As we have said many times, courts and the legal profession do not understand what healthcare practitioners do. Healthcare practitioners are well educated, highly trained, and have a language of their own. Lawyers and judges lack the education to have an understanding of what is involved. Often, they do not even have the vocabulary. Naturally, they are reluctant to substitute their judgment for the judgment of practitioners. Healthcare practitioners are designated professionals. They are allowed to set their own standard of care and to serve as experts to testify what the standard is. Nonetheless, the courts serve as the last bastion of protection for people who are treated unfairly or wrongly. Society’s willingness to have its problems decided by the legal system and not by force is what makes society “civilized.”

Granting of privileges
Society relies on healthcare experts to maintain the level of care in hospitals and other settings. The key to this process is the granting of “privileges” or determining “credentials.” A hospital permits a practitioner to engage only in those activities for which the practitioner is privileged. Granting these privileges is often delegated to an appropriate department or group of peers capable of determining the candidate’s capabilities. The institution must determine that the practitioner may safely perform the action for which privileges are to be granted and that the practitioner has the education, the experience, and the skill to engage in the activity.

But the power to determine in what areas a practitioner may practice and from which areas the practitioner will be excluded can be used to benefit others besides society and patients. This power can be perverted to benefit the person granting the privileges rather than patients. For example, in Oltz (656 F. Supp. 760 (D. Mont. 1987)), the court found that a group of anesthesiologists had forced a nurse anesthetist out of a hospital, not for the purpose of protecting the quality of care in the community, but simply to remove a competitor from their midst.

So, while society is dependent upon healthcare practitioners, even if they are competitors, to eliminate incompetent or substandard practitioners, there should be a counterbalance, some protection to keep the power of “privileging” from being corrupted so that it is exercised not for the benefit of patient care, but simply to reduce competition. While there are a variety of tools designed to reduce potential abuses in the privileging process, many of these tools were developed without a complete understanding of all the competitors who might be affected by privileging decisions.

For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 2002 Hospital Accreditation Standards spell out the criteria for a privileging system, and Standard MS 3.1.6.1.7 requires that there be a “mechanism for fair-hearing procedures” among medical staff recommendations. Traditionally, hospital bylaws protect physicians in the privileging process from an abuse of discretion by physicians with whom they compete. They provide for fair hearings, the right to present evidence and correct accusations, and a right of appeal. However, many of these protections simply overlook the fact that not all competitors who require protection are members of the medical staff. Because of the importance of anesthesia, some nurse anesthetists are members of the medical staff and entitled to these protections. But some are not. They must still have privileges, but they are not automatically given the same protections as members of the medical staff.

The American Association of Nurse Anesthetists’ Practice Department has received complaints from nurse anesthetists who have been treated unfairly in the hospital credentialing process and have been denied privileges for no apparent reason. This can become especially problematic if practitioners are obligated to report that they have been turned down for hospital privileges when applying for future positions. In one incident of exceptional unfairness, a Certified Registered Nurse Anesthetist (CRNA) applied for privileges at 2 hospitals simultaneously. She took the first job that was offered. Subsequently, she heard from the other hospital that her
privileges were denied. Although she never learned why her privileges were denied, she was nonetheless obligated to inform her new employer that another institution had denied privileges. When the employer learned that the other hospital had denied privileges, it revoked her privileges and the CRNA whose only fault had been that she was not certain which hospital would offer her employment so she applied for positions at 2 hospitals, found herself with a job at none.

While society is dependent on healthcare professionals to evaluate the competence of their fellow practitioners, it recognizes that these decisions may sometimes be incorrect because healthcare practitioners compete with each other, form likes and dislikes on bases that have nothing to do with competence or practice, and are influenced intentionally or unintentionally by the fact that those who make the decisions compete with or are otherwise rivals of the very persons they are asked to evaluate. The loss of privileges can have profound effects on a practitioner's practice and income. When a practitioner's privileges are curtailed or denied, what legal recourse does a practitioner have?

**Canady v Providence Hospital**

The case of Canady v Providence Hospital, 942 F. Supp. 11 (D.C., 1996) is a collection of the legal remedies that are often used to attack the denial or restriction of privileges. Jerome Canady, MD, a surgeon, met with the representatives of a hospital in the District of Columbia, indicating that he wanted to perform vascular and thoracic surgery, as well as general surgery. Over the next few months, Dr Canady met with a number of physicians associated with the hospital, discussing various types of procedures that he wished to perform but, when viewed in retrospect, not necessarily being guaranteed that he would be allowed to do so. He finally received a letter from the president of the hospital informing him of his provisional appointment to the staff, but the letter was silent as to privileges. When Dr Canady inquired what his privileges were, the president of the hospital responded verbally that as far as she knew he had been granted everything he applied for. However, the president of the hospital was not the person authorized to grant privileges.

Not long after Dr Canady began operating at the new hospital, things went rapidly downhill. Four months after he began performing operations at the hospital he was sent a letter stating that the hospital would not schedule a patient for thoracic surgery if Dr Canady was the private primary surgeon. As a result of problems he was having with the hospital, he reviewed his credentials file and discovered, for the first time, that he had not been given thoracic or vascular privileges.

Consequently, Dr Canady retained a lawyer and brought suit against the hospital. This resulted in a settlement in which both sides appeared to save face. The suit was withdrawn, Dr Canady's privileges were reinstated, and Dr Canady agreed to furnish a written second opinion for certain cases. However, it turned out that this did not resolve the matter. Misunderstandings continued about Dr Canady's compliance, and Dr Canady did not get satisfactory answers to questions about his privileges. Matters continued largely unresolved until winter when there was another incident in which another staff physician questioned Dr Canady's competence. A proceeding for “corrective action” was instituted, and the process ultimately resulted in the suspension of Dr Canady's privileges. Dr Canady's suit is a catalog of legal theories that a practitioner can use to challenge the actions of a hospital in denying privileges.

**Legal remedies**

The first legal theory is a claim that the action of the hospital is a violation of the Sherman Antitrust Act: “Every contract…or conspiracy in restraint of trade…is declared to be illegal.” (15 USC §1.) The argument is that a decision by a committee of peers denying privileges to a practitioner is equivalent to a group boycott. The committee's decision denying privileges is an agreement or “contract,” which by its very nature restraints trade. Well, maybe the case is not quite that easy. There are some hurdles to be overcome in bringing an antitrust case. Among the first is the need to show that the defendants had some type of monopoly power. For hospitals located in metropolitan areas, this is sometimes a difficult burden. Where it can be met, the plaintiff still has to show that the decision was based on economic concerns. Under the so-called “Rule of Reason,” some agreements are acceptable even though they may restrain trade. If the hospital can establish that its peer review group denied privileges because of valid patient concerns rather than a fear of competition, there will be no antitrust violation. The court found merely that Dr Canady had not proved his antitrust case, specifically that any of the surgeons were in direct economic competition with him.
Dr Canady also brought a claim of economic misbehavior, an allegation that the hospital violated a provision of the District of Columbia code prohibiting a hospital from requiring that a physician be willing to send a certain number of patients in order to be considered for privileges. Dr Canady claimed that the hospital was upset because of his transfer of patients out of the hospital, but the court said that the record was clear that the hospital’s concern “was with the medical appropriateness of transferring unstable patients; with the volatile, hostile and uncooperative way in which Dr Canady dealt with the hospital staff; and with its perception that Dr Canady was improperly transferring patients in order to escape [the] hospital’s appropriate medical oversite.”

A third cause of action was breach of contract. Dr Canady claimed that the hospital’s suspension of his ability to operate in certain areas violated the contract he entered into at the time he went to work at the hospital. The court dismissed this charge on the grounds that there was no completed application for these privileges, and while there was activity that could have given rise to a misunderstanding on the part of Dr Canady, the hospital had not engaged in activity that indicated that it had agreed to give Dr Canady these privileges. Although the hospital’s bylaws contained a provision that a physician would be notified when privileges were denied, the court found that the absence of a completed application did not trigger the protection of the bylaws.

Finally, Dr Canady claimed that the hospital’s denial of his privileges was equivalent to “tortious interference with prospective business advantage.” The hospital defended its activities on the ground that it was privileged and immune from tort liability. Before examining the hospital’s claim of privilege, the court examined whether Dr Canady had asserted the basic elements of tortious interference with business. These basic elements were first that there be damage resulting from the tortious interference and second that the tortious interference must be intentional and willful, calculated to cause damage, and done with an unlawful purpose. While there was sufficient evidence in the case that the hospital’s actions denying privileges had resulted in damage, there was no evidence that the hospital had applied its corrective action arbitrarily or capriciously or, in fact, with anything but the proper motive of attempting to protect patients in the hospital. Thus, all of the grounds brought by Dr Canady were dismissed.

**Due process**

Even when CRNAs are not guaranteed “due process” by hospital bylaws, the CRNA may still be entitled to them. Under the US Bill of Rights, governments may not take property without due process of law. “Due process” requires a number of safeguards, including the right to examine witnesses and present evidence. Hospitals not obligated to provide “due process” by a bylaw provision may be obligated to provide it because they are owned by a governmental unit. However, the “due process” protections can be waived by contract or otherwise unavailable. In the absence of an express agreement it can be very difficult to sustain a suit against a hospital when privileges have been denied.

In *Randall v Buena Vista County Hospital*, (75 F. Supp. 2d 946, Iowa, 1999), the court held that a CRNAs employment agreement was terminable at will, and thus he did not have a due process protected property interest despite the fact that the hospital that employed him was a public hospital. The court found that the contract between the nurse anesthetist and the hospital took precedence over the due process with which a government is normally required to act.

In *Ferraro v Board of Trustees of Labette County Medical Center*, (28 Fed. Appx., 899 (10th Circuit, Kansas, 2001)), the US Court of Appeals held that a nurse anesthetist working as an independent contractor at a county hospital was not entitled to the same relief as an employee even when the hospital finally provided him with due process. Thus, even public hospitals may not be obligated to provide CRNAs with due process and legal remedies in the absence of contractual provisions. A CRNA who has been denied privileges may not have a right, at least, not a right enforceable in court, to be treated fairly, or even to learn the reason why privileges were denied.

**Rights may be requested contractually**

Can anything be done to correct this oversight? Even though JCAHO standards or hospital bylaws may not provide protection for nurse anesthetists, there is no reason why a nurse anesthetist cannot seek similar protections. However, where these rights are not guaranteed by bylaws, they must be sought contractually. For example, in this period of shortage it would not be unreasonable for a nurse anesthetist to pick and choose...
among employment opportunities by preferring those hospitals that were willing to treat the nurse anesthetist fairly with the same due process protections that the hospital would give to physicians. Thus, when submitting an application, the nurse anesthetist could advise the hospital that the application was being submitted only on the condition that he or she be treated fairly and that if the hospital should wish to deny privileges, the hospital must notify the nurse anesthetist, prior to the time of denial, with an explanation, agree to provide a reason for any denial, and provide the nurse anesthetist applicant with a chance to present evidence. [Preparing such a demand is beyond the scope of this article, and nurse anesthetists should seek the advice of their own legal adviser.]

Some hospitals may well refuse to consider applications under these circumstances. They may not be obligated to give the nurse anesthetist due process and may not wish to do so. However, at least the nurse anesthetist would know, in advance, where he or she will be treated fairly and can weigh this bit of information in deciding whether or not to apply, especially if there is more than 1 employment opportunity. There is no assurance that this process will result in privileges being granted, but it may reduce the burden of dealing with an unexplained denial. In cases where the nurse anesthetist was denied privileges for unsubstantial reasons, the nurse anesthetist would have a much easier time providing the explanation to future hospitals.

Future hospitals may feel much more comfortable granting privileges to a nurse anesthetist denied privileges because there were already too many anesthesia personnel than where a hospital gave no reason at all.

Some nurse anesthetists may find that none of the hospitals offering employment would be willing to make this commitment. But even so, they would be no worse off than they are now. And, perhaps, this might encourage hospitals to add the benefit of being fair about the granting or denial of privileges as a way of competing for nurse anesthetists.

REFERENCE