Journal of Dispute Resolution

Volume 1989 | Issue Article 9

1989

Applying ADR to Hospital Staff Privilege Disputes: A Prescription for the Future of Health Care

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COMMENT

APPLYING ADR TO HOSPITAL STAFF PRIVILEGE DISPUTES: A PRESCRIPTION FOR THE FUTURE OF HEALTH CARE?

I. INTRODUCTION

In today's world of rising medical costs, hospital liability for staff negligence, and the uncertainty surrounding the viability of many medical procedures, hospitals are increasingly concerned with having competent doctors who can work effectively in a changing medical environment. In order to regulate staff quality, hospitals have broad discretion in granting, terminating, and reducing hospital staff privileges.[1]

Most physicians and other health professionals must be granted privileges in order to practice their profession because "privileges allow physicians the right to admit and discharge their patients to and from the hospital as well as the right to use hospital facilities."[2] As one commentator noted, "hospitals are to most physicians as courtrooms are to trial attorneys: access is essential to a thriving practice, second only, perhaps, to licensure by the state."[3] Due to the lack of a constitutional right allowing doctors to practice medicine in a hospital,[4] physicians must apply to hospitals for access which will allow them to use the modern technologies and facilities that could not be obtained on an individual basis.[5] Once staff privileges are granted, a physician will be awarded "clinical privileges" which will allow the physician to perform certain procedures according to his medical ability and training.[6] As the costs of medical procedures and medical equipment

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1. Arkin, *Impartiality in Medical Staff Privileges Cases*, 51 CONN. MED. 235, 235 (1987).

2. Classen, *Tying Staff Privileges to Physician Employment Contracts: An Erosion of Due Process or a Necessary Evil?*, 18 SETON HALL L. REV. 4, 7 (1988).

3. Hein, *Hospital Staff Privileges and the Courts: Practice and Prognosis*, 34 FED'N INS. COUNS. Q. 157, 157 (1984).

4. Kling v. Lutheran Charities Ass'n., 523 F.2d 56, 61 (8th Cir. 1975) (citing Hayman v. Galveston, 273 U.S. 414, (1927)).

5. Classen, *supra* note 2, at 7.

6. *Id.* (citing Joint Commission On Accreditation Of Hospitals, *Accreditation Manual for Hospitals* 109 n. 9 (1987)).

increase, the importance of obtaining hospital staff privileges also increases.[7]

The lack of a constitutional basis on which doctors can argue a right to practice medicine, as well as traditional judicial deference to privilege cases, allows hospitals to use broad discretion in deciding which applicants will be able to use their facilities.[8] However, the denial or termination of a physician's privileges can have a negative impact on that person's future practice of medicine.[9] The general judicial acceptance of hospital discretion has created a tremendous number of cases disputing the procedures employed in granting or terminating privileges:

> This tension between the increased demand for staff privileges on the one hand and the restraint in granting privileges on the other has led to frequent controversy between the physician denied of privileges and the hospital making that determination. . . . That physicians have begun to insist on their procedural due process rights by a group of citizens who were, until recently, not highly concerned with the legal aspects of the practice of their profession.[10]

Although hospital policies to restrict privileges serve an essential public purpose in that it encourages review of physicians that cannot be achieved by individual patients,[11] the court congestion created by these policies is probably not justified. Hospitals should be encouraged to incorporate bylaw provisions which provide for extensive internal resolution procedures before a case is taken to court.

Partly as a result of the number of cases filed, and also the concern that physicians whose privileges were revoked or denied could establish privileges at another hospital with an untainted record, Congress enacted the Health Care Quality Improvement Act (HCQIA) of 1986.[12] The HCQIA is "designed to encourage physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional conduct."[13] The Act provides for mandatory reporting by hospitals and other health care entities to a national data base of their professional review actions which adversely

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7. Classen, *supra* note 2, at 7.

8. Sosa v. Board of Managers, 437 F.2d 173 (5th Cir. 1971).

9. Cray, *Due Process Considerations in Hospital Staff Privileges Cases*, 7 HASTINGS CONST. L.Q. 217, 217 (1979).

10. *Id.* at 217-218.

11. *Id.* at 217.

12. 42 U.S.C. §§ 11101-11152 (1986).

13. H.R. 5540, 99th Cong., 2d Sess., 132 CONG. REC. VOL. 132 NO. 141 PART II 9954, 9957 (Oct. 14, 1986).

affect a physician's privileges for more than 30 days.[14] Before granting privileges, a hospital must contact the designated agency of the national data base to determine the applicant's status as to malpractice claims, lawsuits, and former privilege revocations.[15] Subsequent to granting privileges to an applicant, the hospital must inquire with the agency every two years as to any changes in the physician's status.[16] Adequate notice and a hearing must also be given to a physician being brought before the professional review board.[17] The Act also provides immunity from antitrust and other actions for persons who participated reasonably in the review process.[18] The Act does not, however, force hospitals to grant staff privileges.[19] This Comment will examine portions of the HCQIA, cases arising out of privilege disputes, and the role of dispute resolution both within and beyond the confines of the HCQIA.

II. JUDICIAL REVIEW

A. *Common Cases*

Most cases involving privilege conflicts are submitted on an antitrust theory; however, malicious interference with the right to practice a chosen profession, failure to provide due process, and defamation have also been grounds for action.[20] Antitrust cases often arise out of hospital contracts which require certain procedures to be performed exclusively by members of an outside firm.[21] The Supreme Court addressed the antitrust issue in *Jefferson Parish Hospital District No. 2 v. Hyde*.[22] The case involved a physician suing a hospital for denying him the ability to perform anesthesiological services at the hospital.[23] The hospital had an exclusive contract with an outside anesthesiology firm of which the applying doctor was not a member.[24] The Supreme Court held that the hospital did not violate the

14. 42 U.S.C. § 11133 (1986).

15. *Id.* at § 11135(a)(1).

16. *Id.* at § 11135(a)(2).

17. *Id.* at § 11112.

18. *Id.* at § 11111.

19. *Id.* at § 11115(b).

20. P. KRAUS, HEALTH CARE RISK MANAGEMENT-ORGANIZATION AND CLAIMS ADMINISTRATION 13 (1986).

21. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1983).

22. 466 U.S. 2 (1983).

23. *Id.*

24. *Id.*

Sherman Act[25] as the plaintiff failed to show that he could not practice anesthesiology at several other hospitals in the community.[26] As Justice O'Connor stated in her concurring opinion:

> In determining whether an exclusive dealing contract is unreasonable, the proper focus is on the structure of the market for the products or services in question the number of buyers or sellers in the market, the volume of their business, and the ease with which buyers and sellers can redirect their purchases and sales to others. Exclusive dealing is an unreasonable restraint on trade only when a significant fraction of buyers or sellers are frozen out of the market by the exclusive deal.[27]

Although the *Hyde* case may seem to indicate that hospitals will generally be successful in antitrust actions, that is not the point. The issue is whether the number of cases being submitted on antitrust grounds is warranted. The legislature, in enacting the HCQIA, apparently did not think so since it provides antitrust immunity for members of peer review committees who act reasonably and in compliance with the provisions of the Act.[28]

The issue of malicious interference to practice a chosen profession was presented in the 1965 Missouri case of *Cowan v. Gibson*.[29] In *Cowan*, hospital staff members conspired to prevent Dr. Cowan from acquiring staff privileges in their hospital.[30] The court held that the conspiracy violated plaintiff's contractual rights with his patients since it was found that hospital staff membership was necessary to treat patients in the county in which Cowan wanted to practice.[31]

When tensions arise between hospitals and physicians, grounds for a defamation action may also arise. In a Florida case,[32] a disagreement arose between two physicians who were practicing as partners. Subsequently, one of the partners made statements at a staff meeting regarding the other partner's inability to effectively carry out his practice.[33] Based on these

25. 15 U.S.C. § 1 (1982).
26. *Hyde*, 466 U.S. at 30.
27. *Id.* at 45 (citing Standard Oil of California v. United States, 337 U.S. 293 (1949)).
28. 42 U.S.C. §11111 (1986).
29. Cowan v. Gibson, 392 S.W.2d 307 (Mo. 1965).
30. *Id.* at 308.
31. *Id.* at 310.
32. Zambrano v. Devanesan, 484 So. 2d 603 (Fla. Dist. Ct. App. 1986).
33. *Id.* at 605.

statements, the disgruntled partner made a motion to withdraw the other partner's privileges,[34] the other partner not being present at the meeting.[35] By a vote of the staff members at the meeting, the other partner's privileges were revoked.[36] The court found the comments made at the meeting to be libelous.[37] Based on precedent of various defamation cases, the court concluded that the statements contained factual allegations; they were not preceded by any factual background regarding the relationship between the two partners; and there was no reason to believe that the persons present at the staff meeting were aware of the partners' hostility.[38]

B. *Due Process and the Public-Private Distinction*

There have also been numerous cases alleging that a hospital failed to provide due process in granting or denying staff privileges.[39] The question of due process (i.e., adequate notice, hearing, and reasonable justification for denial or termination) has historical importance because of the private-public hospital controversy.[40] However, the HCQIA may alleviate some of these disputes since it applies to virtually all hospitals.[41] Excluded from the Act is "a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anticompetitive practice which had the effect of restricting the practice of licensed health care practitioners."[42] The legislative history of the Act is silent as to why Congress rejected the traditional public-private disparity, but the subsequent discussion of the recent dilution of this disparity may provide part of the answer.

Under the public-private distinction, public hospitals are subject to the fourteenth amendment, thus subjecting staff privilege decisions of hospital governing boards to judicial review.[43] Decisions of private hospitals, however, have not traditionally been found to have a constitutional or statutory basis for court intervention, thus leaving physicians without a

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34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.* at 607.
38. *Id.*
39. Arkin, *supra* note 1, at 235.
40. Hein, *supra* note 3, at 159.
41. 42 U.S.C. § 11151(4)(a).
42. Id. § 11151(4)(B).
43. Hein, *supra* note 3, at 159.

judicial remedy if their privileges are adversely affected.[44] "In its purest form, the doctrine provides private hospital governing boards complete discretion in choosing its medical staff, regardless of the applicant's qualifications or the hospital's refusal to give reasons for its rejection."[45] The principle of judicial exclusion is based on the fundamental right of a private corporation to manage its own internal affairs.[46]

The public-private antithesis has been criticized because it is said that the effect on a physician of an adverse result is the same in either setting.[47] However, there has been some shift in case law which now requires private hospitals to provide due process to physicians in jeopardy of losing their privileges.[48] Although physicians have no unqualified constitutional right to practice medicine in a facility of their choosing,[49] California has adopted a common law approach treating staff privileges as membership in an association:[50]

> it is the power that the association [hospital] is able to exert over the economic necessities of the individual applicant that mandates minimal protections accompanying the association's decision[51]. . . Once admitted, the individual cannot be ousted without protection of a fair procedure even though membership may be subject to periodic review.[52]

California does not necessarily advocate a complete trial; only that "an affected individual must at least be provided with some meaningful opportunity to respond to the 'charges' against him."[53] Physicians are guaranteed additional protection by the fact that even though the fourteenth amendment does not apply to private hospitals, these hospitals are "precluded from acting arbitrarily, capriciously, discriminatorily, or unreason-

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44. Wood v. Hilton Head Hosp., 292 S.C. 403, 356 N.E.2d 841 (S.C. 1987).

45. Hein, *supra* note 3, at 160.

46. Kraus, *supra* note 20, at 131.

47. Note, *Medical Staff Membership Decisions: Judicial Intervention*, 19 U. ILL. L. REV. 473, 485 (1985).

48. Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 81 (1963).

49. Hayman v. Galveston, 273 U.S. 414 (1987).

50. Ascherman v. San Fransisco Medical Soc'y, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974).

51. Cray, *supra* note 9, at 249.

52. *Id.* at 244.

53. Pinkster v. Pacific Coast Society of Orthodontists, 526 P.2d 253, 256, 116 Cal. Rptr. 245 (Cal. 1974).

ably."[54] In *Miller v. Eisenhower Medical Center*,[55] the hospital denied the plaintiff's application for privileges based on a bylaw provision which allowed denial if the applicant was found to have an inability to work with others.[56] Although the court said that a physician's ability to work with other hospital personnel may effect the quality of care, there was a danger that such a rule could be considered arbitrary and capricious.[57] Thus, the court held that in cases of rejection based on the "inability to work with others",[58] the hospital must show:

> [t]hat an applicant's inability to 'work with others'in the hospital setting is such as to present a real and substantial danger that patients treated by him might receive other than a 'high quality of medical care' at the facility if he were admitted to membership.[59]

In attempting to comply with the arbitrary and capricious standards, however, all hospitals should be careful not to grant privileges to a physician known to be incompetent.[60] Granting privileges to this type of person could subject the hospital to liability under the doctrine of respondeat superior arising out of a negligence action.[61]

It is likely that hospitals will struggle with the HCQIA's provisions for providing due process because often members of their professional review committees are staff colleagues who have already learned about potential conflicts.[62] The Act's provisions require adequate notice and hearing to the physician under review or "such other procedures as are fair to the physician under the circumstances."[63] The Act also states that some hearings cannot be held before individuals who are in direct economic competition with the

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54. McCall, *A Hospital's Liability for Denying, Suspending, or Granting Staff Privileges*, 32 BAYLOR L. REV. 175, 213 (1980).

55. 614 P.2d 258, 166 Cal. Rptr. 826 (Cal. 1980).

56. *Id.* at 266, 166 Cal. Rptr. at 826.

57. *Id.* at 265, 166 Cal. Rptr. at 834-835.

58. *Id.* at 266, 166 Cal. Rptr. at 835.

59. *Id.* at 267, 166 Cal. Rptr. at 837-838.

60. McCall, *supra* note 54, at 212.

61. *Id.* at 212, 213.

62. Cray, *supra* note 9, at 255.

63. 42 U.S.C. § 11112(a) (1986). The standards stated in the text of the comment are for illustrative purposes only. See the specific provisions in this section as to the other requirements that hospitals must comply with in taking peer review action.

physician;[64] indeed, physicians are justified in their expectations of being afforded due process:

> By contracting with a physician, a hospital attempts to capitalize on a physician's stature in the community and profit from his talents. A hospital should not be allowed to act in a parasitic manner and totally abandon the physician for another more profitable relationship.[65]

Admittedly, hospitals could cure many problems by specifically providing for due process in their bylaws,[66] but this remedy "may not provide the physician with his ultimate goal: staff membership at a particular hospital."[67] The main reason that due process does not ensure that a physician will be granted privileges is because hospitals can use criteria other than a physician's demeanor and background in determining whether privileges should be granted.[68] Factors such as the economy, lack of technological equipment, and the cost of medical procedures may be employed in determining the need for a particular physician.[69] It is not necessarily improper to employ these other factors in reaching a decision, but physicians must know the reasons behind a denial of privileges. Due process does not require that the reason behind a decision be spelled out; only that a physician is afforded an opportunity to be heard.[70] As will be discussed later, mediation may be a good way for physicians to gain knowledge of all the factors involved in a privileges decision.

C. *Judicial Deference*

Additional suppression of physician satisfaction has come about as a result of the unwillingness of courts to review hospital staff privilege

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64. *Id.* at § 11112(b)(3). See this provision as to the specific application of economic interests.

65. Classen, *supra* note 2, at 25.

66. *Id.* at 10.

67. Nodzenski, *Medical Staff Decisions in Private Hospitals: The Role of Due Process*, 18 LOY. U. CHI. L.J. 951, 988 (1987).

68. *Id.*

69. Classen, *supra* note 2, at 7.

70. Nodzenski, *supra* note 67, at 988.

decisions.[71] One of the most famous cases in this regard is *Sosa v. Board of Managers of Val Verde Memorial Hospital*[72] in which the court stated:

> Human lives are at stake and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise in their peers, subject only to limited judicial surveillance. The court is charged with the narrow responsibility of assuring that the qualifications imposed by the board are reasonably related to the hospital and fairly administered. In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility and unencumbered with irrelevant considerations, a court should not interfere.[73]

The hospital involved in the *Sosa* case was a public one, and thus clearly required to comply with the fourteenth amendment due process provisions.[74]

Although it has been suggested that judicial deference should remain the same whether the decision involves denying initial privileges or terminating existing ones,[75] there is authority to suggest that termination carries more ill effects than denial.[76] The additional problems involved in termination are evident because a disgruntled staff physician has the potential of jeopardizing patient care and interfering with sufficient hospital administration.[77] These problems, however, have not been found to be so significant as to justify the application of a higher judicial review standard in termination cases.[78] One court was persuaded in their decision to defer to the hospital board because of the fact that most hospitals have peer review committees, and most hospitals are regulated through state and federal laws.[79] Due to the unique "crisis atmosphere"[80] created in a hospital

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71. Maimon v. Sisters of the Third Order, 20 Ill. App. 3d 1090, 76 Ill.Dec. 517, 458 N.E.2d 1317 (1983); Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971) (denial of staff privileges based on bylaw provisions would only be set aside if basis was arbitrary, capricious, or unreasonable).

72. 437 F.2d 173 (5th Cir. 1971).

73. *Id.* at 177.

74. *Id.* at 176.

75. Nanavati v. Burdette Tomlin Memorial Hospital, 526 A.2d 697, 702 (N.J. 1987).

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.* at 703.

from the number of people and the types of injuries that need to be handled, judicial review is often limited to "whether procedures employed are fair, standards set by the hospital are fair, and standards are applied with arbitrariness or capriciousness."[81]

Many courts have placed particular emphasis on their own lack of medical expertise in justifying their refusal to review privilege decisions,[82] while other courts have employed the substantial evidence test as a justification for judicial deference.[83] Under the substantial evidence test, a court will uphold a peer review committee's decision unless the decision lacks a reasonable evidentiary basis; i.e., "unless administrative findings 'viewed in light of the entire record, [are] so lacking in evidentiary support as to render [them] unreasonable. . . .'"[84] In *Stretten v. Wadsworth Veterans Hospital*,[85] the court focused on the unique relationships found in hospitals.[86] The *Stretten* court noted the importance of compatibility among all staff members because of the reliance that physicians must place upon other medical personnel in treating a patient. Due to the "constant exercise of professional judgment"[87] which could only be known by those working in the medical field, it is unlikely that courts will supplant their own decision for that made by the medical staff.[88]

III. VIABILITY OF MEDIATION

A. *Overview*

Given limited judicial intervention, the arguments for allowing due process, and the importance of preserving hospital relationships, mediation may be an appropriate way to incorporate these three factors into a cohesive method for resolving many hospital staff privilege disputes. Mediation is a process whereby the disputing parties use a neutral person(s)

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81. *Id.* (citing Miller v. Indiana Hospital, 277 Pa. Super. 370, 375, 419 A.2d 1191, 1194 (1980)).

82. Woodbury v. McKinnon, 447 F.2d 839, 846 (5th Cir. 1971); Laje v. R.E. Thomasen Gen. Hosp., 564 F.2d 1159 (1977).

83. *Laje*, 564 F.2d at 1162; Northern Inyo Hosp. v. Fair Employment Practice Comm'n., 38 Cal. App. 3d 14, 112 Cal. Rptr. 872 (1974); Cipriotti v. Board of Directors, 147 Cal. App. 3d 144, 196 Cal. Rptr. 367 (Cal. Dist. Ct. App. 1983).

84. *Cipriotti*, 147 Cal. App. 3d at 84, 196 Cal. Rptr. at 372 (citing *Northern Inyo*, 38 Cal. App. 3d 14, 24, 112 Cal. Rptr. 872).

85. 537 F.2d 361 (9th Cir. 1976).

86. *Id.* at 368.

87. *Id.*

88. *Id.*

to develop options and formulate alternatives in resolving particular issues.[89] The mediator lacks authority to render a judgment,[90] but he fulfills important functions in helping parties to objectively perceive the ramifications of their actions and the need for a solution.[91] The following discussion will focus on the role of mediation when there is an issue of terminating existing staff privileges. The problems and limitations in employing mediation in initial applications for privileges will be discussed in a subsequent section.

As hospitals become more cost-conscious, the use of some method for improving employer-staff relations may be crucial in helping doctors and hospitals understand each others' needs and concerns.[92] Physicians are often said to have a "God-like" status[93] which causes them to isolate their concerns and fail to seek help in a particular situation. Most doctors have been taught that the patient is their ultimate priority, thus making it difficult for them to work within the current constraints placed on the type and amount of care that can be rendered.[94] Joseph Califano said, "Medicine's high priests, the doctors, have said once too often, and with an arrogance we no longer accept, that only they should know what to prescribe, where to treat us, and how they should be paid."[95] In addition, doctors are faced with the uncertainty posed by medical technology which

89. J. FOLBERG & A. TAYLOR, MEDIATION, A COMPREHENSIVE GUIDE TO RESOLVING CONFLICTS WITHOUT LITIGATION 10 (1984).

90. L. RISKIN & J. WESTBROOK, DISPUTE RESOLUTION AND LAWYERS 196 (1987).

91. *Id.* at 210.

92. Arkin, *supra* note 2, at 235-36.

93. Editorial, *The Oasis Syndrome: The Physician's Need for Refuge*, AM. FAM. PHYSIC. 121, 121 (Oct. 1983).

94. Perhaps the best example of this is the use of Diagnostically-Related Groups (DRG) developed by Medicare. DRGs classify diseases and illnesses and places a constraint on the dollar amount allocated for treating that particular disease or illness in its acute phase. 42 C.F.R. 405 (1986).

95. J. CALIFANO, AMERICA'S HEALTH CARE REVOLUTION-WHO LIVES? WHO DIES? WHO PAYS? 5 (1986).

is capable of both alleviating illnesses and extending the lives of terminally ill or comatose patients.[96] As one commentator noted:

> It is no wonder many practitioners react to the law and lawyers angrily. Obviously they are puzzled, frustrated and frightened. Everything has changed; they seem to have lost control of what used to be their sacred and familiar territory. In a very short span of years, the legal system has moved from a posture of benign indifference about health matters, to an attitude of active intervention in all aspects of health care delivery.[97]

Hospitals are also facing increased legal exposure by being held liable for the negligent acts of their staff,[98] thus reinforcing the need for discretion in making privilege decisions.[99] In addition, there are many problems arising out of the cost constraints imposed by Medicaid, Medicare, and third-party payers.[100]

The tensions between hospitals and physicians, as well as the tensions created by legal considerations, are likely to increase as society tries to deal with the ethical, economic, legal, and emotional concerns created by today's health care industry.[101] The person most likely to be hurt by these increased tensions, however, is the patient, who has no voice in staff privilege decisions.[102] This is not to say that patient feelings go unnoticed since they are not directly involved in decisions regarding staff privileges. The patient suffers because many doctors are working in an environment where they feel unable to express their concerns and fears to the administration.[103] In order to alleviate some current concerns amongst administrators and physicians and provide the best possible environment for their patients, these parties

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96. Springer & Casale, *Hospitals and the Disruptive Health Care Practitioner - Is the Inability to Work With Others Enough to Warrant Exclusion?*, 24 DUQ. L. REV. 377, 379 (1985).

97. *Id.* at 379, fn. 6.

98. Jackson v. Power, 743 P.2d 1376, 1378 (Alaska 1987). (Where there is an existing employment relationship, the doctrine of respondeat superior can be invoked to hold a hospital liable for the physician's negligent acts); Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

99. Roberts, Radany, & Nash, *Privilege Delineation in a Demanding New Environment*, 108 ANNALS INTERN. MED. 880, 880 (1988).

100. *See* 42 U.S.C. § 1395ww (1983); N.J. STAT. ANN. § 26:2H-18(b) (West 1983).

101. Classen, *supra* note 2, at 26.

102. *Id.*

103. *Id.*

need to have direct contact with each other, and mediation may be the appropriate mechanism for such contact.[104]

B. *Communicational and Educational Benefits*

In providing an appropriate forum for due process, the HCQIA recommends three alternative bodies before whom a hearing may be held,[105] none of which include mediation. The legislative history of the Act lacks evidence as to why the drafters failed to incorporate a mediation alternative, but mediation may compliment the HCQIA provisions providing for due process.[106]

The Act provides for three alternative bodies to carry out the notice and hearing requirements.[107] Arbitration is expressly provided for, which, along with mediation, has been hailed as a useful tool in alternative dispute resolution.[108] However, arbitration incorporates more of the aspects of court adjudication than does mediation.[109] Arbitration is "a voluntary process in which people in conflict request the assistance of a partial and neutral third party. . . ."[110] The third-party arbitrator, however, renders a final decision which may be either advisory or binding.[111] In mediation, the mediator's role is to reconcile two parties' interests rather than determine which party is right.[112] Due to the traditional powerfulness of both hospitals and physicians,[113] as well as their concern about due process provisions,[114] leaving the ultimate decision-making authority in the hands of mediators may be in everyone's best interest.

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104. J. FOLBERG & A. TAYLOR, *supra* note 89, at 9.

105. 42 U.S.C. § 11112(3)(A), including an arbitrator, a hearing officer appointed by the hospital who is not in direct economic competition with the hospital in question, or a panel of persons appointed by the hospital who also are not directly in financial competition with the physician in question.

106. *See* 42 U.S.C. § 11112(a).

107. *See* 42 U.S.C. § 11112(b)(3).

108. GOLDBERG, GREEN & SANDER, DISPUTE RESOLUTION 191 (1986). {Need first initials if this is a book}

109. *Id.* at 189.

110. C. MOORE, THE MEDIATION PROCESS-PRACTICAL STRATEGIES FOR RESOLVING CONFLICT 7 (Jossey-Bass 1986).

111. *Id.*

112. *Id.* at 17.

113. J. CALIFANO, *supra* note 95, at 5.

114. Cray, *supra* note 9, at 217.

Futhermore, arbitration does not promote the same type of open communication that may be the key to reducing the number of staff privilege cases:

> [Regarding the use of mediation] The reduction of hostility - by encouraging direct communication - between the participants through the process of mediation - facilitates the permanence of a settlement. It naturally reduces the likelihood that a legal battle will continue beyond the mediation process. Mediation tends to diffuse hostilities by promoting cooperation through a structured process. In contrast, litigation tends to focus hostilities and harden the disputants' anger into rigidly polarized positions.[115]

Although arbitration also encourages more direct party communication than could be obtained in the traditional adjudicative setting, it has been held that "adjudication and arbitration are the most rigid and least satisfactory methods of conflict resolution for participants."[116] This is because the wishes of the two parties are "mutually exclusive" and only one of those wishes can be chosen in reaching a final decision.[117]

Mediation is not necessarily intended to resolve the underlying psychological problems that accompany many disputes,[118] but the normally short time involved in reaching a solution will certainly alleviate the anxiety that can manifest itself when parties are without a solution for a long period of time.[119] The need for expediency is particularly important in a hospital setting. Tension is often created by continually making life and death decisions.[120] It may be too much to demand that a physician worry about whether his privileges are in jeopardy because he may have acted inappropriately in a certain situation.[121]

A potential benefit of mediation is that it fosters the role of a physician as a decision-maker because the physician will be directly involved in the process of resolution. Although physicians engaged in peer review probably do not classify themselves as mediators, it would not be difficult to envision a situation where peer review committees could accomplish the same goals

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115. J. FOLBERG & A. TAYLOR, *supra* note 89, at 10.

116. *Id.* at 26.

117. *Id.*

118. *Id.* at 8.

119. *Id.*

120. Nanavati v. Burdette Tomlin Memorial Hospital, 526 A.2d 697, 703 (N.J. 1987).

121. Chenen, *Hospital Privileges: Speak Softly, But Carry A Big Lawyer*, 50 CONN. MED. 541, 542 (1986).

of mediation. Given the fact that many of the physicians on review committees work in the same hospital as the physician whose standards are being questioned,[122] it is important that reviews be conducted in a fair and open manner. Since suspension rather than termination of privileges could be the end result, physicians need to feel that they will be respected when their privileges are reinstated.[123] To many physicians, peer review, exemplifies their professionalism and their selflessness and devotion to patient care. Believing that they have a collective responsibility as a profession to maintain the quality and contain the cost of medical care, physicians are understandably resentful when their efforts in these decisions are challenged by the court.[124]

Although some might revel in the thought of taking power out of the hands of physicians, doctors currently face enough problems in understanding their roles as healers in society[125] without also being deprived of voicing their concerns in an action against them.[126] As one author said:

> The ultimate authority in mediation belongs to the participants themselves, and they may fashion a solution that will work for them without being strictly governed by precedent or being unduly concerned with the precedent they may set for others. . . .Unlike the adjudicatory process, the emphasis is not on who is right or wrong, but rather on establishing a workable solution that meets the participants' unique needs.[127]

The idea of reaching a workable solution is inordinately appealing to the physician whose privileges are in question because he allegedly made a wrong diagnosis or failed to render the appropriate treatment. Mediation could promote communication is these matters which is particularly important since many aspects of medical care are still without a scientific

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122. Arkin, *supra* note 1, at 235.

123. *Id.* at 237.

124. Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117, 1117 (1985-86).

125. H. BURSTAJN, R. HAMM, R. FEINBLOOM & A. BRODSKY, MEDICAL CHOICES, MEDICAL CHANGES-HOW PATIENTS, FAMILIES AND PHYSICIANS CAN COPE WITH UNCERTAINTY 64 (1981). Doctors are increasingly concerned with whether a particular treatment must be rendered, and yet failure to administer treatment may result in a suit for malpractice. It has been said that consumers' expectations of certainty are fostering the current conflict.

126. J. CALIFANO, *supra* note 95, at 5.

127. J. FOLBERG & A. TAYLOR, *supra* note 89, at 10.

solution.[128] Although it is troublesome to admit that some patients are without an absolute cure, failure to recognize the uncertainty surrounding medical treatment could result in the wrongful termination of a physician's privileges. Indeed, many hospitals may exclude seemingly qualified physicians from practice by evaluating a physician's competency based on the number of patients that he cures.[129] It may seem morally repugnant to reduce healthcare to monetary terms. However, given the current concern over cost-containment, increased physician understanding about the medical crisis can only enhance the relationship between administrators and physicians, and foster doctors' acceptance of privilege decisions.[130]

C. *The Role of Mediation in Reducing Litigation*

Mediation also provides mechanisms for dealing with the problems that often arise in staff privilege disputes. These problems include the concern of being afforded due process, and the motivation behind the contention that a physician acted in a manner that could result in termination of his privileges.[131] It has been suggested that the medical care cost crisis may motivate hospitals to terminate physicians who are perceived as problematic in order to replace them with "physicians who generate a level of income it deems 'acceptable.'"[132]

Although the economic problems cannot be undermined or avoided, a mediator is said to act "as an agent of reality to help the parties probe whether their positions are realistic and what practical effects flow from their choice of outcomes."[133] This makes it likely that a mediator could pinpoint situations where a hospital brings an action for termination solely on the basis of perceived economic necessity.

Cases are lacking on whether economics could be classified as an arbitrary or capricious standard in determining a physician's access to hospital facilities,[134] but doctors should be made aware of the reasons behind the denial or termination of their privileges.[135] Admittedly, informing

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128. L. MCCULLOUGH & J. MORRIS, IMPLICATIONS OF HISTORY AND ETHICS TO MEDICINE-VETERINARY AND HUMAN 26 (1978).

129. Classen, *supra* note 2 at 26.

130. Caplan, *Can We Talk? A Review of Jay Katz, The Silent World of Doctor and Patient*, 9 W. NEW ENG. L. REV. 43, 49 (1987).

131. Arkin, *supra* note 1, at 235.

132. Classen, *supra* note 2, at 26.

133. J.FOLBERG & A. TAYLOR, *supra* note 89, at 247.

134. Classen, *supra* note 2, at 26.

135. *Id.* at 26.

physicians of the specific reasons behind rejection of privileges is more in the interest of preserving physician integrity than adhering to hospital bylaws.[136] However, given the fact that privileges "reflect peer approval and a physician's status in the medical community,"[137] respecting physician integrity may be an important factor in improving doctors' attitudes toward hospitals and administration.

Even if economics is part of the reason for reducing a physician's privileges, the physician should be made aware of this as physicians need to work within the confines created by outside forces.[138] Physicians are often so overwhelmed with keeping abreast of the literature on medical advances that they fail to realize that technical knowledge may be superfluous if a hospital does not have the resources to provide for certain procedures.[139] Since mediation does not require that a final decision be reached, mediation provides a mechanism for reevaluation of a solution if circumstances change.[140] Mediation affords parties the opportunity to become educated about changes in the system to the extent that they could not inform themselves from reading a textbook or journal.[141]

Due process questions can also be resolved through the use of mediation. Since physicians will be allowed a direct opportunity to present their problems and questions, there is little room to later argue that they were not afforded a full and fair opportunity to be heard.[142] Admittedly, problems may arise if the mediator is a colleague, so hospitals must carefully consider the appointment of a mediator(s).[143] There are cases that hold that a person, panel or agency does not necessarily violate due process by performing,

> both an investigative and an adjudicative function, and that administrative fact finders are not necessarily disqualified from participating in an adversary proceeding simply because they have

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136. Caplan, *supra* note 130, at 49.

137. Classen, *supra* note 2, at 8.

138. Roberts, Radanay & Nash, *supra* note 99, at 880.

139. *Id.* at 882.

140. J. FOLBERG & A. TAYLOR, *supra* note 89, at 10.

141. *Id.*

142. Silver v. Castle Memorial Hosp., 53 Haw. 475, 497 P.2d 564 (1972), *cert. denied*, 409 U.S. 1048 (1972).

143. *Klinge*, 527 F.2d at 58. Absent a showing of personal hostility toward a physician, a physician's peers are not prevented from determining a physician's competency in regards to his future employment with a hospital.

been exposed to evidence presented in non-adversary investigative procedures that were followed prior to the adversary hearing.[144]

Although a staff physician may possess the expertise that courts have cited as a basis for judicial deference, mediation must not err on the side of partiality or bias.[145] Courts recognize a presumption of impartiality in privilege cases,[146] so the physician has the burden of proving that there was bias.[147] Hospitals should not take advantage of this presumption, however, because a failure to provide impartiality may violate due process as well as the concept of self-regulation.[148]

At least one medical center, Stanford University, has employed an outside person to act as an ombudsman for resolving particular disputes.[149] The ombudsman is also responsible for monitoring the institution's interpersonal relationships in order to provide for preventive action.[150] The first medical center ombudsman was an emeritus professor of medicine.[151] An ombudsman is not the equivalent of a mediator, but Stanford's success in the employment of an ombudsman provides some precedent for the theory that mediation may be a worthwhile alternative for hospitals to employ.[152]

Although the ombudsman concept is not well developed in this country,[153] Stanford has found their ombudsman beneficial, especially in cases of possible termination of a physician's privileges.[154] Stanford's ombudsman will review the employee's work record to determine whether it ever contained allegations of inadequate performance.[155] The ombudsman will then make a report of his findings to the supervisor. The program has also provided the opportunity for employees to voice their concerns over

144. *Id.* at 63 (citing Withrow v. Larkin, 421 U.S. 35 (1975)).

145. *Withrow*, 421 U.S. at 35.

146. Kiracofe v. Reid Memorial Hosp., 461 N.E.2d 1134, 1140-41 (Ind. Ct. App. 1984).

147. Ritter v. Board of Comm'rs., 637 P.2d. 940, 946 (Wash. 1981).

148. Arkin, *supra* note 1, at 235.

149. Waxman, *A Nonlitigational Approach to Conflict Resolution: The Medical Center as A Model*, 42 ARB. J. 25, 28 (1987).

150. *Id.* at 28.

151. Waxman, Vosti & Barbour, *Role of the Ombudsman in the Modern Medical Center*, 144 W.J. MED. 627, 628 (1986).

152. *Id.* at 629-630.

153. Verkuil, *The Ombudsman and the Limits of the Adversary System*, 75 COLUM. L. REV. 845, 847 (1975).

154. Waxman, *supra* note 149, at 30.

155. *Id.*

non-work related stress, like domestic and financial difficulties.[156] This has resulted in employee counseling and remedial programs, and "in some cases in improved employee performance, thus benefitting both the supervisor and employee."[157]

Stanford's success in resolving many disputes without litigation may be attributable to the fact that the ombudsman's office is separated from the medical facility itself, but is still readily accessible.[158] Although the person initially employed had medical training, an article on Stanford's program did note that not all university ombudsman have been psychiatrists or physicians.[159] The initial cost of employing a mediator may not seem beneficial, but long-term employment of this type of person may reduce the number of bias allegations currently alleged in staff privilege cases.[160]

D. *Mediation's Limitations in Privilege Disputes*

There are problems with devising a system for mediation of denial of staff privileges rather than termination of existing privileges. This is because the concerns with preserving a doctor's relationship with his patients and colleagues are not present as the physician is not yet part of the health care institution. Furthermore, most suits against hospitals for denial of privileges are brought on an antitrust theory, and antitrust actions are not accorded the same judicial deference found in most hospital staff privilege cases.[161] In *American Safety Equipment Corp. v. J.P. Maguire & Co.*,[162] the court denied a request to stay litigation despite a valid arbitration agreement, stating:

> A claim under the antitrust laws is not merely a private matter. The Sherman Act is designed to promote the national interest in a competitive economy; thus the plaintiff asserting his rights under the Act has been likened to a private attorney general who protects the public interest. . . . Antitrust violations can affect hundreds of thousands - perhaps millions - of people and inflict staggering

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156. *Id.*

157. *Id.*

158. Waxman, Vosti & Barbour, *supra* note 151, at 628.

159. *Id.*

160. Withrow v. Larkin, 421 U.S. 35 (1975), Although the Supreme Court has stated that a person's peers are not automatically disqualified from making a determination of that person's competency, an issue of bias is frequently asserted where such peers are employed.

161. American Safety & Equip. Corp. v. J. P. Maguire & Co., 391 F.2d 821 (2d Cir. 1968) (holding that an antitrust suit was properly brought despite the parties' agreement to arbitrate).

162. *Id.*

> economic damage. . . . [T]he issues in antitrust cases are prone to be complicated, and the evidence extensive and diverse, far better suited to judicial than to arbitration procedures.[163]

The public interest concern is indeed warranted, but it is likely that some physicians and administrators will avoid participating in peer review, knowing that antitrust liability may result if they render a decision denying privileges.[164] Mediation is probably not necessary to resolve the physicians' concerns, since compliance with the HCQIA will now relieve peer review participants of antitrust liability as long as the decision was reasonable, and the proper HCQIA procedures were followed.[165] The importance of a final decision is also more prevalent in antitrust cases arising from denial of privileges than it is in cases brought on the basis of potential termination of privileges.[166] This is partly due to the fact that although the doctor is not already in the hospital environment, he will need a final decision in order to apply for other hospital privileges without the fear of bias or prejudice.

Admittedly, there are still arguments for allowing adjudication of certain staff privilege disputes. The need for precedent is persuasive, especially in the context of complex cases with vague laws.[167] On the other hand, it has been argued that precedent does not necessarily resolve the underlying hostilities involved in many disputes,[168] and mediation may be a better method for dealing with individual problems because mediators are not required to apply substantive law.[169] As mediators become better educated in the complex issues involved in privilege disputes, the need for precedent will likely decline.

V. CONCLUSION

Due to the increasing number of hospital staff privilege disputes, there is a need not only to reduce the amount of litigation, but also the need to mend physician-employer relationships. The lower the tension in the

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163. *Id.* at 826-27.

164. Note, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 624 (1988).

165. 42 U.S.C. §11111 (1986).

166. Nanavati v. Burdette Tomlin Memorial Hospital, 526 A.2d 697, 702 (N.J. 1987).

167. Brunet, *Questioning the Quality of Alternative Dispute Resolution*, 62 TUL. L. REV. 1, 20 (1987).

168. Bush, *Dispute Resolution Alternatives and the Goal of Civil Justice: Jurisdictional Principles for Process Choice*, 1984 WIS. L. REV. 893, 915.

169. J. FOLBERG & A. TAYLOR, *supra* note 89, at 26.

hospital, the more likely it is that patients will perceive physicians in a more positive light.[170] Although the HCQIA will likely result in a reduction of lawsuits, mediation may be essential to reducing the hostility that often exists after a physician's conduct is questioned. There are many ways to resolve disputes, but perhaps one commentator's analogy between law and medicine best explains the need for mediation:

> According to this analogy, a dispute is a wound or disease in the social fabric or body politic parallel to a physical wound or disease in the physical body. A judge (or lawyer, or other type of dispute handler) performs the task of healing the rupture in the social fabric, just as the doctor performs that of healing the physical illness. . . . Where treatment is wisely and appropriately applied, a dispute presents the opportunity for improvement, not disruption of societal help and not destruction. As such, disputes are moments of opportunity. . . . Where treatment is haphazard, arbitrary, ill-founded, the opportunity is lost. Indeed, in such a situation, the constructive potential of the dispute may degenerate into a destructive result.[171]

As doctors have potential alternatives for treating patients, lawyers should also have choices for resolving disputes. With states needing to opt-in or out of the act by October 14, 1989,[172] and more regulations still due to be released, attorneys must begin to deal with privilege issues. Perhaps disputes regarding the termination of hospital staff privileges are situations in which mediation is the best prescription.

LAUREL E. SHEALY

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170. Press, *The Predisposition to File Claims: The Patient's Perspective*, 12 LAW, MED., & HEALTH CARE 53 (April 1984). Injury by itself, . . ., does not translate into the intense hostility that a lawsuit expresses. The objective sign must be joined with the subjective state of being angry. . . . Without anger, an act as hostile as a lawsuit, particularly against as well-established authority as a physician, is impossible to contemplate. In short, the incident - the mechanical event itself - is insufficient to explain claims, and thus can only be a partial element in their prevention.
Id.

171. *Id.* at 1032-33.

172. 42 U.S.C. §11111(c)(i) (1986).