A Social and Legal Analysis of the Independent Practice of Midwifery:

Vicarious Liability of the Collaborating Physician and Judicial Means of Addressing Denial of Hospital Privileges

Donna M. Peizer

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INTRODUCTION

The story of midwifery is the story of women's loss of control over childbirth.1 After having been almost totally extinguished by the early twentieth century, midwifery is undergoing a traumatic rebirth which is fraught with controversy, ambivalence, and confusion fueled by a proliferation of competing and conflicting interests. Two distinct groups of midwifery practitioners are involved: lay midwives and nurse-midwives. Each group evolved from a different tradition.2

Lay midwives are the traditional home birth attendants who practice independently from the medical profession. When maternity care moved from the home into the hospital, these practitioners survived by attending women who, because of extreme poverty or geographic or cultural isolation, could not procure hospital birth.3 They practiced primar-
ily in the rural South and in the immigrant ghettos of northern cities. By and large, midwifery was not an occupation upon which a practitioner depended for her living; rather, it was a service informally rendered to the community of which the midwife was a part. Formal training was virtually nonexistent, and, as the years went by, the practice of lay midwifery was made implicitly or explicitly illegal in many states. Nevertheless, enforcement was rare as long as the service was confined to poverty-stricken and/or geographically isolated women.4

Today, lay midwives continue to practice extra-legally or illegally throughout much of the country. Several states, however, have recently revived and legalized the practice of lay midwifery, sometimes making no differentiation between lay midwives and nurse-midwives.5 Though the skill and training of these midwives varies, many are well trained, competent practitioners.

The Farm in Summerhill, Tennessee is an example of such a lay midwifery service. Originally formed in response to the need for medical self-help in a rural commune, the Farm has expanded to accommodate non-Farm residents who travel there before delivery so that they may have their babies with the assistance of Farm midwives. Although the Farm has developed a sophisticated medical backup system, the primary service is not medically controlled and remains in the hands of lay midwives.6

Nurse-midwifery, on the other hand, was introduced to the United States from England in 1926 in response to the need for maternity care in the isolated Appalachian mountains of Kentucky. Mary Breckenridge, founder of the Frontier Nursing Service, established a midwifery service staffed by nurse-midwives trained in Great Britain. Each nurse lived in a log cabin in her own district and served the people located within a five-mile radius. Traveling by horseback, she provided perinatal care, oversaw the health care of infants and children, and gave preventative nursing care to the population in general.7 The Frontier Nursing Service also offered training for nurse-midwives, a role it continues to fulfill today.

4 The same monograph cited at supra note 3 described the midwives of the North as “ignorant, poorly trained, indifferently clean, and too little aware of their limitations.” Id. at 7. The midwives of the South were described as “abysmally ignorant, untrained, very dirty, and superstitious.” Id. After repeatedly emphasizing the degradation and dangers represented by midwives, the startling, seemingly contradictory conclusion was that the midwives were not to blame for the country’s high mortality rate, and that given adequate training and supervision, they were viable, cost-effective birth attendants.

5 See, e.g., ARIZ. REV. STAT. ANN. §§ 36-751 to 36-757 (Supp. 1986); FLA. STAT. ANN. §§ 464.001-.209 (West Supp. 1986); FLA. ADMIN. CODE ch. 10D-36; N.H. REV. STAT. ANN. ch. 326-D (Supp. 1986); N.M. STAT. ANN. §§ 24-1-3(R), 24-1-21 (1982), 61-6-16 (1986); WASH. REV. CODE ANN. §§ 18.50.010-.900 (Supp. 1987).

6 Gaskin, Empirical Midwifery, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 392-93 (Stewart & Stewart eds. 1979) [hereinafter COMPULSORY HOSPITALIZATION].

Several years later, the Maternity Center Association of New York City established an educational facility to teach midwifery to public health nurses "so that they could supervise the immigrant and rural midwives still practicing at the time. The clinic-school was envisioned as part of a larger plan to 'bring . . . midwives under competent medical control.'"8

Thus, the nurse-midwife began practicing as an adjunct to the public health service arising from the tradition of professional nursing, while the lay midwife was an "independent" practitioner in the tradition of lay healers. Whatever the midwife's origin, however, her role was to serve the poor and the geographically and culturally isolated. Although the nurse-midwife was trained in the traditional dependent relationship of nurse to doctor, physician supervision was generally absent in the economically depressed settings in which she served. This was of concern to no one, until the demand for her services by middle-class women forced her to become the economic competitor of the physician. When this development occurred, the nurse-midwife began to experience the full impact of her dual identity. Today she remains trapped between her allegiance to established medical practice on the one hand, and the pull of traditional midwifery on the other. This conflict informs much of the current controversy.

Traditions similar to those that generated two different groups of midwifery practitioners also led to the development of two different models of birth: the medical model and the midwifery model.9

[T]he medical model [arose] out of a male profession in a patriarchal society, [and] reflect[s] . . . the technological orientation of modern industrial society . . . [T]he body is seen as a machine, and the male body is taken as a norm. Pregnancy and birth are at best complications, stresses on the system. At worst, they are disease-like states. In either case, . . . they need treatment, medical management. [The midwifery model, on the other hand, takes] women as their norm . . . . They [see] our reproductive processes in a holistic, naturalistic way. They [believe] that women's bodies are meant to bear children — not necessarily that we should, or have to, but that when we do it, we are no more "stressing" to the system than we are when we are digesting a nutritious meal.10

Practice under the medical model of maternity care consists of a series of routine medical interventions designed to control the birth process. Analgesics and anesthetics are liberally administered during labor and delivery. As a result, doctors may need to use forceps or a vacuum extractor to pull the baby from the birth canal of the sedated or anesthe-

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8 Id. at 13.
9 For simplicity, practice under the medical model of maternity care will be referred to as the practice of "obstetrics," while practice under the midwifery model of care will be referred to as the practice of "midwifery."
tized woman. Membranes may be ruptured artificially to "speed up" labor. If further augmentation is desired, pitocin may be given to further stimulate uterine contractions. Because the woman is not allowed to take food or fluids in case a cesarean section becomes necessary, the administration of intravenous fluids throughout labor is required. Episiotomy, a surgical incision to enlarge the opening to the birth canal, is routine.

The newest intervention is the electronic fetal monitor (EFM), which makes a continuous record of the baby's heart rate during labor and delivery. These machines were originally developed for use in cases where there was reason to anticipate a particularly troublesome delivery. However, EFM is now being used routinely in low-risk deliveries, despite the lack of evidence that it is either accurate or clinically indicated. With the use of the monitor, the laboring woman must lie on her back, as still as possible, so the tracings will reflect the fetal heartbeat rather than maternal movement. Many women find that this position greatly intensifies the discomfort of labor.

When she is ready to deliver, the woman is taken from the labor bed to the delivery room, where she is placed on a narrow table on her back with her feet in stirrups and her hands strapped to her sides. The only position which could further obstruct the force of gravity, which assists

11 "In 1968, the average cesarean rate was 5%. In 1981, the national average had risen to 17%-20%, and in some teaching hospitals it now goes as high as 25%-40% (in some months)." THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, THE NEW OUR BODIES, OURSELVES 385 (1984). These statistics are particularly alarming considering that cesarean sections, "being major operations, carry two or four times greater a risk of death than vaginal deliveries." Id.

12 See Y. BRACKBILL, J. RICE & D. YOUNG, BIRTH TRAP: THE LEGAL LOW-DOWN ON HIGH-TECH OBSTETRICS 9-12 (1984) [hereinafter Y. BRACKBILL]. There are two general types of electronic fetal monitoring: external and internal. When the monitoring is done externally, electrodes are attached to the mother's abdomen. When it is done internally, electrodes are screwed into the unborn infant's scalp. The major criticisms of external fetal monitoring are addressed to its inaccuracy, its questionable safety, and its tendency to subject women to a much higher incidence of cesarean section. Although more accurate, internal fetal monitoring has resulted in complications such as scalp abscesses, herpes simplex, hemorrhage, and leakage of cerebrospinal fluid. The reader interested in the debate surrounding the safety and effectiveness of electronic fetal monitoring is referred to: W. ARNEY, POWER AND THE PROFESSION OF OBSTETRICS (1982); Shearer, Fetal Monitoring: For Better or For Worse?, in 1 COMPULSORY HOSPITALIZATION, supra note 6, at 135-39; Hawerkamp & Orleans, An Assessment of Electronic Fetal Monitoring, WOMEN & HEALTH, Fall/Winter 1982, at 115; Marieskind, Cesarean Section, WOMEN & HEALTH, Fall/Winter 1982, at 179, 189-90; Jarzembski, Benefits, Limitations, Fallacies & Hazards of Electronic Monitoring of the Human Body, in 1 COMPULSORY HOSPITALIZATION, supra note 6, at 143-59; Brasted & Callahan, An Evaluation of the Electronic Fetal Monitor as a Feedback Device During Labor, 17 J. APPLIED BEHAV. ANALYSIS 261 (1984); Wagener, Rycheck, Yee, McVay, Buffenmyer & Harger, Septic Dermatitis of the Neonatal Scalp and Maternal Endomyometritis with Intrapartum Internal Fetal Monitoring, 74 PEDIATRICS 81 (1984); Nieburg & Gross, Cerebrospinal Fluid Leak in a Neonate Associated with Fetal Scalp Electrode Monitoring, 147 AM. J. OBSTET. & GYNECOL. 839 (1983); Curzen, Bekir, McIntlock & Patel, Reliability of Cardiotocography in Predicting Baby's Condition at Birth, 289 BR. MED. J. 1345 (1984); Cordero, Anderson & Zuspan, Scalp Abscess: A Benign and Infrequent Complication of Fetal Monitoring, 146 AM. J. OBSTET. & GYNECOL. 126 (1983); Guill, Anton & Rogers, Neonatal Herpes Simplex Associated with Fetal Scalp Monitor (Letter to the Editor), 7 J. AM. ACAD. DERM. 408 (1982).
in the birth process, would be for the woman to stand on her head.\textsuperscript{13}

By contrast, the midwifery model of care is noninterventionist; the emotional aspects of the birth experience are valued and protected. Midwives encourage the birthing woman to orchestrate the experience, recognizing that birth is most satisfying when it takes place not in isolation, but in an intimate environment where the woman feels connected with those she loves. Midwives encourage family members and friends of the woman's choosing to participate in caring for the woman during her labor and delivery. Finally, midwives recognize the importance of maternal bonding in the first few moments and hours of the infant's life.\textsuperscript{14}

The use of medications that dull the woman's senses and affect the fetus adversely is avoided. The woman is allowed to be up and about during labor, and, if she desires, she may sip nourishing liquids. Depending on the setting, she may assume any position that is comfortable for the delivery of the child. When the child is born, it is immediately placed in bodily contact with the mother, who is awake, alert, and ready to receive the infant. Episiotomy is not routine, and some midwives virtually never perform the operation.\textsuperscript{15}

Differing philosophies regarding the dependent or independent role of the nurse-midwife and which model of birth is indicated in this age of technological medicine have given rise to serious obstacles to the practice of midwifery.\textsuperscript{16} This Article will explore legal means for addressing two of the most severe barriers faced by nurse-midwives: the difficulty in obtaining physician backup, and the denial of hospital privileges.

With respect to the first obstacle, physicians are generally unwilling to provide the kind of medical backup that is necessary for nurse-midwives to practice. Understandably, physicians' aversion to vicarious liability and the realities of the current malpractice crisis are intensifying this problem. This Article will examine the potential vicarious liability of physicians who collaborate with nurse-midwives engaged in independent practice and will conclude that a general rule of nonliability should

\textsuperscript{13} S. ARMS, IMMACULATE DECEPTION 82-84 (1975).

\textsuperscript{14} Id. at 102-05; Klaus, Jerald & Kreger, Maternal Attachment: Importance of the First Post-Partum Days, 286 NEW ENG. J. MED. 460 (1972). See also S. ARMS, supra note 13, at 86, for a description of the difficulties experienced by one young mother who underwent a failure of maternal attachment when she was overmedicated during delivery.

\textsuperscript{15} B. ROTHMAN, supra note 10, at 236-44. Several writers have observed, and at least one study has documented, that it is very difficult for nurse-midwives to practice the midwifery model within the hospital setting. Not only are nurse-midwives trained in institutional, pathology-oriented settings where obstetrical intervention is routine, they are usually employed in medical settings where institutional policies prevail, and they may have little freedom to exercise their own judgment and initiative. B. ROTHMAN, supra note 10, at 76-77; DeVries, Image and Reality: An Evaluation of Hospital Alternative Birth Centers, J. NURSE-MIDWIFERY, May/June 1983, at 3.

\textsuperscript{16} The term "nurse-midwives" as used from this point on in this Article should be understood to include all practitioners of midwifery, whether lay midwives or nurse-midwives, who are licensed to practice by a state agency. See infra note 82 for further explanation.
apply with limited exceptions based on traditional principles of agency law.

With respect to the difficulties nurse-midwives face in being admitted to hospital practice, nurse-midwives are most often completely ineligible for hospital privileges. Even those hospitals whose bylaws ostensibly allow midwives to apply for privileges frequently deny such applications. Using as a paradigm a case that is now pending before the federal district court in Nashville, Tennessee, this Article will discuss some traditional constitutional and common law theories for addressing denial of hospital privileges to nurse-midwives and will argue that nurse-midwives cannot use those legal theories successfully in most cases. Alternatively, the viability of a cause of action under § 1 of the Sherman Act will be explored. The Article will conclude that the potential “bite” of the Sherman Act in such cases rests on the court’s choice of a standard of proof and depends upon the court’s resistance to modifications of the per se rule in applying antitrust doctrine to the professions.

I. A BRIEF HISTORY OF MIDWIFERY

Suppression of midwifery can be traced to the witch hunts of the Middle Ages, which spanned the thirteenth through the seventeenth centuries A.D. The “witches” were lower class women healers who ministered to a poverty and disease-stricken people using a combination of folk remedies and magic. As magicians and spiritualists, they were perceived to be a threat to the rise of Christianity, and a well-financed, well-organized campaign of terror and death was mounted against them. In the Malleus Maleficarum, or Hammer of Witches, which gave religious authority for the witch hunts, the authors asserted that “[n]o one does more harm to the Catholic Church than midwives.” Indeed, millions of women healers were burned during the Middle Ages.

While the witch hunts did not eliminate women healers, the persecution was so intense that they were “branded forever as superstitious and possibly malevolent.” Though childbirth was the centuries-old province of women, the profound discrediting of women healers over the centuries created a cultural climate that allowed male medical practitioners to preempt the field during the seventeenth and eighteenth centuries with relatively little resistance.

In Colonial America, birth was a social occasion. Female friends

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18 B. EHRENREICH & D. ENGLISH, supra note 1.
19 Id. at 13.
20 Id. at 7-9, 13.
21 Id. at 19.
22 Id. at 20.
and relatives gathered around the expectant mother to provide emotional support and household and child care assistance. This allowed the new mother several weeks of freedom from responsibilities other than caring for the newborn and regaining her strength.\(^1\) Midwives were regularly employed by birthing women and were licensed by the state. They performed the official function of attesting to parentage so that cases of "bastardy" and "fornication" could be readily identified in the Puritan community.\(^2\)

By the middle of the seventeenth century, however, "regular" doctors, trained in Europe, were venturing to the colonies equipped with "scientific" medicine that, for childbirth, consisted primarily of using forceps.\(^3\) Despite the danger and brutality of forceps, the new "man-midwives" forged boldly ahead, confident that possession of these tools was a panacea for every problem encountered during birth. They also regarded the forceps as a convenient means to hasten delivery. Shortening the time of labor by the use of forceps thus gave the man-midwife a great competitive advantage over the midwife,\(^4\) who, for reasons that are not entirely clear, very rarely adopted the practice.\(^5\)

During the nineteenth century, male doctors established themselves as the preferred birth attendants for upper-class and middle-class women, and American midwives began to disappear. Establishing male supremacy in the birthing room was no small task in a culture that valued female modesty with an almost religious fervor. In order to triumph over modesty, medicine had to convince the public that childbirth was inherently pathological and unsafe, a dangerous condition that required the attention of the more highly valued male birth attendants.

The profession recognized that this was a political task, not a scientific one. [As] Dr. Hugh Hodge said, "If females can be induced to believe that

\(^{23}\) R. Wertz & D. Wertz, supra note 1, at 3-4.
\(^{24}\) Id. at 7-8.
\(^{25}\) "Probably the single most important event which prepared the way for the acceptance of obstetrics as a science and, as a consequence, brought about the displacement of midwives, was the development of the obstetrical forceps by the British surgeon Peter Chamberlen, the Elder, early in the Seventeenth Century." Litoff, The Midwife Throughout History, J. Nurse-Midwifery, Nov./Dec. 1982, at 3,5; J. Donegan, supra note 1, at 47.
\(^{26}\) R. Wertz & D. Wertz, supra note 1, at 40-41; J. Donegan, supra note 1, at 49-51, 59.
\(^{27}\) "Midwives could neither afford to buy the forceps nor find physicians who would instruct them in their proper use." Litoff, supra note 25, at 5. According to Wertz & Wertz, it is a mystery why most midwives did not use forceps. Perhaps it was the force of custom, which associated men, but not women, with instrumental interference. Or it may simply have been the cost of purchase, as suggested by Litoff. It is also possible that men refused to sell forceps to women. R. Wertz & D. Wertz, supra note 1, at 39. Another factor may have been the systematic exclusion of women from medical schools in this country. (Four schools existed at the time.) "Once this [process of exclusion] had begun, it became increasingly difficult for midwives to keep up with the medical discoveries of the nineteenth century which eventually brought about the development of modern obstetrics." Litoff, supra note 25, at 6. Doctors who did try to develop a shared enterprise with women empirics met with little success, "perhaps because women were uninterested in studying what they thought they already knew, and moreover, studying it under the tutelage of men," a prospect that violated developing notions of Victorian modesty. R. Wertz & D. Wertz, supra note 1, at 45-46.
their sufferings will be diminished, or shortened, and their lives and those of their offspring, be safer in the hands of the profession, there will be no difficulty in establishing the universal practice of obstetrics."

Other social and cultural conditions also helped to bring about midwives' demise. While European governments provided financial support for medical education, including the training of midwives, the United States government provided no such support. Doctors began to actively resist competition from midwives by seeking the patronage of upper- and middle-class women. This was necessary because physicians were not firmly established in their professional role and childbirth was the gateway to practice, as well as to a small guaranteed income. Doctors began to develop an ideology of birth which was more interventionist in nature and required a mastery which nineteenth century women were assumed unable to achieve, because of their supposed weakness and presumed mental instability during menstruation.

Many women ceased to be midwives because of a change in the social attitudes about the proper place of women in society. Known as the "cult of the true woman," motherhood was the Victorian woman's single purpose in life, and leaving the domestic sphere for any reason was thought to endanger her delicate reproductive organs. In addition, midwives never organized but allowed themselves to be pushed further and further into the ghettos of the urban poor and into rural isolation. Finally, for whatever reason, the tastes of upper- and middle-class women simply changed, and male birth attendants were accorded a presumption of greater respectability and safety. By the end of the nineteenth century, "new, tough licensing laws sealed the doctor's monopoly on medical practice."

28 Quoted in W. Arney, supra note 12, at 42. Undoubtedly, the profession was aided in this by puerperal fever, which plagued birthing women from the time interventionist obstetrics appeared until well into the twentieth century, often reaching epidemic proportions. Puerperal fever made childbirth more dangerous in fact. Ironically, puerperal fever was largely an iatrogenic disease, the bacteria being introduced into the woman's blood stream through wounded tissue. Such wounded tissue occurred naturally through birth, but those women on whom forceps and other traumatic interventions were applied were even more susceptible to infection. R. Wertz & D. Wertz, supra note 1, at 119, 127-28.

29 R. Wertz & D. Wertz, supra note 1, at 44-45.

30 Id. at 47, 56-57. See also W. Arney, supra note 12, at 53-55. For a graphic description of the incapacity of nineteenth century women, see B. Ehrenreich & D. English, Complaints and Disorders: The Sexual Politics of Sickness (1973).

31 R. Wertz & D. Wertz, supra note 1, at 93-95; B. Ehrenreich & D. English, supra note 30, at 27-29.

32 R. Wertz & D. Wertz, supra note 1, at 47.

33 Id. As a Boston physician observed in 1820: "If female midwifery is again introduced among the rich and influential, it will become fashionable and it will be considered indelecate to employ a physician." Id. at 55.

34 B. Ehrenreich & D. English, supra note 1, at 33. General anesthesia — chloroform and ether — was discovered during the mid-nineteenth century, but it was not widely used in America, since birthpain was thought of "as a religious curse upon women, or at least, salutary suffering that induced motherlove." R. Wertz & D. Wertz, supra note 1, at 116-17. Hence, the development of anesthesia did not provide nineteenth century doctors with the same kind of competitive edge over midwifery as did the invention of forceps in the 1700s.
In the early twentieth century, the medical profession energetically pursued the elimination of the midwife as part of a drive to consolidate its monopoly on the practice of medicine and to raise the status of obstetrics. The development of institutionalized medicine was in full swing, with medical school and hospital construction heavily funded by both the public and private sectors. Yet, in 1910, fifty percent of the nation's babies were delivered by midwives, leading doctors to conclude that midwives posed a significant economic threat. Doctors further complained that, by monopolizing so much of the market, midwives were depriving medical students of the "material" necessary for their proper training.

In order to accomplish the goals of enhancing professional status, cornering the economic market, and providing the "material" for training, physicians had to attack the residual normality of childbirth by focusing on its "pathological potential." Such an ideology was ably espoused by Dr. Joseph B. DeLee in the first issue of the *American Journal of Obstetrics and Gynecology* in an article entitled "The Prophylactic Forceps Operation."

Dr. DeLee's procedure for a routine, normal birth required sedating the woman through labor, and giving ether for the descent of the fetus. The baby was to be removed from the unconscious mother by forceps. An incision through the skin and muscle of the perineum, called an episiotomy, was to be done before the forceps were to be applied. Removal of the placenta was also to be obstetrically managed rather than spontaneous. Ergot or a derivative was to be injected to cause the uterus to clamp down and prevent postpartum hemorrhage.

DeLee's advocacy of routine intervention was adopted as standard obstetrical practice, and, by 1930, hospital birth was the norm.

Women themselves were attracted by the promised safety of hospital births.

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35 The public campaign against midwives was, of course, couched in terms of the most benevolent concern for the midwives' clientele. Midwives were "hopelessly dirty, ignorant and incompetent, relics of a barbaric past." [The midwife] was a foreign "micrococcus" brought over, as was supposedly the case with other germs, in the holds of ships bearing immigrant workers. The elimination of the midwife was presented as a necessary part of the general campaign to uplift and Americanize the immigrants — a mere sanitary measure, beyond debate. B. EHRENREICH, FOR HER OWN GOOD 95-96 (1979).

36 Despite this sordid picture, a 1912 study conducted at Johns Hopkins University, the most prestigious medical school in the country at that time, reported that most American doctors were less competent than the midwives they were replacing. Kobrin, *The American Midwife Controversy: A Crisis of Professionalization*, 40 BULL. HIST. MED. 350, 353 (1966).

37 J. LITOFF, supra note 1, at 71-73.

38 Id.

39 W. ARNEY, supra note 12, at 54.

40 B. ROTHMAN, supra note 10, at 57-58.

40 Doctors had other reasons for promoting hospital birth. The model of industry taught that controlling the workspace would make them the elite and perhaps bring the power and prestige they desired. The hospital was more convenient once the interventionist approach was adopted. Needed equipment was readily available, and birth could be routinized without the need to defer to the needs and wishes of others in the woman's home environment, particularly if there were objections to the interventionist tools being employed. R. WERTZ & D. WERTZ, supra note 1, at 143-44.
birth. More importantly, women wanted relief from the pain of labor, and the use of analgesics and anesthetics during labor and delivery became routine. For poor urban women who traditionally depended on midwives, the disappearance of lay birth attendants gave them no choice but to enter large city charity hospitals for childbirth.

Were the promises of obstetrics and hospital birth fulfilled? Two studies completed in the 1930s suggest that they were not. The New York Academy of Medicine in 1933 investigated 2041 maternal deaths between 1930 and 1932. The study concluded that two-thirds could have been prevented. Of those avoidable deaths, sixty percent “showed some incapacity in the attendant — lack of judgment, lack of skill, or carelessness.” In addition, the report “included many favorable comments on the work of midwives and on the advisability of home birth, both of which were, however, diminishing as options.”

The White House Conference on Child Health and Protection also issued a report in 1933. Maternal mortality had not declined between 1915 and 1930 despite hospital delivery and the introduction of aseptic technique. The number of infant deaths from birth injuries actually increased by forty to fifty percent during those same years. Both reports cited two reasons for their findings: absent or inadequate prenatal care and excessive intervention improperly performed.

From 1936 on, maternal and newborn mortality rates dropped precipitously as the result of the introduction of antibiotics, advanced surgical techniques, and more skillful prenatal care. By the 1960s, professional and public concern for safety had pruned away improper techniques and egregious incompetence, but not the philosophy that medical arts created the healthful birth. . . . Doctors sensed that they had received a mandate from families and from society to perfect the medical management of birth, that patients shared their view that doctors knew what was best for birth and should manipulate it as fully as possible. This consensus broke down, however, when death became rare; the success of medicine led people to ask whether every birth needed to be treated as if some freak occurrence might threaten the life and health of mother and child. The treatment began to appear to be worse than the threats it prevented.

Thus, the stage was set for the re-emergence of midwifery with its philosophy of nonintervention in the normal birth process.

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41 Id. at 150. In 1930, midwives attended 15% of all births in the United States. By 1973, 99.3% of all births were delivered by physicians in hospitals. J. LITOFF, supra note 1, at 114.
42 R. WERTZ & D. WERTZ, supra note 1, at 161.
43 Id.
44 Id. at 190. “The [White House Conference] report concluded that ‘it seems possible that all the advances in medical knowledge have been almost lost to the parturient woman through too great a recourse to instrumental delivery’ by the physician.” J. LITOFF, supra note 1, at 109.
45 R. WERTZ & D. WERTZ, supra note 1, at 164, 167.
II. THE “MIDWIFE CONTROVERSY”

Midwifery is, in large measure, a child of its own creation, an ancient profession without a modern identity, reinventing itself in the contemporary world. Centuries of suppression, which have shaped the rich historical tradition of midwifery, have also carved a hiatus in its professional and legal identity. Attempts to address the resulting ambiguities in the legal and professional status of midwifery directly challenge physician-dominated, technological medicine and the legal machinery which supports it. In addition, the controversy has been intensified by rapid technological advancements that have further polarized the practice of obstetrics and midwifery, as well as by various social movements that have highlighted the philosophical differences between midwifery and institutionalized medicine.

The midwife controversy is a political, economic, and professional one taking place both within the medical profession on the one hand, and between the medical profession and those it serves on the other. Physicians’ attitudes toward the practice of midwifery generally range from benign tolerance to outright hostility. Understandably, physicians have a powerful economic interest in maintaining the monopoly on obstetrical care which they have so carefully nurtured over the past four centuries. In addition, most physicians express a genuine concern for the safety and well-being of childbearing women, and feel that birth is “low-risk” only in retrospect and that delivering a baby requires the skills of a physician.

Professional, nurse-midwifery is most closely tied with nursing and public health. Lay midwifery, on the other hand, has generally been classified as the limited practice of medicine.

The various mechanisms states have chosen to regulate nurse-midwifery are illustrative of its professional characterization, at least officially. Thirty-four jurisdictions, including California, regulate the practice under Nurse Practice Acts, and most of these states consider nurse-midwives to be a type of nurse-practitioner. (Most of these statutes and regulations are very recent, and the statistic belies the fact that it was not until the advent of extended-practice nursing that the nursing profession began to see nurse-midwifery as more akin to the practice of nursing than the practice of medicine.) In four jurisdictions, certified nurse-midwives (CNMs) are regulated exclusively by the Medical Board. In another four, CNMs are regulated jointly by the Board of Nursing and the Board of Medicine. Six jurisdictions retain the original public health concept of the nurse-midwife and place the regulation of nurse-midwifery within the Department of Public Health. Only one jurisdiction, Utah, has a regulatory scheme independent of both nursing and medicine. Utah has a Committee of Certified Nurse-Midwifery set up within the Department of Business Regulation. All but two states, Nebraska and North Dakota, expressly authorize the practice of nurse-midwifery by statute or regulation.

While nurse-midwives have mounted a well-organized campaign for professional recognition and have gained the clear legal authority to practice, lay midwives have been struggling to retain the bare essentials of legal legitimacy. In some states, the success of nurse-midwifery has sounded the death knell for lay midwifery, while a few states have chosen to legitimize both. Still other states have left lay midwifery undisturbed. Twelve jurisdictions actively regulate the practice of lay midwifery, while 11 states have statutes that authorize lay midwifery practice but under which no new licenses are currently being issued. Two states, Tennessee and Mississippi, do not require licensure. The remaining states have no statutory authority either permitting or prohibiting lay midwifery practice. Id. at 62.

46 Professionally, nurse-midwifery is most closely tied with nursing and public health. Lay midwifery, on the other hand, has generally been classified as the limited practice of medicine.
practicing in a well-equipped hospital setting.\textsuperscript{47}

Both federal and state governments are intimately involved in the midwife controversy and represent yet another set of interests.\textsuperscript{48} Cost-effectiveness is the watchword of the 1980s. In the face of escalating health care costs,\textsuperscript{49} planners and decision-makers have begun to question whether the extraordinarily expensive, increasingly narrow path of high technology obstetrics and neonatology should be pursued so single-mindedly and to the virtual exclusion of preventative health care.\textsuperscript{50} Effective utilization of midwifery services has been proposed as a partial solution to both the need for cost containment and the need to improve care to underserved women.\textsuperscript{51}

\textsuperscript{47} Adamson & Gare, \textit{Home or Hospital Births?}, 243 J.A.M.A. 1732 (1980).
\textsuperscript{48} Since at least the 1930s, the federal government has been concerned with maternal and child health. During the `30s, when it was discovered that physicians were not very effective birth attendants, the focus shifted to better preparation of physicians. J. Litoff, supra note 1, at 109-10. However, in more recent years, the emphasis has been on the development of high-technology intrapartum and neonatal care, with little attention being directed to the problems of preventative care and maldistribution of health care resources. \textit{Infant Mortality Increases in the U.S. Capital and Other American Cities: Oversight Hearing Before the Subcomm. on Fiscal Affairs & Health of the House Comm. on the District of Columbia, 97th Cong., 2d Sess. 1} (1982) [hereinafter \textit{Oversight Hearing}]. At this hearing, Congressman Ron Dellums, Chairman of the Subcommittee, remarked: “\textit{[W]e ... have come to the startling conclusion that roughly 98% of [total health care expenditures] are spent dealing with illness and that ... less than 1% [is spent on] health prevention.}” \textit{Id.} at 22.
\textsuperscript{49} In 1955, the total annual health care bill for the United States was \$17 billion; in 1960, \$25 billion; in 1965, \$38 billion; in 1970, \$69 billion; in 1975, \$115 billion. \textit{American Bar Association, Crisis in Medical Professional Negligence: Fact or Fancy} 14 (Section of Litigation Monograph Series No. 2, 1977).
\textsuperscript{50} \textit{Oversight Hearing}, supra note 48, at 22. In 1982, the Department of Consumer Affairs of the State of California found that

low-income women and infants — particularly those from ethnic and racial minority groups — suffer from perinatal mortality and morbidity rates far above those of other populations. . . . [While] neonatal mortality rates have dropped with the advent of new technology and intensive care nurseries, postneonatal mortality for infants from illnesses related to prematurity and low birthweight is increasing dramatically. This indicates that in a significant number of cases, the new technology does not save lives, but only allows premature and low birthweight infants to be kept alive longer than was possible in the past.


The overriding importance of prenatal care as a preventative health measure has been demonstrated repeatedly.

The most dramatic study to show the importance of prenatal care was conducted in 1968 by the Institute of Medicine of the National Academy of Sciences. Under the direction of David Kessner, professor of community medicine at Georgetown University, the study analyzed 142,017 births in New York City. Statistics were broken down to show the influence of prenatal care on mothers with social risks (poor education, large families, lack of financial support, unwed status); medical risks (high blood pressure, toxemia of pregnancy, diabetes); and low risks. [The study] show[ed] that infants of low-risk mothers who had received adequate prenatal care died at a rate of only 8.7 per thousand births; however, for low-risk mothers who received no prenatal care, deaths of newborn infants soared to 21.0. Similarly dramatic differences were noted with women who were considered to be both social and medical risks; the infant death rate for those who had received adequate prenatal care was 29.9; for those who had not, an incredible 55.1.

S. Arms, supra note 13, at 42.
Birthing women themselves are challenging high-tech obstetrical care for other reasons. The ideologies of feminism and consumerism have produced a new consciousness among women in which good health and reproductive freedom are key issues. This heightened awareness includes a new appreciation of the birth experience and increasing doubts about the necessity and safety of obstetrical intervention. Many women are demanding choice among a range of safe birthing alternatives where obstetrical interventionism is not the norm, where they may exercise as much control over the birth experience as possible, and where values that go to the quality of the birth experience can be fulfilled. Other women, because they are poor or because they live in remote areas where physicians are scarce, simply do not have access to obstetrical care at all unless alternatives are made available.

Midwives also have a number of interrelated economic, professional, and philosophical interests at stake. Most basically, midwives are interested in providing safe, effective, woman-centered care that is noninterventionist in its orientation. To best implement this type of practice, many midwives feel it is necessary to establish a strong professional identity that clearly differentiates the practice of midwifery from the practice of obstetrics, while at the same time facilitating the kind of interprofessional collaboration which guarantees optimum safety for birthing mothers and their babies. How to achieve this goal stirs great controversy within the medical profession, in the legislatures, and among midwives themselves.

Casting a shadow over these varied and often conflicting interests is the specter of medical malpractice. The increasing threat of malpractice suits helps convince practitioners that birth warrants maximum medical intervention, despite evidence that medical intervention is the source of a great many iatrogenic and nosocomial injuries.

52 See B. Rothman, supra note 10, at 78-110 (discussing the importance of consumer movements such as the natural childbirth movement, the La Leche League, and others in the development of alternative birthing). See also S. Ruzek, The Women's Health Movement: Feminist Alternatives to Medical Control (1978); The Boston Women's Health Book Collective, supra note 11, at 361-63.

53 See S. Arms, supra note 13; Y. Brackbill, supra note 12.

54 Many hospitals have responded to the demand for less dehumanizing maternity care by creating in-house alternative birthing rooms that attempt to simulate a home-like environment and provide a setting for the midwifery model of practice. However, a recent study shows that such attempts are failing primarily due to a lack of institutional commitment to the concept of alternative birth. DeVries, supra note 15.

55 The philosophy of the American College of Nurse-Midwives is based on the belief that “every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations. The individual has the right to self-determination, to adequate information, and to active participation in all aspects of care.” Statement of Philosophy of the American College of Nurse-Midwives, 29 J. Nurse-Midwifery 169 (1984) [hereinafter ACNM Philosophy].

56 Y. Brackbill, supra note 12, at 1-45. See generally S. Arms, supra note 13. Apparently, the medical profession has had a great deal of assistance from the plaintiff's bar in adopting its distorted standard of care. Mr. Ralph Drayton, J.D., California Trial Lawyers' Association,
Alternative birth proponent Suzanne Arms has observed that American obstetrics has set out to conquer risk in birth in much the same way that medical science conquered polio. The resulting deception of a "risk-free" birth seduces women into subjecting themselves to the highly authoritarian medical model of modern obstetrics. They pay the price of indulging in the "risk-free" illusion by giving birth in an environment that deprives them of the care and nurturing they need during childbirth and subjects them and their offspring to the often unnecessary risks of drugs and surgery. When the outcome is less than hoped for, women feel angry, disappointed, and wronged; the stage is set for malpractice claims to flourish.

Some feel that midwifery, with its emphasis on noninterventionism, childbirth education and preparation, and emotional support, can impact favorably on the liability problem by promoting greater consumer satisfaction. However, few physicians are willing to put it to the test, and controversy, focused primarily on the issues of independent practice and home birth, continues to rage.

A. The Issue of Independent Practice

The nurse-midwife is defined as a practitioner who is trained to assume the complete management of uncomplicated pregnancy and childbirth. She provides comprehensive prenatal care, performs normal deliveries, offers childbirth education and preparation, takes care of the

testified before the Office of Statewide Health Planning and Development Alternative Birthing Study Committee that he considers it malpractice per se not to use electronic fetal monitoring throughout labor. California Office of Statewide Health Planning and Development: Hearings before the Alternative Birthing Methods Study Committee (June 1985) (testimony of Ralph Drayton, J.D., California Trial Lawyers' Association) (notes on file with author) [hereinafter ABM Study (June 1985)]. But see Y. BRACKBILL, supra note 12, advocating litigation as a means of moving obstetrical care away from its interventionist mode.


58 In a similar vein, malpractice litigator Sheila Johnson says:
The obstetrician-patient relationship appears to be quite a special one in comparison to doctor-patient relationships in general. I believe that, because the patients are exclusively female and the physicians are generally male, the medical relationship is complicated by gender issues, complete with sexual discrimination, including male dominance, female dependence, exploitation, disrespect for a woman's dignity, and underestimation of a woman's intelligence and competence. Women may express continuing reliance upon the obstetrician to "take care of them" and still admire him, describing interactions that have a strong flavor of paternalism. Paradoxically, the same women are extremely angry over the way they were treated by their doctors. They are furious at the disrespect shown them, the rudeness or general insensitivity to their feelings of helplessness while pregnant or in labor, and often they cannot separate the indignity from the potential issues of malpractice.

mother after the birth, and provides a range of normal gynecological services. A Joint Practice Agreement reached between the American College of Obstetrics and Gynecology (ACOG) and the American College of Nurse-Midwives (ACNM) stresses the interdependent (as opposed to dependent) nature of the relationship between physicians and nurse-midwives. The agreement calls for "mutually agreed-upon written medical guidelines/protocols for clinical practice which define the individual and shared responsibilities of the certified nurse-midwife and the obstetrician/gynecologist in the delivery of health care services."59

Despite the language of the agreement, most physicians envision a hierarchical relationship with nurse-midwives based on a traditional employment model headed by the physician/obstetrician. In practice, this has the effect of limiting nurse-midwives to salaried positions in traditional physician-controlled settings — hospitals, physicians' private practices, and group practices of various kinds. It allows physicians and physician-dominated health care facilities to control the economics of health care by determining what nurse-midwives will be paid for their services only as adjuncts to physicians, and not as a distinct class of health care providers in their own right.60

Nurse-midwives, on the other hand, do not envision a mandatory employment relationship. They want greater autonomy to develop practice models which range from profit-sharing arrangements in practices with physicians, to practices in which obstetricians are the employees of nurse-midwives.61 They want horizontal, collaborative relationships with physicians, in which practice agreements are simply bilateral contracts that delineate those circumstances under which midwives refer patients to physicians and describe the backup services physicians agree to provide. Most importantly, they want to develop practice settings, both inside and outside of hospitals, which will allow them to implement a midwifery model of care.62

59 The American College of Nurse-Midwives & The American College of Obstetricians and Gynecologists, Joint Statement of Practice Relationships Between Obstetrician/Gynecologists and Certified Nurse-Midwives (1982), 29 J. NURSE-MIDWIFERY 171 (1984) [hereinafter ACNM/ACOG]. A "certified nurse-midwife" (CNM) is one who has met the requirements for certification established by the ACNM. Not all practicing nurse-midwives are certified.

60 Cohn, Survey of Legislation on Third Party Reimbursement for Nurses, 11 LAW, MED. & HEALTH CARE 260 (1983). In testimony before the Senate Subcommittee on Rural Development, Dr. Edgar Beddingfield, representing the AMA, said, "We do not believe in the concept of an independent physician extender. We believe they should be dependent and supervised.... I believe you maintain control by maintaining control of the money." Quoted in Hackley, Independent Reimbursement from Third-Party Payers to Nurse-Midwives, J. NURSE-MIDWIFERY, May/June 1981, at 17.


62 See Rothman, infra note 78.
B. Home Birth

Since the late 1960s, childbearing women have sought the services of home birth attendants in increasing numbers. Some distrust interventionist obstetric techniques that promise a quick and easy birth but may actually deliver a slow, agonizing, risky, expensive, demoralizing, demeaning, and alienating birth. Others are part of the childbirth reform movement and seek such care because of their desire to give birth in a situation that actively supports natural childbirth techniques and breastfeeding and recognizes the importance of maternal and infant bonding. Still others are part of various self-help movements seeking affordable, humanistic care that allows them to retain their autonomy. Many of these birthing couples have turned to home birth out of frustration with the lack of responsiveness of hospitals and medical professionals to their desires for a different kind of birth experience.

Home birth advocates emphasize "safe alternatives in childbirth," i.e., planned home birth for normal deliveries in circumstances in which adequate medical backup can be obtained in case of emergency. They believe that practitioners who attend home births should be competent and well-trained. They do not advocate the abandonment of hospital birth altogether but merely question whether the hospital is the preferred setting for normal birth.

Despite the controversy surrounding home birth, the actual number of out-of-hospital births is relatively small. Smaller yet are the numbers attended by nurse-midwives. In 1977, the Research and Statistics

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63 S. ARMS, supra note 13, at 51-112. A recent article in the Wall Street Journal stated that 20% of all patients who enter a hospital develop problems caused by the institution itself. Among the hazards: medication errors, excessive testing, infection, and overtreatment. Hull, Surviving a Stay in the Hospital, From Consent Forms to Discharge, Wall St. J., May 2, 1985, at 33, col. 4.

64 Nor have the courts been sympathetic to attempts to force hospitals to be more accommodating to alternative birthing practices. In 1974, the Montana Supreme Court held that the decision of a hospital to adopt rules that were not conducive to the practice of the Lamaze method of natural childbirth, including prohibiting fathers from entering the delivery room, was not arbitrary or capricious. Hulit v. Saint Vincent's Hosp., 520 P.2d 99, 102 (Mont. 1974). The following year, the Seventh Circuit held that the right of marital privacy is not violated by hospital rules excluding fathers from the delivery room, nor does such a rule restrict the physician's constitutional right to practice medicine. Fitzgerald v. Porter Memorial Hosp., 523 F.2d 716, 721 (7th Cir. 1975). See Note, Natural Childbirth: Rights and Liabilities of the Parties, 17 J. Fam. L. 309 (1978-79), in which the author concludes that childbearing couples have no "rights" as such. The California Supreme Court also rejected right to privacy arguments when advanced by consumers who wished to use the services of unlicensed lay midwives. Bowland v. Municipal Court, 18 Cal. 3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976).


66 According to the Bureau of the Census, the number of out-of-hospital births more than doubled between 1970 and 1977, increasing from 23,000 to 49,000. Of these, approximately 25% were delivered by physicians. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 61 (102d ed. 1981).

67 Based on estimates, fewer than five percent of all babies born in the United States are delivered by midwives, in and out of the hospital. Lay midwives deliver approximately two to three
Committee of the ACNM found that out of 1299 nurse-midwives surveyed, only forty-three managed home births. In some states, nurse-midwives are specifically prohibited by law from attending home births. In other states, they may be subject to disciplinary action or license revocation for "unprofessional conduct." Sanctions to discourage the practice may also be imposed on pregnant women who are considering home birth.

Home birth itself is not illegal in any state, nor is it mandated that a physician be in attendance at birth. Thus, physicians have sought to maintain medical control of the normal birth in other ways: by creating a climate of fear of the dire consequences that can result from birth outside of a hospital; by curtailing the availability of birth attendants for out-of-hospital births through licensing laws and other sanctions; and by maintaining a powerful and unwavering opposition to any policy that accommodates the practice.

The first official ACOG opposition to home birth arose in the midst of the furor created by the opening of the Childbearing Center, an out-of-hospital birth center staffed by nurse-midwives. The Maternity Center Association of New York City, a well-established organization that had been providing nurse-midwifery and childbirth education services with the support of the medical community for over sixty years, opened a free-standing birth center with the express purpose of providing a safer alternative to home birth in urban New York City. The fact that the Childbearing Center proposed to serve birthing women who would otherwise choose home birth did not mitigate the response of the medical community, however, and ACOG issued a formal policy statement taking the position that the hazards of birth are such that only the hospital setting can provide the necessary protections.

percent, while nurse-midwives deliver slightly more than one percent. NAPSAC NEWS, Fall 1980, at 6 (available from author).


70 Evenson, Midwives: Survival of an Ancient Profession, 7 WOMEN'S RTS. L. REP. 313, 324 (1982).


73 The policy statement, which was joined by the American Academy of Pediatrics, and later adopted by the AMA, reads as follows: "Labor and delivery, while a physiologic process, clearly presents potential hazards to both mother and fetus, before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation." American College of Obstetricians and Gynecologists, Policy Statement on Home Delivery, as amended, March 1979. The California Medical Association
The fear that planned out-of-hospital birth is less safe than hospital birth has not been substantiated, and there is considerable evidence to the contrary. Striking, but not atypical, is the record of the Frontier Nursing Service in Kentucky. The Frontier Nursing Service provided home birth services in the Appalachian mountains for many years without medical backup. They served a "high risk" population, because the area was economically depressed, and the women served suffered from the effects of poverty and poor nutrition. Between 1925 and 1954, the Frontier Nursing Service attended 10,000 births with only eleven maternal deaths. (By comparison, the national rate between 1939 and 1941 was 36.3 maternal deaths per 10,000.) From 1952 to 1974, there were no maternal deaths in over 8000 deliveries attended by Frontier Nursing Service midwives.

A demonstration project utilizing nurse-midwives in rural Madera County, California in the 1960s showed similar success. Within the first eighteen months of the introduction of midwifery services, the prematurity rate dropped from 23.9 to 10.3 per 1000 live births. Bowing to pressure from the California Medical Association, however, the legislature did not continue to fund the project. When the service was terminated, the prematurity rate increased by almost fifty percent, and the neonatal death rate tripled.

In the early 1970s, Louis Mehl, a medical student at Stanford University, studied the Birth Center in Santa Cruz, California. The Birth Center staff was composed of well-trained lay midwives who provided a home birth service in Santa Cruz County. Based on a sample of 289 women, the perinatal mortality rate was 3.2 per 1000 live births at a time

adopted a similar position. California Medical Association Committee on Maternal, Perinatal and Child Care, Position Statement on Alternatives in Birthing (1980).

Unlike the ACOG and the CMA, the ACNM has resisted taking a position in opposition to home birth. Nonetheless, the ACNM's most recent statement of philosophy would seem to leave the question open: "Every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations. The individual has the right to self-determination, to adequate information, and to active participation in all aspects of care." ACNM Philosophy, supra note 55.

Debra Evenson has correctly recognized the sensitive political position of nurse-midwifery, which makes even the resistance implicit in the ACNM statement of philosophy seem monumental.

[Health care remains dominated by powerful institutions and organizations that have been reluctant to yield to innovations which diminish the role of the physician or the use of technology. Even if disposed to do so, the ACNM can hardly be expected to do battle with legislatures, organizations, and agencies from which it has just recently gained acceptance and recognition, and on which it is dependent for its continued existence.

Evenson, supra note 70, at 324.

74 J. Litoff, supra note 1, at 128.

when the figure for the United States was 27.1 per 1000 live births.\textsuperscript{76}

In the urban setting, the Childbearing Center in New York City attended some 800 births from 1976 to 1981. A quality audit by Blue Cross in 1981 found that the Childbearing Center had been successful in referring out high-risk women according to its established criteria and that it had provided adequate care to the women remaining in the system.\textsuperscript{77}

Considering the apparent safety of out-of-hospital birth, what then is the basis of physician opposition?\textsuperscript{78} A Harris poll of physicians taken


\textsuperscript{77} W. Lazarus, 2 FTC REPORT, \textit{supra} note 72.


The Farm in Summerhill, Tennessee, described in the text preceding note 6, reports the following: After eight years of midwifery practice from 1970 to 1979 and 1000 births, there were no maternal deaths, and a neonatal death rate of 7.5 per 1000, compared to a national rate of 9.8 per 1000 reported in 1977. Gaskin & Gaskin, \textit{Birth in a Community Where Home Is the Norm and Hospital the Exception}, in 3 COMPULSORY HOSPITALIZATION, \textit{supra} note 6, at 940-41; Evenson, \textit{supra} note 70, at 319.


Physicians who oppose home birth also oppose the legitimization of lay midwifery. Since lay midwives practice exclusively outside of hospitals, opposing the licensing or certification of lay midwives is part of the attack on home birth. Since nurse-midwives and physicians are often deterred from attending home births through various legal and professional sanctions, imposing legal obstacles to the practice of lay midwifery will, it is hoped, further deter the practice of home birth. Moreover, if midwives are going to be part of the medical scene, physicians want to see them restricted to a subspecialty of nursing where physician dominance is well established.

Barbara Katz Rothman, a sociologist and consumer advocate for birthing alternatives argues that nurse-midwives should join forces with lay midwives and establish themselves as a profession outside of the hospital setting. Rothman asserts that it is not possible for the art and science of normal birth to develop within a medical establishment that views pregnancy as pathological and childbirth as a surgical event. If normal birth alternatives are to avoid being swallowed up by technology, midwifery must develop and maintain a clear separation between normal birth as a physiologic, nonmedical event, and birth pathology, which requires medical attention. It is impossible to promote this separation in the modern hospital setting, where
in 1981 suggests that the vigorous opposition to out-of-hospital birth for safety reasons may be a thin disguise for more paramount economic concerns. According to the survey, “in general, physicians accept the idea of physician’s assistants and nurse-practitioners providing care to the poor and other medically underserved groups. However, they are much less supportive, and, indeed, are quite divided in their opinion of the value of such care for [wealthier] mothers and children.”

In order to diffuse the tension created by physicians who fear the impact of midwifery, Judith Rooks and others have attempted to de-emphasize the competitive nature of obstetrics and midwifery by insisting that each category of practitioner, nurse-midwife and physician, provides unique services for which the other is not trained. However, the Federal Trade Commission, while considering nurse-practitioners and physicians’ assistants to be “physician extenders,” places nurse-midwives squarely in the category of “physician substitutes,” clearly recognizing the fact that midwives and physicians are in economic competition for the opportunity to care for the normal parturient woman.

Rothman, Childbirth Management and Medical Monopoly: Midwifery as (Almost) a Profession, 29 J. NURSE-MIDWIFERY 300 (1984). Rothman maintains that “demedicalization” may be the way to establish midwifery as a profession, noting that two hallmarks of a profession are control of the workplace and the development of a body of knowledge with the potential of training others in its use. Nurse-midwives, she observes, have sought power by “upgrading” the profession, notably by extending educational requirements. But no matter how much the midwife models herself on the surgeon, no matter how many of his techniques she masters, she has not changed the fundamental balance of power. The only route to professional autonomy for midwives is the demedicalization of childbirth, and as the social-power factors remain essentially what they were in the 1700s, demedicalization might not be possible.

B. ROTHMAN, supra note 10, at 76-77.

Rooks, The Context of Nurse-Midwifery in the 1980s, J. NURSE-MIDWIFERY, Sept./Oct. 1983, at 3, 4. One state has codified the attitude that midwifery is legal for the poor but not the affluent. In 1983, the Arkansas legislature passed a law permitting the practice of lay midwifery in counties where 32.5% of the population or more is living at or below the poverty level. Six counties qualified. The Attorney General is looking at the constitutionality of the Act, and the state's lay midwives have filed a class action suit.

W. LAZARUS, I FTC REPORT, supra note 72.

Competition between lay midwives and physicians tends to manifest itself in the form of stepped-up enforcement of laws prohibiting the practice of medicine without a license and in criminal prosecutions for poor results. In California, the practice of lay midwifery is legal only for those licensed prior to 1949. Since most lay midwives are, therefore, not licensed, the prosecution of lay midwives has been pursued with considerable vigor since the early 1970s, when the demand for midwifery services among the middle class began to grow. See, e.g., S. ARMS, supra note 13, at 220-27 (describing the prosecution of Norman Casserly, a midwife who had been practicing in San Diego County for 25 years and who was convicted of practicing medicine without a license for using a blood pressure cuff); Bowland v. Municipal Court, 18 Cal. 3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976) (prosecution of a group of practicing midwives in Santa Cruz County after entrapment by an undercover agent of the California Department of Consumer Affairs); Hunter, Mothers and Outlaws, NEW WEST, Dec. 22, 1980, at 61 (midwife prosecuted for murder and exonerated of any wrongdoing after infant delivered at home could not be resuscitated); M. EDWARDS & M. WALDORF, supra note 7, at 167-68 (prosecution of Marianne Doshi for murder of an infant delivered at home. After the acquittal, Judge Richard Kilpatrick publicly denounced the medical profession's role in promoting such prosecutions). For legal commentaries on these cases and the issues they raise, see Tachersa, A "Birth Right": Home Births, Midwives, and the Right to Privacy, 12 PAC. L.J.
As a result of the complex historical, economic, political, and social factors that have been discussed, powerful institutional obstacles to the practice of nurse-midwifery have been erected. So persistent are these barriers that legislative enactments encouraging the practice of midwifery have been largely ineffective in promoting the full utilization and integration of these practitioners into the health care delivery system.

Thus, other legal means are needed to assist in removing these barriers to practice. The remainder of this Article will discuss in detail two of the most pervasive obstacles to practice. It will then analyze the ways in which various legal theories may be of assistance both to physicians who must protect themselves from increased malpractice exposure and to nurse-midwives who wish to expand the scope of their practices.

III. OBSTACLES TO PRACTICE

A. Obstacles Interfering with Access to Physician Backup

The nurse-midwife is dependent upon a clearly defined relationship with a physician in order to practice. Accordingly, physicians have been able to pose a formidable obstacle by refusing to enter into such agreements. This barrier is of two distinct origins. First, it is a reaction to


82 These obstacles have a somewhat different impact on lay midwives who practice in those states where lay midwifery is not legalized. Lay midwives who practice extra-legally face all of the same obstacles, but in absolute form: they are simply not eligible for institutional benefits such as hospital privileges, third-party reimbursement, and malpractice insurance. Physician backup may not be available on a formalized basis. However, once the practice is licensed, lay midwives find themselves facing exactly the same difficulties that nurse-midwives face. Sullivan & Weitz, Obstacles to the Practice of Licensed Lay Midwifery, 19 SOC. SCI. MED. 1189 (1984). Since judicial means are only available to address obstacles to practice confronted by licensed practitioners, the term “nurse-midwife” will be used. However, the term, and the discussion, should be understood to encompass lay midwives who practice in those states in which the practice of lay midwifery is licensed.

83 Although a thorough discussion is beyond the scope of this Article, reimbursement policies also pose a barrier to the integration of nurse-midwives into the health care delivery system. In order to develop entrepreneurial practice styles, nurse-midwives are demanding, with some success, direct third-party reimbursement. Federal law mandating reimbursement of nurse-midwives through state Medicaid programs was passed in 1980, and at least 29 states are now in compliance. Cohn, supra note 46, at 61. Government insurance plans for federal employees and military dependents may also cover nurse-midwifery services. Id. at 62. Fourteen states require private insurers to pay for the services of nurse-midwives, and in most other states, a significant number of private insurers voluntarily reimburse nurse-midwives. Id. at 61. In only five jurisdictions are there no private insurers that reimburse nurse-midwives directly, although in three of these, nurse-midwives can be reimbursed indirectly through a physician. Id. at 62.

84 Physicians are the only health care providers with unlimited licensure. The scope of practice of other providers is defined in terms of limitations on practice that maintain a dependence on physicians. Although the full impact of this scheme of professional licensure is not within the scope of this Article, the interested reader is referred to: W. Lazarus, 1 FTC REPORT, supra note 72, ch. III; Watchorn, Midwifery: A History of Statutory Suppression, 9 GOLDEN GATE U.L. REV. 631 (1978-79); Note, Restrictions on Unorthodox Health Treatment in California: A Legal and Economic Analysis, 24 UCLA L. REV. 647 (1977); Solares, Midwifery Licensing:
the threat of physicians who impose harsh sanctions on their colleagues
who agree to enter collaborative relationships with nurse-midwives. Sec-
ond, it is the result of physicians’ reluctance to expose themselves to vic-
arious liability.\textsuperscript{85}

1. The Problem of Professional Ostracism

Some physicians who have chosen to affiliate with nurse-midwives
or other alternative practitioners have been “blackballed” and excluded
from the informal physician referral network, which is the most impor-
tant source of patients, particularly for specialists. Other physicians have
lost their hospital privileges and/or malpractice insurance as a result of
agreeing to provide backup for nurse-midwives.\textsuperscript{86}

Physicians typically acquiesce to informal sanctions imposed to dis-
courage collaborative practice with nurse-midwives. Since a physician’s
financial and professional interests dictate that he remain closely allied

\textit{Pitfalls, Problems, and Alternatives to Licensing, in 2 COMPULSORY HOSPITALIZATION, supra
note 6, at 399; Dolan, The Law and the Maverick Health Practitioner, 26 ST. LOUIS U.L.J. 627
on the Arizona bar’s licensing scheme).}

\textsuperscript{85} See infra notes 135-256 and accompanying text.

\textsuperscript{86} In the words of one physician who was subjected to most of these tactics:

The pressure was overwhelming. Without any overt physician support, lack of mal-
practice insurance, statements by physicians that they would ruin me, lack of referrals,
silent treatment at meetings, removal of favorable policies and procedures, and fear of
physical, as well as further emotional harm, I felt that I was unable to function effec-
tively as a husband and father let alone physician to my patients.

Testimony of Dr. Darrell Martin, \textit{Nurse Midwifery: Consumers’ Freedom of Choice, Hearing
Before the Subcommittee on Oversight and Investigations of the House Committee on Interstate
and Foreign Commerce, 96th Cong., 2d Sess., Serial No. 96-236 (Dec. 18, 1980), at 44 [herein-
after Freedom of Choice Hearing]. Dr. Martin's experiences were part of the series of events
that gave rise to Nurse Midwifery Assocs. v. Hibbett (see infra notes 267-78 and accompany-
ing text).

Locally, the following testimony was given by Carol Barickman, CNM, a nurse-midwife
practicing in Sonoma County, California and a Vice-Chairperson of a Northern California
Chapter of the American College of Nurse-Midwives:

I have encountered many barriers and obstacles in my work, but none is so ubiquitous
or threatening as the problems posed by the physician-owned medical malpractice
insurance companies. Some six months after starting a midwifery service with two
CNM partners, I heard the first story of physician malpractice insurance being denied
to an M.D. working with a CNM who was not an employee of the M.D. We began in
November of 1983 by signing a practice agreement with four ob/gyn physicians for
medical consultation around the clock and applied for hospital privileges. By January
of 1984, we had admitting privileges and our first birth. In February, the physicians’
malpractice insurance carrier asked for clarification of the MD-CNM relationship and
stated their intention to raise each physician’s premium $12,000, or $4000 per CNM.
Over the course of the next twelve months, we struggled with our physician consultants
and our lawyer to draft a practice agreement acceptable to the insurance company and
ourselves. No negotiation was possible. In February of this year the insurance com-
pany informed the physicians, in writing, that unless they severed their relationship
with the CNMs by March 1, 1985, they would no longer have any malpractice
coverage.

California Office of Statewide Health Planning and Development: Hearings on the Alternative
Birthing Methods Study (Oct. 1985) (testimony of Carol Barickman, CNM) (notes on file with
author) [hereinafter ABM Study (Oct. 1985)].
with his fellow physicians, there is little incentive for him to resist such manipulation. Moreover, physicians who have sought legal redress for informal sanctions imposed by colleagues in other circumstances have met with little success due to problems of proof and judicial reluctance to intervene.\(^8\)

Nevertheless, there is evidence of some judicial pressure in opposition to tactics designed to prevent physicians from associating with non-physician health care providers. In *Feminist Women's Health Center (FWHC) v. Mohammad*,\(^8\) a woman-controlled outpatient abortion clinic employed a local obstetrician/gynecologist (ob/gyn) to perform first trimester abortions. Under pressure from his colleagues, the doctor resigned when a newspaper article favorably compared the price of abortion at the FWHC with the price of abortions attended by private physicians.\(^9\)

The ob/gyn staff of Tallahassee Memorial Hospital, composed of virtually all of the ob/gyns in town, then initiated a letter through the local medical society urging physicians not to associate with the FWHC so long as it advertised.\(^9\) Unable to hire another local physician, the FWHC was forced to employ two resident physicians from Jacksonville, over 100 miles away. Nor were local physicians willing to provide emergency aftercare. When FWHC contacted a local ob/gyn who had previously been affiliated with them and requested him to provide aftercare, he refused “for fear of incurring the animosity of his fellow obstetricians whose good will [was] essential to his practice.”\(^9\)

Having successfully foreclosed the possibility of the FWHC obtaining local follow-up, one of the Tallahassee physicians sent a letter to the Florida Board of Medical Examiners stating that the FWHC was performing office surgery with inadequate aftercare. A similar letter was sent to the director of the Jacksonville residency program, informing him that the FWHC was falling below community medical standards. Intimating that providing services for the FWHC would injure the future careers of the two Jacksonville residents, the Tallahassee physicians were

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\(^8\) See, e.g., McElhinney v. Medical Protective Co., 549 F. Supp. 121 (E.D. Ky. 1982), *remanded without op.*, 738 F.2d 439 (6th Cir. 1984) (termination of staff privileges, attempt to have license revoked, and removal from referral list resulting in a drastic decrease in surgery referrals over a period of years did not rise to the level of group boycott); Ascherman v. San Francisco Medical Soc'y, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974) (insufficient evidence that defendants conspired to injure plaintiff professionally when several hospitals terminated plaintiff's privileges, the insurance company refused to insure him, and the medical society took him off of their referral list).

eventually able to procure their resignations.\footnote{A member of the obstetrical staff at the hospital apparently told a Jacksonville physician that the real problem with the clinic was the adverse impact it was having on his income and practice. However, he masked his concern to others with ethical and quality-of-care language.} Left without a physician and with little possibility of hiring a replacement, the FWHC filed an action against selected members of the ob/gyn staff of the hospital charging them with violating the Sherman Act. None of the physicians who were subjected to the sanctions of their colleagues joined.\footnote{What is interesting [about the facts in FWHC] is that very little formal action was required to deter physician cooperation. This is partly a product of two phenomena: physicians know from history how relentless the pursuit of dissenting physicians can be, and the informal network of arrangements which facilitates a physician's practice relies heavily on his "acceptance" by the local provider community.}

The district court granted the defendants' motion for summary judgment, and the FWHC appealed.\footnote{Id.} The appellate court rejected proffered defenses to antitrust liability and held that there were triable issues of fact as to whether the defendants' conduct violated the Sherman Act.\footnote{Id. at 553.} Moreover, the court did not rule out the possible application of the per se rule, which strengthened considerably the FWHC's possibility of success on the merits. On that note, the case was settled.\footnote{Id. at 1192. The McCarran-Ferguson Act exempts the "business of insurance" from antitrust scrutiny if certain criteria are met.}

Similar issues are being litigated in \textit{Nurse Midwifery Associates v. Hibbett}.\footnote{State Volunteer Mutual Insurance Company, Proposed Consent Agreement With Analysis to Aid Public Comment, 48 Fed. Reg. 27,089 (1983) (to be codified at 16 C.F.R. pt. 13).} In that case, the defendant physician, Dr. Hibbett, was a member of one of the hospital committees that denied hospital privileges to two nurse-midwives. Subsequently, Dr. Hibbett was appointed to the board of a physician-owned insurance company that allegedly controlled over eighty percent of the malpractice insurance market in Tennessee. When the midwives' backup physician, Dr. Martin, sought renewal of his malpractice policy from the physician-owned company, coverage was denied. The midwives and the physician sued. Although the case has not yet been tried, the district court has ruled that the defendants are not exempt from antitrust liability under the McCarran-Ferguson Act.\footnote{Id.} Moreover, the Federal Trade Commission was able to negotiate a consent decree in which the insurer agreed to refrain from retaliatory cancellation of physician malpractice insurance in the future.\footnote{Id. at 547. The per se rule would have given the plaintiff a distinct advantage at trial. Under § 1 of the Sherman Antitrust Act, certain violations have been held to be illegal per se. Once the plaintiff has proven the elements of the violation, the court will not consider affirmative defenses asserted by the defendants. United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 218 (1940); Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 351 (1982).}
2. The Problem of Vicarious Liability

a. The Effect of the Malpractice Situation

The powerful threat of vicarious liability is intensified by the continuing "malpractice crisis" that began in the late 1970s. Although the absolute number of malpractice suits filed against physicians has risen steadily since World War II, it was not until the early '70s that the dramatic increase in the number of suits filed and the size of the verdicts began to greatly influence the cost of malpractice insurance. By 1974, suits were pending against one out of every ten physicians. In 1969, juries awarded over $300,000 in only three cases; by 1974 there were thirty-four such awards. From 1974 to 1977, malpractice premiums almost doubled nationwide, and in some areas of the country, malpractice insurance became a scarce commodity.

Commentators have identified several factors that contributed to the development of the malpractice crisis. Some factors are related to the rise of the hospital as the center of a complex health care delivery system, including advancing medical technology with its inherent risks, increasing physician specialization, and the shifting locus of care from office or home to the hospital. These trends have resulted in greater opportunity for maloccurrences, as well as a deterioration in the physician-patient relationship. Other factors contributing to the crisis include the growing consumer movement and the interest of the media in medicine and its advances. While these factors have led to a more informed public, on the one hand, they have promoted the development

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100 The "malpractice crisis" is essentially a crisis in the availability and cost of liability insurance. Although physicians were the first group to feel the impact of the "crisis," the unavailability of insurance, either because insurance companies no longer choose to insure particular risks or because the cost of available insurance is prohibitive, is now in evidence industry-wide in the liability insurance field. Recent news reports have detailed the loss of liability insurance by cities and recreational facilities, such as skating rinks and parks, as well as the loss of medical insurance coverage by potential victims of AIDS. See, e.g., Hoffman & Shearer, Cities Face Liability Insurance Crisis, Contra Costa Sun, Jan. 22, 1986, at 1, col. 1-5; Ragsdale, Gays Face Loss of Coverage: Insurance Firms Accused of Redlining Areas, Groups, San Francisco Examiner, Jan. 19, 1986, at D-1, col. 1; Adams, Citizens' Action Group Targets Insurance Industry, Berkeley Tri-City Post, Jan. 8, 1986, at 3, col. 1-5; Hoffman, Orinda Sets Up Reserve for Liability Insurance, Contra Costa Times, Dec. 18, 1985, at 1, col. 1-6; Tort's Gone Wild, San Francisco Chron., Dec. 1, 1985, at Sunday Punch 1, col. 2-3.


102 Id. at 1338 n.9.

103 A. Murray, The Medical Malpractice Situation in California 8 (Sept. 1986) (Health Policy Program Discussion Paper, University of California School of Medicine, San Francisco, California).


105 A. Murray, supra note 103, at 1.

106 Annas, supra note 101, at 1336-37 n.8.

of unrealistic expectations of the medical profession, on the other.\textsuperscript{108}

As another source of the malpractice crisis, other commentators cite the failure of hospitals and the medical profession to prevent untoward incidents and discipline the ranks.\textsuperscript{109} Confronted with cases involving serious injuries or death, sometimes with evidence of outrageous negligence, the legal system and the courts have taken on the dual role of disciplining physicians and compensating patients.\textsuperscript{110} These efforts have eased the way to recovery through procedural and doctrinal means, such as shortening the locality rule,\textsuperscript{111} employing res ipsa loquitur,\textsuperscript{112} applying lengthy statutes of limitations,\textsuperscript{113} and shifting to the "reasonable patient"

\begin{itemize}
  \item \textsuperscript{108} Annas, supra note 101, at 1336-37 n.8.
  \item \textsuperscript{111} The locality rule governs the admissibility of expert witness testimony in medical malpractice cases. Under this rule, an expert witness must be able to attest to the standard of practice in the local community where the defendant practices. The effect of this rule is to limit the pool of expert witnesses to those in the defendant's community. Since professional colleagues who must live and work in the same community are frequently reluctant to testify against one another, the rule further limits the availability of expert witness testimony. According to Law and Polan, "The erosion of the locality rule has probably had a greater impact on the increase in malpractice claims in recent years than any other change in the law." S. Law & S. Polan, supra note 109, at 100. Applying a regional or national standard of practice thus makes it easier for plaintiffs to get expert witnesses to testify on their behalf.
  \item \textsuperscript{112} The degree to which this doctrine has affected the malpractice situation is equivocal. It was utilized in fewer than 15% of the medical malpractice cases that reached the appellate level. Annas, supra note 101, at 1340. However, another study determined that the plaintiff had a 50% higher chance of winning after invoking the rule of res ipsa loquitur. Study Challenges Assumptions About Medical Malpractice, CAL. L.R., Feb. 1983, at 18, 42 [hereinafter Assumptions About Malpractice].
  \item \textsuperscript{113} Statutes of limitations that allow plaintiffs to file claims many years after an injury has occurred hamper the insurance industry's ability to predict claims volume and potential loss. Formerly, it was common practice for malpractice insurers to provide coverage on an "occurrence basis," meaning that a doctor insured in any given year would remain covered indefinitely for future claims that occurred in that policy year. More recently, however, insurance companies may provide insurance on a "claims made" basis, covering the policy holder only for claims filed during the policy year for which a premium is paid. Physicians who desire to
standard of informed consent. 114 Juries have demonstrated their sympathies for victims of medical injuries by awarding seemingly large recoveries. Furthermore, the plaintiff’s bar has marshalled a swelling cadre of malpractice litigators 115 ready to provide legal services on a contingent fee basis, 116 thus making litigation a possibility for a wide range of possible plaintiffs.

In the mid-70s, fearful that the malpractice crisis would limit the availability of medical services and dramatically increase costs, every state passed legislation designed to control the crisis. 117 Generally, legislation was directed toward accomplishing some or all of the following goals: limiting provider payments to plaintiffs; limiting the use of res ipsa loquitur; tightening the statute of limitations; clarifying the doctrine of informed consent; imposing contingent fee regulation; adding collateral

cover the “long tail” of future claims can do so by purchasing additional coverage. Again, it is difficult to evaluate how significant the impact of a lengthy limitations period actually is. There is evidence suggesting that claims filed five years after the injury result in recoveries that are more than twice as large as the average award. Sloan, supra note 104, at 634. However, there are also data that show that 73% of all claims are filed within three years, and that fewer than two percent of all claims are filed after five years. East Bay Perinatal Council Symposium on Medical Malpractice Crisis (May 17, 1985) (notes on file with author). The vast majority of claims are reported and settled within two years after the occurrence. S. LAW & S. POLAN, supra note 109, at 121.

114 “The shift of a few states to the ‘reasonable patient’ informed consent standard, despite its great conceptual importance, has had almost no practical effect on either the volume or the outcome of malpractice cases.” S. LAW & S. POLAN, supra note 109, at 112.

115 One researcher who conducted a detailed analysis of the incidence of malpractice claims and their relationship to various legal factors, concluded that “the notion that a 10% increase in a state’s lawyer/population ratio leads to almost a like percentage increase in premiums is a distinct possibility.” Sloan, supra note 104, at 643.

116 The effect of the contingent fee system is one of the most hotly debated issues involved in the malpractice crisis. On the one hand, it is argued that the contingent fee system encourages the filing of claims by making counsel available to lower- and middle-class patients who would not have access to such services on an hourly payment schedule. Attorneys, however, point out that there is a disincentive for them to accept malpractice cases that they do not have a reasonable chance of winning or in which the amount at stake is not significant. See, e.g., Annas, supra note 101, at 14; S. LAW & S. POLAN, supra note 109, at 82-86. While this argument may be valid, it fails to address the degree to which plaintiffs’ attorneys may be willing to trade on the cost of defending a suit in court to induce settlement of a case that they would not really wish to try. One recent study suggests that this may be a factor. Researchers at Stanford’s Hoover Institution found that “resolution of these cases appears to follow a very rational pattern, based on tenets of the law. The deviation can be explained by the costs of going to court . . . .” Assumptions About Malpractice, supra note 112, at 68 (emphasis added).

While there are no studies quantifying the number of “nuisance claims” that are settled, in one study insurance experts found that 46% of randomly selected claims were “legally meritorious in terms of liability.” S. LAW & S. POLAN, supra note 109, at 83. The Stanford study concluded that “The fact that half of all claims are dropped with no payment clearly refutes the popular belief that insurance companies stand ready to pay out money freely to be rid of small claims, including unfounded ‘nuisance’ claims.” Assumptions About Malpractice, supra note 112, at 72. St. Paul Fire and Marine Insurance Company, one of the largest malpractice insurers in the country, estimates that one out of every 100 hospitalized patients could legally bring a negligence action against their medical-care provider. Less than 10% of that number actually do. Sommers, supra note 107, at 1. Of the claims that are brought, only 10% actually proceed to verdict. Assumptions About Malpractice, supra note 112, at 68. Of that 10%, verdict is entered for the physician in 75% of the cases that go to the jury. S. LAW & S. POLAN, supra note 109, at 83.

117 A. TOBIAS, supra note 110, at 26.
source provisions; eliminating *ad damnum* clauses; and imposing a locality rule.

Many states also passed legislation providing for mandatory pretrial screening panels, establishing mechanisms for binding arbitration, creating joint underwriting associations, allowing the formation of health care mutual insurance companies, and strengthening provisions for physician discipline. In California, as well as in other states, the lack of affordable malpractice insurance spawned several physician-owned insurance companies.

Data as to the effectiveness of these various measures in quelling the malpractice crisis are equivocal. However, there is evidence to support the conclusion that none of the responses to the malpractice crisis, including the formation of physician-owned insurance companies, had

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118 See generally Sloan, supra note 104, at 629; Annas, supra note 101, at 1340-43; S. LAW & S. POLAN, supra note 109, at 195-205. California's response to the malpractice crisis included the passage of the Medical Injury Compensation Reform Act (MICRA), 1975 Cal. Stat. 2d Ex. Sess., ch. 1, § 1, which provided for enhanced professional discipline; tort reforms, such as abrogation of the collateral source rule, limitations on contingency fee contracts, restrictions on the amount of recovery for pain and suffering, provision for periodic payments on a judgment; modification of the statute of limitations; and creation of joint underwriting associations. The provision for joint underwriting associations was never activated, however, and was repealed in 1980.

Since 1975, the constitutionality of several of the provisions of MICRA has been challenged and upheld by the California Supreme Court. See American Bank & Trust Co. v. Community Hosp. of Los Gatos-Saratoga, Inc., 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr. 671 (1984) (upholding the constitutionality of CAL. CIV. PROC. CODE § 667.7, permitting health care providers who incur judgments of $50,000 or more to pay the judgment through a court-determined plan of periodic payments); Barne v. Wood, 37 Cal. 3d 174, 689 P.2d 446, 207 Cal. Rptr. 816 (1984) (upholding CAL. CIV. CODE § 3333.1(b), denying a collateral source a right of subrogation against the defendant for benefits paid); Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985) (upholding CAL. CIV. CODE § 3333.1(a), providing that payments made by a collateral source be deducted from the recovery in a malpractice action, and § 3333.2, providing that recovery for noneconomic losses be limited to $250,000); Rao v. Lodi Medical Group, 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (1985) (upholding CAL. BUS. & PROF. CODE § 6146, limiting contingent fees to 40% of the first $50,000, 33-1/3% of the next $50,000, 25% of the next $100,000, and 10% of any recovery over $200,000).

119 A. Murray, supra note 103, at 14-18. Several commercial insurers remain in the market, but to a limited degree. Id. at 18. Medical Insurance Exchange of California (MEIC) and Norcal Mutual Insurance Company (Norcal) are both physician-owned and are currently the primary insurers in Northern California. Doctors' Company, located in Santa Monica, also insures some Northern California physicians. Physician-owned companies are now servicing approximately 60% of the malpractice insurance market nationwide. In California, there are virtually no other malpractice insurance options, since most commercial companies have withdrawn from the market, although they may continue to insure clients who antedated their withdrawal. Testimony of Bob Smith, M.D., American College of Obstetricians and Gynecologists, ABM Study (Oct. 1985), supra note 86.

120 See, e.g., Sloan, supra note 104, at 1 ("The empirical results of the study presented here [empirical analysis of state responses to the malpractice crisis] give no indication that individual state legislative actions, or any such actions taken collectively, had their intended effect on premiums."); Note, Proposed Legislation: Amend MICRA to Include Mandatory Mediation of Medical Malpractice Claims, 14 U.S.F.L. REV. 439, 441, 459 (1980). But see, Assumptions About Malpractice, supra note 112, at 68 (suggesting that tort law reforms have had an effect on the increasing incidence of claims: "Such reforms resulted in an average reduction in trial awards of 30%, a reduction in the average settlement of 25%, a reduction in the share of cases going to verdict from 5.1% to 4.6%, and an increase in dropped cases from 43% to 48%.").
the desired effect on malpractice insurance premiums. Premiums increased by more than eighty percent between 1975 and 1983, reaching as high as $80,000 to $100,000 a year for some physicians practicing high-risk specialties in states such as New York, Illinois, Florida, and California. In California, most ob/gyns paid between $25,000 and $35,000 for malpractice coverage in 1985, and an increase of twenty percent was projected for 1986.

Thus, the effects of the malpractice crisis continue to permeate the practice of medicine. The fear of being sued has an impact on the forms of treatment rendered, the cost of medical care, and the distribution and utilization of health resources. An atmosphere of suspiciousness and distrust prevails between professionals and consumers, as well as between health care providers from different disciplines.

The continuing malpractice crisis affects nurse-midwives in two ways: by making malpractice insurance unavailable to them directly,

121 Hirsh, Malpractice Crisis of the ’80s: Part I—The Editor Muses, 13 LEGAL ASPECTS MED. PRAC., Oct. 1985, at 5, 8; address by Michael McGlynn, M.D., East Bay Perinatal Council Symposium on the Medical Malpractice Crisis (May 17, 1985) (notes on file with author).

122 McGlynn, supra note 121.

123 Fear of malpractice affects the cost of medical care by inducing physicians and other practitioners to practice “defensive medicine.” Defensive medicine has been defined as “the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted.” A. Murray, supra note 103, at 37 (quoting DEP’T HEW, PUB. NO. OS 73-88, REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE (1973). The AMA abhors defensive medicine and estimates that defensive medicine and defensive administrative costs total $15.1 billion annually. Hirsh, supra note 121, at 8. An opinion survey reported by HEW indicated that between 50% and 70% of physicians have engaged in various forms of defensive medicine. A. Murray, supra note 103, at 38. Other critics and commentators are not convinced that so-called defensive medicine is not merely a warranted heightened standard of care or a justifiable cost for imposing physician discipline by means of tort liability:

[T]hose studies which have been done, although all in the emergency ward setting, indicate that based on professional standards too few, rather than too many, diagnostic tests are being performed. . . . [W]e do know that much that poses as “defensive medicine,” such as appropriate expert consultations and the keeping of better medical records, is in fact improved health care. The fact that it has been imposed by the tort system is an advantage rather than a disadvantage of the present system. Moreover, its existence demonstrates the ability of the present tort system to change physician behavior, something no other measure, such as continuing education or licensing examinations, has been able to accomplish.

Annas, supra note 101, at 1346. Suffice it to say that the extent to which defensive medicine affects the cost and the quality of care, and in what ways, remains unclear.

124 For a description of the relationship between maldistribution and malpractice, see S. LAW & S. POLAN, supra note 109, at 11-27.

125 Until very recently, approximately 80% of the 1600 members of ACNM practicing nationwide obtained their primary malpractice coverage through a group plan offered by the professional organization. Through 1982, the cost for one million dollars’ coverage was $38 per year. At the end of 1982, this policy was cancelled, not because the absolute number of claims against nurse-midwives was rising, but because the dollar amount paid out per claim had increased thirty-five fold. Another underwriter assumed the policy at a cost of $225 per member. This policy was cancelled at the end of one year when the insurer decided to leave the market, and once again, the ACNM went in search of an underwriter. At the last minute, Mutual Fire and Marine Inland Insurance Company agreed to provide a policy at rates based on the number of deliveries per year. This pricing method resulted in rate increases of 300% to 600% for individual CNMs. As of July 1, 1985, this policy was also cancelled. Although
and by making physician backup difficult to obtain. Physicians who provide backup to nurse-midwives who are not their employees may not be able to get insurance to cover their potential vicarious liability. Even if such coverage is available, the cost may be prohibitive. Additionally, in California, physicians who knowingly backup nurse-midwives who perform home births can get no malpractice insurance at all.

Compounding the problem of insurance unavailability is physicians' fear of vicarious liability, especially in situations where the parameters of such liability have not been clearly established. Physicians understandably find the malpractice threat onerous. Malpractice "carries with it . . . connotations of moral turpitude and near-criminal neglect." Malpractice based on vicarious liability is doubly onerous because, from the point

the ACNM plans to form its own insurance company, the projected cost of $4000 to $10,000 per year will effectively put many nurse-midwives out of business. Thus, the present and future availability of affordable malpractice coverage for nurse-midwives remains precarious at best. ABM Study (Oct. 1985), supra note 86 (testimony of Susan DeJoy, Chairperson, ACNM, Southern California Chapter, and Elaine Germano, Consortium for Nurse Midwifery, Inc.).

Less than five percent of nurse-midwives have ever been named in a malpractice suit, compared with 60% of ob/gyns nationwide and 70% in California. ABM Study (Oct. 1985), supra note 86 (testimony of Susan DeJoy, Chairperson, ACNM Southern California Chapter). Specific reasons cited for the difficulty in obtaining coverage for CNMs include: (1) unavailability of reinsurance; (2) dearth of information about the claims history of CNMs, since CNMs have been pooled separately for only three years; (3) the small number of practicing CNMs, which cannot generate a sufficiently large pool to cover losses; (4) lack of insurer knowledge about CNM practice; (5) deliberate restraint of trade. See ABM Study (Oct. 1985), supra note 86 (testimony of Susan DeJoy, Chairperson, ACNM Southern California Chapter, and John Dorsey, President, American Insurance Services). See also Cohn, The Nurse Midwife: Malpractice and Risk Management, 29 J. NURSE-MIDWIFERY 316 (1984).

As John Dorsey pointed out, the insurance industry will insure ob/gyns for two reasons: (1) because of their longstanding relationship with physicians, and (2) because of the political clout of physicians. Nurse-midwives can rely on neither of these to assist them in their attempt to solve the unavailability problem. ABM Study (Oct. 1985), supra note 86 (testimony of John Dorsey, President, American Insurance Services).

See ABM Study (Oct. 1985), supra note 86. California physician-owned companies provide coverage for the vicarious liability of physicians practicing in collaboration with nurse-midwives on the following basis: no physician-owned company provides liability for CNMs directly. All companies will insure for the vicarious liability of the physician only. Norcal will insure a physician for vicarious liability only if the CNM is an employee of the physician. The charge for such coverage in 1985 was $6580 for each CNM employed. MEIC will insure physicians who provide backup for CNMs who practice independently on a "case-by-case" basis. The physician is surcharged 10% of his premium for such coverage. (Originally, the company wanted a surcharge of 40%, but backed down under pressure from the Federal Trade Commission.) If the nurse-midwife is the employee of the physician, there is no surcharge. Doctors' Company purportedly will insure physicians who backup nurse-midwives, but, in reality, the policy exclusions make the coverage impracticable, since the policy does not cover any services not under the direct physical supervision and control of the physician. Interview with Doug Cardinal, Graduate Assistant, Office of Statewide Health Planning, and Claire Westdahl, CNM, former director of proposed Childbearing Center, Alta Bates Hospital, Berkeley, Cal. (June 1985) (notes on file with author).

Many physicians expect the nurse-midwife to pick up the tab for the physician's additional insurance coverage. Since nurse-midwives typically earn between $20,000 and $25,000 per year, additional insurance costs of $2000-9000 are prohibitive.

Interview with Debora LeVeen, Office of Statewide Health Planning, Alternative Birthing Methods Study Committee Member (June 30, 1985) (notes on file with author).

Note, Tort Liability and the California Health Care Assistant, 45 S. CAL. L. REV. 768, 780 (1972).
of view of physicians, they are being punished for someone else's mistakes under circumstances in which the physicians were free from fault.  

Yet, physicians are the only medical practitioners who enjoy unlimited licensure. The scope of nurse-midwifery practice is defined by state licensing laws and standards of practice which require that the nurse-midwife and a collaborating physician develop specific protocols governing the midwifery practice. Without such an agreement, nurse-midwives cannot legally practice in most states.

Thus, physicians' fear of vicarious liability poses one of the most formidable obstacles to the full utilization of nurse-midwives in the delivery of health care, since decisions to employ or otherwise affiliate with nurse-midwives outside of institutional settings are entirely within physician discretion. This situation gives physicians almost complete control over the degree to which alternative forms of medical practice will be utilized and integrated into the health care delivery system. Society must then bear the costs of decreased health manpower, decreased quality of care, and a higher price tag for medical services.

Setting aside the malpractice insurance problem described above,

129 Id. at 782.

130 Forty-three jurisdictions, including California, now recognize either ACNM certification or graduation from an ACNM-accredited program as the basic credential for the practice of nurse-midwifery in that jurisdiction. In 26 jurisdictions, evidence of a written collaboration agreement with a physician is required. Twenty-five of the remaining jurisdictions do not require evidence of a written agreement. In California, the written protocol must be available to the Board of Registered Nursing on request. In two other jurisdictions, the requirements are either uncertain or unknown. Cohn, supra note 46, at 60.

In addition to the state statutory requirements, physician collaboration is required by both the ACNM/ACOG, supra note 59, at 171, and the American College of Nurse Midwives, Functions, Standards, and Qualifications, Function 5, Standard 9 (revised and approved April 1983), 29 J. Nurse-Midwifery 170 (1984) [hereinafter ACNM, Functions, Standards, and Qualifications].

131 Attempts to define the scope of practice more broadly have met with sharp resistance. In Kansas, for example, the Nurse Practice Act was amended in 1978 to encompass four categories of advanced registered nurse practitioners of which nurse-midwives were one. When regulations written by the Board of Nursing took effect in 1981, the Kansas Medical Society immediately sued, charging that the Board of Nursing's regulations permitted advanced registered nurse practitioners to "engage in the independent practice of medicine." The District Court agreed, and the Board of Nursing was required to promulgate new regulations. Under the new regulations, which became effective in 1984, "a ... nurse-midwife shall perform in an interdependent role as a member of a physician-directed health care team, within the framework of mutually adopted protocols or guidelines." Cohn, Cuddihy, Kraus & Tom, Legislation and Nurse-Midwifery Practice in the USA, 29 J. Nurse-Midwifery 95 (1984). A similar scenario was played out in Texas. Id. at 151.

132 The same obstacle to full utilization is present in the case of other "mid-level practitioners"—nurse practitioners and physicians' assistants. According to one study, the fear of increased malpractice liability because of respondeat superior could pose a threat to the success of the physicians' assistant program in California. See Note, supra note 128, at 780-81.

133 The unavailability problem is critical, and needs judicial and legislative attention. In 1983, a California court of appeal held that insurance companies are entitled to deny policies arbitrarily so long as they don't discriminate on the basis of race, religion, national origin, sex, or marital status. Thus, insurance companies can arbitrarily deny coverage, even though it is a precondition to hospital practice. Wilkinson v. Madera Community Hosp., 144 Cal. App. 3d 436, 192 Cal. Rptr. 593 (1983). The question that remains unanswered is whether denial of
the remainder of this section will explore the parameters of the collaborating physician's vicarious liability for the malpractice of a nurse-midwife who is engaged in independent practice. "Independent practice" simply means that the nurse-midwife is in charge of the economics of her practice, and she is not, in a functional sense, an employee of the physician.

b. Respondeat Superior: A Sketch of the Legal Standard

The doctrine of respondeat superior, or vicarious liability, applies only when a master-servant relationship exists. According to the Restatement (Second) of Agency,

(1) A master is a principal who employs an agent to perform service in his affairs and who controls or has the right to control the physical conduct of the other in the performance of the service.

(2) A servant is an agent employed by a master to perform service in his affairs whose physical conduct in the performance of the service is controlled or is subject to the right to control by the master.

Hence, where a nurse-midwife is the employee of a physician, i.e., the nurse-midwife is hired to perform services for the physician as part of the physician's medical practice, and the acts complained of are performed within the scope of the nurse-midwife's employment, there is no question that the physician is liable for negligent acts of the nurse-midwife under the theory of respondeat superior.

The antithesis of a "servant" is an independent contractor. A principal is not vicariously liable for the torts of an independent contractor. According to the Restatement (Second) of Agency,
An independent contractor is a person who contracts with another to do something for him but who is not controlled by the other nor subject to the other's right to control with respect to his physical conduct in the performance of the undertaking. . . .

In many cases, it is unclear whether an employment relationship or independent contractor status exists. In such cases, the test as to whether a tortfeasor is an employee or an independent contractor involves three elements: 1) the "master" must have assented to the relationship; 2) the "master" must receive some benefit from the relationship; and 3) the "master" must retain a right of control over the specific details of the work to be performed under the contract. In most cases, the first two prongs of the test are easily satisfied, focusing the analysis, as in this case, on the element of control.

Under common law principles of agency, an employer-employee relationship exists when the employer has the legal right to exercise complete and authoritative control over all details of the work to be accomplished, whether or not such control is actually exercised. An independent contractor, on the other hand, is one who "renders service in the course of an independent employment or occupation following his employer's desires only as to the results of the work, and not as to the means whereby it is to be accomplished."

Hence, a plaintiff challenging a nurse-midwife's status as an independent contractor must show that the physician exercised, or had the right to exercise, a high degree of control over the routine activities of the nurse-midwife's practice.


The determination of employee versus independent contractor status is a factual question. See, e.g., Burlingham v. Gray, 22 Cal. 2d 87, 137 P.2d 9, 16 (1943); DeSuza v. Andersack, 63 Cal. App. 3d 694, 700, 133 Cal. Rptr. 920, 925 (1976) (existence or absence of agency is ordinarily a question of fact, triable by a jury, but where evidence is susceptible of only one inference, i.e., absence of agency, no triable issue of fact is presented); Housewright v. Pacific Far East Line, 229 Cal. App. 2d 259, 265, 40 Cal. Rptr. 208, 211 (1964); Stanhope v. Los Angeles College of Chiropractic, 54 Cal. App. 2d 141, 146, 128 P.2d 705, 708 (1942).


See, e.g., May v. Broun, 261 Or. 28, 492 P.2d 776 (1972) (respondent superior did not attach to a physician who did not have direct control over machine or its operation).


McDonald v. Shell Oil Co., 44 Cal. 2d 785, 788, 285 P.2d 902, 903 (1955) (citing Moody v. Industrial Accident Comm'n, 204 Cal. 668, 670, 269 P. 542 (1928) and S.A. Gerrard Co. v. Industrial Accident Comm'n, 17 Cal. 2d 411, 413, 110 P.2d 377 (1936)).
c. A Paradigm of Independent Nurse-Midwifery Practice

Whether vicarious liability should be imposed on a physician who enters a collaborative agreement with an independently practicing nurse-midwife is an issue that is complicated by unique situational elements. To help clarify these situational factors, some of the analysis hereafter will refer to the following hypothetical nurse-midwife/physician agreement.\(^{144}\)

Assume that a nurse-midwife maintains an independent practice in the state of California. She practices both in- and out-of-hospital, and she has one backup physician for her home birth practice and another for her hospital practice. The physician who collaborates on home births reviews each patient’s chart at predetermined, but relatively infrequent, intervals for an hourly fee paid by the nurse-midwife. He sees the patient one time during the pregnancy, and the office visit is paid for by the nurse-midwife. Either party can terminate the contract with 180-days’ notice to the other.

The physician who provides backup for hospital births is paid a flat fee of $150 for every patient the nurse-midwife delivers in the hospital. He sees the patient twice during the pregnancy as required by hospital protocol. If the physician has to be called in because of complications, he bills the patient separately. Either party can terminate the agreement with ninety days’ notice to the other.

Both physicians provide standing orders for prenatal vitamins, routine laboratory studies, and the like, and agree to be available to the nurse-midwife for unlimited consultation. The nurse-midwife is obligated to consult with the backup physician any time a woman’s condition departs from “normal.”

Some collaboration agreements contain well-defined risk criteria carefully detailing the action to be taken under specific circumstances. Regardless of the contractual specificity, however, the seriousness of complications which may arise lies on a continuum, from those that merely threaten to develop, to those which are imminently life-threatening to both mother and infant. If the condition is not acute and is not perceived as life-threatening, the nurse-midwife remains in attendance. As the patient’s condition moves along the continuum from low-risk to high-risk, however, the role of the physician becomes more active, and in some instances, he may assume the physical care of the patient entirely.

A troublesome situational anomaly is immediately apparent from the paradigm. In the traditional role relationships, nurses perform services for doctors. Under principles of agency law, therefore, the doctor is the principal, and the nurse the agent. In the case of a nurse-midwife

\(^{144}\) The pronouns selected for this Article reflect the traditional gender dominance of the midwifery and medical professions.
and her backup physician, however, this situation is reversed: it is the nurse-midwife who contracts for the services of the physician, making the nurse-midwife the principal and the physician the agent. Thus, finding the physician vicariously liable for the acts of the nurse-midwife presents an immediate problem which would require a novel application of agency law. Such a move is not entirely without precedent, however. The Wisconsin Supreme Court, in Fehrman v. Smirl,\textsuperscript{145} acknowledged that it was applying a theory of "respondeat inferior" when it held the physician who was assisting the operating surgeon liable for the malpractice of the operating surgeon.

A court might be justified in reversing the relationship and characterizing the physician as the principal and the nurse-midwife as the agent. The fact that physicians have unlimited license to practice does, in one sense, establish their supremacy in relation to all other practitioners who are granted limited licensure. Thus, the licensing scheme itself might support the argument that the physician is in control \textit{by definition}\textsuperscript{146} and what the nurse-midwife is actually contracting for is a prescribed degree of autonomy which presumably would not exist if she were the physician's employee. By virtue of her training, licensure, and experience, she is able to contract for an attenuated degree of physical supervision and control than would otherwise be the physician-employer's right. This argument, when coupled with the traditional societal view of the "proper" role relationship of doctors to nurses\textsuperscript{147} and official language supporting such an interpretation,\textsuperscript{148} may have the effect of persuading courts that the physician is the principal and the nurse-midwife is the agent, regardless of the outward form of the relationship. Characterizing the physician as the principal will launch courts directly into inquiring whether the nurse-midwife is an "employee" or an "independent contractor" under the common law tests of control.

d. An Analysis of the Right to Control
i. Unlimited Licensure and Supervision

The model of the independent practice of nurse-midwifery does not fit neatly into either the category of "employee" or "independent con-

\textsuperscript{145} 25 Wis. 2d 645, 656, 131 N.W.2d 314, 319 (1964).

\textsuperscript{146} An example of a physician's understanding of his vicarious liability was provided by Dr. Robert Smith, Chairman of the American College of Obstetricians and Gynecologists, District IX: "Working with less skilled individuals ... leaves the practicing obstetrical specialist in a rather precarious situation because he automatically becomes the 'captain of the ship,' and the responsibility for any result legally falls on his shoulders." Testimony of Robert Smith, M.D., ABM Study (Oct. 1985), supra note 86.

\textsuperscript{147} "Community custom in thinking that a kind of service ... is rendered by servants is of importance" in deciding whether an employer-employee relationship exists. \textsc{Restatement (Second) of Agency} § 220 comment m (1958).

\textsuperscript{148} See \textit{infra} notes 150-162 and accompanying text.
tractor." Because of the physician's unlimited license to practice and the nurse-midwife's restricted licensure, the nurse-midwife, in most states, necessarily maintains a formalized relationship with a backup physician by means of standardized procedures and protocols that spell out the mutual responsibilities of each. However, the exact characterization of the relationship varies from state to state.

In some states, statutes authorizing the practice of nurse-midwifery describe the nurse-midwife/physician relationship as a collaborative one. In other states, such as California, the relationship is described in much more restrictive language, thus further complicating the issue of whether the nurse-midwife is an employee or an independent contractor.

Under California law, nurse-midwives may attend cases of "normal" childbirth "under the supervision of a licensed physician and surgeon." The statute further states that "'supervision' shall not be construed to require the physical presence of the supervising physician." Webster's New Collegiate Dictionary defines supervision as "a critical watching and directing (as of activities or a course of action)." Thus, the use of the word "supervision," along with the qualifier that the physical presence of the physician is not required, creates an immediate ambiguity in terms of the degree of control that the physician will exercise.

Although the question has not yet arisen in California, courts may eventually find it necessary to interpret the meaning of the word "supervision" in the statute in order to define the parameters of the physician's vicarious liability. California enacted two very different statutory provisions affecting expanded-practice nursing in the same year. Both of them appear to encompass the practice of nurse-midwifery. One approach to statutory interpretation might be to compare the code provisions authorizing the practice of nurse-midwifery with the code sections authorizing the practice of expanded-practice nursing generally. As discussed in detail below, an examination of these two statutory provisions leads to the conclusion that it would be irrational for courts to hold nurse-midwives to a higher standard of "supervision" than is required under state law for other registered nurses with less training.

In 1974, the California legislature enacted § 2746.5 of the Business and Professions Code authorizing the practice of nurse-midwifery and § 2725 of the Business and Professions Code, a very progressive amendment to the Nurse Practice Act, authorizing expanded-practice nursing. While the nurse-midwifery statute contains restrictive language

150 CAL. BUS. & PROF. CODE § 2746.5 (West Supp. 1986).
151 Under § 2725, questions of the appropriate level of supervision are addressed by the protocols and standardized procedures depending on the diagnostic or treatment function involved. CAL. BUS. & PROF. CODE § 2725 (West Supp. 1986).

Frustrated by the restrictive language of § 2746.5, which does not reflect the realities of
of "supervision" in its definition of the relationship between nurse-midwife and physician, the amendment to the Nurse Practice Act, by contrast, provides a facile mechanism by which physicians may delegate diagnosis and treatment functions to nurses. Because there is no distinction drawn between registered nurses without advanced preparation and more highly trained nurse-practitioners, the statute allows for a flexible, individualized determination of the scope of nursing practice and minimizes the need for periodic legislative attention to keep pace with changes in the accepted modes of practice.

It is curious that two statutes enacted in the same year dealing with very similar subject matter are so different in their approaches. A superficial reading of the two statutes seems to indicate that the legislature intended nurse-midwives to practice under closer supervision than other nurses. However, this is an illogical conclusion for two reasons. First, it is inherently illogical to impose a higher standard of supervision on nurses with advanced training than on nurses who are less well-trained. Second, nurse-midwives are apparently included in the independent practice provisions of § 2725, since there is nothing in the language of either statute to suggest an exclusion.

These observations lead to two conclusions. Most importantly, § 2725, providing for independent practice within the parameters of agreed upon protocols and standardized procedures, applies to nurse-midwives on the same terms as it applies to other nurses. Secondarily, the wording of § 2746.5 is either imprecise or anomalous when read in conjunction with § 2725, and should not be taken literally.

Published statements emanating from various professional organizations do nothing to dispel the confusion reflected in California's statutory scheme. ACNM Standards for the Practice of Nurse-Midwifery state that the practice of nurse-midwifery "occurs interdependently within a health care delivery system." The nurse-midwife must "[demonstrate] a safe mechanism for physician consultation, collaboration and referral within an alliance agreement which includes mutually approved proto-

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practice or the standards of practice that have been developed, California nurse-midwives have turned to § 2725 of the Nurse Practice Act. Nurse-midwives' reliance on § 2725 can be illustrated by the following example. In 1979, the California Attorney General opined that "A nurse-midwife, as referred to in § 2746.5 of the Business and Professions Code, may not perform episiotomies or administer local anesthesia under the direction of her physician employer during cases of normal childbirth." 62 Op. Cal. Att'y Gen. 225 (1979). Nurse-midwives have taken refuge in the "standardized procedures" provision of the Nurse Practice Act and have developed standardized procedures that allow them to perform and repair some episiotomies during normal childbirth.

The only interpretive opinion with respect to § 2725 of the Nurse Practice Act was issued in 1981, in which the Attorney General opined that "A Registered Nurse may not prescribe, furnish, or administer drugs or medications under a 'standardized procedure.'" 64 Op. Cal. Att'y Gen. 240, 241 (1981).

152 ACNM, Functions, Standards, and Qualifications, supra note 130, Standard 8.
The ACNM/ACOG Joint Practice Agreement calls for "mutually agreed-upon" written medical guidelines/protocols for clinical practice which define the individual and shared responsibilities of the certified nurse-midwife and the obstetrician/gynecologist in the delivery of health care services."

"Collaboration," according to Webster's, means "to work jointly with others, especially in an intellectual endeavor." "Consultation" means "to deliberate together." While "supervision" implies a hierarchical relationship between the parties, "collaboration" implies a horizontal or joint effort between professionals of comparable status.

Although the standards of practice suggest a significant degree of functional autonomy backed by a collaborative relationship, ACOG officials have hastened to emphasize that the physician remains very much in control.

It is important that "complete management of the uncomplicated pregnant woman" [the scope of nurse-midwifery practice] not be confused with independent management or final authority for directing the health care team. "Management" is the daily, continuing attention to protocols of maternal health care, with independent judgments limited to selection from among approved alternatives. The making of medical decisions which extend beyond set protocols for management of care requires the training and expertise of a physician. It is therefore not acceptable to permit the practice of nurse-midwifery... without the direction and collaboration of a physician.

Let us define specifically what we mean by "direction."... A directed relationship exists between the physician and non-physician... when the physician manages and is responsible for a patient's care and as long as the prescribed care or therapy continues under the physician's direction...

The physician is responsible for the patient. [Physicians and expanded-role nurses] should collaborate in the development of protocols to be followed in the course of patient care, and physicians must exercise appropriate direction as they carry out their supervisory role...

The ACOG cannot accept a recent draft statement by the ACNM that describes nurse-midwifery practice as "the independent management of care" of essentially normal newborns and women.

The Joint Commission on Accreditation of Hospitals (JCAH), a physician-controlled agency, has also adopted a "dependent model" of nurse-midwifery practice for purposes of hospital privileges. Under JCAH standards, nurse-midwives are not included in the categories of practitioners who are eligible for medical staff privileges because they are

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154 See ACNM/ACOG, supra note 59, at 171 (emphasis added). There is no legal mandate in any state that regulates the practice of nurse-midwifery, nor in the ACNM/ACOG Joint Practice Agreement, which requires or recommends that CNMs be employees of, or in any other way financially dependent upon, the physicians with whom they contract for backup services.
not permitted "by law . . . to provide patient care services independently in the hospital."156 While a nurse-midwife’s limited clinical privileges allow her to admit patients in the name of her collaborating physician, "provision is made for prompt medical evaluation of these patients by a qualified physician."157 The guidelines indicate that the word "prompt" means to be "performed immediately." However, at the discretion of the hospital, the physical presence of the physician is not required, and the "evaluation" may be performed by phone.158

Nevertheless, even if the "supervision" requirement is interpreted narrowly, as ACOG and JCAH seem to want, the fact that the nurse-midwife's work is performed under supervision does not necessarily mean that she cannot be characterized as an independent contractor. In McDonald v. Shell Oil Co.,159 the California Supreme Court enumerated the kinds of supervisory activities in which the principal may engage without shifting the relationship to that of employer-employee. According to the court,

[The principal] may retain a broad general power of supervision and control as to the results of the work so as to insure satisfactory performance of the independent contract — including the right to inspect, the right to stop the work, the right to make suggestions or recommendations as to details of the work, the right to prescribe alterations or deviations in the work — without changing the relationship from that of [principal] and independent contractor or the duties arising from that relationship.160

When the nurse-midwife is practicing within the scope of her license, she is qualified to assume the “complete management” of normal pregnancy, labor, and delivery. The physician’s role under these circumstances is minimal. He does not “direct” the midwife’s activities in caring for her patients, nor does he “inspect,” in the sense of being physically present on the premises at the time the nurse-midwife is rendering care. When consulted by the nurse-midwife, or when performing routine consultation as provided for in the agreement, he may make suggestions or recommendations and prescribe alterations in the course of treatment. Under the McDonald test, however, this is an insufficient exercise of control to subject the physician to vicarious liability.

157 Id. at 120.
158 Information obtained from JCAH Liaison, Alta Bates Hospital, Berkeley, Cal. (Sept. 18, 1985) (notes on file with author). When Alta Bates Hospital was considering an out-of-hospital birth center staffed by community nurse-midwives, it decided to implement the "dependent model of nurse-midwifery practice" suggested by the JCAH guidelines. The legal department, in consultation with the hospital’s insurance carriers, concluded that the hospital would not need to increase its malpractice coverage, but that the backup physicians would. Interview with Claire Westdahl, former director of proposed out-of-hospital birth center, Alta Bates Hospital, Berkeley, Cal. (April 25, 1985) (notes on file with author).
160 Id. at 790, 285 P.2d at 904. See also Stilson v. Moulton-Niguel Water Dist., 21 Cal. App. 3d 928, 936, 98 Cal. Rptr. 914, 918 (1971).
Furthermore, in *Voss v. Bridwell*, the court distinguished the right to control from the supervisory role in a medical malpractice suit. The plaintiff was injured during the administration of an anesthetic before surgery began, and surgery was never performed. The plaintiff attempted to recover both from the head of the department of anesthesiology and from the surgeon on a theory of respondeat superior. The court noted that the surgeon's right to supervise, "even as to the work and the manner of performance, is not sufficient [to establish a right to control]."

### ii. Power to Discharge at Will

Courts have recognized that the power to discharge at will gives the principal ultimate control over the activities of the agent. Thus, the presence of this factor, while not rising to the level of a presumption, is "strong evidence" of control, and if present, may be given conclusive weight in determining that an employer-employee relationship exists.

In the paradigm independent practice agreement, either party may terminate the contract without cause upon giving notice to the other. Since both parties presumably have a beneficial interest in the contract, there is, on the surface at least, an equal degree of control in this respect.

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166 See supra notes 144-48 and accompanying text.
167 In fact, the physician's ability to terminate the contract is "worth more" than the nurse-midwife's because of the difficulties she would face in finding another collaborating physician. Thus it is possible to look behind the contract and to take into account the fact that the social structure giving rise to the contract grants the physician a greater degree of control with respect to termination.

Collaborative agreements that are more specific and perhaps more limited with respect to the circumstances under which the contract might be terminated would tend to defeat an inference that the physician's right to terminate constitutes control. Contract provisions that subject the physician to liquidated damages, for example, might qualify the inferences that could be drawn from the termination clause. Conversely, contract provisions that give the physician an unconditional right to terminate the contract based on his evaluation of the nurse-midwife's performance would probably be interpreted as virtual per se evidence of an employer-employee relationship. See infra note 171 and accompanying text.
iii. The Importance of the Collaboration Agreement and the Conduct of the Parties

If there is a written contract, courts will rely heavily on its terms to determine whether an employer-employee or independent contractor relationship exists. Courts will give particular weight to contracts that explicitly or implicitly grant the right to control the details of the work to the employer. In *Tieberg v. Unemployment Insurance Appeals Board*, the California Supreme Court upheld the trial court's determination that the relationship between the parties was that of employer-employee. The court ruled that the trial court had properly restricted its inquiry to an examination of two contracts between the parties, when there was corroborating evidence that the employer actually exercised the degree of control described in the contracts.

The issue in *Tieberg* was whether the employer was liable for contributions to the unemployment compensation insurance fund for the benefit of his employees. The employees were television script writers who worked on an ad hoc basis. The writers worked on their own time, at their own expense, in their own way, using their own equipment and supplies, at a place of their own liking. There was no necessary continuity between projects for which they were employed. They were free to enter into simultaneous and overlapping commitments with other producers.

Despite these indicia of independent contractor status, the trial court concluded that the script writers were employees of the producer based on the extent of the producer's contractual right to control the details of the script writers' work by requiring extensive changes in the scripts submitted. "The desires, suggestions, requests and directions of [the producer's] staff were in effect commands which had to be and were complied with by the writers. . . . Failure to comply would result in forfeiting future employment."169

The script writers' employment contract also was subject to a separate collective bargaining agreement. Both agreements gave the producer the right to direct the writers to make modifications in their scripts, and both agreements referred to the script writers as "employees." Moreover, the collective bargaining agreement contained pension plan provisions that were appropriate only if the writers were employees. Interpreting these two instruments together, along with evidence of the conduct of the parties, the trial court concluded that the script writers were employees.170

169 2 Cal. 3d at 948, 471 P.2d at 978, 38 Cal. Rptr. at 179.
170 The California Supreme Court took much the same approach in an earlier case, *Burlingham v. Gray*, 22 Cal. 2d 87, 137 P.2d 9 (1943). This case involved the question of an employer's vicarious liability for an employee's tort. The employee was a newspaper carrier who injured a
The *Tieberg* decision strongly suggests that the collaborative agreement between the nurse-midwife and the physician, supported by evidence of the conduct of the parties, may be the most decisive factor in determining independent contractor status. In the context of the independent practice of nurse-midwifery, there will usually be a written agreement available for interpretation. The contract will provide a general description of the roles of the nurse-midwife and the physician in terms of the care of the “normal” parturient woman. In addition, it may describe, or incorporate by reference, established risk criteria which will determine when the role of the physician is to become more active.\(^{171}\)

Since the physician’s involvement is minimal as long as the nurse-midwife is attending the “normal” women who make up the majority of her practice, this is the appropriate focal point for the courts in scrutinizing the contract to determine independent contractor status. Certainly the degree of “control” anticipated in the usual course of practice does not approach that in *Tieberg*. Rather, it is characteristic of the kind of general supervision that, under *McDonald*, a principal may exercise without altering the independent contractor relationship.\(^{172}\) If, under particular circumstances, the degree of control exercised is greater than the level of supervision anticipated in the general course of practice, that fact should not alter the independent contractor status of the nurse-midwife. Rather, it should indicate only that an exception might apply in that instance.\(^{173}\)

iv. Multifactorial Criteria: *Restatement (Second) of Agency and Empire Star Mines*

When independent contractor status remains ambiguous because the “right to control” is not readily apparent from the collaborative agree-

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171 In some cases, there will be no contract, or the contract will be lacking in detail. In those cases, evidence of customary practice, which embodies the use of particular risk criteria, will serve a similar, though less straightforward, evidentiary function.

172 See supra notes 159-60 and accompanying text.

173 See infra notes 201-56 and accompanying text.
ment, the conduct of the parties, or the existence of the power to discharge at will, courts may apply the test formulated in the *Restatement (Second) of Agency*\(^{174}\) and adopted by the California Supreme Court in *Empire Star Mines Co. v. California Employment Commission*.\(^{175}\) Although this test has been particularly important in the absence of a contract specifying the degree of control to be exercised by the employer,\(^{176}\) it has also been used when such a contract exists to add evidentiary weight to the determination of independent contractor status.\(^{177}\) No single element of the *Restatement* test is conclusive.\(^{178}\) Moreover, all of the factors enumerated in the test, taken as a whole, are secondary to the two overriding circumstances analyzed above, namely, the existence of a relatively unambiguous contract between the parties, confirmed by course of conduct,\(^{179}\) and the right to discharge at will.\(^{180}\)

In applying the *Restatement* analysis to the determination of whether the nurse-midwife is an independent contractor, the first factor to consider is "whether or not the one performing services is engaged in a distinct occupation or business."\(^{181}\) In the case of nurse-midwives, it can be argued that nurse-midwifery is a distinct occupation that is distinguishable from the practice of medicine generally and from the practice of obstetrics in particular.\(^{182}\) However, the claim that midwifery is distinguishable from the practice of obstetrics would undoubtedly meet with intense opposition. From the viewpoint of physicians, and possibly many laypeople as well, nurse-midwifery is properly characterized as an adjunct to the practice of obstetrics, and not as a profession with its own distinct attributes. Thus, whether the nurse-midwife qualifies for independent contractor status under this criterion is equivocal. Were such an inquiry to be undertaken, public policy considerations and traditional expectations of the appropriate roles of physician and nonphysician practitioners would undoubtedly play a major part.

Second, the court examines the "kind of occupation with reference to whether, in the locality, the work is usually done under the direction of the principal or by a specialist without supervision."\(^{183}\) While the nurse-midwife does not work under the physician's direction, neither

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\(^{174}\) *Restatement (Second) of Agency* § 220 (1958).


\(^{178}\) See *Restatement (Second) of Agency* § 220 comment c (1958).


\(^{180}\) See *supra* notes 163-67 and accompanying text.

\(^{181}\) *Empire Star Mines*, 28 Cal. 2d at 43, 168 P.2d at 692.

\(^{182}\) See *supra* notes 10-15 and accompanying text.

\(^{183}\) *Empire Star Mines*, 28 Cal. 2d at 43, 168 P.2d at 692.
does she work totally without supervision. The nurse-midwife functions as an independent practitioner in the context of a collaborative relationship with the physician, the relationship being governed by certain guidelines determined by a process of public and private ordering. Her day-to-day work is performed with a minimum of supervision so long as she is providing prenatal care and attending “normal” births within the agreed upon guidelines. As previously discussed, the general supervision that the physician provides is within the limits that the court in *McDonald v. Shell Oil Co.* identified as insufficient to shift the relationship from independent contractor to employee. Thus, on a continuum from one who performs work “under the direction of the principal” to one who performs work “without supervision,” the nurse-midwife lies more toward the latter end. Evaluation of this criterion would suggest, then, that the nurse-midwife is an independent contractor.

Third, the court examines “the skill required in the particular occupation.” An occupation requiring a high degree of skill is indicative of independent contractor status. To argue successfully that the nurse-midwife fulfills this criterion, it must be established that although the skills of the nurse-midwife may overlap with those of the physician, they are also unique. While the physician focuses on the development of crisis-oriented technical skills that can be used when it is necessary to intervene in the birth process, the nurse-midwife is oriented toward creating the conditions that facilitate normal, natural birth without intervention. This differentiation is crucial to support a finding of independent contractor status. If the comparison is based only on differences in technical training, then the obstetrician is, by definition, more highly skilled, and the nurse-midwife would seem to fit into the employee category. If, however, the unique attributes of midwifery are taken into consideration, then the nurse-midwife emerges as the person in the relationship who is most skilled in the practice of midwifery, and the conclusion that the nurse-midwife is an independent contractor is justified.

Whether the parties believe they are creating the relationship of employer-employee is also a significant factor to be considered. In the case of independently practicing nurse-midwives and their backup physicians, there is generally no intent to create an employment relationship. On the contrary, both parties are willing to enter the contract with the understanding that the nurse-midwife is engaged in an independent practice, both functionally and financially, to the full extent of her legal

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184 See *supra* notes 159-67 and accompanying text.

185 *Empire Star Mines*, 28 Cal. 2d at 43, 168 P.2d at 692.

186 See *supra* notes 10-15 and accompanying text.

187 See *Restatement (Second) of Agency* § 220 comment m (1958) (“It is not determinative that the parties believe or disbelieve that the relation of master and servant exists, except insofar as such belief indicates an assumption of control by the one and submission to control by the other.”).
license. The nurse-midwife’s practice is economically independent from that of her collaborating physician, and patients seek her services directly. Thus, under this criterion, the typical practice agreement between nurse-midwife and physician contemplates independent contractor status.

Other factors to be considered are “whether the principal is or is not in business,” “whether or not the work is part of the regular business of the principal,” and whether the worker supplies her own instrumentalities, tools, and place of work. Generally, where the principal himself is engaged in the same business for which he hires the services of the agent, an employer-employee relationship exists. This characterization is strengthened if, in addition, the principal provides the instrumentalities and/or the work space necessary for the agent to carry on the work.

In the course of treating patients who progress normally through pregnancy, labor, and delivery, the interaction between the physician’s and the nurse-midwife’s practice is minimal; the two are functionally and economically autonomous. The practices intersect primarily when a problem arises, but even under those circumstances, they remain economically autonomous. As indicated in the paradigm contract, the nurse-midwife establishes her own fee schedule and pays the physician a set amount for his participation in the care of her patients. When the care of the patient warrants greater physician participation, the fee arrangements are handled between the physician and the patient directly.

The two practices are also functionally autonomous in the sense that patients may seek the services of the nurse-midwife directly and remain in her practice for the purposes of intrapartum health maintenance. When the physician refers a patient to the nurse-midwife, however, that patient remains in the physician’s practice for the purposes of her long-term care. Another differentiating factor is the possibility that the nurse-midwife may be engaged in activities, such as out-of-hospital births, that are not a part of the physician’s practice at all.

Considering the entire interactive structure of the two practices and the ways in which the structure is designed to maintain maximum functional and economic autonomy, it can be argued that the mere fact that the nurse-midwife and the physician are engaged in a similar business activity is not determinative of employee status. This argument is reinforced by the fact that the nurse-midwife typically provides her own office space, equipment, and supplies.

The length of time for which services are to be performed is also important. Since independent contractors are often engaged to perform specific tasks on a short-term basis, the existence of short-term

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188 Empire Star Mines, 28 Cal. 2d at 43-44, 166 P.2d at 692.
189 Id., 166 P.2d at 692.
employment tends to indicate independent contractor status. Thus, the usual long-term contract between nurse-midwife and physician may be indicative of an employment relationship.\textsuperscript{190}

Whether the nurse-midwife can be characterized as an independent contractor under the Restatement/Empire Star Mines criteria is far from clear. Certainly, there are strong arguments supporting an inference of independent contractor status with respect to most of the criteria. However, some of the arguments, though supportable, may be weakened to the extent that they are contrary to the traditional view that physicians are in charge of all other medical practitioners a priori because of their unlimited licensure to practice. The extent to which society feels it is desirable to preserve the traditional role of the physician is as yet unclear, in view of changing attitudes toward health care, the desire for more economical care, and rapid technological development. Thus, it is difficult to predict what effect such arguments would have in a court of law required to determine whether or not an independently practicing nurse-midwife is an independent contractor. Since the scope of the vicarious liability of the supervising physician ultimately rests on such a determination, the court's resolution of the question has far-reaching implications for the future structure and viability of independent practice.

v. Conclusion: The Scope of Physicians' Vicarious Liability for the Malpractice of Independently Practicing Nurse-Midwives

The above analysis suggests that it may be correct to characterize an independently practicing nurse-midwife as an independent contractor, as opposed to an employee. Since the nurse-midwife is contracting for the physician's services, it is most accurate to characterize the nurse-midwife as the principal and the physician as the agent. Under traditional agency law, the agent is not liable for the principal's negligent acts. Even if the physician is characterized as the principal, however, there are tolerable levels of supervision that the physician may exercise without changing the relationship from independent contractor to employer-employee, despite the ambiguous statutory language in California. Independent contractor status is also suggested if the physician does not have the right to terminate the contract at will. Additionally, an analysis of the nurse-midwife/physician relationship using the Restatement/Empire Star Mines\textsuperscript{191} test reveals that there are valid arguments supporting independent contractor status under most of the criteria.

In appropriate cases, these factors, plus an analysis of the particular

\textsuperscript{190} One final factor, "the method of payment," is inapplicable to the independent practice paradigm where the physician is characterized as the principal, since it is the nurse-midwife who pays the physician for services.

\textsuperscript{191} See supra notes 174-90 and accompanying text.
collaboration agreement, should prompt courts to recognize that nurse-midwives engaged in independent practice are independent contractors vis-a-vis their backup physicians.\textsuperscript{192} In accordance with traditional agency principles, a general rule that a physician is not liable for negligent acts of other health care providers who are not his employees should govern,\textsuperscript{193} in the absence of factual circumstances that would trigger an exception.\textsuperscript{194} This proposition is consistent with California's general rule, stated in the 1937 decision in \textit{Hallinan v. Prindle}: "A physician is not liable for the negligence of . . . nurses, attendants or interns who are not his employees if he has no knowledge thereof, or has no connection therewith, or if it is not discoverable by him in the exercise of ordinary care . . . ."\textsuperscript{195}

This principle was recently applied in \textit{Frantz v. San Luis Medical Clinic}.\textsuperscript{196} In \textit{Frantz}, a nurse negligently administered an injection that had been ordered by the physician. The physician was sued on a theory of vicarious liability, but the court did not hold him liable: the administration of the injection was within the expected competency of the nurse, and the physician was not notified of the patient's complaints following the injection and thus had no opportunity to take corrective action.\textsuperscript{197}

Similarly, in the case of a nurse-midwife and her supervising physician, the physician is not in attendance while the nurse-midwife is performing her routine duties. Therefore, he should not be held liable for the malpractice of the nurse-midwife that occurs in the course of caring for patients that meet agreed upon low-risk criteria. If he is notified of a maloccurrence and fails to take corrective action, then liability might attach based on the physician's own negligence.

There are also important policy justifications for adopting a general rule of nonliability. In general, malpractice liability is thought to serve two functions: a compensatory function for injured parties, and a disciplinary function for negligent or incompetent physicians.\textsuperscript{198} The adoption of a rule of nonliability of physicians in the context of independent nurse-midwifery practice will not affect the first goal, that of compensating the injured, since the nurse-midwife is liable for her own negligent acts. With respect to the second goal, there is no indication that the imposition of vicarious liability has any influence whatsoever on the skill

\textsuperscript{192} Of course, the legislature could go much further and simply designate the nurse-midwife as an independent contractor vis-a-vis her physician collaborator. Physicians and surgeons in California now enjoy a rebuttable presumption that they are independent contractors when providing services at licensed health care facilities. \textsc{Cal. Lab. Code} § 275.06 (West Supp. 1986).


\textsuperscript{194} See \textit{infra} notes 201-57 and accompanying text.


\textsuperscript{196} 81 Cal. App. 3d 34, 41, 146 Cal. Rptr. 146, 151 (1978).

\textsuperscript{197} \textit{Id.} at 40, 146 Cal. Rptr. at 151.

\textsuperscript{198} \textit{See supra} note 110 and accompanying text.
and care exercised by the physician, since liability is imposed in situations where the physician’s competence is not at issue. 199 The only effect of the “be careful” message inherent in the imposition of liability is to enhance physicians’ reluctance to enter into practice agreements with nurse-midwives, thereby affecting the availability of health care alternatives. Moreover, if one purpose of the malpractice liability system is to discipline health care providers, then liability should fall where the fault lies. If nurses are going to undertake expanded practice roles, then the profession should be prepared to accept a heightened standard of care and greater exposure to direct liability. 200

The remaining question to be answered is whether there are any exceptions to the general abrogation of the doctrine of respondeat superior in this context, and if so, under what circumstances. The next section will examine two exceptions to the rule that principals are not liable for the negligent acts of independent contractors, and it will assess their applicability to the independent practice of nurse-midwifery.

e. Exceptions to the Rule of Nonliability of the Principal for Negligent Acts of an Independent Contractor

i. The “Captain of the Ship” and the “Borrowed Servant” Doctrines

The “captain of the ship” doctrine is best described as a unique application of the “borrowed servant” doctrine fashioned solely for use in the area of medical malpractice. According to the traditional borrowed servant doctrine, a principal may be liable for the acts of another, not his employee, if the person is negligent while under the temporary direction or control of the principal. 201 While the existence of this “special employment” relationship is generally a question of fact, 202 courts applying the broader captain of the ship doctrine have imposed liability as a matter of law. 203

The captain of the ship doctrine arose in the surgical suite and was

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199 See Note, supra note 128.


201 Marsh v. Tilley Steel Co., 26 Cal. 3d 486, 492, 606 P.2d 355, 358-59, 162 Cal. Rptr. 320, 323-24 (1980) (“When an employer . . . lends an employee to another employer and relinquishes all right of control over the employee’s activities, a ‘special employment’ relationship arises between the borrowing employer and the employee. During this period of transferred control, the special employer becomes solely liable under the doctrine of respondeat superior for the employee’s job-related torts.”).

202 Id. at 493, 606 P.2d at 359, 162 Cal. Rptr. at 324.

203 See generally Note, Separation of Responsibility in the Operating Room: The Borrowed Servant, the Captain of the Ship and the Scope of Surgeons’ Vicarious Liability, 49 Notre Dame Law. 933 (1974).
given its name by the Pennsylvania Supreme Court in *McConnell v. Williams*. In that case, Justice Stearn analogized the surgeon in the operating room to the captain of a ship who has supreme control over all on board. The doctrine arose during a time when hospitals were immune from liability either because of the doctrine of charitable immunity or because the hospital’s professional employees were regarded as independent contractors. Thus, if the plaintiff could not recover from the operating physician, she was left without a remedy. In its most extreme applications, the doctrine lost all connection with the underlying principles of the borrowed servant doctrine and was extended to include preoperative negligence and other independent acts of negligence in which the tortfeasor never set foot in the operating room and in which no right of control was ever established.

Many jurisdictions never adopted or later repudiated the broadest applications of the captain of the ship doctrine. In medical cases, many jurisdictions follow a very narrow version of the borrowed servant doctrine as well. Although the application of traditional agency principles would suggest that the right of the principal to control the acts of the borrowed servant, whether actually exercised or not, is the appropriate showing, in jurisdictions adhering to a narrow interpretation of the borrowed servant doctrine, a showing of actual exercise of control is often required. Undoubtedly, this is due to unlimited licensure, which seems to give the physician a theoretical “right to control” in any medical situation. Failure to limit the doctrine to the actual exercise of control would thus result in a virtual per se rule of liability.

In California, the viability of the captain of the ship doctrine is questionable. The broad application of the doctrine was adopted in 1936 by

206 See, e.g., Ware v. Culp, 24 Cal. App. 2d 22, 28-31, 74 P.2d 283, 285-87 (1937). Neither of these principles apply today. Professional employees are viewed no differently from nonprofessional employees. See Ray v. Tucson Medical Center, 72 Ariz. 22, 36, 230 P.2d 220, 228-29 (1951); Bing v. Thunig, 2 N.Y.2d 656, 664, 143 N.E.2d 3, 7, 9, 163 N.Y.2d 3, 9, 12 (1957) (cases holding that charitable immunity of hospitals cannot be justified).
207 See, e.g., Rockwell v. Kaplan, 404 Pa. 574, 173 A.2d 54 (1961) (surgeon liable for negligent administration of Sodium Pentothal, which was administered out of his presence before the patient was brought into the operating room); Mazer v. Lipschutz, 327 F.2d 42 (3rd Cir. 1964) (remanding for new trial on the issue of respondeat superior as to the surgeon on grounds that it was error for the jury to be charged that a surgeon was not responsible for negligence of blood bank employee who mislabeled blood some time before surgery); Yorston v. Pennell, 397 Pa. 28, 153 A.2d 255 (1959) (operating surgeon held vicariously liable for omission of intern who took patient’s medical history in the emergency room). See also Note, *Pennsylvania’s Captain-of-the-Ship Doctrine: A Mid-Twentieth Century Anachronism*, 71 Dick. L. Rev. 432 (1967).
208 RESTATEMENT (SECOND) OF AGENCY § 227 comment d (1958).
the California Supreme Court in the case of Ales v. Ryan.\textsuperscript{210} However, in the same year, a California court of appeal implicitly rejected the doctrine and adopted a narrower approach. The court declined to impute the negligent acts of an operating room nurse to the operating physician where the operating room nurse erroneously supplied the surgeon with formalin, a powerful disinfectant, instead of the local anesthetic he had requested.\textsuperscript{211} The court based its finding of nonliability on three grounds (which presumably would have been inadequate had the broader version of the doctrine been applied): 1) it was the custom of the surgeon to rely on the technical expertise of the nurse in preparing local anesthetics for injection; 2) the nurse was qualified by training and experience to perform this task without supervision; and 3) the act was not performed in the presence of the physician.\textsuperscript{212} Moreover, the fact that the surgeon had directed the nurse to prepare the medication was of absolutely no consequence and was insufficient to establish the "special employment" relationship necessary for vicarious liability to attach.\textsuperscript{213}

In the famous res ipsa loquitur case of Ybarra v. Spangard,\textsuperscript{214} the court noted in dicta that "the doctor in charge of the operation would be liable for the negligence of those who become his temporary servants for the purpose of assisting in the operation."\textsuperscript{215} While this pronouncement has been cited in later cases as reinforcing the viability of the captain of the ship doctrine in California, such an interpretation is not justified because the court does not specify what showing, if any, is required to establish that the assistants were the surgeon's "temporary servants."

Courts having a more realistic view of surgical practice in modern hospitals tend to reject the captain of the ship doctrine. Recognizing that a surgical team is made up of several different categories of highly trained specialists, these courts understand that to presume that the operating surgeon has "control" over the activities of all of these various practitioners is a legal fiction that is no longer supportable.\textsuperscript{216} Applying this reasoning in the case of Kennedy v. Gaskell,\textsuperscript{217} a California court of appeal explicitly rejected the captain of the ship doctrine. The court held that the operating surgeon was not vicariously liable for the negligence of the anesthesiologist. The anesthesiologist was in full control of the administration of the anesthetic, despite the fact that the surgeon selected the anesthesiologist and instructed him on the type, nature, and purpose

\begin{itemize}
  \item \textsuperscript{210} 8 Cal. 2d 82, 64 P.2d 409 (1936).
  \item \textsuperscript{211} Hallinan v. Prindle, 17 Cal. App. 2d 656, 62 P.2d 1075 (1936).
  \item \textsuperscript{212} \textit{Id.} at 661-62, 62 P.2d at 1077-78.
  \item \textsuperscript{213} \textit{Id.} at 662, 62 P.2d at 1078.
  \item \textsuperscript{214} 25 Cal. 2d 486, 154 P.2d 687 (1944).
  \item \textsuperscript{215} \textit{Id.} at 492, 154 P.2d at 690.
  \item \textsuperscript{217} 274 Cal. App. 2d 244, 78 Cal. Rptr. 753 (1969).
\end{itemize}
of the anesthesia desired.\textsuperscript{218}

Thus, until the 1985 decision in \textit{Schultz v. Mutch},\textsuperscript{219} it seemed that the California courts were moving away from the captain of the ship doctrine. However, the court in \textit{Schultz} not only reinstated the doctrine in full force, but it moved its traditional application from the operating room to the labor and delivery suite. This decision may have a significant impact on the independent practice of nurse-midwifery because it establishes a precedent for greater imposition of vicarious liability on supervising physicians.

In \textit{Schultz}, an infant was born quadriplegic and mentally retarded after the physician and the nursing staff failed to discover that it was experiencing severe distress. The mother was admitted to the hospital in labor at about 11:30 p.m. She was attended by a doctor who was not her regular physician. Sometime after midnight, the physician became involved in performing a cesarean section on another patient. Apparently, the four labor and delivery nurses who were on duty all assisted with the cesarean section, and the plaintiff's mother was left unattended until around 2:25 a.m. At that time, the attending physician examined the patient but failed to check the fetal heart tones. At about 3:00 a.m., it was discovered that the fetus was in severe distress. Although the birth followed shortly thereafter, the record established that it was unnecessarily dilatory.\textsuperscript{220}

The attending physician was held vicariously liable for the malpractice of the nurses. His liability was premised on the finding that he exercised "control" over the nurses and gave them various orders concerning the cesarean section patient. The opinion did not clarify exactly how this exercise of "control" deprived the plaintiff's mother of the care she needed, or if it did. How it happened that all four labor and delivery nurses ended up assisting the attending physician during the cesarean section, leaving no one to care for the plaintiff's mother, was not explained in the opinion.

Was it not the nurses' responsibility to see that both patients were cared for? The opinion hints that this might have been the case, but the court makes it clear that the physician could not rely on the hospital's usual process of providing nursing coverage once he exercised "control." "[A] doctor's reliance, no matter how reasonable, on hospital nursing procedures does not extinguish liability."\textsuperscript{221} Thus, once the physician exercised "control," he also assumed responsibility for the distribution of nursing care, whether he knew it or not.


\textsuperscript{220} \textit{Id.} at 72, 211 Cal. Rptr. at 448.

\textsuperscript{221} \textit{Id.} at 74, 211 Cal. Rptr. at 449.
The fact that the problem of nursing care distribution may have arisen before the physician exercised "control" does not pose much difficulty for the court. No claim was made that the physician exercised control by ordering all of the labor and delivery nurses on duty to assist him with the cesarean section. Logically, one would assume that the physician exercised the degree of control necessary to hold him liable for the nursing staff's abandonment of the plaintiff's mother by inducing all four nurses into the operating room to assist him. However, there is nothing in the opinion to suggest that the physician gave such an order. Rather, the court focused only on the "control" exercised and the orders given by the physician during the cesarean section, admittedly at a time when neither the physician nor the nurses were attending the plaintiff's mother. The court asserted that it was immaterial that the control was exercised in the course of surgery on another patient. "Whether engaged in surgery on a plaintiff or a third party, the physician is the principal and the nurses controlled by him are his agents . . . "

The court noted in passing the "erosion" of the captain of the ship doctrine in Truhitte, Marvulli, and Kennedy, but it explicitly refused to follow this doctrinal trend. In fact, Judge Smerling, in Shultz, chastised the Truhitte court for overlooking the one "cogent and still pertinent justification for the doctrine, namely the special relationship between a vulnerable hospital patient and the physician chosen by that patient." Thus, the last word in California is that the captain of the ship doctrine is alive and well as a means of protecting hospitalized patients from an impersonal health care system. Courts in other jurisdictions, however, have based findings of nonliability on exactly the same concern for the welfare of helpless patients. These courts have opined that to impose a duty on the operating surgeon to "control" the activities of other members of the surgical team is detrimental to the patient because it under-mines the surgeon's ability to concentrate all of his attention on the surgical task for which he is uniquely qualified and solely responsible.

In the context of today's modern hospital, the latter rationale deserves careful consideration. Assume for the sake of argument that it is desirable to require the physician to keep an eye on everybody in the operating room (or delivery room). Can the surgeon realistically be expected to master the technical details of each team member's function in order to perform this task effectively in an environment where each

222 Id. at 74, 211 Cal. Rptr. at 450.
223 Id. at 75, 211 Cal. Rptr. at 450 (citing Ybarra v. Spangard, 25 Cal. 2d at 490-92, for the proposition that the captain of the ship doctrine is justified because of the inability of the hospitalized patient to control what is happening, "as well as the impersonal, bureaucratic nature of hospital care.").
professional's role is becoming increasingly more complex? In cases like *Schultz*, where the physician himself was negligent, does the availability of the captain of the ship doctrine really add anything to the plaintiff's case, or does it just perpetuate a doctrine that is no longer appropriate in today's modern hospital practice?

Assuming that nurse-midwives are generally independent contractors vis-a-vis their backup physicians, the question of the physician's vicarious liability for the negligent acts of the nurse-midwife will arise in those situations in which the woman develops complications that require the physician's close attention. Usually, the woman will be hospitalized, and the scenario will take place in the labor or delivery room. Some circumstances may require only that the physician be available nearby, while others will necessitate the physician's attendance while the nurse-midwife delivers the baby. Still other situations will require the physician to assume the care of the patient with the nurse-midwife assisting.

Clearly, a rigid application of the captain of the ship doctrine as adopted in *Schultz* would subject the physician to vicarious liability for any malpractice committed by the nurse-midwife once the patient passed through the hospital doors. In view of the need to promote personal accountability among professionals, the need to allow the physician to tend to those tasks for which he is uniquely qualified (particularly in intensive treatment situations like the operating room or the delivery room), and the need to broaden the base of health care providers by encouraging the entry of nonphysician practitioners, the inflexible and mechanical application of this doctrine which the court in *Schultz* advocated is ill-advised.

Any finding of liability on the part of the backup physician based on principles of respondeat superior should adhere to a narrow interpretation of the "borrowed servant" doctrine. The approach of jurisdictions that have avoided the captain of the ship doctrine or have attempted to bring it back in line with more traditional "borrowed servant" principles should be adopted, and a showing of actual exercise of control over the details of the other practitioner's work should be required before vicarious liability attaches.

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226 In fact, the very attitude underlying the opinion in *Schultz* may have led to the abandonment of plaintiff's mother in the first place. If, when a doctor walks into the labor and delivery area, nurses feel that the "captain of the ship" has arrived and assumed his supreme command, what is to induce them to exercise their own professional judgment in deciding how to apportion staff resources so that all of the needs are met? How is an open channel of communication with the doctor to be maintained so that appropriate planning and discussion can take place when needs conflict?

Martin v. Perth Amboy General Hospital\textsuperscript{228} is a concrete example of the kind of control that the narrow version of the doctrine contemplates. In Martin, the hospital developed a procedure for keeping track of laparotomy pads during surgery by attaching to each pad a metal ring that remained outside of the incision during the operation. Hence, when all of the rings were picked up, the surgeon could be sure that all of the pads were removed from the wound.\textsuperscript{229} In this case, however, the surgeon ordered the nurse to remove the rings from the laparotomy pads, and a pad was left in the patient's abdomen. The court concluded that the physician, "[b]y exercising control of the nurses to the extent of directing them to remove the rings," became their "temporary and special employer," and he was therefore liable for their negligence in counting the pads.\textsuperscript{230}

A similar factual analysis should be undertaken whenever the question of a backup physician's vicarious liability for the nurse-midwife's practice is raised. The court should not rely on a conclusory and superficial observation that there is a "special relationship" between the nurse-midwife and the physician simply because there is a contractual agreement for medical backup. The purpose of that agreement is not to grant the physician "control" over the nurse-midwife's practice. Rather, the agreement is to guarantee that the patient will get the assistance needed when a complication arises that is beyond the nurse-midwife's scope of practice.

The court should analyze the factual circumstances giving rise to the suit in terms of whether or not the physician exercised actual control over the nurse-midwife's performance of her professional tasks. For example, if a patient in labor develops elevated blood pressure, the nurse-midwife must call in the physician, because managing hypertension is beyond the scope of her licensure. Assuming the patient goes on to have a vaginal delivery assisted by the nurse-midwife in the presence of the physician, any malpractice of the nurse-midwife in conducting the vaginal delivery should not be imputed to the physician simply because he is in attendance for another purpose.

Limiting the scope of vicarious liability in this way does not eliminate the direct liability of either the nurse-midwife or the physician. In the scenario described above, the direct liability of the physician might arise in one of two ways. First, if the physician actively interferes with the performance of the nurse-midwife's tasks or arbitrarily assumes control over the manner and method by which she performs the delivery,
then he should be deemed to have assumed the risk of liability. Secondly, if the physician, by want of ordinary care, fails to observe an act of negligence or observes an act of negligence and fails to object, then his conduct should give rise to liability.

Adoption of a general rule of nonliability, coupled with a “borrowed servant” exception that is governed by careful factual analysis, offers several important advantages. First, this approach allows for a degree of flexibility that reflects the realities of practice and promotes the growth of expanded-role nursing practice. Second, the parties can predict with some degree of certainty the extent of their respective liability exposure. Third, some of the fear of vicarious liability will be removed, since the physician will not be vicariously liable unless he is, in reality, “in control.”

ii. Ostensible Agency

The theory of ostensible agency is a second doctrinal device for overcoming the barrier to respondeat superior posed by the independent contractor status. It is a doctrine that is potentially available in the context of the independent practice of nurse-midwifery if a client wishes to reach either the physician’s assets (based on an underlying claim of malpractice of the nurse-midwife) or the nurse-midwife’s assets (based on an underlying claim of malpractice of the physician).

“An agency is ostensible when the principal intentionally or by want of ordinary care, causes a third party to believe another to be his agent who is not really employed by him.” Also referred to as “apparent agency” or “holding out,” the doctrine has been applied most frequently in the medical malpractice area as a vehicle for the imposition of vicarious liability on hospitals for the malpractice of independent contractor.

231 See, e.g., Majors v. Connor, 162 Cal. 131, 133-34, 121 P. 371, 373 (1912) (general contractor liable for injuries sustained in collapse of brick wall because general contractor, rather than masonry contractor, directed the masonry work).

232 Hallinan v. Prindle, 17 Cal. App. 2d 656, 661, 62 P.2d 1075, 1077 (1936); Morey v. Thybo, 199 F. 760, 762-63 (7th Cir. 1912). See also Note, supra note 207, at 448-49.

233 Mention should be made of cases in which courts impose vicarious liability as a straightforward matter of policy, particularly in “borrowed servant” cases. See, e.g., Strait v. Hale Constr. Co., 26 Cal. App. 3d 941, 949, 103 Cal. Rptr. 487, 493 (1972). By so doing, courts avoid the task of determining who was “in control” of the “borrowed servant” at the time of the negligent act. The theory of these cases is that risks should be borne by the member of a joint enterprise who can best foresee, spread, and control the risk. Courts might consider it appropriate to impose vicarious liability simply because the nurse-midwife and the physician are engaged in a joint enterprise, if nurse-midwives are unable to obtain insurance and physicians are able to do so. However, this approach will have absolutely no practical value in California, except as a way to reach the insurance of the physician if the verdict is in excess of the one million dollars of coverage nurse-midwives are required to carry to maintain hospital privileges: if nurse-midwives cannot obtain insurance, they cannot get hospital privileges. If they continue to practice by delivering out of hospital, neither the nurse-midwife nor the backup physician can obtain insurance.

234 CAL. CIV. CODE § 2300 (West 1954).
physicians who provide ancillary treatment services, such as emergency care, anesthesiology, or radiology.235

A finding of ostensible agency requires that the person dealing with the agent do so with a reasonable belief in the agent’s authority upon which the person relies. The belief in the agent’s apparent authority must be generated by some act or neglect of the principal which induces belief.236

One commentator237 traces the origin of the test for ostensible agency typically applied in malpractice cases to the early case of Brown v. La Societe Francaise de Bien Faisance Mutuelle,238 in which the California Supreme Court applied a two prong test to the hospital-physician relationship. Under Brown, a physician was deemed to be a “servant” of the hospital if: (1) the plaintiff sought treatment from the hospital, and not from the physician; and (2) the physician was a salaried employee of the hospital.239 Over the years, the second prong of the test was modified to reflect the realities of modern hospital practice. There is no longer a requirement that the physician be a salaried employee so long as there is a significant relationship between the physician and the hospital. Thus, in the landmark case of Seneris v. Haas,240 the court found the necessary “significant relationship” between an anesthesiologist and the hospital, because the anesthesiologist was one of a small group of such specialists who practiced at the hospital, he gave anesthetics for no other hospital, he had regular “on-call” duty at the hospital, and he was called by a hospital employee to give the anesthetic that ultimately caused the plaintiff’s injury.241

In Howard v. Park,242 a medical center had an arrangement with an orthopedic surgeon who could be called in when necessary. When called, the surgeon saw the patient on the medical center premises, and, in


236 Hill v. Citizens Nat’l Trust & Sav. Bank, 9 Cal. 2d 172, 176, 69 P.2d 853, 855 (1937). The use of the ostensible agency doctrine in physician-hospital cases has been severely criticized. How can a hospital “intentionally” or “negligently” represent an anesthesiologist to be a servant? How does a patient “rely” on such representation in any way that should justify recovery from the hospital? See Comment, The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians, 50 WASH. L. REV. 385, 399 (1975). See also Southwick, The Hospital’s New Responsibility, 17 CLEV.-MAR. L. REV. 146, 155-56 (1968). Southwick suggests that the doctrine could be applied more rationally if the courts were to require a showing that the hospital made an actual “misrepresentation.”

237 Comment, supra note 236, at 393.
238 138 Cal. 475, 71 P. 516 (1903).
239 Id. at 476, 71 P. at 516.
241 Id. at 829-31, 291 P.2d at 926.
exchange for his use of the center's facilities, turned over fifty percent of
his fee. While at the clinic, the surgeon "conducted himself as a mem-
ber of the clinic." The patient was billed on center letterhead with the
surgeon's name included on it. There was nothing in the record to indi-
cate that the plaintiff should have been on notice that the treating physi-
cian was not an employee of the medical center. On these facts, the court
concluded that the medical center was liable for the malpractice of the
orthopedic surgeon on a theory of ostensible agency.

Two recent cases held hospitals liable on a theory of ostensible
agency merely because they provided a service typically thought of as a
service hospitals provide, and they did not advise the patient that he was
not being treated by the hospital's employee. These cases suggest that
in some instances, solely providing the service, without more, is sufficient
to constitute a "holding out" in the absence of a disclaimer. However,
this proposition has not been extended to strictly private physicians who
use the hospital facilities to treat their private patients. In Mayers v.
Litow, the plaintiff attempted to prove that her private physician was
the ostensible agent of the hospital. The court rejected this claim without
submitting it to the jury. The court based its holding on two facts: there
was no "substantial relationship" between the physician and the hospital
other than the physician's use of the hospital facilities, and there was no
reasonable "reliance," because the plaintiff was familiar with the nature
of the physician-hospital relationship from past experience.

In the context of a nurse-midwifery practice where the backup phy-
sician sees the patient routinely on one or two occasions and the nurse-
midwife and the physician clearly have some kind of relationship, various
claims of ostensible agency could arise. An aggrieved plaintiff might
claim that she had a reasonable belief that the nurse-midwife was the
employee of the physician and that she relied on that representation.
This is particularly likely in light of the traditional role relationship of
doctors and nurses. A person might plausibly claim to have had the
"reasonable belief" that nurse-midwives work only as employees of doc-
tors, or, at the very least, "under" doctors. Although a plaintiff who
seeks treatment from a negligent nurse-midwife and later claims that the

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243 Id. at 498, 195 N.W.2d at 40.
244 Id. at 500, 195 N.W.2d at 41.
245 Id. But see Graddy v. New York Medical College, 19 A.2d 426, 243 N.Y.S.2d 940 (1963)
(case not brought explicitly on an ostensible agency theory, but holding that to extend vicari-
ous liability to two physicians who had a fee-splitting arrangement and an agreement to cover
for one another was "going too far").
248 Id. at 418, 316 P.2d at 354.
249 Although most of the ostensible agency cases have occurred in the institutional setting, there
is no requirement that this be the case. See, e.g., Howard v. Park, 37 Mich. App. 496, 195
N.W.2d 39 (1972) (involving a group practice medical clinic as opposed to a hospital).
nurse-midwife is the ostensible agent of the physician cannot meet the first prong of the *Brown* test, *Mayers v. Litow* indicates that this failing might not be significant. *Mayers v. Litow* suggests that courts might simply rely on what can reasonably be inferred from the patient's past experience in the health care delivery system to determine whether she had a "reasonable belief" in the agency relationship.\footnote{250}{154 Cal. App. 2d at 418, 316 P.2d at 354. The plaintiff in *Mayers* could not meet the first prong of the *Brown* test either, since she sought care from her private physician and not from the hospital. However, the court ignored this failing and went on to analyze her claim under the second prong of the test.}

A woman seeking treatment from a nurse-midwife who then sends her to the physician might also assert a reasonable belief that the physician was the agent of the nurse-midwife. This fact pattern would meet the first prong of the *Brown* test. In analyzing the facts of the case under the second prong of the *Brown* test, the court might adopt the approach taken in *Howard v. Park*.\footnote{251}{37 Mich. App. 496, 195 N.W.2d 39 (1972).} In that case, the court considered where the services were performed, how the services were billed, and the nature of the fee-splitting agreement, and concluded that there was a "significant relationship" between the clinic and the physician justifying the imposition of vicarious liability.\footnote{252}{Id. at 498, 195 N.W.2d at 40.}

Under the paradigm agreement between a nurse-midwife and a physician,\footnote{253}{See supra notes 144-48 and accompanying text.} there are factors indicating that the nurse-midwife and the physician have a "significant relationship." The existence of the agreement itself is probably the strongest evidence of such a relationship. The fact that the nurse-midwife pays for the patient's routine visits to the physician out of the fee that the patient pays the nurse-midwife is further evidence of a "significant relationship." Other situational factors, such as shared office space or shared secretarial or bookkeeping services, would also contribute to a finding of a "significant relationship."

Cases such as *Capan v. Divine Providence Hospital*,\footnote{254}{287 Pa. Super. 364, 430 A.2d 647 (1980).} *Adamski v. Tacoma General Hospital*,\footnote{255}{45 Cal. 2d 811, 291 P.2d 915 (1955).} and *Seneris v. Haas*\footnote{256}{20 Wash. App. 98, 579 P.2d 970 (1978).} make it clear that the physician and nurse-midwife have an affirmative duty to inform patients about the details of their working relationship if they wish to avoid a later inference of ostensible agency. Nurse-midwives and physicians should make this kind of disclosure a routine part of the process of informed consent. In addition, public education about alternative forms of medical practice could be used to dispel misinformation based on stereotypic notions about the relationships of physician and nonphysician practitioners.

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This section has examined the imposition of vicarious liability on physicians who supervise independently practicing nurse-midwives, from the standpoint of traditional agency law. An analysis of these principles suggests that, as a general rule, the law does not support the proposition that a collaborating physician is vicariously liable for the acts of a nurse-midwife who is not an employee. Nevertheless, under certain circumstances exceptions to this rule, such as the captain of the ship doctrine or the doctrine of ostensible agency, might be triggered. However, in the interest of maintaining the possibility of independent practice for nurse-midwives, courts should limit the scope of these exceptions.

B. Obstacles Imposed by the Denial of Hospital Privileges

Lack of access to the hospital severely curtails the scope of nurse-midwifery practice and has the effect of channeling nurse-midwives into practice as employees of traditional medical institutions or private physicians. In these settings, nurse-midwives may not be allowed to attend deliveries, but may be restricted to providing routine prenatal and postpartum care. Midwives who attempt independent practice may be forced to develop home birth practices where they might not otherwise wish to do so. Consumer choice is limited, because midwifery retains an aura of illegitimacy, and, in this atmosphere, clients may not have access to information regarding available choices. The client who desires midwifery care but who would prefer a hospital birth cannot use an independent nurse-midwife, because the practitioner does not have access to the hospital.

Lack of hospital privileges affects the nurse-midwife’s ability to earn a livelihood in at least two important respects. First, if she is forced to practice outside of mainstream medicine, she is excluded from the informal referral network that would give her access to the largest pool of prospective clients. Secondly, home birth practice is very stressful and requires the immediate availability of the nurse-midwife. By its very nature, home birth practice must be limited to a maximum of four to six births a month. Guideline issued by the Joint Commission on Accreditation of Hospitals (JCAH) provide that a hospital’s medical staff may include “fully licensed physicians” and “other licensed individuals permitted by law and by the hospital to provide patient care services independently.” JCAH, supra note 156 at 109. If hospital bylaws permit, nonphysician practitioners may be granted clinical privileges if “provision is made for prompt medical evaluation of these patients by a qualified physician.” Id. at 82. California statutory law limits medical staff membership to physicians, dentists, podiatrists, and clinical psychologists. CAL. ADMIN. CODE tit. 22, § 70701, R. 83, No. 36 (1983). However, § 70706.1 charges each hospital’s Committee on Interdisciplinary Practice with the responsibility for “recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility.” CAL. ADMIN. CODE tit. 22, § 70706.1, R. 83, No. 7 (1983).

This argument assumes that a home birth practice is the alternative to hospital practice, since free-standing birth centers, the other possible alternative, are rarely available.
Most importantly, however, denial of access to the hospital reinforces the attitude that the practice of midwifery is illegitimate. This has the effect of isolating practitioners from mainstream medicine, making it difficult, if not impossible, for them to learn of new developments and take advantage of opportunities for continuing education.\(^{259}\)

In California, for example, nurse-midwives’ access to hospitals is severely restricted. There is only one private hospital in the Los Angeles area that grants privileges to nurse-midwives.\(^{260}\) Similarly, only one nurse-midwife has hospital privileges in Monterey County.\(^{261}\) At Stanford University Hospital, two nurse-midwives were reluctantly granted privileges after a five-year-long struggle that involved an investigation by the Federal Trade Commission (FTC) and a prolonged legal battle.\(^{262}\)

In the San Francisco Bay Area, the presence of the regional office of the FTC may have influenced the recent decision of five private hospitals in San Francisco to extend clinical privileges to nurse-midwives. A “confidential” FTC investigation of Alta Bates Hospital in Berkeley resulted in a similar change in the bylaws of that institution. Only one other private hospital in the East Bay Area extends clinical privileges to nurse-midwives,\(^{263}\) however, and, with one exception, public hospitals in that area do not grant privileges to independently practicing nurse-
midwives.264

The ability to gain access to hospital facilities is vital to sustaining and promoting the practice of nurse-midwifery. There is both a pressing need for effective intervention and a promise of success in addressing such questions through legal action. In general, physicians have become more successful in challenging the denial or termination of hospital privileges since courts have recognized causes of action under the Sherman Antitrust Act. Such theories may be available to nurse-midwives as well.

The first case squarely attacking denial of hospital privileges on behalf of nurse-midwives in independent practice was filed in Nashville, Tennessee in 1981 and has not yet come to trial.265 The plaintiffs, two well-qualified nurse-midwives who were systematically denied hospital privileges by three Nashville hospitals, are claiming, inter alia, that the hospitals acted in violation of §1 of the Sherman Antitrust Act.266

The Nashville case will be used as a paradigm for discussing the likelihood that nurse-midwives will be successful in seeking various forms of judicial redress for the denial of hospital privileges. By analogy to previous litigation in which physicians and other medical practitioners have challenged denial of hospital privileges, the discussion will demonstrate that nurse-midwives cannot expect to succeed by bringing actions based on constitutional and some common law theories. The evaluation of constitutional and common law theories is not intended to be exhaustive, but is included primarily to demonstrate the need for new approaches and to give the reader a basis for comparing the effectiveness of such theories with the potential viability of antitrust doctrines.

264 Contra Costa County Hospital in Martinez. Information obtained from Claire Westdahl, CNM, Berkeley, Cal. (May 17, 1985) (notes on file with author).


Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Section 2 of the Sherman Act, broadly prohibiting monopoly behavior, is also applicable to hospital privileges cases of this type, but a detailed discussion of this cause of action is beyond the scope of this Article.
The Article will then explore the viability of §1 of the Sherman Antitrust Act as a legal tool for addressing denial of hospital privileges to nurse-midwives in appropriate cases. Antitrust doctrine may offer a more effective approach to this problem than constitutional or common law theories. Using the paradigm case as an example, the Article will demonstrate that the viability of antitrust doctrine in hospital privileges cases rests primarily on the willingness of courts to resist modifying the traditional application of the per se rule.

1. Nurse Midwifery Associates v. Hibbett: An Introduction to the Paradigm Case

In the last decade, courts have become increasingly involved in addressing the denial or termination of physicians' hospital privileges. In part, this trend reflects the diminished number of opportunities for hospital practice caused by governmental limitations on hospital growth, coupled with medical school expansion which is producing an oversupply of physicians.267 Thus, nonphysician practitioners are vying for a place in mainstream medicine in a market where the preconditions for disputes over hospital privileges already exist.

As Professor Kissam has observed, the resolution of hospital privileges disputes in favor of nonphysician practitioners is expected to decrease the costs of hospital care, because these practitioners may be able to deliver care at a more competitive price than physicians. A proliferation of successful lawsuits by nonphysician practitioners who are denied hospital privileges is thus expected to "contribute to the development of a sound national policy toward promoting effective competition in health care, maintaining acceptable quality, and restraining the current extraordinary inflation in health care costs."268 Nurse Midwifery Associates v. Hibbett269 represents the first step in the development of the policy foreseen by Kissam, and is the first legal challenge to physician resistance to the more competitive health care market that exists today.

In the late 1970s, two nurse-midwives, Victoria Henderson and Susan Sizemore, attempted to establish a private practice in Nashville, Tennessee. Three local obstetricians, Dr. W. Darrell Martin and his two


269 No. 82-3208 as amended (M.D. Tenn. filed Sept. 3, 1981).
partners, were supportive of the idea and agreed to provide backup. The midwives first applied for hospital privileges at Hendersonville Hospital, where Dr. Martin and his associates already had an active practice. Although their protocol was approved by the obstetric and anesthesiology departments, the pediatric department collectively refused to attend newborns delivered by the nurse-midwives. In order to secure the pediatric department’s approval, the nurse-midwives were asked to provide an outside pediatrician who would agree to attend all infants delivered by nurse-midwives, as well as all other infants delivered in the hospital who were recipients of Medicaid. These recommendations were accepted by the executive committee of the hospital, and since the condition imposed was impossible to fulfill, the midwives decided to go elsewhere.

Dr. Martin’s partners withdrew their support in the face of the controversy at Hendersonville Hospital, and Dr. Martin decided to leave his established practice and move to Nashville, where he hoped to continue his affiliation with the nurse-midwives. Dr. Martin and the midwives applied for privileges at Southern Hills Hospital. Dr. Martin’s application was approved immediately, but the midwives’ was not.

At a meeting with the hospital board, one of the staff obstetricians stated that nurse-midwives would receive privileges at Southern Hills “over his dead body,” and since there were “starving obstetricians in Nashville,” nurse-midwives were not needed at Southern Hills. In addition, the board stated their intention to make certain changes in hospital policies that would make the obstetrical service antithetical to the practice of midwifery, such as closing the birthing room, requiring all women to undergo electronic fetal monitoring one hundred percent of the time, and subjecting all women to IVs, enemas, perineal shaves, and bedrest.

In October, 1980, the Board of Trustees formally voted to deny privileges with the stipulation that the application would be reconsidered if Dr. Martin would agree to provide on-site, over-the-shoulder supervision; if the nurse-midwives could locate a second backup physician; and if the nurse-midwives would purchase insurance indemnifying the hospital for any liability that might accrue as a result of their practice.

At the time that they applied for privileges at Southern Hills, Henderson and Sizemore had simultaneously applied for privileges at Vanderbilt University Hospital. Vanderbilt was planning to move later that year into a new building with two birthing rooms and a delivery capacity of 2500 births per year, an increase of 500 births per year over the old facility. In denying Sizemore and Henderson’s application, the chairman

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270 Amended Complaint, supra note 265, at 9.
271 Freedom of Choice Hearing, supra note 86, at 40.
272 Id. at 41.
273 Id. at 52.
of the obstetrics and gynecology department stated that as a tertiary care center, they could not accommodate any more normal patients (despite evidence to the contrary). Moreover, Sizemore and Henderson were informed that the birthing rooms were there to satisfy the practice needs of the clinical faculty who were full-time employees of Vanderbilt. Despite this pronouncement, private physicians in town were routinely given access to the birthing rooms for their patients. In addition, Susan Sizemore was, at that time, a member of the faculty of the school of nursing with teaching responsibilities in the medical school.

In July of 1980, a local obstetrician, who had threatened to seek cancellation of Dr. Martin's malpractice insurance, was appointed to the board of the physician-owned malpractice provider, State Volunteer Mutual Insurance Company (SVMIC). In October, Dr. Martin was notified that his malpractice insurance would be cancelled as of January 1, 1981, "because of increased risks of undue proportions." Dr. Martin decided to leave the state and relocate in South Carolina, and Nurse Midwifery Associates closed its doors.

As a result of these events, Susan Sizemore, Victoria Henderson, W. Darrell Martin, and two clients of Nurse Midwifery Associates filed suit in federal district court for injunctive relief and damages against the three hospitals that denied the nurse-midwives admitting privileges, SVMIC, the insurance company that cancelled Dr. Martin's malpractice insurance, and several doctors who were involved in these decisions. This is the first such action to ever be filed on behalf of nurse-midwives.

2. Analysis of Constitutional Remedies for Denial of Hospital Privileges

For several reasons, constitutional remedies for denial of hospital privileges may offer insufficient or no relief to nurse-midwives. First, the right to judicial review of constitutional claims is generally limited to claims against public, but not private, hospitals. Second, procedural due process rights for denial of hospital privileges are limited to a guarantee of notice and an opportunity for a hearing. Third, the scope of judicial review of the substantive decisions of hospital boards is limited to (1) whether the applicant was denied procedural due process, and (2) whether, on the record, the board's decision was arbitrary, capricious, unreasonable, or discriminatory. Finally, denial of hospital privileges,

274 Id. at 50-51.
275 Id.
276 SVMIC allegedly controls over 80% of the medical malpractice insurance market in Tennessee.
278 See supra note 86.
except where race is a factor, has not been held to violate the equal protection clause of the Fourteenth Amendment.

a. The Public-Private Limitation on Constitutional Claims

The state action doctrine effectively limits whether or not an applicant has a cognizable constitutional claim for denial of hospital privileges. Only public hospitals are subject to constitutional mandates. Any action challenging denial of hospital privileges on constitutional grounds necessarily involves a threshold inquiry into whether the hospital is a public or private entity. If the hospital is designated a public hospital because it fulfills the state action requirements, it must meet the minimal constitutional requirements of procedural due process — notice and the opportunity to be heard.279 Substantively, courts will review the record only to determine whether the board’s decision was arbitrary, capricious, unreasonable, or discriminatory.280

If, on the other hand, the court does not find state action, and the hospital is designated a private institution, most jurisdictions adhere to the general rule that decisions regarding privileges are within the broad discretionary powers of the hospital management and are not subject to judicial review.281 Some courts have softened this rule by requiring hospitals to adhere to the procedural protections provided in their own bylaws.282 In these cases, however, review is strictly limited to the issue of whether proper procedure was followed, and no judicial review of the substantive aspects of the decision is available.

The distinction between a public and a private hospital thus becomes a compelling focus of litigation and can be determinative of the outcome. In recognition of this harsh reality, some jurisdictions have

recognized a third status for purposes of compelling judicial review of the staffing decisions of private hospitals, that of the quasi-public hospital. The New Jersey Supreme Court in *Griesman v. Newcomb Hospital*\(^{283}\) was the first court to adopt this characterization by holding that Newcomb Hospital, though private in form, was public in substance. The hospital was a nonprofit organization pledged to provide care to the sick and injured, its funds were received primarily from public sources and public solicitation, and its tax benefits were received as a result of its nonprivate, nonprofit aspects. Moreover, since it was the only hospital in an area with a population of 100,000, the hospital had a virtual monopoly on the community's inpatient health care business and could not claim immunity from public supervision and control because it was private in form.\(^{284}\)

Although *Greisman* was decided on public policy, as opposed to constitutional, grounds, some courts have substituted the quasi-public criteria of *Greisman* for traditional state action requirements.\(^{285}\) Under current law, the determination that the activities of an institution involve state action tends to be a considerably more rigorous inquiry than that required to arrive at the conclusion that a hospital is a quasi-public institution.\(^{286}\) By utilizing the quasi-public designation, traditionally private hospitals that would probably not meet the state action requirements are pulled into the public sphere for constitutional purposes, thus broadening the availability of judicial review.\(^{287}\)

In the paradigm case of *Nurse Midwifery Associates v. Hibbett*,\(^{288}\) all of the hospitals that denied the nurse-midwives privileges were "private." The bylaws of all three of the hospitals permitted certified nurse-midwives to apply for limited clinical privileges. However, under established constitutional law principles, judicial review of the denial of hospital privileges would be limited to the narrow question of whether the hospitals had violated the procedural due process requirements of their own bylaws. Thus, the nurse-midwives might well be precluded at the outset

\(^{283}\) 40 N.J. 389, 192 A.2d 817 (1963).

\(^{284}\) Id. at 396, 402-04, 192 A.2d at 821, 824-25.


\(^{288}\) No. 82-3208 as amended (M.D. Tenn. filed Sept. 3, 1981).
from asserting a substantive claim based on the denial of constitutional rights. The scope of substantive review would be somewhat broader only if the action of the hospitals were deemed to be state action, or, in some jurisdictions, if the hospitals were found to be "quasi-public" institutions under *Greisman*.

b. Due Process

i. The Nature of the Constitutionally Protected Interest

In *Hayman v. City of Galveston*, the only hospital privileges case ever to reach the United States Supreme Court, the Court held that a licensed physician has no constitutional right to be appointed to the staff of a public hospital simply by virtue of the fact that he is licensed to practice medicine. However, lower courts have recognized that medical practitioners, including those with limited licensure, such as chiropractors and podiatrists, do have a liberty interest in the right to "engage in the practice of a useful profession." These courts have also held that this liberty interest is sufficient to subject the actions of public hospitals to the procedural and substantive due process requirements of the Fifth and Fourteenth Amendments. Presumably, courts would also recognize such a constitutionally protected right for nurse-midwives.

ii. What Process is Due?

Once a constitutionally protected interest has been identified, courts must then determine what constitutes due process. In the hospital privileges context, one court considered this question in some depth and concluded that "due process . . . requires that a fair and thorough consideration be made of a [doctor's] application for . . . appointment . . . to the staff." The applicant is entitled to a hearing, which need not conform to all of the standards required in a formal judicial proceeding. The applicant should be given notice of the date and time of the hearing well in advance, together with a written statement of the specific reasons the application was denied so that the applicant may prepare an adequate defense. Since a hospital board has no subpoena power, the applicant does not have a right to cross-examine witnesses who have made adverse statements, unless such witnesses voluntarily agree to testify. However,

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291 *Shaw v. Hospital Auth.*, 507 F.2d 625, 628 (5th Cir. 1975).
292 *England v. Louisiana*, 259 F.2d at 627.
the applicant may call witnesses in his own behalf. Participation of counsel for the applicant is at the discretion of the hospital board. The board's ultimate decision must rest on substantial evidence produced at the hearing, and it cannot rely on *ex parte* communications that were not made known to the applicant. Finally, the decision is to be given to the applicant in writing, and it is to include the basis for the decision in order to complete the record for judicial review.294

iii. Scope of Substantive and Procedural Due Process Protections

The term "medical staff privileges" refers to hospital privileges that typically are granted only to licensed allopathic physicians and dentists.295 The recipient of medical staff privileges is allowed to practice as a member of the medical staff of a hospital and is obligated to participate in certain governing and supervisory functions of the hospital. The term "clinical privileges" refers to hospital privileges that may be granted to other health care practitioners to allow them to care for patients in the hospital. These practitioners are not full members of the medical staff, do not participate in the governing functions of the medical staff, and are the object, rather than the subject, of the supervisory function.296

The Joint Commission on Accreditation of Hospitals (JCAH) is an independent quality control agency that is sponsored by five groups, three of which are physicians' professional associations.297 Hospitals voluntarily implement the standards recommended by the JCAH in order to qualify for JCAH accreditation. Accreditation in turn enhances the hospital's desirability in the community it serves, its prestige in attracting the best qualified physicians to its medical staff, its ability to qualify for various types of state and federal funding and reimbursement, and its ability to obtain liability insurance.

The JCAH recommends guidelines for qualifications for medical staff membership, application for staff privileges and renewal procedures, and hearing and appeal mechanisms designed to protect the due process rights of aggrieved applicants.298 These procedures are designed to pro-

294 Id.
297 American Medical Association, the American Academy of Physicians, and the Academy of Surgeons (in addition to the American Hospital Association and the American Dental Association).
298 Professor Kissam notes that the JCAH procedural due process requirement is a weak one in that it fails to provide for an impartial decision-maker and fails to protect the rights to confront adverse evidence and to cross-examine adverse witnesses. In addition, since the JCAH does not require full compliance, violations of the JCAH standards may not be subject to sanction. Kissam, *supra* note 268, at 648.
vide hospitals with extensive mechanisms for evaluating the competence of physicians in order to maintain the quality of care that the hospitals provide.

Hospital bylaws typically incorporate minimum JCAH accreditation standards which provide for full medical staff privileges for physicians and dentists only. Whether to grant limited privileges to other types of providers is strictly discretionary, a discretion that has not been widely exercised.\textsuperscript{299} Thus, in most hospitals, nurse-midwives and other nonphysician practitioners are simply ineligible for clinical privileges of any kind under hospital bylaws. As the ensuing discussion will demonstrate, legal remedies available through application of constitutional law principles may be ineffective to redress denial of hospital privileges to nurse-midwives under both favorable and unfavorable hospital bylaws.\textsuperscript{300}

As previously noted, judicial review of cases where a practitioner's application for hospital privileges was denied and the applicant claims that his or her due process rights were violated involves a two-prong inquiry. First, the court reviews the procedural aspects of the hospital board's decision to determine whether the individual received notice and a hearing that comported with procedural due process standards. Second, the court reviews the record of the proceedings to determine whether the hospital board's decision was arbitrary, capricious, unreasonable, or discriminatory.\textsuperscript{301}

In conducting the second inquiry, most decisions reflect the prevailing view that the hospital governing boards must be given broad discretion in the selection of professional staff.

No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. . . . The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered. In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere. Courts must not attempt to take on the escutcheon of Caduceus.\textsuperscript{302}

\textsuperscript{299} The JCAH Accreditation Manual allows hospitals to grant limited privileges to practitioners who are not members of the medical staff. See generally JCAH, supra note 156, at 117-21.

\textsuperscript{300} See supra notes 260-64 and accompanying text for a survey of nurse-midwives' access to Bay Area hospitals.

\textsuperscript{301} See, e.g., Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173, 176-77 (5th Cir. 1971).

\textsuperscript{302} Id. at 177. But see Silver v. Castle Memorial Hosp., 53 Haw. 475, 497 P.2d 564 (1972), cert. denied, 409 U.S. 1131 (1973) (no need for hospital committees to be empowered to deny privileges; state licensing and review procedures are enough).
Because of this tendency toward judicial deference and the fact that the substantive aspects of such decisions are subject to the "substantial evidence" standard of review, it is likely that the outcome of judicial review would be adverse to nurse-midwives, whether or not the hospital bylaws permitted them to apply for privileges. A comparison of decisions involving hospitals with both favorable and unfavorable bylaws illustrates this probability. The first case involved a physician who was eligible for hospital privileges under the bylaws of the institution to which he applied. The comparison cases involved podiatrists who applied for hospital privileges at hospitals whose bylaws did not extend privileges to them.

Before examining these cases, it should be noted that podiatrists are similar to nurse-midwives in that the state issues them a limited license to practice, they must practice under the supervision of a physician, and, according to JCAH standards, they are eligible for limited hospital privileges. Because of the similarities between these two groups of practitioners, one can infer that cases involving podiatrists would have been similarly decided had they involved nurse-midwives.

In *Sosa v. Board of Managers of Val Verde Memorial Hospital*, the application of a physician, who was eligible to apply for privileges under the hospital's bylaws, was rejected several times. Ultimately, the physician brought suit in federal court alleging that he had been denied his right to due process.

The hospital's bylaws required that applicants be "graduates of an approved medical school, legally licensed to practice in the State of Texas, and practicing in the community or within a reasonable distance of the hospital." The court decided that although the physician applicant met the "paper qualifications," the hospital was entitled "to exact additional standards reasonably related to the operation of the hospital." The court then accepted the hospital's determination that the doctor's character, qualifications, and standing in the community did not meet the hospital's standards.

While the hospital had good reason to reject the physician's application on the basis of demonstrated incompetence in this case, a general policy that allows hospital boards to supplement their objective criteria with broad, subjective requirements gives boards composed of resistant physicians a means to reject the applications of competent nonphysician practitioners such as nurse-midwives. If hospital boards are free to impose additional subjective standards not incorporated into the hospital's bylaws, then virtually any application can be rejected at will. The courts are willing to find that most criteria imposed by hospital boards

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303 437 F.2d 173 (5th Cir. 1971).
304 Id. at 176.
305 Id.
bear a reasonable relationship to proper hospital management. Thus, bylaws that ostensibly invite nurse-midwives to apply for hospital privileges may offer them absolutely no protection from a rejection which will be upheld by the courts.

For example, in the paradigm case of *Nurse Midwifery Associates v. Hibbett*, the bylaws of Southern Hills Hospital invited nurse-midwives to apply for privileges. However, the Board of Trustees imposed the additional requirements that Dr. Martin agree to provide over-the-shoulder supervision, that the midwives provide a second backup physician, and that the midwives purchase insurance to indemnify the hospital. Query whether on review a court would find these additional requirements to be reasonably related to the management of the hospital or would find them to be arbitrary, capricious, or unreasonable.

In cases where the bylaws do not invite application, the review process tends to focus on the "reasonableness" of the bylaws excluding such practitioners from hospital practice. This inquiry, in turn, becomes nothing more than a comparison of the nonphysician's methods of practice with those of allopathic physicians, conducted not by a neutral third party, but by the allopathic physicians themselves. When privileges denied on this basis are subsequently reviewed by courts that give broad discretion to physician decisions, the outcome for the nonphysician practitioner is, once again, likely to be unfavorable.

In *Davidson v. Youngstown Hospital Association*, two experienced, licensed podiatrists petitioned the court for an order to compel the hospital to admit them to its staff. The hospital bylaws did not allow podiatrists to apply for hospital privileges. The podiatrists argued that since they performed a great deal of surgery under local anesthesia, it would be safer for many of their patients with other medical problems, such as cardiovascular disease, to have foot surgery performed in the hospital.

The hospital rejected the applications on the recommendation of the Credentials Committee, which heard an orthopedic surgeon testify that, among other things, the surgery the podiatrists would perform was already being done by present surgical staff; podiatrists are not qualified to do physical examinations; podiatrists are not medical doctors; they are not permitted by law to take care of complications that may arise, such as amputation; podiatrists can only perform minor surgery, and minor surgery unnecessarily burdens the hospital's burgeoning surgical schedule; and physicians must be in attendance when podiatrists perform surgery. In short, the applications were rejected basically because the

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307 See supra notes 271-73 and accompanying text.
309 Id. at 251, 250 N.E.2d at 896.
310 Id. at 253, 250 N.E.2d at 897.
podiatrists did not happen to be orthopedic surgeons. Despite the public welfare implications of the hospital’s decision, the reviewing court concluded that the hospital had not acted arbitrarily, unreasonably, capriciously, or discriminatorily.311

Similarly, in Shaw v. Hospital Authority of Cobb County, the plaintiff’s application for hospital privileges was denied because the hospital bylaws did not extend privileges to licensed podiatrists. However, in reviewing the denial, the Fifth Circuit recognized that the plaintiff had a liberty interest in the right to practice his occupation. The hospital was thus required to extend full due process protection to the plaintiff’s application. Furthermore, in holding that the plaintiff had not been accorded his rights, the court announced that an important constitutional right was at stake and that the hospital must take that right into account when reviewing the podiatrist’s application on remand.

As one member of the court noted, however, in a case where the hospital’s bylaws do not recognize the eligibility of certain practitioners for hospital privileges, “the intrinsic reasonableness of the regulation is the principal matter for inquiry” in the procedural due process hearing.313 Thus, in cases where the bylaws exclude a practitioner from eligibility for hospital privileges, substantive and procedural due process rights guarantee the practitioner only a hearing at which he or she may present arguments as to why the exclusionary bylaws are unreasonable. Presumably, the hospital may then exercise its discretion on that question by asserting that its position is rationally related to its interest in maintaining a high quality of care. No evaluation of the individual practitioner’s competence or qualifications, as was done in Sosa, need be undertaken.

The court in Cameron v. New Hanover Memorial Hospital, Inc., failed to ameliorate this limitation. In that case, two podiatrists, who had formerly enjoyed full privileges, challenged an amendment to the hospital’s bylaws, which totally excluded podiatrists from hospital practice. Unable to persuade the hospital to return to its former bylaws, the podiatrists brought suit alleging that the hospital’s actions “in refusing to amend the . . . bylaws so as to permit plaintiffs’ application for hospital privileges to be considered on its own merits constitutes a denial of procedural and substantive due process of law.”315

While the hospital ultimately granted the podiatrists very limited privileges pursuant to a preliminary injunction, the podiatrists claimed

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311 Id. at 254, 250 N.E.2d at 897-98.
312 507 F.2d 625 (5th Cir. 1975).
313 Id. at 629 (Brown, C.J., concurring).
315 293 S.E.2d at 904.
316 The podiatrists, who had practiced foot surgery for years, were granted “Type 1 podiatric privileges,” which allowed them to “treat the foot by any mechanical, medical, and surgical
at trial that throughout the process, "the sole relevant consideration raised by their application," competency to perform surgical procedures in a hospital, has never been reviewed by [the hospital]." The trial court disagreed, and it granted the defendant's motion for a directed verdict at the close of the plaintiffs' case. The trial court's holding was affirmed on appeal.

Applicants are particularly likely to be rejected where the hospital, and later the reviewing court, does not perceive that the practitioner is offering a unique service that cannot be performed by other members of the existing medical staff. In both Davidson and Cameron, for example, the orthopedic surgeons did not recognize that podiatrists might be uniquely competent to perform delicate foot surgery because of their total concentration on that one area of the body. Similarly, physicians serving on hospital review boards may not recognize that a midwife-attended birth may enhance the well-being of some women and their infants. Failure to perceive these realities leaves decision-makers with a kind of "more is better" mentality that results in decisions such as those in Davidson and Shaw.

As the above discussion demonstrates, it is quite possible for courts to find that no constitutional right to due process has been violated when qualified nurse-midwives are denied hospital privileges, whether or not the nurse-midwives are eligible to apply for privileges under the hospitals' bylaws. This likely result stems from several factors. First, the actions of private hospitals are generally not subject to judicial review. Second, when courts review the actions of public hospitals, the scope of review is limited to whether the applicant received notice and a hearing and whether, on the record, the hospital's decision was arbitrary, capricious, unreasonable, or discriminatory. Finally, in applying the latter

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means in a manner that does not cause bleeding or require an anesthetic," except for removal of toenails. Id. at 905.

317 Id. at 921-22.
318 Id. at 924.
322 507 F.2d 625 (5th Cir. 1975).

In Hay v. Scripps Memorial Hosp.-La Jolla, 183 Cal. App. 3d 753, 228 Cal. Rptr. 413 (1986), plaintiff challenged a limitation of his hospital privileges. Dr. Hay, an experienced family practice physician, requested privileges to perform the dilatation and curettage (D & C) procedure at defendant hospital.

Dr. Hay had performed D & Cs for many years as part of his practice at a hospital in Encinitas, California. He had served a residency in family practice, which included eight months of training in obstetrics and gynecology. Nevertheless, the hospital denied Dr. Hay the privilege of performing D & Cs because he did not meet the requirement of having completed a four-year residency in obstetrics and gynecology.

The court upheld the hospital board's decision, stating that the requirement was rationally related to the hospital's goal of ensuring the competence of its medical staff and preventing an unreasonable risk of harm to patients. The judge explained, "It is not irrational to conclude that more training is better than less training," Id. at 761, 228 Cal. Rptr. at 419.
standard, courts are willing to grant broad discretion to hospital boards. Given these obstacles, it is unlikely that nurse-midwives, such as those in the paradigm case, would be successful in asserting claims based on a due process violation.

c. Equal Protection

Equal protection claims are, of course, also subject to a threshold finding of state action. Where state action is present, claims that the denial of hospital privileges violates equal protection are successful only when race is a factor in the denial. Under those circumstances, courts have found physicians to be a class, and they have required that members of the class be given equal treatment.\textsuperscript{323}

Attempts by practitioners other than allopathic physicians to broaden the class for purposes of equal protection analysis have not been successful. In 1927, the Supreme Court decided \textit{Hayman v. City of Galveston.}\textsuperscript{324} In that case, the plaintiff, an osteopathic physician ineligible for hospital privileges, argued that to allow some physicians but not all to have hospital privileges was a denial of equal protection of the laws. The court rejected this argument and decided that excluding some groups of state authorized practitioners from hospital practice was not unreasonable or arbitrary. Instead, the court found such exclusions to be a permissible exercise of the hospital management's judgment.

Years later, the plaintiff podiatrist in \textit{Shaw v. Hospital Authority of Cobb County}\textsuperscript{325} was no more successful. In that case, the plaintiff argued that to exclude podiatrists as a class "while admitting dentists, who are also limited by law to one area of the body, is a violation of . . . equal protection."\textsuperscript{326} The plaintiff propounded the view that all practitioners of healing arts licensed by the state are members of one class, and restricting eligibility for hospital privileges to physicians and dentists creates classifications lacking a rational basis.\textsuperscript{327} "We believe this argument is too attenuated," responded the court. "Such a class is too large to be meaningful, and we are unable to equate the various branches of the healing arts which would necessarily be included. Therefore, we reject [plaintiff's] equal protection claim."\textsuperscript{328} Given the similarity between podiatrists and nurse-midwives, this case suggests that an equal protec-

\textsuperscript{324} 273 U.S. 414 (1927).
\textsuperscript{325} 507 F.2d 625 (5th Cir. 1975).
\textsuperscript{326} \textit{Id.} at 627.
\textsuperscript{327} \textit{Id.} at 628.
\textsuperscript{328} \textit{Id.}
tion claim would not be a fruitful means for nurse-midwives to challenge denial of hospital privileges.

3. Analysis of Common Law Remedies for Denial of Hospital Privileges

California is an example of a jurisdiction where legal doctrines maximize the value of certain common law principles as tools for redressing denial of hospital privileges, at least for physicians. The genesis of California’s law may be traced to Greisman v. Newcomb Hospital. Although Greisman’s characterization of hospitals as “quasi-public” was adopted primarily by courts wishing to subject “private” hospitals that were private in form to constitutional standards, the Greisman case was actually based on common law principles and public policy considerations.

In Greisman, osteopaths who were ineligible for hospital privileges sued to compel the hospital to admit them. The hospital required its doctors to be members of the County Medical Society in order to be eligible for hospital privileges. Yet, because osteopath training differed from that of allopathic physicians, osteopaths did not qualify for membership in the County Medical Society. Thus, osteopaths were automatically excluded from hospital practice.

The court held that the hospital did not have the right to exclude osteopathic physicians from its staff without consideration of individual merit simply because the bylaws required prospective applicants to be members of the County Medical Society. Underlying the court’s holding was its opinion that the legal system has a responsibility to employ common law doctrines to regulate private business and the professions for the common good. Since hospitals are operated for public as opposed to private ends, the power of the medical staff to grant hospital privileges is a fiduciary power to be exercised in the interest of the public welfare. Thus, the decisions of hospital committees in appointing medical staff members are subject to judicial scrutiny and regulation according to established principles of common law.

Adopting the reasoning in Greisman eventually led the California courts to reject any distinction between public and private hospitals with respect to the availability of judicial review for the denial of hospital privileges. Coupled with the recognition of the common law right of “fair procedure” and the “substantial” right to pursue a legitimate call-

330 Id. at 397, 192 A.2d at 821.
332 For a complete review of the common law doctrine entitling physicians whose hospital privi-
ing or profession without unlawful interference, the obliteration of the public-private distinction made virtually all hospital privileges decisions reviewable on both procedural and substantive grounds.

In reviewing such decisions, however, California courts remain deferential to the management decisions of hospital boards. Procedurally, the courts look to see whether the hospital followed the due process guarantees mandated by its bylaws and whether it gave the required notice. The standard of substantive review is limited to an examination of the proceedings to determine whether the denial was arbitrary, capricious, or entirely lacking in evidentiary support.

Despite the courts’ apparent adherence to traditional standards, common law doctrines have emerged that might facilitate successful challenges by nurse-midwives to adverse hospital privileges decisions. Physician litigants typically bring actions charging hospitals and their respective board members with intentional, unjustified, or unlawful interference with the physician’s right to pursue a lawful business, calling, trade, or occupation. The origins of this tort can be traced to the so-


335 Ascherman v. San Francisco Medical Soc'y, 39 Cal. App. 3d at 647, 114 Cal. Rptr. at 696. In an unpublished opinion of a prior proceeding in the Ascherman case, a California court of appeal “rejected the claim that 'in order to maintain professional standards and medical care of high quality, private hospitals and their staffs must have absolute discretion to exclude doctors from membership, without possibility of suit for damages resulting from the exclusion.' ” Id. at 633, 114 Cal. Rptr. at 686, quoting Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. 2d 806, 810, 376 P.2d 568, 570, 26 Cal. Rptr. 640, 642 (1962). In Ascherman the court also found statutory support for the requirement that private hospitals be governed by the same procedural and substantive criteria as public hospitals. The court concluded that in enacting Cal. Bus. & Prof. Code § 2392.5, which defines the relationship between hospitals and their medical staffs, the legislature intended private hospitals to be governed by the same criteria as public hospitals. Thus, private hospitals may not exclude a physician except for cause and must grant a fair hearing to determine whether or not his qualifications meet the requirements established by law. 39 Cal. App. 3d at 647, 114 Cal. Rptr. at 696.


337 Lewin, 82 Cal. App. 3d at 386, 146 Cal. Rptr. at 903.

338 Id. at 385, 146 Cal. Rptr. at 902-03.


In Boos v. Donnell, 421 P.2d 644 (Okla. 1966), a chiropractor was denied privileges by a hospital whose bylaws granted privileges only to physicians and surgeons. The chiropractor sued on a novel tort theory, claiming that the hospital had failed in its duty to appoint a
called "business torts" — intentional interference with a contractual relationship, a business relationship, or a prospective economic advantage.

The elements of a prima facie case for intentional interference with a prospective economic advantage (IIPEA) include:

(1) an economic relationship between the plaintiff and some third person containing the probability of future economic benefit to the plaintiff;
(2) knowledge by the defendant of the existence of the relationship;
(3) intentional acts on the part of the defendant designed to disrupt the relationship; (4) actual disruption of the relationship; and (5) damage to the plaintiff proximately caused by the acts of the defendant. 340

Once the plaintiff has made a prima facie case, the burden shifts to the defendant to justify his actions by pleading, as an affirmative defense, that his conduct was not improper. 341

California decisional law has modified the traditional elements of IIPEA, however, in cases involving physicians. In Willis v. Santa Ana Community Hospital Association, 342 the court defined the issues to be: "(1) whether there is an interference with the plaintiff's right to practice his calling, (2) whether such an interference is intentional, and if so, (3) whether such interference is either by unlawful means, or by means otherwise lawful, when there is a lack of sufficient justification." 343 Presumably, the plaintiff bears the burden of proof on the issues of whether there has been an interference, whether the interference was intentional, and whether the interference was by illegal means. In deciding whether there was sufficient justification for the denial, the court takes a balancing approach similar to that taken by courts in determining whether the defendant's conduct was improper under traditional interference with contract doctrine. 344

That denial of hospital privileges represents an interference with the physician’s right to practice his profession is easily established. Recent cases recognize that denial of hospital privileges effectively impairs the physician’s right to practice his profession even in the absence of a showing of economic impairment. 345 Thus, the first element of the cause of action poses no obstacle to judicial review.

343 Id. at 810, 376 P.2d at 570, 26 Cal. Rptr. at 642.
Nor is it difficult to establish the "intentional" element of the test. Although the required elements of intent were not specifically addressed in any of the hospital privileges cases that applied the Willis formulation, presumably the elements necessary to show intent parallel those necessary to establish intentional interference with contractual relations. By analogy, then, intent can be established by showing that the interference was either desired by the actor, or that the actor knew that the interference was substantially certain to result from his conduct. Since it is common knowledge that a physician cannot adequately practice medicine without access to hospital facilities, it is patently obvious to a hospital board that an interference with the doctor's practice will result from a denial of hospital privileges.

Thus, the thrust of the inquiry is whether the interference was illegal, unjustified, or contrary to public policy. In analyzing these factors, the courts' persistent discomfort with second-guessing the decisions of hospital boards clearly emerges. Physicians in all of the reported cases that framed the issues according to the Willis approach have been unsuccessful.

Nevertheless, compared to constitutional standards, the very nature of the inquiry expands the scope of substantive review and makes it necessary for the courts to consider the respective interests of both the applicant and the hospital. The potential usefulness of this balancing approach for nurse-midwives is apparent from the Willis decision itself, because of the court's implicit advocacy of close judicial scrutiny of the hospitals' asserted justifications for denial of privileges.

The Willis case involved an appeal from a dismissal for failure to state a cause of action. In reversing the trial court's dismissal, the court stated that "wholly unjustified conduct" was alleged by osteopathic phy-

346 See infra note 350.
347 Restatement (Second) of Torts § 767 (1974).
348 "Unlawful means" has been interpreted as meaning "contrary to public policy." See Lewin, 82 Cal. App. 3d at 386, 146 Cal. Rptr. at 903.
349 "Judges are untrained and courts ill-equipped for hospital administration, and it is neither possible nor desirable for the courts to act as supervening boards of directors for every [hospital]." Id. at 383, 146 Cal. Rptr. at 902.
350 Very few hospital privileges cases in California actually have been litigated under the Willis balancing approach. All of the reported cases have involved closed-staff departments within the hospital (radiology, renal dialysis). The unanimous opinion of the courts has been that closed-staff departments, that by their very nature exclude other specialists from practicing at that hospital, are not unjustified or contrary to public policy. See Centeno v. Roseville Community Hosp., 107 Cal. App. 3d 62, 167 Cal. Rptr. 183 (1979); Lewin v. Saint Joseph Hosp., 82 Cal. App. 3d 368, 146 Cal. Rptr. 892 (1978); Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).
351 See Kessenick, supra note 287, at 54-56, for a review of the grounds courts have found to be sufficient and insufficient to warrant denial of a physician's application for hospital privileges. Grounds found to be sufficient to sustain denial tend to revolve around incompetence or professional misconduct. Grounds found insufficient include the requirement that the applicant be a member of a county medical society and an asserted inability of the applicant to "get along with" other physicians.
352 Willis, 58 Cal. 2d at 810, 376 P.2d at 570, 26 Cal. Rptr. at 642.
sicians "of the highest qualifications" who were denied access to hospital facilities as a result of a conspiracy by allopathic physicians to restrain competition in the medical community. 353 "Whether there is justification is determined not by applying precise standards but by balancing, in the light of all the circumstances, the respective importance to society and the parties of protecting the activities interfered with on the one hand and permitting the interference on the other." 354

By comparison, courts that are less sympathetic to the practitioner’s plight have successfully thwarted the inquiry without any consideration whatsoever of the interests at stake. In Buckner v. Lower Florida Keys Hospital District, 355 for example, the plaintiff physician, whose hospital privileges were terminated, brought an action alleging, inter alia, wrongful interference with his profession. The court recited the rule that the cause of action for wrongful interference with a business relationship "is recognized only when the interference is by one who is not a party to that relationship." 356 Applying this rule in a highly unusual fashion, the court concluded that the hospital’s medical staff, its review boards, its board of trustees, and its administration all constituted a composite group, no part of which had the power to act alone in rendering a decision on hospital privileges. The court concluded that there was no interference by a "third party," and thus no interference with a business relationship that was cognizable under traditional principles of tort law. 357 The court then dismissed the complaint.

The result in Buckner is anomalous, since, by analogy to numerous other business tort cases, the relationship with which the hospital interfered was not the relationship between the physician and the hospital, as Buckner concluded, but was the relationship between the physician and future patients requiring hospitalization. 358 Assuming that the latter characterization is the correct one, then the hospital as a composite group is clearly capable of interfering in the relationship between the physician and certain unnamed third parties, namely his patients who may need his care in the hospital. If the characterization of the Buckner court is accepted, however, a cause of action for intentional interference can never be brought against a hospital, and the merits of the case need never be reached.

353 Id. at 810-11, 376 P.2d at 570-71, 26 Cal. Rptr. at 642-43.
354 Id. at 810, 376 P.2d at 570, 26 Cal. Rptr. at 642.
355 403 So. 2d 1025 (Fla. 1981).
356 Id. at 1028.
357 Id.
A comparison of *Willis* and *Buckner* highlights the necessity of focusing the inquiry on the merits of the hospital board’s decision in order for nurse-midwives to bring successful actions based on common law theories. There are two potential drawbacks to the *Willis* approach, however. Most obvious is the fact that few hospitals allow nurse-midwives to apply for privileges. Where nurse-midwives are not eligible for privileges, a litigant would be hard-pressed to establish that the hospital board’s decision was unjustified or contrary to established public policy, especially in view of the official position of the JCAH, which sanctions hospital privileges for nurse-midwives only on a very restricted basis. Even in those hospitals where nurse-midwives are permitted to apply for privileges, courts have not yet demonstrated a willingness to extend the same kind of protections to practitioners with limited licensure as has been extended to physicians. Still, the fact that *Willis* requires a court to balance the parties’ interests provides a slim possibility of success.

Other related doctrinal developments in California also portend a chance of success for nurse-midwives should they choose to bring actions for denial of hospital privileges based on common law principles. For example, courts are beginning to require hospitals to show that criteria used for staff selection actually affect the quality of patient care, if that is the asserted justification for the rejection. In *Miller v. Eisenhower Medical Center*, the bylaws required that an applicant have “the ability to work with other medical personnel in the hospital setting.” The court concluded that the bylaw presented a danger of “arbitrary and irrational application, . . . and could be used ‘as a subterfuge where considerations having no relevance to fitness are present.’” In order to minimize this danger, the court held that the hospital must demonstrate a nexus between the applicant’s “ability to ‘work with others’ and the effect of that ability on the quality of patient care provided.”

The court recognized that hospital boards may deny privileges for reasons unrelated or only remotely related to standards of patient care. Judicial sensitivity to this possibility in today’s competitive medical marketplace is essential to successful actions by nurse-midwives for denial of hospital privileges. Since hospitals’ claims that they are denying privileges in order to maintain particular standards of care tend to be accepted without question, nurse-midwives against whom this defense might be raised are in a very vulnerable position if courts are unwilling to

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359 *See supra* notes 260-64 and accompanying text.
360 *See supra* notes 297-99 and accompanying text.
361 *See infra* note 377.
363 *Id.* at 628-29, 614 P.2d at 267, 166 Cal. Rptr. at 835.
364 *Id.* at 628, 614 P.2d at 267, 166 Cal. Rptr. at 835.
365 *Id.* at 628, 614 P.2d at 266, 166 Cal. Rptr. at 834.
explore the validity of such assertions more thoroughly. Courts that shift
the burden to the hospital in the way the Miller court did, however,
enhance the likelihood that the applicant for hospital privileges will
prevail.

In Nurse Midwifery Associates v. Hibbett, there appear to have
been several clear-cut examples of intentional interference with the plain-
tiffs' business relationships. To cite one example, a physician, who
served on the board of the malpractice insurer, recommended that the
malpractice insurance of the nurse-midwives' collaborating physician not
be renewed. The physician was thus forced to terminate his contractual
relationship with the nurse-midwives. Termination of the collaboration
agreement defeated any possibility that the nurse-midwives would qualify
for hospital privileges. Since the insurance board member was also a
member of one of the hospital committees that denied the nurse-mid-
wives privileges, he was presumably well aware of the requirement that
nurse-midwives practice with a collaborating physician. He knew that
termination of the collaboration agreement would effectively disqualify
the nurse-midwives.

There is a striking similarity between the facts of Hibbett and the
facts of Willis. In both cases, the defendants were apparently moti-
vated more by anticompetitive desires than by "quality of care" con-
cerns. By applying the balancing approach devised by the Willis
court, it is conceivable that a court might conclude that the insurance
board member's interference in Hibbett was improper and unjustified.
Furthermore, if the hospitals were to assert that exclusion of nurse-mid-
wives was necessary to maintain a particular quality of care, the decision
in Miller v. Eisenhower suggests that the hospitals should have the
burden of demonstrating a nexus between the exclusion of nurse-mid-
wives and enhanced quality of care. Since the hospitals apparently made
a "quality of care" determination at the time they adopted bylaws per-
mitting nurse-midwives to apply for privileges, the burden-shifting effect
of Miller could operate to the advantage of the plaintiffs.

Unfortunately, without the benefit of the courts' insights in Willis
and Miller, the chances of success are remote. A case in point is Cam-
eron v. New Hanover Memorial Hospital, Inc. In Cameron, two podia-
trists were forced to abandon their in-patient practice, which they had
built and maintained for four years, when the two hospitals in which they

366 Nurse Midwifery Assocs. v. Hibbett, No. 82-3208 as amended (M.D. Tenn. filed Sept. 3,
367 Indeed, the plaintiffs are alleging tortious interference with the practice of their profession.
Amended Complaint, supra note 265, at 20.
368 See supra notes 353-54 and accompanying text.
369 See supra notes 342-52 and accompanying text.
370 See supra notes 362-65 and accompanying text.
practiced amended their bylaws to exclude podiatrists from the class of practitioners eligible for hospital privileges. The podiatrists struggled unsuccessfully with the hospitals for a number of years before filing suit.

Their complaint included three causes of action in tort: interference with the plaintiffs' business, interference with the plaintiffs' contractual rights with the defendant hospitals, and interference with the plaintiffs' prospective advantage. These causes of action were directed at certain orthopedic surgeons, who were instrumental in amending the bylaws. The plaintiffs introduced evidence that the orthopedic surgeons had conducted an active campaign to eliminate the practice of podiatry from the two hospitals. Both doctors expressed the opinion that to allow podiatrists to perform in-patient surgery downgraded the profession of orthopedic surgery. At one point, they threatened to withdraw from one of the hospitals and to urge other orthopedic surgeons to do the same if the hospital reinstated its policy of admitting podiatrists to the staff.

The court affirmed a directed verdict for the defendants. Noting that the "gist" of all three torts involved "bad motive," the court concluded that the plaintiffs failed to prove that the defendants "acted with malice and for a reason not reasonably related to the protection of a legitimate business interest of [defendants]." In addition, the court concluded that "the defendants were acting in large measure pursuant to an 'important quality control component' in the administration of the hospital."

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As with the case of constitutional claims, maintaining actions based on common law theories derived from so-called "business torts" also presents the nonphysician practitioner with serious obstacles and limitations. Even in California, the fundamental right to practice a profession without unlawful interference has never been recognized with respect to nonphysician practitioners such as nurse-midwives. If such a right were to be recognized, the need to prove that the interference was unjustified would present a major obstacle to the plaintiff's case. To carry the burden, the plaintiff would be required to prove that her asserted right outweighed the interests of the hospital in excluding her.

A plaintiff may be further hampered in her efforts to obtain judicial review of substantive questions by the existence of immunities extended to hospital peer review activities. Some jurisdictions extend absolute or

372 Id. at 904.
373 Id. at 908.
374 Id. at 909.
375 Id. at 916.
376 Id. at 920.
377 Summerhayes v. Good Samaritan Hosp., No. 513775 (Cal. Super. Ct. demurrer granted June 22, 1983). In Summerhayes, the court granted the defendant's demurrer, ruling that since neither the hospital nor state law required that nurse-midwives be considered for hospital privileges, the plaintiff had no right to sue for not having been granted such privileges.
qualified immunities to certain proceedings in which the qualifications of the applicants are evaluated. In the case of claims of interference with the right to practice, the plaintiff may be unable to prove lack of sufficient justification simply because the proof is inadmissible.\textsuperscript{378}

4. Addressing Denial of Hospital Privileges to Nurse-Midwives by Means of the Sherman Antitrust Act\textsuperscript{379}

a. Prospective Advantages of the Sherman Act

Although \textit{Nurse Midwifery Associates v. Hibbett} is the first antitrust case to be filed on behalf of nurse-midwives,\textsuperscript{380} such an approach may offer claimants several advantages over the common law and constitutional law theories of recovery previously discussed. One advantage is that a claimant does not have to surmount the barrier imposed by the state action doctrine, as does a litigant who brings an action based on constitutional law principles. While there is a state action doctrine that applies to antitrust actions, its impact is not relevant to this discussion. The Sherman Act, with some possible exceptions, is generally applicable to both public and private hospitals.\textsuperscript{381}

Another advantage of the Sherman Act is the available scope of judicial review. When a plaintiff brings an action claiming that she was denied hospital privileges in violation of due process of law, the reviewing court is limited to the substantial evidence standard of review. Similarly, when the plaintiff claims interference with her right to practice a

\textsuperscript{378} See, e.g., \textit{CAL. CIV. CODE} §§ 47(2) and 43.8 (West 1982); \textit{Cameron v. New Hanover Memorial Hosp., Inc.}, 293 S.E.2d 901 (N.C. Ct. App.), \textit{appeal dismissed}, 307 N.C. 129, 297 S.E.2d 399 (1982) (minutes of medical staff meeting are privileged); \textit{Goodley v. Sullivant}, 32 Cal. App. 3d 619, 108 Cal. Rptr. 451 (1973) (statements made at the procedural hearings were absolutely privileged; cause of action for tortious interference was dismissed for lack of sufficient justification); \textit{Hackethal v. Weissbein}, 24 Cal. 3d 55, 592 P.2d 1175, 154 Cal. Rptr. 423 (1979) (statements made before disciplinary boards may be introduced as evidence in actions for defamation and interference with business relationship).

\textsuperscript{379} Because this discussion is meant to be illustrative and is not an exploration of antitrust law per se, it will focus on the most clear-cut violation of the Sherman Act represented by the facts of \textit{Nurse Midwifery Assoc. v. Hibbett}, No. 82-3208 as amended (M.D. Tenn. filed Sept. 3, 1981): a violation of 15 U.S.C.A. § 1 (West 1986). \textit{See supra} notes 267-78 and accompanying text. Section 1 broadly prohibits contracts, combinations, or conspiracies in restraint of trade. Specific offenses that are prohibited under § 1 include price-fixing, division of markets, tying arrangements, group boycotts and refusals to deal, and bottlenecking. For purposes of this discussion, only the offense of group boycott and concerted refusal to deal will be considered. Bottlenecking and illegal tying arrangements are also applicable to the denial of hospital privileges, and they will undoubtedly be explored by nonphysician antitrust plaintiffs in the future.

\textsuperscript{380} In \textit{Cameron v. New Hanover Memorial Hosp., Inc.}, 293 S.E.2d 901 (N.C. Ct. App.), \textit{appeal dismissed}, 307 N.C. 129, 297 S.E.2d 399 (1982), two nonphysician practitioners (podiatrists) unsuccessfully brought an action based on a North Carolina state statute that is substantially identical to § 1 of the Sherman Act.

\textsuperscript{381} While a discussion of the state action doctrine under antitrust law is beyond the scope of this Article, the interested reader is referred to the recent case of \textit{Hoover v. Ronwin}, 466 U.S. 558, \textit{reh'g denied}, 467 U.S. 1268 (1984). \textit{See also} \textit{Kissam}, \textit{supra} note 268, at 619-25 (discussion of whether the state action defense is applicable to hospital privileges cases).
lawful profession in California, the courts also adhere to the substantial evidence standard. In an antitrust action, by contrast, the court functions not as a reviewing court, but as a trial court, and the plaintiff is granted a full trial on the merits. In addition, the plaintiff is not required to exhaust all administrative remedies before filing suit, as she is when the action is based on constitutional and some common law theories.\(^{382}\)

One of the most important advantages of the antitrust approach, however, is its capacity to change the focus of litigation. Instead of deciding whether protected individual rights have been violated or whether a tort has been committed, antitrust doctrine has the potential to focus attention on the closed cartel nature of the health care delivery system and to evaluate that system with respect to national economic policy.

Also inherent in § 1 of the Sherman Act is the potential for applying a very rigorous rule of decision. There are two approaches that the court can take when analyzing § 1 violations. Depending on the particular violation alleged, the court will apply either the "rule of reason" standard or the "per se" rule.\(^{383}\) While most antitrust violations are subject to the rule of reason standard,\(^{384}\) some violations are per se illegal. Under the rule of reason, the court applies a traditional balancing approach in which the anticompetitive effects of a particular practice are weighed against the procompetitive justifications in the light of all of the circumstances, including facts peculiar to the particular business, the history of the restraint, and the reasons it was imposed.\(^{385}\)

Certain violations of § 1 — group boycotts and concerted refusals to deal,\(^{386}\) tying arrangements,\(^{387}\) market divisions,\(^{388}\) and price-fixing schemes\(^{389}\) — have been held to be illegal per se. Per se offenses are those whose anticompetitive effects are so patently obvious that no inquiry into the particular nature of the industry or the background of the restraint is necessary.\(^{390}\)

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\(^{382}\) Westlake Community Hosp. v. Superior Court, 17 Cal. 3d 465, 551 P.2d 410, 131 Cal. Rptr. 90 (1976).

\(^{383}\) For a general discussion of the history and application of the rule of reason and per se approaches, see L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST 165-97 (1977).

\(^{384}\) Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 343 (1982).

\(^{385}\) Id. The rule of reason approach to restraints on trade was delineated by the Supreme Court in Standard Oil Co. v. United States, 221 U.S. 1, 62 (1911). For the classic statement of the rule of reason, see Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).


The impact of the per se rule is extraordinary. There is no balancing of interests, as there is under the rule of reason. Once the plaintiff has proven the violation, the court will not consider affirmative defenses. The burden of proof sufficient to trigger the per se rule is rigorous, but once the plaintiff has met the burden, she is shielded from the defendant's assertions of procompetitive justifications.

The possible application of the per se rule, in combination with the altered focus of the litigation, may enhance the ability of courts to reach and respond to the underlying policy issues in cases such as *Nurse Midwifery Associates v. Hibbett*. The remainder of this Article will develop the idea that in order to fully realize the potential of § 1 of the Sherman Act in addressing denial of hospital privileges to nonphysician practitioners such as nurse-midwives, courts must resist the temptation to modify the per se rule in such a way that the ultimate effect is simply to validate the monopoly of institutionalized medicine a priori and deprive plaintiffs of the potential benefits of the antitrust laws.

b. The Sherman Antitrust Act and the "Learned Professions"

Before 1975, antitrust law had been applied only in instances where denial of hospital privileges was used by fee-for-service physicians as a means of discouraging the development of prepaid health plans that employed physicians on a salaried basis. In other cases, the courts applied the so-called "learned professions exemption" and declined to judge the anticompetitive conduct of professional groups by the same standards that would apply in commercial settings. In *United States v. Oregon State Medical Society*, for example, the court held that proven restraints on trade were justifiable as reasonable means of maintaining proper standards of medical ethics. Although the Supreme Court carefully refrained from holding that there was a "learned professions exemption" to the antitrust laws, many lower courts interpreted dicta

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392 Arizona v. Maricopa County Medical Soc'y, 457 U.S. at 351.
394 343 U.S. 326, 336 (1952) (citing Semler v. Oregon State Bd. of Dental Examiners, 294 U.S. 608 (1935)).
395 The Sherman Act applies to "trade or commerce." Dicta in some Supreme Court cases suggested that there was a distinction between "trade or commerce" and the learned professions which exempted the learned professions from the Act's operation: "Much argument has been addressed to the question of whether a physician's practice of his profession constitutes trade under § 3 of the Sherman Act. In light of what we shall say with respect to the charge laid in the indictment, we need not consider or decide this question." American Medical Assoc. v. United States, 317 U.S. at 528. Similarly, in United States v. National Ass'n of Real Estate Bds., 339 U.S. 485, 489 (1950), the Supreme Court stated "we do not intimate an opinion on the correctness of the application of the term [trade] to the professions."
in cases such as Oregon v. United States Medical Society and Semler v. Oregon State Board of Dental Examiners to mean that such an exemption existed.

It was not until the Court’s decision in Goldfarb v. Virginia State Bar that the Supreme Court explicitly addressed this confusing area of the law. In Goldfarb, the Court considered a price-fixing agreement among lawyers and held that the professions do not enjoy an exemption from the antitrust laws, at least with respect to the business aspects of their professional activities. In the now-famous footnote 17, however, the Court carefully limited its holding to the facts before it, and it preserved the opportunity for courts to exercise discretion in deciding whether to apply the antitrust laws wholesale to the “public service” aspects of professions.

In the year following the Goldfarb decision, the Court decided Hospital Building Co. v. Trustees of Rex Hospital and further enhanced the possibilities for plaintiffs to bring actions based on the Sherman Act by expanding the jurisdictional reach of the Act. The Court held that in

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396 343 U.S. 326 (1952). The Court held that some restraints on trade could be justified as reasonable to maintain proper standards of medical ethics.

We might observe in passing, however, that there are ethical considerations where the historical direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.

*Id.* at 336.

397 294 U.S. 608 (1935). A regulation preventing dentists from engaging in some forms of advertising was upheld against a due process challenge.

The legislature was not dealing with traders in commodities, but with the vital interest of public health, and with a profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition of the market place. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but protection against those who would prey upon a public peculiarly susceptible to imposition through alluring promises of physical relief. And the community is concerned in providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous.

*Id.* at 612.

398 See, e.g., Marjorie Webster Junior College, Inc. v. Middle States Ass’n of Colleges and Secondary Schools, Inc., 432 F.2d 650 (D.C. Cir.), cert. denied, 400 U.S. 965 (1970) (college accreditation is a noncommercial activity not subject to regulation under the Sherman Act).


400 *Id.* at 786-88.

401 *Id.* at 788-89. Footnote 17 states:

The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today.

order to satisfy the Sherman Act's jurisdictional requirement, the activity need not take place in interstate commerce, but may have an indirect and purely local effect on interstate commerce.403 Under this test, if the proscribed activity substantially and adversely affects interstate commerce, the threshold for establishing subject matter jurisdiction will have been met.404 The plaintiff in *Rex* was able to demonstrate the required nexus by alleging that the conspiracy to block expansion of the hospital would have an adverse effect on its purchase of supplies from other states, its billings to Medicare and Medicaid, the volume of out-of-state patients it would attract, its management services contract with its out-of-state parent corporation, and its plans to borrow capital from out-of-state lenders for a large part of the planned expansion.405 Using similar criteria, plaintiffs in subsequent cases regarding denial of hospital privileges have had little difficulty in alleging and proving a sufficient nexus with interstate commerce to establish subject matter jurisdiction.406

This area of law was further developed by the Court's decision in *National Society of Professional Engineers v. United States*.407 In *National Society*, the Court upheld the judgment of the lower court in its application of the per se rule of illegality to one of the Society's ethical canons. The ethical rule in question prohibited competitive price bidding among engineers. The rule was justified by the assertion that the restraint served the public welfare by eliminating price competition in an industry where any diminution in quality could have serious public safety consequences. The Court cautioned that footnote 17 in *Goldfarb* was not to be read as fashioning a broad exemption under the rule of reason for learned professions. However, "we adhere," said the Court, "to the view expressed in *Goldfarb* that, by their nature, professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote this competition, and thus fall within the rule of reason."408

Thus, while applying traditional antitrust principles to the ethical norms of the professional engineers, the Court once again expressed its uncertainty about generalizing this approach to all professional behavior. The holding in *National Society*, with its tacit approval of the application

403 *Id.* at 743.
404 *Id.*
405 *Id.* at 741.
408 *Id.* at 696.
of the per se rule to a situation involving professional ethics on the one hand, coupled with the Court’s manifest adoption of the reticence in Goldfarb on the other, has led to the development of a number of different approaches to the application of antitrust laws to the professions. Relying on the Court’s ambivalence, lower courts have remained sensitive — even hypersensitive — to those aspects of professional behavior that differ from other commercial enterprises. Moreover, because these “differences” remain vague and ill-defined, lower courts have tended to proceed cautiously and to apply the rule of reason in a variety of contexts that would have prompted the application of the per se rule in other industries.

Nevertheless, the Court in National Society was not willing to relax the traditional antitrust standards even where the ethical norms of the profession were at issue. Nor was the Court willing to entertain justifications that did not conform to traditional rule of reason analysis based on procompetitive versus anticompetitive balancing. The Society of Professional Engineers asserted that to allow competitive bidding would lead to shoddy workmanship. The Court flatly rejected this contention solely on the basis that the assertion did not present a procompetitive justification as required by traditional rule of reason analysis. Thus, the Court made it clear that affirmative justifications must improve the competitive functioning of some relevant market in order to engage the Court’s attention, and they cannot be based on the premise that “competition itself is unreasonable.”

The next case to come before the Supreme Court, Arizona v. Maricopa Medical Society, suggests that the Court in National Society actually stood for a much more tough-minded approach than the Court’s discussion of Goldfarb suggested. The Maricopa Medical Society established foundations for medical care to promote fee-for-service medicine. Member doctors agreed to accept maximum fees established by the foundations as full payment for services provided to policy holders of certain

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409 See, e.g., Smith v. Northern Mich. Hosp., Inc., 703 F.2d 942 (6th Cir. 1983); Arizona v. Maricopa County Medical Soc’y, 643 F.2d 553 (9th Cir. 1980), rev’d, 457 U.S. 332 (1982); Everhart v. Jane C. Stormont Hosp., 1982-1 Trade Cas. (CCH) ¶ 64,703 (D. Kan. 1982); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), aff’d, 688 F.2d 824 (3d Cir.), cert. denied, 459 U.S. 971 (1982); Williams v. Kleveland, 534 F. Supp. 912 (W.D. Mich. 1981); Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn., Inc., 518 F. Supp. 1100 (D. Conn. 1981), aff’d, 675 F.2d 502 (2d Cir. 1982); Sausalito Pharmacy, Inc. v. Blue Shield of Cal. (Sausalito II), 1981-1 Trade Cas. (CCH) ¶ 63,885 (N.D. Cal. 1981); Sausalito Pharmacy, Inc. v. Blue Shield of Cal. (Sausalito I), 1980-81 Trade Cas. (CCH) ¶ 63,692 (N.D. Cal. 1980); Feminist Women’s Health Center, Inc. v. Mohammad, 415 F. Supp. 1258 (N.D. Fla. 1976), rev’d on other grounds, 586 F.2d 530 (5th Cir. 1978) (proposing that where the state has authorized physicians to organize to protect the quality of health care, defendants should be allowed to assert a “good faith” defense in medical profession cases where the per se rule would apply if another industry were involved).

410 See supra note 409.

411 435 U.S. at 696.

insurance plans. The Court held that the fact that the scheme established maximum, as opposed to minimum, prices did not remove it from the realm of illegal price-fixing. Relying on United States v. Socony-Vacuum Oil Co.\(^{413}\) for the proposition that all price-fixing agreements are per se illegal, the Court did not hesitate to apply the per se rule. The Court rejected the procompetitive justification that the price-fixing agreement put a beneficial ceiling on prices and disregarded the oft-repeated claim that the Court lacked sufficient judicial experience with antitrust activities in the health care industry.\(^{414}\) The Court, however, did reaffirm its position, gleaned from Goldfarb and National Society, that procompetitive "public service or ethical norms" may serve as an "escape hatch" to remove otherwise per se illegal conduct from the purview of the per se rule.\(^{415}\)

Although it remains unclear whether the professions will be subjected to the same antitrust standards as other industries in all respects, National Society and Maricopa indicate that the "learned professions exemption" is not a viable doctrine in certain circumstances. National Society stands for the proposition that the per se rule will be applied to the professions even where there is a potential conflict between the ethical standards of the profession and the competitive structuring of practice. Maricopa establishes the axiom that the per se rule is applicable to price-fixing in the health care industry on the same basis as in any other industry.\(^{416}\) Both cases together demonstrate the Court’s reluctance to deviate from traditional antitrust doctrine. The effect of this adherence to traditional doctrine has been a somewhat greater willingness on the part of some lower courts since Maricopa to apply the per se rule in cases involving the medical profession both in price-fixing schemes and in cases where the alleged illegal conduct involves other offenses which have been traditionally labeled illegal per se.\(^{417}\)

\(^{413}\) 310 U.S. 150, 222, reh'g denied, 310 U.S. 658 (1940).
\(^{414}\) 457 U.S. at 348-54.
\(^{415}\) Id. at 348-49.
\(^{416}\) The Court in Maricopa quoted approvingly this language from Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1957): "Among the practices which the courts have heretofore deemed to be unlawful in and of themselves are price-fixing, division of markets, group boycotts, and tying arrangements." 457 U.S. at 349 n.15. Some courts have interpreted this statement as the Court's implicit intention not to limit the application of the per se rule to price-fixing in the context of the medical profession. See, e.g., Wilk v. American Medical Ass'n, 719 F.2d 207 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984).
c. Antitrust Principles Governing the Professions and the Denial of Hospital Privileges to Nurse-Midwives

Retention of the per se rule as part of antitrust doctrine involving the professions is critically important to the outcome of cases challenging the denial of hospital privileges to nurse-midwives. An examination of one of the scholarly proposals advocating use of the rule of reason analysis for hospital privileges cases will reveal why this is so.

In 1982, prior to the decision in *Arizona v. Maricopa County Medical Society*, Professor Kissam and his co-authors proposed that courts adopt a "purpose-based" analysis of hospital privileges decisions under the rule of reason.418 Traditional antitrust analysis focuses primarily on the anticompetitive effects of the defendant's conduct, although purpose is not totally irrelevant.419 Kissam's proposal, by contrast, would require the plaintiff to demonstrate by persuasive evidence that the sole or dominant purpose of the particular privileges decision was anticompetitive and that the hospital possessed substantial market power. Although Kissam does not advocate total suspension of the per se rule, decisions regarding hospital privileges for nurse-midwives fall into the category of cases for which he argues that the rule of reason is appropriate. A careful examination of Kissam's approach reveals that its application to decisions denying hospital privileges to nurse-midwives and other nonphysician practitioners would undercut the major advantages of antitrust litigation: the focus on the anticompetitive conduct of the defendants, and the potential application of the per se rule.420

Under JCAH guidelines, the consideration of applications for hospital privileges is delegated to physician committees, which make recommendations to the governing body of the hospital.421 Generally, the recommendations are implemented without question. When there is a divergence of opinion, the standards provide for joint review by the governing body and the medical staff.422 Professor Kissam postulates three

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418 Kissam, *supra* note 268, at 595.
419 *See L. Sullivan, supra* note 383, at 186-89.
420 Kissam (and his co-authors) do not deserve all of the criticism, because they were merely following the lead of the Court. Considering the fact that their article was published before the decision in *Maricopa*, they were marvelously perceptive in predicting where the Court would go and in incorporating that next step into their rule of reason analysis.
421 *JCAH, supra* note 156, at 115-16.
422 Decisions as to whether or not to grant medical staff privileges are viewed as part of the self-regulatory mechanism of the medical profession, and the emphasis placed on this professional function effectively disguises the fact that interests other than maintaining professional standards are at stake. For example, there is an incentive to increase one's competitive advantage by granting privileges in other specialties because this enlarges the professional referral network, as well as enhancing the reputation of the medical staff in the community. At the same time, there is an incentive to limit the number of practitioners in one's own area of specialty so that the available market of patients will not be spread too thinly.

In the case of nurse-midwifery and obstetrics, two therapeutic ideologies are competing for patient acceptance, and neither has proven itself so clearly superior as to gain universal acceptance.
ways of characterizing the relationship between physicians and hospitals in this decision-making process: physician cartel, joint venture, and employer hospital. The first two are apposite to this discussion.

The physician-hospital relationship can be termed "physician cartel" when the physicians’ interests are entirely determinative of the outcome of the privileges decision, and the hospital has no independent interests of its own at stake (other than keeping the physicians happy). In Kissam’s schema, physician cartel decisions are indistinguishable from a line of recent Supreme Court cases holding group boycotts against competitors qua competitors to be per se violations of the antitrust laws. This type of decision-making warrants the application of the per se rule to the medical profession because of “a cartel’s clear harms to competition and the absence of any procompetitive justification for these kinds of decisions.”

Joint venture decision-making exists when the hospital and the medical staff agree on the result, but do so on the basis of their own independent interests. For example, the hospital might be interested in limiting staff membership to certain categories of practitioners in order to enhance its prestige in the community or to limit its exposure to corporate liability. The doctors, on the other hand, might be interested in excluding practitioners for anticompetitive reasons. Because of “tech-

If privileges within a specialty are given to practitioners of another therapeutic ideology, a wholly different competitive threat [to the dominant group] presents itself. If one ideology stresses more pleasant and less technological interventions with less cost but apparently obtains results comparable to those obtained by practitioners using less pleasant, more technological, and more expensive methods, then patients might drift away from the latter group. . . . [One way to] suppress competing ideologies [is to drive the practitioners] out of the mainstream of medicine and into relatively unattractive practice settings where the results are likely to be less satisfactory and therefore less attractive to patients. Denial of admitting privileges is one means of achieving this result. Denial of the hospital work environment with adequate equipment, lavish consultation resources, and emergency backup facilities buoys the practitioners of mainstream ideologies. Just as [individual] practitioners without admitting privileges are stigmatized, so too are entire professions when privileges are denied.


423 Kissam, supra note 268, at 611.
424 Id. at 651.
425 Id.
426 Id. at 656.
427 Kissam, supra note 268, at 608-09 discusses the Darling doctrine, derived from Darling v. Charleston Community Mem. Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966), which is reputed to be the origin of the premise that a hospital can be held liable for negligent selection, supervision, and retention of its medical staff. Other writers, however, present a somewhat different picture: The decision’s psychological impact has been great, but its practical effect has been less than overwhelming. Only nine state supreme courts have voiced approval of its essential holding, that the hospital board has a nondelegable duty to establish policies and procedures to monitor the quality of medical care in the institutions. In only four of these court cases was the hospital actually held liable for failure to meet the standard. In two cases, the courts recognized the applicability of Darling, but held that the patients had not proved any breach of the hospital’s duty. In the three other cases, the
nical” questions that may be involved in joint venture decisions, because of the need for courts to be sensitive to the hospital’s exposure to liability, and because of the difficulty in determining which interests prevailed in any given decision, Kissam advocates the application of a modified rule of reason to decisions resulting from a joint venture decision-making process.\textsuperscript{428}

Kissam places nurse-midwives in the joint venture category because the admission of nonphysician practitioners does in some elemental way change the quality of hospitalization services, or certainly the perception of quality, if not its fact. It may also increase the administration or transaction costs of hospitals, which will need to establish new procedures for ensuring that the [nurse-midwives] provide quality care. Hospitals also may face the risk of additional malpractice liability if malpractice courts and insurers refuse to recognize the services of these new practitioners as mere extensions of the supervising physician. In this view, the change of quality by the use of [nurse-midwives] is an independent interest of the hospital; therefore, it seems appropriate to treat this issue as a joint venture decision by the hospital and medical staff rather than as a physician cartel decision.\textsuperscript{429}

Thus, Kissam summarily deprives nurse-midwives of the potential benefits of the per se rule, while at the same time advocating a weakening of the traditional rule of reason. According to Kissam’s rule of reason analysis, the inquiry should focus not on the anticompetitive effects of the hospital’s conduct as traditional rule of reason doctrine demands, but on whether the primary purpose of the decision was to curtail competition in a market where the hospital has the power to bring about such a result. Kissam proposed this shift in focus because he wished to promote the development of a sensitivity of antitrust doctrine to the “quality-of-care” and liability concerns of hospitals. While this is a worthy goal, it is not served by denying plaintiffs protection from anticompetitive activities in cases like Nurse Midwifery Associates v. Hibbett.

An examination of Hibbett in light of Kissam’s proposed structure reveals that Kissam’s analysis was incomplete and led him to miscategorize those cases that resemble the fact pattern of Nurse Midwifery Associates v. Hibbett. In Hibbett, neither the hospitals’ interests in avoiding additional liability exposure nor maintaining quality of care were at

\textsuperscript{428} Kissam, supra note 268, at 656.

\textsuperscript{429} Id. at 655.
issue in the decisions to refuse hospital privileges to the two nurse-midwives.

First, the independent interests of the hospitals in avoiding additional risk of liability were not at stake because the practice of Nurse Midwifery Associates was based on written protocols with a collaborating physician who was on the medical staff of all three hospitals, as required by the ACNM/ACOG Joint Practice Agreement and the Joint Commission on Accreditation of Hospitals. Therefore, the collaborating physician, and not the hospital or the medical staff generally, was responsible for supervision. The experience of one hospital in the San Francisco Bay Area suggests that, indeed, the collaborating physician, and not the hospital, assumes liability for negligent supervision in such cases. Alta Bates Hospital in Berkeley, California recently considered this question in detail and concluded that the admission of nurse-midwives to practice under the “dependent model,” which seems to be virtually mandated by the JCAH, would not entail increased liability or supervisory responsibility for the hospital.

Nor were quality control issues relevant to the hospitals’ exclusion of Henderson and Sizemore. The nurse-midwives applied to three different hospitals whose respective bylaws all stated that certified nurse-midwives were eligible to practice in those institutions. It is inconceivable to think that the hospitals did not assess their “independent interests” in maintaining a particular quality of care at the time they formulated their bylaws. Therefore, any legitimate justification for rejecting the applications of the nurse-midwives based on quality of care considerations would have to be grounded on the applicants’ failure to meet the professional standards required by the hospitals’ bylaws. Yet Sizemore and Henderson were not rejected by any of the three hospitals because of uncertainty about their individual qualifications. They were excluded for various reasons unrelated to the adequacy of their credentials or the sufficiency of their protocol.

Moreover, where practitioners meet the requirements for state licensure and hospital bylaws grant them the opportunity to apply for hospital privileges, antitrust law imposes certain limitations on the conditions under which privileges can be denied. Antitrust law “does not recognize

430 Conversation with Clair Westdahl, CNM, former director of the proposed Alta Bates out-of-hospital birth center (May 17, 1985) (notes on file with author).

431 See supra notes 270-78 and accompanying text.
the defense that a private group has assumed responsibility for a governmental function." Thus, the medical staff is not permitted to exclude licensed applicants who meet the requirements specified in the hospital's bylaws because it feels that the training, examination, or other aspects of the licensing requirements should be different.

Because of current law defining the scope of practice of nurse-midwifery, the practice standards established by cooperating professional organizations, and JCAH accreditation standards, the paradigm case is representative of virtually all situations involving nurse-midwives who apply to hospitals with favorable bylaws. Kissam's joint venture characterization therefore inaccurately describes such cases, and the decision-making process should be characterized as physician cartel to which, under Kissam's own formulation, the per se rule may be applied. In appropriate cases, plaintiffs should be able to take full advantage of the per se rule in prosecuting actions under § 1 of the Sherman Act. Additionally, courts should not allow institutions with favorable bylaws to assert "public interest or ethical norm" defenses in the form of arguments about quality of care, corporate liability, or administrative inconvenience when those interests are not actually at stake.

Support for the proposition that the per se rule should be applied in appropriate cases where hospital bylaws permit nurse-midwives to apply for hospital privileges can be found in lower court decisions since Maricopa. At least one circuit court has been willing to apply the per se rule to hospital privileges decisions fitting the physician cartel model. In Weiss v. York Hospital, suit was brought on behalf of the plaintiff and ninety-two other osteopaths who claimed systematic exclusion from medical staff privileges in a hospital that permitted osteopaths to practice. Because the hospital did not exclude all (only most) osteopaths, the court had to determine whether the situation was one of discrimination or actual boycott. Because York Hospital did not claim that osteopaths as a group were less qualified than physicians, nor did it raise any other legitimate explanation for its differential treatment of most osteopaths, the court concluded that the situation was one of classic boycott. Relying on its interpretation of Goldfarb, National Society, and Maricopa, the court applied the per se rule because the defendants offered no "public service or ethical norm" rationale for their conduct.

Suppose, however, that the hospital defendant in Weiss had

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433 745 F.2d 786 (3d Cir. 1984), cert. denied, 470 U.S. 1060 (1985). In Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984), a case also decided since Maricopa, the Court did not apply the per se rule simply because the facts of the case did not meet the criteria for a finding of per se illegality. There is no indication whatsoever that the Court would not have applied the per se rule if the allegations of an illegal tying arrangement, the illicit conduct involved in the case, had been sustained.
434 745 F.2d at 821.
advanced such a defense. For example, the hospital might have asserted that its discrimination against osteopaths was justified by its interest in maintaining "a high standard of care," even though its bylaws made no distinction between allopathic and osteopathic physicians. Because this interest is not actually at stake in factual situations such as those in Weiss and Hibbett, the courts should be prepared to recognize an irrebuttable presumption, on the basis of the defendant's own bylaws, that such an assertion is illusory. Defendants in this position should not be allowed to defeat the application of the per se rule simply by coming into court and uttering a "quality of care" defense that is belied by the defendant's own contrary judgment when its written policies were adopted.

Moreover, when the plaintiff is seeking to establish group boycott, as are the plaintiffs in Hibbett, the burden of proof is sufficiently rigorous to protect the kinds of interests that concern Kissam. In order to prove a group boycott that rises to the level of a per se offense, the plaintiff must show concerted action by two or more parties who have both a purpose and the power to exclude or coerce others. Thus, the purpose element, which is the essence of Kissam's modified standard under the rule of reason, is already incorporated into the plaintiff's prima facie case. If the plaintiff can meet the burden of proof, then there is no justification whatsoever for depriving the plaintiff of the potential benefits of the application of the per se rule.

Cases where hospital bylaws are silent or do not permit nurse-midwives to apply for clinical privileges may warrant classification as joint venture decisions because the hospital will presumably assert a "quality of care" defense, and the hospital's interests cannot be judged illusory a priori. In the absence of favorable bylaws that raise a presumption against such a defense, the court will probably conclude, as does Kissam, that application of the rule of reason is appropriate.

Kissam proposes to apply a "purpose-based" rule of reason analysis to hospital privileges decisions characterized as joint ventures. Courts using this approach would condemn such decisions on presentation of persuasive evidence that a particular decision has "a sole or dominant anticompetitive purpose and that the hospital possesses substantial market power." This analysis, Kissam argues, will allow courts to be sensitive to hospital defenses based on quality of care or enhanced risk of exposure to corporate liability, and it will allow medical staffs to continue to perform their self-regulatory functions without fear of running afoul of the antitrust laws. In addition, he hopes that a purpose-based rule will

435 See also E.A. McQuade Tours, Inc. v. Consolidated Air Tour Manual Comm., 467 F.2d 178, 187 (5th Cir. 1972), cert. denied, 409 U.S. 1109 (1973) (absence of coercive conduct requires the application of the rule of reason as opposed to the per se rule).

436 Kissam, supra note 268, at 659.
provide a clearer standard by which hospitals can evaluate their own conduct.

Traditional rule of reason analysis relies on an ad hoc balancing of anticompetitive and procompetitive effects using evidence of purpose only to help "interpret" the effects.437 This method, Kissam argues, places defendants in the position of having few guidelines for knowing when their conduct is in violation of the law. Kissam asserts that a "purpose-based" analysis provides a clearer guideline for determining when conduct is impermissible.438

Using the facts of *Nurse Midwifery Associates v. Hibbett* as an example, what would a proceeding conducted under Kissam's proposed analysis look like? What would the outcome be? Suppose Hendersonville Hospital argued that, despite the inappropriate statements of their committee member,439 the hospital's interest in enhancing its competitive edge in the community by building a medical staff with the highest percentage of board-certified specialists was the prevailing factor in its decision.

Presumably, Kissam intends for the plaintiff to bear the burden of proof on the issue of purpose. Therefore, the nurse-midwives would have to offer evidence that the sole or dominant purpose was to keep them from competing successfully with the board-certified obstetricians. However, most hospital defendants would have no difficulty defending themselves by proving that an institution that enhances its reputation in the manner suggested in the hypothetical is more attractive to physicians in large metropolitan areas. Given the known biases of physicians, this is particularly true if the "other choice" is a hospital staff composed of a percentage of nonphysicians. Furthermore, as is always the case with a "purpose-based" approach, evidence as to real purpose is exclusively in the hands — and minds — of the defendants.440 This hypothetical highlights the fact that if the plaintiff carries the burden of proof on the issue of purpose, the disadvantage of this approach is multiplied.

This example illustrates one of the most serious drawbacks of "purpose-based" analysis where nurse-midwives and other nonphysician practitioners are concerned: the potential for sanctioning the medical monopoly a priori, simply because physicians prefer it (for whatever reasons). The hospital's competitive edge is increased by refusing to give privileges to nonphysician practitioners because physicians — the interested parties, the competitors — say it is. This is exactly the problem that plaintiffs in *Nurse Midwifery Associates v. Hibbett* are trying to

437 Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).
439 See *supra* notes 271-72 and accompanying text.
440 Under traditional rule of reason analysis, whether the stated purpose is the actual purpose or not is a less pressing issue, since the plaintiff still relies primarily on the balancing of observable effects. *See* L. Sullivan, *supra* note 383, at 186-89.
address by invoking the antitrust laws. By eliminating the balancing of clearly observable effects, Kissam’s approach changes the focus of the litigation and removes the one overriding consideration in the plaintiff’s favor — the fact that the defendant’s conduct has severe, injurious anticompetitive consequences for virtually every group outside of the dominant physician group.

To pose another hypothetical based on Hibbett, suppose Hendersonville Hospital argued that despite the improper motives of its physicians, the hospital’s interest in maintaining a high quality of care was the overriding consideration in the denial. In the hospital’s judgment, admission of nurse-midwives would compromise the quality of care, thus diminishing the hospital’s ability to compete in the marketplace. In order to defeat the defendant’s claim, the plaintiff would have to show that the purpose was pretextual, that admitting nurse-midwives to practice would in fact result in no diminution in the quality of care. Because of the paucity of evidence on this point and the fact that the obstetrical and midwifery models are in some respects incomparable, the trial probably would disintegrate into an out-and-out battle between two differing ideologies. Not only is this an inappropriate focus for a court that is supposedly making a judgment based on the anticompetitive prohibitions of the antitrust laws, it is an erroneous framing of the issue. The issue is not whether one ideology is “better;” neither has been proven to be so. The issue is whether birthing women and their partners should have choices.

Wilk v. American Medical Association, a lower court decision issued after Maricopa, shows that the “purpose-based” analysis of a quality of care defense under the rule of reason leads to an ideological battle.\(^4\) Given the long history of judicial deference to the medical profession, it is fairly predictable that courts will side with traditional medicine, as did the court in Wilk, when such a fracas arises.

Wilk was a class action brought by chiropractors in Illinois charging the American Medical Association and other professional associations with violating the Sherman Act by agreeing to induce individual medical doctors to forego any form of professional, research, or educational association with chiropractors, to induce hospitals and other health care facilities to deny access to chiropractors, and to induce actual and prospective patients of chiropractors to avoid seeking chiropractic services.\(^4\) The AMA asserted that its conduct was based on Principle 3 of the AMA Principles of Medical Ethics, which provided that “a physician should practice a method of healing founded on a scientific basis; he

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\(^4\) 719 F.2d 207 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984).
\(^4\) Id. at 228. “It is true that medical doctors are better qualified than most members of the public to form an opinion whether chiropractic poses a threat to public health, safety, and welfare.”
\(^4\) Id. at 211.
should not voluntarily professionally associate with anyone who violates this principle.”

Despite his initial resistance, the trial judge was ultimately seduced into permitting a bitter ideological struggle to take place in his courtroom. The battle was directly attributable to the judge succumbing to the kind of “purpose-based” rule of reason analysis proposed by Kissam.

Also failing to fully perceive the effect of elevating “purpose” to a position of primacy in the inquiry, the Seventh Circuit upheld the trial court’s modification of the rule of reason. In addition, despite its explicit recognition of the similarities between the ethical norms at stake in National Society and in Wilks, the court ruled out the application of the per se rule. The court distinguished the so-called “patient care motive” in Wilks from the “public interest” motive in National Society and held that “the ‘patient care motive’ rendered the case inappropriate for per se treatment.”

As the Wilk case confirms, the attempt to alter traditional rule of reason analysis in the manner suggested by Kissam will not be fruitful for two reasons: (1) it cannot be effectively done, and (2) it is inconsistent with emerging case law. In the final analysis, when hospitals exclude entire groups of practitioners such as nurse-midwives who are seeking to practice within the legal scope of their licensure, courts should rely on legislative judgments implicit in the licensing statutes. Courts will then be free to apply traditional antitrust doctrine in its unmodified form, bal-

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444 Id. at 213.
445 Id. at 216-17.

During the pretrial stages and the trial, the able and experienced district judge suffered from the uncertainty which marks the law of boycotts by professionals: specifically, what legal justification, if any, exists for such boycotts when their effect is to restrain competition. . . . On the eve of the trial, he embraced plaintiffs’ contention that it was irrelevant whether defendants’ conduct had been undertaken in the interest of public health, safety, and welfare . . . and whether that conduct had been non-commercial, and he struck those attempted affirmative defenses. He agreed that a trial on the validity of chiropractic should not be allowed to develop; that it was for legislatures and not defendants to decide whether chiropractic should be permitted to exist; and that even if defendants could prove that their sole motivation was a sincere and well-founded belief in the dangers of chiropractic, they could not escape liability for an otherwise unlawful boycott. But simultaneously, he denied a broad motion by plaintiffs, in limine, to exclude evidence bearing on public health, safety, or welfare. . . . From the moment of their opening statements on through the trial, defendants pressed for the admission of their “public interest” evidence, and over repeated objections, the district court received it. . . .

The trial was dominated by defendants’ efforts to persuade the jury that they had acted in the good faith belief that chiropractic is dangerous quackery. Evidence intended to show that chiropractic is indeed dangerous quackery was introduced to support the proposition that defendants’ belief was genuine. The upshot of all this is that much of the trial, and virtually all of the parties’ arguments to the jury, was a free-for-all between chiropractors and medical doctors in which the scientific legitimacy of chiropractic was hotly debated and the comparative intensity of the avarice of the adversaries was explored.

446 Id. at 221-22.
ancing the anticompetitive and procompetitive effects. This approach will not impair hospitals' ability to exercise their discretion in evaluating the suitability of individual practitioners on traditional criteria of professional competence so long as the requirements imposed are reasonable.

If courts adopt Kissam's approach, the combined effect of excluding all privileges cases involving nurse-midwives from application of the per se rule and the modification of the rule of reason will be sufficient to undercut the potential benefits of litigation based on antitrust theories. Nurse-midwives will not be able to avail themselves of one of the major advantages of the per se rule: being shielded from procompetitive justifications where the interests being asserted are not actually at stake.

Application of Kissam's modified rule of reason will result in changing the focus of the litigation from the anticompetitive effects of the defendant's conduct to speculation about the defendant's inner motives. As Wilks clearly illustrates, an even greater danger is the threat that the issues will be distilled down to the differences in ideology between nurse-midwives and high-tech obstetrics. Given the traditional attitude of judicial deference to institutionalized, allopathic medicine, the application of antitrust doctrine to denial of hospital privileges for nurse-midwives would be short-lived.

CONCLUSION

Because of the interplay of complex historical, economic, and political factors, nurse-midwives face several persistent obstacles to practice. Two of the most severe are the inability to obtain physician backup and the denial of hospital privileges.

Many physicians refuse to provide backup for independently practicing nurse-midwives because of their aversion to the risk of vicarious liability. A detailed examination of the principles of respondeat superior reveals that nurse-midwives who are engaged in independent practice are independent contractors under several common law tests. Therefore, the general rule that a principal is not liable for the negligent acts of agents who are not his employees should apply. However, this general rule of nonliability is subject to two notable exceptions: the captain of the ship doctrine and the doctrine of ostensible agency. Vicarious liability based on a theory of ostensible agency can be limited by a combination of public education and effective informed consent. A broad application of the captain of the ship doctrine, however, may subject physicians to vicarious liability whenever a nurse-midwife and her backup physician attend a high-risk patient simultaneously. A more fact-oriented application of the borrowed servant doctrine, from which the captain of the ship doctrine was derived, will avoid such a draconian result and will also correctly align the incentives for professional accountability and promote the
entrance of nurse-midwives into the health care provider market by limiting physicians’ exposure to vicarious liability.

Nurse-midwives are also restricted in their ability to practice to the full extent of their licensure by denial of access to hospitals. Although certain disadvantages of traditional constitutional and common law theories limit the usefulness of these legal doctrines in seeking review of hospital privileges decisions, antitrust law is more promising.

*Nurse Midwifery Associates v. Hibbett* is the first case to be brought on behalf of nurse-midwives who were denied hospital privileges. This case will test the effectiveness of antitrust doctrine in addressing denial of hospital privileges. The viability of a cause of action under § 1 of the Sherman Act depends on how the courts handle the application of antitrust law to the conduct of medical professionals. Certain proposed modifications of antitrust doctrine, while expressing valid concerns, have the potential to entirely undermine the usefulness of established antitrust principles in addressing denial of hospital privileges to nonphysician practitioners, including nurse-midwives. Thus, the courts should resist adopting modifications of antitrust doctrine that will have the effect of a priori reinforcing the monopoly of physician-dominated institutionalized medicine.