Peer Review: Current Law and Policy Problems

By David A. Hyman

Peer review is not a favorite conversational topic of physicians. Even its defenders say little more for it than it is a necessary evil. Yet, for all its "bad reputation," peer review is the principal mechanism for ensuring the quality and appropriateness of health care provided in the United States. Indeed, it has been hailed as the principal bulwark against medical malpractice, and the best way to deter overutilization and other forms of inappropriate care. Peer review is clearly a process with profound implications for many physicians. Yet it remains widely misunderstood, vilified for conduct it was never intended to engage in, and lauded for results it is unlikely to produce. This overview of peer review is intended to outline some of the legal guideposts and stumbling blocks involved in the conduct of peer review, as well as the implications of our current form of policing the medical profession.

Peer review means little more than evaluation by one's peers, as opposed to laymen, an administrator, or the legal system. The standards for evaluation are intended to be those of the profession—i.e., those relating to professional competence. Peer review describes a range of circumstances—prospective and retrospective, quality and utilization review, sponsored by hospitals, insurance companies, state and federal governments. The goals of peer review can vary from educational to quality assurance to cost-containment. The sanctions that can result range from a warning or suggested practice modifications through mandated supervision, the loss of hospital privileges and medical license, and exclusion from Medicare and Medicaid.

Peer review is not as foreign to most physicians as they imagine. Physicians encounter some form of peer review many times during their careers. The first encounter is typically in medical school and residency, where peer review is used for educational purposes. Morbidity and mortality rounds are a classic example of peer review.[1] Once a physician begins to practice, he must pass another peer review committee, otherwise known as a hospital credentials and privileges committee, if he is to admit patients at a hospital. Routine reaccreditation also continues throughout one's professional life.

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Less lucky physicians may continue their contacts with peer review in the context of the same credentials/privileges committee, a state licensing board, or a peer review organization (PRO). Each of these bodies operates in a particular administrative setting, with different forms of sanctions available to punish those who fall beneath the standards of professional conduct. Yet, the common theme of self-policing to guarantee high professional standards predominates. For purposes of discussion, peer review is divided into that conducted in the private and the public spheres.

Private Peer Review: Hospital Committees

All hospitals have some mechanism for evaluating the credentials of physicians who seek to obtain admitting privileges and determining what clinical procedures any particular physician may perform. Hospitals have a deep and continuous interest in assuring the quality of physicians who are on their staff and limiting those physicians to things they are competent in, both because the reputation of the hospital is at stake and because of liability concerns.

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Hospitals can be held liable for the negligence of physicians who are members of the medical staff.[2] Alternatively, a hospital can be held directly liable in its own right for failing to perform adequate credential review, and consequently failing to protect a patient from a negligent physician.[3] These two distinct claims are collectively known as the corporate negligence doctrine.

The scope of corporate negligence, and the willingness of courts to fix blame on hospitals for physician negligence has grown dramatically in recent years. The immediate result has been predictable: hospitals have become increasingly aggressive at refusing to grant privileges to those who cannot demonstrate professional competence, and have also disciplined or removed privileges from physicians who appear to be incompetent or are otherwise uncooperative. Hospitals have also grown more sophisticated at delineating the scope of physicians' clinical privileges.[4]

The real battleground has been the use of the peer review process to eliminate competition from other physicians by removing their hospital privileges.

Peer review of this sort is not the result solely of concerns about corporate negligence. The JCAHO, as a condition of certification, requires that a hospital have procedures for evaluating the applications of those seeking to join the medical staff and delineating the scope of any physician's clinical privileges. Most states also have a strong public policy in favor of peer review, viewing it as the best mechanism for improving the quality of health care provided in the state.

Private peer review proceedings of this sort generally take place under the auspices of a medical staff organization, the organization of physicians with admitting privileges at a particular hospital. A system of peer review can operate independently of the credentials/privileges committee, but the two are generally connected. For the purposes of this article, the terms are used interchangeably, with the caveat that not all hospitals operate in this way.

Each hospital specifies the procedures that will be followed for any peer review proceeding in the bylaws of the medical staff organization. The bylaws typically describe the procedures for evaluating applicants, reevaluating those currently on staff, and suspending or terminating clinical privileges. The bylaws also address such procedural issues as one's ability to have legal counsel present at peer review proceedings, whether cross-examination is permissible, whether a notarized transcript of proceedings is necessary, the specificity of the notice of a pending peer review proceeding, one's ability to provide witnesses, and many other procedural issues.

Ideally, these procedures encourage consistency, and focus the peer review proceeding on the assessment of clearly articulated standards of professional performance. Unfortunately, that is not always the case. Because peer review can preclude an individual physician from practicing at a particular hospital, the termination of clinical privileges (or refusal to grant them in the first place) can take place for a variety of reasons besides professional competence. Religious, racial, and ethnic discrimination in clinical privilege decisions are now illegal, but at one point hospitals were identified by the religion and race of their physicians. Such overt discrimination is largely a thing of the past.

The new trend in inappropriate clinical privilege decisions are ones based on anticompetitive motives. These motives can coincide with legitimate concerns about the quality of care rendered by an individual or a class of practitioners, but less acceptable factors can play a role as well. Nurse-midwives, nurse-anesthetists, and osteopaths have all had difficulty obtaining clinical privileges, although the evidence of poor quality care has never been especially compelling.

The real battleground, however, has been the use of the peer review process to eliminate competition from other physicians by removing their hospital privileges. Generally such actions are clothed in the language of a concern for quality, or the removal of a "disruptive and uncooperative" physician. Sorting out whether a peer review proceeding is based on legitimate or illegitimate factors is extremely difficult, since one's competitors are those in the best position to assess one's competence, but also those who could operate from the worst of motives.

A classic example of this problem was played out in Astoria, Oregon over the past several years, as a general surgeon had his practice systematically destroyed after he refused a partnership with the local clinic and set up his own surgical practice. The other physicians in the clinic used peer review proceedings, both at the level of the state board of medical examiners and the local hospital, to destroy his practice. Although legitimate quality concerns appeared to exist, every court that examined the peer review proceedings labeled them as having taking place in "bad faith"; the 9th Circuit Court of Appeals characterized the conduct of everyone involved in the proceedings as "shabby, unprincipled and unprofes-

sional."[5] The case has been well described in the medical literature.[6]

Private Peer Review: Legal Issues

A variety of legal issues arise out of a typical peer review proceeding. Since an adverse peer review proceeding can destroy one's practice, these disputes are bitterly fought and tend to end up in court. The physician who is the subject of a peer review proceeding typically has several avenues of legal redress available. Judicial review of the decision as such is available under several theories. If the institution is a public hospital, it is bound by the due process and equal protection clauses of the Constitution, which require certain procedural and substantive protections. At a private hospital, a physician can claim the peer review proceeding did not comport with the substantive and procedural rights contained in the medical staff bylaws.

Some states, unimpressed by the procedures provided in medical staff bylaws, have enacted statutes which require hospitals to provide certain procedural and substantive protections, to ensure the fairness of any peer review proceeding.[7] Several state courts have chosen to scrutinize peer review proceedings on the ground that hospitals are "quasi-public" facilities.[8] This characterization imposes a duty of fairness on the hospitals in their conduct of peer review proceedings. Other states have been less enthusiastic about this approach, and have refused to adopt a common law duty of fairness.[9]

The scope of judicial review of peer review decisions turns on the type of decision (whether individual or class-based) and the type of conduct complained of by the litigant (procedural or substantive shortcomings). Courts are loathe to second-guess a decision involving the professional competence of an individual physician because they have little expertise in the area.[10] Substantial deference is granted to such decisions, unless evidence is offered of bias or animosity.

However, the evaluation of professional competence must turn on factors relevant to the practice of medicine, and not those which simply reinforce the power of the existing members of the medical staff. Class-based exclusions are subject to close scrutiny because of the potential for inappropriate criteria. The actual criteria must generally be "rationally related to the delivery of health care."[11] The blanket exclusion of osteopaths has been struck down, although some courts have deferred to the judgement of the medical staff.[12] The basic claim is that the exclusion of an entire class of practitioners *as a class* is inappropriate; only individualized findings of professional incompetence are acceptable. Requirements which have a disparate impact (i.e., requiring board certification, which is a facially neutral requirement, but which operates to exclude osteopaths) have been treated inconsistently.[13]

Because courts have shown a great deal of deference to individual peer review decisions, the vast majority of litigation has revolved around the appropriateness of the procedural protections that are offered. Some uniform guidelines may be discerned: a formal hearing is typically required prior to any final adverse decision. Adequate notice of the charges must be given, and an opportunity to appear and be heard must be given. The review must take place before a reasonably unbiased panel, with some form of internal appeal. However, little formality is necessary, lawyers may be excluded, and cross examination may be limited or forbidden.

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These protections fall far short of those required by the Constitution in a criminal case. Their acceptability for peer review proceeding demonstrates both the private nature of the dispute, and recognition by the courts of the need for flexibility and the limitations of full adversarial proceedings in ascertaining the truth or falsity of a dispute over professional conduct.

A physician who has exhausted his avenues of appeal within the hospital, and has been unsuccessful in having the decision reviewed by a court, has essentially two other legal alternatives. Rather than being directed at reinstatement on the hospital staff (as the previous claims were), these alternatives aim more at punishing those who participated in the peer review process. The aggrieved physician can bring suit against those involved in the peer review process on tort law principles or under the antitrust laws.

Tort law claims, such as defamation or interference with contract rights, are not specific for conduct arising out of peer review proceedings, and are consequently often difficult to prove. However, the threat of such a suit is often sufficient to terminate a peer review proceeding, or at least cool the enthusiasm of most physicians to participate in peer review. To counter this problem, many states provide for the maintenance of peer review information in confidence, or directly provide varying

levels of immunity for those involved in peer review proceedings.

The other alternative for the physician who has had his clinical privileges terminated is to bring a suit under the antitrust laws. These statutes, both federal and state, reflect a clear public policy in favor of free and open competition. In particular, section one of the Sherman Act prohibits "contracts, combinations, or conspiracies in restraint of trade."[14] Consumers, rather than competitors, are intended to be the ones making decisions about who shall supply a particular demand. Conspiracies that artificially limit the quantity or quality of goods and services are consequently unlawful. As the Supreme Court noted in 1958:

> The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions. But even were that premise open to question, the policy unequivocally laid down by the Act is competition.[15]

The difficulty, of course, is that peer review activities (and, indeed, a self-regulating profession) are largely incompatible with this model. Nonetheless, professions are not immune from antitrust scrutiny.[16] Indeed, the Supreme Court recently reemphasized that section one of the Sherman Act is clearly applicable to peer review proceedings–even those involving only one sanctioned physician.[17]

Demonstrating a violation of section one of the Sherman Act requires the documentation of a series of elements, including a conspiracy and a restraint of trade. The conspiracy element is generally not difficult to demonstrate, since the physician's peers, after all, are the ones conducting the peer review under the auspices of the medical staff.[18] Whether the interaction of the medical staff and the hospital is also a conspiracy is a question on which different jurisdictions have split.[19]

Defendants also must generally concede the existence of the restraint of trade, since limiting the offending physician's practice, after all, is the objective of a peer review proceeding. Since the antitrust laws are intended to protect competition, and not competitors, most defendants argue that the restraint has a pro-competitive effect in improving the quality of health care actually provided.[20] Although this is acceptable, an isolated claim that the restraint was motivated by concern over public safety is rejected outright.[21] The antitrust laws operate to protect competition—not quality.

The devastating effects of an antitrust suit are demonstrated by *Patrick v. Burget*, the suit arising out of the events in Astoria, Oregon discussed earlier. At the trial in federal district court, a jury awarded substantial damages against the the partners of the local clinic. By law the damages were trebled, and totalled $2,288,600. At least one of the physicians involved in the peer review proceedings had 100 percent of his professional income garnished for months.[22] The verdict was ultimately upheld 8-0 by the Supreme Court.[23]

Two forms of protection from the antitrust laws are currently available. The first is known as the state action exemption.[24] A state, by definition, cannot violate the antitrust laws. A private party may engage in anticompetitive behavior if his actions are truly the product of state direction or regulation. The Supreme Court has established a rigorous two-pronged test to determine whether the actions of a private party were state action.

First, the "challenged restraint must be one clearly articulated and affirmatively expressed as state policy." Second, the anticompetitive conduct "must be actively supervised by the State itself." Since most private peer review proceedings are not "actively supervised" by a state, they do not qualify for this exemption from the antitrust laws. A duty to perform peer review and to report adverse proceedings to the state does not bring the proceedings within the exemption. Whether comprehensive judicial review of a private peer review proceeding by a state court might qualify is an open question, but of course such review is inconsistent with the fundamental principles of *peer* review.

The second form of protection from the antitrust laws is statutory. After the verdict was rendered in *Patrick v. Burget*, many physicians indicated they would refuse to participate in peer review proceedings unless they had some assurance their good faith actions would not be subject to scrutiny under the antitrust laws. Because the Sherman Act is a federal statute, only Congress could provide a solution. Congress did act in 1986, with the passage of the Health Care Quality Improvement Act (HCQIA).[25]

The HCQIA provides hospitals, their medical staffs, and certain other individuals with immunity from damages in most types of legal actions brought by individuals whose clinical privileges are adversely affected by a peer review proceeding. Obtaining this immunity requires that certain procedural and substantive safeguards be observed. The immunity provisions of the HCQIA are coupled with a detailed system for the reporting of adverse peer review actions, medical malpractice settlements and verdicts. As yet, the HCQIA has withstood

challenges to its immunity provisions.[26] Because the HCQIA specifically excluded peer review undertaken in bad faith, the case which led to its enactment is ironically (although not surprisingly) excluded from its protection.

The legal ramifications of private peer review reflect the uneasy balance between legal oversight and self-regulation, anticompetitive behavior and promoting the quality of health care, self-interest and the public interest. Because peer review can be misused by those charged with its enforcement, it is not surprising some degree of judicial oversight is retained. (Misuse of the peer review process is not new; Semmelweiss, a medical pioneer of the 19th century, lost his faculty position in a "peer review proceeding" for his impertinent suggestion that obstetricians should wash their hands before delivering babies.)

Although absolute immunity is not available, the degree of protection actually given reflects a desire to protect only good faith peer review proceedings, and to provide legal redress to those who have been the subject of bad faith peer review. The entire process has been appropriately described as analogous to the federal government, with its constitutionally prescribed system of checks and balances.[27]

Public Peer Review: State Boards, PROs

Public peer review is conducted by state licensing boards and PROs. State licensing boards have authority over licensure, and regulate who may practice medicine within any particular state. The activities of the state licensing board are typically laid out in a statute, often called the medical practice act. This act commonly prohibits certain forms of conduct and specifies the grounds for revocation or suspension of a physician's license.

The diversity of state practices precludes much generalization, but all of the states are bound by the due process clause of the Constitution. This imposes certain procedural requirements on any proceeding seeking to suspend or revoke a physician's license to practice medicine. These requirements include formal notice, an impartial hearing, and just cause for any suspension or revocation. Licensure proceedings are also far more formal than private peer review, both because of the constitutional implications and because the adverse consequences are often far greater than those of losing privileges at a particular hospital.

PROs also conduct public peer review. PROs have contracts with the Department of Health and Human Services (HHS) to provide peer review services for the Medicare program. They are principally charged with performing utilization and quality review of the services rendered to Medicare beneficiaries.[28] Their goal is to establish a more cost-effective method of providing services to the Medicare population. PROs review the reasonableness, necessity and appropriateness of hospital admissions, the completeness, adequacy and quality of care provided, and validate the diagnoses which determine reimbursement under the prospective payment system.

The provisions which require utilization review for the Medicare program were originally enacted in the legislation that gave rise to Medicare in 1965. This review was initially left to the fiscal intermediaries, who administered the program on behalf of the federal government. This system was rapidly shown to be ineffective, and led in 1972 to the creation of a Professional Standard Review Organization (PSRO) program.[29]

PSROs were expected to promote the effective, efficient, and economical delivery of all health care services provided to recipients of Medicare. PSROs relied on the involvement of local physicians to conduct peer review and to assess the quality of health care provided to beneficiaries. PSROs attracted criticism when they came to be regarded as agents of cost containment rather than quality improvement.[30] In 1982 the proposal was made to eliminate them entirely, but recognition of the rising cost of Medicare prompted the introduction of the prospective payment system and the transformation of PSROs into PROs. Congress intended the change in name to reflect a modification in mission to include utilization and quality control. Because the advent of prospective payment was expected to have a profound effect on the behavior of hospitals, a more intensive peer review mechanism was thought to be essential to keep the prospective payment system from being undermined.

PROs have multi-year contracts with HHS, during which time they are expected to fulfill certain admission and quality objectives. PRO utilization review can result in the denial of a request for payment, with notification to both physician and patient that the PRO has determined that the services actually provided were not necessary. This is probably the context in which most physicians deal with a PRO.

However, PROs also have the authority to review the quality of care provided to beneficiaries and recommend corrective action or sanctions for physicians who do not meet their obligations under the Medicare program. Since 1972, PROs and PSROs have had the authority to recommend that a physician be excluded from Medicare, but that authority is used only infrequently. From 1973 to 1984, only seventy physicians and hospitals were formally disciplined. From 1984 to February 1990, ap-

proximately 200 sanction recommendations were made to HHS. Of these, 87 were excluded, 86 were reversed or otherwise resolved, and 27 had monetary penalties imposed. These figures may underestimate the enforcement efforts of PROs, since they attempt to use educational interventions and corrective action plans before resorting to sanctions.

A physician who treats a Medicare patient has a series of very specific legal obligations. The care that is provided must be: (a) furnished economically and only when and to the extent it is medically necessary; (b) of a quality that meets professionally recognized standards of health care; and (c) supported by adequate documentation in a form and fashion acceptable to the PRO.[31] If a PRO determines that a physician violated these obligations, it may recommend temporary or permanent exclusion from Medicare or reimbursement to Medicare for the services that were determined to be medically inappropriate or unnecessary.

The sanction process is often confusing to physicians because it involves multiple levels of review, particular procedural requirements and unfamiliar terminology. The enabling statute and regulations provide some guidance to the procedures a PRO must follow in evaluating the care provided.[32] The PRO must report to the Office of Inspector General of HHS (OIG) once it determines a violation has occurred. The report must detail the basis for the PRO's determination and recommend a particular sanction. The OIG does scrutinize the records it receives from sanction proceedings. (In 81 cases in which the OIG rejected PRO sanction recommendations, 32 were because of procedural failings, 36 failed to establish that the physician was unwilling and unable to modify his behavior, and in 13 the medical evidence failed to substantiate the case.)

The OIG disseminates final sanction decisions to state licensing bodies, the hospitals where the violations originated, any hospitals where the physician is known to have privileges, and medical societies. The public is notified by the publishing of the physician's name and the nature of the violation and sanction in a local newspaper.

Public Peer Review: Legal Issues

State licensing boards, like public hospitals, have the outer boundaries of their power defined by the U.S. Constitution. In essence, the right to practice medicine pursuant to a professional license has been held to be a property right, which may not be revoked without just cause and due process of law.[33] So long as the state licensing boards comply with the relevant state and federal laws, their decisions are generally immune from judicial reversal. Statutory immunity from suit is also typically provided to those who participate in licensing decisions.

PROs, despite being private entities, have a similarly privileged position under law. The enabling statute provides virtually unlimited immunity both to those who participate in peer review proceedings and to those who provide information which is subsequently the basis for a peer review proceeding.[34] The antitrust laws, which represent such a stumbling block for private peer review, are not even a factor in public peer review proceedings. PROs have statutory immunity as part of their enabling statute.[35] State licensing boards, by definition, are not subject to the antitrust laws.

How successful is public peer review? State licensing boards are usually criticized for acting only after many patients have been injured. PROs are often attacked on similar grounds. The number of impaired physicians has been estimated to be as high as 10 percent of physicians. Yet PROs only recommended 202 sanctions between 1984 and 1990. State licensing boards rarely revoke a physician's license to practice medicine.

Consider a less drastic intervention—the success of peer review in addressing inappropriate admissions and excessive stays in the hospital. Although the length of average hospital stay has declined steadily since the introduction of the prospective payment system, the General Accounting Office recently concluded that between 7 percent and 19 percent of hospital admissions may be inappropriate because the services were unnecessary or could have been provided in another setting. State licensing boards do not generally consider such matters their province. PRO's, which are more directly charged with such matters, denied payment for "inappropriate care" during the years 1986 through 1988 to only 2.1 percent of hospital admissions.[36]

Neither Placebo Nor Panacea

Both public and private peer review have been subject to great scrutiny. The former is criticized for its focus on cost-containment, inability to effect outcome, and punitive character. The latter is vilified for its use to anticompetitive ends. On the other hand, both are hailed for their ability to decrease the incidence of medical malpractice and protect the public from inappropriate care. Neither the praise nor the criticism seems fully justified, in large part because of the inconsistent policy and legal foundations for peer review.

Peer review *might* be effective for utilization review, if one could decide the appropriate baseline level of a particular procedure. Tremendous difficulties have been encountered with this rather fundamental starting point.

Equally troubling are issues relating to quality of care. At the most trivial level, a procedure performed badly is an obvious quality problem, which peer review has been fairly effective at identifying. It is commonly stated that a relatively small number of physicians is responsible for the vast majority of quality problems of this type.[37] Identifying these physicians and doing something about them is a task peer review is well suited for.

Yet quality encompasses more than simply technical expertise. Characterizing the problem as one of over-utilization or under-utilization is also not helpful. The issue is more connected to the clinical effectiveness of any particular intervention.[38] This issue is the one worth considering for those who wish to spend scarce resources wisely and avoid iatrogenesis. As such, the conduct of the average practitioner is worth asking about, simply because it reflects the majority of patients, physicians, and dollars.

The substantial regional variation in the use of hospital services, and the evidence that indications for certain procedures are often equivocal or lacking, bespeaks tremendous heterogeneity in the "standard of care." Such issues cannot be addressed by peer review proceedings against individuals, both because of resource constraints, and because any particular peer review proceeding is unlikely to construe the practice pattern as inappropriate. The lack of concensus about what constitutes appropriate care, and the problem of 20-20 hindsight are substantial stumbling blocks in accomplishing any significant improvement in quality. Peer review's focus on an individual miscreant physician may well preclude any improvement in the general level of health care, not to mention its limitations in effecting any change in outcome.

Yet, even were there to be a radical refocusing of both private and public peer review to education and outcome, rather than punitive proceedings, there is good reason to be suspicious about the long-term effectiveness of such a change. Physicians are notorious for their resistance to changes in clinical practice, and they tend to revert once an educational intervention has run its course.[39] These efforts also portend increasing interference with the practice of medicine, and the mandating of particular treatments in particular circumstances. All this will come at a time when physician dissatisfaction with loss of professional autonomy has become increasingly prevalent.

Even expecting peer review to address medical malpractice may be overconfident. The HCQIA was enacted with high hopes about its effects on the incidence of medical malpractice. The provisions which require reporting of adverse peer review proceedings and mandate a National Data Bank will certainly address the problem of the incompetent physician who leaves the state and sets up a practice elsewhere, and then proceeds to commit more malpractice.

Yet even these salutary steps may not affect the incidence of medical malpractice substantially. As a recent book noted, "the major part of the liability problem involves competent or good practitioners. . .although regulation may be desirable for other reasons, there is still no evidence that any of the following would have a significant effect on the malpractice problem: . . . correcting laxity in licensure regulations; disciplinary proceedings by state licensing boards with emphasis on incompetent providers;. . . [or] improvements in the regulation of hospital staff privileges."[40]

In short, the malpractice problem has roots which peer review cannot address in any systematic way. As a 1985 evaluation of peer review aptly summarized, there are great difficulties in using peer review to enhance the quality of medical care:

> [Even though] quality assurance sounds simple, it isn't. It certainly cannot be accomplished piecemeal, payer by payer. It requires a broadly based commitment to applied research and to systematic change based on the findings.

Peer review is neither panacea or placebo. Although it is incapable of dramatically improving the quality of health care, it can eliminate the worst practitioners. Unfortunately, its potential use for anticompetitive ends means that it can never be fully unfettered. In the end, peer review reflects the often inconsistent demands of medicine and professionalism, law and free enterprise, and a system of public policy that wants to believe the best of its physicians, but fears the worst.

NOTES

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9. *Barrows v. Northwestern Memorial Hospital*, 525 N.E. 2d 50 (Ill. 1988).

10. *Sosa v. Board of Managers of Val Verde Memorial Hospital*, 437 F.2d 173 (5th Cir. 1971).

11. *Nanavati v. Burdette Tomlin Memorial Hospital*, 526 A.2d 697 (N.J. 1987).

12. *Fritz v. Huntington Hospital*, 384 N.Y.S. 2d 92 (1976); *Stern v. Tarrant County Hospital District*, 778 F.2d 1052 (5th Cir. 1985).

13. *Limmer v. Samaritan Health Services*, 710 P.2d 1077 (Ariz. App. 1985); *Armstrong v. Board of Directors*, 553 S.W. 2d 77 (Tenn. 1976).

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16. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).

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19. *Bolt v. Halifax Hospital Medical Center*, 851 F.2d 1273, 1280 (11th Cir. 1988). Compare with *Weiss* and *Oltz*.

20. *Wilk v. American Medical Association*, 671 F.Supp 1465 (N.D. Ill. 1987), *aff'd*, 895 F.2d 352 (7th Cir. 1990).

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