St. Mary's Law Journal

Volume 20 | Number 4 Article 8

1-1-1989

The Health Care Quality Improvement Act of 1986: A Proposal for Interpretation of Its Protection.

Louise M. Joy

The Health Care Quality Improvement Act Of 1986: A Proposal For Interpretation Of Its Protection

Louise M. Joy

I. INTRODUCTION

The public relies on hospitals to police their medical staffs and weed out incompetent physicians.[1] A hospital, however, cannot carry out this duty

1. *See* Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 256 (Ill. 1965)(landmark case establishing hospitals duty to exercise reasonable care in selection, supervision and retention of physicians), *cert. denied*, 383 U.S. 946 (1966); *see also* Perdue, *The Law of Texas Medical Malpractice*, 22 HOUS. L. REV. 1, 178 (1985)(hospital has nondelegable duty of care in selection, retention and supervision of medical staff members). This duty to exercise care in the selection, retention and supervision of medical staff is the basis for conducting peer review. *See Darling*, 211 N.E.2d at 256. In recognition of this duty, the Joint Commission on Accreditation of Hospitals (JCAH) requires that hospitals establish peer review mechanisms as a part of their quality assurance programs. *See* JOINT COMMISSION ON ACCREDITATION FOR HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 101-120 (1989)(establishing standards and recommendations for quality assurance and medical staff review). The Joint Commission On Accreditation of Hospitals provides accreditation surveys for hospitals who voluntarily participate in the program. *See* Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C.L. REV. 835, 840-45 (1983)(describing function of JCAH). Despite its voluntary nature, hospital accreditation by JCAH satisfies the conditions of participation in and payment by Medicare. *See* 42 U.S.C. § 1395b(a)(1)(2) (1982 & Supp. II 1984)(JCAH accreditation meets participation requirements for Medicare); *see also* Cosposito v. Heckler, 742 F.2d 72, 87-88 (3d Cir. 1984)(Health and Human Services may accept JCAH accreditation to satisfy compliance with Medicare and Medicaid standards), *cert. denied*, 471 U.S. 1131 (1985). Furthermore, Medicare regulations require that participating hospitals have an organized medical staff which "is responsible for

without the assistance and the expertise of the members of its medical staff. Therefore, any obstacles or disincentives to physicians' active participation in peer review[2] pose inherent risks to society's welfare in general and individual patients in particular.

One major obstacle to peer review is the risk of liability for damages in suits brought by physicians whose privileges are terminated, revoked or never granted.[3] The United States Supreme Court's recent decision in *Patrick v. Burget*[4] confirmed this fear of liability by explicitly denying absolute immunity from antitrust litigation where physicians conduct peer review.[5]

---

the quality of medical care provided to patients." *See* Health Care Financing Administration, 42 C.F.R. § 482.22 (1988)(outlining conditions of participation in Medicare).

2. *See* 42 U.S.C. §§ 11101-11152 (Supp. IV 1986). Section 1151 defines peer Review as the process by which a hospital's medical staff reviews the credentials and competence of new applicants and reapplicants for medical staff privileges, conducts on-going evaluations of medical care rendered within the facility, and makes recommendations to the hospital governing body regarding appointment, reappointment and discipline of medical staff members. *Id.* § 11151 (9),(10),(11) (defining professional review action, professional review activity, and professional review body); *see also* Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173, 177 (5th Cir. 1971)(evaluation of competency of physicians best conducted by peers due to specialized expertise).

3. *See* Seidenstein v. National Medical Enterp., Inc., 769 F.2d 1100, 1103 (5th Cir. 1985)(suspended physician sued hospital and physicians for antitrust violations, denial of due process and equal protection, tortious interference with business relationships, deceptive trade practices, trade disparagement, libel and slander); Mulholland, *The Evolving Relationship Between Physicians and Hospitals*, 22 TORT & INS. L.J. 295, 301-02 (1987)(antitrust challenges impose chilling effect on aggressive peer review). Since the United States Supreme Court expanded the application of the Sherman Act to the medical industry, the number of cases involving revocation of hospital privileges increased significantly. *See* Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 743-44 (1976)(antitrust action may be brought against hospital because it affects interstate commerce by purchasing supplies from out of state), *appeal after remand*, 691 F.2d 678 (4th Cir. 1982), *cert. denied*, 464 U.S. 890 (1983); Comment, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 615, 621 (1988)(background information regarding peer review activity and antitrust liability).

4. __ U.S. __, 108 S. Ct. 1658, 100 L. Ed. 2d 83 (1988).

5. *Id.* at __, 108 S. Ct. at 1663-66, 100 L. Ed. 2d at 92-95. The Supreme Court decision in *Patrick* is notable for its rejection of state action immunity from antitrust suit for physicians and hospitals conducting peer review. *Id.* The state action immunity doctrine exists because the Sherman Act was not intended to restrain state action. *See* Parker v. Brown, 317 U.S. 341, 351 (1943)(establishing the state action immunity from suit for antitrust litigation). This immunity applies to private actors when their anticompetitive actions are authorized by state law. Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48, 61-62 (1985). The United States Supreme Court established the *Midcal* two-pronged test to determine if private parties are entitled to state action immunity. *Id.* at 59; California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980). The challenged activity must be 1) "one clearly articulated and affirmatively expressed as state policy" and 2) the state must actively supervise any private activity in restraint of trade. *Midcal*, 445 U.S. at 105-06. In *Patrick*, the Supreme Court found Oregon's supervision of peer review activities insufficient to rise to a

The medical community asserts the *Patrick* case as justification for not participating in peer review.[6] In response to the effect of this case and a desire to encourage productive peer review, Congress passed the Health Care Quality Improvement Act of 1986 (HCQIA).[7] The HCQIA provides protection against damages to physicians and entities conducting peer review, thereby promoting diligent evaluation of physicians by their peers.[8]

If the HCQIA is to achieve its goal of encouraging peer review by providing greater protection, the protection must surpass existing defenses to retaliatory causes of actions brought by disgruntled physicians. Because the protections provided by the HCQIA are unclear, this Comment will first discuss the HCQIA's legislative history, including the basis for medical staffs' conducting peer review. In addition, a discussion of judicial treatment of Sherman Antitrust actions brought prior to the enactment of the HCQIA will analyze pre-existing defenses available for peer review activities. The analysis of prior Sherman Antitrust cases will serve as a basis for proposing that the HCQIA was intended to provide a "qualified immunity" from suit to participants in peer review similar to that enjoyed by government officials. Hence, it will be shown that unless the HCQIA does provide a "qualified immunity" from suit, the HCQIA will not achieve its objective of encouraging peer review activities. Society will bear the costs of permitting incompetent physicians to practice unchecked and, ultimately, individual patients will endure the irreparable losses resulting from medical malpractice.

II. BACKGROUND

A. *Corporate Liability and the Duty to Conduct Peer Review*

The evolving doctrine of corporate liability of hospitals[9] establishes a hos-

---

level of active supervision. *Patrick*, __ U.S. at __, 108 S. Ct. at 1663, 100 L. Ed. 2d at 92. Therefore, the defendants were subject to suit for Patrick's claim of antitrust violations which was filed in retaliation to the revocation of his surgical privileges. *Id.* at __, 108 S. Ct. at 1665-66, 100 L. Ed. 2d at 95.

6. *Patrick*, __ U.S. at __, 108 S. Ct. at 1663-64, 100 L. Ed. 2d at 92-93 (1988)(physicians conducting peer review activities have no state immunity for peer review where State does not supervise their activities); *see also* Holoweiko, *If You Should Lose a Peer Review Suit . . .*, MEDICAL ECONOMICS FOR SURGEONS, Jan. 1989, at 38-51 (detailing economic and emotional devastation incurred throughout trials and appeals of *Patrick* case).

7. 42 U.S.C. § 11101-11152 (Supp. IV 1986).

8. H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384 (purpose of legislation to encourage increased peer review activities by providing protection from damages).

9. *See* Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 257 (Ill. 1965)(hospitals not simply facilities and hospitals responsible for patient care based on Hospital Accreditation Standards and state licensing regulations), *cert. denied*, 383 U.S. 946 (1966). *See generally* Mulholland, *The Corporate Responsibility of the Community Hospital*, 17 U. TOL. L. REV. 343, 349 (1986)(analyzing theory of corporate liability of hospitals); Perdue, *The Law*

pital's duty both to determine the professional competence of a physician before it grants or renews staff privileges[10] and to conduct continuing quality

---

of Texas Medical Malpractice, 22 HOUS. L. REV. 1, 190-94 (1985)(identifying corporate liability as theory of recovery against hospitals); Perdue, *Direct Corporate Liability of Hospitals: A Modern Day Legal Concept of Liability for Injury Occurring in the Modern Day Hospital*, 24 S. TEX. L.J. 773, 792-99 (1983)(describing how corporate liability doctrine permits plaintiffs to recover from hospitals for acts of medical staff); Peters, *Hospital Malpractice: Eleven Theories of Direct Liability*, TRIAL 82, 82-91 (Nov. 1988)(describing theories of recovery within corporate liability doctrine). An employer's responsibility for an independent contractor is the basis for finding hospitals liable for negligent selection or retention of physicians. *See* Pitchfork Land & Cattle Co. v. King, 346 S.W.2d 598, 603 (Tex. 1961)(outlining tests to determine "independent contractor"); GRIFFITH, HOSPITAL LIABILITY FOR PEER REVIEW, IN TEXAS STATE BAR MEDICAL MALPRACTICE CONFERENCE, San Antonio, March 25, 1988, D-3 to D-4 (describing extension of liability for independent contractors to hospital's selection of medical staff). To the extent a person maintains control over a job in terms of the progress of the work and the hours as well as the means used to accomplish the job, the person is an independent contractor. *King*, 346 S.W.2d at 603. An employer is generally responsible for the acts of his employees under the theory of vicarious liability. Standard Oil Co. of Tex. v. United States, 307 F.2d 120, 127 (5th Cir. 1962). On the contrary, employers of independent contractors ordinarily are not responsible for the contractor's negligent acts. Texas Am. Bank v. Boggess, 673 S.W.2d 398, 400 (Tex. App.—Fort Worth 1984, writ dism'd by agr.). An employer, however, has a duty to use ordinary care in the selection and retention of independent contractors. Smith v. Baptist Memorial Hosp. Sys., 720 S.W.2d 618, 627 (Tex. App.—San Antonio 1986, writ ref'd n.r.e.). Therefore, breach of this duty may subject the employer to liability for the negligent acts committed by independent contractors who were negligently selected or retained. *See id.*; *cf.* Classen, *Hospital Liability for Independent Contractors: Where Do We Go From Here?*, 40 ARK. L. REV. 469, 472-74 (1987)(describing vicarious liability and exception for independent contractors). Physicians who have been granted privileges to admit patients and treat patients in the hospital are considered independent contractors. The hospital is not liable for acts of negligence committed by these independent physicians. If, however, the hospital fails to exercise ordinary care in the selection, retention or supervision of these physicians, the hospital may be liable for a physician's negligence. *See* Park N. Gen. Hosp. v. Hickman, 703 S.W.2d 262, 266 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.)(hospital has duty to exercise reasonable care in selection, granting specific privileges and monitoring medical staff members).

10. *See* M. BERTOLET & L. GOLDSMITH, HOSPITAL LIABILITY: LAW AND PRACTICE 278 (5th ed. 1987)(commenting on medical staff appointments and delineation of clinical privileges); R. MILLER, PROBLEMS IN HOSPITAL LAW 123-28 (5th ed. 1986)(describing medical staff appointments and delineation of clinical privileges). In Texas, a medical school graduate merely needs to complete a one year program of graduate medical training and pass an examination by the Board of Medical Examiners to obtain an unrestricted license to practice medicine. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.04(a)(5) (Vernon Supp. 1989). A physician's membership on the hospital medical staff consists of two parts: the appointment to the medical staff and the delineation of privileges. The appointment to staff is of no value to a physician without the delineation of privileges defining the scope of practice within the hospital. Since the medical license does not restrict a physician's practice to a particular specialty such as general surgery, orthopedic surgery, cardiology, or internal medicine, the hospital must set minimum standards for granting clinical privileges in these areas. M. BERTOLET & L. GOLDSMITH, HOSPITAL LIABILITY: LAW AND PRACTICE 278 (5th ed. 1987). Therefore, hospitals inquire more specifically into the post-graduate training and experience of applicants

assurance assessments of care provided by its physicians.[11] The corporate liability doctrine provides that a hospital is liable for its medical staff member's negligence if the hospital knew or should have known that such member was incompetent.[12]

Given the risk of liability created by this doctrine, hospitals should have a

---

seeking hospital staff membership and clinical privileges. Consequently, the hospital grants specifically delineated clinical privileges to each physician to restrict each medical staff member's hospital practice to his or her area of competence. R. MILLER, PROBLEMS IN HOSPITAL LAW 123-28 (5th ed. 1986). To obtain these privileges, the physician must prove competence through letters of recommendation from physicians familiar with his or her practice, letters demonstrating successful completion of post-graduate residencies in his or her area of specialty, as well as letters from all hospitals in which the physician has ever practiced. *Id.* In addition, the hospital will contact the medical school and residency programs to verify graduation and completion. The physician must also give proof of current licensure in the state of Texas as well as current registration with the Drug Enforcement Administration and Texas Department of Public Safety for permitting the prescribing of controlled substances. *Id.* Based on this information and the recommendation of members of the medical staff appointed to evaluate physician credentials, the governing body of the hospital decides whether to appoint the physician to staff and, thereafter, whether to grant or deny the privileges requested. *Id.*

11. *See* Park N. Gen. Hosp. v. Hickman, 703 S.W.2d 262, 266 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.)(hospital duty to exercise reasonable care in admitting and granting privileges to medical staff and reviewing competency once privileges granted); *see also* Mulholland, *The Corporate Responsibility of the Community Hospital*, 17 U. TOL. L. REV. 343, 349-33 (1986)(responsibility derived from state regulation, Medicare participation and accreditation standards); Perdue, *The Law of Texas Medical Malpractice*, 22 HOUS. L. REV. 1, 190-94 (1985)(cause of action based on negligent selection, retention, or supervision of physicians); Perdue, *Direct Corporate Liability of Hospitals: A Modern Day Legal Concept of Liability for Injury Occurring in the Modern Day Hospital*, 24 S. TEX. L.J. 773, 792-99 (1983)(hospitals responsible for negligent selection, retention and supervision of physicians); Peters, *Hospital Malpractice: Eleven Theories of Direct Liability*, TRIAL 82, 82-91 (Nov. 1988)(hospitals must confirm physician competence before granting or renewing privileges as well as conduct continuing quality of care assessments).

12. *See, e.g.*, Fridena v. Evans, 622 P.2d 463, 466 (Ariz. 1980)(hospital liable for single negligent act of physician because physician's involvement in administration gave hospital instant knowledge of negligent act); Mitchell County Hosp. Auth. v. Joiner, 189 S.E.2d 412, 414 (Ga. 1972)(hospital independently negligent in permitting physician to continue practicing when his incompetency is known); Fiorentino v. Wenger, 227 N.E.2d 296, 299 (N.Y. 1967)(hospital not liable unless it had reason to know physician might commit malpractice); *see also* Classen, *Hospital Liability for Independent Contractors: Where Do We Go From Here?*, 40 ARK. L. REV. 469, 496 (1987)(discussing corporate liability and advocating return to doctrine of charitable immunity for hospitals); Janulis & Hornstein, *Damned If You Do, Damned If You Don't: Hospitals Liability for Physician's Malpractice*, 64 NEB. L. REV. 689, 705-06 (1985)(discussing hospital's liability for independent contractor physicians). *But see* Ferguson v. Gonyaw, 236 N.W.2d 543, 550-51 (Mich. App. 1975)(hospital not liable for failure to conduct investigation of doctor's credentials when no evidence would have been found to justify denial of privileges).

strong incentive to police their medical staff.[13] While the hospital bears the risk of liability for the negligence of independent physicians, the members of the peer review body bear no liability for the action of their incompetent peers when the peer review body fails to take disciplinary action.[14] Furthermore, when the peer review body takes disciplinary action, individual members are subject to liability in retaliatory suits for antitrust violations,[15] wrongful termination of privileges,[16] or defamation.[17] Therefore, members

---

13. *See* Atassi v. Massillon Community Hosp., 1983 W.L. 6554, 1 No. 6075 (Ohio App. Jul. 25, 1983)(WESTLAW, Ohio Cases database).

> At this point we observe in passing, what must be obvious to all, that the legal profession generally, and the judiciary specifically, recognize that if hospitals are to be derivatively liable for the negligence of the physicians they allow to practice therein, they must be given a free hand to choose those whose potential misconduct might bankrupt them and put them out of business.

Id; *see also* Mulholland, *The Evolving Relationship Between Physicians and Hospitals*, 22 TORT & INS. L.J. 295, 300 n.22 (1987)(quoting *Atassi*)(scope of corporate liability doctrine approaching strict liability standard regarding acts and omissions of physicians in hospital settings).

14. Elam v. College Park Hosp., 183 Cal. Rptr. 156, 165 (Cal. Ct. App. 1982)(hospital responsible for negligently screening physician competency); Johnson v. Misericordia Community Hosp., 294 N.W.2d 501, 507 (Wis. Ct. App. 1980)(governing body of hospital ultimately responsible for quality control functions carried out by medical staff), *aff'd*, 301 N.W.2d 156 (1981); Comment, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 AM. J. L. & MED. 115, 128-30 (responsibility for credentialing of physicians placed on hospital governing body not on peer reviewers). *But see* Corleto v. Shore Memorial Hosp., 350 A.2d 534, 539 (N.J. Super. Ct. Law Div. 1975)(entire medical staff amenable to suit where it knew or should have known physician incompetent to perform surgery). In *Corleto*, the majority argued that subjecting members of the medical staff to liability would make them more aware of their responsibility to assure that only competent physicians practiced within their hospitals and thereby, improve the quality of medical care rendered in each institution. *Id.* The court noted that the time and expense involved in engaging in litigation with unnecessary parties may deter a plaintiff from suing every member of the medical staff when a suit against the hospital and the negligent physician would bring the same recovery. *Id.* This consideration may account for *Corleto* being the only reported medical malpractice action being maintained against a hospital's medical staff. *Id.*

15. *See* Patrick v. Burget, __ U.S. __, __, 108 S. Ct. 1658, 1661-62, 100 L. Ed. 2d 83, 90 (1988)(individual physicians conducting peer review liable for damages for antitrust violations); Nanavati v. Burdette Tomlin Memorial Hosp., 857 F.2d 96, 101-02 (3d Cir. 1988)(cardiologist brought antitrust claim against fellow physician, hospital executive committee, and hospital), *petition for cert. filed*, 57 U.S.L.W. 3472 (U.S. Dec. 24, 1988) (No. 88-1068); Seidenstein v. National Medical Enter., Inc., 769 F.2d 1100, 1103 (5th Cir. 1985)(suspended physician brought suit against hospital and physicians for antitrust violations under section one and two of Sherman Act).

16. *See* Greisman v. Newcomb Hosp., 192 A.2d 817, 818-19 (N.J. 1963)(suit maintained against hospital and medical staff to force hospital to consider application for privileges). *But see* Barrows v. Northwestern Memorial Hosp., 525 N.E.2d 50, 51 (Ill. 1988)(dismissing suit against hospital and medical staff for wrongful denial of privileges). Texas case law, however, holds that there is no judicial review of disciplinary actions taken by private hospitals. *See, e.g.*, Tigua Gen. Hosp. v. Feuerberg, 645 S.W.2d 575, 578 (Tex. App.—El Paso 1982, writ dism'd)(private hospital acts at own discretion when granting or renewing medical staff privi-

of the medical staff have no positive or negative incentives to conduct peer review.

Yet, without participation of their medical staffs, hospitals have little expertise to evaluate the adequacy and appropriateness of care given by physicians.[18] The quandary becomes obvious. The basis for making hospitals responsible for credentialing and supervising physicians is that these institutions are in the best position to monitor physicians because they have access to information in the form of patient records and a mechanism to carry out this duty.[19] Until they can motivate physicians to participate in peer review, the process is unproductive.

---

leges and not subject to judicial review); Hodges v. Arlington Neuropsychiatric Center, Inc., 628 S.W.2d 536, 538-39 (Tex. Civ. App.—Fort Worth 1982, writ ref'd n.r.e.)(no cause of action against private hospital even if termination of staff privileges was arbitrary and capricious); Charter Medical Corp. v. Miller, 605 S.W.2d 943, 951 (Tex. Civ. App.—Dallas 1980, writ ref'd n.r.e.)(hospital's decision to terminate medical staff privileges not subject to judicial review); Weary v. Baylor Univ. Hosp., 360 S.W.2d 895, 897 (Tex. Civ. App.—Waco 1962, writ ref'd n.r.e.)(no judicial review of privilege denials or terminations by private hospital); *cf.* Armintor v. Community Hosp. of Brazosport, 659 S.W.2d 86, 89 (Tex. App.—Houston [14th Dist.] 1983, no writ)(hospital's rejection of physical therapist's application within discretion of board of trustees and not subject to judicial review).

17. *See* Seidenstein v. National Medical Enter., Inc., 769 F.2d 1100, 1101-05 (1985)(cardiologist brought suit for defamation arising from disciplinary action); Jiricko v. Coffeyville Memorial Hosp. Medical Center, 700 F. Supp. 1559, 1560-61 (D. Kan. 1988)(member of executive committee subject to suit for defamation). In addition, members of peer review committees may be liable for damages for emotional distress caused by arbitrary removal of privileges even where the physician subsequently receives a fair hearing which confirms the previous revocation of privileges. *See* Marin v. Citizens Memorial Hosp., 700 F. Supp. 354, 361-62 (S.D. Tex. 1988)(members of executive committee liable for damages for emotional distress for procedural irregularities).

18. *See* Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173, 177 (5th Cir. 1971)(medical peer review requires physicians' specialized expertise); *see also* Trail & Kelley-Claybrook, *Hospital Liability and the Staff Privileges Dilemma*, 37 BAYLOR L. REV. 315, 333 (1985)(physicians' participation in medical staff credentialing and review process logical); Comment, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 AM. J. L. & MED. 115, 128-29 (1984)(physicians much better prepared than lay governing bodies to evaluate clinical judgments of peers).

19. *See* Moore v. Board of Trustees of Carson-Tahoe Hosp., 495 P.2d 605, 608 (Nev.)(medical license does not assure quality of medical care so protection must come from hospital), *cert. denied*, 409 U.S. 879 (1972); Johnson v. Misericordia Community Hosp., 294 N.W.2d 501, 507 (Wis. Ct. App. 1980)(hospital responsible for quality of care rendered to patients), *aff'd*, 301 N.W.2d 156 (1981); Comment, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 AM. J. L. & MED. 115, 124 (1984)(hospitals have mechanism and data from patient records to carry out on-going review of medical staff). The traditional means of monitoring physician misconduct have been through self-regulation carried out by medical societies and specialty boards, review by state licensure bodies and PSROs, and malpractice liability. Comment, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 AM. J. L. & MED. 115, 117-20 (1984). These mechanisms have been

B. *Antitrust and Peer Review*

The establishment of the hospital's duty to monitor physician competency is evidence of a public policy favoring the peer review process.[20] Conversely, public policy embodied in the Sherman Antitrust Act protects an individual physician from anticompetitive restraint of his practice of medicine for which the state has granted him a license.[21] Since these policies conflict, it is the legislature's responsibility to establish which interest controls—society's interest in quality medical care or the individual physician's interest in practicing medicine without interference or restraint.[22] If the latter is preferred, the current system of holding hospitals liable for the torts of their medical staff must end. The hospital cannot limit its liability for incompetent physicians so long as the physician's interest in maintaining his or her medical staff privileges outweighs the public interest in promoting quality patient care by restricting the privileges of incompetent physicians.[23]

C. *Health Care Quality Improvement Act of 1986*

Congress passed the Health Care Quality Improvement Act of 1986 (HC-

---

unsuccessful at detecting and disciplining incompetent physicians so hospitals now are responsible. *Id.*

20. *See* H.R. REP. NO. 99-903, 99th Cong., 2d. Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (legislation embodies policy favoring peer review to improve quality of medical care); *see also* Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 169 (Wis. 1981)(noting state legislature's intent to improve quality of medical care by imposing duty to select and monitor physicians carefully).

21. *See* Patrick v. Burget, __ U.S. __, __, 108 S. Ct. 1658, 1661, 100 L. Ed. 2d 83, 90 (1988)(doctor awarded approximately $2,000,000 dollars damages by trial court for antitrust violation); Miller v. Indiana Hosp., 843 F.2d 139, 144-45 (3d Cir.)(hospital subject to antitrust liability for revoking physician's privileges), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 147 (1988); Weiss v. York Hosp., 745 F.2d 786, 812 (3d Cir. 1984)(involvement of competing physicians in peer review established basis of antitrust claim), *cert. denied*, 470 U.S. 1060 (1985); *see also* Sherman Antitrust Act, 15 U.S.C. §§ 1, 15 (1982).

22. *See Patrick*, __ U.S. at __, 108 S. Ct. at 1665-66, 100 L. Ed. 2d at 95 (policy determination regarding exemptions from liability for Congress to decide). The Supreme Court did note that Congress provided immunity from liability for certain peer review activities by passing the Health Care Quality Improvement Act of 1986. *See id.* at __ n.8, 108 S. Ct. at 1665 n.8, 100 L. Ed. 2d at 95 n.8; Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (Supp. IV 1986)(peer review conducted in reasonable belief that action necessary to promote quality of care receives immunity).

23. *See* Mulholland, *The Evolving Relationship Between Physicians and Hospitals*, 22 TORT & INS. L.J. 295, 300 (1987)(commenting on success of hospitals in identifying incompetent staff members). Hospitals have been successful in denying initial staff membership to incompetent physicians but the red tape involved in restricting or revoking existing staff privileges has limited the removal of incompetent staff members. *Id.* Also, the threat of antitrust litigation chills aggressive peer review and creates additional conflict between the hospital and medical staff. *Id.* at 301.

QIA)[24] to encourage good faith peer review of physicians practicing in hospitals and to provide an information network to prevent incompetent physicians from relocating without detection.[25] To meet these objectives, the HCQIA contains provisions which protect persons or entities conducting peer review from liability[26] and allows recovery of attorneys' fees and costs of defense where a frivolous claim is brought against a hospital or physician conducting peer review.[27] The Act mandates the establishment of a reporting system[28] to collect information on insurance payments for settlements and judgments,[29] sanctions by state boards of medical examiners,[30] and peer review actions taken by health care entities.[31] In addition, the HCQIA requires that hospitals request status reports on physicians applying and reapplying for privileges to inhibit the movement of incompetent physicians from one place to another.[32]

To protect physicians who are the subject of peer review actions, the HCQIA contains procedural due process requirements which must be fulfilled before the individuals and hospital conducting the peer review action receive the Act's liability protection.[33] The Act provides, in pertinent part:

> A professional review action must be taken—
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after reasonable effort to obtain the facts of the matter,

---

24. Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11153 (Supp. IV 1986)(effective Nov. 14, 1986). Section 11111 of the Act provides that a state may opt out of this legislation if the state does not want the protections from liability provided by the Act to apply to state law causes of action. *Id.* § 11111(c). For those states which do not take affirmative action to opt-in or opt-out of HCQIA before October 14, 1989, the legislation applies automatically on or after that date. *Id.* Texas adopted HCQIA and incorporated its provisions under the Medical Practice Act. TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06 (Vernon Supp. 1989). Therefore, HCQIA applies to Texas state law claims filed on or after September 1, 1987. *Id.*

25. *See* 42 U.S.C. §§ 11101-11152 (Supp. IV 1986)(protection of peer review necessary to encourage activity so quality of medical care improves).

26. *See id.* § 11111(1)(a) (providing "limitation on damages" for professional review activity conforming to Act's standards).

27. *Id.* § 11113 (recovery of attorneys' fee and cost of defense permitted).

28. *Id.* § 11134 (mandating reports to Secretary of Health and Human Services or designate).

29. *Id.* § 11131 (reporting of medical malpractice payments).

30. *Id.* § 11132 (reporting of physician sanctions or surrenders of license to state boards of medical examiners).

31. *Id.* § 11133 (requires reporting of actions that adversely affect privileges of physician for more than 30 days).

32. *Id.* § 11135 (hospitals have duty to request information when physician applies and every two years thereafter).

33. *Id.* § 11112 (establishing standards for peer review).

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).[34]

The HCQIA provides a permissive presumption that a peer review action has met these standards unless the plaintiff rebuts it by a preponderance of the evidence.[35] Although there are specific requirements of "adequate notice and hearing," the HCQIA states that failure to comply with each criteria does not, in itself, invalidate the protection from liability.[36] A physician under review may successfully rebut the presumption of reasonable action by establishing that a member of the medical staff who participated in the hearing was in direct competition with the physician.[37] Direct economic competition would exist between any members of the same or related specialties since, for example, these physicians may increase their patient base when a competing physician loses his or her privileges.[38]

By excluding the participation of direct competitors in the hearing process, medical staff members with the most insight to the appropriate standard of care are barred from assisting in the evaluation of the allegedly incompetent physician.[39] As an alternative, hospitals may seek input from

---

34. *Id.* § 11112(a).

35. *Id.* § 11112(a) (permissive presumption in favor of peer review but rebuttable by preponderance of evidence).

36. *Id.* § 11112(b) (outlining adequate hearing and notice requirements). The physician must be given the reasons for the action and the right to request a hearing within at least thirty days. *Id.* § 11112(b)(1). The hearing officer and panel of individuals who conduct the peer review may not be in direct economic competition with the physician involved. *Id.* § 11112(b)(3)(A)(ii),(iii). The HCQIA, however, provides that failure to meet the conditions described in section 11112(b) does not, in itself, constitute failure to meet the requisite standard. *Id.* § 11112(b)(3).

37. *See id.* § 11112(b)(3)(A) (participants in hearing cannot be in direct competition with physician). Under this section, the health care entity may choose whether the hearing is held before an arbitrator mutually acceptable to both the physician and the health care entity, a hearing officer appointed by the entity who is not in direct economic competition with the physician, or before a panel of individuals appointed by the health care entity who are not in direct economic competition with the physician. *Id.* § 11112(b)(3)(A); *see also* Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1123-24 (1988)(discussing due process requirements for hearing).

38. *See* Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 714-17 (1981)(discussing effect of economic competition between physicians of same or related specialties).

39. H. R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6393 (recognizing potential difficulty of requiring that hearing panel members not be in direct economic competition with physician).

specialists practicing outside the community to participate in the hearing.[40] The requirement to use outside specialists, however, is an additional deterrent to peer review activity because the requirement delays the hospital's ability to take action until an appropriate specialist is found.[41] Given these constraints on the peer review process, it is unlikely that peer review activity will increase as a result of the HCQIA.

In addition to the obstacles relating to peer review, the nature of the protection provided by the HCQIA is unclear.[42] It is uncertain whether compliance with the Act provides immunity from suit or only a defense to liability.[43] Prior to the HCQIA, evidence that a hospital terminated a physician's privileges after an investigation and hearing in a reasonable belief that the physician was incompetent was a defense to an antitrust violation.[44]

---

40. *Id.*

41. *See id.* at 6393 (noting inconvenience and alternative of obtaining reviewers from out of town); *see also* Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1124 (1988)(discussing inconvenience imposed by noncompetitive requirements).

42. *See* Comment, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 628 (1988)(legislation does not indicate when court should determine if defendant qualifies for protection). If HCQIA affirmatively stated when the court should determine whether the defendant qualified for protection, such a statement would identify the protection as an immunity from suit or a defense to liability. *Id.*

43. *Compare* Health Care Quality Improvement Act, 42 U.S.C. § 11111(a)(1) (Supp. IV 1986)(states defendant "shall not be liable in damages") *with* 42 U.S.C. § 11115 (Supp. IV 1986)(language of statute explicitly states "nothing in this subchapter shall be construed as changing the liabilities or immunities under law"). Furthermore, the House of Representatives Report explaining this legislation describes the protection of section 11111 in terms of "limited, but essential, immunity." *See* H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (limited immunity). The same report also makes various references to HCQIA protection as being protection from damages and immunity under federal law. *Id.* Additionally, Congress' failure to use the word immunity leaves a margin for interpretation of the language in so far as the express statement of protection from liability may exclude an immunity from suit under the maxim, *expressio unius est exclusio alterius* (if not expressly stated it is excluded). An example of prior legislation with very specific language providing immunity from suit was the Swine Flu Immunization Program. *See* 42 U.S.C. § 247b(j-l) (1976). That legislation explicitly provides protection from liability by mandating that the exclusive remedy for plaintiffs claiming injury from the vaccine is an action against the United States. *See* 42 U.S.C. § 247b(k)(1)(A) (1976); *see also* Sparks v. Wyeth Laboratories, Inc., 431 F. Supp. 411, 414-16 (W.D. Okla. 1977)(interpreting Swine Flu Immunization Program Legislation and finding defendant immune from suit). Other examples of legislation providing more specifically stated protections include the Child Abuse Protection Act and the Defense Production Act of 1950. *See* Child Abuse Prevention Act, 42 U.S.C. § 5103 (b)(2)(A) (1982)(requiring state laws provide immunity for persons reporting child abuse for states to be eligible for federal grants to fund child abuse prevention programs); Defense Production Act of 1950, 50 U.S.C. app. § 2158(j) (1982)(compliance with Defense Production Act available as a defense to violation of federal or state antitrust laws).

44. *See* Miller v. Indiana Hosp., 843 F.2d 139, 143 (3d Cir.)(incompetence and unprofes-

Therefore, the protection provided by the HCQIA must be an immunity from suit since the Act was intended to promote peer review by providing new and additional protection from liability when the Act's requirements are met.[45] Since an antitrust claim is the retaliatory measure most feared by physicians conducting peer review,[46] antitrust cases decided before and after enactment of the HCQIA will illustrate its protection.

An analysis of antitrust cases before and after the HCQIA indicates that the protection from suit provided to government officials in terms of "qualified governmental immunity" is the type of protection which Congress intended that the HCQIA provide. This analysis should resolve the ambiguity regarding the protection from suit that the HCQIA provides and serve as a model for litigation under the HCQIA.

III. SHERMAN ANTITRUST LITIGATION PRE-HCQIA

To establish a prima facie case under section one of the Sherman Antitrust Act, a plaintiff must establish the existence of four elements: (1) that there was a contract, combination or conspiracy (2) in restraint of trade which (3) affects interstate commerce and (4) injured the plaintiff.[47] The physician satisfies the "restraint of trade" requirement with proof of the denial or revo-

---

sional conduct are defenses to antitrust claims), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 147 (1988).

45. *See* H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (limited immunity). The House of Representative Report explaining the Act describes the protection of section 11111 in terms of "limited, but essential, immunity." *Id.* The same report also makes various references to HCQIA protection as being protection from damages and immunity under federal law. *Id.* at 6384-92. Further indication that HCQIA protection is a qualified immunity is that the committee report also states that the HCQIA's protection provisions were intended to allow defendants to file motions to resolve the existence of the immunity as expeditiously as possible. *Id.* at 6394. Therefore, the provisions permit courts to make determinations as to whether the defendant complied with the Act's requirements even if other issues in the case remain to be resolved. *Id.* The Committee's language demonstrates that the protection provided by HCQIA is an immunity from suit unless the plaintiff is seeking injunctive or declaratory relief.

46. *See* McGinn, *Patrick Disconcerts Medical Community; Peer Review Linked to Antitrust Suit*, Am. Med. News, Jan. 6, 1989, at 13; *Full Immunity For Peer Review Suffers a Blow*, Am. Med. News, May 27, 1988, at 1, 9, 12, 18; *Oregon Ruling Had 'Chilling Effect' On Review*, Am. Med. News, Oct. 24, 1986, at 33, col. 4 (despite reversal *Patrick* decision has chilling effect); *Bill Stiffens Discipline, Protects Reporting*, Am. Med. News, Oct. 3, 1986, at 2; Rust, *Privileges Major Issue in Antitrust Cases*, Am. Med. News, Jan. 3, 1986, at 36.

47. Sherman Antitrust Act, 15 U.S.C. § 1 (1982). The Sherman Antitrust Act provides, in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation,

cation of privileges.[48] The Supreme Court has found that the burden of proving an effect on interstate commerce is met through evidence of the hospital's purchase of medical supplies from out of state.[49] The burden of establishing a contract, combination or conspiracy is somewhat more difficult. A hospital by itself does not satisfy this element because it requires two or more entities.[50] Also, a hospital cannot conspire with its own medical staff if the staff is acting in the interest of the hospital because the staff is deemed to

---

or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Id.; *see also* Comment, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 621 (1988)(outlining elements of antitrust violations). In addition, the Sherman Act provides recovery of treble damages under Section 15 as follows:

> Any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee.

Sherman Antitrust Act, 15 U.S.C. § 15 (1986) (establishing civil cause of action providing recovery of treble damages and reasonable attorney's fees); United States v. Cooper Corp., 312 U.S. 600, 608 (1941)(Sherman Act provides recovery of treble damages in cause of action for private injury). Texas law also provides relief from antitrust violations under the Texas Free Enterprise and Antitrust Act of 1983. *See* TEX. BUS. & COM. CODE ANN. §§ 15.05, 15.21 (Vernon 1987). The Texas law, however, provides specific criteria which may be used to evaluate the reasonableness of the restraint of the sale or delivery of professional services. TEX. BUS. & COM. CODE ANN. § 15.05(i) (Vernon 1987); *see also* Nafrawi v. Hendrick Medical Center, 676 F. Supp. 770, 774-77 (N.D. Tex. 1987)(analyzing Texas antitrust law in relation to physician's termination of privileges). The factors include whether activity is directed at improving the quality of services, or limiting or reducing the costs of services to benefit the public interest. *Id.* Section 15.21 relates to suits by injured persons or Governmental entities and allows recovery of treble damages only when a violation was "willful or flagrant." TEX. BUS. & COM. CODE ANN. § 15.21(a)(1) (Vernon 1987).

48. *See* Miller v. Indiana Hosp., 843 F.2d 139, 143 (3d Cir.)(revocation and refusal to reinstate privileges to prevent competition satisfied restraint of trade requirement), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 147 (1988).

49. *See* Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 743-44 (1976)(antitrust action may be brought against hospital because it affects interstate commerce by purchasing supplies from out of state); Comment, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 613-15 (1988)(reviewing expansion of antitrust jurisdiction to hospitals); *see also Miller*, 843 F.2d at 144 n.5 (treatment of out-of-state patients and receipt of insurance money from out of state satisfies element requiring affect on interstate commerce); Weiss v. York Hosp., 745 F.2d 786, 824 (3d Cir. 1984)(requirement of "affect on interstate commerce" satisfied by out-of-state-patients and reimbursement including federal funds), *cert. denied*, 470 U.S. 1060 (1985).

50. *See* Bolt v. Halifax Hosp. Medical Center, 851 F.2d 1273, 1280 (11th Cir.) (section one of Sherman Antitrust Act does not apply to unilateral acts), *reh'g granted and vacated*, 861 F.2d 1233 (1988); Sherman Antitrust Act, 15 U.S.C. § 1 (1982). A combination, contract, or conspiracy each require at least two parties. Sherman Antitrust Act, 15 U.S.C. § 1 (1982).

be part of the hospital and, therefore, the two constitute one entity.[51] However, a single entity made up of independent, competing entities, such as a medical staff made up of individual, competing physicians, does satisfy the joint action requirement of the Sherman Act.[52] The final issue of an antitrust action, damages, is a fact question easily established by showing the loss of patients or practice income after the revocation or denial of privileges.[53]

While some antitrust violations are classified as per se unreasonable,[54] the

---

51. Weiss v. York Hosp., 745 F.2d 786, 816-17 n.1 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985). Just as a corporation cannot conspire with corporate officers and employees if they are acting in the interest of the corporation, a hospital cannot conspire with its medical staff if the medical staff is acting in the interest of the hospital because the medical staff is not considered a separate entity from the hospital. *See id.* In an analogous situation, the Supreme Court explained why a corporation and a wholly-owned subsidiary could not legally conspire:

> A parent and its wholly owned subsidiary have a complete unity of interest. Their objectives are common, not disparate; their general corporate actions are guided or determined not by two separate corporate [consciences], but one. They are not unlike a multiple team of horses drawing a vehicle under the control of a single driver. With or without a formal "agreement," the subsidiary acts for the benefit of the parent, its sole shareholder. If a parent and a wholly owned subsidiary do "agree" to a course of action, there is no sudden joining of economic resources that had previously served different interests, and there is no justification for [section] 1 scrutiny.

Copperweld Corp., v. Independence Tube Corp. 467 U.S. 752, 771 (1984)(describing why parent and wholly owned subsidiary are unity). *Contra* Oltz v. St. Peter's Community Hosp., 861 F.2d 1440, 1450 (9th Cir. 1988)(anesthesiologists not acting like corporate officers so hospital had capacity to conspire with them).

52. *See* Miller v. Indiana Hosp., 843 F.2d 139, 144 n.5 (3d Cir.)(medical staff's joint action satisfies conspiracy requirement), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 147 (1988). As a matter of law, medical staff action fulfills the "contract, combination or conspiracy" requirement of section 1 of the Sherman act because it is a group of doctors who practices medicine independently. *See* Weiss v. York, 745 F.2d 786, 814-15 (3d Cir. 1984)(as matter of law medical staff is "combination"), *cert. denied*, 470 U.S. 1060 (1985). Since each medical staff member has a separate economic interest which may be in competition with other medical staff members, the medical staff is not a single economic entity for antitrust analysis. *Id.* at 815. Antitrust analysis relies on the economic substance of the entity, not the form it chooses to take. *Id. See generally* Carlson, *Physician Credentialing Decisions and the Sherman Act*, 18 CUMB. L. REV. 418, 421-425 (1988)(analyzing two or more actors requirement).

53. Patrick v. Burget, __ U.S.__, __, 108 S. Ct. 1658, 1661, 100 L. Ed. 2d 83, 90 (1988)(jury awarded $650,000 in damages for antitrust violations).

54. *See* Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 342-44 (1982)(discussing differences between per se violations and violations subjected to "rule of reason" analysis). Per se violations involve practices so likely to be intentionally anticompetitive they are presumed to be violative of the Sherman act. *Id.* Identification of certain practices as being per se violations is made after the courts have had sufficient experience and analysis of various devices to find there is no justification to excuse their inherent anticompetitive threat. *See* White Motor Co. v. United States, 372 U.S 253, 265 (1963)(discussing per se violations and rule of reason analysis); Hahn v. Oregon Physicians' Serv., 860 F.2d 1501, 1505-06 (9th Cir. 1988)(explaining difference between per se violations and rule of reason analysis); Trail & Kelley-Clay-

courts analyze most actions brought by individual physicians challenging the loss or limitation of hospital privileges using the "rule of reason."[55] Under the "rule of reason" analysis, the court will find antitrust violations where the challenged activity's anticompetitive effects outweigh its procompetitive effects.[56] Accordingly, courts analyzing staff privilege antitrust claims have

---

brook, *Hospital Liability and the Staff Privileges Dilemma*, 37 BAYLOR L. REV. 315, 348 (1985)(distinguishing per se violations from rule of reason offenses). Since in-depth inquiry into the reasonableness of a challenged business practice requires extensive court time and money, the costs of litigation are reduced by the courts' conclusive presumption that some business practices are unreasonable. *See Maricopa County Medical Soc'y*, 457 U.S. at 343-45. Per se violations include price fixing, market division and customer allocations, tying arrangements, and group boycotts. White Motor Co. v. United States, 372 U.S. 253, 265 (1963)(identifying types of per se violations); Trail & Kelley-Claybrook, *Hospital Liability and the Staff Privileges Dilemma*, 37 BAYLOR L. REV. 315, 348-49 (1985). Price fixing occurs when competitors agree to set the same prices for their products or services. *Maricopa County Medical Soc'y*, 457 U.S. at 343-45 (price-fixing by physicians per se violation); United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 224, 226 n.59 (1940)(no reasonable justification for price-fixing). Market division or consumer allocation occurs where competitors agree to allocate customers or divide their market territories or product lines. United States v. Topco Assoc., 405 U.S. 596, 608 (1972)(describing a territorial market division), *aff'd*, 414 U.S. 801 (1973). Tying arrangements are agreements which condition the sale of one product on the purchase or lease of another product in situations where the seller has sufficient market power to substantially affect the sales of the tied product. United States Steel Corp. v. Fortner Enters., 429 U.S. 610, 617 (1977)(defining tying arrangements). A group boycott occurs when competitors collectively refuse to deal with a buyer or seller for the purpose of increasing market share, fixing prices or establishing a monopoly. *See* Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 212 (1959)(defining group boycott); *see also* St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 543 (1978)(defining group boycotts relating to medical malpractice insurance market); Hahn v. Oregon Physicians' Serv., 860 F.2d 1501, 1510-11 (1988)(HMO's failure to deal with podiatrists as a class formed basis of group boycott claim). *But see* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 458-59 (1986)(professional association's group boycott not unreasonable per se where uncertainty existed regarding economic impact of activity); Wilk v. American Medical Ass'n, 719 F.2d 207, 226-28 (7th Cir. 1983)(professional association's concern for quality of patient care triggered "rule of reason" analysis of group boycott), *cert. denied*, 467 U.S. 1210 (1984).

55. *See* Robinson v. Magovern, 521 F. Supp. 842, 914-25 (W.D. Pa. 1981)(rule of reason applies where hospital's action based on physician's incompetency and inability to work with staff), *aff'd*, 688 F.2d 824 (3d Cir.), *cert. denied*, 459 U.S. 971 (1982); Carlson, *Physician Credentialing Decisions and the Sherman Act*, 18 CUMB. L. REV. 419, 427 (1988)(credentialing decisions based on quality of care, incompetency or professional misconduct often trigger rule of reason analysis); Trail & Kelley-Claybrook, *Hospital Liability and the Staff Privileges Dilemma*, 37 BAYLOR L. REV. 315, 357 (1985)(courts do not apply per se analysis to physician credentialing decisions). The Fourth Circuit Court of Appeals stated, "[t]he practical difference between a per se offense and a rule of reason offense is that under the per se rule, anticompetitive impact of the alleged offense is presumed, while under the rule of reason, its anticompetitive impact must be proven." Hospital Bldg. Co. v. Trustees of the Rex Hosp., 691 F.2d 678, 684 (4th Cir. 1982), *cert. denied*, 464 U.S. 890 (1983).

56. *See, e.g.*, Continental T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36, 50 n.16 (1977)(balance severity of anticompetitive effects against procompetitive consequences); Horn-

considered whether the hospital and its medical staff's decisions were directed at maintaining patient care by excluding incompetent physicians (procompetitive) or at decreasing competition within the community at the recommendation of a competing member of the medical staff (anticompetitive).[57] Procedurally, if the plaintiff-physician establishes a prima facie antitrust violation, the defendant's reasons for taking this action will be considered as a defense but they will not serve as a basis for denying the claim through summary judgment.[58] Because section 11112 of the HCQIA establishes criteria for conducting good faith peer review, and good faith peer review is an existing defense to physician antitrust actions, the enactment of the HCQIA will only be effective if it adds to existing defenses for peer reviewers.

Miller v. Indiana Hospital[59] illustrates how good faith peer review activities operated as a defense to an antitrust claim prior to the passage of the HCQIA.[60] In addition, the case illustrates how protracted antitrust litigation involving the revocation of staff privileges can become.[61] In 1977, Indiana Hospital revoked Dr. Miller's privileges after a patient under his care died and a hearing committee found numerous problems in his delivery of patient care.[62] A Pennsylvania superior court found that the hospital had

---

sby Oil Co. v. Champion Spark Plug Co., 714 F.2d 1384, 1394 (5th Cir. 1983)(balance anticompetitive evils against procompetitive benefits); Kestenbaum v. Falstaff Brewing Corp., 575 F.2d 564, 571 (5th Cir. 1978)(claim defeated when anticompetitive effect offset by procompetitive justification), *cert. denied*, 440 U.S. 909 (1979).

57. Weiss v. York Hosp., 745 F.2d 786, 821-22 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985)("Rule of reason" analysis applied where hospital's denial of privileges to osteopath is based on incompetency or unprofessional conduct); *see also* Comment, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 616-19 (1988)(applying antitrust law to staff privilege terminations). A hospital's categorical denial of privileges to all osteopaths, however, constituted a per se violation of the Sherman Antitrust Act. *Weiss*, 745 F.2d at 821-22.

58. *See* Miller v. Indiana Hosp., 843 F.2d 139, 143 (3d Cir.)(incompetence and unprofessional conduct are defenses but may not serve as basis to grant summary judgment in antitrust actions), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 147 (1988).

59. Miller v. Indiana Hosp., 562 F. Supp. 1259 (W.D. Pa. 1983), *dismissed*, 660 F. Supp. 250 (W.D. Pa. 1986), *rev'd*, 843 F.2d 139 (3rd Cir.), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 147 (1988); *see also* Miller v. Indiana Hosp., 419 A.2d 1191 (Pa. Super. 1980). Application for Allowance of Appeal denied by the Pennsylvania Supreme Court in 1980. *See Miller*, 843 F.2d at 142.

60. *See Miller*, 843 F.2d at 143 (findings of incompetence and unprofessional conduct by peer review committee may be offered as defenses in antitrust actions).

61. *Id.* at 141-45. Litigation began in 1977 and continues today as a result of the Third Circuit's decision to reverse and remand the case. *Id.* at 141-45 (reviewing course of litigation).

62. *See id.* at 141. The committee found Miller's behavior toward staff members "disruptive, insulting, intimidating, disrespectful, disparaging, abusive" and improper; his care of the deceased patient was improper due to his failure to request a medical consultation or to order

sufficient basis for revoking Miller's privileges and the procedure was carried out in a "fair and impartial manner."[63] The Pennsylvania Supreme Court denied Miller's petition for appeal.[64] Thereafter, Miller reapplied for staff privileges in 1977, 1978, and 1980, but these requests were denied.[65] In 1981, Miller filed this action in federal court claiming violation of his civil rights and violations of state and federal antitrust laws.[66] Miller also sought an injunction to force the hospital to process his medical staff application.[67]

After dismissing all claims except the antitrust violations,[68] the district court granted defendants' motion for summary judgment because Miller could not demonstrate that the hospital lacked substantial evidence to support its decision to terminate Miller's privileges.[69] On appeal, the court found that evidence of Miller's incompetence and unprofessional conduct may be a defense, but such evidence could not be considered until a jury had considered the plaintiff's allegations of anticompetitive intent on the part of the hospital and its effect on competition.[70] This holding demonstrates the preference for an individual physician's right to maintain staff privileges where the plaintiff can establish any type of competitive motive on the part of the hospital, over the hospital or peer review body's right to restrict the practice of incompetent physicians within the hospital.[71]

Pursuant to *Miller*, which did not consider whether the HCQIA protec-

---

certain tests and his improper entries in the patient's chart; he failed to comply with the Bureau of Medical Assistance order barring him from writing medical assistance prescriptions; his action in discussing confidential patient information with a layperson was unprofessional; and he failed to carry out certain administrative duties. *Id.*

63. *Miller*, 419 A.2d at 1196 (Pa. Super. 1980)(finding hospital acted reasonably in revoking Miller's privileges).

64. *Miller*, 843 F.2d at 142 (noting that record shows Supreme Court of Pennsylvania denied Miller's application for allowance of appeal).

65. *Id.* (discussing Miller's numerous reapplications for staff privileges).

66. *Id.*

67. *Id.* (requesting injunction to force hospital to process application for privileges).

68. Miller v. Indiana Hosp., 562 F. Supp. 1259, 1267-68, 1285-86 (W.D. Pa. 1983)(order denying defendants' motion for summary judgment on the pleadings regarding antitrust claim), *dism'd*, 660 F. Supp. 250 (W.D. Pa. 1986), *rev'd*, 843 F.2d 139 (3rd. Cir.), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 178 (1988).

69. *Miller*, 660 F. Supp. at 252-53 (hospital board had substantial evidence to support termination of privileges).

70. *Miller*, 843 F.2d at 143.

71. *See Miller*, 843 F.2d at 142 (finding of incompetency does not dispose of antitrust claim). Although a hospital is entitled to withdraw privileges from an incompetent physician, incompetency is not the threshold issue in an antitrust case. *Id.* at 142-43. Under the holding in *Miller*, the finding of an anticompetitive intent on the part of physicians participating in the decision to revoke or deny Miller's privilege is the primary consideration. *Id.* at 143. Since Miller may receive damages based on an antitrust violation although he has been found incompetent, the consideration of anticompetitive motive takes precedence over proof that Miller, in fact, was incompetent. *Id.*

tion applied,[72] a hospital is subject to extensive litigation although it has a valid defense to the antitrust allegation.[73] As long as the physician claims that there was an anticompetitive motive on the part of the hospital or a member of the medical staff, the court must evaluate this claim first.[74] To the extent that any member of the medical staff or the hospital itself may be considered a competitor, the plaintiff readily establishes a prima facie antitrust claim.[75] Thus, even when a claim may be defeated with proof of physician incompetence, a hospital may be hesitant to take disciplinary action because of the time and money required to defend against the claim, and instead, may choose to take the risk of malpractice litigation in the future.[76] Hence, to effect the purposes enunciated by Congress, the protection provided by the HCQIA should be more than a mere defense to liability for damages.

IV. SHERMAN ANTITRUST LITIGATION POST-HCQIA

Since the passage of the HCQIA, few decisions have been reported interpreting its application to state or federal antitrust claims.[77] In the *Patrick*

---

72. *Id.* at 143 n.4 (applicability of HCQIA not considered).

73. *Id.* at 141-42. The antitrust litigation which began in 1977 continues indefinitely since the Third Circuit Court of Appeals reversed and remanded the case for further proceedings. *Id.* at 141-42, 145.

74. Miller v. Indiana Hosp., 843 F.2d 139, 142-43 (3d Cir.), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 178 (1988). The threshold inquiry in an antitrust case cannot be avoided merely because a hospital can prove a physician is incompetent. *Id.*

75. *See* Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 714-17 (1981)(describing extent of economic competition existing among physicians of the same or related specialties and physicians incentives for limiting medical staff membership). Evidence of this economic competition forms the basis of a colorable antitrust claim because it establishes a motive for the restraint of trade. *See* 15 U.S.C. § 1 (1982)(requirement of contract, conspiracy and motive involve intent and are more easily proven by establishing motive).

76. *See* Holoweiko, *If You Should Lose A Peer Review Suit . . .*, MEDICAL ECONOMICS FOR SURGEONS, Jan. 1989, at 38 (neither hospital or professional liability insurance covered antitrust judgment). There is also some question whether insurance coverage extends to antitrust awards since judgment for the plaintiff is based on an intentional act in the form of a conspiracy, contract or combination. Telephone interview with Joseph Westheimer, Professor of Insurance Law, St. Mary's University School of Law (Jan. 23, 1989)(antitrust damages usually not covered by general liability insurance). Also, the economic devastation suffered by the defendant-physicians in the *Patrick* case is sufficient to prevent doctors or hospitals from trying to defend against malpractice claims. *See* Holoweiko, *If You Should Lose A Peer Review Suit . . .*, MEDICAL ECONOMICS FOR SURGEONS, Jan. 1989, at 38 (describing economic and emotional devastation resulting from *Patrick*). At least with malpractice cases, physicians and hospitals find themselves on familiar ground and feel secure that their malpractice carrier will provide their defense and pay any judgment to the extent of the policy limits.

77. *See, e.g.*, Patrick v. Burget, __ U.S. __, __, 108 S. Ct. 1658, 1665 n.8, 100 L. Ed. 2d 83, 95 n.8 (1988)(noted passage of HCQIA "essentially immunizes peer-review action from

case, the Supreme Court noted the enactment of the HCQIA but did not apply it to Patrick's antitrust claim because the act was not yet in force when Patrick's claim was filed.[78] Under similar circumstances, the Third Circuit Court of Appeals noted that the HCQIA provides a degree of immunity for peer review decisions, but the protection is only available for peer review actions taken after November 14, 1986.[79]

Nafrawi v. Hendrick Medical Center[80] provides the only current example of a federal court's interpretation of the HCQIA. The Medical Board and Trustees of Hendrick Medical Center restricted Nafrawi's surgical and admitting privileges after following a multilevel peer review procedure.[81] Nafrawi brought suit in Texas state court charging that the hospital and two members of the medical staff had violated his rights to due process and equal protection under the United State Constitution[82] and the Texas Free Enterprise and Antitrust Act of 1983.[83] After the suit was removed to federal court, Nafrawi amended his claim to delete all federal claims and substitute a state due process claim.[84] Although the plaintiff's state law claims should not have been subject to the HCQIA because it was not effective against

---

liability" if in compliance); *Miller*, 843 F.2d at 143 n.4 (HCQIA not applicable to disciplinary actions taken prior to November 14, 1986); Tambone v. Memorial Hosp. for McHenry County, Inc., 825 F.2d 1132, 1134 n.2 (7th Cir. 1987)(noting HCQIA not applicable and even if applicable existing reporting mechanism non-compliant); Nafrawi v. Hendrick Medical Center, 676 F. Supp. 770, 777 (N.D. Tex. 1987)(prematurely applying Texas' adoption of HCQIA to state antitrust claim); Gill v. Mercy Hosp., 245 Cal. Rptr. 304, 312-13 (Ct. App.)(since HCQIA inapplicable, no violation where hospital did not permit physician to be represented by attorney at ad hoc hearing), *cert. denied*, __ U.S. __, 109 S. Ct. 227, 102 L. Ed. 2d 217 (1988). The only other reported case to refer to HCQIA involved interpretation of its provisions protecting peer review committee reports from discovery in a medical malpractice action. *See* Goodspeed v. Street, 747 S.W.2d 526, 527-30 (Tex. App.—Fort Worth 1988, no writ)(HCQIA requires party alleging waiver of privilege to plead and prove waiver).

78. *Patrick*, __ U.S. at __ n.8, 108 S. Ct. at 1665 n.8, 100 L. Ed. 2d at 95 n.8 (HCQIA enacted well after events in case and not retroactively applied). Accordingly, the Supreme Court stated that the legislature, not the Court, must decide if peer review is entitled to immunity from suit. *Id.* Noting the enactment of HCQIA, the Court recognized that HCQIA did not limit or provide state action immunity. *Id.*; *see also* 42 U.S.C. § 11115(a) (Supp. IV 1986). Texas, however, explicitly rejected the state action immunity from suit in its adoption of HCQIA. TEX. REV. CIV. STAT. ANN. 4495b, § 5.06(u) (Vernon Supp. 1989).

79. Miller v. Indiana Hosp., 843 F.2d 139, 143 n.4 (3d Cir.)(application not considered since HCQIA not effective until after peer review action taken), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 147 (1988).

80. 676 F. Supp. 770 (N.D. Tex. 1987).

81. *Id.* at 771-72.

82. *Id.* at 771 (N.D. Tex. 1987)(equal protection and due process violations alleged); U.S. CONST. amend. XIV (due process and equal protection clauses).

83. *Nafrawi*, 676 F. Supp. at 771 (state antitrust claim); TEX. BUS. & COM. CODE ANN. § 15.05(a)(Vernon 1987)(Texas equivalent to Sherman Antitrust Act).

84. *Nafrawi*, 676 F. Supp. at 771 (deletion of all federal claims); TEX. CONST. art. 1, § 19 (Texas due process provision—no deprivation of life, liberty, or property except by due course

Texas state law claims until September 1, 1987,[85] the case illustrates an interpretation of the protection from damages provided for peer review under the HCQIA.

Following the traditional analysis taken in antitrust claims, the court first considered the plaintiff's allegations,[86] and determined the plaintiff had not provided sufficient evidence to establish the elements of an antitrust claim because there was no evidence of a conspiracy, restraint of trade, or anticompetitive effect.[87] The court noted that even if the plaintiff had proven the antitrust violation, Texas' adoption of the HCQIA provided the physician-defendants with immunity from civil damages if they acted without malice.[88]

Although the *Nafrawi* court considered that the Texas-HCQIA protections applied to the case, it did not grant summary judgment for the defendants based on compliance with the HCQIA because the defendants sought declaratory relief in their counterclaim.[89] Instead, the district court expedited trial in compliance with the spirit of the HCQIA in protecting the peer review entity from lengthy litigation while verifying that the peer review action provided due process and was reasonable.[90] A trial court judge may exercise broad discretion in granting expedited trials.[91] Since an expedited trial still exposes the peer review body to suit although they have complied with the requirements of the Act, reliance on the granting of expedited trials will not give the protection contemplated by the HCQIA. Consequently, for

---

of law). Because of the risk of harm to Nafrawi from loss of medical staff privileges, the court expedited the trial. *Nafrawi*, 676 F. Supp. at 773.

85. TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06(f) (Vernon Supp. 1989)(effective date September 1, 1987—not retroactive).

86. Nafrawi v. Hendrick Medical Center, 676 F. Supp. 770, 773-74 (N.D. Tex. 1987); *see also* Miller v. Indiana Hosp. 843 F.2d 139, 142-43 (3d Cir.)(antitrust inquiry not preceded by consideration of physician's professional incompetency), *cert. denied*, __ U.S. __, 109 S. Ct. 178, 102 L. Ed. 2d 178 (1988).

87. *Nafrawi*, 676 F. Supp. at 774-75 (no evidence of conspiracy, restraint of trade or anticompetitive effect).

88. *Id.* at 777 (interpreting HCQIA protections for physicians participating in peer review).

89. *Id.* at 771.

90. *Id.* at 773.

91. *See* Seidenberg v. Seidenberg, 219 F.2d 769, 771 (D.C. Cir. 1955)(granting of expedited trial within discretion of trial court). Expedited trials must be granted in cases of writs of habeas corpus, requests for temporary injunctions and where litigant shows "good cause." 28 U.S.C. § 1657 (Supp. II 1984). Good cause exists where the litigant shows that a constitutional or statutory right will be protected by expedited consideration of the claim. *Id.* In addition, where the litigant demonstrates the risk of serious injury or financial harm which will be caused by waiting for trial, the court may advance consideration of the case. *See, e.g.*, Rich v. Ellerman & Bucknall S.S. Co., 278 F.2d 704, 708 (2d Cir. 1960)(expedited trial appropriate where injury occurred seven years prior); Hawkins v. Board of Control of Fla., 253 F.2d 752, 752-53 (5th Cir. 1958)(expedited trial appropriate where applicant spent eight years in litigation in attempt to secure acceptance in law school).

the HCQIA to serve as an incentive to peer review, physicians and hospitals subjected to liability must be able to rely on uniform treatment of claims which invoke the HCQIA's protection. By treating the protection provided by the HCQIA in the same manner as the "qualified immunity" available to government officials, federal courts would assure uniform treatment.

V. QUALIFIED IMMUNITY—MODEL FOR THE HCQIA PROTECTION

Qualified immunity evolved from the policeman's common-law defense to a wrongful arrest action.[92] Where a police officer could prove that he acted in good faith and with probable cause, he had a defense against an action for an unconstitutional arrest.[93] The Supreme Court extended this defense to create a "qualified immunity" for government officials.[94] A government official receives immunity from a civil rights suit where he pleads and proves that his actions were based on an objectively reasonable belief that his actions did not violate existing law.[95] The Supreme Court adopted this objec-

---

92. *See* Butz v. Economou, 438 U.S. 478, 496 (1978)(discussing origins of qualified immunity); Pierson v. Ray, 386 U.S. 547, 555-57 (1967)(qualified immunity analogous to policemen's good faith defense for wrongful arrest); Comment, *Quick Termination of Insubstantial Civil Rights Claims: Qualified Immunity and Procedural Fairness*, 38 VAND. L. REV. 1543, 1546 (1985)(qualified immunity based on common-law good faith defense).

93. *See* Pierson v. Ray, 386 U.S. 547, 555-57 (1967)(recognizing policeman's defense of good faith and probable cause as defense to claim of civil rights violations); *see also* Comment, *Quick Termination of Insubstantial Civil Rights Claims: Qualified Immunity and Procedural Fairness*, 38 VAND L. REV. 1543, 1546 (1985)(discussing origin of qualified immunity).

94. *See Butz*, 438 U.S. at 507-08 (extending qualified immunity to government officials); *see also* Comment, *Quick Termination of Insubstantial Civil Rights Claims: Qualified Immunity and Procedural Fairness*, 38 VAND. L. REV. 1543, 1546 (1985)(discussing establishment of qualified immunity for government officials); Note, *An Examination of Immunity for Federal Executive Officials*, 28 VILL. L. REV. 956, 967-972 (1983)(examining development of qualified immunity for presidential aides).

95. *See* Harlow v. Fitzgerald, 457 U.S. 800, 813-15 (1982)(granting qualified immunity to federal officials who satisfy objective standard); *see also* Balcerzak, *Qualified Immunity for Government Officials: The Problem of Unconstitutional Purpose in Civil Rights Litigation*, 95 YALE L.J. 126, 132-34 (1985)(discussing objective standard of qualified immunity); Berg & Dryden, *The Modification of the Qualified Immunity Test: An Analysis of* Harlow v. Fitzgerald's *Effect on Actions Under 42 U.S.C. § 1983*, 33 FED. INS. COUNS. Q. 353, 356-59(1983)(analysis of qualified immunity); Sowle, *The Derivative and Discretionary-Function Immunities of Presidential and Congressional Aides in Constitutional Tort Actions*, 44 OHIO ST. L.J. 944, 945-50 (1983)(analyzing objective standard for qualified immunity protection); Comment, Harlow v. Fitzgerald*: The Lower Courts Implement the New Standard for Qualified Immunity under Section 1983*, 132 U. PA. L. REV. 901, 918-920 (1984)(application of objective standard to qualified immunity); Comment, *Immunity: Eliminating the Subjective Element from the Qualified Immunity Standard in Actions Brought Against Government Officials*, 22 WASHBURN L.J. 577, 586-89 (1983)(discussing objective standard adopted by Supreme Court in *Harlow v. Fitzgerald*); Note, *Remedies—Immunity—President Absolutely Immune From Civil Damages Liability For Official Acts*—Nixon v. Fitzgerald, 102 S. Ct. 2690 (1982); *Presidential Aides Entitled To Qualified Immunity From Civil Damages Liability For Official Acts*—

tive standard for evaluating pleas of qualified immunity to permit speedy disposal of insubstantial claims by summary judgment.[96] The Court balances the competing interests of government officials to be protected from the risks in litigating insubstantial claims and the public interest in preventing abuse of office.[97]

In determining the risk of subjecting governmental officials to all civil rights claims, the United States Supreme Court considered the costs to society.[98] These include the cost and time of litigation as well as the official's distraction from carrying out his appointed duty to serve the public.[99] Further, to the extent an individual can maintain a claim, albeit insubstantial, the risk of suit deters able citizens from seeking public office or aggressively carrying out their responsibilities.[100] Therefore, the objective standard al-

---

Harlow v. Fitzgerald, 102 S. Ct. 2727 (1982), 13 SETON HALL L. REV. 374, 379-84 (1983)(discussing foundation for qualified immunity and absolute immunity); Note, *An Examination of Immunity for Federal Executive Officials*, 28 VILL. L. REV. 956, 972-77 (1983)(analyzing qualified immunity doctrine).

96. Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982)(use of objective standard permits summary judgment and avoids lengthy litigation). Under Rule 56, a court may only grant summary judgment when there is no genuine issue of material fact so that the movant is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c). Consequently, the Supreme Court's adoption of an objective standard to determine if a governmental official's belief regarding the state of the law at the time of the action was reasonable permits a trial court judge to determine the defendant's mental state as a matter of law. *Harlow*, 457 U.S. at 818; *see also* Comment, Harlow v. Fitzgerald: *The Lower Courts Implement the New Standard for Qualified Immunity Under Section 1983*, 132 U. PA. L. REV. 901, 913-15 (1984)(discussing policies underlying objective standard for qualified immunity); Comment, *Quick Termination of Insubstantial Civil Rights Claims: Qualified Immunity and Procedural Fairness*, 38 VAND. L. REV. 1543, 1547 (1985)(purpose of objective standard to permit summary judgment and avoid lengthy litigation).

97. *See Harlow*, 457 U.S. at 814 (striking balance between vindication of individual rights and protection of government officials so they can perform their jobs free from unrestrained risk of liability); Berg & Dryden, *The Modification of the Qualified Immunity Test: An Analysis of* Harlow v. Fitzgerald's *Effect on Actions Under 42 U.S.C. § 1983*, 33 FED'N INS. COUNS. Q. 353, 359-361 (1983)(analyzing *Harlow* and basis for decision). The lower courts have identified two basic policies underlying the adoption of the objective standard: to free officials from risk of unnecessary trial or discovery and the quick termination of insubstantial claims. *See* Krohn v. United States, 742 F.2d 24, 28 (1st Cir. 1984)(primary purpose of qualified immunity is to protect government officials right to not stand trial); Powers v. Lightner, 752 F.2d 1251, 1256 (7th Cir. 1985), *cert. dismissed sub nom.*, Jones v. Lightner, 474 U.S. 801 (1985)(primary purpose of qualified immunity is termination of insubstantial claims); *see also* Comment, *Quick Termination of Insubstantial Civil Rights Claims: Qualified Immunity and Procedural Fairness*, 38 VAND. L. REV. 1543, 1573-75 (1985)(lower courts recognize two policies behind qualified immunity).

98. *Harlow*, 457 U.S. at 813-14 (striking balance between competing interests).

99. *Id.* at 814; *see also* Schuck, *Suing Our Servants: The Court, Congress, and the Liability of Public Officials for Damages*, 1980 SUP. CT. REV. 281, 324-27 (discussing social costs of suits against public officials).

100. *Harlow*, 457 U.S. at 816-17 (threat of litigation deters capable persons from govern-

lows efficient disposal of insubstantial claims, while protecting against the potential abuse of office which might result with an absolute immunity[101] from all claims.[102]

The same policy arguments apply to physicians and hospitals conducting professional review.[103] The risk of suit deters physician involvement in peer review evaluations and inhibits both physicians and hospitals from taking necessary disciplinary action.[104] Since the HCQIA utilizes objective standards which must be met to justify the protection it offers, federal district courts may use the criteria to determine if the defendant-physician, hospital or peer review entity qualifies for protection.[105] Thus, if the defendant qualifies for protection, the court may grant summary judgment or dismiss the suit. Therefore, federal courts may consider the HCQIA's protection from liability to be a "qualified immunity" from suit which is due the same consideration as the qualified immunity from suit enjoyed by government officials.[106]

Furthermore, the Supreme Court has interpreted "qualified immunity" as

---

ment service); *see also* Gregoire v. Biddle, 177 F.2d. 579, 581 (2d Cir. 1949)(Learned Hand's warning that exposure to liability inhibits government officials from the "unflinching discharge of [their] duties") *quoted in* Nixon v. Fitzgerald, 457 U.S. 731, 752 n.32 (1982)(most persuasive argument supporting extension of qualified immunity to government officials is need to encourage government officials to carry out duties without fear of litigation), *cert. denied*, 339 U.S. 949 (1950).

101. *See, e.g., Nixon*, 457 U.S. at 751-52 (President entitled to absolute immunity from suit); Stump v. Sparkman, 435 U.S. 349, 362-63 (1978)(absolute immunity for judges regarding judicial functions); Eastland v. United States Servicemen's Fund, 421 U.S. 491, 507 (1975)(recognizing absolute immunity for legislators acting in their legislative capacity).

102. *Harlow*, 457 U.S. at 818-19 (reliance on objective standard allows quick termination of insubstantial claims while protecting public from lawless conduct).

103. *Compare* H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385-86 (identifying reasons for providing protection from peer review) *with Harlow*, 457 U.S. at 813 (identifying similar reasons for protecting government officials with qualified immunity).

104. *Compare* H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (even though peer reviewers may win lawsuit, threat of litigation inhibits disciplinary action because of time and money spent defending suit) *with Harlow*, 457 U.S. at 814 (time and money spent on litigation is part of social cost to be avoided by qualified immunity). Even the time involved in litigation decreases time physicians have available to conduct necessary peer review activities. *Compare* H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (physicians will not take necessary peer review action when threat of litigation exists) *with Harlow*, 457 U.S. at 816-17 (involvement in litigation prevents government officials from carrying out their duties).

105. *Compare* 42 U.S.C. § 11112 (Supp. IV 1986)(objective criteria for establishing good faith peer review) *with* Harlow v. Fitzgerald, 457 U.S. 800, 818-19 (1982)(establishing objective criteria if government official entitled to qualified immunity).

106. *Compare* Harlow v. Fitzgerald, 457 U.S. 800, 818-20 (1982)(establishing qualified immunity based on objective standard of good faith) *with* 42 U.S.C. § 11112(a) (Supp. IV

the defendant's right to be free from litigation when he has complied with the law.[107] Because denial of summary judgment violates that right by subjecting the defendant to trial, the defendant is entitled to appeal the summary judgment.[108] Otherwise, his right to be free from suit is lost when a case is erroneously permitted to go to trial.[109] Accordingly, denials of summary judgments where defendants invoke the protection of the HCQIA should be subject to appeal as well,[110] since entities and participants in peer review are entitled not to stand trial when they have complied with the HCQIA.

To the extent that the HCQIA requires reporting of peer review actions, physicians affected by these actions have more incentive to sue and fewer alternatives.[111] Consequently, physicians and hospitals require even more protection from the increased threat of litigation.[112] Texas has made the

---

1986)(establishing objective standards for determining reasonable belief that peer review action taken to promote quality of health care).

107. *See* Mitchell v. Forsyth, 472 U.S. 511, 525 (1985)(qualified immunity confers right to not stand trial under specific circumstances); *see also* Comment, *Quick Termination of Insubstantial Civil Rights Claims: Qualified Immunity and Procedural Fairness*, 38 VAND. L. REV. 1543, 1580 (1985)(analyzing *Mitchell v. Forsyth* and government official's right not to stand trial).

108. *See Mitchell*, 472 U.S. at 526. If denial of summary judgment is not appealable, then the court's decision conclusively denies the defendant's right to avoid litigation, leaving defendant without a remedy, because there would be no alternative once litigation commences. *Id.* at 527; *see also* Comment, *Quick Termination of Insubstantial Civil Rights Claims: Qualified Immunity and Procedural Fairness*, 38 VAND. L. REV. 1543, 1580 (1985)(analyzing right to appeal denial of summary judgment when official claims qualified immunity).

109. *See Mitchell*, 472 U.S. at 526 (qualified immunity is right not to stand trial, not just defense to liability); Sorey v. Kellett, 849 F.2d 960, 961 (5th Cir. 1988)(applying *Forsyth* to denial of summary judgment where defendant plead state qualified immunity).

110. *See Mitchell*, 472 U.S. at 524-30 (explaining basis for entitlement to appeal when qualified immunity denied). Under federal law, there is no appellate jurisdiction unless the district court has rendered a final decision. 28 U.S.C. § 1291 (1982). A final decision, however, is not necessarily a final judgment disposing of all issues in a case. Gillespie v. United States Steel Corp., 379 U.S. 148, 152 (1964). Accordingly, a district court decision regarding a right which will be violated unless reviewed before proceedings continue may be appealed. Cohen v. Beneficial Indus. Loan Corp., 337 U.S. 541, 546 (1949)(establishing the "collateral order" doctrine permitting appeal of decisions which are not interlocutory or will not be affected by decision on merits of case). Therefore, denial of summary judgment constitutes a final decision which violates the defendant's right not to stand trial and may be appealed because proceeding to trial on the merits violates this right. *Mitchell*, 472 U.S. at 526-27.

111. H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (reporting requirement will result in increased litigation because disciplined physicians will feel compelled to challenge action taken against them).

112. H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (likelihood of increased litigation necessitates statutory protection from damages for physicians and hospitals conducting peer review).

reporting of adverse peer review actions mandatory.[113] At the same time, the Texas version of the HCQIA provides an explicit immunity from suit for peer review actions taken and reported without malice.[114] The federal protection for peer review should also be interpreted as a qualified immunity because the drafters failed to explicitly state that the protection was an immunity from suit.

VI. CONCLUSION

The courts should interpret the protection provided by the HCQIA as a qualified immunity of the same type as is enjoyed by government officials. In doing so, this qualified immunity should give physicians and hospitals conducting peer review in good faith the protection they seek, while also protecting physicians subject to disciplinary action. The objective standard places both the participants in and subjects of peer review on notice as to their relative rights and duties. Given the clarity of the rights and duties, the participants must follow the procedural safeguards to qualify for the immunity, so the peer review committee cannot act arbitrarily in disciplining a physician or take action against a competent physician to restrict competition.[115] To the extent hospitals and peer reviewers can rely on protection from suit, hospital administrators, hospital trustees, and physician peer review committees can take necessary action to restrict or revoke the privileges of incompetent physicians. Without this protection, hospitals and physicians conducting peer review committees will avoid taking disciplinary action exposing them to liability when an incompetent physician threatens to bring an antitrust suit. The failure to act results in incompetent physicians practicing without supervision or restriction. This result is contrary to the intentions of the Health Care Quality Improvement Act and presents a great risk of harm to patients and society in general.

Included within the liability risk associated with participation in peer review is the risk of litigation. Insofar as the peer review policy concerns mir-

---

113. *See* TEX. REV. CIV. STAT. ANN. art. 4495b,§ 5.06(b) (Vernon Supp. 1988)(statutory duty to report professional review actions resulting in revocation, restriction or suspension of privileges for more than 30 days).

114. *See* TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06(l) (Vernon Supp. 1988). The Medical Practice Act provides in pertinent part:

> A cause of action does not accrue against the members, agents, or employees of a medical peer review committee or against the health-care entity from any act, statement, determination or recommendation made, or act reported, without malice, in the course of peer review as defined by this Act.

Id.

115. H.R. REP. NO. 99-903, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6391 (broad protection from suit subject to abuse so protection only provided for peer review conducted in compliance with Act).

ror the policy concerns underlying the recognition of a qualified immunity for government officials, the protection for peer review should be treated procedurally in the same manner as the qualified governmental immunity. Hence, the immunity should be recognized as an entitlement not to stand trial. As an entitlement not to stand trial, the denial of this right by a trial court's failure to grant summary judgment would be subject to appeal prior to final judgment.

This interpretation of the HCQIA's protection should also assist courts handling cases involving defendants claiming immunity. If application of the HCQIA qualified immunity is determined in the same manner as the application of qualified governmental immunity, district courts may look to existing case precedent for guidance in disposing of claims under the HCQIA. Thereafter, hospitals, peer review physicians, and disciplined physicians will receive the protection provided by the HCQIA. While, society will benefit from the increased identification and restriction of incompetent physicians and a concomitant decrease in medical malpractice.