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# An Ounce of Prevention is Worth aPound of Cure: The Need for Statesto Legislate in the Area of HospitalProfessional Review Committee Proceedings

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# AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE: THE NEED FOR STATES TO LEGISLATE IN THE AREA OF HOSPITAL PROFESSIONAL REVIEW COMMITTEE PROCEEDINGS

Currently, courts must untangle a web of legal theories to resolve suits that physicians, alleging that a hospital professional review committee wrongfully has revoked the physician's medical staff privileges, have brought against the members of professional review committees.[1] State legislatures have the power to enact legislation that can ease the courts' burden and simultaneously improve the professional review process.[2] State legislatures should use their power to streamline the law applicable to physicians' antitrust suits against the members of hospital professional review committees that have revoked the physicians' hospital medical staff privileges.[3]

To comply with accreditation standards that the Joint Commission on Accreditation of Healthcare Organizations has established,[4] most hospital bylaws require that the members of the hospital's medical staff organize a professional review committee.[5] One significant purpose of the professional

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1. *See infra* notes 25-100 and accompanying text (describing analysis necessary to resolve antitrust cases physicians have brought against members of professional review committees).

2. *See infra* notes 170-75 and accompanying text (explaining that state legislatures can enact legislation to simplify legal analysis necessary to resolve physicians' antitrust actions against members of professional review committees).

3. *See infra* notes 201-10 and accompanying text (explaining how state legislation can simplify judicial analysis of antitrust cases physicians have brought against members of professional review committees).

4. *See generally* Joint Comm'n on Accreditation of Healthcare Orgs., *1989 Accreditation Manual for Hospitals* (1988) [hereinafter JCAH *Manual*] (describing hospital accreditation procedures and criteria). Although participation in the accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAH) is entirely voluntary, hospitals seek JCAH accreditation for two significant reasons. *See* 1 W. Lazarus, E. Levine, L. Lewin, Lewin & Assocs., Inc., Competition Among Health Practitioners: The Influence of the Medical Profession on the Health Manpower Market IV-10 (Executive Summary & Final Rep't, Rep't for Federal Trade Comm'n, Feb. 1981) (discussing importance of JCAH accreditation). First, JCAH accreditation is a prerequisite for certain federal funding programs and other institutional benefits. *Id.* For example, JCAH accreditation meets the certification requirements necessary for the hospital to receive Medicare funding. *Id.* Also, Blue Cross contracts typically require covered patients to receive treatment at hospitals that the JCAH has accredited or hospitals that comply with standards comparable to those that JCAH has set for hospital accreditation. *Id.* Second, a hospital must receive JCAH accreditation for residency accreditation, which is necessary if the hospital is affiliated with a medical school. *Id.* Finally, JCAH accreditation provides a hospital with increased respectability in the medical community. *Id.* Consequently, the majority of the hospitals in America participate in the JCAH accreditation program. *Id.*

5. *See* JCAH *Manual*, *supra* note 4, MS.3.5, at 108 (requiring medical staff to organize executive committee to grant, delineate, and terminate individual clinical privileges, and organization of medical staff's quality assurance activities); *see also* Kopit, *Commentary:*

review committee is to assess the competence and professional conduct of the physicians currently holding medical staff privileges at the hospital.[6] Medical staff privileges provide physicians with the right to perform medical procedures within a hospital and to participate in the hospital's governing structure.[7] If the professional review committee finds that a staff physician's performance adversely affects the quality of patient care at the hospital, either because the physician's performance endangers patient health or disrupts the medical staff, the professional review committee may recommend to the hospital's governing board that the hospital revoke the physician's medical staff privileges at the hospital.[8] Without medical staff privileges,

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*Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1170, 1172 (1986) (defining "professional peer review" as process whereby hospital establishes standards for appropriate quality of care and then medical staff judges individual physicians for compliance with standards); Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117, 1117 (1986) (defining "professional peer review" as fellow physicians overseeing practices of individual physicians for purpose of maintaining quality and containing cost of medical care).

6. *See* JCAH *Manual*, *supra* note 4, QA.2.1, at 220 (requiring medical staff to monitor and evaluate quality of patient care and performance of all individuals with privileges). JCAH accreditation standards require the hospital medical staff to review individual physicians' qualifications for medical staff membership when a physician applies for membership, every two years for reappointment purposes, and upon allegations of misconduct or incompetence. *See id.* MS.3.5.2.1.3, MS.5.2, at 108, 115 (requiring medical staff to review applications, reappointments, and quality of care). The hospital's professional review committee reviews applications from physicians seeking medical staff privileges at the hospital and makes recommendations to the hospital's governing board. *See id.* MS.3.5.2, MS.3.5.2.1.3 to 3.5.2.1.4, at 108 (requiring medical staff executive committee to recommend to governing body individuals for medical staff membership and delineated clinical privileges for each eligible individual). After the hospital has granted an applicant physician membership on the medical staff, JCAH accreditation standards require physicians to apply for reappointment to the hospital medical staff at least every two years. *Id.* MS.5.2, at 115. In addition to conducting professional review of a physician's professional conduct on a regular basis for reappointment purposes, JCAH accreditation standards require the medical staff to review a physician's conduct when department heads or medical staff members identify important problems in patient care and clinical performance. *Id.* MS.6.1.1.4, at 118. In both the reappointment proceedings and proceedings initiated by allegations of misconduct, the professional review committee considers a number of factors, including incompetence, habitual use of intoxicants or drugs, mental or physical impairments that adversely may affect patient care, liability in medical negligence or malpractice actions, failure to comply with the policies that a quality assurance commission has established, and ability to harmonize with other staff members. *See* Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 712 (1981) [hereinafter Dolan & Ralston] (stating that hospitals can revoke physician's medical staff privileges for any reason related to performance).

7. *See* Kissam, Webber, Bigus, & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595, 596 n.1 (1982) [hereinafter Kissam] (stating that physicians with medical staff privileges have right to perform medical procedures within hospital and to participate in hospital's governing structure).

8. *See* Dolan & Ralston, *supra* note 6, at 712 (stating that hospital can revoke medical staff privileges due to misconduct, incompetence, debilitation, or any other reason related to performance). In addition to revoking a physician's privileges because the physician is incompetent, a professional review committee may recommend that the hospital revoke the physician's

a physician is unable to have his patients admitted to the hospital or to treat his patients during their stays in the hospital.[9] Therefore, the lack of medical staff privileges at a local hospital disadvantages a physician as he competes with other physicians practicing in the same geographic area.[10] Moreover, a physician who has lost medical staff privileges as the result of an unfavorable professional review decision bears the stigma of a second-class physician in the eyes of the medical community and consumers.[11] Thus, the professional review committee's decision to grant or withdraw a physician's medical staff privileges can determine the success of the physician's future career.[12]

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medical staff privileges because the physician's behavior disrupts the operation of the hospital. *See* J. HORTY, ACTION KIT FOR HOSPITAL LAW 1 (1984) (stating that courts have upheld hospitals' authority to terminate physicians whose behavior disrupts hospital operations). Horty distinguishes disruptive physicians from physicians whose lifestyles are not to the liking of medical staff members, but who competently treat patients and do not foment trouble among the staff members. *Id.* at 2. Unlike physicians who are merely different or unorthodox, the behavior of disruptive physicians affects the ability of others to successfully complete their jobs. *Id.*

9. *See* Note, *Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?*, 19 IND. L. REV. 1219, 1222 (1986) (stating that health care provider must have medical staff privileges to admit patients to hospital and to care for patients in hospital). A physician without medical staff privileges at a hospital loses many important opportunities. *See* Dolan & Ralston, *supra* note 6, at 714 (discussing various opportunities physicians without medical staff privileges lose). For example, a physician without medical staff privileges at the hospital where his patient wishes to receive medical treatment must refer the patient to a physician with medical staff privileges at that hospital. Weiss v. York Hosp., 745 F.2d 786, 792 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985). Consequently, the patient's physician loses the opportunity to treat and charge his patient. *Id.* Furthermore, the patient may choose to retain the new physician upon the patient's release from the hospital. *Id.* at 794. In addition to losing the physician's patients to a physician with medical staff privileges, a physician without medical staff privileges loses opportunities to attract new patients. Dolan & Ralston, *supra* note 6, at 714. Members of the hospital's medical staff often staff the hospital's emergency room. *Id.* Because patients admitted to the emergency room frequently have no regular physician, those physicians working in the emergency room attract new patients. *Id.* Also, a physician without medical staff privileges loses an opportunity to work with other physicians who might wish to enter a referral relationship. *See id.* (explaining that physician with medical staff privileges might enter joint referral relationship with other physicians on staff). Lastly, a physician without medical staff privileges cannot participate in a community that evaluates the physician's skills and provides educational opportunities. *See id.* (stating that physicians with medical staff privileges belong to community that evaluates physicians' skills and provides educational opportunities). Because physicians often practice in unsupervised outpatient clinics with few educational opportunities, hospitals frequently serve as the only practical place where physicians may receive the benefits of evaluation and education, particularly in locations far from a medical school. *Id.*

10. *See* Dolan & Ralston, *supra* note 6, at 714 (stating that physician without medical staff privileges has competitive disadvantage with other physicians practicing in same geographic area).

11. *See id.* (stating that physician who has lost medical staff privileges bears stigma of second-class physician).

12. *See supra* notes 9-11 and accompanying text (describing effects loss of medical staff privileges has on physician's career).

Because of the importance of medical staff privileges to the successful practice of medicine, physicians who believe that a hospital, acting on the recommendation of a professional review committee, unjustly has revoked or denied their medical staff privileges have brought suit against the members of professional review committees to regain lost privileges.[13] One legal method physicians have used to seek recourse against allegedly wrongful professional review actions is a federal antitrust action.[14] In fact, in recent years, physicians who have lost medical staff privileges as a result of unfavorable professional review actions have filed a large number of antitrust actions in federal courts against hospitals and the members of professional review committees.[15]

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13. *See* Enders, *Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges*, 17 Loy. U. Chi. L.J. 331, 331 (1986) [hereinafter Enders] (stating that hospital's exclusion of physician from access to hospital facilities may result in substantial economic damage sufficient to motivate physician to file lawsuit); Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1076 [hereinafter *Doctors and Hospitals*] (noting recent increase in litigation concerning revocations of physicians' hospital admitting privileges).

14. *See Doctors and Hospitals*, *supra* note 13, at 1076 n.13 (stating that nearly half of pending antitrust cases in health care industry involve disputes over medical staff privileges); Kissam, *supra* note 7, at 596 (stating that in recent years disappointed applicants for medical staff privileges have filed increasing number of antitrust claims against hospitals and medical staffs). In addition to filing a federal antitrust action to regain lost medical staff privileges, physicians may rely on other legal theories to regain their lost privileges. *Id.* at 601 n.21. First, the physician may allege that the hospital deprived him of privileges in violation of constitutional and common-law due process requirements. *See generally* McCall, *A Hospital's Liability for Denying, Suspending and Granting Staff Privileges*, 32 Baylor L. Rev. 175 (1980) (discussing various theories of common-law and constitutional liability that physicians may use against hospital that has revoked physician's privileges). Second, the physician may allege that the hospital's actions violated state statutes granting physicians' procedural and substantive rights. *See* N.Y. Pub. Health Law § 2801-b(1), (2) (McKinney 1985 & Supp. 1989) (providing that, if hospital governing board has terminated physician's medical staff privileges without stating reasons, physician may file complaint with state public health council). Finally, the physician may allege that the hospital has violated various contract and tort theories. *See* 132 Cong. Rec. H9954, H9963 (daily ed. Oct. 14, 1986) (statement of Rep. Tauke) (noting that physicians bring defamation actions against members of professional review committees); Kissam, *supra* note 7, at 601 n.21 (stating that physician may bring contract and tort actions against hospital).

15. *See* Marrese v. Interqual, Inc., 748 F.2d 373, 381 (7th Cir. 1984) (stating that, since late 1970s, federal antitrust courts have been deluged with hospital privileges suits), *cert. denied*, 472 U.S. 1027 (1985). Although some conflict among physicians traditionally has existed, recent economic changes in the market for health care and hospital services have intensified the conflict between physicians who have medical staff privileges and those physicians who do not have medical staff privileges, resulting in an increased number of antitrust cases involving medical staff privileges. Note, *Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?*, 19 Ind. L. Rev. 1219, 1223 (1986). These economic changes include federal and state governmental attempts to limit health care costs by curbing hospital growth. *See* Kissam, *supra* note 7, at 599 (explaining that federal and state governments have attempted to curb hospital growth to limit health care costs). At the same time that federal and state governments have attempted to curb hospital growth, however, the supply of physicians in the country has increased dramatically, a trend experts

Physicians who file antitrust actions against the members of professional review committees attempt to prove that by terminating the physicians' medical staff privileges the committee members sought to restrain competition in the market for medical services.[16] The physicians proceed on the theory that because physicians without medical staff privileges at a local hospital cannot compete effectively against physicians in the geographical area who have medical staff privileges, the physician committee members have restrained competition by wrongfully excluding potential competitors.[17] A plaintiff physician who has filed an antitrust action against the members of a professional review committee may seek various remedies, including monetary damages and injunctive relief.[18]

Although a physician's theory of recovery in an antitrust suit against the members of a professional review committee is analogous to other antitrust suits, the legal analysis necessary to resolve a physician's antitrust suit against the members of a professional review committee is more complex than the analysis required to resolve other, more common types of antitrust suits.[19] Because legislators desire to protect consumers from incompetent physicians, the subjects of medical care quality and hospital regulation are areas of particular legislative concern.[20] Congress, therefore, has enacted

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project will continue for several decades. *See id.* (stating that recent expansion of American medical schools will increase substantially number of physicians practicing in this country during next several decades); Katz, Warner, & Whittington, *The Supply of Physicians and Physicians' Incomes: Some Projections*, 2 J. HEALTH POL., POL'Y & L. 227, 228 (1977) (listing six factors contributing to increased supply of physicians). *See generally* BUREAU OF HEALTH PROFESSIONS, U.S. DEP'T OF HEALTH & HUMAN SERVS., PROJECTIONS OF PHYSICIAN SUPPLY IN THE U.S. (1985) (projecting supply of physicians in United States through year 2000). As these discordant trends continue, the barriers to hospital staff privileges that some physicians already have experienced will grow. *See* Kissam, *supra* note 7, at 599 (stating that barriers to hospital staff privileges will continue as governments attempt to curb hospital growth and supply of physicians increases).

16. *See* 15 U.S.C. §§ 1, 2 (1985) (prohibiting all combinations and conspiracies that restrain trade illegally and monopolies).

17. *See supra* notes 9-12 and accompanying text (discussing importance of medical staff privileges).

18. *See* 15 U.S.C. §§ 15, 26 (1985) (permitting court to award treble damages and injunctive relief to successful antitrust plaintiffs).

19. *Compare infra* notes 25-100 and accompanying text (summarizing analysis necessary to resolve physician's antitrust action against professional review committee members that have revoked physician's privileges—analysis much longer than basic antitrust analysis) *with infra* notes 73-100 and accompanying text (summarizing basic antitrust analysis). The judicial analysis necessary to resolve antitrust actions that physicians have brought against professional review committee members is longer than basic antitrust analysis because the court also must apply the standards that the HCQIA requires. *See infra* notes 25-100 and accompanying text (summarizing analysis necessary to resolve physician's antitrust action against professional review committee members that have revoked physician's privileges).

20. *See* 42 U.S.C. § 11101(1), (2) (Supp. 1988) (stating Congressional findings that need to improve quality of medical care and need to restrict ability of incompetent physicians to move between states requires national legislation to remedy problems).

legislation specifically regarding hospital professional review actions.[21] In addition to the applicable statutory law, a court must examine anticompetitive actions of professional review committees in light of court-made exceptions to federal antitrust laws.[22] Consequently, the court must apply several different laws and legal theories to resolve a physician's antitrust suit against the members of a professional review committee.[23] The necessary judicial analysis is complicated and long, and would benefit greatly from state legislation that consolidates the various applicable legal theories into one statute.[24]

A court that must resolve an antitrust suit a physician has brought against the members of a professional review committee for wrongful revocation of the physician's medical staff privileges must apply the first of several legal theories to decide the defendants' inevitable motion for summary judgment based on Title IV of the Health Care Quality Improvement Act of 1986 (HCQIA).[25] Congress enacted Title IV of the HCQIA out of concern that the staggering damage awards plaintiff physicians had received in antitrust actions from members of professional review committees would discourage physicians from engaging in legitimate professional review actions against incompetent physicians.[26] Through the protection the HCQIA

21. *See* H.R. REP. No. 903, 99th Cong., 2d Sess. 3 (1986), *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385-86 (stating that Health Care Quality Improvement Act of 1986 protects helpless consumers from incompetent physicians' abuses); 132 CONG. REC. H9954, H9963 (daily ed. Oct. 14, 1986) (statement of Rep. Tauke) (stating that all representatives are committed to ensuring that all citizens receive high quality health care services); *infra* notes 25-42 and accompanying text (describing Health Care Quality Improvement Act of 1986).

22. *See infra* notes 45-62 and accompanying text (describing state action doctrine).

23. *See infra* notes 25-100 and accompanying text (summarizing analysis necessary to resolve physician's antitrust actions against professional review committee members that have revoked physician's privileges).

24. *See infra* notes 25-100 and accompanying text (summarizing analysis necessary to resolve physician's antitrust actions against professional review committee members that have revoked physician's privileges); *infra* notes 201-10 and accompanying text (summarizing proposed state legislation).

25. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660 (codified as amended at 42 U.S.C. §§ 11101-11152 (Supp. 1988) [hereinafter HCQIA]; *infra* notes 26-42 and accompanying text (discussing intent and requirements of HCQIA).

26. *See* 132 CONG. REC. H9954, H9963 (daily ed. Oct. 14, 1986) (statement of Rep. Tauke) (stating that threat of antitrust liability is major deterrent to physicians involved in professional review actions); *id.* at H9963-64 (statement of Rep. Wyden) (noting that risk of lawsuit against physicians participating in professional review actions prevents good, honest physicians from participating in professional review actions). In enacting the HCQIA, members of Congress specifically referred to a case in the United States District Court for the District of Oregon where the jury awarded $1,950,000 against a professional review committee for a wrongful revocation of a physician's medical staff privileges. *See* Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986), *rev'd*, 108 S. Ct. 1658 (1988) (detailing facts and holdings in Oregon case that members of Congress referred to in debates on HCQIA); 132 CONG. REC. H9954, H9960 (1986) (daily ed. Oct. 14, 1986) (statement of Rep. Edwards) (citing $2,000,000 jury award made in Oregon case); James, *Peer Review Among Doctors Receives Boost*, Wall St. J., Oct. 10, 1986, at 31, col. 3, *reprinted in* 132 CONG. REC. H9954, H9961-62 (daily ed. Oct.

accords to physicians engaged in professional review actions, Congress attempted to encourage physicians to participate in the professional review process, and thus maintain a high standard of quality for medical care in the country.[27] To achieve this goal, the HCQIA provides that all participants in a professional review action which meets certain statutory definitional and substantive standards shall not be liable in damages under any federal, state, or local law because of the action.[28] The HCQIA thereby provides comprehensive protection for participants in legitimate professional review actions from all liability, including antitrust liability.[29]

Although the HCQIA provides almost absolute immunity for members of professional review committees engaging in legitimate professional review actions, the statute does not provide immunity from liability for all professional review committees.[30] In order for the actions of a particular professional review committee to be within the scope of HCQIA protection, the

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14, 1986) (stating that, as result of large damage awards in Oregon antitrust action against members of professional review committee, many physicians are refusing to participate in professional review actions).

27. *See* H.R. REP. No. 903, 99th Cong., 2d Sess. 2 (1986), *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384 (stating that purpose of HCQIA is to improve quality of medical care by encouraging physicians to engage in professional review of other physicians). Congress cited five legislative findings that induced Congress to enact the HCQIA. 42 U.S.C. § 11101 (Supp. 1988). First, Congress found that the increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems requiring all states to act together. *Id.* § 11101(1). Second, Congress found a national need to restrict the ability of incompetent physicians to move from state to state and thus preventing other hospitals from discovering the physician's previous incompetent performance. *Id.* § 11101(2). Third, Congress believed that effective professional peer review could remedy these initial two problems. *Id.* § 11101(3). Fourth, Congress found that the threat of private money damage liability under federal laws, including treble damage liability under federal antitrust laws, unreasonably discouraged physicians from participating in effective professional peer review. *Id.* § 11101(4). Finally, Congress found an overriding national need to protect physicians engaging in effective professional peer review. *Id.* § 11101(5).

28. 42 U.S.C. § 11111(a) (Supp. 1988). In addition to establishing substantive and procedural standards for professional review actions and providing immunity for committee members that meet the statutory standards, the HCQIA requires the Secretary of Health and Human Services (Secretary) to create a national system for reporting malpractice and disciplinary actions against physicians. *Id.* §§ 11131-11137. The statute authorizes the Secretary to designate a public or private agency to collect, store, and disseminate the information that the statute requires insurance companies and health care organizations to report. *Id.* § 11134(b). The statute requires insurance companies that make payments in satisfaction of medical malpractice claims to report the payments and the challenged acts to the designated agency. *Id.* § 11131. The statute also requires state Boards of Medical Examiners, licensed hospitals, health care service organizations, and professional physicians' societies to report disciplinary actions to the designated agency. *Id.* §§ 11132-11133. Furthermore, the statute requires hospitals to request from the designated agency information concerning physicians who apply for medical staff privileges at the hospital and, every two years, information concerning physicians holding medical staff privileges at the hospital. *Id.* § 11135(a).

29. 42 U.S.C. § 11111(a); *see supra* note 14 (describing various legal theories, other than antitrust, which physicians may use against professional review committee members).

30. *See infra* notes 31-41 and accompanying text (describing limitations on immunity provided in HCQIA).

professional review committee must base its actions on a physician's competence or professional conduct rather than the committee members' anticompetitive business concerns.[31] For example, the statute does not immunize professional review decisions that are based on a physician's refusal to associate with a particular professional organization.[32] The statute also does not immunize professional review decisions that are based on a physician's fees or advertising.[33] Thus, the first of many issues on which the court must hear evidence is whether the defendants based their action on improper motives.[34]

Not only must the professional review committee base its action upon a physician's competence or professional conduct to come within the scope of HCQIA protection, but the HCQIA does not immunize professional review committee members from liability unless the committee complies with four substantive requirements.[35] First, the professional review committee must act in the reasonable belief that the committee's action will further the goal of providing quality health care.[36] Second, the professional review committee must not act until the committee makes a reasonable effort to ascertain the facts surrounding the conduct under investigation.[37] Third, the committee must not act until the physician under investigation has received adequate notice and hearing.[38] Finally, the professional review committee

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31. *See* 42 U.S.C. § 11152(9) (Supp. 1988) (defining permissible justifications for professional review committee action). According to the HCQIA, if a physician is under attack for professional conduct and not for competence, the conduct at issue must affect adversely or have the potential to affect adversely patients' health or welfare. *Id.*

32. 42 U.S.C. § 11151(9)(A) (Supp. 1988).

33. 42 U.S.C. § 11151(9)(B) (Supp. 1988). The HCQIA lists three additional impermissible grounds for professional review action. 42 U.S.C. § 11151(9) (Supp. 1988). First, a professional review committee may not base an action on a physician's participation in prepaid health plans, salaried employment, or any other manner of delivering health services. *Id.* § 11151(9)(C). Second, a professional review committee may not base an action on a physician's association with a member of a group of particular health care practitioners such as chiropractors. *Id.* § 11151(9)(D). Third, Congress included a "catchall" clause that prohibits professional review action based on any matter that is unrelated to a physician's competence or professional conduct. *Id.* § 11151(9)(E).

34. *See supra* notes 32-33 and accompanying text (illustrating improper motives for professional review committee action under HCQIA).

35. 42 U.S.C. § 11112(a) (Supp. 1988); *see infra* notes 36-39 and accompanying text (summarizing statutory requirements for professional review action).

36. 42 U.S.C. § 11112(a)(1) (Supp. 1988).

37. *Id.* § 11112(a)(2).

38. *Id.* § 11112(a)(3). The HCQIA provides an amplified description of the statutory requirements for adequate notice and hearing. *Id.* § 11112(b). First, the committee must give the physician notice stating that the committee has proposed to take a professional review action against him and stating the reasons for the action. *Id.* § 11112(b)(1)(A)(i), (ii). The notice also must state that the physician has the right to request a hearing on the committee's proposed action. *Id.* § 11112(b)(1)(B)(i). Finally, the notice must summarize the rights the physician has in the hearing. *Id.* § 11112(b)(1)(C). If the physician requests a hearing, the committee must notify the physician of the time, place, and date of the hearing, and provide a list of witnesses that may testify for the committee. *Id.* § 11112(b)(2). Furthermore, the

reasonably must believe that the facts surrounding the allegations warrant the committee's action.[39] These substantive requirements assure that the committee complies with due process requirements of notice and a fair hearing.[40] Thus, by restricting the scope of protected professional review actions and by enumerating substantive requirements that standardize committee procedures, Congress has limited immunity to participants in professional review actions that act in good faith.[41] However, Congress also has placed a substantial burden on a plaintiff physician who, to survive a motion for summary judgment and proceed to the merits of an antitrust case, must demonstrate that the defendants based their action on improper motives or failed to provide the plaintiff with adequate notice and a fair hearing.[42]

After reviewing the evidence from the plaintiff and the defendant on the issue of HCQIA immunity, if a reviewing court determines that the professional review committee satisfied the requirements of the HCQIA, the court cannot impose liability on the members of the professional review committee and must dismiss the suit.[43] However, if the professional review committee's actions fail to fall within the scope of the HCQIA's protection, the court next must consider the defendants' second inevitable summary judgment motion alleging that the state action doctrine exempts the defen-

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committee must conduct the hearing according to the standards set out in the HCQIA. *Id.* § 11112(b)(3). The HCQIA requires that a neutral arbitrator, hearing officer, or panel of individuals conduct the hearing. *Id.* § 11112(b)(3)(A). During the hearing, the physician has a right to have an attorney represent him; to have the committee make a record of the proceedings; to call, examine, and cross-examine witnesses; to present relevant evidence; and to submit a written statement at the close of the hearing. *Id.* § 11112(b)(3)(C). Finally, upon the completion of the hearing, the physician has the right to receive from the person who presided over the hearing a written recommendation that states the basis for the recommendation and to receive from the hospital a written decision that states the basis for the hospital's decision. *Id.* § 11112(b)(3)(D). The statute adds, however, that the professional review committee's failure to meet the standards outlined in § 11112(b) shall not, in itself, constitute a failure to provide adequate notice and hearing procedures. *Id.* § 11112(b).

39. *Id.* § 11112(a)(4). The HCQIA requires a court to presume that a professional review action has met the requirement of § 11112(a) unless the plaintiff physician rebuts the presumption by a preponderance of the evidence. *Id.*

40. *See* H.R. REP. No. 903, 99th Cong., 2d Sess. 10 (1986), *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6393 (stating that professional review committees can meet HCQIA's due process requirements by following standards set in 42 U.S.C. § 11112(b)).

41. *See* H.R. REP. No. 903, 99th Cong., 2d Sess. 8 (1986), *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6391 (stating that HCQIA provides limited protection from liability for persons conducting professional review actions based on competence or professional conduct of individual physicians); 132 CONG. REC. H9954, H9957 (daily ed. Oct. 14, 1986) (statement of Rep. Waxman) (stating that HCQIA does not protect illegitimate actions taken under guise of furthering quality of health care).

42. *See supra* notes 25-41 and accompanying text (describing statutory requirements for professional review action that plaintiff physician must prove to impose liability on defendants).

43. 42 U.S.C. § 11111(a) (Supp. 1988). Despite the broad immunity granted in the HCQIA, a court may impose liability on the members of a professional review committee if the court finds that the committee action violated any federal or state laws pertaining to civil rights. *Id.*

dants from antitrust liability.[44] In the context of a federal antitrust suit, the state action doctrine can provide immunity from antitrust liability to private parties who act anticompetitively pursuant to a directive from a state legislature.[45] In 1942 the United States Supreme Court first enunciated the state action doctrine in *Parker v. Brown*[46] when the Court ruled that Congress did not intend the federal antitrust laws to restrict the anticompetitive conduct of a state acting as a sovereign.[47] The Court found that Congress, in enacting the antitrust legislation, intended to focus the legislation on anticompetitive activities of private individuals and business or-

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44. *See* Enders, *supra* note 13, at 339 (stating that defendants who successfully invoke state action doctrine will cause dismissal of complaint); *infra* notes 45-62 and accompanying text (discussing state action doctrine).

45. *See* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (stating that state action doctrine protects private parties if they act pursuant to clearly articulated state policy and if state actively supervises conduct of private parties); *supra* note 44 and accompanying text (stating that court must consider whether state action doctrine exempts defendants from antitrust liability if court finds that professional review committee's actions fail to fall within scope of HCQIA's protection).

46. 317 U.S. 341 (1943).

47. *See* Parker v. Brown, 317 U.S. 341, 350-51 (1943) (finding that language and legislative history of Sherman Act do not suggest congressional purpose to restrain state or state's officers or agents from activities that state legislature directed). In *Parker* the United State Supreme Court considered the validity, under the Sherman Act, of a prorate marketing program that regulated the handling, distribution, and prices of raisins that California growers had produced. *Id.* at 344. The State of California had instituted the program pursuant to the California Agricultural Prorate Act (Act). *Id.* The stated purpose of the Act was to conserve the state's agricultural wealth and to prevent economic waste in marketing the state's agricultural products. *Id.* at 346. The Act authorized the California Director of Agriculture, upon completion of a statutorily-defined public hearing process, to select a program committee from among nominees that qualified producers in the defined production zone had chosen. *Id.* The Act empowered the program committee, composed of private parties, to formulate a proration marketing program for raisins produced in a production zone. *Id.* at 347. After the Agricultural Prorate Advisory Commission had approved the program committee's proposed program, the raisin producers in the affected zone voted on the proposed program. *Id.* If 65% of the producers in the zone owning 51% of the acreage devoted to the production of the regulated commodity approved the program, the Act required the Director of Agriculture to institute the program. *Id.*

The Supreme Court in *Parker* noted that the challenged program would violate §§ 1 and 2 of the Sherman Act if private parties, acting without state authorization, had instituted the program. *Id.* at 350. However, the Court found that the prorate program derived its authority from the state legislature. *Id.* The Supreme Court cited federalist principles in its analysis of the language and purpose of the act. *Id.* at 351. The Court stated that, in a dual system of government, states are sovereign except as Congress constitutionally subtracts from the states' authority. *Id.* Therefore, the Court noted that, as sovereigns, states may choose to displace competition with regulation. *Id.* Upon examining the language of the Sherman Act, the Court found that the Sherman Act does not imply a purpose to restrain state action or official action that the state directs. *Id.* Furthermore, the Court found no suggestion of a purpose to restrain state action in the Act's legislative history. *Id.* Consequently, the Court found that the Sherman Act does not prohibit a state from anticompetitive action. *Id.* at 352. Accordingly, the *Parker* Court held that the challenged prorate marketing program did not violate §§ 1 and 2 of the Sherman Act. *Id.*

ganizations, and not on states acting in their sovereign capacity.[48] In adopting the doctrine, the Court allowed states to retain the power to act anticompetitively to promote values that the state ranks more highly than competition.[49] Since the inception of the doctrine, the Court has expanded the state action doctrine to protect anticompetitive actions not only of the state legislature but also actions of the state judiciary,[50] actions of municipal governments,[51] and actions of state administrative agencies.[52]

In some situations the state action doctrine permits states to authorize private individuals to enact anticompetitive regulations without being subject to antitrust laws.[53] State legislatures may require physician members of hospital medical staffs to regulate themselves by forming professional review committees to improve the quality of health care in the state.[54] The state action doctrine will immunize the anticompetitive actions of the hospital as if the state itself was engaging in the conduct.[55] For the authorized private individuals to enact anticompetitive regulations without subjecting themselves to antitrust penalties, however, the state must ensure that the parties' actions further legitimate government concerns for public health and welfare

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48. *See Parker*, 317 U.S. at 351 (stating that legislative history of Sherman Act does not suggest purpose to restrain action of state).

49. *See* Comment, Patrick v. Burget: *The State Action Doctrine and Bad Faith Peer Review*, 74 VA. L. REV. 609, 620 (1988) (stating that, through state action doctrine, Court allowed states to act anticompetitively to promote values that state ranks more highly than values associated with competition).

50. *See* Bates v. State Bar of Ariz., 433 U.S. 350, 362 (1977) (finding that state bar rule that Arizona Supreme Court made satisfied both requirements of state action doctrine).

51. *See* Town of Hallie v. City of Eau Claire, 471 U.S. 34, 47 (1985) (upholding municipality's regulation of sewage services pursuant to clearly articulated state policy to displace competition without requiring showing of active state supervision). Since the *Hallie* decision, Congress explicitly has exempted from antitrust liability all local governments and local government officials and employees acting in an official capacity. 15 U.S.C. § 35 (Supp. 1989).

52. *See* New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co., 439 U.S. 96, 109 (1978) (ruling that state agency's decisions to regulate establishment of new automobile dealerships constituted state action).

53. *See* Parker v. Brown, 317 U.S. 341, 346-47 (1943) (describing state agricultural program in which state authorized private raisin producers, packers, and handlers to formulate proration marketing program for raisins); Llewellyn v. Crothers, 765 F.2d 769, 772 (9th Cir. 1985) (describing state workers' compensation program in which state authorized two medical doctors to promulgate reasonable rates employers should pay for medical services).

54. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 32128 (West Supp. 1989) (requiring hospital rules to provide that medical staff review work that physicians performed in hospital); IDAHO CODE § 39-1392f (Supp. 1988) (providing that hospitals shall require medical staffs to organize to review professional practices of members of medical staff); IND. CODE § 34-4-12.6-1 (1986) (requiring hospitals to establish professional review committees); N.Y. PUB. HEALTH LAW § 2805-j.1(a) (McKinney Supp. 1989) (requiring hospitals to establish quality assurance committees to review services rendered in hospital to improve quality of medical care of patients); OR. REV. STAT. § 44.055(3)(d) (1987) (requiring medical staff to review professional practices of facility).

55. *See supra* notes 45-52 and accompanying text (discussing development of and rationale behind judicially-created state action doctrine).

and do not further the parties' private anticompetitive motives.[56]

The United States Supreme Court has articulated a two-pronged test for courts to use to determine whether a particular private party purporting to act anticompetitively pursuant to state authorization satisfies the requirements for immunity from antitrust liability under the state action doctrine.[57] First, the state legislature must have articulated clearly and affirmatively the state's intent to displace normal principles of free competition with the challenged private action that restrains competitive commerce.[58] Courts may find a state's expression of intent if a relevant statute explicitly empowers a private party to act in an anticompetitive manner or if the purpose of the private individual's action is a purpose for which the legislature empowered the private individual to act.[59] Second, the state actively must supervise those private individuals that the state has designated to displace free competition.[60] The active supervision requirement requires the state to

56. *See* Patrick v. Burget, 108 S. Ct. 1658, 1663 (1988) (stating that court designed active supervision requirement of state action doctrine to ensure that state action doctrine shelters only anticompetitive acts of private parties that further state policies).

57. *See* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (enunciating two-pronged test to determine whether state action doctrine immunizes anticompetitive conduct from antitrust liability). In *Midcal* the United States Supreme Court considered whether the state action doctrine immunized California's resale price maintenance and price posting statutes for the wholesale wine trade from antitrust liability. *Id.* at 99. The California statute required all wholesalers in a specified area to adhere to the wine prices that a single producer set. *Id.* at 99-100, 103. The Court enunciated a two-part test to determine whether the *Parker* state action doctrine immunized private anticompetitive conduct from antitrust liability. *Id.* at 105. First, the state must articulate clearly and express affirmatively that the challenged restraint is state policy. *Id.* Second, the state must actively supervise the policy. *Id.* The *Midcal* Court found that the California wine pricing system satisfied the first standard. *Id.* However, in applying the second standard to the California program, the Court found that the state simply authorized price setting and enforced prices private parties have set without reviewing the reasonableness of the price schedules or engaging in any pointed reexamination of the program. *Id.* at 105-06. Consequently, the *Midcal* Court found that the California program failed to satisfy the second standard. *Id.* at 105. The Court therefore found that the state action doctrine did not immunize program participants from antitrust liability. *Id.*

58. *Id.*

59. *See* 1 P. AREEDA & D. TURNER, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 214d at 89 (1978) [hereinafter AREEDA & TURNER] (stating that courts can find state's expression of intent stated explicitly in words of relevant statute, or courts can imply state's intent to displace competition). In determining whether a state legislature has implied an intent to displace federal antitrust law, courts consider the rationale for state involvement, the kinds of factors the agency considers in arriving at an administrative decision, customs, and a presumption that competition serves the state's interests unless the state has fairly clearly expressed a different view. *See id.* ¶ 214a, at 81 (discussing factors courts may use in determining whether state legislature has implied intent to displace federal antitrust laws).

60. California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980). The state action doctrine's requirement that states actively supervise parties whom the state has designated to regulate competition substitutes for the economic restraints of the competitive marketplace. *See* AREEDA & TURNER, *supra* note 59, ¶ 213a, at 73 (stating that active supervision requirement of state action doctrine substitutes for restraints of competitive marketplace).

exercise ultimate control over the anticompetitive conduct of the private parties.[61] If the state both intends to allow and supervises the private individuals' action, the private actors qualify for immunity from antitrust liability under the state action doctrine.[62]

To rule on a professional review committee's motion to dismiss based upon the state action doctrine, a court must review extensive evidence of the state's purpose and the extent of state supervision.[63] At this point, the volume of evidence the court already has reviewed probably exceeds the volume of evidence necessary to decide the merits of the plaintiff physician's antitrust action itself.[64] However, if the court determines that the members of the professional review committee are not immune from liability under the state action doctrine, the court must proceed to analyze the merits of the plaintiff physician's antitrust claims.[65] While the proof requirements for this portion of the plaintiff's claim do not differ from other antitrust claims, the nature of the evidence that a physician must produce to demonstrate his injury and right to recovery is inherently speculative and thus very difficult and time-consuming to prove.[66]

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61. *See* Southern Motor Carriers Rate Conf., Inc. v. United States, 471 U.S. 48, 51 (1985) (noting that state public service commissions have and exercise ultimate authority and control over intrastate rates); *infra* notes 155-61 and accompanying text (summarizing Supreme Court's state action doctrine analysis in *Patrick*).

62. *See* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. at 105 (stating that parties who satisfy two-pronged state action test immune from antitrust liability). Under the state action doctrine, the private actors retain their immune status even if the motives underlying the action were bad faith motives. *See* Llewellyn v. Crothers, 765 F.2d 769, 774 (9th Cir. 1985) (stating that availability of state action doctrine does not depend on subjective motivations of individual actors but on satisfaction of doctrine's objective requirements). For example, often the parties that the state has chosen to regulate an occupational area also are involved in the occupation that they regulate, and thus the private parties have ulterior motives in regulating their competition in a way that restrains the competition. *See* Parker v. Brown, 317 U.S. 341, 346-47 (1943) (describing state agricultural program in which state authorized private raisin producers, packers, and handlers to formulate proration marketing program for raisins); *Llewellyn*, 765 F.2d at 771-72 (describing state workers' compensation program in which state authorized two medical doctors to promulgate reasonable rates employers should pay for medical services). However, once a court determines that the private actors qualify for state action immunity, the court is not to inquire into the members' underlying motives. *Id.* at 774. According to the *Llewellyn* Court, the possibility that courts could intrude upon internal state affairs to determine whether the individual actors acted in good faith is contrary to the principles of federalism and state sovereignty underlying the state action doctrine. *Id.*

63. *See supra* notes 57-62 and accompanying text (summarizing requirements of state action doctrine).

64. *Compare supra* notes 25-62 and accompanying text (summarizing judicial analysis under HCQIA and state action doctrine) *with infra* notes 73-100 and accompanying text (summarizing judicial analysis under federal antitrust laws).

65. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 790-92 (1975) (stating that, where defendants fail to qualify for immunity under state action doctrine, their action is within reach of Sherman Act).

66. *See infra* notes 73-100 and accompanying text (discussing elements of antitrust case plaintiff physician must prove to succeed on antitrust claim).

The Sherman Antitrust Act (Sherman Act) is the basis of federal antitrust law.[67] Congress enacted the Sherman Act in 1890 to restrict the growth of corporations occurring during the period of industrial expansion following the Civil War.[68] Through the Sherman Act, Congress expressed its intent to encourage the competitive nature of the United States' economy by prohibiting unreasonable restraints on trade.[69] Accordingly, section 1 of the Sherman Act prohibits all combinations, contracts, or conspiracies that restrain interstate commerce.[70] Similarly, section 2 of the Sherman Act prohibits all persons from monopolizing any portion of interstate commerce.[71] The aim of section 1 of the Sherman Act is to prohibit several persons or corporations from working together to suppress competition or to exclude persons or corporations from competing in the same market, while the aim of section 2 of the Sherman Act is to prohibit a single entity from controlling or dominating a market, thus rendering the market non-competitive.[72]

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67. Sherman Antitrust Act, 15 U.S.C. §§ 1-7 (1985).

68. *See* Note, *Application of the Antitrust Laws to Anticompetitive Activities by Physicians*, 30 RUTGERS L. REV. 991, 991 n.2 (1977) (stating that Congress enacted Sherman Act in 1890 in response to public opposition of industrial monopolies).

69. *See* 21 CONG. REC. S2455, S2457 (daily ed. Mar 21, 1890) (statement of Sen. Sherman) (stating that antitrust bill does not affect combinations in aid of production where free and fair competition exists).

70. 15 U.S.C. § 1 (1985); *see* 21 CONG. REC. S2455, 2456 (daily ed. Mar. 21, 1890) (statement of Sen. Sherman) (stating that § 1 provides federal courts jurisdiction to restrain and control combinations that interfere injuriously with foreign and interstate commerce). Although § 1 of the Sherman Act expressly prohibits all combinations or conspiracies that restrain trade, the Supreme Court has interpreted § 1 to prohibit only those combinations or conspiracies that unreasonably restrain trade. *See* Standard Oil Co. v. United States, 221 U.S. 1, 59-60 (1911) (stating that § 1 prohibits all contracts, combinations, and conspiracies that unduly restrain interstate and foreign commerce). Consequently, most alleged antitrust violations require courts to determine if the restraint on trade is unreasonable by weighing the procompetitive reasons for the restraint against the anticompetitive effect. *See* Note, *Application of the Antitrust Laws to Anticompetitive Activities by Physicians*, 30 RUTGERS L. REV. 991, 1003-05 (1977) (explaining per se violations and violations that require rule of reason analysis); Note, *Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?*, 19 IND. L. REV. 1219, 1220 (1986) (explaining that, where defendants have not committed per se antitrust violation, court must weigh procompetitive reasons for restraint against anticompetitive effect).

71. 15 U.S.C. § 2 (1985). Section 7 of the Sherman Antitrust Act defines "person" to include corporations as well as individuals. *Id.* § 7.

72. *See* Six Twenty-Nine Productions, Inc. v. Rollins Telecasting, Inc., 365 F.2d 478, 484 (5th Cir. 1966) (stating that § 2 fills gap in § 1 by allowing one business entity to violate § 2, while § 1 requires at least two independent business entities for violation). The Supreme Court has stated that Congress designed § 2 of the Sherman Antitrust Act to supplement § 1 and to ensure that no anticompetitive act could frustrate or evade § 1. Standard Oil Co. v. United States, 221 U.S. 1, 60 (1911). Section 2 therefore prohibits all attempts to restrain trade, even acts that do not fall under § 1. *Id.* at 61.

To enforce the prohibitions against conspiracies or monopolies that restrain trade, the Sherman Act provides that all persons who violate either § 1 or § 2 of the Sherman Act are guilty of a felony and subject to monetary penalties and incarceration. 15 U.S.C. §§ 1, 2

Before a court will consider a physician's claim that the actions of a professional review committee violate the Sherman Act, the physician must establish that he has standing to seek relief to survive a third motion for summary judgment.[73] To establish standing to seek relief under the Sherman Act, the physician must show that he has a right to either injunctive relief[74] or treble damages.[75] To establish that the physician has standing to receive injunctive relief, the physician must demonstrate that an impending violation of antitrust laws or an existing violation likely to continue or recur threatens significant injury to the physician.[76] To establish that the physician has standing to receive treble damages, the physician must demonstrate a causal relationship between the defendants' unlawful conduct and the physician's economic injury.[77] In addition, before the court can hear the substance of the plaintiff's antitrust claims, the physician must define a specific relevant product market, such as the market for orthopedic surgical services, and a specific relevant geographic market, such as a town or portion of a county.[78]

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(1985). In addition to criminal sanctions, the Sherman Act provides that those who violate the Act are civilly liable in damages to the parties the violators' anticompetitive conduct injured. *Id.* at § 15(a). The Sherman Act requires the court to treble automatically the damages that a plaintiff receives from defendants who have violated the Sherman Act. *Id.* The Sherman Act also requires a court to award a successful plaintiff reasonable attorney's fees and other litigation expenses. *Id.* Moreover, a court has the discretion to award the successful plaintiff interest on the actual damages. *Id.* The possibility of treble damages has important ramifications for members of professional review committees who lose an antitrust action that a physician has brought against the committee that revoked his medical staff privileges. *See supra* notes 26-27 and accompanying text (discussing Congress' desire, in enacting HCQIA, to protect physicians who participate in professional review actions from antitrust liability).

Congress first provided a treble damages remedy for persons that an antitrust violation has injured in § 7 of the Sherman Antitrust Act. Pfizer Inc. v. Government of India, 434 U.S. 308, 311 (1978). In 1914 Congress reenacted § 7 without substantial change as § 4 of the Clayton Act (codified at 15 U.S.C. § 15 (1985)). *Id.* The Supreme Court has stated that the treble damages remedy provided in § 4 of the Clayton Act serves two purposes. *Pfizer*, 434 U.S. at 314. First, the threat of treble damages deters antitrust violators and deprives violators of "the fruits of their illegality." *Id.* Second, treble damages compensate the victims of antitrust violations for their injuries. *Id.*; *see* 21 CONG. REC. S3145, S3146-48 (daily ed. Apr. 8, 1890) (statements of Sen. Reagan and Sen. George) (explaining that, unless antitrust plaintiffs can recover treble damages, damages award will be inconsequential to large, wealthy business combinations).

73. *See* Weiss v. York Hosp., 745 F.2d 786, 805-06 (3d Cir. 1984) (stating requirements for antitrust plaintiff to establish that plaintiff has right to relief), *cert. denied*, 470 U.S. 1060 (1985); *infra* notes 74-79 and accompanying text (describing elements antitrust plaintiff must show to establish right to seek relief).

74. Clayton Act § 16, 15 U.S.C. § 26 (1985).

75. Clayton Act § 4, 15 U.S.C. § 15 (1985).

76. *See* Weiss v. York Hosp., 745 F.2d 786, 829 (3d Cir. 1984) (describing how plaintiff physician establishes standing to receive injunctive relief for antitrust violation), *cert. denied*, 470 U.S. 1060 (1985).

77. *See id.* at 805 (discussing how plaintiff physician establishes standing to receive treble damages for antitrust violation).

78. *See* Weiss v. York Hosp., 745 F.2d 786, 825 (3d Cir. 1984) (stating that, to define relevant market for § 2 claim, court must define both product market and geographic market),

Consequently, the physician must present, the defendants must rebut, and the court must review a substantial amount of evidence to determine whether the physician has satisfied the standing requirements for continuing with his antitrust claims.[79]

If the court determines that the plaintiff has a right to seek relief and has properly defined the relevant markets, the physician must establish a prima facie case of conspiracy under section 1 of the Sherman Act or monopoly under section 2.[80] If the physician has alleged a conspiracy in violation of section 1 of the Sherman Act, the physician must establish three elements to survive yet a fourth motion for summary judgment.[81] First, the physician must establish that the individual defendants acted as part of a contract, combination, or conspiracy.[82] In the context of a hospital professional review committee, a physician may satisfy the conspiracy element with a showing that the individual members of the professional review committee conspired among themselves to revoke another physician's medical staff privileges to decrease the number of physicians competing for patients.[83] In some cases, however, because most hospital governing boards

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*cert. denied*, 470 U.S. 1060 (1985); Dolan & Ralston, *supra* note 6, at 741 (stating that, under rule of reason analysis of § 1 claim, plaintiff must show that defendants wield substantial economic power in relevant market); *infra* note 133 (describing how plaintiff physician Patrick alleged relevant product and geographic markets in *Patrick*). The plaintiff physician in an antitrust action must define the relevant product or services market and the relevant geographic market. Enders, *supra* note 13, at 360. The relevant product or services market includes all products or services that consumers perceive as reasonable substitutes for each other. Pontius v. Children's Hosp., 552 F. Supp. 1352, 1366 (W.D. Pa. 1982). The relevant geographic market includes the geographic area of effective competition that the defendant encounters when the defendant offers the designated product or service to the consumer. *Id.*; *see infra* note 133 (describing how plaintiff in *Patrick* defined relevant product and geographic markets).

79. *See supra* notes 73-78 and accompanying text (explaining that, before court can proceed with plaintiff's antitrust action, physician must prove standing to seek relief and must define relevant market).

80. *See* Weiss v. York Hosp., 745 F.2d 786, 805 (3d Cir. 1984) (stating that plaintiff must demonstrate that defendants have violated antitrust laws), *cert. denied*, 470 U.S. 1060 (1985).

81. *See id.* at 812 (listing elements plaintiff must show to allege violation of § 1 of Sherman Act).

82. *See id.* at 813 (stating that, to allege violation of § 1 of Sherman Act, physician must show that individual defendants acted as part of contract, combination, or conspiracy).

83. *See* Enders, *supra* note 13, at 350 (stating that staff privileges case may involve allegation that individual members of hospital's existing medical staff conspired among themselves to revoke competing physician's medical staff privileges); Weiss v. York Hosp., 745 F.2d 786, 814 (3d Cir. 1984) (holding that medical staff satisfies, as matter of law, conspiracy requirement of § 1 of Sherman Act), *cert. denied*, 470 U.S. 1060 (1985). In *Weiss v. York Hospital* the United States Court of Appeals for the Third Circuit considered whether individual members of a medical staff could constitute a conspiracy without an allegation that the hospital was a coconspirator. *Id.* at 814-17. The Third Circuit stated that each physician member of a medical staff practices medicine in an individual capacity, as an independent practitioner in competition with other physicians in the area. *Id.* at 815. Consequently, each member of the medical staff has an economic interest separate from and in competition with the interests of other medical staff members. *Id.* The Third Circuit held, therefore, that as a matter law, the

have reserved the authority to revoke medical staff privileges upon the professional review committee's recommendation, the plaintiff physician must include the hospital, through its governing board, as an alleged coconspirator.[84] Proving the existence of a conspiracy is especially difficult for physicians because the physicians must prove both that the defendants acted as separate entities and that the defendants acted pursuant to an agreement.[85] Second, the physician alleging a section 1 violation must establish that the defendants' conduct in revoking the physician's medical staff privileges imposed an unreasonable restraint on trade by wrongly excluding the physician from the local competitive market for physicians' services.[86] The physician may allege that the committee's decision to revoke the physician's medical staff privileges unreasonably restricts competition in the local medical services market because the committee members, in their capacities as private practitioners, agreed among themselves not to deal with a certain physician in the hospital.[87] Third, the physician must allege that

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medical staff is a combination of individual physicians, and any action that the medical staff takes can satisfy the contract, combination, or conspiracy requirement of § 1 of the Sherman Act. *Id.* at 814; *see also* Miller v. Indiana Hosp., 843 F.2d 139, 144 n.5 (3d Cir. 1988) (stating that joint action that medical staff took satisfied § 1 conspiracy requirement).

84. *See* Enders, *supra* note 13, at 351-52 (stating that plaintiff physician must include hospital as alleged coconspirator). Courts deciding antitrust cases that physicians have brought against the members of the professional review committee and the members of the governing board do not accept uniformly allegations that the hospital governing board conspired with the members of the medical staff. *Compare* Weiss v. York Hosp., 745 F.2d 786, 817 (3d Cir. 1984) (holding that hospital could not, as matter of law, conspire with medical staff), *cert. denied*, 470 U.S. 1060 (1985) *with* Robinson v. Magovern, 521 F. Supp. 842, 907 (W.D. Pa. 1981) (stating that members of medical staff, because they have independent, personal stake in hospital's action to deny application for privileges, can conspire with hospital corporation).

85. *See* Enders, *supra* note 13, at 351-52 (discussing what plaintiff physician must show to allege violation of § 1 of Sherman Act). Plaintiffs who allege that the defendants have combined or conspired in violation of § 1 of the Sherman Act must prove that two or more distinct entities agreed to take action against the plaintiff. *See id.* (stating that, to allege violation of § 1 of Sherman Act, plaintiff must show that at least two entities agreed to take action against plaintiff); *supra* note 72 and accompanying text (explaining that violation of § 1 requires at least two parties). Furthermore, to present sufficient evidence to take the conspiracy issue to the jury, the plaintiff must present evidence that tends to exclude the possibility that the multiple defendants acted independently. *See* Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 764 (1984) (stating that plaintiff must present evidence excluding possibility that multiple defendants acted independently).

86. *See* Weiss v. York Hosp., 745 F.2d 786, 812 (3d Cir. 1984) (stating that physician alleging § 1 violation must establish that defendants' conduct imposed unreasonable restraint on trade), *cert. denied*, 470 U.S. 1060 (1985); 15 U.S.C. § 1 (1985) (invalidating combinations that restrain trade among states).

87. *See* Apex Hosiery Co. v. Leader, 310 U.S. 469, 511 (1940) (stating that restraint of trade requirement of § 1 of Sherman Act necessitates showing of restriction on competition with accompanying detrimental effect on consumers); Enders, *supra* note 13, at 354 (stating that horizontal group boycott may arise if physicians, in their individual capacities as private practitioners, agree among themselves not to deal with individual physician in hospital). In antitrust actions that physicians have brought against professional review committee members, the court will evaluate the defendants' allegedly anticompetitive conduct using rule of reason

the defendants' conduct substantially affects interstate commerce.[88] To establish that a professional review committee's action substantially affects interstate commerce, physicians have alleged a variety of far-reaching and fairly speculative effects on commerce.[89] For example, physicians have

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analysis. *See* Kissam, *supra* note 7, at 647 (noting that courts apply rule of reason balancing approach to antitrust cases involving medical professionals). Under rule of reason analysis, the defendants successfully may defend their anticompetitive action by establishing legitimate reasons for their action. *Id.* Thus, if the defendant members of the professional review committee justify a decision to revoke a physician's medical staff privileges with motives that include incompetence or professional conduct, the defendants insulate themselves from antitrust liability under § 1. *See* Pontius v. Children's Hosp., 552 F. Supp. 1352, 1372 (W.D. Pa. 1982) (stating that Sherman Act does not prevent hospital from revoking medical staff privileges of incompetent physician); Williams v. Kleaveland, 534 F. Supp. 912, 917 (W.D. Mich. 1981) (stating that hospitals may revoke physician's medical staff privileges for misconduct); Enders, *supra* note 13, at 357-58 (stating that, in antitrust suit, defendants may claim action justified on basis of maintaining or improving overall quality of medical care delivered to patients).

88. *See* Weiss v. York Hosp., 745 F.2d 786, 812 (3d Cir. 1984) (stating that physician must allege that defendants' conduct substantially affects interstate commerce), *cert. denied*, 470 U.S. 1060 (1985); 15 U.S.C. § 1 (1985) (invalidating combinations in restraint of trade that affect commerce among states). To satisfy the interstate commerce requirement of § 1, the plaintiff physician must allege that the effects of the alleged violation will impact interstate commerce, not that the sum total of defendants' activities impact interstate commerce. Kissam, *supra* note 7, at 632-33 (explaining that physician must state that effects of alleged antitrust violation will impact interstate commerce); Doe v. St. Joseph's Hosp., 788 F.2d 411, 417 (7th Cir. 1986) (stating that plaintiff must allege that defendants' activities that allegedly violate § 1 of Sherman Act will have not insubstantial effect on interstate commerce).

89. *See* Enders, *supra* note 13, at 332-33 (discussing ways physicians may allege effect on interstate commerce). The plaintiff can satisfy the interstate commerce requirement of § 1 of the Sherman Act in one of two ways. *See* Weiss v. York Hosp., 745 F.2d 786, 824 (3d Cir. 1984) (stating ways in which plaintiff can satisfy Sherman Act's interstate commerce requirement), *cert. denied*, 470 U.S. 1060 (1985); Kissam, *supra* note 7, at 628 (same). First, the physician may show that the defendants' allegedly anticompetitive conduct occurred within the flow of interstate commerce. *See* Kissam, *supra* note 7, at 628 (stating ways in which plaintiff can satisfy Sherman Act's interstate commerce requirement). Because most physicians and hospitals operate in a purely local market, however, this alternative is difficult for complaining physicians to satisfy. *See id.* at 628-29 (stating ways in which plaintiff can satisfy Sherman Act's interstate commerce requirement). Consequently, the Supreme Court enunciated an alternative method of alleging an effect on interstate commerce in *Hospital Building Co. v. Trustees of Rex Hospital*. *See id.* at 628 (summarizing *Rex Hospital*). In *Rex Hospital* the United States Supreme Court addressed an antitrust suit that a corporation operating a 49-bed proprietary hospital brought against a private hospital, two of the hospital's officers, and a health planning officer. Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 740 (1976). The plaintiff's complaint alleged that the defendants conspired to block the plaintiff hospital's planned relocation and expansion. *Id.* The Supreme Court noted that the plaintiff's complaint alleged that the defendants' alleged anticompetitive conduct would affect the amount of purchases plaintiff made from out-of-state suppliers. *Id.* at 744. In addition, the plaintiff alleged that the defendants' conduct would affect the amount of revenues the plaintiff received from out-of-state insurance companies. *Id.* The Supreme Court found that these alleged effects on interstate commerce, in combination with effects on the amount of money the plaintiff would pay to its out-of-state parent corporation and the effect on the multi-million dollar financing largely from out-of-state institutions, sufficiently established a substantial effect on interstate commerce under the Sherman Act. *Id.* The *Rex Hospital* alternative allows a physician

forecasted monetary losses the hospital will suffer due to lost out-of-state patients; loss of revenues from out-of-state insurance companies, Medicare, and Medicaid; and monetary losses to out-of-state medical supply companies that will suffer because of the loss of the physician's patronage.[90] Although the magnitude of the effect on interstate commerce that the Sherman Act requires remains unclear, a physician operating in even a purely local market generally can withstand a summary judgment motion if the physician alleges basic effects on interstate commerce.[91]

In addition to or as an alternative to filing an antitrust action under section 1 of the Sherman Act, a physician may file an action against a professional review committee as a monopolistic entity under section 2 of the Sherman Act.[92] If a physician has alleged a violation of section 2, the physician must establish that the defendant monopolized interstate commerce by controlling prices in a certain market or excluding or restricting competition from a certain market.[93] To survive summary judgment in a section 2 suit, the statute requires the physician to allege two elements.[94] First, the physician must show that the professional review committee exercised undue

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to show that the defendants' conduct substantially affects interstate commerce, instead of requiring a physician to allege that the defendants' conduct occurred within the flow of interstate commerce. *See id.* (stating that physician may allege substantial effect on interstate commerce to meet Sherman Act's interstate commerce allegation requirements).

90. *See* Enders, *supra* note 13, at 337-38 (listing means by which plaintiff physicians have met Sherman Act's interstate commerce requirement); *infra* note 133 (describing how plaintiff physician Patrick alleged substantial effect on interstate commerce in *Patrick*).

91. *Compare* Miller v. Indiana Hosp., 843 F.2d 139, 144 n.5 (3d Cir. 1988) (stating that plaintiff's allegations that hospital treats out-of-state patients, purchases medical supplies from out-of-state suppliers, and receives money from out-of-state sources satisfies interstate commerce requirement) *and* Weiss v. York Hosp., 745 F.2d 786, 824-25 (3d Cir. 1984) (same), *cert. denied*, 470 U.S. 1060 (1985) *and* Pontius v. Children's Hosp., 552 F. Supp. 1352, 1361 (W.D. Pa. 1982) (stating that modern medical practice generally involves sufficient interstate commerce to satisfy § 1 of Sherman Act) *with* Hayden v. Bracy, 744 F.2d 1338, 1342-43 (8th Cir. 1984) (holding that plaintiff failed to establish sufficient effect on interstate commerce with allegations that defendants' conduct would raise prices of out-of-state patients and insurance companies) *and* Doe v. St. Joseph's Hosp., 788 F.2d 411, 417 (7th Cir. 1986) (holding that plaintiff failed to establish sufficient effect on interstate commerce by alleging that defendants' conduct would lessen purchase of medicine and supplies that travel in interstate commerce, and would affect payment of medical bills through out-of-state private and governmental insurance programs, out-of-state patients, and general sharing of information and medical training across state lines).

92. *See* Patrick v. Burget, 800 F.2d 1498, 1504 (9th Cir. 1986) (stating that plaintiff physician filed action against hospital and professional review committee for violations of §§ 1 and 2 of Sherman Act), *rev'd on other grounds*, 108 S. Ct. 1658 (1988); Weiss v. York Hosp., 745 F.2d 786, 799 (3d Cir. 1984) (stating that plaintiff physician filed action against hospital, medical staff, and professional review committee for violations of §§ 1 and 2 of Sherman Act), *cert. denied*, 470 U.S. 1060 (1985).

93. 15 U.S.C. § 2 (1985); *see* Weiss v. York Hosp., 745 F.2d 786, 827 (3d Cir. 1984) (defining monopoly power as ability to control price in or to exclude or restrict competition from relevant geographic market), *cert. denied*, 470 U.S. 1060 (1985).

94. *See* Weiss v. York Hosp., 745 F.2d 786, 825 (3d Cir. 1984) (listing elements plaintiff must show to establish violation of § 2 of Sherman Act), *cert. denied*, 470 U.S. 1060 (1985).

control over the relevant market.[95] Often the defendant will attempt to demonstrate that the physician has other sources of employment within the relevant product market and relevant geographic market.[96] If the defendant successfully establishes that the plaintiff had reasonable alternative employment options in the relevant market, which is often fairly easy in localities with more than one hospital, a court is unlikely to find a monopoly.[97] The second element that a plaintiff physician must allege to survive summary judgment in a section 2 suit is that the defendant professional review committee willfully acquired or maintained monopolistic power.[98] If the defendants acquired or maintained a superior market position because of normal growth or development resulting from superior products, business acumen, or historical accident, the physician will fail on the section 2 claim.[99] Therefore, if the defendant committee members show that they acquired a large share of the medical services market because of superior medical or business skills, the defendants will prevail against the plaintiff on the section 2 claim.[100]

Courts resolving antitrust cases against members of professional review committees must digest voluminous amounts of evidence regarding the committee members' motives and conduct in the professional review action,[101] the state statutory scheme,[102] and the elements of federal antitrust violations.[103] State legislative action can simplify the present complex legal analysis, protect competent physicians from abusive professional review actions, and better protect the members of professional review committees

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95. *See id.* (stating that plaintiff must establish that defendant possessed monopoly power in relevant market); *supra* note 78 (defining relevant markets). In assessing whether the defendant in an antitrust suit has monopoly over the relevant markets, courts primarily consider defendant's market share. Weiss, 745 F.2d at 827. Consequently, courts considering an antitrust action under § 2 of the Sherman Act must define the relevant markets. *See id.* at 825 (stating that, to define relevant market for § 2 claim, court must define both product market and geographic market).

96. *See* Pontius v. Children's Hosp., 552 F. Supp. 1352, 1366 (W.D. Pa. 1982) (stating that defendant has power over market if defendant can exclude competition from particular territory).

97. *See Weiss*, 745 F.2d at 826 n.68 (stating that, in typical antitrust action, defendant attempts to prove widest possible relevant market and plaintiff attempts to prove narrowest possible relevant market because defendant has lower percentage of market in large market).

98. *See id.* at 827 (listing elements plaintiff must show to establish violation of § 2 of Sherman Act).

99. *See id.* at 825 (distinguishing between monopoly power acquired and maintained willfully and monopoly power acquired and maintained unintentionally); Dolan & Ralston, *supra* note 6, at 767 (same).

100. *See* Weiss at 825 (distinguishing between monopoly power acquired and maintained willfully and market dominance gained through means not intended to acquire monopoly control).

101. *See supra* notes 31-42 and accompanying text (summarizing standards committee members must meet to qualify for immunity under HCQIA).

102. *See supra* notes 58-62 and accompanying text (summarizing judicial analysis under state action doctrine).

103. *See supra* notes 73-100 and accompanying text (summarizing antitrust analysis).

from liability.[104] A 1988 United States Supreme Court decision illustrates the present confused status of antitrust law in the context of professional review actions as well as the need better to protect both the members of professional review committees and the physicians whose privileges the committee has challenged.[105] In *Patrick v. Burget*[106] the plaintiff, an Oregon physician, filed an antitrust suit in the United State District Court for the District of Oregon against the members of a professional review committee that had revoked the physician's hospital privileges.[107] The plaintiff, Patrick, was a surgeon trained in general and vascular surgery.[108] In 1972 Patrick had joined the Astoria Clinic (Clinic), a partnership of local physicians, and had received medical staff privileges at Columbia Memorial Hospital (Hospital) in connection with his clinical practice.[109] Columbia Memorial Hospital is the sole hospital in Astoria, Oregon, a town of 10,000 people.[110] All the members of the Hospital's professional review committee also were partners in the Astoria Clinic.[111] In 1973, when Patrick's initial contract with the Clinic expired, the Clinic partners asked Patrick to become a partner.[112] Patrick refused the offer to join the Clinic partnership because Patrick felt that the Clinic had not compensated Patrick adequately in proportion to the amount of income Patrick generated for the Clinic.[113] Consequently, Patrick chose to open an independent medical practice in Astoria in 1975.[114]

From the time Patrick left the Clinic, the Clinic doctors reacted negatively to Patrick's establishment of an independent practice.[115] According to the *Patrick* circuit court, the Clinic doctors referred virtually no patients to Patrick for surgery, even during the time that the Clinic had no general surgeon on staff.[116] In addition, if Patrick treated a Clinic patient, Clinic doctors reacted angrily.[117] On several occasions Clinic doctors accused Patrick of stealing Clinic patients.[118] Ironically, while Clinic doctors accused

104. *See infra* notes 201-10 and accompanying text (explaining proposed state legislation).

105. *See infra* notes 107-63 and accompanying text (examining facts and court decisions in *Patrick v. Burget*).

106. 800 F.2d 1498 (9th Cir. 1986), *rev'd*, 108 S. Ct. 1658 (1988).

107. Patrick v. Burget, 800 F.2d 1498, 1504 (9th Cir. 1986), *rev'd on other grounds*, 108 S. Ct. 1658 (1988).

108. *Id.* at 1502. As a vascular surgeon, the plaintiff in *Patrick* was a physician trained to perform surgery on blood vessels. *See* TABER'S CYCLOPEDIC MEDICAL DICTIONARY (15th ed. 1985), *reprinted in* AM. JUR. 3d *Proof of Facts* 1838 (1985) (defining "vascular").

109. *Patrick*, 800 F.2d at 1502.

110. *Id.*

111. *Id.* During the relevant time period in *Patrick*, the majority of the Hospital medical staff were employees or partners of the Clinic. *Id.*

112. *Id.*

113. *Id.*

114. *Id.* Although the Ninth Circuit in *Patrick* did not explicitly note the fact, Patrick retained his medical staff privileges at the Hospital after Patrick left the Clinic. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

Patrick of patient-theft, Clinic doctors attempted to convert Patrick's patients into Clinic patients and to prevent new patients from seeing Patrick.[119] This practice was especially noticeable in the pattern of treatment of emergency room patients.[120] Specifically, patients would come to the emergency room, ask for Patrick, and the emergency room staff would respond that Patrick was unavailable.[121] Later, the patients discovered that Patrick was available and that the emergency room staff had made no effort to contact Patrick.[122] Clinic doctors consistently refused to care for Patrick's patients in return for similar favors from Patrick, yet at the same time Clinic doctors criticized Patrick repeatedly for his failure to get adequate back-up coverage.[123]

In 1981 the Hospital medical staff initiated proceedings to terminate Patrick's medical staff privileges.[124] The Executive Committee (Committee), which was responsible for reviewing claims of professional misconduct against Hospital physicians,[125] voted to recommend that the Hospital terminate Patrick's medical staff privileges because the Committee found that Patrick's care of patients fell below hospital standards.[126] The Committee allowed Patrick a hearing at which the Hospital presented the case against Patrick, and Patrick presented his defenses to the Hospital's allegations.[127] The Committee selected nine cases to use as evidence against Patrick from a period during which Patrick had performed 2,000-2,500 surgeries.[128] Al-

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119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.* The *Patrick* circuit court found that the strained relations between Patrick and the Clinic doctors erupted into serious confrontations in the fall of 1979. *Id.* at 1503. Finally, the members of the Hospital's medical staff requested the Board of Medical Examiners (the Board), the state agency charged with licensing physicians and disciplining licensed physicians, to take disciplinary action against Patrick. *Id.*; *see* OR. REV. STAT. § 677.265 (1987) (granting licensing powers to Board of Medical Examiners). The Hospital staff executive committee referred the charts from 15 cases that the Hospital claimed Patrick had handled poorly to the Oregon Board of Medical Examiners. *Patrick*, 800 F.2d at 1503. Patrick had not been the treating doctor in some of the cases. *Id.* After the Board had investigated the 15 cases, the Board sent a letter of reprimand to Patrick. *Id.* However, the Board retracted the letter when Patrick petitioned for judicial review of the Board's proceedings. *Id.*

124. *Id.* at 1504.

125. Amended Pre-Trial Order, *reprinted in* Joint Appendix for the Supreme Court 13, 15-16, Patrick v. Burget, 108 S. Ct. 1658 (1988) (No. 86-1145). The Hospital medical staff in *Patrick* had organized pursuant to medical bylaws. *Id.* at 15. The medical staff executive committee consisted of the officers of the medical staff, the chiefs of each clinical service, and one member that the staff elected at large. *Id.* The executive committee conducted professional review proceedings if an officer of the medical staff, a chief of any service, the chairman of any standing committee of the medical staff, the Chief Executive Officer, or the Hospital's governing board requested the executive committee to do so. *Id.* at 16.

126. *Patrick*, 800 F.2d at 1504.

127. *Id.*

128. *Id.* According to the *Patrick* circuit court, the charges against Patrick originally encompassed 21 cases, some of which Patrick had not handled. *Id.* The Ninth Circuit stated that the experts at trial disagreed as to the magnitude of Patrick's errors in the nine cases. *Id.*

though Patrick requested that the committee members testify as to personal knowledge of the cases under investigation and as to personal biases against Patrick, the committee members refused.[129] Furthermore, the committee members were inattentive during Patrick's presentation.[130] As Patrick believed that the Committee ultimately would revoke his medical staff privileges because of the members' personal biases against him, Patrick resigned from the Hospital before the Committee had completed its proceedings.[131]

On the basis of the Committee proceedings and Patrick's resulting forfeiture of staff privileges, Patrick filed an antitrust action in the United States District Court for the District of Oregon in early 1981, naming the members of the Executive Committee and the Hospital as defendants.[132] In his complaint, Patrick alleged that the defendant Clinic partners had initiated and participated in the hospital review proceedings to reduce competition from Patrick, rather than to improve patient care, thereby violating sections 1 and 2 of the Sherman Act.[133] The district court jury found that three individual Clinic members had violated section 1 of the Sherman Act and that the Clinic had violated section 2 of the Sherman Act.[134] Accordingly, the district court awarded Patrick damages of $650,000 against the three individual Clinic members and the Clinic as a unit.[135] Pursuant to the federal antitrust laws, the district court trebled Patrick's damages, bringing Patrick's

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129. *Id.*

130. *Id.* During the hearings to revoke Patrick's medical staff privileges in *Patrick*, the members of the professional review committee read, did paperwork, and in one case, tied fishing lures. *See* Comment, Patrick v. Burget: *The State Action Doctrine and Bad Faith Peer Review*, 74 VA. L. REV. 609, 615 (1988) (describing defendants' conduct during professional review hearing).

131. *Patrick*, 800 F.2d at 1504.

132. *Id.*

133. Patrick v. Burget, 108 S. Ct. 1658, 1661 (1988). The plaintiff in *Patrick* alleged that the defendant physicians conspired among themselves to restrain competition in and to monopolize the practice of surgery within the relevant market, thereby violating §§ 1 and 2 of the Sherman Act. Second Amended and Supplemental Complaint, *reprinted in* Joint Appendix for the Supreme Court at 2, 4, Patrick v. Burget, 108 S. Ct. 1658 (1988) (No. 86-1145). Patrick defined the relevant product market as the practice of general, vascular, and thoracic surgery. *Id.* at 3. Patrick defined the relevant geographic market as northern Clatsop County, Oregon, and the southern part of Pacific County, Washington. *Id.* Patrick alleged a substantial effect on interstate commerce by alleging that total surgical fees in the relevant geographic market exceeded $1,000,000 per year, a substantial portion of which Washington residents pay. *Id.* at 3-4. Furthermore, Patrick alleged that the practice of surgery within the relevant geographic market substantially affects interstate commerce because the hospital and surgeons purchase a substantial quantity of medical equipment and supplies from out-of-state manufacturers. *Id.* at 4. Finally, Patrick alleged that the hospital and surgeons received substantial amounts of money from out-of-state sources, such as Medicare, Medicaid, and insurers. *Id.*

134. *Patrick*, 800 F.2d at 1504.

135. *Id.* at 1504-05. The district court jury in *Patrick* awarded Patrick $20,000 in compensatory damages and $90,000 in punitive damages against three individual defendant physicians on a state law claim. *Id.* at 1505. In addition, the court awarded Patrick $228,600 in attorney's fees. *Id.*

total damages award for antitrust violations to $1,950,000.[136] The Clinic doctors appealed the district court decision to the United States Court of Appeals for the Ninth Circuit on the ground that state statutes mandated their professional review activities at the hospital, and consequently, the state action doctrine exempted the Committee members from federal antitrust liability.[137]

On appeal the Ninth Circuit did not apply the HCQIA to the facts of *Patrick* because Congress did not enact the HCQIA until after the professional review proceedings in *Patrick* had occurred.[138] Rather, the Ninth Circuit considered only whether the professional review committee's actions were immune from antitrust liability under the state action doctrine.[139] First, the Ninth Circuit considered whether the professional review committee acted pursuant to a clearly articulated and affirmatively expressed state policy to displace competition with regulation.[140] The court noted in general that defendants could establish that a state clearly has articulated an anticompetitive policy by demonstrating that the state legislature contemplated the kind of activity of which the plaintiff has complained.[141] The court found that the Oregon statutes regulating hospital licensing required hospital governing boards to establish procedures for restricting medical staff privileges.[142] Furthermore, the court found that Oregon statutes mandated that each hospital's medical staff organize to review each other's professional practices at the hospital, and that other physicians participate actively in determining whether a physician's performance endangers patient care.[143] Consequently, the Ninth Circuit found that Oregon, by compelling

136. *Id.* at 1504-05. Since the district court awarded judgment in the *Patrick* case, the Astoria Clinic has filed for bankruptcy and is seeking a buyer. Snow, *Trust Versus Antitrust*, THE ATLANTIC, Sept. 1986, at 26, 28.

137. *Patrick*, 800 F.2d at 1505. The defendants in *Patrick* raised the state action doctrine as an affirmative defense in their answer to Patrick's Second Amended and Supplemental Complaint. Answer to Second Amended and Supplemental Complaint, *reprinted in* Joint Appendix for the Supreme Court at 8, 11, Patrick v. Burget, 108 S. Ct. 1658 (1988) (No. 86-1145). Evidently, the district court rejected the state action doctrine as an affirmative defense for the defendants, as the case proceeded to the jury for a verdict. *See Patrick*, 800 F.2d at 1504 (discussing jury verdict in *Patrick*).

138. Patrick v. Burget, 108 S. Ct. 1658, 1667 n.8 (1988).

139. *Patrick*, 800 F.2d at 1505.

140. *Id.*

141. *Id.*

142. *Id.* The Ninth Circuit in *Patrick* found that Oregon requires its health care facilities to receive a license from the state. *Id.*; *see* OR. REV. STAT. § 441.015 (1987) (stating that no person or governmental unit shall establish, maintain, or manage health care facility in state of Oregon without license).

143. *Patrick*, 800 F.2d at 1505. The *Patrick* circuit court stated that the state designed the statutes to reduce morbidity and mortality and to improve patient care. *Id.*; *see* OR. REV. STAT. § 441.030(2) (1987) (stating that Health Division may suspend or revoke license if Health Division finds health care facility has failed substantially to comply with statutory requirements); OR. REV. STAT. § 441.055(3)(c), (d) (1987) (requiring governing body of health care facility to insure that procedures for granting, restricting, and terminating privileges exist and that medical

physicians to review their competitors in the health care market, affirmatively had expressed a policy to replace pure competition with anticompetitive regulation.[144]

The Ninth Circuit next considered whether Oregon's statutory scheme satisfied the second prong of the state action test by providing for active state supervision of the professional review committees' actions.[145] The *Patrick* court found that Oregon statutes require a hospital that revokes a physician's privileges to report promptly to the state's Board of Medical Examiners (Board) all facts and circumstances that necessitated the revocation.[146] The court concluded that this required report to the Board constituted supervision.[147] Furthermore, the court reasoned that, because the Board is a state agency, supervision by the Board of professional review committee action is equivalent to supervision by the state.[148] In addition, the Ninth Circuit noted that the Oregon courts had jurisdiction to review all hospital decisions revoking a physician's medical staff privileges.[149] The *Patrick* circuit court concluded that the combination of the hospital's system of internal review, the Board's review of the professional review committee's decision, and the possibility of further judicial review constituted adequate state supervision to satisfy the second prong of the state action test.[150] Consequently, the Ninth Circuit held that the members of the professional review committee in *Patrick* were immune from antitrust liability under the state action doctrine.[151] Because the committee members were immune from liability under the state action doctrine, the court ruled that the substantial evidence which demonstrated that the defendants had acted in bad faith in the professional review process was irrelevant.[152] Consequently, the Ninth

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staff reviews professional practices of facility). The Ninth Circuit also found that the Oregon statutory scheme requires doctors to participate actively in regulating their peers. *Patrick*, 800 F.2d at 1506. Consequently, the court found that, under the Oregon statutory scheme, competitors regulate each other through the peer review process. *Id.*

144. *Id.* at 1505-06.

145. *Id.* at 1506. The Ninth Circuit in *Patrick* found that the Oregon statutory scheme requires health care facilities to regularly review privilege termination procedures to ensure that the procedures conform with applicable law. *Id.*; *see* OR. REV. STAT. § 441.030(2) (1987) (stating that Health Division may revoke hospital's license if Health Division finds that hospital has failed to comply substantially with statutory requirements); OR. REV. STAT. § 441.055(3)(c) (1987) (requiring governing body of health care facility to insure procedures for terminating privileges exist).

146. *Patrick*, 800 F.2d at 1506; *see* OR. REV. STAT. § 441.820(1) (1987) (requiring health care facility to promptly report to Board all privilege terminations and facts and circumstances that resulted in termination).

147. *Patrick*, 800 F.2d at 1506.

148. *Id.*

149. *Id.* In *Patrick* the Ninth Circuit stated that Oregon courts have reviewed adverse privilege decisions to determine if the hospital made the decision in good faith pursuant to fair procedures and that the facts supported the hospital's decision. *Id.*

150. *Id.*

151. *Id.* at 1509.

152. *Id.* at 1507. The Ninth Circuit in *Patrick* conceded that Patrick had presented

Circuit reversed the district court's judgment on the antitrust claims against the members of the professional review committee.[153] Patrick appealed the decision of the Ninth Circuit to the United States Supreme Court on the ground that the state action doctrine did not protect the members of the committee from antitrust liability.[154]

When the Supreme Court reviewed *Patrick* in 1988, the Court considered whether the Oregon statutory scheme that regulated hospital and physician licensing satisfied the two requirements of the state action doctrine, thereby protecting the members of the professional review committee in *Patrick* from antitrust liability.[155] The Court began its analysis of the professional review action by examining the nature of state supervision over the anticompetitive conduct of hospital professional review committees in general.[156] The *Patrick* Court stated that to constitute active supervision, the state must have and must exercise the power to review specific anticompetitive acts of private parties and to disapprove those anticompetitive acts that fail to accord with state policy because the acts promote only the party's anticompetitive interests.[157] However, in *Patrick*, the Court found no evidence that

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substantial evidence that defendants acted in bad faith in the peer review process. *Id.* However, the *Patrick* circuit court stated that, once the court has determined that a state has acted to replace competition with regulation in a given market, the state regulations displace federal antitrust laws. *Id.*; *see supra* note 62 (explaining that, once court has determined defendants' anticompetitive conduct is immune from antitrust liability under state action doctrine, evidence of defendants' bad faith irrelevant).

153. *Patrick*, 800 F.2d at 1507. In addition to reversing the judgment of the district court, the *Patrick* circuit court remanded the case to the district court to determine whether Patrick had any other actionable antitrust claims based on conduct other than the professional review process. *Id.*

154. Patrick v. Burget, 108 S. Ct. 1658, 1660 (1988).

155. *Id.* at 1662-63; *see supra* notes 57-62 and accompanying text (describing two-pronged test for determining whether state action doctrine bars antitrust action). The Supreme Court did not apply the HCQIA to the facts in *Patrick* because Congress enacted the HCQIA after the professional review proceedings in *Patrick* had occurred and because the HCQIA was not retroactive. *Patrick*, 108 S. Ct. at 1667 n.8.

156. *Patrick*, 108 S. Ct. at 1663. The Supreme Court in *Patrick* stated that it need not analyze the Oregon statutory scheme under the first prong of the test to determine whether the members of the committee acted pursuant to a clearly articulated state policy to displace competition with regulation because the professional review action failed the second requirement of the state action doctrine. *Id.* In analyzing the second prong of the state action doctrine, the *Patrick* Court noted that the active supervision requirement recognizes that where a private party engages in anticompetitive activity his actions may further his own interests and not the state's interests. *Id.* Therefore, according to the *Patrick* Court, the active supervision requirement of the state action doctrine ensures that the state action doctrine will shelter only the acts of private parties that, in the judgment of the state, actually further state regulatory policies. *Id.*

157. *Id.* According to the Supreme Court in *Patrick*, the mere presence of some state involvement or monitoring is insufficient to satisfy the active supervision requirement of the state action test. *Id.* Rather, the state must exercise ultimate control over the anticompetitive conduct of private parties. *Id.* Without such active supervision, a court has no assurance that a private party's anticompetitive conduct promotes state policy and not the interests of the individual. *Id.*

the Oregon Health Division, the Board of Medical Examiners, or the state judicial system could review private decisions regarding hospital privileges to determine whether the decisions of professional review committees furthered state regulatory policies by promoting quality health care.[158] Furthermore, the Court found that none of the three conceivable state actors—the Health Division, the Board, and the courts—reviewed private decisions regarding hospital privileges to protect against abuses of the professional review system.[159] Therefore, although the Oregon state statutes compelled

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158. *Id.*; *see infra* note 159 and accompanying text (discussing *Patrick* Court's rationale for holding that Oregon statutory scheme did not provide Health Division, Board, or judiciary with power to review private decisions regarding hospital privileges).

159. *Patrick*, 108 S. Ct. at 1663-65. In *Patrick* the Supreme Court analyzed the statutory powers of the state's Health Division, the Board, and the judiciary. *Id.* The Court acknowledged that Oregon's Health Division has general supervisory powers over matters relating to the preservation of life and health and over hospital licensing and health law enforcement. *Id.* at 1663-64; *see* OR. REV. STAT. § 431.110(1) (1987) (providing Health Division with direct supervision of all matters relating to preservation of life and health of people of state); OR. REV. STAT. § 441.025(1) (1987) (stating that Health Division shall license health care facility if Health Division finds that applicant facility complies with statutory requirements); OR. REV. STAT. § 441.030(2) (1987) (stating that Health Division may deny, suspend, or revoke hospital's license if Division finds hospital has failed to comply substantially with Oregon statutes). OR. REV. STAT. § 431.120 (1) (1987) (empowering Health Division to enforce state health policies and rules); OR. REV. STAT. § 431.150 (1987) (providing Health Division with general enforcement powers); OR. REV. STAT. § 431.155(1) (1987) (providing that Health Division may institute court proceedings to enjoin health care facility, officers, agents, employees, and representatives from violating public health laws). However, despite the Health Division's extensive powers, the Supreme Court in *Patrick* found that the statutory scheme does not constitute a state program of active supervision over peer review decisions. *Patrick*, 108 S. Ct. at 1664. In so holding, the Supreme Court distinguished between the Health Division's authority over the procedures used to terminate hospital privileges and the termination of privileges itself. *Id.* Accordingly, the Court stated that the state does not actively supervise this restraint on competition unless a state official has and exercises authority over private privilege determinations. *Id.* Because the Oregon statutory scheme fails to provide the Health Division with authority to review private peer review decisions and overturn a decision that fails to conform to state policy, the Court concluded that the activities of the Health Division under Oregon law fail to satisfy the active supervision requirement of the state action doctrine. *Id.*

The Court next considered whether the Board actively supervised private peer review decisions. *Id.* The Court stated that the Board's principal function is to regulate licensing of physicians in the state. *Id.* The Court recognized that Oregon statutes require hospitals to promptly notify the Board of a decision to terminate or restrict a physician's privileges. *Id.*; *see* OR. REV. STAT. § 441.820(1) (1987) (requiring health care facility to report in writing to Board any privilege restrictions or terminations and all surrounding facts and circumstances). However, the Court found that the Oregon statutes do not provide the Board with power to review private privilege decisions. *Patrick*, 108 S. Ct. at 1664. Consequently, the Court concluded that the Board does not engage in active supervision over private peer review decisions. *Id.*

Finally, the Court in *Patrick* considered whether the state judiciary actively supervises private peer review decisions. *Id.* at 1664-65. The Court stated initially that Oregon has no statute expressly providing for judicial review of privilege terminations. *Id.* at 1665. Moreover, the Court could cite no case in which an Oregon court held that judicial review of peer review decisions is available. *Id.* In addition, the Supreme Court found that, even if Oregon courts were to review hospital peer review proceedings, the reviewing court only would determine

hospitals to conduct professional review,[160] the Court found that Oregon's statutory provisions failed to meet the active supervision requirement of the state action doctrine.[161] Accordingly, the Court found that in the State of Oregon, professional review committees and individual committee members are not immune from antitrust liability under the state action doctrine.[162] Thus, the Supreme Court reversed the decision of the Ninth Circuit and reinstated the district court's judgment.[163]

The judicial analyses of the Ninth Circuit and the Supreme Court in *Patrick* demonstrate the confused state of antitrust law in professional

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whether the hospital afforded the plaintiff some sort of reasonable procedure and whether evidence existed from which the peer review committee could find that plaintiff's conduct posed a threat to patient care. *Id.* The Supreme Court found that this kind of deferential judicial review failed to satisfy the state action doctrine's requirement of active supervision because the court would not review the merits of a termination decision to determine whether the decision accorded with state regulatory policy. *Id.*

160. *See* OR. REV. STAT. § 441.055(3)(c), (d) (1987) (requiring hospital governing boards to insure that procedures exist for terminating privileges and to insure that medical staff reviews professional practices of facility).

161. *Patrick*, 108 S.Ct. at 1665.

162. *Id.* at 1665-66.

163. *Id.* at 1666. Although the acts challenged in *Patrick* occurred before Congress enacted the HCQIA, the HCQIA would not immunize the actions of the defendants in *Patrick. See* 42 U.S.C. § 11111(a) (Supp. 1988) (immunizing members of professional review committee if professional review action satisfies statutory definition of professional review action and if committee adhered to statutory standards); 42 U.S.C. § 11112(a) (Supp. 1988) (listing standards professional review committees must follow to receive immunity from liability under the HCQIA); 42 U.S.C. § 11151(9) (Supp. 1988) (defining "professional review action" as action of professional review committee that committee takes based on competence or professional conduct of individual physician). In enacting the HCQIA, Congress did not intend to immunize professional review committees that take illegitimate anticompetitive actions under the guise of furthering the quality of health care. *See* H.R. REP. 5540, 99th Cong., 2d Sess., 132 CONG. REC. 9954, 9957 (1986) (statement of Rep. Waxman) (stating that HCQIA does not immunize professional review committees that base actions on anticompetitive purposes). Accordingly, the HCQIA protects only professional review committee members participating in a good faith review based on the individual physician's competence or professional conduct that endangers the health or welfare of patients. *See* 42 U.S.C. § 11151(9) (Supp. 1988) (defining "professional review action" as action based on competence or professional conduct of individual physician). In *Patrick* the Supreme Court found a great deal of evidence that the professional review committee members based their decision to revoke Patrick's medical staff privileges on Patrick's refusal to join the Clinic partnership rather than on Patrick's competence as a physician or Patrick's ability to get along with the other members of the medical staff. Patrick v. Burget, 108 S. Ct. 1658, 1661-62; *see supra* notes 115-30 and accompanying text (summarizing evidence that professional review committee members acted in bad faith). Consequently, because the members of the professional review committee in *Patrick* based their action on considerations other than Patrick's competence or professional conduct, the members would not qualify for immunity from liability under the HCQIA. *See* 42 U.S.C. § 11111(a) (Supp. 1988) (immunizing members of professional review committee if professional review action satisfies statutory definition of "professional review action" and if committee adhered to statutory standards); 42 U.S.C. § 11151(9) (Supp. 1988) (defining "professional review action" as action of professional review committee that committee takes based on competence or professional conduct of individual physician).

review committee cases.[164] Examining the applicable statutes, the Ninth Circuit in *Patrick* found that the state action doctrine protected the members of the professional review committee from antitrust liability.[165] Looking at the same statutes, the Supreme Court reversed the Ninth Circuit and held that the state action doctrine does not protect members of professional review committees in Oregon from liability.[166] Furthermore, the *Patrick* analysis did not even consider the professional review committee's action under the HCQIA, which would have complicated and lengthened the analysis significantly.[167] The *Patrick* case also demonstrates the kinds of abuses that can occur in the professional review procedure, in which private

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164. *See supra* notes 138-63 and accompanying text (summarizing Ninth Circuit's and Supreme Court's opinions in *Patrick*).

165. *See supra* notes 138-54 and accompanying text (summarizing Ninth Circuit's reasoning in *Patrick*); *cf.* Marrese v. Interqual, Inc., 748 F.2d 373, 374 (7th Cir. 1984) (concluding that members of professional review committee exempt from federal antitrust law under state action doctrine), *cert. denied*, 472 U.S. 1027. In *Marrese* the Seventh Circuit evaluated the Indiana statutory scheme under the state action doctrine to determine whether the members of a professional review committee were immune from antitrust liability. *Id.* at 387-95. The Seventh Circuit found that Indiana statutes required hospitals to establish a peer review committee to evaluate patient care. *Id.* at 388; *see* IND. CODE § 34-4-12.6-1 (1986) (requiring hospitals to establish peer review committees). Accordingly, the Seventh Circuit found that the defendants acted according to a clearly articulated state policy to displace competition with regulation, thereby meeting the first requirement of the state action doctrine. *Marrese*, 748 F.2d at 388-89. The Seventh Circuit next analyzed whether the state of Indiana satisfied the second prong of the state action doctrine by actively supervising the medical review process. *Id.* at 389-94. The Seventh Circuit construed Indiana statutes that authorized peer review committees to release their records to the Indiana Medical Licensing Board for recommended disciplinary action as statutes that transformed the Indiana Medical Licensing Board into an official state body to review the determinations of medical peer review committees. *Id.* at 389; *see* IND. CODE § 34-4-12.6-2(b) (1986) (allowing peer review committees to disclose records to state board of licensure that committee believes is necessary for recommended disciplinary action). *But see Patrick*, 108 S. Ct. at 1664 (stating that, because Oregon statutes do not authorize Board to disapprove private privileges decisions, Board does not actively supervise professional review committee conduct). The *Marrese* circuit court also found that Indiana statutes entitled the Indiana Hospital Licensing Council to review the confidential minutes of medical staff peer review committees to determine whether hospitals are providing quality medical care while acting in accordance with approved medical standards. *Marrese*, 748 F.2d at 389-90; *see* 410 IND. ADMIN. CODE § 15-1-8(1)(c) (1984) (authorizing Licensing Council inspectors to review minutes of medical staff review committees). *But see Patrick*, 108 S. Ct. at 1664 (stating that state does not actively supervise professional review committees' activities unless state has and exercises ultimate authority over private privilege determinations). Because the *Marrese* court found that the Medical Licensing Board and the Hospital Licensing Council actively supervised the conduct of professional review committees, the court found that the defendants' conduct satisfied the second element of the state action test. *Marrese*, 748 F.2d at 390-91. Accordingly, the *Marrese* court held that the state action doctrine exempted the defendants' actions from federal antitrust laws, thereby affirming the district court's dismissal of the plaintiff's complaint. *Id.* at 395.

166. *See supra* notes 155-63 and accompanying text (summarizing Supreme Court's decision in *Patrick*).

167. *See supra* note 138 and accompanying text & note 155 (stating that Ninth Circuit and Supreme Court did not analyze *Patrick* using HCQIA).

doctors have the power unfairly to impair their competitors' careers.[168] The confusion and complexity of judicial analysis, the need to protect participants in good faith professional review actions from crippling liability, and the need to protect competent physicians from vindictive professional review actions indicate the need for corrective state legislation.[169]

Principles of federalism give the states, as independent sovereigns, power to act judicially or legislatively to protect the state's commerce and further legitimate state goals.[170] The judicially-created state action doctrine allows the states, acting as sovereigns, to further state goals of promoting quality medical care and protecting public health through good faith professional review, by overriding federal antitrust law.[171] In the same manner that the states have used the judicially created state action doctrine, states can use their power as sovereigns to enact legislation that would lessen the burdens of courts deciding physicians' antitrust suits against professional review committee members.[172] A state statute legislating professional review actions would consolidate into one source all the issues that a court must consider in deciding a physician's suit against the members of a professional review committee.[173] Additionally, because the statute explicitly would describe the procedures that professional review committees must follow in evaluating a physician's medical staff privileges, the members of the professional review committee more easily could adhere to the statutory requirements necessary to immunize their actions.[174] Thus, states could further the goal of promoting quality medical care and the goal of protecting public health by protecting physicians who participate in good faith professional review actions and protecting competent physicians from wrongful professional review actions, while simultaneously increasing the efficiency of the courts.[175]

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168. *See supra* notes 115-30 and accompanying text (describing defendants' conduct in *Patrick*).

169. *See supra* notes 25-100 and accompanying text (describing complicated judicial analysis necessary to resolve antitrust action physician has brought against members of professional review committee); *supra* notes 26-27 and accompanying text (explaining Congress' desire to protect participants in legitimate professional review actions from liability); *supra* notes 115-30 and accompanying text (describing defendants' vindictive behavior and bad faith professional review proceedings in *Patrick*).

170. *See supra* note 47 (summarizing federalist rationale behind state action doctrine).

171. *See supra* notes 58-62 and accompanying text (explaining two-pronged test courts use to determine whether individuals' actions satisfy state action doctrine).

172. *See supra* notes 58-62 and accompanying text (explaining two-pronged test courts use to determine whether actions of individuals satisfy state action doctrine); *infra* notes 201-10 and accompanying text (describing how satisfying state action doctrine through appropriate legislation would decrease amount of judicial analysis required to resolve physician's antitrust suit).

173. *See infra* notes 201-10 and accompanying text (describing how satisfying state action doctrine through appropriate legislation would decrease amount of judicial analysis required to resolve physician's antitrust suit).

174. *See infra* notes 201-10 and accompanying text (describing how satisfying state action doctrine through appropriate legislation would decrease amount of judicial analysis required to resolve physician's antitrust suit).

175. *See infra* notes 206-15 and accompanying text (explaining how proposed legislation would further states' goals).

State legislatures could achieve their objectives of decreasing the amount of judicial analysis necessary to resolve antitrust cases and protecting the parties involved in the professional review process in several ways.[176] Several states have chosen to alleviate the complexity of judicial analysis by providing blanket immunity for the members of professional review committees, regardless of the propriety of members' motives in revoking a physician's medical staff privileges.[177] Legislation providing immunity even for bad faith professional review action eliminates the current complexity of the law by eliminating a plaintiff physician's cause of action against the members of the professional review committee.[178] In addition, statutes providing blanket immunity serve the purpose of encouraging competent physicians to participate in professional review proceedings.[179] However, statutes providing blanket immunity for the professional review committee members have profound disadvantages.[180] First, competent physicians who are unpopular or eccentric in some way not detrimental to public health may suffer a loss of livelihood because professional review committees wrongfully can remove the physicians from the hospital medical staff without fear of liability.[181] Second, the legislation does not provide the best possible protection for the public.[182] Public health suffers if professional review actions based on bad faith motives have the effect of removing competent physicians from the competitive market by terminating existing medical staff privileges and hindering the physician's ability to get medical staff privileges at other hospitals.[183] Consequently, contrary to the legislature's goals of promoting

176. *See infra* notes 177-210 and accompanying text (describing alternative methods state legislatures could utilize to prevent lengthy judicial analysis in antitrust cases).

177. *See* IDAHO CODE § 39-1392c (1985) (immunizing members of professional review committees from civil liability without conditioning immunity on good faith standard); ILL. REV. STAT. ch. 111 1/2 para. 151.2 (Smith-Hurd 1988) (same); IND. CODE ANN. § 16-12.6-3 (Supp. 1988) (immunizing committee members if they act in good faith); ME. REV. STAT. ANN. tit. 32, § 3293 (1988) (same); OHIO REV. CODE ANN. § 2305.25 (Baldwin Supp. 1988) (same); R.I. GEN. LAWS § 23-17-25(b) (1985) (same).

178. *See supra* note 177 (listing statutes abolishing physicians' cause of action against members of professional review committee).

179. *See* James, *Peer Review Among Doctors Receives Boost*, Wall St. J., Oct. 10, 1986, at 31, col. 3 (stating that, as result of district court's treble damages award in *Patrick*, many physicians began to refuse to participate in peer reviews); H.R. REP. No. 903, 99th Cong., 2d Sess. 3 (1986), *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385 (stating that doctors who are sufficiently fearful of threat of litigation will not do meaningful peer review).

180. *See infra* notes 181-84 and accompanying text (discussing disadvantages of blanket immunity statutes).

181. *See* 1 Lewin & Assocs., *Competition Among Health Practitioners: The Influence of the Medical Profession on the Health Manpower Market*, Executive Summary and Final Report, Feb. 1981, II-28 (stating that, for many physician specialists, hospital privileges are indispensable to their practice); *supra* notes 9-12 and accompanying text (discussing effects loss of medical staff privileges has on physician's career).

182. *See infra* notes 183-84 and accompanying text (describing harmful effect blanket immunity statutes has on public health).

183. *See* M. Pollard & R. Liebenluft, *Antitrust and the Health Professions: Policy Planning Issues Paper* 100-02 (FTC Office of Policy Planning July 1981) (summarizing ways consumers

the public health and improving the quality of health care, the quality of public health care presumably will decline if professional review committees wrongfully may revoke, without threat of sanctions, a physician's medical staff privileges.[184]

In addition to failing to provide the best possible protection for the public and failing to protect competent but unpopular physicians from wrongful professional review actions, statutes providing blanket immunity undercut the purpose of the federal antitrust laws.[185] For example, a statute providing blanket immunity for the members of professional review committees would immunize from liability even the members of the professional review committee in *Patrick*, whose behavior the Ninth Circuit termed as "shabby, unprincipled and unprofessional."[186] Congress designed the antitrust laws to protect businesses from monopolies and restraints on trade imposed by larger companies or combinations of companies.[187] Similarly, antitrust laws also should operate to protect unpopular, although competent, physicians from restraints on trade and monopolistic conduct that fellow physicians impose.[188] Because blanket immunity statutes protect committee members who have based their actions on anticompetitive motives instead of a concern for improving the quality of health care, blanket immunity statutes circumvent the legitimate purposes of the antitrust laws.[189] Consequently, state statutes providing blanket immunity to members of professional review committees fail to protect the general public and a physician whose medical staff privileges a professional review committee wrongfully

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suffer when hospitals unreasonably limit privileges). According to Pollard and Liebenluft, consumers suffer in several ways when hospitals unreasonably limit privileges. *Id.* at 100. Restricting the supply of physicians enables physicians with medical staff privileges to charge higher fees. *Id.* More significantly for consumers, however, adverse professional review decisions restrict the choices of available physicians. *Id.* at 101. Not only may consumers lose the services of physicians the consumers prefer, but especially in rural and underserved areas, consumers may lose the only available source of care. *Id.*

184. *See* H.R. REP. No. 903, 99th Cong., 2d Sess. 2 (1986), *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384 (stating that purpose of HCQIA is to improve quality of medical care by encouraging physicians to identify and discipline incompetent physicians).

185. *See supra* notes 68-69 and accompanying text (explaining procompetitive intent of Sherman Act).

186. *See* Patrick v. Burget, 800 F.2d 1498, 1509 (9th Cir. 1986) (describing conduct of members of professional review committee in *Patrick*), *rev'd on other grounds*, 108 S. Ct. 1658 (1988); *e.g.*, IDAHO CODE § 39-1392c (1985) (immunizing members of professional review committees from civil liability without conditioning immunity on good faith standard); ILL. REV. STAT. ch. 111 1/2 para. 151.2 (Smith-Hurd 1988) (same); ME. REV. STAT. ANN. tit. 32, § 3293 (1988) (same); OHIO REV. CODE ANN. § 2305.25 (Baldwin Supp. 1988) (same); R.I. GEN. LAWS § 23-17-25(b) (1985) (same).

187. *See supra* notes 68-69 and accompanying text (discussing congressional intent behind Sherman Act).

188. *See supra* notes 68-69 and accompanying text (discussing congressional intent behind Sherman Act).

189. *See supra* notes 68-69 and accompanying text (discussing purposes of Sherman Act); *supra* notes 31-41 and accompanying text (discussing limited immunity that HCQIA provides to professional review committee members).

has revoked, and provide undue protection for the members of professional review committees acting in bad faith.[190]

As an alternative to a state statute providing blanket immunity to members of professional review committees regardless of the members' underlying motives in terminating a physician's medical staff privileges, some states have chosen to enact statutes that are similar to the HCQIA.[191] These state statutes immunize committee members only if the members have acted in good faith, and have based their decision on a reasonable belief that the facts, as determined after reasonable investigation, warranted revoking the physician's medical staff privileges.[192] Under statutes that

190. *See supra* notes 180-89 and accompanying text (describing disadvantages of blanket immunity statutes).

191. *See infra* note 192 and accompanying text (listing state statutes with provisions similar to HCQIA's).

192. *See* ALA. CODE § 6-5-333(a) (Supp. 1988) (immunizing committee members if they act without malice and in reasonable belief that facts warrant action); ALASKA STAT. § 18.23.020 (1986) (immunizing committee members if they act in reasonable belief that facts warrant action); ARIZ. REV. STAT. ANN. § 36-2402(B) (Supp. 1988) (immunizing committee members if they act without malice); ARK. STAT. ANN. § 20-9-502(a) (immunizing committee members if they act without fraud or malice); CAL. CIV. CODE § 43.7(b) (West Supp. 1989) (immunizing committee members if they act without malice, have made reasonable effort to obtain facts of matter as to which they act, and act in reasonable belief that facts warrant action); CONN. GEN. STAT. ANN. § 38-19a(c) (West 1987) (immunizing committee members if they act without malice and in reasonable belief that facts warrant action); DEL. CODE ANN. tit. 24, § 1768(a) (Supp. 1988) (immunizing committee members if they act in good faith and without malice); FLA. STAT. ANN. § 395.011(8) (Supp. 1988) (immunizing committee members if they act in good faith and without intentional fraud); GA. CODE ANN. § 31-7-132(a) (Supp. 1988) (immunizing committee members unless malice motivated action); HAW. REV. STAT. § 36-663-1.7(b) (Supp. 1987) (immunizing committee members if they act without malice); KAN. STAT. ANN. § 65-4442(a) (1985) (immunizing committee members if they act in good faith and without malice); KY. REV. STAT. ANN. § 311.377(1) (Baldwin Supp. 1988) (providing that any person to whom hospital has granted medical staff privileges waives claim for damages for committee members' good faith actions); MD. HEALTH OCC. CODE ANN. § 14-601(f) (Supp. 1988) (immunizing committee members if actions are in good faith); MICH. COMP. LAWS ANN. § 331.531 (West 1980) (immunizing committee members unless they act with malice); MINN. STAT. ANN. § 145.63 subdiv. 1 (West Supp. 1989) (immunizing committee members if they act without malice and in reasonable belief that facts warrant committee's action); MISS. CODE ANN. § 73-25-93(b) (Supp. 1988) (immunizing committee members if they act without malice); MO. ANN. STAT. § 537.035 (Vernon 1988) (immunizing committee members if members act in good faith and without malice); MONT. CODE ANN. § 37-2-201(1) (1987) (immunizing committee members if they act without malice and in reasonable belief that facts warrant committee's action); N.J. STAT. ANN. § 2A:84A-22.10 (West Supp. 1988) (same); N.M. STAT. ANN. § 41-9-4 (1987) (same); N.Y. PUB. HEALTH LAW § 2805-j.2 (McKinney Supp. 1989) (immunizing committee members if members act in good faith and without malice); N.C. GEN. STAT. § 131E-95(a) (1988) (immunizing committee members if they act without malice or fraud); N.D. CENT. CODE § 23-01-02.1 (Supp. 1987) (immunizing committee members if they act without malice and in reasonable belief that facts warrant committee's action); OKLA. STAT. tit. 76, § 28 (Supp. 1989) (immunizing committee members from all liability except for civil rights violations and antitrust violations if members act in good faith and pursuant to statutory procedural requirements); OR. REV. STAT. § 41.674(4) (1987) (immunizing committee members if they act in good faith); S.D. CODIFIED LAWS ANN. § 36-4-25 (1986) (immunizing committee

condition immunity from liability on the committee members' good faith actions, committee members who base an action on reasons unrelated to the physician's competence or professional conduct are liable for their wrongful actions.[193] Therefore, statutes basing immunity for members of professional review committees on the good faith of the committee members provide better protection for unpopular but competent physicians from wrongful professional review actions than statutes providing blanket immunity for committee members.[194] However, statutes providing immunity for good faith professional review actions do little to alleviate the complex legal analysis courts must apply in considering antitrust suits against the members of a professional review committee.[195] At a minimum, a court still must hear evidence of the professional review committee's motives.[196] If a physician fails to prove that the committee members acted in bad faith, the suit is dismissed without the further analysis that the HCQIA, the state action doctrine, and the antitrust laws require.[197] If, however, the physician

members if they act without malice and in reasonable belief that facts warrant committee action); TENN. CODE ANN. § 63-6-219(b) (Supp. 1988) (immunizing committee members if they act in good faith, without malice, and on basis of facts reasonably believed to exist); TEX. REV. CIV. STAT. ANN. art. 4447d, § 3 (Vernon Supp. 1989) (immunizing committee members if they act without malice and in reasonable belief that facts warrant committee's action); UTAH CODE ANN. § 58-12-25(1) (Supp. 1988) (immunizing committee members if they act in good faith and without malice); VT. STAT. ANN. tit. 26, § 1442(a) (Supp. 1988) (immunizing committee members if they act without malice and in reasonable belief that facts warrant committee's action); VA. CODE ANN. § 8.01-581.16 (Supp. 1988) (immunizing committee members unless they act in bad faith or with malicious intent); WASH. REV. CODE ANN. § 4.24.240(2) (1988) (immunizing committee members if they act in good faith); W. VA. CODE § 30-3C-2(b) (1986) (immunizing committee members if they act without malice and gross negligence); WIS. STAT. ANN. § 146.37(1) (West Supp. 1988) (immunizing committee members if they act in good faith); WYO. STAT. § 35-17-103 (1988) (immunizing committee members unless their acts are malicious or grossly negligent and result in harm to another).

193. *See, e.g.*, ALASKA STAT. § 18.23.020 (1986) (immunizing committee members if members act in reasonable belief that facts, as known to members after reasonable efforts to obtain facts upon which is action based, warranted action); FLA. STAT. ANN. § 395.011(8) (Supp. 1988) (immunizing committee members if act in good faith and without intentional fraud); N.C. GEN. STAT. § 131E-95(a) (1988) (immunizing committee members if members act without malice or fraud).

194. *See supra* notes 192-93 and accompanying text (explaining why statutes that condition immunity from liability on good faith of committee members provide better protection for competent but unpopular physicians).

195. *See infra* notes 196-98 and accompanying text (describing appropriate judicial analysis in states with statutes providing immunity to professional review committee members who have acted in good faith).

196. *See, e.g.*, CAL. CIV. CODE § 43.7 (West Supp. 1989) (immunizing committee members if members act without malice, have made reasonable effort to obtain facts of matter as to which members act, and act in reasonable belief that facts known to members warranted action); FLA. STAT. ANN. § 395.011(8) (Supp. 1988) (immunizing committee members if members acted in good faith and without intentional fraud); VA. CODE. ANN. § 8.01-581.16 (Supp. 1988) (immunizing committee members unless members acted in bad faith or with malicious intent).

197. *See supra* notes 26-42 and accompanying text (summarizing HCQIA analysis); *supra* notes 57-62 (summarizing state action doctrine analysis).

succeeds in establishing that the members of the professional review committee acted in bad faith, the state statute would not immunize the members from liability, and as a result, the physician still must overcome the state action doctrine and prove his antitrust case.[198] Because the evidence necessary to prove that the committee members acted with improper motives is inherently speculative, bad faith is very difficult to prove, and thus good faith immunity statutes provide inadequate protection for physicians whose privileges the committee has wrongfully revoked.[199] Therefore, while the blanket immunity statutes go too far in immunizing all professional review committees regardless of motive, the good faith immunity statutes do not reach far enough to be of significant value in protecting physicians from wrongful conduct or in solving the problems of overloaded courts.[200]

The *Patrick* case provides a key to the solution to the task facing state legislatures in their attempt to lessen courts' burdens in resolving antitrust cases against professional review committee members and to protect the interests of all parties involved in the professional review process.[201] In *Patrick* the Supreme Court rested its decision to deny state action doctrine immunity to the members of the professional review committee members on the lack of adequate supervision from the state of Oregon over the conduct of professional review committees.[202] If the Oregon statutes explicitly had provided for adequate supervision, the state action doctrine may have provided immunity for the defendants, and the court would have been one step closer to resolving the case without extensive review of the members' motives or the plaintiff's antitrust case.[203] Thus, if a state legislature were,

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198. *See supra* notes 57-62 and accompanying text (summarizing state action doctrine analysis); *supra* notes 73-100 and accompanying text (summarizing antitrust analysis). If the physician proved that the members of the professional review committee fail to qualify for immunity under the state statute because they did not act in good faith, the committee members would not receive immunity from liability under the HCQIA. *See* 42 U.S.C. § 11151(9) (Supp. 1988) (defining "professional review action" as action of professional review body that the body has based on competence or professional conduct of individual physician); 42 U.S.C. § 11111(a) (Supp. 1988) (stating that members of professional review committee are immune from liability if professional review action complies with definition in 42 U.S.C. § 11151(9)).

199. *See* 132 CONG. REC. H9954, H9961 (daily ed. Oct. 14, 1986) (letter of Rep. Edwards) (stating that physicians have difficulty challenging fairly administered professional review actions because courts are reluctant to second guess decisions that medical professionals have made regarding physician's competency); *supra* notes 31-33 and accompanying text (describing nature of evidence plaintiff must present to show that defendant committee members acted in bad faith for purposes of HCQIA).

200. *Compare supra* notes 180-90 and accompanying text (discussing disadvantages of blanket immunity statutes) *with supra* notes 195-99 and accompanying text (discussing disadvantages of good faith immunity statutes).

201. *See infra* notes 201-04 and accompanying text (explaining why *Patrick* provides state legislatures with solution to problem of lessening courts' burdens and protecting interests of parties involved in professional review process).

202. *See supra* notes 155-63 and accompanying text (summarizing Supreme Court's decision in *Patrick*).

203. *See supra* notes 155-63 and accompanying text (summarizing Supreme Court's decision

in effect, to satisfy permanently the requirements of the state action doctrine by incorporating the intent and supervision requirements into a statute, courts could eliminate the currently necessary factual review and dismiss many cases based solely upon a review of the state statute.[204]

Additionally, if the statute incorporated the requirements of the HCQIA, a single state statute could determine the outcome of not only antitrust suits, but also suits based on all other legal theories of recovery.[205] A single source for all the relevant law would streamline analysis greatly.[206] In this way, courts reviewing antitrust cases would have only to ascertain that a statutory scheme satisfies the state action doctrine and that the professional review committee proceedings complied with the requirements of the statute.[207] If the statute accurately reflects the requirements of the state action doctrine, and if the hospital complies with the terms of the statute, the members of the professional review committee would qualify for immunity from antitrust liability under the state action doctrine and for immunity from liability under all other legal theories under the HCQIA.[208] The first inquiry is straightforward, and involves only reading the words of the statute to determine that the legislature intended to displace competition with regulation. The second inquiry would involve determining whether the state supervisor named in the statute had, in fact, monitored the professional review proceedings to ensure that the committee members based their actions on legitimate motives.[209] If the court finds that supervision that the statute required did not, in fact, take place, the court could proceed directly to traditional antitrust analysis.[210]

By enacting legislation that consolidates the state action doctrine with the HCQIA standards, the legislature not only shortens the judicial analysis

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in *Patrick*). To satisfy both requirements of the state action doctrine, the Oregon statutory scheme would have had to articulate clearly and express affirmatively the state's intent to displace competition with regulation, as well as provide for adequate state supervision. *See supra* note 156 (stating that Supreme Court did not analyze whether Oregon statutory scheme satisfied first requirement of state action doctrine).

204. *See infra* notes 207-10 and accompanying text (explaining judicial analysis necessary to resolve physicians' antitrust actions in states that have enacted proposed regulations).

205. *See infra* notes 207-10 and accompanying text (explaining judicial analysis necessary to resolve physicians' antitrust actions in states that have enacted proposed regulations).

206. *See infra* notes 207-10 and accompanying text (explaining judicial analysis necessary to resolve physicians' antitrust actions in states that have enacted proposed regulations).

207. *See infra* note 210 and accompanying text (summarizing judicial analysis if proposed statute existed).

208. *See infra* notes 216-34 and accompanying text (describing proposed state legislation).

209. *See infra* notes 216-34 and accompanying text (describing proposed state legislation).

210. *See infra* notes 216-34 and accompanying text (describing proposed state legislation); *supra* notes 73-100 and accompanying text (explaining antitrust analysis). The court would not have to determine whether the state action doctrine exempts the members of the professional review committee from antitrust liability because, by finding that the committee failed to comply with the statutory scheme satisfying the state action doctrine, the court has found that the state did not supervise actively the conduct of the committee members. *See supra* notes 60-61 and accompanying text (describing active supervision requirement of state action doctrine).

necessary to resolve a physician's action against the members of a professional review committee, but the legislature also furthers its goals of promoting public health and safety.[211] The legislature encourages physicians to participate on professional review committees because the committee members are immune from liability under all state and federal laws.[212] The proposed state legislation also furthers the state's interest in protecting competent physicians from wrongful professional review actions.[213] By incorporating the requirements of the HCQIA explicitly in the state statute, the state will ensure that professional review committees base their actions on the physician's competence or professional conduct and that those physicians whose medical staff privileges the professional review committee has revoked lost their medical staff privileges because of incompetence or professional misconduct.[214] In sum, appropriate state legislation would improve the professional review proceedings by ensuring proper motives, providing better protection for the members of the professional review committee, lessening the chance for litigation, and reducing the amount of judicial analysis required to untangle the legal theories involved.[215]

To achieve its goals effectively, the legislative enactment must incorporate both requirements of the state action doctrine.[216] First, the state legislation must articulate clearly and affirmatively a legislative intent to displace competition with professional review committee regulation.[217] Legislatures can satisfy this requirement easily by inserting the appropriate language into the statute.[218] In addition, if the statute does not state explicitly

211. *See infra* notes 213-15 and accompanying text (explaining how proposed state legislation furthers state's goals of promoting public health and safety).

212. *See* 132 CONG. REC. H9954, H9957 (daily ed. Oct. 14, 1986) (statement of Rep. Waxman) (stating that limited immunity that HCQIA provides to members of professional review committees is essential to encourage hospitals and physicians to participate in effective peer review). Because the proposed legislation would protect the members of the professional review committee from all liability if the committee complied with the statute, the legislation would discourage physicians from filing suits against members of professional review committees. *See* 42 U.S.C. § 11111(a) (Supp. 1988) (immunizing from all liability professional review actions that satisfy the HCQIA definitions and standards).

213. *See infra* note 214 and accompanying text (explaining how proposed legislation protects competent physicians from wrongful professional review actions).

214. *See* Patrick v. Burget, 108 S. Ct. 1658, 1663 (1988) (stating that active state supervision requires that state officials have and exercise power to disapprove anticompetitive action of private parties that promote private parties' individual interests); *infra* note 226 and accompanying text (explaining how state legislation satisfying state action doctrine ensures that professional review committee members base actions on good faith motives).

215. *See infra* notes 237-41 and accompanying text (describing advantages of state legislation satisfying state action doctrine and HCQIA standards).

216. *See infra* notes 217-34 and accompanying text (proposing means legislatures may use to satisfy both requirements of state action doctrine).

217. *See* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (stating that state must articulate clearly and express affirmatively state policy to displace competition with regulation); *supra* notes 57-62 and accompanying text (explaining state action analysis).

218. *See* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97,

a legislative intent to displace competition with regulation, a court will infer a legislative intent to displace competition if the court finds that the legislature contemplated that professional review committees would revoke physicians' medical staff privileges.[219] Consequently, the legislature easily can satisfy the first requirement of the state action doctrine.[220]

The legislature's more difficult task is to satisfy the second requirement of the state action doctrine—providing for active state supervision of all professional review decisions.[221] Although some state statutes require that hospitals promptly notify the state health department or the state board of medical examiners if a hospital has revoked a physician's medical staff privileges, the statutes do not provide that the state agency monitor the proceedings or review the hearing record.[222] The Supreme Court in *Patrick* stated that the active supervision prong of the state action doctrine requires that the state exercise ultimate control over the professional review committee's conduct.[223] Consequently, according to the *Patrick* Court, the active supervision prong of the state action doctrine requires that state officials have and exercise power to review the acts of professional review committees and disapprove those acts that do not comply with state policy.[224] Therefore, the state legislature must provide that a state agency, such as the state health department or state board of medical examiners, review all professional review committee decisions affecting a physician's medical staff privileges.[225] The state agency that the statute indicates will review the

105 (1980) (stating that state must articulate clearly and express affirmatively state policy to displace competition with regulation).

219. *See* Southern Motor Carriers Rate Conf., Inc. v. United States, 471 U.S. 48, 64 (1985) (stating that private party acting pursuant to anticompetitive state regulatory program need not point to specific detailed legislative authorization to justify challenged conduct); Scott v. City of Sioux City, Iowa, 736 F.2d 1207, 1211 (8th Cir. 1984) (stating that state has adequately articulated intent to displace competition in certain area when authority given to municipality to operate in area indicates that legislature contemplated kind of activity antitrust plaintiff challenges).

220. *See supra* notes 217-19 and accompanying text (explaining how state legislation can satisfy first requirement of state action doctrine).

221. *See infra* notes 222-26 and accompanying text (discussing difficulties of satisfying second requirement of state action doctrine in proposed legislation); *supra* notes 60-61 and accompanying text (explaining second requirement of state action doctrine).

222. *See* Patrick v. Burget, 108 S. Ct 1658, 1664 (1988) (stating that, although Oregon statutes require hospitals to promptly notify Board of decision to terminate privileges, Oregon statutes do not provide Board with power to disapprove private privilege decisions); OR. REV. STAT. § 441.820(1) (1987) (requiring health care facility that terminates physician's privileges to promptly report, in writing, to Board all facts and circumstances that resulted in termination).

223. Patrick v. Burget, 108 S. Ct. 1658, 1663 (1988).

224. *Id.* The Supreme Court in *Patrick* noted that unless the state actively supervises acts of professional review committees by reviewing professional review committee decisions and disapproving committee decisions that fail to accord with state policy, the state cannot ensure that the professional review committee's acts promote state policy rather than the interests of the individual members. *Id.*

225. *See id.* at 1664 (stating that state does not actively supervise termination of medical staff privileges unless state official has and exercises ultimate authority over private privilege determinations).

professional review committee's decisions must ascertain that the members of the professional review committee based the committee's decision on the physician's competence and professional conduct, and not on personal anticompetitive motives.[226]

The legislature may provide for review of professional review committee decisions in any of three ways.[227] First, the legislature may provide that a state agency review the record of the professional review committee proceedings after the committee has completed the proceedings.[228] This method, although requiring minimal effort on the part of the agency, may be inadequate to detect the kinds of procedural improprieties that occurred during the professional review committee proceedings in *Patrick*.[229] Furthermore, unless the reviewing agency supplements the record with its own investigation, the agency may not know about prior events unrelated to the physician's conduct in the hospital that spurred the members of the professional review committee to terminate the physician's privileges, such as the physician's refusal to join a medical association.[230]

Second, the legislature may require the reviewing agency to conduct its own separate de novo hearing.[231] This alternative is inefficient because a separate hearing unnecessarily duplicates already completed proceedings.[232] Third, the legislature may require agency representation at the professional review proceedings.[233] The presence of an agency representative at the hearing would improve the chances that the physician would receive a fair hearing, and the agency representative immediately could interview immediately those parties central to the proceeding to determine whether reasons other than

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226. *See id.* at 1663 (stating that, unless state actively supervises termination of medical staff privileges, state cannot ensure that private party's anticompetitive conduct promotes state policy rather than merely party's individual interests).

227. *See infra* notes 228-34 and accompanying text (describing alternative methods states may use to ensure state actively supervises professional review actions).

228. *See Patrick*, 108 S. Ct. at 1664 (stating that, under Oregon statutory scheme, Health Division does not actively supervise privilege termination because Division has no power to review private peer review decisions).

229. *See supra* notes 129-30 and accompanying text (describing defendants' conduct at hearing to terminate Patrick's medical staff privileges).

230. *See supra* notes 112-14 and accompanying text (describing Patrick's rejection of Clinic partners' offer to join Clinic partnership and instead establishing independent practice in Astoria).

231. *See Patrick*, 108 S. Ct. at 1663 (stating that active supervision requirement of state action doctrine requires that state exercise ultimate control over challenged anticompetitive conduct).

232. *See* 132 CONG. REC. H9954, H9960 (daily ed. Oct. 14, 1986) (statement of Rep. Edwards) (stating that costs of challenging wrongful peer review involve costs to challenging physician and to peer review participants).

233. *See* Patrick v. Burget, 108 S. Ct. 1658, 1663 (1988) (stating that active supervision requirement of state action doctrine requires that state officials have and exercise power to review private parties' anticompetitive acts and disapprove those acts that fail to accord with state policy).

the concern for improving the quality of health care motivated the members of the professional review committee to act.[234]

A state statute that satisfies both requirements of the state action doctrine effectively will protect the members of the professional review committee from antitrust liability if the committee complies with the statute.[235] However, a state statute satisfying the state action doctrine will not protect the members of the professional review committee from other types of liability, leaving a court to evaluate the suit under other legal theories.[236] Therefore, to make the court's analysis as easy as possible, to provide maximum protection to the members of the professional review committee, and to prevent the committee from taking vindictive professional review actions against competent physicians, the state statute should also include the standards for professional review actions that the HCQIA sets.[237] A state statute that satisfies the state action doctrine ensures that the professional review committee bases its actions on a physician's competence and professional conduct, thereby complying with the HCQIA's definition of professional review action.[238] To fully satisfy HCQIA standards, the statute also must require professional review committees to act in the reasonable belief that their actions further quality health care; to act after a reasonable effort to obtain the facts of the matter; to act after providing adequate notice and hearing; and to act in the reasonable belief that the facts warranted the committee's action.[239] Because the supervision provision of the statute would require a neutral state agency official to oversee the professional review proceeding, the official could attest that the members of the committee based their action on legitimate motives and adhered to the statutory notice and hearing requirements.[240] If the statute satisfied the state action doctrine and required professional review committees to comply

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234. *See supra* notes 107-31 and accompanying text (describing facts of *Patrick* and defendants' conduct at committee hearings).

235. *See supra* notes 216-34 and accompanying text (explaining methods that legislature can use to satisfy state action doctrine).

236. *See supra* note 14 (summarizing other legal theories physicians may use in action against members of professional review committees).

237. *See supra* notes 30-39 and accompanying text (discussing HCQIA standards for professional review actions).

238. *See supra* note 226 and accompanying text (explaining how statute will ensure professional review committee bases its action on physician's competence and professional conduct); 42 U.S.C. § 11151(9) (Supp. 1988) (defining "professional review action").

239. *See* 42 U.S.C. § 11112(a) (Supp. 1988) (establishing standards for professional review actions); *supra* notes 36-39 and accompanying text (summarizing adequate notice and hearing procedures in context of HCQIA).

240. *See* 42 U.S.C. § 11151(9) (Supp. 1988) (defining "professional review action"); *id.* § 11112 (establishing standards for professional review actions); *id.* § 11111(a) (immunizing members of professional review committees that meet definition of professional review action and comply with statutory standards); *supra* note 226 and accompanying text (describing how statute satisfying state action doctrine ensures that members of professional review committees base their actions on physician's competence and professional conduct).

with HCQIA, then the members of the professional review committee would be immune from all liability under any state or federal law.[241]

Currently, courts deciding physicians' antitrust suits against members of professional review committees must untangle a complex web of legal theories to analyze the action.[242] The court must apply the Health Care Quality Immunity Act,[243] the state action doctrine,[244] and standard antitrust doctrine.[245] The state legislatures now have the opportunity to play a significant role in simplifying the existing judicial analysis.[246] State legislatures should enact legislation that ensures that the conduct of professional review committees meet the requirements of the state action doctrine and the HCQIA.[247] This legislation should take the form of a clear expression of the legislative intent to displace antitrust laws with professional review committee regulation of physicians' medical staff privileges, coupled with provisions for active state supervision of professional review committees.[248] Additionally, the legislation should satisfy the HCQIA's standards by requiring professional review committees to base their actions on good faith motives and provide notice and a fair hearing to the physicians whose medical staff privileges the committee has challenged.[249] State legislation that addresses these points greatly could streamline the judicial analysis necessary to resolve physicians' antitrust claims against the members of professional review committees, by merging all the relevant law into one statute.[250] Additionally, the legislation would ensure legitimate professional

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241. *See* 42 U.S.C. § 11111(a) (Supp. 1988) (immunizing members of professional review committees from all liability if actions comply with definitions and standards of HCQIA).

242. *See supra* notes 25-100 and accompanying text (describing legal theories courts must apply to resolve physicians' antitrust suits against members of professional review committees).

243. *See supra* notes 31-39 and accompanying text (describing judicial analysis necessary to determine whether members of professional review committee qualify for immunity under HCQIA).

244. *See supra* notes 58-61 and accompanying text (describing judicial analysis necessary to determine whether members of professional review committee are exempt from antitrust liability under state action doctrine).

245. *See supra* notes 73-100 and accompanying text (describing antitrust analysis). In addition to examining plaintiff physician's antitrust suit under the HCQIA, the state action doctrine, and federal antitrust analysis, the court must consider whether the members of the professional review committee qualify for immunity under an applicable state statute. *See supra* note 177 (listing state statutes that provide blanket immunity for members of professional review committees); *supra* note 191 (listing state statutes that immunize members of professional review committees if members acted in good faith).

246. *See supra* notes 170-72 and accompanying text (explaining how states have power to enact proposed legislation).

247. *See supra* notes 201-10 and accompanying text (explaining reason states should enact legislation satisfying state action doctrine and HCQIA requirements).

248. *See supra* notes 216-34 and accompanying text (explaining how legislature may satisfy requirements of state action doctrine).

249. *See supra* notes 236-41 and accompanying text (explaining how proposed legislation will satisfy HCQIA standards).

250. *Compare supra* note 241 and accompanying text (describing judicial analysis necessary to resolve physician's antitrust suit if state statute satisfies state action doctrine and HCQIA

review actions by protecting professional review committee members from liability and competent physicians from wrongful professional review actions.[251] Consequently, state legislatures promptly should enact the proposed legislation to simplify the necessary judicial review and to protect more fully both professional review committee members and physicians whose medical staff privileges are under attack.[252]

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standards) *with supra* notes 25-100 and accompanying text (describing judicial analysis necessary to resolve physician's antitrust suit if no state statute satisfies state action doctrine and HCQIA standards).

251. *See supra* notes 211-15 and accompanying text (explaining that proposed state statute would protect participants in good faith professional review action from liability and competent physicians from wrongful professional review actions).

252. *See supra* notes 210-15 and accompanying text (summarizing reasons state legislature should enact legislation satisfying state action doctrine and HCQIA standards).