

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
THIRTEENTH DIVISION

BRUCE E. MURPHY, M.D.,
SCOTT L. BEAU, M.D.,
DAVID C. BAUMAN, M.D.,
D. ANDREW HENRY, M.D.,
DAVID M. MEGO, M.D.,
WILLIAM A. ROLLEFSON, M.D.,
PAULO RIBEIRO, M.D.,
CHARLES CALDWELL, M.D.,
P.J. FLAHERTY, M.D.,
CARL LEDING, M.D.,
JEFFREY STEWART, M.D., and
WILSON WONG, M.D.

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PLAINTIFFS

AMERICAN MEDICAL ASSOCIATION (AMA); and
ARKANSAS MEDICAL SOCIETY (AMS)

INTERVENOR PLAINTIFFS

vs.

NO. CV 2004-2002

BAPTIST HEALTH

DEFENDANT

ORDER FOR PERMANENT INJUNCTION

INTRODUCTION AND FINDINGS OF FACT

As the Arkansas Supreme Court observed, “. . . physicians are not fungible as to their relationships with patients or their specialties of practice.” *Baptist Health v. Murphy*, 365 Ark. 115, 131, 226 S.W.3d 800, 813 (2006). The heart of this case is the patient-physician relationship. The relationship is entitled to exceptional protection. According to Plaintiff Bruce Murphy, the relationship is forged in trust, confidence, rapport, and intimate knowledge. He and the other plaintiffs testified that the relationship develops over time, through the care and treatment of chronic conditions and traumatic medical emergencies, with the physician learning the patient’s history and exercising professional

judgment in evaluating the patient's complaints and treating the patient's ailments. Strong patient-physician relationships are the underpinning of good medicine, and it was uncontroverted at trial that patients who have long term relationships with their doctors have better outcomes.

The plaintiffs in this case are cardiologists. The testimony of Dr. Murphy and other witnesses indicates that cardiac patients typically suffer from chronic, long-term illnesses requiring medical care for years or even decades. As a consequence, the plaintiffs and their patients generally have, and expect to have, long-term relationships.

In May of 2003, the Baptist Health Board of Trustees adopted the Economic Credentialing Policy (later renamed the Economic Conflict of Interest Policy and sometimes herein referred to as the "Policy.") Under the Economic Credentialing Policy, any physician who, directly or indirectly, acquires or holds an ownership or financial interest in a hospital anywhere in Arkansas is ineligible for initial or renewed professional staff appointments or clinical privileges at any Baptist hospital. *Baptist Health v. Murphy*, 365 Ark. 115, 119, 226 S.W.3d 800, 805 (2006).

The Economic Credentialing Policy provides in part:

From and after the adoption of this Economic Conflict of Interest Policy, no practitioner who, directly or indirectly, acquires or holds an ownership or investment interest in a competing hospital shall be eligible to apply for initial or renewed appointment or clinical privileges in the Professional Staff of any Baptist Health hospital.

The Policy applies to owners, investors and their immediate family members. The Policy defines "immediate family member" in broad terms; "husband or wife, birth or adoptive parent, child, sibling, stepparent, stepchild, stepbrother, father-in-law, mother-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent and spouse of grandchild."

The plaintiffs are partners in Little Rock Cardiology Clinic, P.A. (“LRCC”). LRCC owns a 14.5 percent interest in the Arkansas Heart Hospital and, as partners in LRCC, each plaintiff indirectly own an interest in the Arkansas Heart Hospital (“AHH”). In addition, two of the plaintiffs, Bruce E. Murphy, M.D., and D. Andrew Henry, M.D., have a direct ownership interest in the AHH. As a result, the plaintiffs will be ineligible for staff appointment and clinical privileges at Baptist Health facilities if the Economic Credentialing Policy is deemed enforceable. The AHH is a private acute care hospital in Little Rock, Arkansas, with a full time emergency room. It provides specialized, in-patient care for cardiac patients. AHH opened in 1997, six years before Baptist Health’s adoption of the Economic Credentialing Policy.

The plaintiffs seek a declaration that the Economic Credentialing Policy tortiously interferes with Plaintiffs’ relationships with their patients, and with the business expectancies that necessarily accompany those patient-physician relationships, that the Economic Credentialing Policy is contrary to public policy, and that the Economic Credentialing Policy is an unconscionable business and trade practice in violation of the Arkansas Deceptive Trade Practices Act. The plaintiffs seek a permanent injunction prohibiting Baptist from enforcing the Economic Credentialing Policy.

On March 22, 2004, this Court preliminarily enjoined Baptist Health from enforcing the Economic Credentialing Policy against the plaintiffs. After two appeals to the Arkansas Supreme Court, numerous discovery motions by both parties, and three motions to dismiss and twelve motions for summary judgment by Baptist Health, this case was tried to the Court from March 10, 2008, through March 20, 2008.

CONCLUSIONS OF LAW

I. Tortious Interference

To establish a claim of tortious interference, the plaintiffs must prove: (1) the existence of a valid contractual relationship or business expectancy; (2) knowledge of the relationship or expectancy on the part of the interfering party; (3) intentional interference inducing or causing a breach or termination of the relationship or expectancy; and, (4) resultant damage to the party whose relationship or expectancy has been disrupted. *Stewart Title Guaranty Co. v. American Abstract & Title Co.*, 363 Ark. 530, 540, 215 S.W.3d 596 , 601. (2005). The law also requires that the interference must be improper. *Id.*

A. Contractual Relationships and Business Expectancies

The plaintiffs allege that Baptist Health has tortiously interfered with the patient-physician relationship. Physicians and their patients have contractual relationships. Physicians agree to provide care and treatment to patients, patients agree to accept that care and treatment and physicians are compensated for the care and treatment they provide.

At trial, the concept of continuity of care was considered at length. The uncontroverted testimony of Dr. Murphy and other witnesses was that the patient-physician relationship is important and often physicians and patients will have relationships that span for years and even decades. Further, it was undisputed that continuity of care aids patient outcomes. Thus, the patient-physician relationship carries with it a reasonable business expectancy with resulting and justifiable economic expectations.

Further, the Court considered a physician's relationship with referring physicians. Often a physician such as the plaintiffs gain new patients through referrals from general practitioners. For

example, Dr. Henry, a plaintiff, testified that referral relationships are the lifeblood of the existence of a specialty physician such as a cardiologist.

The plaintiffs have proven the existence of valid contractual relationships and business expectancies.

B. Baptist Health's Knowledge

The Court finds that Baptist Health had knowledge of the plaintiffs' contractual relationships and business expectancies. Witness for Baptist Health acknowledged that patient-physician relationship carries an expectancy of continuing in the future and that the Plaintiffs have established referral relationships. President and CEO Russ Harrington and Board of Trustees members Jim Harris and Buddy Sutton testified that they knew the Economic Credentialing Policy would disrupt patients' relationships with the physician of their choice.

C. Intentional Interference by Baptist Health

Under longstanding Arkansas law, an actor is presumed to intend the natural consequences of their acts. *Metcalfe v. Jelks*, 177 Ark. 1023, 8 S.W.2d 462, 464 (1928); *Rogers v. Willard*, 144 Ark. 587, 223 S.W. 15, 16 (1920). A result is deemed intentional if it is the natural and probable consequence of an act as "normally a person is presumed to intend the natural and probable consequences of its acts." *Great American Ins. Co. v. Ratcliff*, 242 F.Supp. 983, 991 (E.D. Ark. 1965). Recently in *McSparrin v. Direct Insurance*, —S.W.3d —, 2008 WL 1821865 (April 24, 2008), the Arkansas Supreme Court cited *Ratcliff* favorably and held that "the presence or absence of particular intent can be inferred logically and legally from the facts and circumstances leading up to, surrounding, and following the act or omission in question."

The Court finds that Baptist Health intended to interfere with the patient-physician relationships of the plaintiffs. As Plaintiff's Exhibit 74 demonstrates, before the Policy was adopted, Baptist Health specifically identified several of the plaintiffs as physicians who would be affected. Further, one advantage of the policy identified by Baptist Health was that, once adopted, the Policy would make it difficult for any physician associated with LRCC to admit patients to Baptist Health.

From the testimony of Baptist Health's President and CEO, Russ Harrington, the Court finds that Baptist Health knew that it participated in insurance networks that steered patients to Baptist Health, including some networks for which Baptist Health was the exclusive, in-network provider. As far back as 1995, Russ Harrington, Baptist Health's President and CEO, warned Plaintiff Murphy that physician owners of specialty hospitals would be excluded from insurance networks. When Baptist Health considered adopting the Policy in 2003, Harrington testified that he knew the plaintiffs would be excluded from the Blue Cross Blue Shield insurance provider panel if they lost their privileges at Baptist. Baptist Health is a part owner in Blue Cross Blue Shield. In 2003, physicians were required to be on a provider panel and a condition for being on Blue Cross Blue Shield's panel was being on staff at Baptist Health. As demonstrated in Plaintiff's Exhibit 3 and as Harrington testified, when Baptist Health began to consider adopting the Economic Credentialing Policy, someone at Baptist Health confirmed with Blue Cross Blue Shield that the plaintiffs exclusion of Baptist's staff would have meant exclusion from the Blue Cross Blue Shield network. These insurance relationships provide patients with compelling financial reasons to receive medical care at a Baptist Health facility because as Harrington testified Blue Cross Blue Shield would not pay for services provided by a physician who was not on its panel. Baptist Health knew of these relationships.

Finally, at trial, members of the Baptist Health Board of Trustees acknowledged that they knew the Economic Credentialing Policy would affect patients and would affect patient-physician relationships. In fact, Board members testified that Baptist Health knew that some patients would need to make a choice between their physicians and Baptist Health, and wanted patients to make that choice in its favor.

Baptist Health knew that the natural and probable consequence of passing the Economic Credentialing Policy was the exclusion of the plaintiffs from its staff. The Court finds that Baptist intended that result. Baptist Health also knew that a natural and probable consequence of adopting the Economic Credentialing Policy would be interference with the relationships between patients and physicians. Again, Baptist Health intended this result. Parties intend the natural and probable consequences of their acts and Baptist Health intended to interfere with the plaintiffs' relationships with their patients.

D. Resultant Damage

The plaintiffs must prove that they have suffered some actual damage even though they do not seek to recover any money damages. Because of this Court's preliminary injunction, most of the plaintiffs have never lost their privileges at Baptist Health. The ability of the plaintiffs to prove damages is limited and therefore, the most problematic part of their argument. "To authorize recovery of more than nominal damages in an action in tort, facts must exist which afford a basis for measuring plaintiff's lost with reasonable certainty." *Missouri & A. Ry. Co. v. Treece*, 210 Ark. 63, 194 S.W.2d 203 (1945). The reason for this rule of law is that verdicts should not be based on speculation or conjecture. *Id.* The Court understands this case law to mean that in cases where plaintiffs seek money

damages, some facts must be introduced to give the trier of fact a reasonable basis for awarding money damages. However, because the plaintiffs do not seek money damages, the requirement for proof with reasonable certainty of the amount of loss is not necessary.

The evidence shows that the Policy caused the plaintiffs actual injury by disrupting their relationships with patients and referral sources. The strongest example of actual damages comes from the testimony of Dr. Paulo Ribeiro. Plaintiff Ribeiro was excluded from practicing at Baptist Health for over a year before he was made a party to the Court's injunction. Dr. Ribeiro testified that, on the day his staff privileges were revoked, he was denied the opportunity to treat a patient of his that had been admitted to Baptist Health. Because Dr. Ribeiro's privileges were revoked, a business partner and fellow plaintiff treated his patient. Irrespective of the patient being treated by his partner, Dr. Ribeiro suffered a loss of professional fees associated with that treatment and there was interference with his relationship with his patient.

Even during the period when this Court's injunction covered Dr. Ribeiro and the other plaintiffs, they were nonetheless harmed by the Policy. Referrals are a major source of business for physicians, particularly for specialists. Plaintiff Henry called these referrals the lifeblood of the existence of a specialty physician. According to Plaintiff Bauman, referring physicians, unsure of the continuing status of the plaintiffs at Baptist Health, have chosen to refer patients to other physicians whose privileges are not in doubt. Furthermore, Dr. Phil Peters, a witness for Baptist Health and its 2003 chief of staff, testified that referrals usually come to physicians that practice often at a hospital. He admitted that if a physician lost privileges at Baptist, then the physician would also lose referrals. Courts consider referrals to be protectable business interests. *See, e.g., Ibdeis v. Wichita Surgical Specialists*, 279

Kan. 755, 769, 112 P.3d 81, 90 (Kan. 2005). As a result of the Policy, the plaintiffs have lost referrals, the new patient relationships reasonably certain to accompany those referrals, and the prospective compensation they would receive for treating those new patients.

The Court finds that the plaintiffs have proven that they suffered damage as a result of the implementation of the Economic Credentialing Policy. While the plaintiffs have not proven the amount of damages with reasonable certainty, this does not hinder their case. The plaintiffs need only prove with reasonable certainty that damages occurred because they do not seek to recover money damages. To take the opposite position that this evidence did not amount to damage seems to be contrary to the state of Arkansas' strong policy of protecting the patient-physician relationship.

E. Impropriety

The law requires that Baptist Health's interference must be improper. *Stewart Title*, 363 Ark. at 550, 215 S.W.3d at 607. Seven factors guide the determination of impropriety: (1) the nature of Baptist Health's conduct; (2) Baptist Health's motive; (3) the interests of the Plaintiffs with which Baptist Health's conduct interferes; (4) the interests sought to be advanced by Baptist Health; (5) the social interests in protecting the freedom of action of Baptist Health and the contractual interests and business expectancies of the Plaintiffs; (6) the proximity or remoteness of Baptist Health's conduct to the interference; and (7) the relations between the parties. *Id.* Both Arkansas Courts and the Arkansas Model Instruction Committee cite with approval the factors outlined in section 767 of the Restatement (Second) of Torts for guidance about what is improper. See *Mason v. Wal-Mart Stores, Inc.*, 333 Ark. 3, 11, 969 S.W.2d 160, 164 (1998); Comment to AMI Civil 2007, 404.

1. Nature of Baptist Health's Conduct

First, Baptist Health's Economic Credentialing Policy is contrary to public policy.

"[Q]uestions of public policy...when not controlled by the Constitution, laws, or treaties of the United States, or by the principles of the commercial or mercantile law or of general jurisprudence, of national or universal application, are governed by the law of the state as expressed in its own Constitution and statutes, or declared by its highest court." *Hartford Fire Ins. Co. v. Chicago, M. & St. P. Ry. Co.* 175 U.S. 91 (1899). Courts frequently look to professional codes of ethics when finding the public policy of a state. See, e.g., *Murfreesboro Medical Clinic v. Udom*, 166 S.W. 3d 674, 676 (Tenn. 2005) (American Medical Association's Code of Ethics); *Spiegel v. Thomas, Mann & Smith, P.C.*, 811 S.W.2d 528, 529 (Tenn. 1991) (American Bar Association's Formal Opinions for Professional Ethics); *Pierce v. Ortho Pharmaceutical Corp.*, 84 N.J. 58, 71, 417 A.2d 505, 512 (N.J. 1980) (professional code of ethics is expression of public policy so long as the code of ethics is not designed to serve only the interests of a profession); *Boyle v. Vista Eyewear, Inc.*, 700 S.W.2d 859, 871 (Mo. App. 1985) (same); *Colorado in Rocky Mountain Hosp. and Medical Service v. Mariani*, 916 P.2d 519, 524 (Colo. 1996) (same).

One form of improper conduct is the violation of recognized ethical codes or established business ethics and customs.

Violation of established recognized ethical codes for a particular area of business activity or of established customs or practices regarding disapproved actions or methods may also be significant in evaluating the nature of the actor's conduct as a factor in determining whether his interference with the plaintiff's contractual relations was improper or not.

Restatement (Second) of Torts, § 767 cmt. c (1979).

Thus, the public policy of Arkansas is found in its constitution, statutes, and judicial opinions, the Constitution of the United States, the common law, professional codes of ethics, and principles of national and universal application. See also *Jeffries v. State*, 212 Ark. 213, 218, 205 S.W.2d 194, 196 (1947) (citing *Arlington Hotel Co. v. Rector*, 124 Ark. 90, 186 S.W. 622, 629 (1916)).

a. The Economic Credentialing Policy Disrupts the Patient-Physician Relationship

As a matter of public policy, Arkansas protects the patient’s right to the physician of their choice. An act, such as Baptist Health’s Economic Credentialing Policy, that interferes with that choice, and that, by extension, interferes with the patient-physician relationship, is contrary to public policy.

This public policy springs from numerous sources. First, this public policy is recognized by Arkansas courts. In *Jaraki v. Cardiology Associates of Northeast Arkansas, P.A.* 75 Ark. App. 198, 55 S.W.3d 799 (2001), the Arkansas Court of Appeals held that it is “contrary to public policy to unduly restrict the public’s right of access to physicians of their choice.” *Jaraki*, at 204, 55 S.W.3d at 802. In *Duffner v. Alberty* 19 Ark. App. 137, 718 S.W.2d 111 (1986), which is cited with approval in *Jaraki*, the Court of Appeals refused to enforce a covenant not to compete that would have prohibited an orthopedic surgeon from practicing medicine within thirty miles of Fort Smith. The *Duffner* Court held that, “all other considerations must give way where matters of public policy are involved” and found that the challenged covenant not to compete constituted “an undue interference with the interests of the public right of availability of the orthopedic surgeon it prefers to use” *Duffner*, at 139, 718 S.W.2d at 112.

In both *Jaraki* and *Duffner*, the physician willfully entered into a contract that included a non-

compete clause. Each of these physicians knew that the consequence of leaving the medical clinic in which they practiced would be that a non-compete clause would go into effect. Yet, the Court of Appeals held that these doctors' covenants not to compete were unenforceable because the rights of patients are paramount to contractual obligations. The Court contrasts the situations of Dr. Jaraki and Dr. Duffner with the original plaintiff physicians who chose to invest in the Arkansas Heart Hospital without the knowledge that the investment might affect their ability to treat patients at Baptist Health. Like Jaraki and Duffner, Dr. Caldwell, Dr. Flaherty, Dr. Leding, Dr. Stewart, and Dr. Wong knew that their investment in the Arkansas Heart Hospital would result in the loss of their privileges at Baptist Health if this Policy is deemed enforceable. Regardless of whether the plaintiff physicians knew the effect of their decision to invest in Arkansas Heart Hospital, case law indicates that it is Arkansas public policy that a patient has the right to access the physician of his or her choice.

Second, the patient's right is recognized by the Arkansas legislature in the Patient Protection Act of 1995, Ark. Code Ann. §§ 23-99-201 through 209, and the Patient Protection Act of 2005, Ark. Code Ann. §§ 23-99-801 through 803, which ensures enforcement of the earlier Act, and the Arkansas Deceptive Trade Practices Act. In passing the Patient Protection Act of 1995, the Arkansas General Assembly found and declared that, "patients should be given the opportunity to see the health care provider of their choice. In order to assure the citizens of the State of Arkansas the right to choose the provider of their choice, it is the intent of the General Assembly to provide the opportunity of providers to participate in health benefit plans." Ark. Code Ann. §23-99-202.

Third, this public policy is recognized by the Medicare Act, which guarantees patients basic freedom of choice: "Any individual entitled to insurance benefits under this subchapter may obtain health

services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.” 42 U.S.C. § 1395a(a).

Fourth, this public policy is recognized by the AMA Code of Ethics, which provide that, “free choice of physicians is the right of every individual.” (AMA Opinion 9.06).

b. Public policy favors the establishment and existence of specialty hospitals and disfavors economic credentialing

Physician investment in specialty hospitals and the referral of patients by physician owners to the specialty hospitals they own have been the subject of extensive study and debate. Dr. Allen Dodson, a healthcare economist who holds a PhD in economics, testified on these issues. He has worked on both sides of the issue of community and specialty hospitals. He summarized federal studies by MedPAC, an independent advisory agency created by Congress to advise Congress, and the Center for Medicare and Medicaid Services (“CMS”), an agency that runs the Medicare and Medicaid services for the U.S. government, which concluded that economic credentialing does not benefit the community.

Likewise, economic credentialing punishes physician investment in specialty hospitals and punishes physicians for engaging in conduct that is wholly legal, negatively affects patient care, impedes advancements in medical technology and the construction of a modern healthcare infrastructure, and interferes with patient choice and patient-physician relationships. Dr. John Wayne Smith, a former Board of Trustees member for Baptist Health, testified that historically, it has been the investment of doctors that has led to the creation of new and innovative hospitals. Further, Plaintiff Murphy testified that the lack of technology at Baptist Health was the foremost reason that compelled him to consider

investing in a specialty hospital. The Policy inhibits competition and denies the community the advantages created by competition in the health care markets. Economic credentialing is disfavored as a matter of national public policy. See AMA Policy H-230.976.

Also, by engaging in an act contrary to public policy, Baptist Health acted contrary to its obligations as a 501(c)(3) not-for-profit, tax-exempt charitable organization. In service to the corporation and the public, one of the nonprofit board's most important functions is to ensure that the organization maintains its status as tax-exempt. In order to maintain its nonprofit status, a community hospital must operate for the benefit of the community. *St. David's Health Care System v. U.S.*, 239 F.3d 232, 234 (5th Cir. 2003). The Internal Revenue Service has developed a list of "community benefit" factors by which a hospital may demonstrate that it qualifies for tax-exempt status. *Id.* at 235 (citing Rev. Rul. 69-545, 1969 WL 19168 (1969)). One of the key factors in this analysis is that the hospital is willing to hire any qualified physician. *Id.* Thus, in adopting the Economic Credentialing Policy, a policy with the effect and intention of excluding certain physicians from Baptist Health's professional staff, the Board of Trustees had a fiduciary duty to inquire into, and satisfy itself, that adopting the Economic Credentialing Policy would not close Baptist Health's medical staff and jeopardize its not-for-profit, tax-exempt, 501(c)(3) status.

c. Public Policy Does Not Support Suppression of Competition

It has long been the public policy of this State to protect competition in order to provide consumers with better quality goods and services at lower cost to the consumer. See, e.g., *Dawson v. Temps Plus, Inc.*, 337 Ark. 247, 254 (1999) ("Public policy favors competition"); *Miller v. Fairfield Bay, Inc.*, 446 S.W.2d 660 (Ark. 1969); *Nelson v. Berry Petroleum Co.*, 242 Ark. 273,

279 n.2 (Ark. 1967) (“[A]n attempted monopoly ... was a criminal conspiracy at common law.”); *Quality Liquid Feeds, Inc. v. Plunkett*, 199 S.W.3d 700, 705 (Ark. App. 2004) (“In Arkansas, covenants not to compete are not favored by the law...”); *Hardesty Co. v. Williams*, 368 F.3d 1029 (8th Cir. 2001) (Ark. law) (“[C]ovenants not to compete are not looked upon with favor by the law” (internal quotation marks omitted)).

Here, the evidence demonstrates that Baptist Health adopted the Policy specifically to suppress competition from specialty hospitals. Baptist Health’s CEO, Russ Harrington, readily admitted the Policy’s anticompetitive purpose. By adopting the Policy, Baptist Health did its “best to suppress competition by these [specialty] hospitals.” Baptist Health hoped “to send a message to physicians on staff at Baptist that neither they, nor any relative, had better invest in a competing hospital or they would lose their privileges at Baptist.” The Policy said to these physicians, “[W]e don’t want to see any more specialty hospitals with physician investors come to our community.” True to Baptist Health’s intent, the Policy has had the effect of stifling competition in the market for hospital services. The evidence demonstrates that, in light of Baptist Health’s market share, its exclusive relationships with important payors, and its unique authorization to perform certain procedures, (e.g., heart transplants), the threat of losing hospital privileges at Baptist Health serves as a significant deterrent to physician investment in hospitals that compete with Baptist Health. Again, Dr. John Wayne Smith and Dr. Murphy testified that, historically, it has been the investment of both time and financial resources by physicians that has led to the creation of new and innovative hospitals and other health care service in the State. Thus, all else being equal, the Policy will deter construction of hospitals to compete with Baptist Health.

The Policy’s suppression of competition will harm consumers. Baptist Health’s own economic

expert, Dr. Jean Mitchell, testified that “[c]ompetition is good because it can result in lower prices and better quality.” Studies introduced at trial and discussed by Dr. Dodson show that competition from specialty hospitals has had precisely just this effect. According to Dr. Dodson, it alerts hospitals like Baptist Health, long the dominant players in the market, that they must innovate to remain attractive to patients. By deterring physician investment, Baptist Health’s Policy mutes this “wake-up call” and suppresses competition.

d. Public Policy Protects the Institution of Marriage

“It is the public policy of this state to surround the marriage relation with every safeguard and to support and maintain the marriage status wherever it is reasonable to do so.” *Hatcher v. Hatcher*, 265 Ark. 681, 699, 580 S.W.2d 475, 484 (1979). The reason is that the family unit is “perhaps the most fundamental social institution of our society.” *Id.*, at 698, 580 S.W.2d at 483 (quoting *Trimble v. Gordon*, 430 U.S. 672 (1977)). The Policy contravenes this important public interest in some cases by pitting spouses and other family members against one another.

The Court was presented with compelling evidence on this issue from Dr. Janet Cathey, a gynecologist who has practiced almost exclusively at Baptist Health for nearly 22 years. In March of 2005, Janet Cathey’s privileges at Baptist Health were in jeopardy because of her husband Dr. Steve Cathey’s ownership interest in a surgical hospital that would compete with Baptist Health. Janet Cathey sent a letter to Doug Weeks, the administrator for Baptist Health Medical Center - Little Rock and the Senior Vice President of Baptist Health, and they spoke a few days later. At their meeting, Doug Weeks gave her a copy of the Economic Credentialing Policy. According to Janet Cathey’s testimony, she told Weeks that the application of the policy would destroy her practice. She asked him

if they felt bad about that and he replied, “Yes, we feel terrible.” Dr. Cathey also testified that Weeks suggested that if the Policy was a problem, then her husband should sell his interest in the Spine Hospital. Doug Weeks, described the Policy’s application to Janet Cathey as “unfortunate”. Further, Dr. Phil Peters, Baptist Health’s chief of staff in 2003, called the Policy’s application to Janet Cathey “unjust” and “unreasonable.” Nonetheless, Baptist Health forced Janet Cathey to face a choice between losing her privileges at Baptist Health and its potentially devastating results to her practice, coercing her husband to give up his association with a facility that he helped to build, or divorce him. The strain this placed on the Catheys’ marriage contravenes the State’s interest in protecting the institution of marriage and affronts one’s sense of justice and reasonableness.

While Janet Cathey’s situation may seem remote, the broad language in the Economic Credentialing Policy could result in many more “unjust,” “unreasonable,” and “unfortunate” applications. The Policy defines “immediate family members” as “husband or wife, birth or adoptive parent, child, sibling, stepparent, stepchild, stepbrother, father-in-law, mother-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent and spouse of grandchild.” Because of the broad definition of immediate family members, it is conceivable that many more physicians could be affected by the Policy.

e. Evidence Does Not Support Baptist Health’s Countervailing Justification For The Policy

Of course, the public interests contravened by the Policy are not absolute. However, none of the countervailing interests advanced by Baptist Health in support of the Policy are supported by evidence. According to Baptist Health, the Policy purports to serve four purposes:

- (1) To prevent physicians from selectively referring profitable patients to

their own facilities while dumping unprofitable patients on Baptist Health;

- (2) To protect Baptist Health's financial health so that it may carry out its charitable mission;
- (3) To prevent physicians from recruiting Baptist Health staff members to work for the facility the physician owns; and
- (4) To foster hospitable physician-hospital relations.

As explained in the sections below, none of these justifications is sufficiently supported.

i. The Proffered Justifications Are Pretextual

At the outset, the evidence adduced at trial demonstrates that other interests of Baptist Health's motivated it to adopt the Policy. In this regard, it is noteworthy that neither the Board nor the Executive Committee considered any of the four proffered justifications when they voted to adopt the Policy. For example, although Arkansas Heart Hospital had been in operation for six years, Baptist Health did not analyze the referral patterns of the physicians at that hospital to determine whether they had in fact engaged in selective referral of patients. Nor did Baptist Health analyze the effect that the Heart Hospital had on Baptist Health's profitability. As a result, Baptist Health had no basis upon which to believe at the time it adopted the Policy that any of its proffered justifications outweighed the adverse impact the Policy would have on patients, physicians, and competition.

ii. The Proffered Justifications Were Not Supported By The Evidence

The evidence does not support any of Baptist Health's four justifications.

Baptist Health contends that it adopted the policy to protect patients from the conflict of interest that arises when a physician has an ownership interest in a hospital. The theory is that physicians who

have an ownership interest in a hospital will be incented to treat their patients in that facility and will perform unnecessary procedures in order to increase the amount of money that the physician earns. The un rebutted evidence demonstrates that physicians affiliated with the physician-owned specialty hospitals in Arkansas adhere to strict ethical rules requiring them to make hospitalization decisions based solely on the interests of the patient. Each plaintiff testified that they adhered to these ethical requirements, and no evidence to contradict this was offered. No evidence was presented to support the contention that the plaintiffs perform unnecessary procedures. Further, Baptist Health could provide no examples of the plaintiffs selectively referring lucrative patients to their facility for treatment.

For the ten years that the Heart Hospital had been in operation, Baptist Health could provide only two alleged examples of selective referral by AHH physicians. Even there, the evidence is directly contrary to Baptist Health's position. The supposedly profitable patient transferred by Dr. Bauman to Arkansas Heart Hospital was actually uninsured. Moreover, records show that the patient transferred by Dr. Mego from the Heart Hospital to Baptist Health was covered by private insurance that had more favorable terms to the insured if treated at Baptist Health.

Similarly, there is no evidence to support the assertion that the existence of physician-owned specialty hospitals threatens Baptist Health's economic viability or its ability to carry out its charitable mission. In fact, despite competing with two such specialty hospitals for a number of years, Baptist Health enjoyed annual excesses of revenue over expenses of between \$30 million and \$40 million, which is consistent with its historical experience and the margins of similar hospitals nationwide. At the national level, Dr. Dodson testified that both governmental and academic studies show that margins at hospitals like Baptist Health are not harmed and are even helped by the entry of physician-owned

specialty hospitals.

Likewise, there was no evidence to support Baptist Health's contention that the Policy is necessary to protect human resources. Baptist Health attempted to show that over the six years between 1997 and 2003, fifty employees had moved from Baptist Health to Arkansas Heart Hospital. However, there was no evidence that the plaintiffs had ever approached these Baptist Health staff members to solicit their employment. It is equally plausible that the employees left Baptist Health because they independently learned that the Heart Hospital offered higher wages, better working conditions, better location, and any number of other advantages.

Finally, Baptist Health did not attempt to prove its claim that the Policy was necessary to protect physician-hospital relations. There was no evidence that any plaintiff has ever disrupted hospital operations or been uncooperative with hospital management. In fact, plaintiff Charles Caldwell, M.D. serves on Baptist Health's Quality Review Committee, which is the committee responsible for overseeing the operation of the hospital and for reviewing physician conduct and utilization of procedures.

Several witnesses testified that, if it wanted to protect itself from physicians who selectively referred lucrative patients for treatment at a facility in which the physician had an ownership interest, Baptist Health could initiate investigations of facts relating to specific physicians. Notably, Baptist Health has never tried an approach less restrictive than rigid enforcement of the Policy.

iii. The Policy is Overbroad.

Even if Baptist Health had demonstrated that its proffered justifications had some basis in fact, the Policy adopted would still be unreasonably overbroad. On this point, the case of *Duffner v. Alberty*, 718 S.W.2d 111 (Ark. App. 1986) (en banc), is particularly instructive. There, the court stated:

The test of reasonableness of contracts in restraint of trade is that the restraint imposed upon one party must not be greater than is reasonably necessary for the protection of the other, and not so great as to injure a public interest.

Id. at 112. Baptist Health's own witnesses acknowledge this need to tailor very narrowly any policy that restrains trade. Specifically, Jim Harris, a Baptist Health Board of Trustees member, testified that Baptist Health had to make the Policy "as narrow as possible to accomplish [its] goals." Contrary to the teaching of *Duffner* and the objectives stated by Mr. Harris, the evidence makes clear that the Policy is far broader than "reasonably necessary" for Baptist Health's protection.

The Policy's overbreadth stems principally from its failure to afford physicians the opportunity to demonstrate that they have not acted in an unethical or unprofessional manner. It creates an irrebuttable presumption that physicians will act unethically. It affords physicians no opportunity to show that they have not in fact selectively referred patients or otherwise acted in a manner contrary to the legitimate interests of Baptist Health.

The overbreadth of the Policy is also shown by the fact that it applies to physicians who could not possibly selectively refer lucrative patients when making hospital admissions decisions. For example, while purporting to address this concern in admissions decisions by physicians, the Policy applies to physicians who do not admit patients to any hospital, e.g., radiologists, anesthesiologists, and

pathologists. It also applies to physicians, like Janet Cathey, who may have an indirect ownership interest in a competing hospital through an immediate family member, but who have no reason or opportunity to refer patients to the competing facility. Baptist Health's witness, Doug Weeks described these examples of the grasp of the Policy as "unfortunate," and Dr. Phil Peters described them as "unfair" and "unjust."

The Policy is also overbroad in that it applies, pursuant to subsection Section 6(b), to "any interest, directly or indirectly, in real or personal property used by a competing hospital." Thus, if a physician (or a family member) were to lend money to a car rental agency that leased an automobile to a competing hospital, such arrangement would disqualify the physician's medical staff privileges. That is too tenuous a reason to expect a physician to breach his ethical duties.

The Policy is further overbroad geographically. Under Section 6(a), a "competing hospital" includes "[every] hospital licensed in Arkansas." Consequently, the Policy would apply to a physician who practices in one location and whose family member owns an interest in a hospital in a far-off location to which the physician could not possibly refer patients. For example, a family physician is unlikely to see patients that live outside his or her immediate community, and there is no reasonable likelihood that the physician's ownership of a hospital outside that area could harm Baptist Health. Moreover, while Baptist Health has hospitals in the Little Rock area, in Arkadelphia, and in Heber Springs, it does not have a hospital facility elsewhere in the State. A physician-owned specialty hospital located in Fayetteville, for example, which would draw patients almost exclusively from the immediate area, would not pose a substantial competitive threat to Baptist Health. Yet, the Policy penalizes any member of the Baptist Health medical staff who might invest in such a facility.

2. Baptist's Health's Motive

Baptist Health argued that it adopted the policy to protect the sanctity of all types of patient care in Arkansas. As a 501(c)(3) corporation, Baptist Health offers many services that are not profitable. It is Baptist Health's contention that it must provide enough profitable services such as cardiac services to counteract the money it loses providing services that are not profitable such as emergency services. Baptist Health's position is that specialty hospitals which provide profitable services interfere with Baptist's ability to provide services that are not profitable. Further, Baptist Health claims that they adopted the Policy because of the conflict of interest that physicians with ownership interests in hospitals have. Baptist Health asserts that physicians with an ownership interest in a hospital would screen to identify ("cherry-pick") the most lucrative patients and provide unnecessary services which could adversely affect the state of health care.

The Court finds that Baptist Health has a strong interest in protecting its economic viability. However, the Court finds this was not the motivation for Baptist Health's adoption of the Policy. For example, Baptist Health did little research of economic credentialing prior to the adoption of the Policy. Minutes from board meetings indicate that the Policy and the reason for implementing the Policy were not discussed. Similarly, some doctors, such as Dr. John Wayne Smith a former Baptist Health Board of Trustees member, expressed concerns about the Policy and these concerns were not communicated to the Board. Further, Baptist did not research the financial affect that the Arkansas Heart Hospital had on its economic viability except to note that adopting the policy would amount to a loss of \$36 million dollars for the hospital (the amount of money that accounts for the business the plaintiffs conducted at the hospital). Finally, Dr. Dodson's research indicates that the profit margins of community hospitals

are not harm and are even helped when specialty hospitals enter the market.

Baptist Health also contended that its motive was to protect patients from the inevitable conflict of interest that physicians with ownership interests in a hospital will have. The theory is that physicians who have an ownership interest in a hospital want to selectively refer lucrative patients to that facility and will also provide unnecessary procedures in order to increase the amount of money that the physician earns. To begin, a physician's ethical duties require him or her to make medical decisions based solely on the patient's well-being, and there was no evidence to dispute that the plaintiffs were acting in accordance with their ethical duties. Secondly, the Court notes that every patient-physician relationship requires that a physician suggest and administer treatment to patients. The potential conflict of interest that arises from a physician who provides unnecessary procedures is available to most physicians regardless of whether they have an ownership interest in a medical facility. Further, Baptist officials admitted at trial that Baptist allows physicians to have ownership interests in facilities such as imaging centers, outpatient surgery centers and ambulatory surgery centers. In each of these cases, Baptist co-owns the facilities with the physicians and these physicians are not at risk of losing their privileges. The Court finds that Baptist's concern over the plaintiffs' conflict of interest is not well-founded.

The Court finds that Baptist Health's motive was to discourage competition by physicians who considered investing in specialty hospitals. The Arkansas Heart Hospital had been in existence for six years before any action was taken by Baptist Health. Both Weeks and Harrington admitted that they began to consider the policy when the second specialty hospital was on the horizon and Harrington added that the primary purpose of the policy was to ensure that no additional specialty hospitals would

enter the local market. The testimony indicates that the Economic Credentialing Policy was considered as a possible deterrent to doctors who were considering opening a spine hospital. Baptist Health's motive was to exclude specialty hospitals from its market, secure patient referrals, and punish physicians who invested in specialty hospitals. Significantly, the evidence at trial was that Baptist Health wanted to force the patients to make a decision between the plaintiffs and Baptist Health.

3. The Plaintiffs' Interests with which Baptist Health's Conduct Interferes

The physicians assert that they are challenging this Economic Credentialing Policy because it interferes with and adversely affects the patient-physician relationship and because Baptist Health's conduct also interferes with the Plaintiffs' right to engage in lawful competition.

A number of witnesses testified that the patient-physician relationship is extremely important. In fact, this was never controverted. Similarly, the concept of continuity of care was discussed at length at trial with no witness controverting its importance. The plaintiffs testified that patient-cardiologist relationships can last decades. Witnesses testified that a disruption in the patient-physician relationship would adversely affect the quality of care provided to patients. An example of the possible negative effects of this Policy comes from the testimony of Mr. Charles Brocato and Plaintiff Rollefson. Mr. Brocato had a heart attack was transported via ambulance to Baptist Health for treatment. Dr. Rollefson testified that he is Mr. Brocato's cardiologist and they have a longstanding relationship. Dr. Rollefson treated Mr. Brocato and he had a full recovery. Dr. Rollefson testified that his relationship with Mr. Brocato helped him appropriately treat the heart attack. Dr. Rollefson hypothesized that a physician who did not have an established relationship with Mr. Brocato might have given more conservative treatment thinking that Mr. Brocato was too advanced in age to recover from this major

surgery. The Court finds, and case law supports its finding, that the plaintiffs' interests are of utmost importance. *Jaraki v. Cardiology Associates of Northeast Arkansas, P.A.* 75 Ark. App. 198, 55 S.W.3d 799 (2001). See also *Duffner v. Alberty* 19 Ark. App. 137, 718 S.W.2d 111 (1986).

4. The Interests Sought to be Advanced by Baptist Health

Baptist Health has an interest in protecting its economic viability and an interest in ensuring all patients get the best healthcare available. However, as discussed previously in Section I(E)(2), there is no evidence to show that either were threatened by the introduction of specialty hospitals.

5. The Social Interests in Protecting the Freedom of Action by Baptist Health and the Contractual Interests of the Plaintiffs

There is a strong social interest in protecting the sanctity of the patient-physician relationship as society is composed of people who are or will most likely become patients. It is the patients' health that is affected by any interference with this relationship.

There are social interests in ensuring that patients in Arkansas hospitals have a high quality of care. The Court considers the quality of care at local hospitals as well as the resources available in the community. Through the testimony of Dr. Michael Pine, a board certified cardiologist and the president of a consulting firm which analyzes quality of care provided by physicians and hospitals, the plaintiffs attempted to prove that Arkansas Heart Hospital patients have better outcomes than patients at Baptist Health and that therefore, the quality of care at Arkansas Heart Hospital is higher. Dr. Pine presented to this Court his research on the quality of care at local hospitals. He examined quality of care by analyzing the rate of death and the rate of adverse outcomes associated with being admitted to a particular hospital. Dr. Pine's findings indicated that there was a lower rate of death and adverse

outcomes at Arkansas Heart Hospital. His research bolsters the plaintiffs' contention that patients have better results at the Arkansas Heart Hospital and that the introduction of the hospital was beneficial to society. However, the evidence also indicated that patients with complications go to Baptist Health because the Arkansas Heart Hospital is a specialty hospital that is not equipped to deal with non-cardiac complications in the same way that Baptist Health is. The fact that patients with complications go to Baptist Health indicates that Dr. Pine's research may not accurately measure the quality of care at local hospitals.

Testimony at trial, as presented by Dr. Murphy and other witnesses, indicates that there is a shortage of cardiac beds in Arkansas. As a result, often all three major hospital with cardiac beds in the Little Rock area are on deferment. Each hospital rotates taking local patients. Patients in outlying areas without cardiac services can linger in those areas for days before they can be transferred to Little Rock. The lack of cardiac beds concerns the Court, but the Court has no opinion as to whether the enforcement of the Policy will close the Arkansas Heart Hospital and further reduce the available number of cardiac beds. What matters to the Court about Baptist Health's decision to adopt the Policy is that it would adopt this policy with the intent to stifle competition even though there is a shortage of cardiac beds. Knowing these facts, the Court finds that Baptist Health acted in a way directly adverse to its goal of providing services to the community.

Our society has a great need for non-profit hospitals such as Baptist Health. Members of our community depend on the charitable services it provides. Because of that, society has a strong interest in ensuring that Baptist Health remains an economically viable institution. Baptist Health maintained at trial that it must provide profitable services like cardiac services in order to continue unprofitable

services like emergency care. Baptist Health contends that when specialty hospitals enter the marketplace, its economic viability is jeopardized. However, the evidence indicates that those interests were not threatened, and Baptist Health's fear of this threat was not based in fact. To begin, the evidence shows that Baptist Health officials did little research on economic credentialing policies prior to their adoption of one. Minutes from board meetings indicate that the policy and the reason for implementing it were not discussed. Similarly, some doctors expressed concern about the Policy and these concerns were not communicated to the Board. Further, Baptist did not research the financial affect that the Arkansas Heart Hospital had on its economic viability except to note that adopting the policy would amount to a loss of \$36 million dollars (the amount of money that accounts for the amount of business the plaintiff physicians conducted at the hospital). Finally, Dr. Dodson's research indicates that community hospitals actually increase their profitability when specialty hospitals enter the market. His research is supported by the earnings reports of Baptist Health since the Arkansas Heart Hospital has been in existence. While, the Court finds that society has a strong interest in Baptist Health and other community hospitals remaining economically viable. The facts of this case indicate that Baptist Health's finances were never at risk.

The Court finds that society has a strong interest in ensuring that the most financially lucrative patients are not selected by specialty hospital physicians leaving uninsured or under insured patients to be treated at community hospitals. Dr. Jean Mitchell, who holds a PhD in economics and specializes as a healthcare economist, researched the referral patterns of doctors in several areas; her research did not include any hospitals in Arkansas. Her research indicates that all doctors who have an ownership interest in specialty hospitals will tend to accept lucrative patients at the hospital in which they have an

ownership interest (“cherry pick”), even if it is inadvertent. While the Court finds Dr. Mitchell’s testimony significant, as mentioned previously, Baptist Health failed to prove that any plaintiff had engaged in “cherry picking.”

6. The Proximity or Remoteness of Baptist Health’s Conduct to the Interference

Baptist Health’s adoption of the Economic Credentialing Policy directly caused the interference, and directly and proximately caused the plaintiffs’ damages.

7. The Relations Between the Parties

Here the plaintiffs are physicians who cannot practice their skills unless a hospital grants them privileges to practice.

8. Finding of Impropriety

After considering each of the factors of impropriety, the Court finds that Baptist Health’s interference with the plaintiffs was improper. The Court finds that Baptist Health adopted this policy in order to suppress competition. In fact, Russ Harrington admitted this at trial. The public policy of Arkansas indicates that the patient-physician relationship is of utmost importance. To interfere with that relationship is improper if the motive for interfering is to stifle competition especially when the evidence showed that competition will not interfere with quality of care for all patients. Finally, the policy of state of the Arkansas that a patient’s right to select a physician of his choice prevails any concerns raised by Baptist Health at trial because there has been no evidence to support the concerns mentioned by Baptist.

F. Baptist Health's Defenses

1. The Stranger Doctrine

Baptist Health asks the Court to adopt the stranger doctrine which precludes a claim for tortious interference where the third party is actually a part of an interwoven contractual relationship. Baptist Health maintains that the policy at issue only prevents the plaintiffs from treating patients at Baptist Health's facilities and not from practicing medicine. Therefore, when a plaintiff treats a patient at one of its facilities, Baptist Health and the plaintiffs are parties to an "interwoven contractual relationship" such that Baptist cannot tortiously interfere with the relationship.

Arkansas has not adopted the stranger doctrine nor the line of reasoning applied by the courts that have adopted the doctrine. The stranger doctrine has been adopted only in a "limited number of jurisdictions, including Georgia, Alabama, and Florida." *BCD, LLC v. BMW Mfg. Co., LLC*, 2007 WL 128887 (D.S.C. Jan. 12, 2007). (where the South Carolina court recently and expressly rejected the stranger doctrine). The stranger doctrine provides that "one deriving an economic benefit from a contractual or business relationship between others is considered to be a party to that relationship and cannot, as a matter of law, tortiously interfere in the relationship. *Physicians Specialists in Anesthesia v. MacNeill*, 246 Ga. App. 398, 539 S.E.2d 216 (2000). Specifically, in *Pruitt Corporation v. Stahley*, 270 Ga. 430, 510 S.E.2d 821 (1999), the court applied the stranger doctrine and denied a psychologist's tortious interference claim on the basis that the psychologist had an "interwoven relationship" with his patient and the nursing home, the nursing home was not a "stranger" and could not interfere with the psychologist's relationship with his patient. In reaching this conclusion, the Georgia Supreme Court found that Georgia's Bill of Rights for Residents of Long Term Care Facilities did not

provide nursing home residents the right to choose a psychologist - only a physician and pharmacist - concluding that the state legislature did not intend to protect nursing home resident's right to select a psychologist. This rationale is unsound in light of the fact that the Arkansas legislature has adopted a series of statutes protective of Arkansas' patients' rights to choose physician. Ark. Code Ann. § 23-99-201 through 209 and Ark. Code Ann. § 23-99-801 through 803.

Because the stranger doctrine is a minority approach not adopted by Arkansas courts and contrary to Arkansas public policy, this Court declines to adopt the stranger doctrine.

2. Refusal to Deal

Baptist Health argues that it cannot be compelled to grant staff privileges to the plaintiffs because it has an absolute right of refusal to deal and that one party cannot compel another to contract. In support of this proposition, Baptist cites *Davis v. Southern*, 231 Ark. 211, 330 S.W.2d 276 (1959) and *McMaster v. Ford Motor Co.*, 122 S.C. 244, 115 S.E. 244 (S.C.1921).

Davis v. Southern Farm Bureau Casualty Ins. Co. is the leading case on Arkansas's application of the refusal to deal doctrine. 231 Ark. 211, 330 S.W.2d 276 (1959). This case arose out of a car collision between Ed Davis, who was uninsured, and a vehicle owned by Bud Williams and insured by Southern Farm Bureau. Southern Farm Bureau notified the Revenue Department about the accident and Davis was notified that his driver's license was subject to suspension if he did not pay Williams for the damage or get a release signed by Williams. Davis proposed that Williams sign a contract in the nature of a release or agreement not to sue in order to protect Davis' driving privileges. Williams refused, and Davis filed suit. The Arkansas Supreme Court found that because Williams had "an absolute right to refuse to contract," Davis had no cause of action against Williams for his refusal to

sign a release. *Id.* At 215, 330 S.W.2d at 278-79.

The second case Baptist Health relies on, *McMaster v. Ford Motor Co.*, places limitations on the doctrine of refusal to deal. 122 S.C. 244, 115 S.E. 244 (S.C.1921). In *McMaster*, an inventor sued Ford and Ford's dealers alleging conspiracy and antitrust violations because Ford would not allow its dealers to use McMaster's products on Ford manufactured automobiles. The Court dismissed the action, explaining there was no contract between the parties and that the weight of authority favored the general proposition that, since Ford owed McMaster no duty, refusing to deal or contract with McMaster was not actionable. *Id.* at 246-7. Further, the *McMaster* court emphasized that the concept of refusal to deal is not absolute:

It would be difficult, if not impracticable, to make a fixed classification of rights, or to formulate a general rule to be applied in all cases, because of the great variety of rights which men enjoy in their intercourse with each other and the infinitely varying circumstances in which they are exercised. Therefore, while we approve the proposition above stated as a general rule, we are not prepared to hold that it is inflexible, and may not be modified by circumstances. It is sufficient for this case to say that the rights which defendants exercised are superior to any right of plaintiff to prevent exercise thereof.

McMaster, 115 S.C. at 246-47.

Davis and *McMaster* are distinguishable from the case at hand. Neither is a tortious interference case, neither involves interruption by a third party of an existing relationship or business expectancy; and neither involves physicians, hospitals, patients, medical care, insurance networks, or public policy. Other authorities confirm that the right to refuse to deal is not absolute. The Restatement

(Second) of Torts § 766 cmt. B, states:

Deliberately and at his pleasure, one may ordinarily refuse to deal with another, and his conduct is not regarded as improper, subjecting the actor to liability. . . . There is no general duty to do business with all who offer their services, wares or patronage; but there is a general duty not to interfere intentionally with another's reasonable business expectancies of trade with third persons, whether or not they are secured by contract, unless the interference is not improper.

Similarly, parties may not refuse to deal with one another where refusal constitutes an illegal restraint of trade:

Arkansas has followed the trend in this area by requiring a party challenging the validity of a covenant to show that it is unreasonable and contrary to public policy. Without statutory authorization, or some dominant policy justification, a contract in restraint of trade is unreasonable if it is based on a promise to refrain from competition that is not ancillary to a contract of employment or to a contract for the transfer of good will or other property. . . . [T]he law will not protect parties against ordinary competition.

Bendinger v. Marshalltown Trowell Co., 338 Ark. 410, 417-18, 994 S.W.2d 468, (1999).

This Court declines to find that Baptist has an absolute right to refuse to deal with the Plaintiff physicians. A party may not refuse to deal where the refusal is illegal, unconscionable, or contrary to public policy.

G. Conclusion

The Court finds that the Plaintiffs have proven their claim of tortious interference by a preponderance of the evidence.

II. Arkansas Deceptive Trade Practices Act

The Plaintiffs allege that Baptist Health's adoption of the Economic Credentialing Policy constituted an unconscionable trade practice and a violation of the Arkansas Deceptive Trade Practices Act ("ADTPA"). The ADTPA prohibits, "engaging in any . . . unconscionable . . . act or practice in

business, commerce, or trade.” Ark. Code Ann. § 4-88-107(a)(10). Any person who suffers actual damage or injury as a result of an offense or violation has a cause of action to recover actual damages, if appropriate. Ark. Code. Ann. § 4-88-113(f). To prove this violation, the plaintiffs must show: (1) Defendant engaged in an act or practice in connection with “business, commerce, or trade”; (2) Defendant has engaged in an “unconscionable” act or practice; and, (3) plaintiffs have sustained actual damage or injury as a result of the unconscionable act or practice. *See* Ark. Model Jury Instr., Civil AMI 2900 (2008 ed.).

A. Connection With Business, Commerce, or Trade

The evidence demonstrates that Baptist Health adopted the Policy in connection with its “business, trade, or commerce.” Russ Harrington testified that the Policy relates to the management of Baptist Health’s hospitals. Those hospitals comprise Baptist Health’s business. Baptist Health does not appear to dispute this point.

B. Actual Damage or Injury

The evidence also shows that the Policy caused the plaintiffs actual injury by disrupting their relationships with patients and referral sources. *See* Section I(D) above.

C. Unconscionable Acts or Practices

As the Supreme Court explained on appeal in this case, “[a]n unconscionable act is an act that affronts the sense of justice, decency, or reasonableness.” *Baptist Health v. Murphy*, 365 Ark. 115, 128 n. 6, 226 S.W.3d 800, 811 n.6 (2006) (internal quotation marks and alteration omitted). Here, the Policy affronts the sense of justice, decency, and reasonableness because it impinges on fundamentally important public policies without adequate countervailing justification.

An act “affronts the sense of justice, decency, and reasonableness” if it is “violative of public policy.” *Baptist Health v. Murphy*, 365 Ark. 115, 122, 226 S.W.3d 800, 811 (2006). Because an act is unconscionable if it is violative of public policy, the Court refers to Section I(E)(1) above for a discussion of how the Economic Credentialing Policy violates public policy.

D. Conclusion

The Court finds that the plaintiffs have proven by a preponderance of the evidence their cause of action for a violation of the Arkansas Deceptive Trade Practices Act.

III. Injunctive and Declaratory Relief

Plaintiffs seek a declaration that Baptist Health’s Economic Credentialing Policy is void as against public policy and unconscionable; and therefore unenforceable.

A. Declaratory Judgment

A party is entitled to declaratory judgment when four conditions are met: (1) there is a justiciable controversy; (2) it exists between parties with adverse interests; (3) those seeking relief have a legal interest in the controversy; and, (4) the issues involved are ripe for decision. *Dukes v. Norris*, 369 Ark. 511, ---S.W.3d— (May 3, 2007).

These conditions have been satisfied in this case. First a justiciable controversy has arisen by virtue of Baptist’s adoption of the Economic Credentialing Policy, which violates the ADTPA and Arkansas public policy. Second, the plaintiff’s interests are unquestionably adverse to those of Baptist Health, as the plaintiffs directly challenged a policy adopted by Baptist Health. Third, both parties have a legal interest in the controversy - the plaintiffs in preserving their patient-physician relationships and their interests associated with those relationships, and in protecting the public policy of Arkansas, and

Baptist Health in defending and enforcing its Economic Credentialing Policy. Finally, the case has been tried on the merits and submitted to the Court. The issues are ripe for decision. Accordingly, entry of declaratory judgment is proper.

B. Injunctive Relief

To establish sufficient grounds for an injunction, a plaintiff must show: (1) that it is threatened with irreparable harm; (2) that this harm outweighs any injury that granting the injunction will inflict on other parties; and (3) that the public interest favors the injunction. *Jones v. Juanita S. Wood Family Ltd. Partnership*, 95 Ark. App. 326, 332, 236 S.W.3d 573, 578 (2006); *see also Dawson v. Temps Plus, Inc.*, 337 Ark. 247, 261, 987 S.W.2d 722, 730 (1999).

1. Irreparable Harm

First, the Court finds that the Policy threatens to cause physicians irreparable harm. As the Supreme Court explained on appeal in this case, “physicians are not fungible as to their relationships with patients or their specialties of practice.” *Murphy*, 365 Ark. 115, 131, 226 S.W.3d 800, 813 (2004). The Policy threatens to disrupt the relationships physicians have with their patients, and no after-the-fact remedy can truly compensate for that disruption. The Policy also threatens irreparable harm to physicians because the economic injury of the disruption of patient-physician relationships and referral relationships may be difficult to quantify for purposes of determining compensatory damages.

2. Harm to the Plaintiffs Outweighs Any Injury to the Defendant

Second, an injunction barring Baptist Health from enforcing its Policy would cost Baptist Health little or nothing. Baptist Health has been unable to enforce the Economic Credentialing Policy for over 0 four years. The evidence at trial demonstrated that Baptist Health has suffered no harm as a result of

specialty hospitals opening their doors in the Little Rock area - indeed, Baptist Health's witnesses testified that they had not even studied the issue. Further, Dr. Dodson testified that his research indicates that the introduction of specialty hospitals actually increases profitability of general hospitals.

The Plaintiffs presented evidence to the Court that indicated that Baptist Health maintained its level of profitability or saw an increase after the inception of the Arkansas Heart Hospital. No evidence was produced that Baptist Health's ability to provide charity care and unprofitable services has been threatened by the introduction of specialty hospitals. In fact, Doug Weeks testified that he could not say that the Economic Credentialing Policy was necessary for Baptist Health to continue to provide charity care and unprofitable services. To the contrary, the evidence at trial established that Baptist Health is financially sound and earns multi-millions of dollars in revenues each year. Indeed, the evidence established that Baptist Health was willing to suffer lost revenues in excess of \$36 million (the amount of money estimated to have been earned for Baptist Health by the plaintiffs) to adopt the Economic Credentialing Policy.

In light of the serious negative consequences of the policy and the relatively minor cost if any to Baptist Health if the Court issues its injunction, the balance of harm weighs heavily in favor of issuing the injunction.

3. The Public Interest

Third, the public interest weighs in favor of an injunction. The Economic Credentialing Policy violates public policy, tortiously interferes with contracts and business expectancies, and is an unconscionable trade practice under the ADTPA. Tortious conduct is contrary to the public interest. Unconscionable conduct is contrary to the public interest. And acts contrary to public policy are, by

definition, contrary to the public interest.

Finally, the Court notes that the law favors injunctive relief for claims involving the public interest: “The public interest is seldom found to be on the side of the unrestrained commission of tort.” Restatement (Second) Torts, § 936, cmt. C; see also *id.* § 942. Further,

In many modern cases, such as those involving business torts when the paramount purpose is to prevent the continuation of a tortious practice regarded as contrary to the public interest, injunctive relief is, as a matter of course, treated as the only appropriate remedy to provide adequate relief for all persons affected.

Id. at § 933, cmt. a; see also *id.* § 766, cmt. u (“In appropriate circumstances under the general rules relating to equitable relief (see § 933-951), one may be enjoined from conduct that would subject him to liability under the rule stated in this section.”); and § 766B cmt. g.

Such is the case here. A permanent injunction is the only just and appropriate remedy.

IV. Case Law from Other Jurisdictions

Baptist Health cites several cases from other jurisdictions as guidance on how the issues in this case should be decided. As will be discussed below, the court finds that while these cases are somewhat factually similar, they lack the similarity in legal concepts to be helpful to the Court’s analysis.

In the case of *Mahan v. Avera St. Luke’s*, 621 N.W.2d 150 (S.D. 2001), the private, non-profit hospital closed its medical staff to new orthopedic surgeons, and no new doctors in that specialty were granted privileges. The evidence showed that the hospital enacted this policy because it did not have a neurosurgeon and needed to recruit one. The small town in which the hospital was located did not have a large amount of neurosurgery cases, so the neurosurgeon would have to supplement his or her finances by doing orthopedic surgeries. An orthopedic clinic recruited a doctor after the policy was

implemented. This new orthopedic surgeon and his partners sued the non-profit hospital for breach of contract because the medical staff had not approved the closure. The Court finds that the *Mahan* case differs from our case. The facts are somewhat dissimilar, but most importantly, the cause of action is breach of contract and thus, the legal analysis is different.

In *Rosenblum v. Tallahassee Memorial Regional Medical Center, Inc.*, No. 91-589 (Fla. 2d Cir. 1992), a Florida trial court upheld a hospital's decision to deny staff appointment to a heart surgeon with contractual commitments to a competing hospital. The Court held that the hospital could consider economic considerations when determining staff membership. The Court based its decision largely on a Florida statute that the court read as having authorized the use of economic considerations in hospital credentialing. The statute provided that, in addition to traditional elements that hospitals consider in making credentialing decisions, a Florida hospital may take into consideration, "such other elements as may be determined by the governing board [of the hospital]." *Id.* at 3. Finally, the Court held that even though hospitals have a statutory right to consider economic factors in making credentialing decisions, use of such factors must not be "arbitrary" or "capricious." *Id.* at 4. This case did not aid the court because the Florida court bases its analysis largely on a Florida statute that Arkansas does not have.

The case of *Walborn v. UHHS/CSAHS-Cuyahoga, Inc.*, Case No. CV-02-479572, slip. op. (Ct. Common Pleas, Cuyahoga Cnty. June 16, 2003), is the case most factually similar to this case. The hospital in this case had an economic conflict of interest policy that precluded physicians with ownership interests in competing hospitals from having privileges. However, the policy in question in that case provided physicians a right to a hearing before an administrative review committee and

authorized the hospital administration to grant individual exceptions for “appropriate reasons.” *Id.* at 7, 9. The Court in *Walborn* held that the non-profit hospital demonstrated that its economic credentialing policy was “a reasonable means of protecting [the hospital’s] continued viability.” *Id.* at 30. The facts in our case do not support such a finding. *Walborn* also discounted the physicians’s argument that exclusion from the hospital staff would damage their practices and harm their patients because the physicians had allowed their own privileges to lapse for long periods of time for failure to complete necessary paperwork. *Id.* at 11-12. The same is not true here. The Court in *Walborn* placed significant weight on the fact that the facility with which the physician-plaintiffs were affiliated had a corporate policy steering patient referral to other physicians and facilities also affiliated with the hospital. *Id.* at 31. Here, there is no evidence that the Arkansas Heart Hospital requires or encourages the plaintiff physicians to steer their patients to the Arkansas Heart Hospital. The Ohio court did not analyze the facts of its case in terms of tortious interference of violations of a deceptive trade practice statute. Therefore, the court’s opinion does not aid this Court.

Finally, in *Williamson v. Sacred Heart Hosp. Of Pensacola*, 1993 W.L. 543002 (N.D.Fla., May 28, 1993), the court was faced with a lawsuit based on the anti-trust principles. A radiologist owner of a competing clinic was denied medical staff appointment. The Court concluded that denying appointment to a competitor would be justified. The analysis in this case does not aid this Court in its analysis because the legal principles guiding this Court’s decision are based on anti-trust law rather than tort.

If any Conclusion of Law shall be deemed to be a Finding of Fact, the Court intends the Conclusion of Law to be construed as a Finding of Fact.

CONCLUSION

For the reasons stated above, the Court hereby finds that the plaintiffs have proven their claims for tortious interference and violations of the Arkansas Deceptive Trade Practices Act by a preponderance of the evidence. Further, The Court finds that the plaintiffs are entitled to a declaratory judgment and permanent injunctive relief that will enjoin Baptist Health from denying the plaintiffs professional staff appointment and clinical privileges on the basis of its Economic Credentialing Policy.

IT IS SO ORDERED.

Collin Wilgore

Circuit Judge

FEB 27 2009

Date

