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Contents:

Medical Staff Closure Antitrust Considerations	2
<i>By Lynn Gordon, Esq.</i>	
Mealey's Corner	7

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Medical Staff Closure Antitrust Considerations

By
Lynn Gordon, Esq.*

I. Introduction

As service areas become more competitive and specialists are vying for exclusivity, hospital governing boards and medical executive committees (MECs) must occasionally respond to proposals by specialty groups to close the hospital's medical staff in their particular specialty. Such closure would then result in the hospital declining future applications for clinical privileges in this service area/specialty.

In light of the feasible impact staff area closures may have on competition, it is important that MECs and the governing board understand the antitrust implications of a faulty approach. Also, in connection with such potential exposure, the hospital board should be well informed in order to meet its duties of care and loyalty to the organization as it oversees medical staff decision making.

II. Antitrust Implications of Medical Staff Closures Generally

Decisions to close staff privileges to new providers may have anticompetitive consequences, which implicate antitrust laws. Most antitrust cases brought by

physicians whose privileges have been denied, reduced, or terminated allege a conspiracy involving one of three combinations: between the hospital and its medical staff; between the hospital and individual staff members; or between individual medical staff members conspiring among themselves. These cases typically allege an unlawful boycott to exclude a physician(s) or a similar agreement to restrain trade in violation of state and/or federal antitrust laws.

From an antitrust perspective, the most sensitive issue regarding privilege decisions is the involvement in decision making of medical staff members, since some members are generally in direct competition with the physician whose privileges may be denied, reduced, or terminated. It is usually the involvement, or alleged involvement, of direct competitors of an excluded physician that gives rise to boycott claims. Even when specialists in the same practice area as the excluded physician do not directly participate in staff closure decision making, the excluded physician may allege that other members of the medical staff are acting on behalf of the excluded physician's competitors to exclude him or her for anti-competitive purposes.

III. State Judicial Deference to Hospital Decision Making

While both state and federal antitrust rules and regulations are implicated by one or more closed areas for a medical staff, some state courts are very hesitant, as a matter of public policy, to interfere with staffing decisions of hospitals. For example, the Illinois Supreme Court has consistently held that a "rule of nonreview" applies to cases involving private hospital staff privileges, under which, as a matter of public policy, internal staffing decisions of private hospitals are not subject to judicial review.¹ The only exception is when the

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¹ *Garibaldi v. Applebaum*, 194 Ill. 2d 438, 451 (2000), citing *Barrows v. Northwestern Memorial Hosp.*, 123 Ill. 2d 49 (1988), *Knapp v. Palos Community Hosp.*, 176 Ill. App. 3d 1012 (1988), and *Adkins v. Sarah Bush Lincoln Health Center*, 129 Ill. 2d 497 (1989).

decision involves a revocation, suspension, or reduction of existing staff privileges. In such cases, the hospital's action is subject to a limited judicial review to determine whether the decision made was in compliance with the hospital's bylaws. As the court explains, "the judicial reluctance to review these internal staff decisions reflects the unwillingness of courts to substitute their judgment for the professional judgment of hospital officials with superior qualifications to consider and decide such issues."²

In assessing an antitrust claim in connection with a medical staff privileging decision, the court of appeals stated that one of the seminal Illinois cases in this area, *Shulman v. Washington Hospital Center*,³ serves as a guide as to the meaning of "limited judicial review":

The rule is well established that a private hospital has a right to exclude any physician from practicing therein. The action of hospital authorities in refusing to appoint a physician or surgeon to its medical staff, or declining to renew an appointment that has expired, or excluding any physician or surgeon from practicing [*sic*] in the hospital, is not subject to judicial review. The decision of the hospital authorities in such matters is final.⁴

The court further noted that, "The only possible exception is in a case in which there is a failure to conform to procedural requirements set forth in its constitution, bylaws, or rules and regulations. In that event, the extent of judicial review is to require compliance with the prescribed procedure." It concluded, "Beyond that, the courts do not interfere."⁵ Please note that other states may vary in their approach to this issue. As such, an applicable state assessment should be done accordingly.

IV. Federal Antitrust Claims

With respect to federal antitrust claims and relevant to staff closure issues, there is case law which addresses physician claims under the Sherman Act. This Act prohibits every contract, combination in the form of trust or otherwise, or conspiracy (i.e., group

boycott), in restraint of trade or commerce among the several states.⁶ In such cases, courts generally apply a rule of reason analysis, whereby the plaintiff must demonstrate that under all the circumstances of the case the restrictive practice imposes an unreasonable restraint on competition. Part of this analysis is whether the defendants have substantial market power in the relevant market. Market power, for federal antitrust purposes, is the power to control prices or exclude competition for the relevant product in the relevant geographic market.

For example, in connection with a denial of medical staff privileges based on department closure, a plaintiff would have to demonstrate that denial of privileges amounted to a restraint or restrictive practice that results in a substantial foreclosure of competition in an area of effective competition (i.e., the hospital's market). Thus if there are a limited number of physicians and hospitals in the relevant hospital's market, this would be a formidable but not impossible hurdle for any plaintiff.

However, the Seventh Circuit has held that terminating or denying privileges is not necessarily anticompetitive. In reviewing an anesthesiologist's charges of restraint of trade based on her loss of privileges in connection with an exclusive agreement for anesthesiology services, the Seventh Circuit quoted the following:

A closed department may enhance competition among the hospitals in the market by increasing the quality of medical care available. It may also serve to benefit competition among anesthesiology groups if the terms of the exclusive contracts are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals.⁷

Correspondingly, the Seventh Circuit concluded that the purpose of an exclusive contract is to enhance patient care and its restraint on competition in the field of anesthesiology is minimal. The court also cited other cases that held that a closed-staff system may promote competition among hospitals resulting

² *Id.* at 451-452.

³ 222 F. Supp. at 60 (D.D.C. 1963).

⁴ *Knapp v. Palos Community Hosp.*, 176 Ill. App. 3d 1012, 1020 (1988), emphasis added, citing *Shulman v. Washington Hospital Center*, 222 F. Supp. 59, 63 (D.D.C. 1963).

⁵ *Id.*, emphasis added.

⁶ We note that there are other federal antitrust claims under both the Sherman Act and the Clayton Act that may apply to privileging decisions. In general, the likely federal claim is that discussed herein.

⁷ *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1354 (7th Cir. 1982), citing *Hyde v. Jefferson Parish Hospital Dist. No. 2*, 513 F. Supp. 532, 541 (E.D. La. 1981).

in improved quality of patient care. These conclusions indicate that federal courts are disinclined to challenge medical staff closure determinations as a general rule, but relevant federal circuit court holdings should be consulted as applicable.

V. General Guidance Under State and Federal Antitrust Law

Clearly, the Illinois rules of nonreview and of limited review regarding medical staff privileging afford reasonable protection to Illinois hospitals in staffing decisions, and the same may be true in other states.⁸ While such deference is less apparent in federal court, case law in general indicates that federal courts are very hesitant to criticize closed-staff models under federal antitrust laws. It also appears that Sherman Act allegations can be difficult to prove in any market with strong competition. Nevertheless, given the potential limited review in state antitrust cases—which would allow the court to consider whether written protocols were in fact followed as privileging actions were taken—standards of prudent practice mandate that hospitals adhere to written policy and procedure regarding privileging as adopted by the governing body. Moreover, to avoid having to address state antitrust allegations and related tort actions in the first place (i.e., to avoid the cost and distraction of defending lawsuits, notwithstanding the likely success of such defenses), and to avoid federal antitrust law violations, hospitals with closed areas should operate under written policy and procedure that can demonstrate that each closed area is the result of careful planning for efficient operations and not in consideration of any current medical staff member's self interests related to limiting competition. Thus, at a minimum, in adopting and implementing medical staff closure policy and procedure, final decisions regarding medical staff limitations should be made by the governing board of a hospital to avoid conflict of interest decision making at the medical staff level that could fuel such antitrust allegations. To the extent a decision that excludes providers is based on guidelines premised on quality of care, overcrowded conditions, or the hospital's own independent economic interests, and the hospital has

properly documented same, it will be more likely to prevail in any state or federal antitrust claims. Typically, closure determinations are made because these arrangements can be more efficient and provide a more consistent, closely supervised level of care because services are provided by only a few static physicians.

For these situations, where a closed staff situation that may be the functional equivalent of providing certain physicians an exclusive contract (i.e., where there are not at least two independent physicians or practice groups rendering the same service at the hospital), the hospital is at risk of a successful state antitrust claim (using Illinois as an example) if (i) an excluded physician can demonstrate that the decision to maintain a closed area is the product of lobbying by the existing practitioners for the purpose of protecting them from competition, or other non-legitimate reasons by the hospital, and (ii) the excluded physician can overcome judicial deference to hospital decision making regarding privileging matters by demonstrating that such decision making was primarily in the hands of existing practitioners. Such an argument could distinguish an antitrust case against the hospital from the line of cases where the Illinois Supreme Court has upheld the rule of nonreview. Also, in the event the rule of limited review would be applied, again the hospital would be challenged in that it may not be able to demonstrate compliance with board approved policy and procedure in this matter.

Although federal courts have recognized that exclusive arrangements (such as those that exist at many hospitals) may in fact promote competition in the relevant geographic market, they also note such may not always be the case. Again, a federal antitrust action could be successful if the affected provider can demonstrate an adverse impact on competition.

VI. Duties of the Board of Directors

While the MEC should provide input in the decision making process regarding medical staff closure matters, the hospital's governing board must make any final determinations in this matter. In working through these issues it is important to understand how the board's duties of care and loyalty may be implicated by the antitrust and related liability issues arising out of even inadvertent deference to current staff physicians regarding staff closures. In general,

⁸ Again, applicable state law should be analyzed in connection with any proposal to close a service area.

the duty of care requires directors of a not-for-profit organization to be attentive to the organization's activities and finances, and to actively oversee the way in which its assets are managed. For-profits have similar requirements. Directors should attend and participate in meetings, read and understand financial, strategic planning and other materials, ask questions, and exercise sound judgment. The duty of loyalty requires directors to pursue the interest and mission of the organization with undivided allegiance. Private interests must not be placed above the organization's interest. Accordingly, as a board considers potential closure of a specialty group, it needs to focus solely on what is best for the hospital and the community that it serves, and not any private interests of the existing specialty group or staff or other such specialists who may wish to join the staff.

VII. Recommendations

Based on the antitrust implications of a closed staff model, we recommend that hospitals and their governing boards carefully assess whether this model would be appropriate in the hospital's current environment and is currently in line with the hospital's strategic planning. Keeping the medical staff open to all qualified applicants except for areas closed by contract (e.g., house-based services such as radiology and anesthesiology which are commonly under exclusivity) certainly would be a less complicated approach both from an antitrust perspective, and in terms of easing the administrative burdens associated with appropriately maintaining a closed staff model.

In the event a hospital and its governing board decide to move forward with a closure initiative, the decision must be made on a rational basis and the board should take the following into consideration before closing the medical staff to new applicants:

- Effect on the organization's census in the affected specialty (typically a high census that taxes resources may deem closure a necessary measure).
- Organization and community needs for additional physicians in certain medical and surgical specialties and subspecialties.
- Strain that additional staff will put on the organization's relevant supporting departments (e.g., radiology and laboratory services).
- Effect of denying medical staff privileges to applicants who presently are located within the geographic area of the organization and serving community residents.
- Effect on any contracts the organization may have with other health care delivery systems, such as health maintenance organizations.
- Effect a moratorium will have on physician groups that may desire to add a partner.
- Effect additional staff may have on the quality of care rendered in the organization.
- Whether closing an area will confine control of the organization's beds to the existing medical staff, allowing them to enhance their economic interests at the expense of their patients and other qualified physicians.
- Existence of a mechanism for periodic review of the need to continue closure.
- Effect that medical staff resignations during the moratorium closure may have on the organization's census in the relevant specialty.
- Existence of a mechanism for notifying potential medical staff candidates at such time that the organization determines that there is a need for an expanded medical staff in the relevant specialty.
- Characteristics of the medical staff in the affected specialty (e.g., is the staff aging and in need of new membership?).
- Potential for restraint of trade legal action under antitrust laws.
- Effect on physicians without staff privileges whose patients are admitted to the hospital.
- Formation of a committee composed of representatives from the governing body, medical staff, administration, and legal counsel to develop an appropriate closure policy.
- Engagement of a consultant to study the demographics marketplace, physician referral patterns, literature and organization use; conduct a medical staff opinion poll; develop patient-physician population ratios; determine population shifts; develop a formula to determine optimal staffing levels by department and section; and provide this information to the governing body for use in

determining the appropriateness of closing the staff to selected medical departments and/or sections.

In summary, a hospital's governing board must ensure that any proposed action to close an organization's medical staff is based on objective criteria.

Unless an organization can show that its actions are based on legitimate patient-care concerns or concerns related to the objectives of the organization, adversely effected physicians might be successful in using antitrust and tort law to challenge the organization's actions.