Cornell Law Review

Volume 60
Issue 6 *August 1975*

Article 8

Physician-Hospital Conflict the Hospital Staff Privileges Controversy in New York

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PHYSICIAN-HOSPITAL CONFLICT: THE HOSPITAL STAFF PRIVILEGES CONTROVERSY IN NEW YORK

Hospital staff privileges are the physician's key to the use of hospital facilities. Without these privileges, the physician cannot admit his patients to, and treat them in, the hospital. In recent years the process by which American hospitals grant or deny these staff privileges has become the focus of growing concern. Increasing numbers of physicians have turned to the courts for protection and aid in solving the problem. This Note will examine the controversy from both the legislative and litigative standpoint, including an analysis of state and federal judicial treatment. This examination is intended to provide the aggrieved physician and his attorney with an overview of the staff privileges situation in New York, with the purpose of providing guidance in the resolution of these problems.

I

HISTORY OF THE HOSPITAL STAFF PRIVILEGES PROBLEM

A. *General Background*

Hospital staff privileges can best be defined as "the ability of a member of a hospital staff . . . to admit his patients to the hospital for care."[1] Privileges are granted to the physician in various medical specialty areas, depending predominantly upon professional competence.[2] The physician does not become an employee of the hospital. Nevertheless, the privileges enable the physician to benefit from the hospital facilities as if he were an independent contractor.[3]

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[1] McLaughlin, *Public Hearing on Hospital Staff Privileges*, 72 N.Y.S.J. MED. 2445 (1972).

[2] See Horty, *Hospital Must Specify Criteria for Medical Staff Membership*, 115 MOD. HOSP., Oct. 1970, at 88, for a general discussion emphasizing the consideration of additional factors, including the physician's temperament and his ability to function as part of a group.

[3] Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146, 155 (1968). Under traditional independent contractor law, the hospital was able to insulate itself from injuries caused by the physician's negligence. W. PROSSER, THE LAW OF TORTS 468 (4th ed. 1971). *But see* Darling v. Charleston Community Memorial Hosp., 50 Ill. App. 2d 253, 200 N.E.2d 149 (1964), *aff'd*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966). *Darling* was the first case to hold a hospital responsible for the negligent acts of physicians on its medical staff. Previously, the injured patient was only able to sue the physician, but *Darling* imposed a duty on the hospital to ensure that quality care was rendered under its auspices. The impact of the case in the health-care field has been likened to that of the *Palsgraf* case in the area of general negligence. Springer, *Medical Staff Law and the Hospital*, 285 NEW ENG. J. MED. 952, 954-55 (1971).

The hospital's role in modern society has undergone a significant evolution. Whereas the hospital initially served as a quarantine facility to isolate the sick from the healthy, it evolved during the 1960's to serve as the physician's workshop.[4] The hospital has moved beyond this stage and now exists as the primary community health-care center. By integration of a sophisticated system of health-care units, it serves patients far beyond the needs and capabilities of the individual physician.[5]

The sophistication of the modern hospital and of current medical science make hospital affiliation a professional and financial necessity for the physician.[6] In addition, the continuing education, both formal and informal, provided through hospital affiliation is essential to maintaining the physician's competence.[7] However, the physician's need for privileges must be balanced against the hospital's desire to maintain a high standard of quality care.[8] For this reason, hospitals have established comprehensive procedures for the selection of physicians for staff privileges, in addition to yearly reevaluations of current staff members.

The application procedure normally follows three steps.[9] The applicant is first evaluated by a credentials committee, composed of physicians and administrative personnel. This committee reviews the applicant's standing in the medical community by referring to

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[4] Kauffman, *Hospital-Physician Relations,* 2 HOSP. MED. STAFF, Dec. 1973, at 24, 25.

[5] Springer, *supra* note 3, at 953; *see also* Moore v. Board of Trustees of Carson-Tahoe Hosp., 88 Nev. 207, 211-12, 495 P.2d 605, 608, *cert. denied,* 409 U.S. 879 (1972); Kauffman, *supra* note 4.

[6] It has been said that "[w]ithout staff privileges the modern physician is professionally crippled and his patients are endangered." *Hearings on S. 5610 Before the New York State Senate Comm. on Health,* Sept. 24, 1971 (statement of M. C. McLaughlin, Commissioner, New York City Department of Health) [hereinafter cited as *Senate Hearings*]. See also Moore v. Board of Trustees of Carson-Tahoe Hosp., 88 Nev. 207, 213, 495 P.2d 605, 609, *cert. denied,* 409 U.S. 879 (1972) (dissenting opinion), for judicial recognition of the importance of staff privileges.

[7] Letter from E. D. Pellegrino, M.D., Dean, School of Medicine, State University of New York at Stonybrook, to State Senator Tarky Lombardi, Jr., Sept. 27, 1971, on file at the *Cornell Law Review.*

[8] The hospital is not only concerned with its level of care as it is perceived by the potential patient population, but the hospital must also be concerued with possible responsibility for the negligent acts of staff physicians. *See* note 3 *supra.* Therefore, the hospital considerations are not limited to an image-conscious feeling, but also include a desire to limit this potential liability.

[9] *Senate Hearings,* Nov. 5, 1971 (statement of E. A. Aksel, Central New York Hospital Association, Inc.). *See generally* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 1970 (1971); JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, GUIDELINES IN THE FORMULATION OF MEDICAL STAFF BYLAWS, RULES AND REGULATIONS (1971); Porterfield, *Granting of Clinical Privileges—Part 2,* 2 HOSP. MED. STAFF, May 1973, at 5, 6-7.

letters of recommendation, prior training, license status, and other similar criteria.[10] The recommendation of the credentials committee is forwarded to a medical executive committee, composed solely of physicians, for further consideration of the applicant's medical qualifications. Finally, all recommendations are forwarded to the ultimate decision maker, the hospital governing board, which is normally composed of laymen.[11]

As the sole authority for determining hospital accreditation, the Joint Commission on Accreditation of Hospitals has enormous impact on all hospital procedures.[12] Beyond the staff privileges application procedure, the Joint Commission recommends an extensive hearing and appeal mechanism, guaranteeing protection of the due process rights of the physician.[13] This is consistent with the current position of the American Medical Association.[14] Therefore,

[10] *Senate Hearings, supra* note 9. *See also* Porterfield, *Evaluation of Physician Performance in the Credentials Process,* 3 HOSP. MED. STAFF, Nov. 1974, at 34.

[11] The composition of the hospital governing board is currently the center of another major controversy. There has been much discussion concerning medical representation on the lay governing boards. *See, e.g.,* Mack, *Can Physicians Influence Hospital Policy?,* 1 HOSP. MED. STAFF, April 1972, at 25-28; Sherman, *The Physician as Trustee,* 1 HOSP. MED. STAFF, March 1972, at 2.

[12] The Joint Commission on Accreditation of Hospitals [hereinafter cited as J.C.A.H.] is an independent organization whose purpose is to improve the quality of patient care in hospitals throughout the United States and Canada. In addition to setting minimum standards of quality, the J.C.A.H. provides many procedural guidelines for internal operations. The Commission grants accreditation to hospitals after inspection of the facility and a determination that there has been compliance with the necessary standards.

Although a hospital is not legally compelled to seek J.C.A.H. accreditation, many hospitals participate in the program. An important consideration is the fact that accreditation will satisfy the great majority of prerequisites for participation in the federal Medicare program. 20 C.F.R. § 405.1901(b) (1974). For additional information on the J.C.A.H. and its functions see AMERICAN HOSPITAL ASSOCIATION, HOSPITAL ACCREDITATION REFERENCES (1957); AMERICAN MEDICAL ASSOCIATION, REPORT OF COMMITTEE TO REVIEW THE FUNCTIONS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (1956); N.Y. Times, March 31, 1975, at 54, col. 1; N.Y. Times, March 23, 1975, § 1, at 43, col. 2.

The significance of J.C.A.H. accreditation has also been considered by some courts in staff privileges cases. *E.g.,* Aasum v. Good Samaritan Hosp., 395 F. Supp. 363 (D. Ore. 1975); Rao v. Board of County Comm'rs, 80 Wash. 2d 695, 698, 497 P.2d 591, 593, *cert. denied,* 409 U.S. 1017 (1972). *But see* Hoberman v. Lock Haven Hosp., 377 F. Supp. 1178 (M.D. Pa. 1974), where the court refused to accord any significance to J.C.A.H. guidelines because the J.C.A.H. is a private body, even though federal and state funding is premised on accreditation in many instances. *Id.* at 1187-88.

[13] JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, GUIDELINES IN THE FORMULATION OF MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, art. VIII, 21-30 (1971).

[14] The position of the American Medical Association has been stated as follows:

> The basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. These basic guarantees are: a specific charge, adequate notice of hearing, the opportunity to be present and to hear the evidence, and to present a defense.

Brief for A.M.A. as Amicus Curiae at 5, Martin v. Catholic Medical Center, 35 N.Y.2d 901,

strong external influence is placed upon all hospitals to provide the proper protection for the physician whose staff privileges are affected.[15]

The physician may be confronted by many problems throughout this application and review procedure. These problems may include racial discrimination,[16] denial of various due process requirements,[17] hiring moratoria based on bed capacity[18] or geographic factors,[19] discrimination based on the type of medical specialty,[20] or simply anti-competitive, monopolistic motives on the part of the hospital.[21] Once denied either initial appointment or subsequent reappointment, the physician is normally left without any recourse.[22] For this reason, physicians have turned to the courts for help.

B. *Judicial Intervention*

During the past ten years, physicians, in increasing numbers, have brought their hospital staff privileges complaints to the courts. The problem became a major controversy in the late 1960's,[23] and prompted some legislatures to enact limited

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324 N.E.2d 362, 364 N.Y.S.2d 893 (1974). *See also* AMERICAN MEDICAL ASSOCIATION, OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL 20 (1971).

[15] However, the continuing presence of staff privileges problems makes it apparent that this external influence is inadequate. For example, physicians have alleged that these external controls can be circumvented through the implementation of monopolistic practices. *See* note 143 and accompanying text *infra*.

[16] Cypress v. Newport News General & Nonsectarian Hosp. Ass'n, 375 F.2d 648 (4th Cir. 1967) (black physician denied staff privileges by an all-white hospital medical staff); Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964) (black physicians and patients totally denied any access to hospital facilities).

[17] Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971) (notice of the charges and right of cross-examination held to comply with minimum standards of due process); Citta v. Delaware Valley Hosp., 313 F. Supp. 301, 308 (E.D. Pa. 1970) (right to a hearing prior to the reduction of the privileges); Ascherman v. San Francisco Medical Soc'y, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (Ct. App. 1974) (right to a hearing prior to the deprivation of privileges).

[18] Davis v. Morristown Memorial Hosp., 106 N.J. Super. 33, 254 A.2d 125 (Ch. 1969) (hospital moratorium on granting of staff privileges due to inadequate bed space).

[19] *Id.*; Letter from E. D. Pellegrino, *supra* note 7. A hospital utilizing a geographic moratorium would require a "relationship between the hospital, the physician using the hospital, and the community of people to be served," before staff privileges would be granted to any individual. *Id.*

[20] Greisman v. Newcomb Hosp., 76 N.J. Super. 149, 183 A.2d 878 (L. Div. 1962), *aff'd*, 40 N.J. 389, 192 A.2d 817 (1963) (osteopath excluded by hospital bylaws); State *ex rel.* Carpenter v. Cox, 61 Tenn. App. 101, 453 S.W.2d 69 (1969) (osteopath excluded by hospital bylaws).

[21] *See* note 15 *supra*.

[22] The New York statutory scheme has presented the physician with a new, viable alternative. *See* notes 144-93 and accompanying text *infra*.

[23] This observation is based upon the volume of litigation, in addition to the abundance

legislation.[24] But the focus of the controversy was clearly the judiciary.

The courts initially faced the problem of the public-private dichotomy.[25] In the case of the public hospital, the courts did not hesitate to intervene.[26] The public hospital was treated in the same way as a public or municipal corporation.[27] The physician was protected from arbitrary or capricious action as the courts scrutinized the problem to assure reasonable regulations and procedures.[28]

However, with respect to a hospital chartered as a private corporation, the courts were much more hesitant to act. Relying upon the classic doctrine of *Trustees of Dartmouth College v. Woodward*,[29] the courts were unwilling to intervene in the internal

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of law review articles written on the subject. *See, e.g.*, Ludlam, *Physician-Hospital Relations: The Role of Staff Privileges*, 35 LAW & CONTEMP. PROB. 879 (1970); Southwick, *Hospital Medical Staff Privileges*, 18 DEPAUL L. REV. 655 (1969); Note, *Denial of Hospital Staff Privileges: Hearing and Judicial Review*, 56 IOWA L. REV. 1351 (1971); Note, *Hospital Staff Privileges: The Need for Legislation*, 17 STAN. L. REV. 900 (1965); Note, *Selection of Hospital Staff Members*, 40 U. CIN. L. REV. 797 (1971); Note, *The Physician's Right to Hospital Staff Membership: The Public-Private Dichotomy*, 1966 WASH. U.L.Q. 485. *See also* Annot., 37 A.L.R.3d 645 (1971); Annot., 24 A.L.R.2d 850 (1952).

[24] *See, e.g.*, IND. ANN. STAT. § 16-12.1-5-1 (Burns 1973) (hospitals must have reasonable regulations and cannot discriminate among schools of medicine); LA. REV. STAT. ANN. § 37:1301 (West 1974) (nonprofit hospitals may not discriminate against physicians that participate in medical group practice and may not require membership in a specialty body or medical society as prerequisite to the granting of staff privileges); N.M. STAT. ANN. § 67-8-12 (1974) (protection of the rights of osteopathic surgeons); N.Y. PUB. HEALTH LAW § 206-a (McKinney 1971) (protection of those physicians involved in medical group practices and nonprofit health insurance plans); ORE. REV. STAT. § 441.077 (1973) (hospitals cannot discriminate among schools of medicine); S.D. COMPILED LAWS ANN. § 34-8-8 (1972 Rev.) (county hospitals cannot discriminate among schools of medicine); WYO. STAT. ANN § 35-97.1 (Cum. Supp. 1973) (hospitals must have reasonable rnles and regulations and cannot discriminate among schools of medicine).

[25] Hospitals can generally be classified as either public or voluntary-not-for-profit (private). This topic has been thoroughly considered in Note, *The Physician's Right to Hospital Staff Membership: The Public-Private Dichotomy*, 1966 WASH. U.L.Q. 485. A third category of hospitals is growing in size and importance. This group is composed of facilities organized by physicians or other interested persons and is operated on a profit-making basis. This Note does not deal with these private, profit-making hospitals because their recent significance has not yet manifested itself in the staff privileges area.

[26] *See, e.g.*, North Broward Hosp. Dist. v. Mizell, 148 So. 2d 1 (Fla. 1962); Wallington v. Zinn, 146 W. Va. 147, 118 S.E.2d 526 (1961).

[27] North Broward Hosp. Dist. v. Mizell, 148 So. 2d 1, 3 (Fla. 1962).

[28] *See, e.g.*, Martino v. Concord Community Hosp. Dist., 233 Cal. App. 2d 51, 43 Cal. Rptr. 255 (1965); Bryant v. City of Lakeland, 158 Fla. 151, 28 So. 2d 106 (1946); Jacobs v. Martin, 20 N.J. Super. 531, 90 A.2d 151 (Ch. 1952). *See also* note 24 *supra*.

[29] 17 U.S. (4 Wheat.) 518 (1819):

> [P]ublic corporations are such only as are founded by the government for public purposes, where the whole interests belong also to the government. If, therefore, the foundation be private, though under the charter of the government, the corporation is private, however extensive the uses may be to which it is devoted, either by the bounty of the founder, or the nature and objects of the institution.

operating procedures of the private hospital. This hesitancy empowered the private institution to grant or deny staff privileges with unfettered discretion and without justification.[30] The first slight modification of this judicial noninterference occurred when the courts began to require that hospitals follow their own bylaws in granting or denying staff privileges.[31]

It may be asked why the private hospital should be accorded any different treatment from that given a private association of any other type.[32] Unlike the private country club or fraternal organization that is formed solely to benefit its members, both the private, nonprofit hospital and the public hospital are formed to meet the health needs of a particular community.[33] The community therefore has an interest in the quality of medical care that is available at the facility. In order to protect this interest and assure the highest possible quality levels, properly qualified physicians must not be unreasonably excluded.

This reasoning led the New Jersey courts in *Greisman v. Newcomb Hospital*[34] to take the first major step in abrogating the public-private distinction. The trial court recognized the general public duty of all hospitals, and concluded that judicial intervention was necessary to protect the public's right to efficiently operated medical facilities.[35] In unanimously affirming the lower court

Id. at 668-69. *But compare* the following subsequent statement by the Court:

> Property does become clothed with a public interest when used in a manner to make it of public consequence, and affect the community at large. When, therefore, one devotes his property to a use in which the public has an interest, he, in effect, grants to the public an interest in that use, and must submit to be controlled by the public for the common good, to the extent of the interest he has thus created.

Munn v. Illinois, 94 U.S. 113, 126 (1876).

[30] Edson v. Griffin Hosp., 21 Conn. Supp. 55, 144 A.2d 341 (1958); Levin v. Sinai Hosp. of Baltimore City, Inc., 186 Md. 174, 46 A.2d 298 (1946).

[31] Shiffman v. Manhattan Eye, Ear & Throat Hosp., 35 App. Div. 2d 709, 314 N.Y.S.2d 823 (1st Dep't 1970); Gluck v. Lenox Hill Hosp. (Sup. Ct.), in 153 N.Y.L.J., April 26, 1965, at 17, col. 3. The impact of these decisions becomes more significant as the J.C.A.H. guidelines begin to play a more important role.

[32] *See* Moose Lodge No. 107 v. Irvis, 407 U.S. 163 (1972), where the Court refused to characterize the racially disriminatory policies of the Moose Lodge as state action. The Moose Lodge was a local chapter of a national fraternal organization that had been issued a liquor license by the Pennsylvania Liquor Control Board. The Court refused to find that the state had "significantly involved itself with [the] invidious discriminations." *Id.* at 173, *quoting* Reitman v. Mulkey, 387 U.S. 369, 380 (1967). The Court characterized the Lodge as a "private club in the ordinary meaning of that term." 407 U.S. at 171.

[33] A prerequisite to the establishment of a hospital in New York is a finding by the Public Health Council that there is a "public need for the existence of the institution at the time and place and under the circumstances proposed." N.Y. PUB. HEALTH LAW § 2801-a(3) (McKinney 1971).

[34] 76 N.J. Super. 149, 183 A.2d 878 (L. Div. 1962), *aff'd*, 40 N.J. 389, 192 A.2d 817 (1963).

[35] 76 N. J. Super. at 157-58, 183 A.2d at 882. The court based both the public duty of the

decision, the New Jersey Supreme Court imposed a fiduciary duty on the hospital in relation to the public when passing on questions involving staff privileges.[36]

The *Greisman* decision opened the door to judicial scrutiny of private hospitals. Using the fiduciary capacity rationale, the courts began to act with a much freer hand.[37] A second rationale for intervention was based upon federal and state funding of private hospitals.[38] The most significant form of this funding has been that granted under the Hill-Burton Act,[39] which provides federal subsidies to public and other nonprofit facilities for hospital construction and modernization programs. This funding has been the focal point of many federal jurisdictional controversies, often providing the basis for a finding of state action.[40] The immediate consequence of this finding is the application of constitutional guarantees, most importantly the fourteenth amendment's equal protection clause, thereby providing additional protection for the physician.[41]

II

LITIGATION IN NEW YORK

A. *Public Hospitals*

The public hospital is created by a municipal or government charter that vests management responsibility in a board of direc-

hospital and the public's right to medical care on the monopolistic position of the hospital. The Newcomb Hospital was the only hospital within an expansive geographic, metropolitan area. Furthermore, the certificate of incorporation specifically provided that the hospital be used for the residents of the area. The court concluded that this control must carry with it certain public responsibilities that the hospital could not shirk because of its private status. *Id.* at 156-58, 183 A.2d at 881-82.

[36] Greisman v. Newcomb Hosp., 40 N.J. 389, 401-04, 192 A.2d 817, 824-25 (1963).

[37] *See, e.g.*, Silver v. Castle Memorial Hosp., 53 Haw. 475, 482, 497 P.2d 564, 570, *cert. denied*, 409 U.S. 1048 (1972) (fiduciary trust relationsbip between the hospital, its staff and the public). *But see* Gonzales v. Personal Collection Serv., 494 P.2d 201, 206 (Wyo. 1972), where the members of the hospital board of trustees were characterized as fiduciaries, but were accorded a presumption of regularity on decisions relating to hospital management and operation.

[38] Federal funding is provided under various programs. These include Medicare, Medicaid, and Hill-Burton funds to supplement hospital construction. State funding normally takes the form of tax exempt status granted all hospitals. *Greisman* also discusses the impact of public contributions. 76 N.J. Super. at 157, 183 A.2d at 882.

[39] 42 U.S.C. §§ 291-291*o* (1970).

[40] *See* notes 74-106 and accompanying text *infra*.

[41] An example of the impact of the fourteenth amendment is found in Foster v. Mobile County Hosp. Bd., 398 F.2d 227 (5th Cir. 1968). In *Foster*, two black physicians had been denied staff privileges. The court invoked the equal protection clause because "members of the same class (i.e. physicians)" had not been accorded equal treatment. *Id.* at 230. The court also relied upon the due process clause in attacking the hospital bylaws and application procedures as patently unfair. This pattern repeats itself throughout the federal court cases.

tors appointed by the government entity involved.[42] Thus, there is a clear connection with the state, and any discriminatory procedures can be attributed directly to the state.

The classic New York case involving physicians' rights in public hospitals is *Alpert v. Board of Governors.*[43] The plaintiff physician had been denied reappointment after ten years on the active medical staff. He alleged that the decision was arbitrary and, because he had not been given notice of the charges or an opportunity for a hearing, that he had been denied due process. The court examined the duty of the public hospital in relation to the community that it serves. The conclusion reached was that the public hospital does not possess unbridled discretion and cannot arbitrarily exclude persons, whether physicians or patients, from the facility.[44] *Alpert* was a major step in New York; it recognized the courts' ability to examine the internal operating procedures of public hospitals to assure their reasonableness.

This initial step proved fruitful for the plaintiff in *Alpert* and for physicians faced in the future with a similar dilemma.[45] Although it restated the doctrine that the physician has "no constitutional right to practice medicine in a public hospital,"[46] the court recognized that a physician could not be denied the use of a public hospital on the basis of unreasonable rules or regulations.[47] Further bolstering the rights of the physician, the court said:

> If the right of the general public to use the hospital is to have any meaning, they must have the concurrent right to be treated by their own physicians, unless the latter are excluded for adequate cause.[48]

Therefore, the court not only granted substantial new rights to the physician, but also granted concomitant rights to the patient.

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[42] See Van Campen v. Olean General Hosp., 210 App. Div. 204, 206, 205 N.Y.S. 554, 556 (4th Dep't 1924), *aff'd,* 239 N.Y. 615, 147 N.E. 219 (1925), for a narrow New York definition of a public hospital.

[43] 286 App. Div. 542; 145 N.Y.S.2d 534 (4th Dep't 1955).

[44] *Id.* at 547, 145 N.Y.S.2d at 538.

[45] *See, e.g.,* Tuchman v. Trussel, 43 Misc. 2d 255, 250 N.Y.S.2d 913 (1964), where the court reviewed the termination of a physician's privileges at a city hospital. Although the *Alpert* case was not specifically relied upon, the court examined the hospital's charter and bylaws without hesitation. The court concluded that the provisions had not been followed and, therefore, that the termination was invalid.

[46] 286 App. Div. at 547, 145 N.Y.S.2d at 538. *See also* note 108 and accompanying text *infra.*

[47] *Id.* at 546, 145 N.Y.S.2d at 537.

[48] *Id.* at 547, 145 N.Y.S.2d at 538. For a codification of this right of patients, see IND. ANN. STAT. § 16-12-23-1 (Burns 1973).

The *Alpert* court took one additional step in strengthening the case of the physician denied reappointment, as opposed to initial appointment. Without mandating specific guidelines, the court reasoned that by continued practice in the public hospital, the physician acquired "a species of tenure."[49] A necessary component of this tenure is the guarantee of notice and an opportunity to be heard when the hospital decides whether to revoke staff privileges.[50]

B. *Private Hospitals*

There has been a clear division within the courts throughout the country as to their ability to intervene and limit the discretion of the private hospital governing board.[51] The New York courts adhere to the majority position in refusing to interfere in discretionary private hospital decisions.[52]

As in the public hospital area, New York case law is based upon a single classic decision, *Van Campen v. Olean General Hospital.*[53] In *Van Campen,* a physician denied reappointment argued that the acceptance of government and municipal funds would transform the otherwise private facility into a public institution. However, the court emphatically rejected this argument: "The fact that they may receive a donation from the government . . . or funds from a city or county . . . does not affect their character as private institutions."[54] The court concluded that a public hospital was one established by a municipality and not by a private corporation.[55]

The conclusion that the hospital was private prevented the *Van Campen* court from examining the hospital's internal operating procedures. The court found no absolute right of the patient or the physician to use the facilities of a private hospital, in contrast to a public hospital.[56] The court explained that the private hospital's

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[49] 286 App. Div. at 548, 145 N.Y.S.2d at 539. *Compare* Gluck v. Lenox Hill Hosp. (Sup. Ct.), in 153 N.Y.L.J., April 26, 1965, at 17, col. 3, where the court refused to grant tenure status in a dispute involving a private hospital.

[50] 286 App. Div. at 548, 145 N.Y.S.2d at 539.

[51] *See* notes 29-33 and accompanying text *supra.*

[52] For a further explanation of the majority position see Annot., 37 A.L.R.3d 645, 659 (1971).

[53] 210 App. Div. 204, 205 N.Y.S. 554 (4th Dep't 1924), *aff'd,* 239 N.Y. 615, 147 N.E. 219 (1925).

[54] *Id.* at 207, 205 N.Y.S. at 556.

[55] *Id.* at 206, 205 N.Y.S. at 556.

[56] *Id.* at 209, 205 N.Y.S. at 558.

directors must have almost unlimited discretion, and could not be interfered with in the absence of bad faith or fraud.[57]

The court specifically dealt with the physician's due process contentions, concluding that a hearing was unnecessary.[58] Therefore, in this seminal New York decision, the hospital was granted, in the court's own words, "wide discretion."[59] The unrestrained power permitted by the *Van Campen* decision presents many problems for the physician, as the potential for abuse by the hospital is increased.[60]

If the hospital's purpose is to serve the public and provide the community with an efficient health-care center, the public or private character of the hospital should not be controlling. Nevertheless, the New York courts have refused to abandon the public-private distinction.[61] Physicians in New York have tried countless legal theories to invoke the courts' protection, but continue to be unsuccessful.[62]

Although the New York courts continue to adhere to this unrealistic distinction, there are signs of a gradual retreat. While refusing to interfere with the discretionary decisions of the private hospitals, the courts have examined, on numerous occasions, their bylaws and internal procedures.[63] This examination has two ele-

[57] *Id.*, 205 N.Y.S. at 557-58.

[58] *Id.* at 208, 205 N.Y.S. at 557.

[59] "They [the hospital's directors] have wide discretion in determining policies, and its exercise in a given matter is not subject to review by the court unless there is clearly error in the performance of a legal duty." *Id.* at 209, 205 N.Y.S. at 557-58.

[60] For recent criticism of the *Van Campen* formulations see *Senate Hearings*, Nov. 5, 1971 (statement of A.E. Gunn, Legislative Committee Chairman, Monroe County Medical Society).

[61] Leider v. Beth Israel Hosp. Ass'n, 33 Misc. 2d 3, 229 N.Y.S.2d 134 (Sup. Ct. 1960), *aff'd*, 13 App. Div. 2d 746, 216 N.Y.S.2d 664 (1st Dep't 1961), *aff'd*, 11 N.Y.2d 205, 182 N.E.2d 393, 227 N.Y.S.2d 900 (1962); Manczur v. Southside Hosp., 16 Misc. 2d 989, 183 N.Y.S.2d 960 (Sup. Ct. 1959); Zlotowitz v. Jewish Hosp., 193 Misc. 124, 84 N.Y.S.2d 61 (Sup. Ct. 1948), *aff'd*, 277 App. Div. 974, 100 N.Y.S.2d 226 (1st Dep't 1950).

[62] Halberstadt v. Kissane, 51 Misc. 2d 634, 273 N.Y.S.2d 601 (Sup. Ct. 1966), *aff'd*, 31 App. Div. 2d 568, 294 N.Y.S.2d 841 (3d Dep't 1968) (presence of federal and public funding); Leider v. Beth Israel Hosp. Ass'n, 33 Misc. 2d 3, 229 N.Y.S.2d 134 (Sup. Ct. 1960), *aff'd*, 13 App. Div. 2d 746, 216 N.Y.S.2d 664 (1st Dep't 1961), *aff'd*, 11 N.Y.2d 205, 182 N.E.2d 393, 227 N.Y.S.2d 900 (1962) (hospital bylaws created a contractual right); Manczur v. Southside Hosp., 16 Misc. 2d 989, 183 N.Y.S.2d 960 (Sup. Ct. 1959) (third party beneficiary of contract between hospital and medical staff); Loewinthan v. Beth David Hosp., 9 N.Y.S.2d 367 (Sup. Ct. 1938) (action for malicious injury).

[63] Shiffman v. Manhattan Eye, Ear & Throat Hosp., 35 App. Div. 2d 709, 314 N.Y.S.2d 823 (1st Dep't 1970); Halberstadt v. Kissane, 51 Misc. 2d 634, 273 N.Y.S.2d 601 (Sup. Ct. 1966), *aff'd*, 31 App. Div. 2d 568, 294 N.Y.S.2d 841 (3d Dep't 1968); Leider v. Beth Israel Hosp. Ass'n, 33 Misc. 2d 3, 229 N.Y.S.2d 134 (Sup. Ct. 1960), *aff'd*, 13 App. Div. 2d 746, 216 N.Y.S.2d 664 (1st Dep't 1961), *aff'd*, 11 N.Y.2d 205, 182 N.E.2d 393, 227 N.Y.S.2d 900 (1962).

ments: (*1*) the court questions whether the hospital has properly followed its own procedures; (*2*) the court questions the reasonableness of the procedures.

With respect to the first element of the examination of private hospitals' internal procedures, the court seeks to protect the physician from arbitrary action by the hospitals in their application of their own bylaws.[64] Therefore, if the hospital's procedures require a hearing, the physician must be granted one.[65] Concomitantly, if a hearing is not guaranteed, the court will not interfere with the discretion of the hospital to refuse one.[66] However, the requirement of a hearing would seem to have much impact today due to the standards of the Joint Commission on Accreditation of Hospitals. These guidelines require detailed procedural protection for the physician, including the right to a hearing.[67]

In considering the second element, the court performs a balancing function in seeking to keep the private hospital in its insulated position, but at the same time trying to assure that a physician is not unreasonably excluded. In *Kurk v. Medical Society*[68] the court examined the reasonableness of a regulation excluding osteopaths from the county medical society, a private organization. Membership in the society was a prerequisite to membership on a nearby hospital staff.[69] Although concluding that the regulation was consistent with state policy, the court recognized that if the physician was in a position of economic necessity due to the monopolistic position of the society, a cause of action would exist.[70] There is no sound explanation why this same reasoning cannot be

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[64] However, this applies only to the bylaws of the hospital, not to bylaws promulgated by the medical staff in their independent capacity. Manczur v. Southside Hosp., 16 Misc. 2d 989, 183 N.Y.S.2d 960 (Sup. Ct. 1959).

[65] Gluck v. Lenox Hill Hosp. (Sup. Ct.), in 153 N.Y.L.J., April 26, 1965, at 17, col. 3.

[66] Leider v. Beth Israel Hosp. Ass'n, 33 Misc. 2d 3, 5, 229 N.Y.S.2d 134, 136 (Sup. Ct. 1960), *aff'd*, 13 App. Div. 2d 746, 216 N.Y.S.2d 664 (1st Dep't 1961), *aff'd*, 11 N.Y.2d 205, 182 N.E.2d 393, 227 N.Y.S.2d 900 (1962). The court set forth a narrow standard for intervention:

> A board of trustees of a private, voluntary hospital . . . is charged only with the duty of exercising best judgment, and the board cannot be controlled in the reasonable exercise and performance of that duty. The members have wide discretion in the exercise of their judgment, and equity will not attempt to correct errors of judgment absent manifest failure in the performance of a legal duty.

Id. at 5-6, 229 N.Y.S.2d at 137.

[67] *See* note 13 and accompanying text *supra*.

[68] 24 App. Div. 2d 897, 264 N.Y.S.2d 859 (2d Dep't 1965), *aff'd*, 18 N.Y.2d 928, 223 N.E.2d 499, 276 N.Y.S.2d 1007 (1966).

[69] *Id.* at 898, 264 N.Y.S.2d at 861.

[70] *Id.*

applied to the private hospital, at least when the physician can show economic hardship.[71]

Finally, the New York courts have maintained the *Van Campen* position, despite changing case law throughout the country, in their treatment of the effect of public funding on the private hospital.[72] The courts have specifically refused to characterize hospitals receiving Hill-Burton funds, Medicare and Medicaid supports, tax exempt status, and other public contributions as participating in state action.[73] The courts have thus foreclosed another possible mode of attack for physicians denied staff privileges in private hospitals.

III

Litigation in the Federal Courts

The physician aggrieved by a denial of staff privileges has one remaining judicial alternative: the federal courts. Jurisdiction in staff privileges cases has normally been based upon 28 U.S.C. § 1343(3),[74] and the cause of action has been based upon 42 U.S.C. § 1983.[75] These statutes relate to deprivations of federal rights, privileges or immunities and, in both instances, it is necessary for

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[71] *See* note 6 *supra*.

[72] *See* notes 77-106 and accompanying text *infra*. See also *Senate Hearings, supra* notes 6 & 60; *Minutes of the 1974 House of Delegates,* Governmental Affairs and Legal Matters, 74 N.Y.S.J. Med. 1236, 1272 (1974), for general recognition of this changing case law by interested persons in New York.

[73] Halberstadt v. Kissane, 31 App. Div. 2d 568, 294 N.Y.S.2d 841 (3d Dep't 1968); Martin v. Catholic Medical Center (Sup. Ct.), in 169 N.Y.L.J., Jan. 12, 1973, at 16, col. 5, *aff'd,* 43 App. Div. 2d 540, 349 N.Y.S.2d 690 (1st Dep't 1973), *aff'd,* 35 N.Y.2d 901, 324 N.E.2d 362, 364 N.Y.S.2d 893 (1974). *See also* Mulvihill v. Julia L. Butterfield Memorial Hosp., 329 F. Supp. 1020 (S.D.N.Y 1971).

[74] This section provides in relevant part:

> The district courts shall have original jurisdiction of any civil action authorized by law to be commenced by any person:
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> . . . .
>
> (3) To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States . . . .

28 U.S.C. § 1343(3) (1970).

[75] This section provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983 (1970).

the physician to prove the requisite "color of state law." This requirement is easily satisfied in the case of a public hospital,[76] but has caused a sharp split among the federal courts when private hospitals are the focus of the dispute.[77]

The basis of the jurisdictional controversy has been the effect of governmental involvement in the form of state and federal regulation, and funding provided under the Hill-Burton program.[78] Some federal courts have stated that the reception of Hill-Burton funds by an otherwise private hospital confers federal jurisdiction and "the obligation to observe Federal Constitutional mandates."[79] A New Hampshire district court has reluctantly recognized that "the weight of authority holds that the acceptance of Hill-Burton funds is sufficient to cloak a private hospital and its medical staff with a mantle of state law."[80] Another group of federal courts has based jurisdiction on substantial governmental involvement in both the regulatory and funding areas.[81] An important factor in these decisions has often been the proportion of the accepted funds to the general operating budget.[82] Finally, one

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[76] It is apparent that in the case of the public hospital state action is present and federal jurisdiction can be readily invoked. *See* Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971); Sosa v. Board of Managers of the Val Verde Memorial Hosp., 437 F.2d 173 (5th Cir. 1971).

[77] *See* notes 78-106 and accompanying text *infra*.

[78] 42 U.S.C. §§ 291-291*o* (1970). See notes 38-41 and accompanying text *supra*, for an explanation of the funding.

[79] Citta v. Delaware Valley Hosp., 313 F. Supp. 301, 307 (E.D. Pa. 1970) (footnote omitted). *See also* Christhilf v. Annapolis Emergency Hosp. Ass'n, Inc., 496 F.2d 174 (4th Cir. 1974); Sams v. Ohio Valley General Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969); Meyer v. Massachusetts Eye & Ear Infirmary, 330 F. Supp. 1328 (D. Mass. 1971).

[80] Bricker v. Sceva Speare Memorial Hosp., 339 F. Supp. 234, 237 (D.N.H.), *aff'd sub nom.* Bricker v. Crane, 468 F.2d 1228 (1st Cir. 1972), *cert. denied*, 410 U.S. 930 (1973) (footnote omitted). However, the court of appeals specifically excluded the district court's ruling on the state action issue from its final decision affirming the holding against the plaintiff physician. 468 F.2d at 1231.

[81] The most important federal regulatory guidelines are set out in the Federal Health Insurance for the Aged Programs (Medicare and Medicaid). Hospital qualification for funds under these programs is contingent upon certain procedures being followed within the institution. These include procedural standards for the medical staff appointment process and guidelines for appointment qualifications. 20 C.F.R. §§ 405.1021, .1023 (1974).

State involvement is embodied in the various state hospital codes regulating licensure of hospitals and internal operating procedures. A comprehensive example is the New York State Hospital Code. *See* notes 136-43 and accompanying text *infra*.

As examples of this group of cases, see O'Neill v. Grayson County War Memorial Hosp., 472 F.2d 1140 (6th Cir. 1973); Chiaffitelli v. Dettmer Hosp., Inc., 437 F.2d 429 (6th Cir. 1971); Suckle v. Madison General Hosp., 362 F. Supp. 1196 (W.D. Wis. 1973), *aff'd*, 499 F.2d 1364 (7th Cir. 1974).

[82] *See, e.g.*, Chiaffitelli v. Dettmer Hosp., Inc., 437 F.2d 429 (6th Cir. 1971), where 14% of the hospital's budget was derived from governmental funds. These statistics were enough

court has considered only the general function of the hospital, rejecting as immaterial the public or private status of the institution.[83]

Conversely, many federal courts in this situation have refused to recognize any basis for federal jurisdiction. On the question of acceptance of Hill-Burton funds, it has been said that this does not create "personal rights or causes of action as such, nor does it confer jurisdiction on federal courts of controversies involving civil or other personal rights."[84] Even in cases where there is significant funding and governmental regulation, jurisdiction has been refused.[85]

The Southern District of New York, the only federal court in the state to consider the problem, has twice declined to accept jurisdiction. In *Mulvihill v. Julia L. Butterfield Memorial Hospital,*[86] the court expressed its view with the following strong language:

> There can be little doubt that the State of New York plays a substantial role in supervising the operations of private hospitals within its borders. . . . [But this] does not make the acts of these hospitals in discharging physicians the acts of the state.[87]

The basis for this general line of reasoning seems to be the lack of causal connection between the state conduct and the resultant wrong to the physician.[88] This reasoning was further articulated in a three-pronged state action test by the Southern District in *Barrett v. United Hospital.*[89] The *Barrett* court held that state action could

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to clothe the hospital with public status. *Id.* at 430. *But see* Ward v. Saint Anthony Hosp., 476 F.2d 671 (10th Cir. 1973), where the hospital received five percent of its total construction costs under the Hill-Burton program, during a 13 year period. The court held that this small percentage was insufficient to invoke federal jurisdiction. *Id.* at 675. In a subsequent case, a hospital had received approximately 30% of its construction costs under the Hill-Burton program during a four year period. However, the court distorted the figures and concluded that the funds received were again insufficient to invoke federal jurisdiction. Ozlu v. Lock Haven Hosp., 369 F. Supp. 285, 286 (M.D. Pa. 1974).

[83] Duffield v. Memorial Hosp. Ass'n, 361 F. Supp. 398 (S.D.W. Va. 1973), *aff'd*, 503 F.2d 512 (4th Cir. 1974). The court specifically stated that "[t]he public or private status of the hospital . . . is not considered material." *Id.* at 401 n.2.

[84] Don v. Okmulgee Memorial Hosp., 443 F.2d 234, 235 (10th Cir. 1971).

[85] Mulvihill v. Julia L. Butterfield Memorial Hosp., 329 F. Supp. 1020 (S.D.N.Y. 1971); Ozlu v. Lock Haven Hosp., 369 F. Supp. 285 (M.D. Pa. 1974).

[86] 329 F. Supp. 1020 (S.D.N.Y. 1971).

[87] *Id.* at 1023.

[88] *Id.*; *see also* Ward v. Saint Anthony Hosp., 476 F.2d 671 (10th Cir. 1973); Hoberman v. Lock Haven Hosp., 377 F. Supp. 1178 (M.D. Pa. 1974).

[89] 376 F. Supp. 791 (S.D.N.Y.), *aff'd mem.*, 506 F.2d 1395 (2d Cir. 1974). The prerequisites for a finding of state action are:

(1) that the state's involvement with the private institution is "siguificant," (2) "that

not be present "in the absence of a nexus between the governmental function performed and the violative activity alleged."[90] Therefore, because the denial of the privileges was entirely that of the hospital and was "in no way fostered, approved or encouraged"[91] by the state, the test was not satisfied.[92]

The *Mulvihill* court analogized the staff privileges situation to the expulsion of a student from a private school.[93] However, this comparison fails to recognize the basic health-care function of the hospital and the severe impact on the physician.[94] The private school serves as an alternative means of education, whereas the private hospital, in many communities, is the only facility of its kind. Although the expelled student may reenter the public schools, the physician without privileges will be professionally crippled and may be forced to relocate his practice.[95] Both the student and the physician will be

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> the state must be involved not simply with *some* activity of the institution . . . but with the activity that caused the injury" . . . (3) that the state's involvement must aid, encourage or connote approval of the complained of activity.

Id. at 797. (emphasis in original, footnotes omitted). The court further detailed two situations where there is a departure from strict adherence to the tests: racial discrimination and public function cases. The former was inapplicable and the court believed that the latter was not satisfied because the private hospital did not perform a traditionally governmental function. *Id.* at 797-99.

[90] *Id.* at 799 (footnote omitted). This finding was made despite allegations by the plaintiff that the hospital was performing a public function, accepted significant Hill-Burton funding and tax exemptions, was extensively regulated by a pervasive statutory scheme, and was the only facility in a large geographic area. *Id.* at 796. The court specifically rejected any notion that the geographic monopoly migbt give the hospital a quasi-public status. *Id.* at 799. *Contra,* Greisman v. Newcomb Hosp., 76 N.J. Super. 149, 156-57, 183 A.2d 878, 882-83 (L. Div. 1962), *aff'd,* 40 N.J. 389, 192 A.2d 817 (1963).

[91] 376 F. Supp. at 805. *But see* Aasum v. Good Samaritan Hosp., 395 F. Supp. 363 (D. Ore. 1975), where, in a similar situation, the court concluded that state action existed within the confines of the three-prong *Barrett* test. Both courts rejected many of the same factors as a basis for state action. *Compare Id.* at 367-69 *with* note 90 *supra.* However, the *Aasum* court concluded that the presence of specific regulations promulgated by a state board of medical examiners established the necessary nexus. 395 F. Supp. at 369. Although the court went on to conclude that the existing discrimination was justified under the fourteenth amendment, the utilization of a state medical board, a very common regulatory body, as a basis for federal jurisdiction, could bave far-reaching impact on future staff privileges decisions.

[92] The court also considered the impact of N.Y. PUB. HEALTH LAW § 2801-b (McKinney Supp. 1974). Although the plaintiff could not avail bimself of the law's protection because he was denied privileges 12 days before the law became effective, the court again refused to find any state action based on the presence of the law:

> [T]he mere fact that the state has legislated in the area of the conduct complained of does not in and of itself constitute sufficient participation to be appropriately denominated "state action".

376 F. Supp. at 805.

[93] 329 F. Supp. at 1024.

[94] *See* notes 5-6 and accompanying text *supra.*

[95] *See* note 6 *supra.*

stigmatized, but the burden and the costs of relocating will far outweigh those of reentering the public school.

The attitude of those federal courts denying jurisdiction in staff privileges cases was recently buttressed by the Health Programs Extension Act of 1973.[96] The purpose of the Act was to extend a group of expiring health programs, among them Hill-Burton funding, and to give the Congress a reasonable time to consider the programs' merits and future needs.[97] In response to the growing controversy over hospital freedom to make facilities available for abortions and sterilization procedures, the Congress specifically limited the courts' power to require a hospital to perform these operations, premised on the receipt of federal funds under the Act.[98] The stated congressional purpose was to provide that

> receipt of financial assistance under any of the aforementioned Acts does not constitute legal basis for a judicial or administrative order . . . . requiring the provision of personnel or facilities by any entity for the performance of sterilization or abortion . . . .[99]

Congress also provided that hospitals receiving such funds could not discriminate in the granting of staff privileges for any reasons relating to the performance of, or refusal to perform, abortions or sterilization operations by a physician applicant.[100]

These provisions are confined solely to controversies involving the use of hospital facilities and discrimination against physicians related to abortion and sterilization operations. There is no evidence that Congress intended to circumscribe the discretion of the federal courts in all staff privileges cases when considering the factors necessary to determine the "color of state law" jurisdictional prerequisite.[101] However, in two cases admittedly involving

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[96] Health Programs Extension Act of 1973, Pub. L. No. 93-45, 87 Stat. 91 (June 18, 1973).

[97] H.R. REP. No. 227, 93d Cong., 1st Sess. 4 (1973).

[98] 42 U.S.C. § 300a-7 (Supp. III 1973).

[99] H.R. REP. No. 227, *supra* note 97, at 15.

[100] 42 U.S.C. § 300a-7(b) (Supp. III 1973). See notes 102-04 and accompanying text *infra*, for additional discussion of this section.

[101] There is no one specific test for this determination. However, the state court in Adler v. Montefiore Hosp. Ass'n, 453 Pa. 60, 311 A.2d 634 (1973), *cert. denied*, 414 U.S. 1131 (1974), articulated a two-pronged test for determining state action consistent with the guidelines of Burton v. Wilmington Parking Authority, 365 U.S. 715 (1961). The first situation in which state action exists is where a

> hospital which receives funds in large measure from public sources and through public solicitation, receives tax benefits by reason of its nonprofit and nonprivate character, and holds a virtual monopoly in the area it serves.

abortion-related controversies, the courts made broad, unsupported statements that they were prohibited from finding state action in any situation based upon the acceptance of Hill-Burton funds.[102] Furthermore, although it is unclear from the opinion, it seems that the physician in *Watkins v. Mercy Medical Center*[103] was denied staff privileges solely because he desired to perform abortions at hospitals other than the Mercy Medical Center. The court disregarded the congressional mandate specifically prohibiting this type of discrimination and inaccurately characterized the physician's position as a demand that Mercy Medical Center's facilities be made available for the performance of abortions, thereby according the hospital protection under the Act.[104]

It is clear that the federal courts have failed to provide uniform guidelines to deal with jurisdictional controversies in this area. In New York, the only federal court to consider the staff privileges problem has aligned itself with those that refuse to grant jurisdiction.[105] However, due to the ever-changing state of the law in the federal courts, and the current trend toward according the private hospital a quasi-public status,[106] it is important that the New York physician be cognizant of the treatment of the staff privileges cases in the federal courts that have accepted jurisdiction.

The basic premise for judicial scrutiny of the staff privileges

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453 Pa. at 70, 311 A.2d at 639-40. The second independent situation occurs when a hospital "receives construction funds from the federal government and participates generally in the benefits available under the Hill-Burton Act." *Id.* at 71, 311 A.2d at 640. A federal district court in New York has utilized a three-prong test. *See* note 89 *supra*.

[102] Taylor v. Saint Vincent's Hosp., 369 F. Supp. 948 (D. Mont. 1973); Watkins v. Mercy Medical Center, 364 F. Supp. 799 (D. Idaho 1973). *But see* Ozlu v. Lock Haven Hosp., 369 F. Supp. 285 (M.D. Pa. 1974), where the court fails to find state action but makes no mention of 42 U.S.C. § 300a-7.

[103] 364 F. Supp. 799 (D. Idaho 1973).

[104] *Id.* at 801.

[105] Barrett v. United Hosp., 376 F. Supp. 791 (S.D.N.Y.), *aff'd mem.*, 506 F.2d 1395 (2d Cir. 1974); Mulvihill v. Julia L. Butterfield Memorial Hosp., 329 F. Supp. 1020 (S.D.N.Y. 1971). It is also interesting to note that the area encompassed by the Southern District, *i.e.*, New York City, is the area in the state where the staff privileges problem is most acute. In 1971, the Commissioner of the New York City Department of Health stated that between 20 and 30% of licensed physicians in New York City did not have staff privileges. *Senate Hearings, supra* note 6. *See also* note 150 *infra*.

[106] Silver v. Castle Memorial Hosp., 53 Haw. 475, 497 P.2d 564, *cert. denied*, 409 U.S. 1048 (1972) provides the best explanation of this general trend. The court recognized that patients are the primary concern of hospitals. Therefore, although the hospital is still private in the non-governmental sense, once there is nominal government involvement in the form of funding, the hospital's power to process staff applications becomes fiduciary and subject to judicial review. *Id.* at 482, 497 P.2d at 570. *See also* note 72 and accompanying text *supra*.

process can be found in *Schware v. Board of Bar Examiners.*[107] Although the Supreme Court has held that a physician has no constitutional right to practice medicine in a hospital,[108] in *Schware* the Court stated:

> A State cannot exclude a person from the practice of law or from any other occupation in a manner or for reasons that contravene the Due Process or Equal Protection Clause of the Fourteenth Amendment.[109]

Furthermore, it is apparent that fourteenth amendment freedoms include the right of an individual to engage in any occupation free from unreasonable interference "under the guise of protecting the public interest," but which, in fact, has no relation to a purpose "within the competency of the State to effect."[110] Therefore, once a hospital has been characterized as acting under "color of state law" these guidelines must apply.

Although many federal courts have accepted jurisdiction of staff privileges cases, they have remained hesitant to review the discretionary hospital decisions.[111] This hesitancy reflects the belief that the previously rendered peer review of a physician is a more accurate evaluation than any judgment that could be made by a court.[112] In cases involving controversies over professional competency, the court will give considerable weight to the findings of the hospital.

The key issue litigated in the federal courts has been the due process rights of the physician,[113] involving predominantly the physician's right to a hearing and his right to be confronted by the evidence against him. A Pennsylvania district court has held that a hearing must be afforded at some point during the process of revocation or suspension of privileges.[114] However, the Court of Appeals for the Tenth Circuit has recognized that the state of the

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[107] 353 U.S. 232 (1957).

[108] Hayman v. Galveston, 273 U.S. 414, 416-17 (1927).

[109] 353 U.S. at 238-39 (footnote omitted).

[110] Meyer v. Nebraska, 262 U.S. 390, 400 (1923).

[111] Sosa v. Board of Managers of the Val Verde Memorial Hosp., 437 F.2d 173, 177 (5th Cir. 1971) (limited judicial surveillance); Williams v. Robinson, 432 F.2d 637, 641 (D.C. Cir. 1970) (strictly limited).

[112] Suckle v. Madison General Hosp., 362 F. Supp. 1196, 1209 (W.D. Wis. 1973), *aff'd*, 499 F.2d 1364 (7th Cir. 1974); Sosa v. Board of Managers of the Val Verde Memorial Hosp., 437 F.2d 173, 177 (5th Cir. 1971).

[113] For recent considerations of this issue, see Poe v. Cbarlotte Memorial Hosp., Inc., 374 F. Supp. 1302 (W.D.N.C. 1974) and Note, *Denial of Hospital Staff Privileges: Hearing and Judicial Review,* 56 IOWA L. REV. 1351 (1971).

[114] Citta v. Delaware Valley Hosp., 313 F. Supp. 301, 308-09 (E.D. Pa. 1970).

law on this question is unsettled.[115] The case before the Tenth Circuit involved an initial denial of staff privileges and the court ruled that although a hearing was not necessary, the physician was "entitled to overall fairness and a good faith consideration of his qualification and background."[116] In other similar situations, federal courts have ordered the hospitals to conduct a hearing when a case was still at the pretrial stage.[117]

Another aspect of the due process issue has been the composition of the hearing board, that is, whether persons who have previously considered the evidence may participate in the ultimate hearing. There has been no specific ruling on the issue, but one court has held that the tribunal must be impartial.[118] In general, it has been said that the decision-making process need not be "as antiseptic in this context [of staff privileges decisions] as it is required to be, for example, in a criminal prosecution."[119]

The standards used to evaluate due process in staff privileges cases are flexible. Although each case has been judged on the specific fact situations involved, the necessary components can best be summarized in the following manner:

> Due process normally requires that [the hospital] give advance notice of the charges in sufficient detail to permit intelligent response, and allow the accused doctor full *opportunity* to *appear and be heard,* to question and cross-examine adverse witnesses and accusers, to challenge the accusations of wrong doing, and to present evidence in his own behalf.[120]

Therefore, it would seem that once a physician can successfully invoke federal jurisdiction, he will be accorded considerable due process protection by the courts. This protection should enable the physician to defend his position in the overall context of a fair decision-making process.

IV

Legislation in New York

Applicable legislation can be examined in two separate categories. First, the state possesses a series of laws regulating the

[115] Don v. Okmulgee Memorial Hosp., 443 F.2d 234 (10th Cir. 1971).

[116] *Id.* at 238.

[117] Schooler v. Navarro County Memorial Hosp., 375 F. Supp. 841 (N.D. Tex. 1973); Duffield v. Memorial Hosp. Ass'n, 361 F. Supp. 398 (S.D.W. Va. 1973), *aff'd,* 503 F.2d 512 (4th Cir. 1974).

[118] Woodbury v. McKinnon, 447 F.2d 839, 844 (5th Cir. 1971).

[119] Suckle v. Madison General Hosp., 362 F. Supp. 1196, 1210 (W.D. Wis. 1973), *aff'd,* 499 F.2d 1364 (7th Cir. 1974).

[120] Poe v. Charlotte Memorial Hosp., Inc., 374 F. Supp. 1302, 1310-11 (W.D.N.C. 1974) (emphasis in original).

practice of medicine and the operation of hospitals.[121] Second, legislation dealing specifically with staff privileges controversies has been enacted.[122] An examination of each category follows.

A. *Medical Licensure*

In New York, the power to issue professional licenses is vested in the department of education.[123] Issuance of licenses is supervised by the state board of regents, which in turn appoints a state board of medicine to assist it.[124] Included as part of the statutory guidelines is a list of qualification requirements.[125] These criteria are very general in nature and, with respect to the applicant's experience and character, are determined by vague, subjective standards.[126]

Some states use similar medical licensure proceedings as a basis for providing the physician with a right to hospital staff privileges.[127] For example, Indiana provides that a licensed physician is eligible for staff privileges at any hospital, whether public or private.[128] Although the hospital is granted the power to make reasonable rules and regulations, in the case of a county-supported facility the burden of proof is on the institution to justify the regulations.[129]

However, possession of a medical license should not be the sole criterion for determining eligibility for staff privileges. In New York, possession of a medical license confers a life-long privilege on the licensee to practice the profession in the state, unless the license is revoked, annulled, or suspended by the board of regents.[130] Furthermore, there is no requirement of reevaluation to maintain the validity of the license, but only a requirement of biennial registration with the department of education.[131] Thus,

[121] N.Y. EDUC. LAW §§ 6500-28 (McKinney 1972 & Supp. 1974); N.Y. PUB. HEALTH LAW §§ 2800-10 (McKinney 1971 & Supp. 1974).

[122] *See* notes 144-93 and accompanying text *infra*.

[123] N.Y. EDUC. LAW § 6504 (McKinney 1972).

[124] *Id.* §§ 6504, 6523.

[125] *Id.* § 6524. For a thorough discussion of these requirements see Quirin, *Physician Licensing and Educational Obsolescence: A Medical-Legal Dilemma,* 36 ALBANY L. REV. 503 (1972).

[126] The applicant must "be of good moral character" and have "experience satisfactory" to the state board of medicine. N.Y. EDUC. LAW § 6524 (McKinney 1972). *See also* 8 N.Y.C.R.R. §§ 28.1-.6.

[127] *See* IND. ANN. STAT. § 16-12.1-5-1 (Burns 1973); S.D. COMPILED LAWS ANN. § 34-8-8 (1972). *Contra,* MINN. STAT. ANN. § 147.23 (1970).

[128] IND. ANN. STAT. § 16-12.1-5-1 (Burns 1973).

[129] *Id.* §§ 16-12-23-1, -12.1-5-1 (Burns 1973).

[130] N.Y. EDUC. LAW § 6502 (McKinney 1972).

[131] *Id.*

since revocation procedures are rare,[132] the state does not vouch for the continuing competence of the practitioner, but only sets a minimum standard.[133]

Once it is recognized that possession of a state license is not commensurate with a continuing high level of medical competence, it is evident that the license alone should not guarantee staff privileges.[134] The hospital must have the ability to promulgate additional rules and regulations to determine the eligibility for staff privileges.[135] The inquiry into professional competence cannot be limited to the possession of a license, although the license may provide prima facie evidence of competence.

B. *Hospital Regulation*

Related to the regulation of physicians' licenses is the regulation of hospital operations within the state. Under article 28 of the New York Public Health Law, the state department of health has the "central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital[s]."[136] This regulatory power specifically includes both public and private hospitals within the state.[137] Article 28 provides general guidelines for the hospitals, but more specific regulations are contained in the State Hospital Code.[138] These regulations provide guidelines for all internal operating procedures, including the organization and administration of the medical staff.[139]

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[132] Generally speaking, because disciplining by way of revocation or suspension is a drastic measure, it is resorted to infrequently. Quirin, *supra* note 125, at 507.

[133] *Compare* Dunbar v. Hospital Authority of Gwinnett County, 227 Ga. 534, 540, 182 S.E.2d 89, 93 (1971); Rao v. Board of County Comm'rs, 80 Wash. 2d 695, 699, 497 P.2d 591, 593, *cert. denied,* 409 U.S. 1017 (1972), *with* Silver v. Castle Memorial Hosp., 53 Haw. 475, 487-88, 497 P.2d 564, 573, *cert. denied,* 409 U.S. 1048 (1972) (concurring opinion); Porter Memorial Hosp. v. Harvey, 279 N.E.2d 583, 590 (Ind. Ct. App. 1972). In the latter two cases, the courts determined that state licensure evidenced a legislative intent to set the standard of competency for physicians and thereby preempted a hospital's power to consider different standards.

[134] Dunbar v. Hospital Authority of Gwinnett County, 227 Ga. 534, 182 S.E.2d 89 (1971).

[135] *See* notes 147-53 and accompanying text *infra. See also Senate Hearings,* Sept. 24, 1971 (statements of Hospital Association of New York State and M.C. McLaughlin, Commissioner, New York City Department of Health).

[136] N.Y. PUB. HEALTH LAW § 2800 (McKinney 1971). Specifically, no hospital can be established in the state without written approval of the Public Health Council. *Id.* § 2801-a. But see N.Y. Times, March 31, 1975, at 1, col. 1, for an example of the practical problems faced in controlling hospitals in the state.

[137] N.Y. PUB. HEALTH LAW § 2800 (McKinney 1971).

[138] 10 N.Y.C.R.R. §§ 700.1-782.14. The authority for promulgating these rules is found in N.Y. PUB. HEALTH LAW § 2800 (McKinney 1971) and N.Y. EXEC. LAW § 102 (McKinney 1972).

[139] 10 N.Y.C.R.R. §§ 720.1-724.2.

The State Hospital Code provides comprehensive rules governing the application procedure for staff privileges.[140] The Code specifically requires that a due process mechanism be available for physicians denied initial appointment or subsequent reappointment.[141] Furthermore, the Code incorporates the standards of the Joint Commission on Accreditation of Hospitals by requiring that the hospital bylaws be consistent with those standards.[142]

At first glance, the State Hospital Code would seem to provide adequate protection for any physician involved in a staff privileges controversy. However, the recurrent problems faced by physicians in the staff privileges area reveal that these guidelines can be easily circumvented. This is often accomplished by the monopolistic practices implemented by those physicians in controlling positions. It has been alleged that these physicians have the ability to delay unreasonably staff applications and often to cast deciding votes on applicants who will be their eventual competitors.[143]

C. *Staff Privileges Legislation*

The first legislative attempt to regulate hospital staff privileges in New York occurred in 1963. The legislature passed Section 206-a of the Public Health Law making it an "unlawful discriminatory practice" to base a denial of staff privileges on "participation [by the physician] in any medical group practice or non-profit health insurance plan authorized by the laws of the state . . . ."[144] Section 206-a, although limited in its application, provides a comprehensive scheme for dealing with alleged violations.[145] The department of health is granted extensive powers to

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[140] *Id.* §§ 720.1, .5(6), 721.1.

[141] *Id.* § 720.1(c)(3).

[142] *Id.* § 721.1(c). The impact of the J.C.A.H. is apparent throughout the Code. An application for an operating certificate must include a statement as to whether the institution is accredited by the J.C.A.H. (*Id.* § 701.1(a)), therefore implying that this may be a factor in the department's consideration. Furthermore, the department must be notified as to any change in the status of J.C.A.H. accreditation. *Id.* § 720.4.

[143] These allegations were voiced by physicians in testimony given before the state Senate Committee on Health. NEW YORK STATE SENATE COMMITTEE ON HEALTH, REPORT OF ACTIVITIES 12-13 (Dec. 31, 1971) [hereinafter cited as SENATE REPORT].

[144] N.Y. PUB. HEALTH LAW § 206-a(1) (McKinney 1971). This includes action by the hospital to deny or withhold the privileges, or to exclude, expel, curtail, terminate, or diminish the privileges.

[145] A deputy commissioner of the department of health is granted the power to conduct an investigation of the situation upon the receipt of a duly verified complaint. *Id.* §§ 206-a(2), (3). If this investigation results in a finding of probable cause, the complaint is credited and the deputy commissioner seeks to eliminate the problem by "conference, conciliation and persuasion." *Id.* § 206-a(3). If settlement cannot be reached, a formal hearing is conducted. *Id.* § 206-a(4). A finding that the hospital has violated the section

investigate complaints and to resort to judicial enforcement if necessary.[146] Although the physician is accorded a thorough method of review and protection, the limited application of section 206-a minimizes its value.

In 1971, the state Senate faced the problem of hospital staff privileges discrimination in broad, general terms. In response to complaints of arbitrary discrimination against qualified physicians within certain medical specialties, a bill was proposed to establish concrete guidelines in the granting of hospital staff privileges.[147] These guidelines were limited to "public, objective standards, based on professional competence."[148] The enforcement mechanism in the proposed law closely paralleled that in section 206-a.[149]

Introduction of this bill signified legislative recognition that hospital discrimination was an identifiable problem in New York[150] and that the courts were not providing a satisfactory avenue for its resolution.[151] The proposed legislation sought to correct the problem by premising the privileges on narrow standards of competency and by providing a strong enforcement mechanism vested with the power to correct any discriminatory situation.[152]

results in a cease and desist order issued by the department of health. *Id.* § 206-a(6). The statute also provides for judicial review of the final order and mandates that "[t]he findings of the hearing officer as to the facts shall be conclusive if supported by substantial evidence on the record considered as a whole." *Id.* § 206-a(10).

There are additional procedural guidelines applicable only to § 206-a included in the State Hospital Code. 10 N.Y.C.R.R. §§ 95.1-.12.

[146] N.Y. PUB. HEALTH LAW § 206-a(10) (McKinney 1971).

[147] (1971) Sen. Int. No. 5610 (Mr. Langley). *See* SENATE REPORT 9.

[148] (1971) Sen. Int. No. 5610, § 2 (Mr. Langley).

[149] *Compare id.* §§ 7-11 *with* notes 144-46 and accompanying text *supra*.

[150] In 1971, as many as 30% of New York City-area physicians were without staff privileges, albeit a small minority of those were by choice. *Senate Hearings, supra* note 6. In the Albany area, although all physicians had privileges at a minimum of one hospital, there was evidence that monopolistic practices had effectively excluded many physicians from the most prestigious hospital in the area. SENATE REPORT at 12-13. But see *Senate Hearings,* Nov. 5, 1971 (statements of A.E. Gunn, Legislative Committee Chairman of Monroe County Medical Society and R.L. Scheer, Onondaga County Medical Society), indicating that discriminatory practices are not present in the upstate area.

[151] Legislation as a necessary protection was a theme sounded throughout the hearings. *See Senate Hearings, supra* notes 6 & 60 and letter from E.D. Pellegrino, *supra* note 7. But see *Senate Hearings,* Nov. 5, 1971 (statement of R.L. Scheer, Onondaga County Medical Society) and Dec. 7, 1971 (statement of the Medical Society of the State of New York) where the necessity of legislation was questioned.

[152] The proposal included provisions for detailed investigatory proceedings after a physician had claimed that he was aggrieved by unlawful hospital practices. (1971) Sen. Int. No. 5610 §§ 3-9 (Mr. Langley). Upon the culmination of the investigation and a finding that the hospital had, in fact, violated the law, the commissioner of the department of health was empowered to issue a cease and desist order. *Id.* § 7. To assure ultimate compliance with the law, the commissioner was further empowered to obtain court enforcement of this order. *Id.* § 11.

The bill met substantial opposition because of the proposed limitation on the hospitals' ability to determine standards for the granting of staff privileges. Much of the criticism directed at the bill's restriction of discretion was voiced by those in favor of some form of staff privileges legislation.[153] Other opponents were severely critical of the potential ability of physicians to obtain unlimited, multiple staff appointments.[154] It was contended that multiple appointments would bave two damaging effects: the inability of the physician to meet the demands of numerous hospitals,[155] and the potential overstaffiing of certain hospitals.[156]

Additional criticism focused upon the lack of special treatment for teaching hospitals[157] and the general feeling that statewide legislation was unnecessary.[158] It was also argued that since the

[153] *Senate Hearings, supra* note 6. A recurrent theme was that the required public, objective standards could not be the sole criteria for granting privileges. *Id.*, Dec. 7, 1971 (statements of E.G. Gooby, Administrator, St. Luke's Hospital, Newburgh and of the Medical Society of the State of New York). The fear expressed was that a hospital would be unable to deny privileges to a state-licensed physician because the state board of medicine had previously set down public, objective standards of competence. *Id.* (statement of T.L. Hawkins, Director, Albany Medical Center); *see also* note 127 and accompanying text *supra*. This would endanger the ultimate goal of providing optimal health-care to the public. *See* notes 130-35 and accompanying text *supra*.

[154] Letter from E.D. Pellegrino, *supra* note 7. Multiple staff appointments appeared possible if the hospitals would be unable to deny privileges to any competent physician. However, this fails to recognize that minimization of appointments could be considered when determining public, objective standards of competence.

[155] Staff privileges are not limited to the use of hospital facilities, but require the physician to accept certain responsibilities in the hospital. *See, e.g., Senate Hearings, supra* note 6. At some point, it is unlikely that a physician would be able to meet the demands imposed by numerous hospitals, indirectly endangering the quality of care in a specific hospital. Letter from E.D. Pellegrino, *supra* note 7. It has been argued that this possibility militates in favor of some form of geographic limitation, requiring a community of interest between the physician seeking staff privileges and the hospital. *Id. See also Senate Hearings,* Dec. 7, 1971 (statement of T.L. Hawkins, Director, Albany Med. Center).

[156] Overstaffing is likely to occur once the physician is assured of privileges at any hospital he desires. Physicians would gravitate to the better equipped, more prestigious hospitals, at the expense of the smaller hospitals. This could result in a severe maldistribution of available health care, precluding efficient, quality care to the public. *Senate Hearings,* Sept. 24, 1971 (statement of R. Lawrence, President, N.Y. State Society of Anesthesiologists); *Id.*, Dec. 7, 1971 (statement of Sister E. Lawlor, Exec. Director, St. Peter's Hospital, Albany). The consequences of overstaffing have been characterized as "at least as adverse to quality care as improper denial of [staff] privileges." *Senate Hearings,* Dec. 7, 1971 (statement of the Medical Society of the State of New York).

[157] *See Senate Hearings, supra* note 6; *Id.*, Nov. 5, 1971 (statement of D. Oken, Chrmn., Department of Psychiatry, Upstate Medical Center); Letter from C.A. Ashley, Director, Mary Imogene Basset Hospital, Cooperstown to State Senator Tarky Lombardi, Jr., Nov. 15, 1971, on file at the *Cornell Law Review*.

[158] *Senate Hearings*, Sept. 24, 1971 (statement of The Rev. Monsignor C. Kane, Director, Division of Health and Hospitals, Catholic Charities of the Archdiocese of New York); *Id.*, Dec. 7, 1971 (statement of Sister E. Lawlor, Director, St. Peter's Hospital, Albany).

Joint Commission on Accreditation of Hospitals had recently established new guidelines for the granting of staff privileges, these guidelines should be allowed to operate without interference and should be given the opportunity to remedy the problem.[159] The cumulative effect of these criticisms led to a conclusion by the State Senate Committee on Health that the legislative proposal based on public, objective standards of competence would be no more effective than the new Joint Commission guidelines; both could be easily circumvented.[160] However, the Committee recognized the need for an appeal board that would provide protection for physicians, but would not establish limiting guidelines for criteria in the granting of privileges.[161]

As a direct result of the 1971 Health Committee hearings, New York Senator Tarky Lombardi, Jr. proposed a bill in 1972, which incorporated the Committee's recommendation for an appeal mechanism.[162] The bill sought to establish an independent review board under the auspices of the Public Health Council.[163] The declared purpose of the board was to "allow both parties to present their cases . . . in an informal and completely confidential manner," thereby promoting settlement.[164]

Unlike the previous proposal, the legislation sponsored by Senator Lombardi won the approval of the general consensus of interested parties.[165] Because the 1971 hearings had revealed that discriminatory practices were prevalent in certain areas of the state, the proposal received enthusiastic support in the legislature, resulting in the enactment of section 2801-b of the New York Public Health Law.[166]

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[159] *Senate Hearings,* Dec. 7, 1971 (statements of Hospital Ass'n of New York State and Sister E. Lawlor, Director, St. Peter's Hospital, Albany). *But see Senate Hearings, supra* note 60.

[160] SENATE REPORT 13.

[161] *Id.* at 14.

[162] (1972) Sen. Int. No. 8092-A (Mr. Lombardi). *See* letter from H. Morse, Director, Senate Committee on Health, to the *Cornell Law Review,* Sept. 20, 1974, on file at the *Cornell Law Review. See also* SENATE REPORT 13-14; NEW YORK LEGISLATIVE SERVICE, INC., NEW YORK STATE LEGISLATIVE ANNUAL 1972, at 195 (1972).

[163] Letter from Senator Tarky Lombardi, Jr. to M. Whiteman, Counsel to the Governor, April 17, 1972, on file at the *Cornell Law Review.*

[164] NEW YORK STATE LEGISLATIVE ANNUAL, *supra* note 162.

[165] Letter from H. Morse, *supra* note 162.

[166] The overwhelming support for the action was evidenced by a unanimous vote in the state Senate (195 N.Y. SENATE JOURNAL 306 (1972)), and a near unanimous vote in the state assembly (195 N.Y. Assembly Journal 1265 (1972) ((1972) Assy. Int. No. 9256-A (Ms. Cook))).

N.Y. PUB. HEALTH LAW § 2801-b (McKinney Supp. 1974) provides:

> 1. It shall be an improper practice for the governing body of a hospital to refuse to act upon an application for staff membership or professional privileges or to deny or withhold from a physician, podiatrist or dentist staff membership or

The most obvious difference between the law as enacted and the legislation as proposed in 1971 is the lack of enforcement machinery in the final version. The initial power of the Public Health Council to accept a verified complaint and to conduct an investigation, originally lodged with a deputy commissioner of the department of health, remains intact.[167] However, if the investigation reveals that the physician has a legitimate grievance, the Council's power is limited to crediting the complaint, advising the hospital of its decision, and requesting the hospital to review its files.[168] The Council no longer has the ability to petition the courts

professional privileges in a hospital, or to exclude or expel a physician, podiatrist or dentist from staff membership in a hospital or curtail, terminate or diminish in any way a physician's, podiatrist's or dentist's professional privileges in a hospital, without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant.

2. Any person claiming to be aggrieved by an improper practice as defined in this section may, by himself or his attorney, make, sign and file with the public health council a verified complaint in writing which shall state the name and address of the hospital whose governing body is alleged to have committed the improper practice complained of and which shall set forth the particulars thereof and contain such other information as may be required by the council.

3. After the filing of any such complaint, the public health council shall make a prompt investigation in connection therewith. In conducting such investigation, the public health council is authorized to receive reports from the governing body of the hospital and the complainant, as the case may be, and the furnishing of such information to the public health council, or by the council to the governing body or complainant, shall not subject any person or hospital to any action for damages or other relief. Such information when received by the public health council, or its authorized representative, shall be kept confidential and shall be used solely for the purposes of this section and the improvement of the standards of patient care and patient welfare. The records of such proceedings shall not be admissible as evidence in any other action of any kind in any court or before any other tribunal, board, agency, or person. If the council shall determine after such investigation that cause exists for crediting the allegations of the complaint, the council shall promptly so advise the governing body of the hospital against which the complaint was made, and shall direct that such governing body make a review of the actions of such body in denying or withholding staff membership or professional privileges from the complainant physician, podiatrist or dentist or in excluding or expelling such physician, podiatrist or dentist from staff membership or in curtailing, terminating or in any way diminishing such physician's, podiatrist's or dentist's professional privileges in the hospital.

4. The provisions of this section shall not be deemed to impair or affect any other right or remedy.

In 1973, the Virginia legislature enacted a similar statute. VA. CODE ANN. § 32-211.16 (Cum. Supp. 1974). Although the Virginia statutory purpose is identical to that of New York, i.e. prevention of improper hospital practices in the context of staff privileges disputes, the statute does not include the detailed investigatory procedures that are a part of section 2801-b. However, if the State Board of Health finds that a hospital has committed an improper practice, as defined by the statute, then the Board has the power to suspend or revoke the hospital operating license. *Id.* This is one area where section 2801-b is insufficient. *See* notes 170-172 and accompanying text *infra*.

[167] N.Y. PUB. HEALTH LAW §§ 2801-b(2), (3) (McKinney Supp. 1974).

[168] *Id.* § 3. A complaint is formally credited by the Council after a detailed investigatory procedure that includes the evaluation of evidence submitted by both sides. *Id. See also* note

for enforcement of the order.[169] This lack of enforcement power has been the focus of much criticism and renewed calls for stronger legislation.[170] In 1974, an amendment was introduced in the state Assembly to empower the Council to direct a hospital "to provide [a] physician . . . with the next available staff membership or professional privileges arising within such physician's . . . profession, field of specialization and/or department in such hospital."[171] However, the proposed amendment never reached the floor of the legislature for a vote.[172] Despite these criticisms, the chairman of the Public Health Council has expressed his belief that the law is accomplishing its purpose through a deterrent effect on the hospitals.[173]

Two apparent advantages of the law are its initiation of "a mechanism for dialogue and input from a disinterested, therefore, objective third party," and its ability to reduce prolonged legal proceedings.[174] During the first two years of the statute's existence, sixteen complaints have been filed with the Council.[175] Some of these complaints have involved physicians denied initial appointment to hospital staffs.[176] This group of physicians had never before attempted to utilize the judicial forum as a means of solving their problem in New York. They had previously been hesitant to become involved in litigation and publicize their problem to a potential patient population.[177] Instead, it was easier to relocate a new practice or to seek privileges at another hospital within the

174 *infra*. The statute requires that there be *cause* to credit the complaint. N.Y. PUB. HEALTH LAW § 2801-b(3) (McKinney Supp. 1974).

169 *See* note 146 and accompanying text *supra*. Although N.Y. PUB. HEALTH LAW § 2801-c (McKinney Supp. 1974) does provide that the courts can enjoin any violations of article 28 when requested to do so by the Public Health Council, this would not seem effective because § 2801-b provides that all proceedings are confidential and "shall not be admissible as evidence in any other action of any kind." N.Y. PUB. HEALTH LAW § 2801-b(3) (McKinney Supp. 1974).

170 *See Minutes of the 1974 House of Delegates, supra* note 72; Editorial, *Bill of Rights for the Doctor*, 74 N.Y.S.J. MED. 40 (1974).

171 (1974) Assy. Int. No. 8904 (Mr. Stavisky).

172 The bill never left the Assembly Health Committee. 1974 NEW YORK LEGISLATIVE RECORD AND INDEX A522.

173 Letter from N.S. Moore, M.D., Chairman, Public Health Council, to the *Cornell Law Review*, Sept. 9, 1974.

174 Letter from D.C. Walker, M.D., Assistant Comm'r for Health Manpower, to the *Cornell Law Review*, Sept. 11, 1974.

After the physician has filed the required verified complaint with a detailed chronology of the facts, the hospital is notified and requested to respond to the challenge. The Public Health Council thereafter reviews all facts and decides whether to credit the complaint. This entire procedure may take anywhere from six to seven weeks. *Id.*

175 *Id.*

176 *Id.*

177 NEW YORK STATE LEGISLATIVE ANNUAL, *supra* note 162.

area. The law now provides that all proceedings are to be kept confidential,[178] thereby protecting the physician from unwanted publicity and providing him with a viable forum.

Once a physician's complaint has been credited, the Council has had limited success in attempting to reach final resolution of the particular dispute. In most instances, the hospital has agreed to make a bona fide effort to review its files, but the Council is without power to follow up or to compel additional action.[179] Strong policy statements have been made, however, in a number of cases.[180] The Council has declared that a requirement that an osteopath have completed an AMA-approved internship or residency program in order to qualify for staff privileges is inappropriate.[181] Furthermore, the Council has stated that a hospital's refusal to participate in a section 2801-b review is unwarranted when based upon the fact that the excluded physician has previously filed a complaint in court.[182]

The implicit authority of the Council was evident in a case where a physician denied initial appointment filed a section 2801-b complaint. Before the complaint could be fully investigated, the hospital reversed its decision and placed the physician on its staff.[183] In another case, where a physician alleged that he was denied fair appeal procedures, the Council followed the guidelines of the Joint Commission on Accreditation of Hospitals. The hospital was informed that it did not comply with these guidelines, and it is now considering the alteration of its procedures.[184] These last two instances are obvious examples of the deterrent effect of the law on the hospitals. The Public Health Council is an arm of the state department of health, which has the sole authority for hospital licensure;[185] therefore, there is at least indirect pressure on the state's hospitals to comply with the law.

To date, there have been only two judicial tests of section 2801-b. In *Martin v. Catholic Medical Center*[186] the plaintiff com-

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[178] N.Y. PUB. HEALTH LAW § 2801-b(3) (McKinney Supp. 1974).

[179] Letter from D.C. Walker, *supra* note 174. *See* notes 167-72 and accompanying text *supra*.

[180] These statements have been generously supplied by Dr. Walker and do not violate the confidentiality provisions of the statute because anonymity of the parties has been retained.

[181] Letter from D.C. Walker, *supra* note 174.

[182] *Id.*

[183] *Id.*

[184] *Id.*

[185] N.Y. PUB. HEALTH LAW §§ 220, 2801-a (McKinney 1971).

[186] Martin v. Catholic Medical Center (Sup. Ct.), in 169 N.Y.L.J., Jan. 12, 1973, at 16, col. 5, *aff'd*, 43 App. Div. 2d 540, 349 N.Y.S.2d 690 (1st Dep't 1973), *aff'd*, 35 N.Y.2d 901, 324 N.E.2d 362, 364 N.Y.S.2d 893 (1974).

plained that his administrative, but not clinical, privileges had been withdrawn, allegedly without due process. The physician sought to use section 2801-b as evidence of the requisite due process standards. The court rejected this approach, and outlined the limits of the law:

> [T]he language of the statute itself clearly demonstrates that it was intended to cover hospital staff appointments and privileges, that is, the ability to admit and treat patients in a hospital. It is clear that it does not in any way cover the internal management or administration of hospitals and has no effect on supervisory or administrative positions therein.[187]

More recently, in *Barrett v. United Hospital*,[188] the aggrieved physician introduced the statute as evidence of a pervasive state regulatory scheme that exemplified the state's concern with the staff privileges problem and thereby warranted a finding of state action.[189] The district court rejected this theory, reasoning that the presence of governmental regulation designed to prevent discriminatory policies in a private institution did not justify a finding of state action.[190]

Although the law has met with a fair degree of success,[191] the Medical Society of the State of New York has called for "*a restatement and clarification of due process for physicians in hospitals* and the creation of a means of implementing [the] same."[192] At the June 1974 meeting of the Medical Society House of Delegates, a comprehensive legislative proposal was approved and recommended for implementation.[193] The proposed legislation would bolster the physician's rights within the hospital during the application and reevaluation periods and guarantee due process protection throughout. Therefore, it would complement section 2801-b and would provide a more complete program of protection for the physician.

CONCLUSION

The physician confronted with a problem related to hospital staff privileges in New York now has a number of viable alternatives. The physician's initial attempt at remedying the problem

[187] *Id.* at 16, col. 6.

[188] 376 F. Supp. 791 (S.D.N.Y.), *aff'd mem.*, 506 F.2d 1395 (2d Cir. 1974). *See* notes 89-92 and accompanying text *supra*.

[189] *Id.* at 802-05.

[190] *Id.* at 804-05. *See also* note 92 *supra*.

[191] Aside from these two cases, there has been no other litigation in New York at a time when litigation throughout the country has maintained the significant volume of the 1960's. *See* Annot., 37 A.L.R.3d 645 (1971).

[192] Editorial, *supra* note 170, at 41 (emphasis in original).

[193] *Minutes of the 1974 House of Delegates, supra* note 72, at 1272-73.

should be through section 2801-b of the Public Health Law (or section 206-a if applicable). Although the Public Health Council possesses no direct enforcement power, its deterrent effect on hospital practices enhances the physician's chances for success. The physician cannot be guaranteed admission or retention of the privileges, but the impending review of a dispute by the Council forces a hospital to conduct thorough investigations and to produce valid justifications for its eventual decision.

If the physician is unsuccessful under the statutes, or chooses to enter the courts directly, there is a choice of forum. In either state or federal court, the physician should receive identical treatment, *i.e.*, protection against arbitrary or capricious actions, in a controversy involving a public hospital. In the case of a private hospital, prior to the passage of section 2801-b, both state and federal courts were unreceptive to the physician's problem. Furthermore, the only federal court in the state to deal with the problem has reaffirmed this position subsequent to the enactment of section 2801-b. One can only speculate as to which forum will provide the physician with a greater likelihood for success. It is possible that the continuing debate in the federal courts throughout the country may influence the federal courts in New York to alter their position in favor of the physician. However, in light of the narrow attitude expressed in *Barrett,* it is more reasonable to expect that the presence of section 2801-b will produce a more favorable treatment in the state courts.

The statutory reform in New York is unique and has provided the physician with a substantial advantage over his professional colleagues in other states. The effort to remove the problem from the courts and place it with impartial panels deserves recognition and commendation. However, an appeal mechanism without the power of resolution is insufficient. Although the strong deterrent effect of the law may be one reason that staff privileges litigation in New York has decreased dramatically in recent years, one cannot be sure if the problem has been completely remedied. Indeed, the continuing outcry from physicians for additional protection may indicate that the current laws are inadequate. The legislature must act to strengthen the Public Health Council, but at the same time, it must not completely limit the discretion of the hospitals. This can be accomplished by granting the Council the ability to petition the courts for enforcement of its rulings in those situations where there has been a violation of section 2801-b.

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