Memorial Hosp. Corp., 513 F.2d 873 (5th Cir.), *cert. denied*, 423 U.S. 1000 (1975); Jackson v. Norton-Children's Hosps., Inc., 487 F.2d 502 (6th Cir. 1973), *cert. denied*, 416 U.S. 1000 (1974); Doe v. Bellin Memorial Hosp., 479 F.2d 756 (7th Cir. 1973); Ward v. St. Anthony Hosp., 476 F.2d 671 (10th Cir. 1973).

87. *See, e.g.*, Theissen v. Watonga Mun. Hosp. Bd., 550 P.2d 938 (Okla. 1976) (public hospital met standards of fairness and rational basis when it denied privileges to physician with past drug problem offering no evidence of rehabilitation).

88. 40 N.J. 389, 192 A.2d 817 (1963).

89. *Id.* at 396, 402; 192 A.2d at 821, 824.

90. *See, e.g.*, California: Anton v. San Antonio Community Hosp., 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977); Pinsker v. Pacific Coast Soc'y, 1 Cal. 3d 160, 460 P.2d 495, 81 Cal. Rptr. 623 (1969) (private orthodontists' discretionary exclusion subject to judi-

of procedural protection upon various rationales, for example, the receipt of extensive governmental funding[91] and the protection of a physician's property right to practice medicine.[92]

When review of hospital staff decisions is permitted, the substantive grounds for dismissal must not be arbitrary, capricious, or unreasonable. The often-quoted standard of reasonableness in *Sosa v. Board of Managers of Val Verde Memorial Hospital*[93] states that matters must be reasonably related to hospital management. "No court should substitute its evaluation of [a physician's ethical and professional competence] for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors."[94]

Substantial evidence of incompetence is clearly sufficient grounds for refusing hospital staff privileges.[95] Moreover, if the hospital adopts new rules requiring additional experience or qualifications, application of the new standards to existing staff members is not unfair or unreasonable.[96] Courts, however, have not accepted all substantive grounds for refusal, restriction, or

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cial scrutiny); Ascherman v. San Francisco Med. Soc'y, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974); New Jersey: Garrow v. Elizabeth Gen. Hosp., 79 N.J. 549, 401 A.2d 533 (1979); Guerrero v. Burlington County Mem. Hosp., 70 N.J. 344, 360 A.2d 334 (1976); Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963); Walsky v. Pascack Valley Hosp., 145 N.J. Super. 393, 367 A.2d 1204 (1976); Sussman v. Overlook Hosp. Ass'n, 95 N.J. Super. 418, 231 A.2d 389 (1967). *Cf.* Falcone v. Middlesex County Med. Soc'y, 34 N.J. 582, 170 A.2d 791 (1961) (extending judicial scrutiny of such decision to private voluntary organizations such as county medical societies).

91. *See, e.g.*, Klinge v. Lutheran Charities Ass'n, 523 F.2d 56 (8th Cir. 1975); Sterrs v. Lutheran Hosps. & Homes Soc'y of America, Inc., 609 P.2d 24 (Alaska 1980).

92. *See* Anton v. San Antenio Community Hosp., 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977). *See also* Stretten v. Wadsworth Veterans Hosps., 537 F.2d 361 (9th Cir. 1976). For a discussion of emergent procedural causes of action, see Kessenick & Peer, *supra* note 62, at 52.

93. 437 F.2d 173 (5th Cir. 1971).

94. *Id.* at 177.

95. *Id.* Plaintiff in *Sosa* had, according to the hospital, abandoned a patient in active labor because she could not pay her bill. The physician had also been suspended by the licensing board of the state of Texas, had been found "guilty of two felonies," and had shown instability toward patients, fellow physicians, and support persounel. *Id.* at 175. Although his paper qualifications met the standards set forth in the written bylaws, the court held that the hospital board had the authority to add supplemental requirements concerning an applicant's character. *See also* Battle v. Jefferson Davis Memorial Hosp., 451 F. Supp. 1015 (S.D. Miss. 1976), *aff'd*, 575 F.2d 298 (5th Cir. 1978); Rao v. Auburn Gen. Hosp., 19 Wash. App. 124, 573 P.2d 834 (1978).

96. *See, e.g.*, Holmes v. Hoenıako Hosp., 117 Ariz. 403, 573 P.2d 477 (1977) (rule requiring staff members to carry malpractice insurance held reasonable as protecting hospital and patients). *But see* Rosner v. Peninsula Hosp. Dist., 224 Cal. App. 2d 115, 36 Cal. Rptr. 332 (1964). It should be noted that the California court decided *Rosner* before the malpractice crisis of the 1970s and before the *Darling* decision.

termination of privileges. For example, the *Greisman* court held that nonmembership in the county medical association was insufficient to prevent plaintiff from attaining staff membership.[97] Other grounds for exclusion rejected by the courts include specialty board certification,[98] maintenance of an office in the county within which the hospital is located,[99] and failure to provide recommendations from the hospital's own active staff physicians.[100]

A recent California case, *Miller v. Eisenhower Medical Center*,[101] held that a private hospital's exclusion of a physician from hospital privileges must be directly related to patient care. This case represents a significant extension of judicial intervention in a private hospital's staff selection process. Plaintiff, a family practitioner, had been denied staff privileges four times between 1971 and 1975. At the time of his last application he submitted the names of twenty-five physicians whom the hospital might question concerning his qualifications. The hospital's medical executive committee informed plaintiff that privileges were denied "on the basis of recommendations received from references furnished by you."[102] At the subsequent hearing, requested by plaintiff before the judicial review committee, no evidence was introduced that the references faulted plaintiff as to his professional competence; rather the damaging evidence concerned only his "controversial" and "disruptive" character.[103] The judicial review committee affirmed the executive committee's denial of privileges, stating that its decision was based upon "the determination that sufficient doubt exists concerning [plaintiff's] ability to work with others as stated . . . in the Medical Staff Bylaws."[104]

On appeal, the hospital's board also denied plaintiff privileges. Plaintiff then sued defendant hospital, having exhausted the inter-

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97. Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963).

98. Armstrong v. Board of Directors of Fayette County Gen. Hosp., 553 S.W.2d 77 (Tenn. App. 1976) (public hospital must determine applicant's competency from evidence before it; hospital most not rely exclusively upon outside specialty board standards). *But see* ACCREDITATION MANUAL, *supra* note 68, at 96: "Specialty Board certification or eligibility as defined by the appropriate board is an excellent benchmark to serve as a basis for privilege delineation." Private hospitals often employ this basis for determining privilege.

99. Sams v. Ohio Valley Gen. Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969) (no rational classification).

100. Ascherman v. St. Francis Memorial Hosp., 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975).

101. 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980).

102. *Id.* at 619, 614 P.2d at 260, 166 Cal. Rptr. at 828.

103. *Id.* at 620 & n.4, 614 P.2d at 261 & n.4, 166 Cal. Rptr. at 829 & n.4.

104. *Id.* at 620-21, 614 P.2d at 261, 166 Cal. Rptr. at 829.

nal procedures. The trial court found for defendant, stating that the membership requirements were rational and neither arbitrary nor capricious. The California Supreme Court reversed on the grounds that the bylaw section used as a basis for exclusion did not meet basic due process standards. The majority opinion emphasized that "ability to work with others," as stated in the medical staff bylaws, "must . . . be read to demand that there be a demonstrable nexus between the applicant's ability to 'work with' others and the effect of that ability on the quality of patient care provided"[105]—a significant departure from the general *Sosa* standard of reasonable relationship to hospital management.[106] Therefore, "an otherwise competent physician, although considered 'controversial,' outspoken, abrasive, hypercritical, or otherwise personally offensive by some of his hospital colleagues, may nevertheless have the ability to function as a valuable member of the hospital community and should not be denied the opportunity to do so as a result of personal animosities or resentments alone."[107] A "specific and realistic" threat to the quality of medical care offered patients must be the basis for rejecting a physician's application for privileges.[108]

D. Governmental Impact on Health Care Service

The crisis of the Depression and the high rate of medical exemptions from service in the Armed Forces pointed up the need for government programs in the health care field.[109] Inspired by World War II's demonstration of the competence of the American people and their technology, the federal government initiated large-scale programs to improve the nation's health care. In late 1945 President Truman sent a message to Congress requesting legislation that would guarantee adequate health care to all

105. *Id.* at 628-29, 614 P.2d at 266, 166 Cal. Rptr. at 834.

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

107. 27 Cal. 3d at 631-32, 614 P.2d at 269, 166 Cal. Rptr. at 837.

108. *Id.* In dissent, Justice Mosk asserted that the majority opinion had blurred the line between due process rules applicable to private hospitals and those applicable to public hospitals. *Id.* at 636, 614 P.2d at 272, 166 Cal. Rptr. at 840 (Mosk, J., dissenting). In his opinion, the one exception that would justify judicial interference in private hospital matters would be monopoly status by the hospital institution, a position substantially undercut by Ezekial v. Winkley, 20 Cal. 3d 267, 572 P.2d 32, 142 Cal. Rptr. 418 (1977), in which the same court held that due process does not necessarily depend upon the existence of monopoly power held by an institution when that institution has the practical power to affect substantially an important economic interest.

109. R. RUSHMER, *supra* note 17, at 12.

Americans.[110]

For the purposes of this Note, the first of President Truman's five objectives—the building or modernization of physical hospital facilities[111]—has particular relevance, since it resulted in the passage of the Hill-Burton Act.[112] Although laudable as an isolated policy objective, this goal combined with hospital-oriented insurance plans such as Blue Cross and Blue Shield[113] to produce not only a "boom" in hospital construction, but also a skewed concentration of health power in the hospital and a concomitant neglect of other possible competitive institutional providers such as nursing and convalescent homes, surgical centers, and out-patient treatment centers. The hospital became the primary focus of medical service, and hospital staff privileges for doctors became an economic and professional necessity. Denied hospital access, the medical specialist in many fields cannot practice, and the medical generalist loses his patients to physicians with access; this exacerbates the perceived impersonality of medical treatment and increases the risk of malpractice suits.

The groundwork for President Truman's third objective —encouragement of medical education and research—predates the post-World War II health care explosion.[114] The well-financed and successful research done under government-supported programs during the war was a primary factor in reducing the profession's suspicions about socialized medicine and in showing the medical

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110. President Harry S. Truman, Message to Congress on Health Legislation, [1945] U.S. CODE CONG. SERV. 1143. The President listed five areas in which governmental support was necessary: the construction of hospitals and related health facilities; the expansion of public health, maternal, and children's services; encouragement of medical education and research; prepayment of medical costs to insure access to medical services; and protection against lost income by the working man during sickness or disability.

111. For a discussion of the purpose as expressed in the legislative history of Hill-Burton, see Note, *Due Process for Hill-Burton Assisted Facilities*, 32 VAND. L. REV. 1469, 1475 (1979).

112. Hospital Survey and Construction Act, ch. 958, 60 Stat. 1040 (1946) (current version at 42 U.S.C. §§ 291-291o (1976 & Supp. III 1979)).

113. "Private medical insurance has focused primarily on medical services rendered within a hospital." K. DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS, AND CONSEQUENCES 19 (1975). Blue Cross, organized during the Depression when hospital revenue and patient occupancy dropped precipitously, currently has approximately 40% of the hospital insurance market. It was largely financed by hospitals, and until 1972 the Blue Cross name and insignia were owned by the American Hospital Association. Until very recently, most health insurance policies have excluded reimbursement to alternative institutions such as nursing homes, outpatient facilities, and surgicenters, in which hospital stay is minimized for minor surgical procedures. *Id.* at 19-20 (quoting S. LAW, BLUE CROSS: WHAT WENT WRONG 6-7, 18-30 (1974)).

114. R. RUSHMER, *supra* note 17, at 13.

community the opportunities offered by government financing of research. This new emphasis on research accompanied the enthusiastic move toward specialization. Once again the result was to funnel physicians into a hospital situation in which clinical research was possible.

E. Technological Innovation

Although intraprofessional restraints and governmental regulations bave significantly molded the relationship between physician and hospital, their effect has been conditioned largely upon the third major influence upon that relationship, the rise of medical technology. Patient dependence solely upon the family physician has been replaced by reliance upon a battery of specialists, who, in turn, depend upon the proliferation of technology that has become the hallmark of modern American medicine.

The enormous "economic" costs of technology in combination with third-party payment, patient-consumer ignorance, increasing labor costs, and the general orientation of the individual physician to the individual patient[115] have contributed to the massive inflation in health care costs over the past quarter-century.[116] While some critics have suggested a complete structural reorganization of medicine,[117] the need for cost containment has generated only piecemeal responses, such as the "certificate of need" legislation in the National Health Planning and Resources Development Act of

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115. For good general discussions of these and other health care issues, see Blumstein & Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL., POL'Y & L. 382 (1979); Blumstein & Zubkoff, *Perspectives on Government Policy in the Health Sector*, 51 MILBANK MEMORIAL FUND Q. 395 (1973).

In a normal transaction, the buyer of goods pays the seller directly out of his own assets; such direct payment induces the buyer to compare prices and forces the seller to offer his goods and services at a reasonably competitive price. In a health care transaction, however, third parties—insurance companies—bear the direct cost of health services. Thus, no incentive on the part of the patient or the health care provider to "count the cost" is present. Moreover, the economic concept of "consumer sovereignty" cannot operate if the consumer-patient does not have the knowledge to make an informed choice about his health care alternatives. The doctor or other health care provider traditionally makes all such decisions for him. In making such decisions, the physician is, quite naturally, oriented toward using whatever resources are available to maximize the well-being of his individual patient, rather than toward using the available resources to maximize the public benefit.

116. Health care represented slightly under 10% of the GNP during the past decade. Blumstein & Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, *supra* note 115, at 396.

117. *See, e.g.*, R. CARLSON, THE END OF MEDICINE (1975); E. GINSBERG, THE LIMITS OF HEALTH REFORM: THE SEARCH FOR REALISM (1977); A. SOMERS, *supra* note 1, at 34-35.

1974.[118]

The innovators in medical technology at the great academic medical centers have taught physicians to rely upon technology[119] and to utilize their technological expertise in an ever-narrowing medical subspecialty. This technological dependence—in combination with rapid hospital growth—has been predictable: "as these young specialists left the hallowed halls of academe to use their hard-won skills, they set up shop in these new hospitals and established highly sophisticated subspecialty units that duplicated those on which they had been trained in teaching centers."[120]

For purposes of this Note, the more important effect of technological innovation and subspecialty proliferation has been a concentration of these expensive services in the hospital institution.[121] Hospital accreditation committees and often state law[122] require hospitals to maintain such subspecialty services, resulting in the reinforcement of the hospital's power and a concomitant diminution in ease of access for highly-trained medical professionals. The reduced access follows in part from the common practice of exclusive dealing contracts. Because the hospital requires certain highly technical services on an "as need" basis,[123] and because it is economically more sound, a hospital often contracts with a single specialist or small group of specialists to run the particular service to the exclusion of other physicians either on the staff or desirous of becoming affiliated with that hospital. Courts have traditionally upheld such contracts, finding the hospital's action reasonable when the "practical problems inherent in operating an institution as complex as a hospital [are balanced] against the restriction on the right of an individual physician to practice the specialty for

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118. 42 U.S.C. §§ 300k-300t (Supp. III 1979).

119. *See also* Vogel, *supra* note 1, at 112-13, quoting a turn-of-the-century physician, Dr. Thomas Howell:

> Not having been taught to improvise, they do not realize how much can be accomplished with the crude implements to be found in the ordinary household. The graduates of cheaply equipped institutions, on the other hand, have been required to exercise ingenuity throughout their apprenticeship, and, as a result, they are not only more resourceful in emergencies, but their adaptability enhances their professional reputation.

Id.

120. Rogers & Blenden, *The Academic Medical Center: A Stressed American Institution*, 298 NEW ENG. J. MED. 946 (1978).

121. *See* ACCREDITATION MANUAL, *supra* note 68.

122. *See, e.g.*, TENN. CODE ANN. § 53-5201 (1976) (duty to furnish emergency room service).

123. *See* Kessenick & Peer, *supra* note 62.

which he or she has been trained."[124]

In *Dattilo v. Tucson General Hospital*[125] defendant hospital gave an exclusive contract in nuclear medicine to two physicians other than plaintiff. Plaintiff brought suit against the hospital alleging a common law restraint of trade as well as a violation of state antitrust law. The court upheld the contract, stating that contracts such as those in areas of medical specialty inextricably bound to the hospital—radiology, nuclear medicine, and pathology, for example—are necessary for several reasons: to maintain control and standardization of procedure, to ensure the effective, efficient operation of the department in question and greater ease of monitoring by the hospital board, and to guarantee better patient care through better scheduling.[126] The court also cited other reasons to uphold the contract: the economical operation of the department, more consistent training of technicians, and the contracting specialists' ability to avail themselves of medical and technical advances in the field. Finally, the court found no interference with the right of a patient to select his own doctor.[127]

Based on this overwhehning list of justifications, the court held that "this exclusive contract is necessary for proper patient care."[128] The court found no unreasonable interference with plaintiff's right to practice medicine, since he retained his internal medicine privileges, even though defendant hospital was the only osteopathic hospital in the vicinity and plaintiff was an osteopath.

Hospitals usually grant exclusive dealing contracts in highly specialized technological areas, such as pathology and radiology, which they consider essential to the adequate provision of a wide range of medical services. Hospitals and the courts treat an exclusive dealing contract within one of the broad-based specialties as if such a contract were a "natural monopoly." Blumstein and Zubkoff assert that this form of monopoly occurs

> when cost structure and market size make competition inefficient and unfeasible. If market size and production technology allow a single firm to operate in the decreasing cost portion of the long-run cost curve, with any additional output at lower marginal cost, then the economies of scale cannot be ex-

124. *Id.* at 70. *See, e.g.*, Benell v. City of Virginia, 258 Minn. 559, 104 N.W.2d 633 (1960). In *Benell*, one of the earliest exclusive dealing contract cases, the court relied upon the complexity of radiology equipment, the need for a high degree of expertise to use the equipment, and the desire for efficiency and uniformity in upholding the contract.

125. 23 Ariz. App. 392, 533 P.2d 700 (1975).

126. *See id.* at 396-97, 533 P.2d at 704-05.

127. *Id.*

128. *Id.*

> hausted at any given level of market demand. . . . The utility companies are often cited as the example of this form of monopoly. In the utility case, the economies of scale in production and distribution are so marked that if several companies were in competition, costs would be substantially higher and significant inconvenience and misallocation of resources would occur.[129]

In the medical field the clearest example of a "natural monopoly" is the rural hospital, because it "provid[es] a service for which there is no close substitute and [operates in a market] in which additional entry is not economically feasible because of the high capital costs and economies of scale."[130] These justifications almost always apply to the exclusive dealing contract as a natural monopoly because *any* individual hospital—rural, urban, or suburban—is viewed as a self-contained unit of production "for which there is no close substitute" and a market into which "additional entry is not economically feasible." Staff privileges are highly visible evidence of this perception, since privileges are granted on a hospital by hospital basis.[131] Thus, the effect of the exclusive dealing contract on hospital privileges is to restrict entry by other qualified physicians because of the "high capital costs and economies of scale."[132]

Government's intuitive response to the high cost of medical technology and to the evidence of "market failure" inherent in monopoly has been intervention, but intervention that does not interfere with productivity.[133] The most visible governmental response—certificate of need legislation[134]—is often applied to the

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129. Blumstein & Zubkoff, *Perspectives on Government Policy in the Health Sector, supra* note 115, at 403.

130. *Id.* at 404.

131. *See* ACCREDITATION MANUAL *supra* note 68, at 96.

132. *See, e.g.*, Marsh v. Finley, 160 N.J. Super. 193, 389 A.2d 490, 491 (1978):

> The cost of acquiring [a C.A.T. scanner] ranges from $350,000 to $550,000 and, after site preparation, from $400,000 to $600,000. In addition, operational costs, depending upon the numbers of procedures performed range from $290,000 to $301,500 per year. This includes extensive technical and professional staff necessary to operate the equipment and perform the diagnostic procedures associated with the equipment.

133. *See* Blumstein & Zubkoff, *Perspectives on Government Policy in the Health Sector, supra* note 115, at 396-405. *See also* Blumstein & Calvani, *State Action as a Shield and a Sword in a Medical Services Antitrust Context:* Parker v. Brown *in Constitutional Perspective*, 1978 DUKE L.J. 389, 391-92.

134. National Health Planning & Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (codified at 42 U.S.C. §§ 300k-300t (1976), *as amended by* Health Planning & Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592).

In its broadest sense, certificate of need (CON) legislation is a kind of governmental regulatory control over health facilities' capital expenditures. Under § 1122 of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1386 (codified at 42 U.S.C. § 1320a-1 (1976), *as amended by* Act of Nov. 1, 1978, Pub. L. No. 95-559, § 14(b), 92 Stat. 2141), federal reimbursement for certain capital costs is denied unless capital expenditures are made with state health planning agency approval. Under the National Health Planning

technology underlying most exclusive dealing contracts. The certificate of need (CON) theoretically distributes high capital cost items among hospitals within a given community or geographical area. The majority view, however, is that the program has been a failure: "the most damaging piece of evidence in support of this conclusion is the extremely high approval rate in those states with CON programs—the great majority of all projects submitted for review have been approved."[135] Perhaps one reason for this failure is a rejection by CON committees of the theoretical model of the individual hospital as a single unit within a larger production model in favor of the "naturally monopolistic" concept of technologically dependent units within a single hospital—a view reinforced by accreditation standards and by the courts.[136]

Courts tolerate and even encourage natural monopolies because their economic and social benefits accrue not only to the monopolists themselves but also to the community at large. In the medical industry exclusive dealing contracts protect and regulate many of the naturally monopolistic broad-based subspecialties. In contrast to these are other technologically dependent procedures within subspecialties which threaten to become "unnatural monopolies": "situation[s] in which a producer is supplying its market with a good for which there are no close substitutes. The monopolist, in order to maximize profits, will restrict output and charge high prices."[137] In other words, community benefit is significantly lessened while primary benefits accrue to the monopolists themselves. The antitrust laws are generally concerned with the unnatural monopoly offense. Some technologies that began as "natural" monopolies and were protected by exclusive dealing contractual

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and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (codified at 42 U.S.C. §§ 300k-300t (1976), *as amended by* Health Planning & Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592), states without agencies to conduct CON review by 1980 will be denied funds for development, expansion, or support of health resources. 42 U.S.C. §§ 300m(d), 300m-2(a)(4)(B) (1976). *See generally* H. HYMAN, HEALTH REGULATION: CERTIFICATE OF NEED AND 1122 (1977); Schonbrun, *Making Certificate of Need Work*, 57 N.C. L. REV. 1259 (1979). The certificate of need also attempts to correct another problem related to the exclusive dealing contract: that technology conforms to Roemer's law—the variation of which might read "a CAT scanner bought is a CAT scanner used." *See* Roemer, *Bed Supply and Hospital Utilization*, HOSPITALS, Nov. 1, 1961, at 36, *quoted in* Schonbrun, *supra*, at 1263 ("A bed built is a bed filled.").

135. A twenty state study conducted in 1975 found that 93% of all CON projects submitted to review were approved. Schonbrun, *supra* note 134, at 1266 & n.37.

136. *See, e.g.*, North Miami Gen. Hosp. v. Office of Community Medical Facilities, 355 So. 2d 1272 (Fla. Dist. Ct. App. 1978).

137. Blumstein & Zubkoff, *Perspectives on Government Policy in the Health Sector*, *supra* note 115, at 403.

arrangements may be in the process of transformation into "unnatural" monopolies with the passage of time, the proliferation of successful alternative techniques, and, ironically, improved technology.[138]

IV. Emergent Issues: The Demand For Access

The health care industry has been perhaps the most vigorous industry of the past forty years. This dynamism will probably continue despite the varied pressures exerted upon the health care field by intraprofessional governance, continued expansion of technological dependence, and governmental restraints ranging from mere influence to outright regulation. As discussed previously, however, the effect of these various pressures has been to limit access to hospitals while simultaneously elevating the hospital to its premier status as *the* legitimizing institution in the health care industry. Two important challenges have been aimed at the exclusivity and economic self-protection endemic to hospital privilege systems, which are but one characteristic of the hospital monolith.

An increase in antitrust actions in the health care field has presented one challenge to the privilege system. Competing institutions, such as surgical outpatient centers or birthing centers, may present attractive, safe, and economical alternatives to the upwardly-spiralling costs of inpatient hospital care. By denying hospital privileges to the professionals staffing such alternative institutions, or, more blatantly, by denying continuing privileges to those professionals attempting to serve on the staffs of both institutions, the hospital could expose itself to antitrust liability.[139] The importance, and limitation, of antitrust litigation is determined to a significant degree by the challenge to physicians' entrenched

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138. For example, in Moles v. White, 336 So. 2d 427 (Fla. Dist. Ct. App. 1976), the court refused to review the denial of privileges by a private hospital to an open-heart surgeon even though the hospital was the only one in the community with necessary facilities. With the decreased technological costs attendant upon open-heart surgery, it is probable that cases like *Moles* will be more closely scrutinized for antitrust violations.

139. Recent literature has scrutinized extensively the increase of antitrust litigation in the health care field. *See, e.g.*, Borsody, *The Antitrust Laws and the Health Industry*, 12 Akron L. Rev. 417 (1979); Calvani & James, *Antitrust Law and the Practice of Medicine*, 2 J. Legal Med. 75 (1980); Curran, *The Confrontation Between National Health Planning and the Federal Antitrust Laws*, 70 Am. J. Pub. Health 425 (1980); Grad, *The Antitrust Laws and Professional Discipline in Medicine*, 1978 Duke L.J. 443; Rich, *Medical Staff Privileges and the Antitrust Laws*, 2 Whittier L. Rev. 667 (1980); Rosoff, *Antitrust Laws and the Health Care Industry: New Warriors in an Old Battle*, 23 St. Louis U. L.J. 446 (1979); Note, *supra* note 39.

dominance of hospital privileges by other health professionals.[140] This Note now turns to an examination of several of these professional challenges.

A. Osteopaths

Osteopathic physicians (D.O.s) were the first group of health professionals other than licensed medical doctors (M.D.s) to push for acceptance onto hospital staffs, and they have, by and large, achieved parity with M.D.s. The only Supreme Court case to examine the right of hospital access arose when a state hospital denied staff privileges to an osteopathic physician because he was an osteopath.[141] Plaintiff based his claim upon equal protection and due process grounds, but the Court held that exclusion of an osteopathic physician from a state hospital was within the state's police power. The Court found that licensed physicians have no constitutional right to practice medicine in a state institution. Moreover, hospital management necessitates "some choice in methods of treatment . . . and selection [of medical staff members] based upon a classification having some basis in the exercise of the judgment of the state board whose action if challenged is not a denial of equal protection of the laws."[142]

Excluded osteopaths have brought many of the landmark cases concerning hospital access. *Falcone v. Middlesex County Medical Society*[143] held that a county medical society's unwritten requirement that all potential members be graduates of a four-year, AMA-approved medical school was arbitrary, unreasonable, and illegal. Plaintiff had attended a four-year osteopathic college that offered instruction in all "normal" medical subjects as well as in osteopathic theory. He was unrestrictedly licensed by the state of New Jersey. Following the declaration of ineligibility by the medical society, area hospitals dropped plaintiff from their staffs because they required staff members to be members of the local society. Thus, the local medical society had a "virtual monopoly over the use of local hospital facilities"[144] and was not entitled to the same protection afforded voluntary membership organizations

140. *See, e.g., Nurse Midwifery: Consumers' Freedom of Choice, Hearing Before the House Comm. on Oversight and Investigation*, 96th Cong., 2d Sess. (Dec. 18, 1980) (investigation of denial of access to nurse-midwives) [hereinafter cited as *Hearing*].

141. Hayman v. City of Galveston, 273 U.S. 414 (1927).

142. *Id.* at 417.

143. 34 N.J. 592, 170 A.2d 791 (1961).

144. *Id.* at 598, 170 A.2d at 799.

since it was a society "which engages in activities vitally affecting the health and welfare of the people."[145] Finding that the medical society had breached its fiduciary duty to the public, the court affirmed the lower court's writ of mandamus compelling admission of plaintiff into the county medical society.[146]

The historical basis for denial of hospital privileges to osteopaths lies in the discipline's original dedication to bone manipulation as a means of "structural realignment" for the cure of all disease.[147] Although such a theory was no less reasonable than other similar theories advanced during the years predating scientific medicine, osteopathy's fervent adherents refused to consider or recognize growing scientific knowledge about the nature of illness and its cure.[148] Therefore, with some justification the AMA condemned practitioners of osteopathy as "cultists" and forbade M.D.s to associate professionally with D.O.s. By 1940, however, osteopathic colleges were teaching the bases of scientific medicine as well as osteopathic manipulation, and in recent decades the education received by M.D.s and D.O.s has become virtually indistinguishable. Legal recognition followed, and most states now grant unrestricted licenses to D.O.s.[149]

Blackstone contends that, in spite of legal recoguition of D.O.s, the AMA has always had monopolistic intent with respect to osteopathy.[150] He cites numerous attempts by organized medicine to restrict potential competition by osteopaths: opposition to inclu-

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145. *Id.*

146. Other exclusion cases involving osteopaths include: Don v. Okmulgee Memorial Hosp., 443 F.2d 234 (10th Cir. 1971); Peterson v. Tucson Gen. Hosp., Inc., 114 Ariz. 66, 559 P.2d 186 (1976) (exclusion held proper because of failure to maintain adequate hospital records); Dattilo v. Tucson Gen. Hosp., 23 Ariz. App. 392, 533 P. 2d 700 (1975); Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963) (quasi-public hospital's exclusion of doctor could not be arbitrary or capricious); Hagan v. Osteopathic Gen. Hosp., 102 R.I. 717, 232 A.2d 596 (1967) (exclusion of osteopathic physician held proper on grounds of personality conflict with hospital administrator, hospital board's preference for another physician, and his potential to be a disruptive force in hospital); Fritz v. Huntington Hosp., 48 A.D.2d 614, 367 N.Y.S.2d 847 (1975) (exclusion of osteopaths held proper on grounds that they failed to complete an AMA-approved internship or residency). *See also* text accompanying notes 75-87 *supra.*

147. *See* Note, *Malpractice and the Healing Arts—Naturopathy, Osteopathy, Chiropractic,* 9 UTAH L. REV. 705, 710 (1965). The founder of osteopathy said "we use the bones as fulcrums and levers to adjust from the abnormal to the normal that the harmonious functioning of the viscera of the whole body may show forth perfection, that condition which is known as good health." *Id.* at 709 (quoting BOOTH, HISTORY OF OSTEOPATHY 399 (1905)).

148. *See id.* at 710.

149. *See id.* at 711.

150. Blackstone, *supra* note 40. *See also* E. RAYACK, *supra* note 20, at 241-53.

sive licensure, denial of hospital access, prevention of governmental recognition and financial support of osteopathy, and refusal to allow, on ethical grounds, consultation or teaching privileges between M.D.s and D.O.s.[151] Another indication of monopolistic intent by the AMA was its exclusion of osteopaths from participation in AMA-approved internships and residencies. This restriction, however, may have actually had a salutary effect on the practice of medicine as a whole. In the post-World War II period, osteopaths, excluded from the specialties, filled the void in general practice left by M.D.s who entered medical specialties in overwhelming numbers.[152]

It was not until 1961 that the AMA relaxed its interdict against association with D.O.s. Immediately D.O.s gained admission into AMA-approved speciality training, and the incomes of both D.O.s and M.D.s increased, since the latter were now "ethically" able to receive referrals from the former.[153] Another significant development in 1961 was the merger of the California Medical Association with the California Osteopathic Association. The terms for merger were as follows: first, the transformation of the California osteopathic medical school into a school with certified AMA approval; second, the issuance of an M.D. degree to each osteopath holding an unlimited California license; third, the creation of a new medical society to accommodate the combined disciplines; and last, support of legislation to prevent future state licensing of D.O.s and elimination of the Board of Ostepathic Examiners except for those recalcitrant osteopaths who refused merger.[154]

Although the AMA has enthusiastically embraced the concept of merger, the American Osteopathic Association is interested in preserving its own identity. That reduction of competition would result from merger is undeniable. It is also undisputed that organized medicine's motives have been open to question in the past.

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151. *See* Blackstone, *supra* note 40, at 411-17. In the late 1950s Congress granted to osteopaths the right to hold medical commissions in the Armed Forces, Armed Forces Act, Pub. L. No. 85-861, § 1(77), 72 Stat. 1467 (1958) (codified at 10 U.S.C. § 3294 (1976)); to serve in Veterans Administration Hospitals, Veterans Benefits Act, Pub. L. No. 85-857, 72 Stat. 1244 (1958) (codified at 38 U.S.C. § 4105 (1976)); and to participate in the Public Health Service, Public Health Service Act, ch. 83, § 5(b), 62 Stat. 40 (1948) (codified at 42 U.S.C. § 209(d) (1976)).

152. *See* Blackstone, *supra* note 40, at 417.

153. *See generally id.*

154. *Id.* at 418-19. *See also* Osteopathic Physicians & Surgeons of Cal. v. California Medical Ass'n, 224 Cal. App. 2d 378, 36 Cal. Rptr. 641 (Dist. Ct. App. 1964) (California District Court of Appeal upheld the merger despite opposition from osteopaths).

For example, it was not until the 1960s when the supply of M.D.s was extremely low that the AMA finally tapped the alternative source of interns and residents from osteopathy by giving its approval to the acceptance of D.O.s into AMA-approved programs. As Blackstone points out, the legitimacy of the "quality" argument upon which exclusion of osteopaths had been based was questionable in light of the AMA's previous acceptance of foreign medical graduates into such programs.[155]

From the health policy perspective, total merger is not an attractive alternative. Competition between parallel medical care delivery systems of equal quality and efficiency can only benefit the consumer-patient. Moreover, the traditional strengths of the osteopathic physician in the area of general practice are necessary to meet health care demand in the next decade.[156] If a merger of osteopathic and allopathic medicine should occur, the traditional supply of general practitioners generated by osteopathic colleges could diminish at a time when such physicians are most needed. Furthermore, osteopaths have traditionally sought less highly developed and more rural areas in which to practice. If complete absorption were accomplished, the same reluctance exhibited by M.D.s to go outside the urban or suburban setting may well extend to their new D.O. associates.[157]

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155. *See* Blackstone, *supra* noto 40, at 421.

156. The Graduate Medical Education National Advisory Committee explicitly divided osteopathic general practice from "allopathic" family practice and predicted that each will have 105% of the practitioners necessary to meet the projected need in 1990. GMENAC SUMMARY REPORT, *supra* note 40, at 4, fig. 1. *See generally* Bloom, *supra* note 60.

157. *See* Blackstone, *supra* note 40, at 431. Blackstone offers other arguments against merger. *See id.* at 430-31.

A second problem concerns general practitioners. As the supply of physicians expands and competition increases, physicians (both M.D. and D.O.) with less training are in potential danger of being "squeezed out" of specialized hospital staff privileges. The prime example is the restriction on surgical privileges granted to the general practitioners (G.P.). Note the effect of the multi-tiered certification approach to hospital privileges advocated by the Joint Commission on Accreditation of Hospitals. *See* ACCREDITATION MANUAL, *supra* note 68, at 95-99. *See also* AM. MED. NEWS, Oct. 17, 1980, at 1 (discussing the American Academy of Family Practitioners' agreement to support a Nebraska lawsuit brought by excluded general practitioners and a general surgeon against the American College of Surgeons).

The restricting hospital's arguments generally follow the "quality" defense offered in *Dattilo* and other exclusive contract cases. The general practitioner counters by citing a need to treat the "whole" patient, especially when the G.P. is qualified to perform such procedures. Hospitals respond in different ways, for example by allowing categories of privileges with certain levels of training required for each category, *see* ACCREDITATION MANUAL, *supra* note 68, at 95-99, or by following "grandfather" clauses—allowing G.P.s with less training to continue operating in their areas of demonstrated competence, but with yearly quality review. *See* Yankauer, *Who Shall Deliver Primary Care?*, 70 AM. J. PUB. HEALTH

From a policy perspective, there is presently no rational ground upon which to base wholesale denial of hospital privileges to an osteopath solely because his professional degree is "D.O." instead of "M.D." To do so would undoubtedly raise a serious threat of antitrust litigation. Moreover, for the first time in history, an equally sophisticated competitor is challenging the M.D. Thus, such competition should be encouraged and not dulled by merger or by the historical bias against osteopaths.

B. Podiatrists

A podiatrist has four years of specialized training in diseases of the foot. Although the American Podiatry Association has been actively campaigning for increased hospital access over the past fifteen years, courts have generally upheld the right of the hospital to exclude, provided the basis for nonadmittance is reasonable.[158] A significant impetus, however, for the medical establishment's acceptance of the podiatrist has been the rise in popularity of running and jogging with their attendant foot injuries.[159] Although, under Standard I of the Medical Staff certification requirements, the Accreditation Manual states that "[m]edical staff membership shall be limited, unless otherwise provided by law, to individuals who are currently *fully* licensed to practice medicine and, in addition, to licensed dentists," the same standard later delineates extensively the privileges available to podiatrists.[160] The podiatrist must be appropriately licensed to obtain clinical privileges, but, if the hospital bylaws refer specifically to podiatric privileges, he is afforded the same kinds of privileges as any other specialist within the area of his expertise.

1048 (1980).

158. *See, e.g.*, Shaw v. Hospital Auth., 614 F.2d 946 (5th Cir. 1980). *See generally* Hollowell, *The Growing Legal Contest—Hospital Privileges for Podiatrists*, 23 ST. LOUIS U. L.J. 491 (1979).

159. *See, e.g.*, Brody, *Running Injuries*, 32 CLINICAL SYMPOSIA (no. 4, 1980).

160. *See* ACCREDITATION MANUAL, *supra* note 68, at 93, 97-98 (emphasis added). The JCAH amended its accreditation manual to allow podiatrists to admit patients with the concurrence of a medical doctor. This amendment was part of the settlement reached in Levin v. Joint Comm'n on Accreditation of Hosps., 354 F.2d 515 (D.C. Cir. 1965), an antitrust suit brought by a podiatrist challenging exclusionary hospital practices. The trial court found that compliance with the JCAH standards, which at that time did not sanction the granting of staff privileges to podiatrists, was sufficient to support the defendant's motion for summary judgment. Levin v. Doctors Hosp., Inc., 233 F. Supp. 953, 955 (D.D.C. 1964). The court of appeals reversed and remanded, holding that a court should not decide a complex antitrust suit on summary judgment; thus, the court avoided the substantive issue. 354 F.2d at 518.

The admission of podiatrists to hospital staffs clearly illustrates the current dilemma in health care delivery. On the one hand, there is a great push to attain the social goals of medical cost containment, the development of less expensive but equally effective alternative methods of delivery, and decreased emphasis on inpatient hospital use. On the other hand, there is the perception held by the public and by the health care profession that patients and professionals should not be denied the "essential facilities of a twentieth century hospital."[161] Whether the hospital is "essential" to all health care delivery in the last fifth of the twentieth century is perhaps the central issue.

C. *Chiropractors*

A recent study suggests that the public does not perceive chiropractors as being interchangeable with physicians; they have "a constituency of [their] own."[162] Thus, even when orthodox medical practitioners are available, chiropractors will not suffer a loss of clients; conversely, chiropractic does not seem to be a competitive threat to medicine.[163]

Chiropractic theory postulates that all illness and disease arise from a single cause: "subluxation" or misalignment of the spinal vertebrae that causes nerve compression and, in turn, disease. The "chiropractic cure" involves palpation and manipulation of these vertebrae in order to "adjust" them. Until very recently, the only legal attention focused upon chiropractic has concerned territorial disputes arising between its schools of practice[164] and the defense of chiropractors in either tort[165] or criminal cases.[166] Within the

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161. Shaw v. Hospital Auth., 507 F.2d 625, 629 (5th Cir. 1975) (Brown, C.J., concurring).

162. Silver, *Chiropractic: Professional Controversy and Public Policy*, 70 AM. J. PUB. HEALTH 348, 348 (1980).

163. *See id.*

164. *See, e.g.*, Rosenthal v. State Bd. of Chiropractic Examiners, 413 A.2d 882 (Del. 1980). Two schools have merged within chiropractic organization. The first school—"straight" chiropractic—believes that only the practitioner's hands should he used to readjust the spine. The second, more liberal school, called "mixer," believes that chiropractic may incorporate additional methods of treatment, such as light, heat, water, electricity, and vitamins. *See* Note, *supra* note 147, at 713.

165. *See, e.g.*, Malmstrom v. Olsen, 16 Utah 2d 316, 400 P.2d 209 (1965) (chiropractor found guilty of malpractice after violent jerk of the neck ruptured plaintiff's cervical disks and produced paralysis).

166. *See, e.g.*, People v. Phillips, 42 Cal. Rptr. 868 (Dist. Ct. App. 1965), *rev'd and vacated*, 64 Cal. 2d 574, 414 P.2d 353, 51 Cal. Rptr. 225 (1966) (chiropractor charged with felony murder following the death of an eight year old child suffering from cancer).

last three years, however, several suits[167] have alleged that radiologists and others have conspired (by refusing professional consultation) to boycott chiropractors.[168] If the courts follow the per se rules generally applicable to group boycotts,[169] then no matter what professional justification the radiologists may have for refusing to consult, the finding of a group boycott could automatically result in a successful antitrust suit.

If, instead, courts adopt the rule of reason approach,[170] radiologists would have to establish that concern for patient health as opposed to anticompetitive design is the motivation for the collective refusal to deal.[171] Calvani and James, however, suggest that even under the rule of reason group boycotts of chiropractors will trigger the imposition of antitrust penalties, primarily because consumer protection may demand that radiologists "oversee" the

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167. *E.g.*, New Jersey Chiropractic Soc'y v. Radiological Soc'y, 156 N.J. Super. 365, 383 A.2d 1182 (1978); Wilk v. AMA, No. Civ. 76C 3777 (N.D. Ill. Jan. 31, 1981).

On January 30, 1981, a jury directed a verdict in favor of defendants in *Wilk* on all antitrust counts. Plaintiffs are appealing the verdict. *See* New York Times, Feb. 1, 1981, § 1, at 19; 24 AM. MED. NEWS, Feb. 13, 1981, at 1, col. 1. *See also* Wolinsky, *What the Jurors Heard as Chiropractic Trial Concluded*, 24 AM. MED. NEWS, Feb. 13, 1981, at 34, col. 1. As reported by Wolinsky, the "quality" defense was among the arguments used by defendants. The AMA contended that its opposition to chiropractic was based upon "protect[ion of] the public from health hazards, rather than protect[ion of medicine's] economic interests." *Id.* In addition, another defendant, the American College of Radiologists, stated that opposition to chiropractic was actually detrimental to the economic interests of radiologists but that such opposition was covered under the first amendment right to free speech. *Id.* at col. 3.

168. Under the 1972 revision to the Social Security laws, chiropractors may receive Medicare and Medicaid reimbursement for treatment of "subluxation" confirmed by X-ray. Social Security Amendments of 1972, Pub. L. No. 92-603, § 273(a), 86 Stat. 1329 (codified at 42 U.S.C. 1395x(r) (1976)). *See generally* Calvani & James, *supra* note 139, at 83-89.

169. The United States Supreme Court has consistently held that group boycotts are per se violations of the Sherman Act, 15 U.S.C. §§ 1-7 (1976); this forecloses the consideration of justifications and defenses offered by defendants. *See generally* 2 E. KINTNER, FEDERAL ANTITRUST LAW §§ 10.30-.31 (1980); Note, *supra* note 39.

> In order to establish violation of the Sherman [Anti-Trust] Act it is not necessary to show that the challenged arrangement suppresses all competition between the parties or that the parties themselves are discontented with the arrangement. The interest of the public in the preservation of competition is the primary consideration. The prohibitions of the statute cannot "be evaded by good motives. The law is its own measure of right and wrong, of what it permits, or forbids, and the judgment of the courts cannot be set up against it in a supposed accommodation of its policy with the good intention of parties, and it may be, of some good results."

Paramount Famous Lasky Corp. v. United States, 282 U.S. 30, 44 (1930) (footnote omitted).

170. Some lower federal courts have in recent years recognized that "the purpose of every refusal to deal is not to further some anticompetitive objective." 2 E. KINTNER, *supra* note 169, § 10.31 at 168-69.

171. *See* note 167 *supra*. *See also* Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530 (5th Cir. 1978).

practicing chiropractor since "[i]t may be that consultation with radiologists will uncover disease which would have gone undetected and untreated in the hands of a chiropractor alone."[172] In addition, the assumption in an antitrust analysis is that consumers are the best judges of what is in their interest: "To deny this assumption is to suggest that government enforced consumer protection regulation ought supplant antitrust and the [medical] economy it seeks to protect."[173]

In response to the first fear expressed by Calvani and James, the threat of disease undetected by chiropractors, it would be more reasonable to penalize the chiropractor rather than the radiologist. Antitrust law should not burden the radiologist with responsibility for the chiropractor's predictable mistakes. In addition, it seems that chiropractors are attempting to have it "both ways": they argue that the same standards do not apply to chiropractic as to scientific medicine,[174] yet demand that radiologists legitimize chiropractors by consultation. If the true goal of antitrust legislation is "consumer welfare,"[175] then perhaps the chiropractors should be upgraded through more stringent educational requirements into true "competitors." Moreover, if chiropractic is indeed a separate "paradigm," then antitrust litigation is an improper cause of action. If there is indeed no competition, then there is no basis for an antitrust suit. It seems specious to suggest that simply because radiologists and chiropractors use the same X-ray technology, the former should oversee the latter.

In answer to Calvani and James' second concern, consumer protection regulation has often supplanted antitrust law.[176] To suggest that "government-enforced consumer protection regulation" is a new concept in the field of health care is to ignore, for example, the justification for the licensure laws that define initially the areas in which the physician or the chiropractor is competent to practice.

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172. Calvani & James, *supra* note 139, at 89.

173. *Id.* at 88-89.

174. [Chiropractic] does not pretend to be, nor does it ask to be considered, as a form of *medical* practice. It does not see itself simply as a deranged form of scientific medicine, but outside the theoretical structure of modern medicine altogether. It sees itself as an integrated healing system. In the popular parlance of the day, it is a separate "paradigm." It *is* unscientific by scientific medical standards . . . . Since chiropractors ask to be judged solely on their own standards, it is pointless to examine the theory or practice by the standards of orthodox medicine.

Silver, *supra* note 162, at 348 (emphasis in original). *See generally* Note, *supra* note 147, at 721 n.129.

175. Calvani & James, *supra* note 139, at 76.

176. *See, e.g.*, Silver v. N.Y. Stock Excb., 373 U.S. 341 (1963).

At present, chiropractors seem to seek hospital entry through the back door, demanding access to hospital records and radiological consultation. Such legitimization is unwise when viewed from the long-range health policy perspective. The granting of further hospital access would be a significant setback in the current attempts to deemphasize hospital care—one proven means for achieving the ultimate policy goal of cost containment. Chiropractors have treated their clients successfully—if consumer satisfaction is a guide—for years outside the hospital institution, working under the philosophy that "burden of health resides with the patient, and [that] it is within the patient that the motivation and ability for health accrue."[177] Increased patient responsibility for his own health is an approach currently advocated as a cost containment method. If the "burden of health" resides with the patient, then the emphasis is on prevention, and "the result is less reliance on expensive institutional care." Such nonhospital-based philosophy should be encouraged.

The potential for hospital liability for a chiropractor's misdiagnosis caused by justifiable ignorance probably constitutes a rational and nonarbitrary basis for a hospital's denial of staff privileges to a chiropractor.[178] To suggest that the chiropractor be granted staff privileges on the same basis as the physician or podiatrist—with medical review of his patients—is to ignore the real differences in the standards and philosophic bases of scientific medicine and chiropractic.

As an example of the problems following from these different orientations toward medical practice, the radiologic confirmation of the chiropractic subluxation mandated by the 1972 Social Security amendments[179] has resulted in hopeless confusion. To most radiologists, "subluxation" does not exist.[180] To most chiropractors, science has nothing to do with chiropractic. Moreover, since patients also view chiropractic as an alternative to medicine,[181] it is uncertain whether consumers of chiropractic would consent to medical overview. Again, perhaps, the wiser legislative course

177. Wild, *Social Origins and Ideology of Chiropractors*, 22 Soc. Symp. 33 (1978) *quoted in* Silver, *supra* note 162, at 350.

178. *See* text accompanying notes 90-108 *supra*.

179. Social Security Amendments of 1972, Pub. L. No. 92-603, § 273(a), 86 Stat. 1329 (codified at 42 U.S.C. 1395x(r) (1976)).

180. There are no scientific studies (if this is not a chiropractic paradox) confirming "subluxation." *See* Silver, *supra* note 162, at 348.

181. *See* Silver, *supra* note 162.

would be to upgrade the licensing requirements for the chiropractic profession so that the kind of medical paternalism embodied in the 1972 Social Security amendments would be unnecessary.

D. The New Health Professionals (NHPs)

Although the problems inherent in legitimization of chiropractic have existed for decades, entirely new problems regarding hospital access and legitimization of health professionals have arisen with the development of alternative forms of health care delivery during the 1970s. The creation and expansion of the new health professionals' fields[182] resulted from the perceived loss of person rapport between patients and physicians trained primarily as technologists, the ballooning cost of hospital-oriented care, and the short supply of physicians during the 1970s.[183] The renewed emphasis placed by medical schools upon care and patient rapport, coupled with the predicted oversupply of physicians,[184] mandates reassessment of the role of the NHPs. To complicate the situation, while the number of nonphysician *autonomous* health care providers has risen, essential *supervised* health care providers, such as nurses, are in extremely short supply.

The new health professionals group consists primarily of nurse practitioners, (NPs)—those persons generally educated as nurses, but who, with further education, are qualified to perform independent medical acts in addition to those traditionally delegated to nurses. The term includes nurse-midwives, nurse associates, and nurse clinicians. Physicians' assistants (PAs) are recognized under a PA statute as qualified to perform medical acts under the supervision of physicians.[185] This section of the Note uses the nurse-midwife as a paradigm for those new health professionals seeking hospital staff privileges.[186]

The renewed demand for nurse-midwives arose with the women's movement of the 1970s and expressed itself as part of the

> strong desire to take women's health care out of the hands of male physicians and put the control and care of women's bodies back where it belongs—with women. Therefore, this decade has seen an increased withdrawal by women

182. *See* Chapman & Record, *Defensibility of New Health Professionals at Law: A Speculative Paper*, 4 J. HEALTH POL., POL'Y & L. 30, 42-44 (1979).

183. *See id.* at 30-32; Yankauer, *supra* note 157.

184. *See* GMENAC SUMMARY REPORT, *supra* note 40.

185. Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 U. KAN. L. REV. 1, 1 n.4 (1975).

186. *See Hearing*, *supra* note 140 (investigation of denial of malpractice insurance to a physician who provided back-up service for nurse midwives).

> from the traditional institutions of medicine, including an increase in the desire for home birth attended by a midwife.[187]

The justifications for the new health professionals in general[188] are particularly applicable to nurse-midwives. In addition, midwives generally offer a service in underserved geographical areas at a lower cost.[189] Moreover, midwifery care traditionally has been offered outside the hospital, either in a "birthing center" or in the home.

The growing pressure for hospital access is predicated on the increasing need of the nurse-midwife, an innovative health professional, to achieve legitimization by admission to hospital privileges. Ironically, the basis for this pressure has been "quality care," the long-standing rallying cry of the physicians. Hospital-based midwifery service is also supposed to offer the patient a "choice"—one which the patient will prefer. Both the quality of care and the patient choice arguments stem from the physician-reinforced assumption that *only* the hospital institution can deliver "essential" medical care, but the low rate of maternal and infant mortality associated with midwife-assisted deliveries belies this assumption.[190]

The struggle over hospital access is understandable in light of the economics of the obstetrical specialty. The declining American birthrate means that the obstetrical pie will inevitably be sliced more thinly. Thus, midwifery is an innovative service offered in a declining market with predicted oversupply.[191] Because of this market situation, the hospitals' denial of access inevitably sets the stage for antitrust litigation against hospitals and competing obstetricians.[192] Beyond antitrust theory and defense, however, the policy arguments for diversification of health care personnel, services, and institutions makes even better economic sense.

Because the nurse-midwives seem to presage a new stage in health care delivery—the advent of a viable alternative institution—it is distressing to witness the continual retreat toward that bastion of the medical establishment, the hospital. Widespread acceptance of midwifery services provides the most successful oppor-

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187. 9 GOLDEN GATE U.L. REV. 631, 632 (1978-1979) (citing S. ARMS, IMMACULATE DECEPTION, A NEW LOOK AT WOMEN AND CHILDBIRTH IN AMERICA 147 (1975)).

188. *See* text accompanying note 183 *supra*.

189. Midwives' clientele, however, is increasingly middle class, because of the women's movement and the economic incentives.

190. The Tennessean, Nov. 23, 1980, at 17A, col. 1.

191. *See* GMENAC SUMMARY REPORT, *supra* note 40.

192. *See generally Hearing*, *supra* note 140.

tunity to educate consumers and encourage their patronage of alternative, lower-cost health care providers and institutions.

Unrestricted access to hospitals by nurse-midwives and other new health professionals may be a short-sighted, emotionally-based overreaction to the stubborn and equally short-sighted opposition of the obstetrical establishment in particular and the hospital-based medical community in general. Given the extremely low maternal and infant mortality rates in midwife-assisted births, the argument in favor of hospital access based upon the "quality" of hospital care seems specious, since the mortality rates for physician-assisted births in hospitals is higher.[193] Moreover, the present quality of care in hospitals is dangerously low because of a widespread nursing shortage. To burden an already overladen system with essentially "healthy" patients[194] when reasonable alternatives exist is a foolish course of action—one not in the best interests of the patient. Home or birth-center delivery is less expensive than hospital delivery[195] and, for the healthy population that midwifery serves, is a safer alternative.

In spite of the predicted oversupply of health providers, new health professionals will still have many needs to fill. Most "under-offered" services[196]—nutrition counseling, behavior modification, work with the terminally ill, maternal and infant services, and geriatric care—are presently offered almost exclusively within the hospital. All could be offered at an equal or higher level of quality—and at a lower cost—in other health care settings such as nursing homes, expanded home-based care, outpatient clinics, new health professionals' partnership groups, and birthing centers.

Furthermore, given the predicted oversupply of physicians and the steadily increasing supply of new health practitioners,[197] the existing hospital facilities will not be sufficient for the supply of primary care personnel. The certificate of need program and the push toward cost containment have discouraged the building of new acute care hospitals for the primary purpose of accommodating providers. Again, less expensive alternative facilities and institutions seem to be a necessary component of future health care

193. *See Hearing, supra* note 140.

194. *See* Bowland v. Municipal Court, 18 Cal. 3d 479, 487, 556 P.2d 1081, 1084, 134 Cal. Rptr. 630, 633 (1976) (midwifery is not treatment of the "sick or afflicted").

195. In the United States it takes approximately 2.5 staff persons to care for one hospital patient. M. ROEMER, *supra* note 22, at 100.

196. *See* Chapman & Record, *supra* note 182, at 44-45.

197. *See* Yankauer, *supra* note 157, at 1049.

services. Unless such alternatives are pursued, an even greater monopolistic concentration of health care power in the hospital institution could fuel yet another kind of antitrust action in the health care field.

The noneconomic benefits offered by the new health professionals must also be taken into account. A new emphasis on care would be a welcome complement to the emphasis on technological innovation that has dominated the medical profession during the last four decades. The attributes of caring and personal concern commonly offered by the new health professionals are those thought lost with the passing of the old, prescientific family doctor. Under the competitive pressure of the new health professionals, these attributes are once again beginning to percolate through the medical system. The combination of old concerns and technology promises a more satisfactory relationship between health providers and patients.

V. CONCLUSION

This Note has dealt in large part with the genesis and present status of hospital access problems for physicians. The historical development of both the hospital and the medical profession has created an increasingly uneasy interdependence between the institution and the profession. In recent history access problems have been forged, in the main, by the competing and often contradictory demands of the medical profession itself, the government, and scientific technology.

The medical profession has laudably stressed the need for quality care and individualized physician attention without regard to cost. The executive and legislative branches of government have proposed and implemented various programs designed to achieve equality of access by all patients to that "quality" care offered by physicians. In efforts to achieve that praiseworthy goal, the government has subsidized a plethora of new hospitals and programs such as Medicare and Medicaid[198] and has approved increases in the base numbers and kinds of health professionals.[199] Because the government often did not consider long term cost at the time of implementation, health care prices have increased, especially in the

198. Social Security Act Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42, 45 U.S.C.).

199. *E.g.*, Health Professionals Education Assistance Act of 1976, Pub. L. No. 94-484, 90 Stat. 2243 (codified as amended in scattered sections of 8, 42 U.S.C. (1976 & Supp. II 1978)).

past fifteen years. The unchecked proliferation of medical technology over the past four decades has produced so many new developments that it can be constrained only by an increase in government regulation, a decrease in the quality of care, or elimination of technological one-upsmanship of the professionals. The province of the judiciary has been to balance and accommodate these and other conflicting interests when disputes have arisen between physicians and hospitals over questions of professional access.

In addition to examining these major forces currently shaping the question of physicians' access, the Note has also posited one large area of future conflict: the accommodation of the growing number of health professionals other than physicians who desire access to hospital privileges. The gradual acceptance of osteopaths into the mainstream of modern American medicine and the present demands of chiropractors and nurse-midwives for hospital access have foreshadowed this conflict.

There is no doubt that the range of professional services offered by a health care provider and the income received by such a provider are increased by expanded use of inpatient hospital facilities. Whether the maximal range of services is necessary for adequate health care is conjectural. Gains of extended staff privileges—primarily "legitimization" of all health care providers and an extension of options offered to patients who want to choose hospital inpatient care for services traditionally offered in less expensive circumstances—may be offset by the increased costs and the increased concentration of health care services in the hospital institution, but with the resultant danger of institutional monopolization.

Despite these considerations the hospital will remain the primary health care institution in the 1980s, but it "will be the arena for resolution of the tensions between [professional and] community and institutional needs."[200] McNerney's use of the word "arena"—with its suggestion of conflict and trial by combat—is an apt metaphor. The inpatient hospital facility will be the core institution of the 1980s, but its dominance will not go unchallenged. The necessary adaptation of the health care system to meet the needs of the consumer-patient, the challenge of cost containment, and the expansion of health care providers (both in numbers and in kind) will be accomplished by a variety of new approaches.

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200. McNerney, *Control of Health-Care Costs in the 1980's*, 303 NEW ENG. J. MED. 1088, 1094 (1980).

Some of these will demand an adjustment by the medical profession. For example, the toleration, acceptance, and support by licensed physicians of diverse and *autonomous* health care professionals would be revolutionary,[201] but would free physicians to devote themselves to treatment of disease[202] rather than to maintenance of health. In like manner, a recognition by governmental licensing boards of the changing roles of the new health professionals would demand a restructuring and expansion of the licensed scope of their expertise. This expansion would, it is hoped, offer consumer-patients alternative and less expensive forms of health care delivery. Cooperation between health professionals, government, and business should produce diverse health care delivery systems that would challenge the monolithic hospital industry—for example, health maintenance organizations,[203] expanded and improved nursing homes,[204] new health professional partnership groups,[205] and broader, innovative prepayment insurance plans.[206] Such diversity would allow professional providers to "earn a [living] wage and make less use of the hospital's inpatient facilities,"[207] with resultant benefit to consumer-patients and to the economy.

It is important to note that the success of a diversified health care industry depends in large measure upon the attitude and acceptance of the consumer-patient. As the emphasis on fitness and health maintenance proliferates, there is a growing recognition that the patient himself is the physician's primary competitor;[208] the patient's health depends on his own initiative rather than upon

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201. *See* Connelly & Connelly, *Physicians' Patient Referrals to a Nurse Practitioner in a Primary Care Medical Clinic*, 69 AM. J. PUB. HEALTH 73 (1979) (physicians' attitudes toward nurse practitioners generally favorable, but referrals to the nurse practitioners fewer than expected).

202. *See* Oppenheim, *Healers*, 303 NEW ENG. J. MED. 1117 (1980).

203. For a discussion of health maintenance organizations (HMOs), see McNeil & Schlenker, *HMOs, Competition, and Government*, 53 MILBANK MEMORIAL FUND Q. 195 (1975).

204. *See* Butler, *Assuring the Quality of Care and Life in Nursing Homes: The Dilemma of Enforcement*, 57 N.C. L. REV. 1317 (1979).

205. *See* Chapman & Record, *supra* note 182, at 42-44. (discussion of potential tort liabilities for NHPs in various hypothetical working arrangements).

206. *See generally* A. ENTHOVEN, HEALTH PLAN (1980). For discussions of Enthoven's Consumer-Choice Health Plan (CCHP), see Ginzberg, *Competition and Cost Containment*, 303 NEW ENG. J. MED. 1112 (1980); Neuhauser, *Enthoven's "Health Plan"*, 303 NEW ENG. J. MED. 1115 (1980).

207. McNerney, *supra* note 200, at 1094.

208. *See, e.g.*, Thorne, *Patient Self-Care: May Improve Care, Cut Costs*, 14 INTERNAL MEDICINE NEWS & CARDIOLOGY NEWS 3 (1981).

that of the physician. It is to a great extent the legal profession's role to maintain order and perspective within this new diversity. Although antitrust law is a possible cure for the ills of the health care industry,[209] its limitations vis-á-vis diversity should be recognized, especially in hospital cases. Avoidance of *hospital* monopoly power is as desirable as avoidance of *physician* monopoly power. More positively, the development of varying standards of care for the emerging health institutions[210] and professionals[211] is a matter of first importance for the legal profession. For example, standards for physicians have not been applied to chiropractors[212] or nurses and should not be applied in the future as autonomous professionals compete with physicians. Such salutary competition, from the health policy perspective, promises that as institutional and professional diversity develops, the physician may, with the tables turned, sue for access into nonhospital health care institutions from which he has been excluded.

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209. *See* articles cited in note 139 *supra.*

210. *See, e.g.,* Hackler, *Expansion of Health Care Providers' Liability: An Application of* Darling *to Long-Term Health Care Facilities,* 9 CONN. L. REV. 462 (1977).

211. *See, e.g.,* Chapman & Record, *supra* note 182.

212. *See, e.g.,* Malmstrom v. Olsen, 16 Utah 2d 316, 400 P.2d 209 (1965).