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Medical Staff Decisions in Private Hospitals: The Role of Due Process

Thaddeus J. Nodzenski*

I. INTRODUCTION

Why should a hospital concern itself with the composition of its medical staff? An excellent medical staff enhances the reputation of an institution. Moreover, each hospital is legally required to monitor its staff’s quality and admission standards under the doctrine of hospital corporate liability. In *Darling v. Charleston Community Memorial Hospital*, the Supreme Court of Illinois first recognized that hospitals, whether public or private, can be liable to patients for negligent administration of the hospital. *Darling* and its progeny have imposed a duty upon hospitals to take all reasonable steps necessary to ensure that physicians granted medical staff membership and clinical privileges are competent.

A more controversial question concerns the role that courts should play in the medical staff decisions of private hospitals. Medical staff decisions are based upon factors that typically involve the expertise used by hospital medical staff in evaluating medical staff applications, rejecting requests for privileges, and revoking the existing privileges of an incumbent. Because of the highly techni-

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2. Id. at 332-33, 211 N.E.2d at 257.
4. Factors serving as the basis for medical staff decisions include licensure, board certification, educational and practical background, experience, health, training, demonstrated competence, adherence to applicable professional ethics, reputation, and ability to work with others.
5. The rejection of a physician’s medical staff application or disciplinary action against a physician may be based upon improper reasons. For example, staff physicians might wish to limit their competition for referrals by keeping the membership in that specialty low. Consequently, they might recommend rejecting the application or revoking the privileges of any potential competitor. Whether such anticompetitive behavior is immunized by the Illinois rule of not reviewing initial medical staff decisions under *Mauer v. Highland Park Hosp. Found.*, 90 Ill. App. 2d 409, 232 N.E.2d 776 (2d Dist. 1967), is beyond the scope of this article. Instead, this article focuses on whether a “due process” theory should be available to physicians who have been denied medical staff membership or privileges by a private hospital.
cal nature of such decisions, many courts are reluctant to enter this arena.⁶

6. For example, the Fifth Circuit in Laje v. R. E. Thomason Gen. Hosp., 564 F.2d 1159 (5th Cir. 1977), reh'g denied, 568 F.2d 1367 cert. denied, 437 U.S. 905 (1978), reversed a district court's decision to overrule the decision of a hospital because the district court, which lacked medical expertise, substituted its own judgment for that of the hospital. Laje, 564 F.2d at 1162. The Laje court stated:

the decision of a hospital's governing body concerning the granting of hospital privileges is to be accorded great deference. This is so because of the court's obvious lack of medical expertise. Judicial intervention must be limited to an assessment of those factors which are within the court's expertise to review. For this reason, our cases have gone no further than to require that the procedures employed by the hospital are fair, that the standards set by the hospital are reasonable, and that they have been applied without arbitrariness and capriciousness... The decision resulting from the hearing must be untainted by irrelevant considerations and supported by sufficient evidence to free it from arbitrariness, capriciousness or unreasonableness.

Laje, 564 F.2d at 1163 (citations omitted).

The court further rejected the physician's attempt to challenge the substantiality of the evidence relating to his professional competence that was presented against him in the hospital proceedings. The court stated:

To discount the evidence against Dr. Laje because of statistical flaws in the nonrandom selection of cases and the small sample size is improper. The hospital, and not the courts, must set the level of competence to be required of staff members.

The court in Laje relied heavily on the Fifth Circuit's decision in Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173 (5th Cir. 1971), which stated:

No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance. The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered. In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere.

Laje, 564 F.2d at 1163 (citations omitted).

More recently, the Eighth Circuit refused to consider whether an obstetrical-gynecologist exercised poor medical judgment in performing cesarean sections in Hayden v. Bracy, 744 F.2d 1338 (8th Cir. 1984).

A United States District Court in Arkansas also refused to review a hospital's decision to restrict an osteopathic-physician's privilege to perform surgery because the hospital believed that the physician was not competent to perform such procedures. Branch v. Hempstead County Memorial Hosp., 539 F. Supp. 908 (W.D. Ark. 1982). After quoting Sosa at length, the court stated:

As was indicated by the case law cited above, there is good reason for limiting the function of a court, and this Court does not intend, in this case, or any other
Accordingly, many courts tend to avoid such issues or assume a role of very limited judicial review in cases regarding a private hospital's medical staff decisions. The majority position of limited judicial review is exemplified by Illinois courts. Illinois courts have rejected physicians' requests to review initial membership decisions of private hospitals since 1967. The Illinois courts also have held that judicial review of a hospital's disciplinary action against an incumbent staff member is limited to determining whether the hospital followed its own bylaws governing such disciplinary procedures. Thus, even when judicial review is appropri-
ate under Illinois law, the hospital retains a significant amount of control over its procedures because it is required to follow only approved and adopted bylaws.\(^{11}\)

Though some courts will review medical staff decisions, they often defer to the expertise of the hospital.\(^{12}\) A few courts, however, have reviewed private hospital medical staff decisions comprehensively.\(^{13}\) This approach is exemplified by courts that have held that physicians have common law procedural and substantive due process rights based upon the physician's right to practice medicine, the patient's right to select a physician and the quasi-public nature of hospitals.\(^{14}\) Under this approach, New Jersey courts have reviewed and reversed hospital medical staff decisions because the hospital's decisions were either procedurally unfair or

\(^{11}\) Most hospitals are accredited by the Joint Commission on Accreditation of Hospitals ("JCAH"), a national organization. To obtain such accreditation a hospital must satisfy numerous requirements, including the JCAH requirements with respect to medical staff relations. The JCAH medical staff requirements, which are extensive, require the hospital to adopt: (1) a medical staff appointment mechanism that is approved and implemented by the medical staff and the governing body, which is fully documented in the medical staff bylaws, rules, regulations and policies; (2) a mechanism for a fair hearing when the recommendations regarding initial appointment are adverse to the applicant; and (3) medical staff bylaws which have fair-hearing and appellate review and corrective action mechanisms. Medical Staff Ch. 10, 101-13 JCAH ACCREDITATION MANUAL FOR HOSPITALS (1986).

\(^{12}\) For example, in Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173 (5th Cir. 1971), the court stated:

This court has recently indicated that staff appointments may be constitutionally refused if the refusal is based upon "any reasonable basis, such as the professional and ethical qualifications of the physicians or the common good of the public and the Hospital." Admittedly, standards such as "character qualifications and standing" are very general, but this court recognizes that in the area of personal fitness for medical staff privileges precise standards are difficult if not impossible to articulate. The subjectives of selection simply cannot be minutely codified. The governing board of a hospital must therefore be given great latitude in prescribing the necessary qualifications for potential applicants. So long as the hearing process gives notice of the particular charges of incompetency and ethical fallibilities, we need not exact a precis of the standard in codified form. Sosa, 437 F.2d at 176 (citations omitted).

\(^{13}\) See Silver Castle Memorial Hospital, 53 Haw. 563, 497 P.2d 564, 569 n.5, cert. denied, 409 U.S. 1048 (1972) (contains various citations to cases in which courts have extensively reviewed private hospital decisions regarding staff applicants and incumbents).

substantively irrational.\textsuperscript{15}

Illinois and New Jersey law represent respectively the majority and minority view regarding the extent to which courts take an active decision-making role regarding the medical staff decisions of hospitals. This article will begin by analyzing the constitutional underpinnings of due process in the context of medical staff decisions of private hospitals. Next, it will describe the nature and extent of a physician's due process rights in the private hospital setting under the common law of Illinois and New Jersey, and evaluate the role of due process in providing remedies for physicians whose rights have been violated. Finally, the article will suggest medical staff bylaws create a contractual relationship between the hospital and its physicians and this contract defines exclusively a physician's procedural rights.

\textbf{II. CONSTITUTIONAL DUE PROCESS IN PRIVATE HOSPITALS}

The distinction between public and private institutions is critical in evaluating due process in a constitutional sense. Private hospitals receive substantial funding from the federal and state government and are subject to extensive regulation ranging from patient care requirements to certain reimbursement qualifications. Despite this interaction, the federal courts unanimously have rejected the application of the due process clause of the fifth\textsuperscript{16} and fourteenth amendments\textsuperscript{17} to the medical staff decisions of private hospitals.\textsuperscript{18}

\textsuperscript{15} See supra note 14.
\textsuperscript{17} U.S Const. amend. XIV.
\textsuperscript{18} With the exception of the First and Eleventh Circuits, which have not addressed the "state action" question regarding private hospitals, all of the remaining circuits have held that public funding and regulation of hospitals does not turn them into "state actors." See Loh-Song Yo v. Cibola General Hosp., 706 F.2d 306, 308 (10th Cir. 1983) (state must be responsible for the specific conduct of which the plaintiff complains.); Modaber v. Culpeper Memorial Hosp., Inc., 674 F.2d 1023, 1026 (4th Cir. 1982) (the mere fact that hospitals implement a governmental program does not mean the hospital acts in an exclusively state capacity); Newsom v. Vanderbilt Univ., 653 F.2d 1100, 1115 (6th Cir. 1981) (more than partial federal funding is needed to constitute state action); Musso v. Suriano, 586 F.2d 59, 62-63 (7th Cir.) (state must provide affirmative support of the private action challenged), \textit{cert. denied}, 440 U.S. 971 (1979); Hodge v. Paoli Memorial Hosp., 576 F.2d 563, 564 (3d Cir. 1978) (private hospital action may be state action if the hospital acts as a state instrumentality, performs traditionally exclusive sovereign functions, or is compelled or encouraged by the state to take that action.); Schlein v. Milford Hospital, Inc., 561 F.2d 427, 428-29 (2d Cir. 1977) (state must put its weight on the side of the procedures or standards complained of); Madry v. Sorel, 558 F.2d 303, 305 (5th Cir. 1977) (the receipt of financial assistance does not mean that the acts of a
The fourteenth amendment, which on its face applies exclusively to acts attributable to the state,\(^9\) does not limit purely private behavior. An act must involve "state action" to be violative of due process under the Constitution. For a private hospital's conduct to constitute state action, a "sufficiently close nexus" must exist between the state and the regulated hospital, warranting treatment of the activity of the hospital as that of the state itself,\(^20\) the state must be responsible for the hospital's behavior.\(^21\) Such a "nexus" may be established if the private hospital acts in one of three ways — exclusively in a state capacity; for the state's direct benefit; or at the state's specific behest.\(^22\)

A hospital acts exclusively in a state capacity when it exercises powers traditionally and exclusively reserved to the state.\(^23\) Although hospitals provide an "essential public service," they do not exercise powers traditionally and exclusively reserved to the state.\(^24\) States have been traditionally involved in providing health care but their role in this area is not exclusive, as it is, for example, when states hold elections.\(^25\)

A private hospital acts for the state's direct benefit if it shares its profits and responsibilities with the state.\(^26\) Though private hospitals are subject to extensive government regulation, they are solely responsible for providing their services and are solely entitled to any profits earned.\(^27\) Thus, state regulation of hospitals has not made the state a beneficiary of the hospital's enterprise. Because any gain or credit realized by the hospital belongs exclusively to that institution and does not reflect upon or inure to the state, the second prong of state action analysis is not satisfied.

hospital equal the acts of the state), cert. denied, 434 U.S. 1086 (1978); Bricoe v. Bock, 540 F.2d 392, 394-96 (8th Cir. 1976) (nexus must exist between the state's relationship to the hospital's operations and the action of the hospital to justify attribution of such action to the state); Watkins v. Mercy Medical Center, 520 F.2d 894, 896 (9th Cir. 1975) (finding of state action must be based upon significant state involvement in the specific activity of which a party complains).

19. See Flagg Brothers, Inc. v. Brooks, 436 U.S. 149, 156 (1978); see generally U.S. CONST. Amend. XIV.


22. Modaber, 674 F.2d at 1025.
24. See Newsom, 653 F.2d at 1114-15.
25. Id. at 1114.
27. Modaber, 674 F.2d at 1026.
Finally, a hospital acts at the state's specific behest when the state directs or encourages the action.28 Medical staff decisions, however, typically are not the subject of state statutes or regulations.29 Consequently, when states do not intervene in the procedures for making staff privileges decisions, the private hospital is not a state actor.30 In Schlein v. Milford Hospital, Inc.,31 the Second Circuit rejected the claim that a private hospital's staff decision was state action, noting that the state did not (1) play a part in the formation of the procedures and standards utilized by the hospital to reach its decision, (2) play a role in making the decision, or (3) require all licensed hospitals to adopt any particular standards or procedures for the granting of staff privileges.32 Therefore, there was no nexus between the hospital's rejection of the physician and the state's involvement with the hospital.

If the state does not instruct hospitals to follow certain procedures with respect to medical staff matters, the state has not played a role in violating a physician's due process rights. Thus, while the Constitution subjects government operations to certain due process restrictions, the same limitations do not apply to private hospitals simply because they are pervasively regulated by government in areas outside the medical staff arena.

Nevertheless, under the Illinois Attorney General's Opinion of Rule 3-1.1(c)33 of the Illinois Hospital Licensing Requirements, the Illinois Department of Public Health ("IDPH" or the "Department") may have created state action by requiring all Illinois hospitals to provide procedural due process in the constitutional sense to all physicians, osteopaths, oral surgeons, and podiatrists applying for medical staff membership. Thus, physicians may be able to bring civil rights actions in federal court against private hospitals for failing to provide them with the due process mandated by Rule

28. See Jackson, 419 U.S. at 357.
29. See, e.g., ILL. REV. STAT. ch. 111 1/2, paras. 6503-4 (1985), which states: "It is not the intent of the General Assembly, nor shall it be the policy of the State of Illinois, to take from medical staffs and hospitals the determination as to the qualifications of practitioners for purposes of granting medical staff memberships and privileges."
30. Modaber, 674 F.2d at 1026; Schlein, 561 F.2d at 427.
31. 561 F.2d 427 (2d Cir. 1977).
32. Id. at 428-29.
33. Op. Att’y Gen. No. 84-004 (April 4, 1984). The Attorney General's Opinion was issued following the Department's request for the procedures that a licensed, private hospital must follow in reviewing a podiatrist's application for medical staff privileges to satisfy the due process guarantee of Rule 3-1.1 of the Illinois Hospital Licensing Requirements.
34. 77 ILL. ADMIN. CODE tit. x, § 250.310 (1984).
3-1.1(c) if the IDPH, as a co-conspirator in the deprivation, fails to enforce this regulation.

A. The Presence of State Action through Rule 3-1.1(c) and the Attorney General's Opinion

Rule 3-1.1(c) arguably exposes the IDPH, a state actor, to liability as a co-conspirator to the violation of a physician's due process rights. Section (c) of Rule 3-1.1 requires that the medical staff bylaws, rules, and regulations provide "a policy that specifies a procedure for processing applications for staff privileges and guarantees due process and fair hearing for each such applicant." Under Rule 3-1.1(c), the state directs private hospitals to take certain "due process" action regarding their medical staff decisions. Therefore, the IDPH's failure to take corrective action against the hospital or any acquiescence by the IDPH in such misconduct makes the Department a party to the due process violation. Pursuant to this regulation, Illinois physicians should be able to bring Section 1983 civil rights claims against private hospitals and the IDPH for any due process rights violations. Such claims should be meritorious if the Illinois Attorney General's interpretation and analysis of Rule 3-1.1(c) is correct.

In a 1984 opinion, the Illinois Attorney General decided that the Rule required a hospital to afford the following rights to each applicant for medical staff membership: reasonable notice; the opportunity to appear and be heard, in person and by counsel, at each level of the application review process; the opportunity to present evidence and examine evidence tendered against him; and the opportunity to present, confront, and cross-examine witnesses. While acknowledging the difficulty of precisely defining due process, the Attorney General defined "due process" in terms of an equally vague term — "fundamental fairness." To give both con-

35. See Modaber, 674 F.2d at 1023; Schlein, 561 F.2d at 427.
37. See, e.g., Schlein, 561 F.2d at 428. In Schlein, the Second Circuit found no state action because the state was not involved in the decision-making process. Id. at 428-29. Under Rule 3-1.1(c), the state mandated the process to be used by private hospitals in making these decisions and required all licensed hospitals to provide physicians with due process. If the IDPH refused to enforce this rule following a physician's complaint of a violation, the state's refusal would make the state a party to the violation. Under this scenario, it might be fair to attribute the violation to the state because the IDPH refused to enforce its own regulations in violation of a physician's right to due process.
40. See id.
cepts some substance, the Attorney General relied on three cases, stating that they related "specifically to due process rights of applicants for hospital staff privileges." According to the Attorney General, the overall thrust of the applicable case law outlined the procedural due process elements available to hospital medical staff applicants. If this synthesized definition of due process is correct, private hospitals in Illinois are directed by the state to give initial staff applicants quasi-judicial hearings whenever an applicant is rejected.

In light of the Attorney General's Opinion regarding Rule 3-1.1(c), physicians could have used the Rule to bring due process claims against private hospitals. Given the broad implications of

41. See infra note 42.
43. The Attorney General's Opinion failed to address several important issues. First, it did not explain what constitutes an appearance "at each level of the application review process" or whether hospitals can avoid this problem by no longer taking "applications." The Attorney General also failed to explain whether if three people review an application submitted to a hospital, such review constitutes one or three levels of review. The Attorney General further failed to tell hospitals how close they must come to actually providing judicial proceedings. The Opinion also did not explain whether the parties must engage in motion practice, whether the Illinois rules of evidence apply, who has the burden of proof and what standard of proof must be met.
44. The Attorney General, however, failed to interpret Rule 3-1.1 properly. Under this rule a hospital's medical staff bylaws, rules and regulations must provide "(1) written procedures for accepting and processing applications for medical staff membership; and . . . (3) a procedure for processing applications for staff privileges which guarantees due process and a fair hearing for each such applicant." See 77 ILL. ADMIN. CODE § 250.310(a)(1), (3) (1984) (emphasis added).

This rule speaks in terms of both staff membership and staff privileges. These terms are not interchangeable and the distinction is critical. A medical staff member of a hospital possesses all of the rights of membership under the bylaws, but the extent of his clinical practice depends on his staff privileges. Thus, an application for membership is not an application for privileges. To receive privileges one must first become a staff member. Thereafter, the physician obtains clinical privileges which define the scope of his clinical practice in the institution. The requirement of due process under Rule 3-1.1(c) only applies to a request for staff privileges. Therefore, the Attorney General inappropriately and incorrectly confused these separate concepts as one and required hospitals to provide due process to initial applications for staff membership.
45. Until June 17, 1986, physicians throughout the country arguably had due process rights created by Medicare regulations promulgated by the Health Care Financing Administration ("HCFA"). To be reimbursed for providing hospital services to Medicare patients, a hospital must meet certain Medicare conditions of participation. Medicare & Medicaid Guide (CCH) ¶ 12,330 (1985). Hospitals accredited by the JCAH are deemed to meet these conditions unless HCFA promulgates standards which exceed the accreditation requirements. Id. One such standard existed prior to June 17, 1986—HCFA required hospitals participating in the Medicare program to provide a "procedure for
this Opinion, it was no surprise that hospitals in Illinois challenged the Attorney General’s position.

Perhaps in response to the controversy that erupted over the Attorney General’s Opinion, the IDPH promulgated amendments to Rule 3-1.1(c) that require hospitals to establish medical staff bylaws, rules, and regulations specifically providing procedures for initial applicants that are equally applicable to physicians, osteopaths, dentists, and podiatrists. Under the amendments, hospitals also must adopt procedures for current staff members entitling them to written notice of an adverse decision by the Governing Board, an explanation and reasons for an adverse decision, the right to examine and/or present copies of relevant information related to an adverse decision, an opportunity to appeal an adverse decision, and written notice of the decision resulting from the appeal. Finally, the notice procedures must include time frames for giving such notice.

appeal and hearing by the governing body or their designated committee if the applicant or medical staff feels the decision is unfair or wrong.” 42 C.F.R. § 405.1021(e)(7) (1985). This regulation apparently created procedural and substantive due process rights for physicians. Remarkably, given all of the medical staff litigation throughout the country, no physician has brought a civil rights claim in federal court against either a hospital for failing to comply with this due process regulation or against HCFA for failing to enforce it. On June 17, 1986, HCFA promulgated new conditions of participation for hospitals which delete this due process regulation. 51 Fed. Reg. 22013, 22013-16 (proposed June 17, 1986) (to be codified at 42 C.F.R. 405). HCFA rejected adoption of a due process regulation for physician applicants and incumbents because it felt that such a regulation was “too prescriptive for federal requirements and is unrelated to ensuring patient health and safety.” Id. This change, of course, should not diminish any violations of physicians’ due process right which accrued before June 17, 1986.


47. Id.

48. Id.

49. Id.

50. Id.

51. See 77 ILL. ADMIN. CODE § 250.310(a)(1), (3) (1984). As of October 1, 1984, Rule 3-1.1(a-c) of the IDPH Hospital Licensing Requirements, Rules and Regulations has been codified in 77 ILL. ADMIN. CODE § 250.310 (1984). The proposed amendments to Rule 3-1.1 read as follows:

The medical staff shall be organized in accordance with written bylaws, rules and regulations, approved by the Governing Board. The bylaws, rules and regulations shall specifically provide but not be limited to the following provisions:

1. written procedures relating to the acceptance and processing of initial applications for medical staff membership, granting and denying of medical staff reappointment, and medical staff membership or clinical privileges disciplinary matters.

(A) The procedures for initial applicants at any particular hospital may differ from those for current medical staff members. However, the procedures at any particular hospital shall be applied equally to each practitioner eli-
Despite these amendments, revised Rule 3-1.1(c) fails to apprise hospitals of how they are to treat initial applicants. The Rule requires the hospital to employ application procedures "equally" for physicians, osteopaths, dentists, and podiatrists, yet provides no guidance regarding the treatment of such applicants.


52. The question of which health care professionals may qualify for medical staff membership is beyond the scope of this article.

53. By no longer requiring hospitals to provide initial applicants for medical staff membership with due process, however, the IDPH's rule is consistent with the minimum requirements for a due process claim in the constitutional sense. Absent a protected "life, liberty, or property" interest in a position on a hospital's medical staff, a medical staff applicant is not entitled to due process. See Board of Regents v. Roth, 408 U.S. 564, 577 (1972) ("(a) person clearly must have more than an abstract need or desire for it . . . . He must, instead, have a legitimate claim of entitlement to it."); Perry v. Sindermann, 408 U.S. 593, 601 (1972); Northeast Ga. Radiological Ass'n v. Tidwell, 670 F.2d 507 (5th Cir. 1982). See also Shahawy v. Harrison, 778 F.2d 636, 643 (11th Cir. 1985) (prerequisite for due process protection is the existence of an implied contract or such severe injury to the plaintiff that he would be unable to practice in the area). It is premature for a physician to assert a property interest—an expectancy of medical staff membership at a particular hospital—when a physician has no protected right to be on a particular medical staff. In Illinois, a physician simply does not have a legitimate expectation of being on a hospital's medical staff either by statute, rule, custom or practice. Unlike the plaintiff in Perry, who taught in the state college system for ten years, 408 U.S. at 594, and thus, arguably had a property interest in his teaching position at the school, an initial medical staff applicant has no protected due process interest. The mere filing of an application for medical staff membership does not create a property interest in such membership. Illinois law, which is the source of any property interest in this area, is clear—a doctor, no matter how qualified or how hurt he might be by the denial of medical staff membership, has no vested right to be on the medical staff of the private hospital of his choice. See Jain v. Northwest Community Hosp., 67 Ill. App. 3d 420, 425, 385 N.E.2d 108, 112 (1st Dist. 1978). Because initial staff applicants have never served on a hospital's staff, they are not entitled to due process hearings under fundamental due process analysis.

A physician does have a protected procedural due process interest in being on a hospital's medical staff if he is a member of that staff. See, e.g., Northeast Ga. Radiological Ass'n, 670 F.2d at 511; see also Knapp v. Palos Community Hosp., 125 Ill. App. 3d 244, 256, 465 N.E.2d 554, 563 (1st Dist. 1984) (the only process that a hospital owes a physi-
B. The Absence of a Statutory Basis for Due Process Claims in Illinois

Although Rule 3-1.1(c) provides Illinois physicians due process rights, the most fundamental unresolved legal issue presented by this Rule is whether the IDPH had any statutory basis for promulgating the Rule. For example, the Illinois Hospital Licensing Act (the "Act") is designed to protect patients. On its face, the Act provides that public health should be protected by standards governing patient care, as well as by proper hospital construction, maintenance, and operation. Accordingly, the Act authorizes the physician, who is already on the hospital's medical staff, to be informed of the hospital's bylaws in reviewing the physician's application for reappointment (emphasis added). As the California Supreme Court recognized, "the essential nature of a qualified physician's right to use the facilities of a hospital is a property interest which directly relates to the pursuit of his livelihood." Anton v. San Antonio Community Hosp., 19 Cal. 3d 802, 823, 140 Cal. Rptr. 442, 454, 567 P.2d 1162, 1174 (1977). Accord Stretten v. Wadsworth Veterans Hosp., 537 F.2d 361, 366-68 (9th Cir. 1976) (doctor has a property interest in his position at a hospital to earn a living and to protect his reputation). A reduction of privileges or a termination of staff membership can also carry the stigma of medical incompetence. On the other hand, the hospital has a compelling interest in maintaining the highest standards of medical care for its patients. Accordingly, it has a duty to identify and discipline incompetent physicians. A hospital's due process mechanism must balance the competing concerns of protecting a physician's property interests and maintaining quality patient care.

Another weakness with the amendments is that they are illogical. According to the revised rule, an incumbent has a right to written notice of an adverse decision by the governing board of the hospital. 77 Ill. Admin. Code § 250.310(1)(C). From such notice follows the right to examine and present copies of relevant information affecting the decision as well as the right to appeal it. This "due process" scheme is problematic because the governing body of the hospital is the "court of last resort" regarding such matters. Consequently, once it reaches a decision that is adverse to the physician, the matter is closed. The time for presenting information relevant to a disciplinary action or to appeal an adverse decision is before the hospital board reaches a final decision. Once it has reviewed the matter and reached a decision the prospects of a successful appeal before this same board are limited. See Garrow v. Elizabeth Gen. Hosp., 79 N.J. 549, 564, 401 A.2d 533, 544 (1979) (Pashman, J., concurring and dissenting in part). ("It is naive to believe that the hospital committee, having once made a final determination as to the [physician's] lack of qualifications, will be able to conduct a new hearing totally free from the taint of the first . . . hearing. It is too much to expect that even well-meaning administrators will be able to perform the mental gymnastics necessary to approach the new hearing completely fresh and open-minded."). Rule 3-1.1(c), as amended, on its own terms shows a fundamental misunderstanding of how hospital disciplinary action takes place. Typically, complaints against a physician are brought before a hospital peer review committee to investigate the matter. The most critical time for a physician to have due process rights is when he becomes the subject of such an investigation, not after many levels of review have already occurred.

55. Ill. Rev. Stat. ch. 111 1/2, § 143 (1983). The purpose of the Act is: to provide for the better protection of the public health through the development, establishment and enforcement of standards (1) for the care of individuals in hospitals, (2) for the construction, maintenance and operation of hospitals.
IDPH to prescribe rules to effect its purpose.  
While the IDPH may act to ensure the professional competence of hospital medical staff members, the Act, even in its broadest construction, does not allow the IDPH to affect the procedural rights of medical staff applicants or incumbents. Requiring hospitals to treat initial applicants equally or to give incumbents certain due process rights furthers no patient care objectives. Therefore, if Rule 3-1.1(c), as amended, establishes such rights, it exceeds the IDPH's statutory rulemaking authority and is invalid.

The conclusion that physicians' procedural rights were of no concern to the Illinois legislature in passing the Act is further supported by its enforcement provisions. Sections 155 and 156 of the Act allow the Attorney General and the State's Attorney to pursue criminal sanctions and injunctive relief against hospitals operating without a license. The Act, however, provides neither physicians nor other private parties a means of suing hospitals for violating the Act.

The Illinois Health Financing Reform Act ("HFRA") also fails to guarantee a physician certain due process rights regarding his application for staff membership or privileges at a particular hospital. The HFRA states in pertinent part:

It is not the intent of the General Assembly, nor shall it be the policy of the State of Illinois, to take from medical staffs and hospitals the determination as to the qualifications of practitioners for purposes of granting medical staff membership and which in light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals, and (3) that will have regard to the necessity of determining that a person establishing a hospital have the qualifications, background, character and financial resources to adequately provide a proper standard of hospital service for the community.

Id.

56. ILL. REV. STAT. ch. 111 1/2, para. 151(c) (1985).
57. An administrative agency can neither add provisions to a statute nor can it create substantive rights through its rule making powers. See Northern Ill. Auto Wreckers v. Dixon, 75 Ill. 2d 53, 60, 387 N.E.2d 320, 324 (1979) (Secretary of State had statutory authority to promulgate rule requiring certain licensed business associations to maintain particular records); Chicago Div. of Horsemen's Benevolent & Protective Ass'n v. Illinois Racing Bd., 53 Ill. 2d 16, 19, 289 N.E.2d 421, 423 (1972) (statutory grant of authority to the Illinois Racing Board to "prescribe rules, regulations and conditions under which all horse races shall be conducted" did not give the Board power to set a minimum fee schedule for jockeys); Fahey v. Cook County Police Dept. Merit Bd., 21 Ill. App. 3d 579, 583, 315 N.E.2d 573, 576 (lst Dist. 1974) (administrative agencies regulating merit employment systems required to substantiate any claimed authority with statutory support, either express or implied).
58. ILL. REV. STAT. ch. 111 1/2, para. 155, 156 (1985).
privileges.60

On its face, this language does not create any due process rights for physicians regarding applications for medical staff membership or medical staff disciplinary actions. Indeed, the legislature expressly declined to invade the decision-making process of a hospital and its medical staff in determining who shall have hospital staff privileges.61 Thus, the Illinois legislature has recognized that such decisions are best left to the discretion of the hospital and its medical staff.62 This recent legislative pronouncement affirmed the long-standing common law of Illinois that initial medical staff appointment decisions are not subject to judicial review and that incumbent staff decisions must comport only with the hospital's bylaws.63

Because neither the Act nor the HFRA contemplate the creation of procedural safeguards for medical staff applicants and incumbents, a cause of action cannot be implied from either. A private right of action can be implied only if it is consistent with the underlying purpose of the Act and is necessary to achieve the aim of the legislation.64 Thus, neither the Hospital Licensing Act nor the Illinois Health Financing Reform Act provide Illinois physicians with any statutory basis for asserting due process rights.

III. THE MAJORITY APPROACH — COMMON LAW DUE PROCESS IN ILLINOIS

A. Initial Applicants

Mauer v. Highland Park Hospital Foundation65 first articulated

60. Id. at para. 6503-4.
61. See id. This language from the legislature provides even further support for the conclusion that the IDPH has exceeded its authority under the Hospital Licensing Act by promulgating Rule 3-1.1 which mandates due process for all doctors seeking initial staff appointments.
62. Id.
63. See infra notes 65-129 and accompanying text.
64. The courts will imply a private cause of action under an Illinois statute if (1) the plaintiff is a member of the class for whose benefit the statute was enacted, (2) a private cause of action is consistent with the underlying purposes of the Act, (3) the plaintiff's injury is one the statute was designed to prevent, and (4) a private remedy is necessary to provide adequate relief against such harm. See Sawyer Realty Group, Inc. v. Jarvis Corp., 89 Ill. 2d 379, 388, 432 N.E.2d 849, 853 (1982).
65. 90 Ill. App. 2d 409, 232 N.E.2d 776 (2d Dist. 1967). Hospital anti-discrimination statutes outside of Illinois might give courts the opportunity to review initial staff application decisions. For example, in the District of Columbia, the hospital rules must provide clinical privileges for psychologists, podiatrists, nurse practitioners, nurse midwives and nurse anesthetists without categorical discrimination. D.C. Reg. §§ 8-7:107(a)(2), 8-7:108(a)(3), 8-7:104 (1983). Other statutes prohibit discrimination against physicians
the Illinois rule that courts will not review a private hospital’s refusal to appoint a physician to its medical staff. In *Mauer*, an osteopath applied for medical staff privileges at a private hospital. The hospital, employing its customary procedures for initial staff appointments, denied the application. According to the official minutes of the hospital’s board of managers, the osteopath was rejected because his application and supporting documents failed to establish his qualifications and the physicians named as references had insufficient knowledge of his medical capabilities. The appellate court held that “it is a well-settled rule that a private hospital has the right to refuse to appoint a physician or surgeon to its medical staff, and this refusal is not subject to judicial review; the decision of the hospital authorities in such matters is final.” The court relied on several cases from other states that held that the decisions of private hospitals regarding initial staff applications were not reviewable if the hospital followed its customary procedures and bylaws properly. Accordingly, the *Mauer* court refused to consider the merits of Dr. Mauer’s application and deferred to the judgment of the hospital administrators.

Because the osteopath in *Mauer* did not allege that the hospital violated its procedures or bylaws in ruling on his application, the *Mauer* rule left unclear the issue of whether a court could review an initial staff appointment decision by a private hospital. Subsequent decisions, however, suggest that courts may review a decision to determine whether the staff committees and the hospital board properly followed their bylaws before rejecting the application.

In *Jain v. Northwest Community Hospital*, a doctor with outstanding medical qualifications applied for initial staff privileges as more generally. See, e.g., Mich. Stat. Ann. § 14.15 (20152) (Callaghan 1983) (selection and appointment of physicians to the medical staff shall be without discrimination and solely upon the basis of their license or registration as physicians or osteopaths).

67. Id. at 412, 232 N.E.2d at 778.
68. Id. at 412-13, 232 N.E.2d at 778.
a surgeon at the defendant hospital, a private facility and the only major hospital in the area.\textsuperscript{73} After being denied entrance, Dr. Jain argued that his medical practice suffered as a result of his exclusion from the hospital.\textsuperscript{74} Though Jain’s qualifications far surpassed Mauer’s, the appellate court relied on \textit{Mauer} and refused to inquire into the reasons behind the denial of Dr. Jain’s application.\textsuperscript{75} The court, however, stated in dicta that when a physician’s existing staff privileges are revoked, a private hospital must follow its own bylaws or be subjected to limited judicial review.\textsuperscript{76} Thus, the \textit{Jain} court established that initial applicants would be treated differently than incumbent staff members.

Subsequently, a podiatrist attempted to use the \textit{Jain} approach to show that the \textit{Mauer} doctrine of judicial non-intervention no longer controlled in Illinois. In \textit{Settler v. Hopedale Foundation},\textsuperscript{77} the hospital had dissolved its podiatry staff. Dr. Settler, a podiatrist who had been a member of that staff, applied for staff privileges as a podiatric consultant.\textsuperscript{78} His application for the position was denied, but he was granted the privilege of being a podiatric surgical assistant.\textsuperscript{79} He brought suit against the hospital, arguing, in part, that \textit{Jain} allows Illinois courts to review private hospital staff appointments.\textsuperscript{80} Two counts of Dr. Settler’s complaint were based, in part, on the allegation that he was wrongfully terminated at the hospital.\textsuperscript{81} The appellate court, rejecting Settler’s use of \textit{Jain}, noted that \textit{Jain} reaffirmed the \textit{Mauer} rule that initial hospital staff appointment decisions are not subject to judicial review.\textsuperscript{82} While the \textit{Settler} court held that initial appointment decisions are immune from judicial review, it also applied the \textit{Mauer} rule to the counts based on wrongful discharge, thus blurring the initial applicant/incumbent distinction set forth in \textit{Jain}.

\textbf{B. Incumbents}

As a result of \textit{Mauer} and \textit{Jain}, Illinois courts will not review a hospital’s decision to terminate or reduce the staff privileges of a medical staff member unless he can allege a substantial violation of

\begin{itemize}
\item \textsuperscript{73} \textit{Id.} at 422, 385 N.E.2d at 110.
\item \textsuperscript{74} \textit{Id.}
\item \textsuperscript{75} \textit{Id.} at 427, 385 N.E.2d at 110.
\item \textsuperscript{76} \textit{Id.}
\item \textsuperscript{77} 86 Ill. App. 3d 1074, 400 N.E.2d 577 (3d Dist. 1980).
\item \textsuperscript{78} \textit{Id.} at 1075, 400 N.E.2d at 578.
\item \textsuperscript{79} \textit{Id.}
\item \textsuperscript{80} \textit{Id.} at 1076, 400 N.E.2d at 579.
\item \textsuperscript{81} \textit{Id.} at 1077, 400 N.E.2d at 579.
\item \textsuperscript{82} \textit{Id.} at 1078, 400 N.E.2d at 580.
\end{itemize}
the hospital's bylaws.\textsuperscript{83} For example, in \textit{Nagib v. St. Therese Hospital, Inc.},\textsuperscript{84} an Illinois appellate court considered a dispute regarding the meaning of a private hospital's bylaws. A physician, who was dismissed from the hospital's staff, argued that under the medical staff bylaws his dismissal should have been reviewed by the full medical staff.\textsuperscript{85} The bylaws specifically provided that, in any case in which the executive credentials committee recommends a reduction in privileges, the recommendation must be approved by a two-thirds majority of the medical staff.\textsuperscript{86} The bylaws, however, also contained a separate section regarding staff dismissals requiring the governing board to consult with the executive credentials committee before dismissing a staff member.\textsuperscript{87} The dismissal section of the bylaws further provided the physician with an opportunity to address the charges against him, but it did not specifically require two-thirds of the medical staff to approve a decision to dismiss a staff member.\textsuperscript{88}

The physician in \textit{Nagib} argued that the two bylaw provisions should be read together, thus requiring two-thirds of the medical staff to approve his dismissal.\textsuperscript{89} The hospital, however, maintained that the privileges and dismissal sections were unrelated and that staff approval was not required for a dismissal of a physician from

\begin{itemize}
\item \textsuperscript{83} See \textit{infra} notes 82-124 and accompanying text.
\item \textsuperscript{84} 41 Ill. App. 3d 970, 355 N.E.2d 211 (2d Dist. 1983).
\item \textsuperscript{85} \textit{Id.} at 971, 355 N.E.2d at 212.
\item \textsuperscript{86} The bylaws provided:
\begin{quote}
In any case where the Executive Credentials Committee does not recommend reappointment, or where reduction of privileges is recommended, the administrator shall notify the physician concerned and he shall be given an opportunity of appearing before the Executive Credentials Committee. He may request an open hearing before the Medical Staff. After a hearing as outlined above, the Executive Credentials Committee shall make final recommendation to the Governing Board. This recommendation of dismissal or changes in privileges as recommended by the Executive Committee shall be subject to approval by a two-thirds majority of the staff voting at the next duly convened regular staff meeting with a quorum of the staff present.
\end{quote}
\textit{Id.} at 972, 355 N.E.2d at 213.
\item \textsuperscript{87} The bylaws provided that:
\begin{quote}
Dismissal from the Medical Staff may be initiated either by the Medical Staff or by the Governing Board. Before taking action, the Governing Board shall consult with the Executive Credentials Committee. The physician in question shall be given the opportunity of presenting his explanation of the incident or incidents concerning which complaints may have arisen. Action by the Medical Executive Committee recommending dismissal of a member shall be subject to review by the Governing Board before final action is taken.
\end{quote}
\textit{Id.} at 972, 355 N.E.2d at 213.
\item \textsuperscript{88} \textit{Id.} at 973, 355 N.E.2d at 214.
\item \textsuperscript{89} \textit{Id.} at 972, 355 N.E.2d at 213.
the medical staff. The hospital further argued that the right to appeal a medical staff decision to the medical staff was limited to reductions of privileges; it did not control dismissals of physicians.

The court rejected the hospital's position and held that a reduction of privileges includes an elimination of privileges by dismissal. The Nagib Court applied an earlier Illinois Supreme Court decision holding that a "reduction" of liability can include a lessening of liability to the point of extinction. Though the earlier case did not involve a medical staff dispute, the Nagib court relied on it and held that a reduction of privileges could include a termination of privileges. Therefore, the court concluded that the hospital violated its bylaws by not obtaining medical staff approval of the decision to dismiss this physician.

More recently, in Maimon v. Sisters of the Third Order, the Illinois Appellate Court for the Fourth District determined that the Nagib decision was based on faulty reasoning and rejected the conclusion that a reduction in privileges necessarily equals an expulsion from the medical staff. In Maimon, the court carefully reviewed the bylaw provisions cited in Nagib, noting the inconsistencies between them. According to the Maimon court, the court in Nagib ignored or rejected the review mechanism set out in the dismissal section of the bylaws in favor of the review mechanism applicable to reduction of privileges under the appellate section. The court noted that in addition to involving different review mechanisms, the two sections concerned different committees of the hospital.

The Maimon court concluded that a hospital could adopt different review mechanisms for different situations. It rejected the physician's argument that the departmental review procedures applicable to reduction in privileges also applied to his expulsion.

90. Id.
91. Id.
92. Id. at 973, 355 N.E.2d at 214.
93. See Bishop v. Bucklen, 390 Ill. 176, 183, 60 N.E.2d 872, 976 (1945).
94. Nagib, 41 Ill. App. 3d at 973, 355 N.E.2d at 214.
95. Id.
96. 120 Ill. App. 3d 1090, 458 N.E.2d 1317 (4th Dist. 1983).
97. Id. at 1102, 458 N.E.2d at 1325.
98. Id. at 1101-02, 458 N.E.2d at 1324.
99. Id. at 1102, 458 N.E.2d at 1324.
100. Id.
101. For example, a hospital could adopt streamlined procedures where potentially dangerous situations called for quick action. See Maimon, 120 Ill. App. 3d at 1102, 458 N.E.2d at 1325.
from the staff. Instead, the court held that the hospital had to follow the bylaws only to the extent they involved staff dismissals. Significantly, the court found that the bylaw dismissal procedures were fundamentally fair and it reinstated the physician's expulsion from the staff.

No other appellate court in Illinois has addressed the conflict between Nagib and Maimon. Nevertheless, these cases arguably can be reconciled on fairness grounds. The bylaws in Nagib repeatedly referred to staff approval with respect to actions affecting physician's rights at the hospital. By contrast, the bylaws in Maimon carefully set out separate review procedures tailored to meet different situations. In each case, the physician was provided with all the rights he was entitled to under the respective bylaws of the hospital. Because the bylaws defined the legal relationships between the hospital and the physician, it was fair to hold each party to the terms of the bylaws. Although the Nagib court never mentioned fairness in its analysis, the concern is implicit in the opinion. This same concern motivated the Maimon decision.

Nagib and Maimon require a hospital in Illinois to treat the medical staff according to its bylaws. To plead a violation of bylaws, a physician must make specific factual allegations regarding his rights under the hospital's bylaws and the violation of those rights.

Even when physicians have made factual allegations of specific bylaw violations, judicial review is not rigorous. For instance, in Knapp v. Palos Community Hospital, a group of internists sued a private hospital for wrongful denial of their medical staff privileges. The hospital board decided not to reappoint the doctors because a peer review process disclosed that they had provided inadequate medical care in the past. The Illinois Appellate Court for the First District cited Jain for the proposition that an Illinois

102. Id. at 1103, 458 N.E.2d at 1325.
103. Id.
104. Id. at 1103-04, 458 N.E.2d at 1325-26.
105. See Nagib, 41 Ill. App. 3d at 971-72, 355 N.E.2d at 213.
106. See also Rao v. St. Elizabeth's Hosp., 140 Ill. App. 3d 442, 456, 488 N.E.2d 685, 695 (5th Dist. 1986) (a court should not bar expulsions from a hospital unless unfairness is demonstrated by the failure to follow the hospital's constitution or bylaws).
108. See infra notes 109-24 and accompanying text.
110. Id. at 246, 465 N.E.2d at 557.
111. Id. at 246-47, 465 N.E.2d at 557.
court will review a hospital staff decision when a physician’s privileges are revoked or reduced only if the hospital fails to follow its own bylaws in making this decision.\(^{112}\) The court rejected the doctors’ argument that the hospital in this case committed seven by-law violations,\(^ {113}\) and held that the trial court abused its discretion in granting the preliminary injunction because the facts did not disclose any bylaw violations.\(^ {114}\) Though the court considered the seven alleged bylaw violations, its review was not rigorous. With respect to two of the seven alleged violations, the court specifically stated that under the facts there was no substantial violation of the hospital bylaws.\(^ {115}\) Consequently, in light of Knapp, strict compliance with hospital bylaws in medical staff reappointment matters may not be required; instead, substantial compliance may be sufficient.

Even when a hospital clearly fails to follow its own bylaws, the Illinois courts are reluctant to interfere with the medical staff’s decision-making process. In Rao v. St. Elizabeth’s Hospital,\(^ {116}\) the expelled physician alleged four major bylaw violations: failure to give him adequate notice of the charges against him;\(^ {117}\) failure of the medical executive committee to appoint a representative to present the case against the physician before the ad hoc committee of the medical staff;\(^ {118}\) failure to provide witnesses for cross-examination;\(^ {119}\) and improper invocation of the summary suspension provisions of the bylaws.\(^ {120}\)

The court held that the physician waived his claim of inadequate notice because he acquiesced in the decision of the ad hoc committee to proceed with the hearing as convened.\(^ {121}\) Regarding the second violation, the court held that the bylaw requiring the executive

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\(^{112}\) Id. at 256, 465 N.E.2d at 563 (citing Jain, 67 Ill. App. 3d 420, 385 N.E.2d 108 (1978)).

\(^{113}\) See Knapp, 125 Ill. App. 3d at 256, 465 N.E.2d at 564 (alleged violations included no committee review of patient charts, no notice or hearings given of adverse evaluation determinations, and untimely ad hoc hearings).

\(^{114}\) Id. at 259, 465 N.E.2d at 565.

\(^{115}\) Id.

\(^{116}\) 140 Ill. App. 3d 442, 488 N.E.2d 685 (5th Dist. 1986).

\(^{117}\) Id. at 457, 488 N.E.2d at 695.

\(^{118}\) Id. at 458, 488 N.E.2d at 696.

\(^{119}\) Id. at 459, 488 N.E.2d at 696.

\(^{120}\) Id. at 459, 488 N.E.2d at 697.

\(^{121}\) Id. at 458, 488 N.E.2d at 696. Subsequently, the Illinois Appellate Court for the Fourth District relied on Rao in Lapidot v. Memorial Medical Center, 144 Ill. App. 3d 141, 494 N.E.2d 838 (4th Dist. 1986), and held that even if the discharged physician was not given formal written notice as provided for in the bylaws, the hospital substantially complied with this provision because it gave the physician actual notice of the charges against him. Lapidot, 144 Ill. App. 3d at 148, 494 N.E.2d at 844.
committee to appoint a representative to present evidence to the ad hoc committee did not require that representative to appear before the ad hoc committee. The physician argued that the committee acted as both "prosecutor and jury" in reviewing the charges against him. The court responded that if the absence of a prosecutor had any effect, it would benefit the physician charged with misconduct. Thus, the court construed this bylaw provision against the physician by applying a rather flexible concept of fairness in evaluating the proceedings.

Similarly, the court essentially eliminated the right of confrontation as provided in the bylaws by holding that the right to confront adverse witnesses does not require the hospital to make such witnesses available for cross-examination. The court's analysis thus illustrated a lack of concern for whether the proceedings against the physician were fundamentally fair, despite the court's recitation of this principle earlier in its opinion.

Finally, the Rao court refused to review the hospital's determination of whether summary suspension was justified in this case. Under the bylaws, a physician could be summarily suspended when such suspension was in the best interest of the patient. Because the court considered this decision to be within the scope of the hospital's medical judgment, it held that such suspensions were not subject to any judicial review. Thus, in Rao, the court went to great lengths to rule in favor of the hospital. Rao also is significant because it appears to adopt a rule of no judicial review, when the action involves medical judgment, despite express allegations of bylaw violations.

Knapp is consistent with Rao to the extent that the Knapp court ruled in favor of the hospital though the physician had alleged and established technical violations of the hospital's bylaws. In doing so, the Knapp court held that substantial compliance with the hospital's bylaws would be sufficient to discharge its obligations to the physician. Rao, however, went further by refusing to review substantial bylaw violations merely because they involved the exercise of medical judgment, and by construing the procedural bylaws

123. Id. at 458, 488 N.E.2d at 696.
124. Id. at 459, 488 N.E.2d at 696.
125. Id. at 459, 488 N.E.2d at 697.
126. Id. at 460, 488 N.E.2d at 697.
127. Id.
129. See id.
against the physician to the extent that fairness is no longer an aspect of the court's analysis.

IV. THE MINORITY APPROACH-COMMON LAW DUE PROCESS IN NEW JERSEY

In contrast with the Illinois courts, the New Jersey courts have actively reviewed the medical staff decisions of private hospitals on procedural and substantive due process grounds. Judicial intervention into medical staff matters under New Jersey law finds its source in *Falcone v. Middlesex County Medical Soc.* 130 In *Falcone*, an osteopath engaged in the practice of surgery and obstetrics was denied full membership in a medical society because he did not fulfill an unwritten membership requirement of four years of study at a medical school approved by the American Medical Association. 131 Because the area hospitals required their staff physicians to be members of this society, the osteopath lost his privileges at two hospitals. 132 The New Jersey Supreme Court recognized that, without the use of local hospital facilities, the osteopath could neither continue his practice nor serve his patients. 133 Although the court acknowledged its reluctance to interfere with the internal affairs of membership associations, it held that this case presented considerations of policy and justice that warranted judicial scrutiny and relief. 134

According to the *Falcone* court, membership in the society was an "economic necessity" for the osteopath. 135 Consequently, the court stated that it had to protect the public welfare and advance the interests of justice by safeguarding the osteopath's opportunity to earn a living while not impairing the proper standards and objectives of the medical society. 136 The court relied heavily on the society's virtual monopoly over the use of local hospital facilities. 137 The court stated that public policy required that this quasimonopolistic power should be judicially viewed "as a fiduciary power to be exercised in a reasonable and lawful manner." 138 The court also noted that the medical society was engaged in activity

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130. 34 N.J. 582, 170 A.2d 791 (1961).
131. Id. at 586, 170 A.2d at 793-94.
132. Id. at 586-87, 170 A.2d at 794.
133. See id. at 598, 170 A.2d at 800.
134. Id. at 590, 597, 170 A.2d at 796, 799.
135. Id. at 592, 170 A.2d at 796-97.
136. Id. at 592, 170 A.2d at 797.
137. See id. at 597, 170 A.2d at 799.
138. Id.
that vitally affected public health and welfare and that the exclusion of the osteopath denied him the ability to practice his profession and restricted the patient's freedom to select his services.\textsuperscript{139}

After the court established its power to intervene in the case, it concluded, with little discussion, that the requirement of four years of attendance at an approved medical college was patently arbitrary, unreasonable, and beyond the pale of the law.\textsuperscript{140} Consequently, it affirmed the lower court's order granting the osteopath membership in the medical society.\textsuperscript{141}

In the landmark case of \textit{Greisman v. Newcomb Hospital},\textsuperscript{142} the New Jersey Supreme Court relied on \textit{Falcone}, holding that a provision of a private hospital's bylaws that excluded osteopaths from its medical staff was contrary to public policy.\textsuperscript{143} The \textit{Greisman} court directed the hospital to consider the complaining osteopath's application in light of the remaining bylaw provisions.\textsuperscript{144} The hospital had argued that because it was a private institution its actions were not subject to judicial review.\textsuperscript{145} The court responded, stating that although the hospital was nongovernmental, it was not private because the hospital was a nonprofit corporation dedicated to serving the sick and impaired, its funds were largely received from public sources and public solicitation, and it enjoyed tax-exempt status.\textsuperscript{146} Moreover, the hospital had a "virtual monopoly" in the Vineland metropolitan area, the community in which it functioned.\textsuperscript{147} Consequently, the court held that the hospital could not claim immunity from public supervision and control because of its private nature.\textsuperscript{148}

Following \textit{Falcone}, the court held that a private hospital's power to approve staff membership applications is a fiduciary power that must be exercised in furtherance of the common good.\textsuperscript{149} The hospital's exclusion of osteopaths violated this public trust. The \textit{Greisman} court recognized that doctors needed hospital facilities to serve their patients.\textsuperscript{150} The court also observed that physicians

\textsuperscript{139} Id. at 596-97, 170 A.2d at 799.
\textsuperscript{140} Id. at 598, 170 A.2d at 800.
\textsuperscript{141} Id.
\textsuperscript{142} 40 N.J. 389, 192 A.2d 817 (1963).
\textsuperscript{143} Id. at 401, 192 A.2d at 824.
\textsuperscript{144} Id.
\textsuperscript{145} Id. at 395, 192 A.2d at 820.
\textsuperscript{146} Id. at 396, 192 A.2d at 821.
\textsuperscript{147} Id.
\textsuperscript{148} Id.
\textsuperscript{149} Id. at 403, 192 A.2d at 824-25.
\textsuperscript{150} Id. at 403-04, 192 A.2d at 825.
practicing in the Vineland metropolitan area would desire membership on the staff of the defendant hospital's medical staff because it was the only hospital in Vineland. The court rejected arguments that a patient residing in Vineland could enter the hospital under the care of a current staff member, noting that the patient's chosen physician could not participate in his treatment. The court also dismissed arguments that the physician could use hospitals outside of Vineland, stating that they might be too distant or unsuitable for the physician's needs and desires.

Though invalidating the hospital's bylaws, the court recognized the tremendous discretion that hospital administrators possess regarding the improvement of hospital standards and the quality of health care. Despite the private nature of these concerns, hospitals are operated for the benefit of the public. Judicial intervention in staffing decisions is thus appropriate, the court stated, when membership applications are denied for a reason related neither to proper hospital practices nor "in furtherance of the common good." The Greisman court thereby set the stage for the application of the vague principles of public policy to the review of private hospital staffing decisions in New Jersey.

A. Initial Applicants

The first medical staff applicant case in New Jersey following Greisman was Schneir v. Englewood Hospital Association. In Schneir, an osteopath sued to require a private hospital to consider

151. Id. at 402, 192 A.2d at 824.
152. Id.
153. Id.
154. Id. at 403-04, 192 A.2d at 824-25.
155. The court stated:

Hospital officials are properly vested with large measures of managing discretion and to the extent that they exert their efforts toward the elevation of hospital standards and higher medical care, they will receive broad judicial support. But they must never lose sight of the fact that the hospitals are operated not for private ends but for the benefit of the public, and that their existence is for the purpose of faithfully furnishing facilities to the members of the medical profession in aid of their service to the public. They must recognize that their powers, particularly those relating to the selection of staff members, are powers in trust which are always to be dealt with as such. While reasonable and constructive exercises of judgment should be honored, courts would indeed be remiss if they declined to intervene where, as here, the powers were invoked at the threshold to preclude an application for staff membership, not because of any lack of individual merit, but for a reason unrelated to sound hospital standards and not in furtherance of the common good.

Id. at 403-04, 194 A.2d at 825.
his membership “application in good faith, reasonably and for the public good.” The hospital credentials committee recommended that the application be deferred after considering the following: the applicant was ranked forty-first in a class of sixty-five students; he obtained an M.D. degree from a California medical school, without attending it; he lacked post-graduate training; the hospital knew very little of the applicant’s medical practice; the hospital was experiencing a bed shortage; and the applicant was on staff at two other area hospitals. The hospital, as a general practice, admitted doctors with medical specialties who had served residencies, passed specialty board examinations, had considerable post-graduate experience, had more medical experience than the osteopath, and filled specialty positions that the hospital needed.

The Schneir court, dismissing the action, held that the hospital gave the applicant full consideration. Though the court recognized that the applicant’s qualifications were questionable, it held that it did not have to evaluate them. Instead, the court only had to determine that the qualifications were considered fairly. Because the hospital processed the application according to its usual procedures, the court gave the hospital’s decision “broad judicial support,” despite the osteopath’s complaint that the reasons for the deferral of his application were never communicated to him.

Three subsequent New Jersey cases addressing initial staff decisions involved hospitals’ attempts to deny applicants staff membership based on the hospital’s alleged inability to accommodate additional members and patients. These cases demonstrate that New Jersey courts will not only review the procedural adequacy of private hospitals’ application procedures, but they also will decide whether the hospitals’ decisions are substantively correct.

In Davis v. Morristown Memorial Hospital, two obstetricians practicing obstetrics and gynecology were denied admission to a

157. Id. at 528, 221 A.2d at 560.
158. Id. at 528-31, 221 A.2d at 560-62.
159. Id. at 532, 221 A.2d at 562.
160. Id. at 533, 221 A.2d at 563.
161. Id. at 534, 221 A.2d at 563.
162. Id.
163. Id. at 534, 221 A.2d at 564.
164. Id. at 532, 221 A.2d at 563.
private hospital’s staff because they failed to qualify for any of the exceptions the hospital adopted under its moratorium regarding those specialties.\textsuperscript{167} Although the evidence suggested that the physicians would not be harmed economically by the denial of staff membership, the court decided that the case involved “substantial enough” questions affecting their professional status to warrant judicial review of the validity of the hospital’s policy.\textsuperscript{168}

In reviewing the hospital’s decision, the court considered whether the policy was “reasonable.”\textsuperscript{169} The court first found that the hospital had an occupancy problem in its obstetrical department.\textsuperscript{170} The physicians argued that the hospital should build additional facilities and add more obstetrical beds.\textsuperscript{171} In addition to the obvious feasibility problems with such a proposal, the court recognized that it did not have the power to order the hospital to add more beds.\textsuperscript{172}

The physicians also urged the court to require the hospital to coordinate multiple staff appointments among all of the hospitals in the county to limit patient admissions geographically, and to send patients to other hospitals when space was unavailable.\textsuperscript{173} The court rejected these suggestions as unnecessary, potentially harmful to patients, and without legal basis.\textsuperscript{174}

In finding that the hospital’s policy was reasonable, the court noted that the hospital administrator requested reports from both the obstetrics department and a hospital consultant and collected statistical information concerning the potential patient load diverted to the hospital from another hospital that was closing its

\textsuperscript{167} Id. at 36-37, 254 A.2d at 127. The hospital adopted the following policy: Until an adequate number of medical-surgical, OBS-GYN, and psychiatric beds can be provided, doctors who newly apply for appointment to the Medical Staff and would be admitting patients to any of these beds will be informed that action on their applications must be deferred, except for such doctors as may qualify under one or more of the following criteria:
1. Is setting up practice in a community that is within the hospital primary service area and urgently needs such a physician.
2. Provides specialized professional skills that will substantially improve a service of the hospital.
3. Requests, and qualifies for, a temporary appointment.

\textsuperscript{168} Id. at 39, 254 A.2d at 129.

\textsuperscript{169} Id. at 43-54, 254 A.2d at 131-37.

\textsuperscript{170} Id. at 46, 254 A.2d at 133.

\textsuperscript{171} Id.

\textsuperscript{172} Id. at 47, 254 A.2d at 133.

\textsuperscript{173} Id.

\textsuperscript{174} Id. at 49, 254 A.2d at 134-35.
The court, however, warned that the failure to admit qualified physicians when occupancy was not a problem "would steer the hospital into a collision course with the court." 

Similarly, in Guerrero v. Burlington County Memorial Hospital, the New Jersey Supreme Court upheld a hospital's decision not to expand the surgical staff at a satellite facility. In making its decision, the board of trustees considered the following factors: the size of the satellite facility was small (one hundred beds); the satellite was operating at near capacity; surgical coverage was adequate; an enlargement of the surgical staff would lead to an increase in surgery performed at the satellite, which would overtax the facility and diminish the quality of patient care; the community's needs, which were largely medical, would not be served by such additional surgery; and additional applications would be considered if the facility expanded. In reviewing the hospital's decision, the court considered whether the decision was "supported by substantial credible evidence and was neither arbitrary nor capricious." The court reviewed the record and found that the decision was motivated by the hospital's unwillingness to permit the quality of patient care to deteriorate, as it would if the facility were overtaxed by additional surgical cases. The court noted, however, that any denial of medical staff privileges, "if motivated by a desire to exclude newcomers in order to maintain the status quo of the staff, would not be judicially tolerated."

Nevertheless, shortly after the Guerrero decision, a New Jersey lower court struck down a moratorium on new staff admissions adopted by the hospital board. Applying the Guerrero standard of review, the court in Walsky v. Pascack Valley Hospital struck down the moratorium because it represented an arbitrary and capricious exercise of discretion on the part of the board of trustees and did not contribute to the maintenance of the quality of patient care.

175. Id. at 53, 254 A.2d at 137.
176. Id. at 53-54, 254 A.2d at 137.
177. 70 N.J. 344, 360 A.2d 334 (1976).
178. Id. at 349, 360 A.2d at 336.
179. Id. at 354, 360 A.2d at 339.
180. Id. at 356, 360 A.2d at 340.
181. Id. at 358, 360 A.2d at 341. In addition, despite the fact that these physicians were denied their rights to notice of the specific reasons for denial of their applications prior to any hearing, the court upheld the hospital's denials without further explanation. See id.
182. Id. at 358, 360 A.2d at 341.
care at the hospital.\textsuperscript{184} The court supported its holding by showing that the board acted inconsistently.\textsuperscript{185} Although the hospital had a high occupancy problem, frequently operating at one hundred percent occupancy levels, the court found that the moratorium was not aimed at alleviating that problem because exceptions were made for applicants who promised not to become members of other medical staffs.\textsuperscript{186} Had the moratorium been a genuine attempt to reduce occupancy, the court reasoned, the board would have encouraged additional staff memberships when possible to alleviate the burdens of high hospital utilization.\textsuperscript{187} Furthermore, the hospital had cited the moratorium as a major reason for its need to expand when it applied for government approval to build additional facilities.\textsuperscript{188} Having obtained such approval, however, the hospital did not lift the moratorium.\textsuperscript{189} In addition, the court found that the moratorium had no affect on the occupancy problem and its continuance could not be justified. Thus, the court held that the hospital had adopted an irrational means to achieve the acceptable objectives of controlling its occupancy problems and furthering the quality of patient care.\textsuperscript{190}

In contrast to \textit{Guerrero}, which disregarded the hospital’s failure to inform physicians of the reasons for its actions before their hearing, \textit{Garrow v. Elizabeth General Hospital}\textsuperscript{191} established comprehensive procedural due process rights for physician-applicants. In \textit{Garrow}, a rejected surgeon commenced an action seeking disclosure of the documents in his application file prior to a hearing on his denial; the trial court dismissed his complaint, but the appellate court reversed.\textsuperscript{192} The supreme court, affirming but modifying the appellate court decision, cited \textit{Guerrero} for the proposition that “fundamental fairness” requires the hospital to apprise the physician of the specific charges against him.\textsuperscript{193} Although the court also recognized the physician’s right to a hearing regarding his application, which could include the presentation of supporting witnesses and material, the hospital did not have to provide a “full scale

\textsuperscript{184} Id. at 413-14, 367 A.2d at 1215.
\textsuperscript{185} Id. at 412, 367 A.2d at 1214.
\textsuperscript{186} Id. at 412, 367 A.2d at 1215.
\textsuperscript{187} Id. at 412-13, 367 A.2d at 1215.
\textsuperscript{188} See id. at 410, 367 A.2d at 1214.
\textsuperscript{189} Id.
\textsuperscript{190} Id. at 413-14, 367 A.2d at 1215.
\textsuperscript{192} Id. at 556, 401 A.2d at 537.
\textsuperscript{193} Id. at 557, 564, 401 A.2d at 537, 541.
trial-type hearing." While the rules of evidence do not apply to such hearings, the hospital's conclusions must be based on reasonable grounds. The court further diminished the holding in Guerrero by concluding that the hospital record must contain "sufficient reliable evidence, even though of a hearsay nature, to justify the result." Under Guerrero, the record had to contain "substantial reliable evidence."

The Garrow court also provided that hospitals must allow the physician to be represented by counsel at the hearing because of the substantial interest of the physician in such proceedings. The court envisioned counsel's role to include advising the physician during the hearing, presenting evidence, meeting and explaining adverse data, and presenting arguments to the hearing body. The court also stated that counsel's participation "will be subject to the reasonable rules laid down by the Hospital's board of trustees or other authorized persons and management." The court further held that the relevant data that supported the hospital's conclusion should be made available to the physician prior to the hearing so that he could prepare for it adequately.

Limitations regarding certain specialties or training also can be legitimate bases for exclusion from a hospital's medical staff. In Writable v. Community Memorial Hospital, a licensed registered nurse, certified in psychiatric nursing, sought admission to the adjunct medical staff of the hospital to treat her patients when they were in the hospital. The hospital's bylaws, however, allowed only medical doctors, osteopaths, and dentists onto its staff. The nurse sued the hospital, challenging the restriction. Applying the "sufficient reliable evidence" standard of review to the hospital's bylaws, the court upheld the restriction because the hospital had no psychiatric department, was neither designed nor equipped to handle psychiatric care patients, lacked standards for evaluating the credentials of psychiatric nurses, and had no means of monitoring the decisions of the psychiatric nurse. Thus, the court con-

194. Id. at 564-65, 401 A.2d at 541.
195. Id. at 565, 401 A.2d at 541.
196. Id. (emphasis added).
197. Id. at 566, 401 A.2d at 542.
198. Id.
199. Id. at 566-67, 401 A.2d at 542.
200. Id. at 567-68, 401 A.2d at 542.
202. Id. at 440-41, 501 A.2d at 188-89.
203. Id. at 441, 501 A.2d at 189.
204. Id. at 443, 501 A.2d at 190.
cluded that the hospital was unable to review the nurse's credentials or supervise her activities.205

In Desai v. St. Barnabas Medical Center,206 a recent New Jersey Supreme Court decision involving medical staff applicants, the court held that limiting admission to physicians who join the medical practice of a current member of the hospital's medical staff was invalid.207 Although the "single most important factor" in the denial was that the physician was not associated with another staff member at the hospital, the notice to the physician stated that the hospital had "insufficient medical and surgical beds" and that the physician lacked the special skills that would have enhanced the expertise of the current staff.208

The New Jersey Supreme Court noted that extensive hospital regulation supports the hospital's primary purpose: serving the public.209 Consequently, the hospital's powers must be exercised reasonably for the public good and it must consider the needs of patients, particularly the reasonable opportunity to select physicians and to have adequate access to hospital facilities.210 The court stated that its role in these matters is to determine whether the hospital's policy was supported by adequate information. In Desai, the issue was whether the requirement that an applicant be associated with a current staff member served a health-care objective.211 The court stated that although the evidence was disputed regarding whether the hospital had an overcrowding problem, the hospital nevertheless legitimately could take steps to address the imminent overcrowding that could occur.212

The hospital argued that limiting new staff admissions to those physicians associated with current staff members would curb overcrowding.213 It also argued that this limitation was justified because doctors associated with one another would treat each others' patients.214 The court, however, reviewed the trial court findings, and held that the hospital's justifications were "pure supposition,"215 with no supporting evidence. Because the hospital had

205. Id. at 443-44, 501 A.2d at 190.
207. See id. at 99, 510 A.2d at 672.
208. See id. at 85, 510 A.2d at 665.
209. Id. at 89, 510 A.2d at 667.
210. Id. at 90-91, 510 A.2d at 668.
211. Id. at 93, 510 A.2d at 669.
212. Id. at 93-94, 510 A.2d at 669-70.
213. Id. at 95-96, 510 A.2d at 670.
214. Id.
215. Id.
provided no public health justification, the court invalidated the restriction, holding that it arbitrarily discriminated against otherwise qualified applicants. The court suggested that the hospital could have carried its burden by showing the regularity with which doctors in the same practice cover the patients of their associates or by showing that doctors joining existing practices would not increase the number of patients seeking access to the hospital.

On the same day it decided Desai, the Supreme Court of New Jersey reviewed a challenge to a hospital resolution designed to limit appointments to a hospital’s staff in Berman v. Valley Hospital. The hospital in Berman adopted a resolution limiting future appointments to the active staff to physicians maintaining an office within the primary service area of the hospital and stating that physicians who practiced medicine for two years within a certain geographic area prior to applying for membership were ineligible unless their specialties were in demand at the hospital.

Plaintiff-physicians who were rejected by the hospital because they were subject to the two-year practice limitation challenged the resolution in court. The hospital argued that it had adopted the resolution to address the overcrowding of patients, a problem that reduced the quality of health care. The trial court, reviewing the evidence regarding the resolution, found it unreasonable. The trial court found that the resolution was drafted to benefit the doctors currently on staff and to minimize competition by keeping established non-member physicians off the staff.

The appellate court reversed this decision, based on the trial court’s failure to determine whether the resolution was supported by “sufficient reliable evidence.” The reviewing court upheld the resolution, concluding that sufficient evidence existed and that the resolution was reasonably designed to accomplish a legitimate goal. The Supreme Court of New Jersey, however, agreed with the trial court, reversing the appellate court’s decision because the two-year practice limitation “appeared too vague and attenuated in
its relation to its professed health care objective . . . "227 The court found that the hospital’s rationale for the restriction lacked empirical or academic support and concluded that the hospital failed to establish that its restrictive admissions policy was sufficiently related to a genuine and legitimate health-care objective.228

B. Incumbents

The first medical staff case in New Jersey, one of the few addressing incumbents, involved a physician who sued a hospital for damages and reinstatement as a member of its "Emeritus staff."229 In Joseph v. Passaic Hospital Association,230 the hospital’s bylaws allowed physicians a hearing regarding their reappointment and placed the final responsibility for the decision with the hospital’s board of governors.231 The trial court, dismissing the case, concluded that the board’s failure to give the physician a hearing was a “mere irregularity.”232 In reversing the trial court, the New Jersey Supreme Court noted that by ratifying the bylaws, the board of governors made them an essential part of the hospital’s “elemental law.”233 According to the court, the hearing provided under these bylaws was “clearly intended to protect the staff member against arbitrary, capricious and oppressive action involving his professional qualifications, standing and prestige and the opportunity and facilities for continued services and for the good of the hospital as well.”234 Thus, the hearing was not a mere formality. Moreover, the court articulated a contract theory of interpreting the bylaws,235 invalidating the hospital’s action because it violated the hospital’s “basic law” — its bylaws.236

Twenty years later, in Gareeb v. Weinstein,237 a suspended physician sued several doctors for conspiracy to illegally suspend his privileges without notice or a hearing.238 The physician had sued

227. Id. at 113, 510 A.2d at 680.
228. Id.
229. See infra notes 230-36 and accompanying text.
231. Id. at 565-66, 141 A.2d at 22.
232. Id. at 570, 141 A.2d at 25.
233. Id. at 568, 141 A.2d at 24.
234. Id. at 568-69, 141 A.2d at 24.
235. Id. at 571, 141 A.2d at 25. The court stated: "The [hospital's bylaws] are essentially conventional; the compact derives from the common consent of the parties, and is limited accordingly." Id.
236. Id.
238. Id. at 8, 390 A.2d at 709.
the hospital, in an earlier action, alleging a denial of due process, which resulted in a ruling in favor of the hospital.\textsuperscript{239} The physician-defendants in the second lawsuit argued that this previous action precluded the suit against them.\textsuperscript{240} The court refused to apply the doctrine of collateral estoppel because the plaintiff-physician was denied his \textit{Garrow} right to counsel and discovery in the previous action.\textsuperscript{241} The court’s application of \textit{Garrow}, a case involving a medical staff applicant, to a case involving an incumbent staff member, illustrates that due process requirements in New Jersey for applicants and incumbents are the same, a result rejected by the Illinois courts.\textsuperscript{242}

The application of identical standards for New Jersey applicants and incumbents is further supported by the decision of the New Jersey Supreme Court in \textit{Belmar v. Cipolla}.\textsuperscript{243} In \textit{Belmar}, a group of terminated anesthesiologists sued a hospital for its entrance into an exclusive contract for anesthesiology services with a competing group of anesthesiologists.\textsuperscript{244} The court upheld the decision of the hospital, finding it reasonable under the circumstances.\textsuperscript{245} Thus, the same test of reasonableness applies regardless of whether the physician is an applicant or an incumbent under New Jersey law.

V. Evaluation of Common Law Due Process

A. Majority Approach

The rule disallowing judicial review of initial medical staff appointment decisions\textsuperscript{246} is well-founded. In the absence of some anticompetitive behavior by certain physicians against an applicant or other economic harm, courts should refrain from reviewing such matters. If anticompetitive behavior or economic harm is present, the physician should not be bringing due process claims but antitrust law suits. The applicant has no constitutional, statutory or regulatory right to be on the staff of any particular hospital. Therefore, he lacks a protected due process interest in staff membership at a particular institution.

When a physician gains staff membership, he enters into a relationship with the hospital under conditions set out in the hospital’s
bylaws and regulations. Illinois courts are thus correct to hold hospitals to their bylaws and regulations. In light of Knapp and Rao, however, Illinois courts appear to be at best indifferent to the rights of physicians under a hospital’s bylaws and regulations.

The elimination of the physician’s rights by the court in Rao is remarkable. The court’s decision to affirm the denial of the right to cross-examine adverse witnesses because the hospital need not produce them is particularly troublesome. One would expect the judiciary to be especially sensitive to a physician’s need to confront his accusers. Cross-examination is intended to aid in the fact finding process. Without cross-examination, the search for an accurate assessment of a physician’s ability is hampered. Moreover, the hospital’s failure to notify the physician of the charges against him or its prosecution of him by the committee which was to decide the matter are patent and substantial violations of the hospital’s bylaws. To suggest that the Rao case did not involve a substantial violation of the bylaws ignores the importance of these bylaw provisions.

The standard of review in Illinois is thus substantially undermined by Rao. After Rao it will be hard to find a case that meets the “substantial violation” test.

B. Minority Approach

Judicial review of a hospital’s medical staff decision in New Jersey is based essentially on three factors: judicial protection of the physician’s right to practice medicine; judicial protection of the patient’s right to choose a physician; and permissible judicial regulation of hospitals based on their quasi-public natures. Under close analysis, however, these justifications for judicial review lack merit.

1. The Physician’s Right to Practice Medicine

A physician’s right to practice medicine at a private hospital was

247. See supra notes 109-129 and accompanying text.
248. See supra note 122 and accompanying text. The Rao court failed to indicate why the hospital did not produce the physician’s accusers for cross-examination. Private hospitals cannot compel the presence of witnesses at a peer review hearing because they lack subpoena power. If the accusers in Rao refused to appear as witnesses, the court’s holding regarding the lack of cross-examination would be more defensible. If, however, the hospital encouraged the accusers not to appear at the hearing, it clearly and substantially violated the physician’s rights under the bylaws.
250. Id.
251. Id.
created neither by the federal or state constitutions, nor by any statute or regulation. Its only possible source in New Jersey lies in tort law as developed by the courts.

If New Jersey courts are willing to protect the right to practice a profession affecting the "common good," other professionals who are denied employment by private employers should be entitled to the same due process safeguards afforded physicians. Physicians, individually and as a class, are not more vulnerable than other professionals and thus deserving of special judicial protection. The New Jersey courts fail to explain why unfairness or incorrect decision-making is subject to judicial review in the private hospital-physician setting and not in other settings such as the private university-faculty environment. Professional educators need access to educational institutions and facilities to the same extent physicians need access to hospitals.

These problems become especially acute when one realizes that a physician need not allege that a particular hospital has monopoly control over an area or that membership at a particular hospital is essential for the physician's practice. Without some showing of necessity, the physician's claims turn on matters of convenience. If inconvenience to a physician constitutes a denial of the physician's right to practice his profession, that right has no limits. Yet, in some cases, hospital restrictions can outweigh the court's desire to protect this right. The problem is knowing when a hospital has gone too far.

The New Jersey courts have failed to define the precise nature and content of a physician's right to practice medicine in private hospitals. While some physicians (surgeons, for example) require hospital facilities to practice their specialties, a general practitioner can treat patients without utilizing the hospital. Moreover, assuming a physician is a staff member at a hospital, his right to practice medicine is not being denied. More importantly, if a qualified physician is being precluded from practicing medicine in every hospital in the state, he should be bringing an antitrust claim rather than an amorphous denial of due process claim. Courts are more adept

252. See supra notes 165-76 and accompanying text.
253. See, e.g., Walsky, 145 N.J. Super. at 402, 367 A.2d at 1209 (physician sought staff membership at the hospital principally because the facilities, services and general patient care available there was superior to another area hospital).
255. For an insightful analysis of how courts should treat antitrust claims raised by
at addressing matters involving anticompetitive behavior than physicians' qualifications for medical staff membership.

Consequently, the right to practice medicine at a private hospital is too uncertain. Moreover, judicial recognition of this "right" gives physicians rights over and above those of similarly situated professionals. The creation and protection of such a right without applying the same standards to other similar professions seems unfair under equal protection analysis. Because the antitrust laws should provide adequate protection of a physician's right to earn a living, the due process right to practice medicine under New Jersey's common law is unnecessary.

2. Patient Choice

The New Jersey courts' concern for the right of a patient to choose a physician is pretextual. If a patient's freedom of choice actually was violated, the patient is the proper party to challenge the hospital's conduct. A patient, however, has never brought such a claim. The consideration of patients' desires is therefore unsupported. Furthermore, it is unsound because a person typically may not seek a judicial remedy on behalf another.

In addition, there is no judicial protection of a patient's right to choose the services of a particular physician at a particular hosp-

256. It would be difficult to conceive of a legal theory on which a patient would prevail.

257. See Fuchs v. Bidwill, 65 Ill. 2d 503, 509-10, 359 N.E.2d 158, 161-62 (1976); Lynch v. Devine, 45 Ill. App. 3d 743, 747-748, 359 N.E.2d 1137, 1140 (3d Dist. 1977); Weihl v. Dixon, 56 Ill. App. 3d 251, 253-54, 371 N.E.2d 881, 883 (5th Dist. 1977). For example, in Weihl, an attorney attempted to file annual reports with the Illinois Secretary of State on behalf of his corporate clients which did not employ a corporate secretary. Weihl, 56 Ill. App. 3d at 252, 371 N.E.2d at 882. The Secretary of State, however, refused to accept such reports pursuant to a state statute which required all business corporations to have a secretary as one of their officers. Id. The attorney sued the Secretary of State on behalf of his clients for a declaration that a corporate secretary was not required under the law. Rather than reaching the merits of this case, the court dismissed the attorney's claim because he lacked standing to assert the interests of his corporate clients. Id. at 255, 371 N.E.2d at 884. The court rejected the attorney's argument that he was "interested" in the construction of the statutes in this case because it would affect his future conduct as an attorney. Id. at 254-55, 371 N.E.2d at 883-84. In so doing the court stated:

No annual report of plaintiff's was refused by defendant but only those plaintiff's clients. It is they whose rights are allegedly infringed and thus, it is they who must seek redress. Plaintiff may not invoke a remedy on behalf of others who do not seek or desire it. Consequently, we find plaintiff lacks standing to bring the instant action.

Id. at 255, 371 N.E.2d at 884.
Patients have only the right to retain the services of a particular physician, his medical staff memberships notwithstanding. Thus, the patient's freedom of choice consideration is further unwarranted.

Judicial recognition that patients typically do not select particular specialists has further eroded this justification for judicial intervention.\textsuperscript{258} Most specialists require hospital facilities to practice their specialties. Additionally, specialists lack the patient contact that general practitioners enjoy. This lack of contact with patients increases the specialist's need for hospital staff membership, which operates as a referral network. Within the network, patients are referred to these specialists by their primary care physicians. Significantly, general practitioners, for whom patient choice is an actual concern, are not bringing lawsuits in New Jersey. On the contrary, specialists, who typically are not "chosen" by the patients but, rather, by the patient's primary care physicians, generally are the ones filing claims against the hospitals.\textsuperscript{259} Thus, patient choice is clearly not a valid justification for routine judicial intervention in hospital medical staff decisions.

3. Hospital Regulation and Public Support

Hospital regulations and public financial support have no causal relationship with due process rights for physicians. If a hospital violates a public health regulation or misuses funds derived from the government or the public, the appropriate remedy is found within the state regulatory scheme or the terms under which the money was provided. For example, if a hospital fails to satisfy hospital licensing requirements, it should lose its license. If it fraudulently solicits money from the public, it should be sued by the donor and by appropriate criminal law enforcement entities. If it violates the conditions of tax-exempt status, it should lose that status. No New Jersey court has cited a regulatory or funding provision that requires hospitals to provide physicians with due process. Given the current extensive regulation of hospitals, however, the New Jersey courts find judicial regulation of their medical staff decisions appropriate.

The fiduciary trust theory\textsuperscript{260} propounded by the New Jersey

\textsuperscript{258} See Belmar v. Cipolla, 96 N.J. 199, 209, 475 A.2d 533, 539 (1984) ("patients rarely select an anesthesiologist").


\textsuperscript{260} See supra notes 137-38, 147 and accompanying text.
courts fails to limit those parties who can enforce the trust. In addition, the case law's fiduciary trust language illustrates a judicial desire to correct what is perceived to be unfair or incorrect "hiring" decisions by private hospitals. The common good always will be violated when one concludes that an act is unfair or incorrect. The courts have delineated no restriction by which one can determine how or when the "public" is injured by a hospital's medical staff decision, and whether a member of the public can thus file suit. Without standards for measuring public injury, the New Jersey courts remain free to make ungrounded decisions. Thus, in New Jersey there is no medical staff law; there are only cases.

IV. THE REMEDY FOR DUE PROCESS VIOLATIONS

The appropriate remedy for a denial of procedural due process is to provide due process. Such a result, however, may not provide the physician with his ultimate goal: staff membership at a particular hospital. An alternative remedy, compensatory damages, may not be recovered unless the physician can prove actual injury. Furthermore, the calculation of this relief is highly speculative and does not provide the physician with a place to treat his patients. Showing actual injury in such cases could be very difficult for physicians who have privileges at several hospitals. Even if such proof was available, many states, including Illinois, have statutes that bar actions for damages by physicians against hospitals for their credential and peer review activity. Even the Supreme Court of New Jersey dismissed a damages claim based on a denial of procedural due process for failing to state a cause of action.

The remedy for a violation of a physician's substantive due process is equally unavailing. The physician could seek a court order placing him or her on the staff of a particular hospital. The more appropriate, and more likely, relief would be an injunction preventing the hospital from using an illegitimate basis for denying the physician either staff membership or privileges. This remedy is

262. The proper measure of damages from a wrongful suspension of privileges or termination of membership is the loss of the physician's income due to such misconduct, minus any mitigation of damages by the physician through use of his privileges at other hospitals. See McMillan v. Anchorage Community Hosp., 646 P.2d 857 (Alaska 1982). Determining the economic harm to a physician who is denied medical staff membership in one hospital in an area that provides many opportunities for the physician to practice medicine is guesswork, at best.
263. See, e.g., ILL. REV. STAT. ch. 111 1/2, para. 151.2 (1985).
265. See supra notes 206-28 and accompanying text.
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inadequate, however, because a hospital can still reject or discharge him on some other independent, legitimate basis. Thus, although a due process claim may be appealing to lawyers representing physicians, it does little to further the goals of the physician who is bringing the action.

VI. MEDICAL STAFF BYLAWS AS CONTRACTS

The medical staff is an entity that defies legal categorization. At best, it can be viewed as a diffusive, unincorporated association whose existence depends upon the existence of the hospital. The relationship between the hospital and its medical staff is symbiotic: a spirit of cooperation is essential for either entity to prosper.

Medical staff membership and clinical privileges allow a physician to practice medicine in the hospital by treating the patients who seek his services. The hospital, on the other hand, provides the physician with facilities, equipment, and support services necessary for the treatment of the patient for which it is recompensed. In exchange, the physician discharges whatever obligations and responsibilities he has under the medical staff bylaws, rules, and regulations. The hospital benefits from this relationship because it charges the patient for its hospital services and the physician benefits from the relationship because he charges the patient for his professional services. The productive co-existence between the hospital and its staff results in economic gain for both entities.

Furthermore, hospitals are unique institutions, governed by two sets of bylaws. One set is composed of the corporate hospital bylaws that establish the organizational structure of the hospital. The other is the medical staff bylaws, which define the relationships between the hospital and its physicians. Medical staff bylaws usually set out the following: (1) the purposes of the medical staff; (2) the staff’s relationship to the hospital; (3) the criteria and application procedures for staff membership and clinical privileges; (4) disciplinary or corrective procedures; (5) organization of the hospital’s clinical departments; (6) the medical staff officers and their responsibilities; and (7) the medical staff committees.

The courts are split over whether these bylaws are an enforcea-

266. See supra notes 156-205 and accompanying text.
ble agreement among the hospital, the staff, and the individual physicians.\textsuperscript{269} The more reasonable analysis, supported in both Illinois and New Jersey, is that the medical staff bylaws are an integral part of the contractual relationship between the hospital and the members of its staff.\textsuperscript{270}

In \textit{Fahey v. Holy Family Hospital},\textsuperscript{271} a general surgeon challenged the hospital’s rule requiring him to consult with a member of the department of obstetrics and gynecology before performing any major gynecological surgery in the hospital. The surgeon argued that this rule reduced his surgical privileges in violation of the hospital’s bylaws. The court recognized that the bylaws were an “integral part of the contractual relation between a hospital and the members of its staff,”\textsuperscript{272} but held that the hospital rule was reasonable and proper.\textsuperscript{273} Because the \textit{Fahey} parties failed to contest that the bylaws constituted a contract, the court was not asked to address the split in the law over this issue.

Inexplicably, the New Jersey Supreme Court’s contractual analysis in \textit{Joseph}\textsuperscript{274} has never appeared again in subsequent New


\textsuperscript{270} \textit{See supra} notes 268-70 and accompanying text.

\textsuperscript{271} 32 Ill. App. 3d 537, 336 N.E.2d 309 (1st Dist. 1975).

\textsuperscript{272} \textit{Id.} at 543, 336 N.E.2d at 314.

\textsuperscript{273} \textit{Id.} at 546-47, 336 N.E.2d at 316.

\textsuperscript{274} \textit{See supra} note 235-36.
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Jersey decisions. Nevertheless, the majority of courts, especially the more recent decisions,275 favor a contractual analysis of the medical staff bylaws.

The courts rejecting this contractual theory never cite any legal theory upon which the relationship between the hospital and its staff members is based.276 The courts also fail to explain why a hospital would draft, adopt, and approve bylaws that are not contractually binding on the hospital. Moreover, a hospital that seeks to avoid the restrictions of the medical staff bylaws is operating under a double standard. Most, if not all, medical staff applications ask the physician to certify that he has read the medical staff bylaws and that he agrees to be bound by them if he attains staff membership. If a hospital intends to enforce the bylaws against a prospective staff member, it must be ready to assume its obligations under the same bylaws.

A physician considering staff membership at a particular hospital should carefully review the bylaws of that hospital. The bylaws provide an indication of what type of treatment the medical staff applicant may expect if admitted.277 If a physician observes something in the medical staff bylaws that appears unfair, the physician should seriously consider whether he desires to be a staff member at that hospital.

The physician should pay particular attention to the sections regarding (1) the relationship between the staff and the hospital, (2) amendments to the bylaws, (3) the appointment and reappointment process, (4) the delineation of clinical privileges, and (5) disciplinary or grievance procedures. These five areas are the most likely to invite controversy. It is imperative for the physician to understand and be comfortable with the provisions covering these items. If these provisions seem unfair, he should seek staff membership elsewhere.

While the physician may be unhappy about the lack of particular rights under the bylaws, he may be unable to secure admission to a staff that will provide him with what he seeks. He then should accept membership on present terms with the hospital, and attempt to negotiate changes as a medical staff member. Though his bargaining power as an individual is weak compared to that of the hospital, the entire medical staff, as an entity, wields a great deal of

275. See supra notes 237-45 and accompanying text.
276. Id.
277. Effective in 1987, the JCAH'S ACCREDITATION MANUAL FOR HOSPITALS will require that "[n]either body may unilaterally amend the medical staff bylaws."
power over the hospital. Thus, a concerted action by the staff may effect the desired changes.

The benefits of negotiating specific contractual rights through the medical staff bylaws include (1) recognition by the hospital and the physician that they have explicit rights and responsibilities which are carefully articulated in the bylaws, (2) avoidance of judicial intervention on vague and slippery "fairness" or "due process" grounds which can easily be interpreted out of existence or interpreted so expansively that no one intended such an interpretation, and (3) reduction of disputes between the physician and the hospital over the rights to which either party is entitled. Viewing medical staff bylaws as a contract between the physician and the hospital will add certainty to their relationship. Doctors and hospitals thus would be responsible for clarifying their relationship. Such clarification could reduce misunderstandings and avoid the need for courts to intervene or restrict such intervention. The provisions of a contract are to be strictly construed against the hospital.278 Physicians and hospitals would benefit from clarification in their relationships, especially when both possess the power to define those relationships. The current state of the law confuses, rather than clarifies, these relationships.

VII. CONCLUSION

The legal relationship between hospitals and physicians is in need of greater certainty. "Due process" is a vague concept that gives courts, regulators, and attorneys general room to misinterpret the rights and responsibilities of the parties involved. The case law from Illinois, which appears to ignore the clear rights of physicians under the medical staff bylaws, and the case law from New Jersey, which is incomprehensible and unpredictable, illustrate that courts do not provide an appropriate forum for resolving differences between physicians and hospitals on due process grounds. Hospitals and physicians will be better off if they substitute negotiation for litigation. Once hospitals and physicians begin to see their relationship as contractual, they will negotiate the specific protections they need to function in their patient-care environment. More importantly, in the event of litigation over the contracts, courts will be forced to construe the bylaws strictly. Judicial review thus will be limited by the principles of contract interpretation rather than tort law. This approach should greatly reduce the

278. Saddler v. National Bank of Bloomington, 403 Ill. 218, 85 N.E.2d 733 (1949) (contracts must be construed most strongly against the drafter).
influence of third party regulators including courts, attorneys general, and administrative agencies. Moreover, it will allow hospitals and physicians to be in greater control of their destiny in a spirit of cautious cooperation.