

Antitrust and Hospital Privileges: Testing the Conventional Wisdom

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This Article concerns the potential impact of antitrust law upon decisions by hospitals to deny or limit medical staff and clinical privileges for physicians and other health care practitioners.¹ This study promises to be significant in three ways. First, disappointed applicants for hospital privileges have begun to file an increasing number of antitrust claims against hospitals and medical staffs in recent years.² The satisfactory resolution of the issues presented by these claims should effect an efficient and fair allocation of hospital privileges and promote increased competition and cost-consciousness in the health care sector. Second, hospital privilege decisions are a quintessential form of professional self-regulation, and the application of antitrust law to these decisions thus should have many direct implications for other antitrust cases that involve collective professional behavior. Third, the resolution of privilege disputes will involve the use of several antitrust doctrines that themselves appear to be in something of a parlous state. This case study thus will necessarily raise and suggest answers to some

1. The term "medical staff privilege" refers to the right of a physician or dentist to participate in a hospital's governing structure as a member of its medical staff, and the term "clinical privilege" refers to any health care practitioner's right to perform medical procedures within the hospital. *See* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS: 1979 EDITION 53-55, 81-86 [hereinafter cited as JCAH MANUAL]. For convenience, we shall often use the term "hospital privilege" or "privileges" to refer to both medical staff and clinical privileges.

2. *See, e.g.*, Crane v. Intermountain Health Care, 637 F.2d 715 (10th Cir. 1981); Capili v. Shott, 620 F.2d 439 (4th Cir. 1980); Harron v. United Hosp. Center, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976); Wolf v. Jane Phillips Episcopal-Memorial Medical Center, 513 F.2d 684 (10th Cir. 1975); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981); Sinith v. Northern Mich. Hosps., 1981-2 Trade Cas. (CCH) ¶ 64,181 (W.D. Mich. July 15, 1981); United States v. Halifax Hosp. Medical Center, 1981-1 Trade Cas. (CCH) ¶ 64,151 (M.D. Fla. June 24, 1981) (consent agreement); Hyde v. J. Jefferson Parish Hosp. Dist. No. 2, 1981-1 Trade Cas. (CCH) ¶ 63,932 (E.D. La. Jan. 26, 1981); Robbins v. Ong, 452 F. Supp. 110 (S.D. Ga. 1978); Zamiri v. William Beaumont Hosp., 430 F. Supp. 875 (E.D. Mich. 1977); Sokol v. University Hosp., 402 F. Supp. 1029 (E.D.N.Y. 1975); Pollack v. Methodist Hosp., 392 F. Supp. 393 (E.D. La. 1975); Datillo v. Tucson Gen. Hosp., 23 Ariz. App. 392, 533 P.2d 700 (1975); Douglas v. Hospital of St. Raphael, 33 Conn. Supp. 216, 371 A.2d 396 (Super. Ct. 1976); Moles v. White, 336 So. 2d 427 (Fla. Dist. Ct. App. 1976), cert. denied, 355 So. 2d 516 (Fla. 1978); Anne Arundel Gen. Hosp. v. O'Brien, 49 Md. App. 362, 432 A.2d 483 (Ct. Spec. App. July 13, 1981); Silver v. Queen's Hosp., 629 P.2d 1116 (Hawaii 1981); *see also* New York v. American Medical Ass'n, 1980-2 Trade Cas. (CCH) ¶ 63,456 (E.D.N.Y. June 9, 1980) (settlement by the American Hospital Association of the state's antitrust claim that medical and hospital organizations have opposed chiropractors, including their access to hospitals, in an illegal fashion); Ohio v. Joint Comm'n on Accreditation of Hosps., No. C-2-79-1158 (S.D. Ohio filed Dec. 14, 1979) (an antitrust attack on the JCAH standards that discourage the grant of hospital privileges to clinical psychologists).

fundamental questions about the current direction of several antitrust doctrines of general significance.

Our primary thesis is that antitrust law has an effective but limited role to play in policing hospital privilege decisions. A set of relatively clear antitrust rules could be recognized that would guard against blatant anticompetitive abuses without disrupting the legitimate interests of hospitals and medical staffs in providing efficient and high quality medical care. This result will be achieved, however, only if antitrust courts are able to avoid two very different temptations: on the one hand, to defer unthinkingly to claims of professional expertise and, on the other, to treat hospitals as public utilities that ought to serve all licensed practitioners who wish to provide inpatient services within the scope of their licenses. These "deferential" and "public utility" approaches to hospital privilege decisions are both possible if antitrust courts try to resolve privilege cases by balancing the anticompetitive and procompetitive effects of each decision on an ad hoc basis, a method that seems to be invited by antitrust's so-called Rule of Reason.³ We argue, to the contrary, that antitrust courts should avoid ad hoc balancing and its consequences by following a few "purpose

3. The Rule of Reason is the basic paradigm of antitrust reasoning. The standard requires that substantive antitrust rules be based upon a consideration of the anticompetitive and procompetitive effects of different types of conduct. *See National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 687-92 (1978); *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918); *Standard Oil Co. v. United States*, 221 U.S. 1, 55-75 (1911). Within this paradigm, it is conventional to talk about two kinds of analysis: one for activities whose general nature is so clearly anticompetitive that the activities are deemed to be illegal per se, and the other for activities "whose effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed." *National Soc'y of Professional Eng'rs*, 435 U.S. at 692. These analytical categories are frequently referred to as the "per se" and "rule of reason" approaches to antitrust analysis, and the latter is often thought to require an ad hoc balancing of the anticompetitive and procompetitive effects of the challenged behavior. Examples of this apparent "balancing" may be found quite readily in antitrust hospital privilege cases, *see, e.g.*, *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981); *Hyde v. J. Jefferson Parish Hosp. Dist. No. 2*, 1981-1 Trade Cas. (CCH) ¶ 63,932 (E.D. La. Jan. 26, 1981), and in the existing literature on the potential application of antitrust law to hospital privilege decisions, *see M. THOMPSON, ANTITRUST AND THE HEALTH CARE PROVIDER* 149-69 (1979); *Calvani & James, Antitrust Law and the Practice of Medicine*, 2 J. LEGAL MED. 75 (1980); *Rich, Medical Staff Privileges and the Antitrust Laws*, 2 WHITTIER L. REV. 667 (1980). The rule of reason or balancing approach to antitrust analysis, however, does not logically preclude the recognition of general standards or rules that are based upon a balancing of effects for entire categories of behavior. *See, e.g.*, *R. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE* 171-217 (1976).

Much of this Article is devoted to the development of general standards that should guide antitrust courts in applying antitrust's rule of reason or balancing approach to various categories of hospital privilege decisions. *See infra* Part IV. Another recent article also suggests a rule-oriented approach to antitrust privilege cases, but the approach taken in that article would threaten to turn hospitals into public utilities that must provide privileges to all licensed practitioners who are competent within the terms of their licenses. *See Dolan & Ralston, Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. REV. 707 (1981). For our critique of this approach, *see infra* text accompanying notes 371-74.

based" categorical rules.⁴ We suggest that such rules can be drawn from existing precedents, and that a purpose based approach to antitrust law might be appropriate not only for hospital privileges but for other areas of antitrust law as well.

In Part I we outline the central problems that will need to be addressed by antitrust analysis of hospital privileges. In Part II we try to dissect the rather tangled legal, economic, and political relationships between physicians and hospitals that affect privilege decisions. The characterization of these relationships will be important to the resolution of many privilege cases in antitrust law. Then in Part III we consider several problematic issues of antitrust jurisdiction that will be raised in privilege cases. In Part IV we analyze the major substantive issues that will be faced in applying antitrust law to various kinds of privilege decisions. Finally, in Part V, we summarize our conclusions about this area of antitrust law and the more fundamental questions about antitrust doctrine that are raised by this study.

I. CENTRAL PROBLEMS

Hospital privileges are scarce resources that ought to be allocated efficiently and fairly, but may not be. Consider three situations. A hospital grants medical staff privileges only to physicians who join partnerships of present staff members.⁵ A hospital denies obstetrics privileges to family practitioners, even though they have received their obstetrics training in a residency program approved by organized medicine's Liaison Committee on Graduate Medical Education.⁶ A hospital denies clinical privileges to podiatrists who wish to perform inpatient foot sur-

4. See *infra* Part IV. Our discussion of "purpose based" rules in this Article draws on the distinctions between motive, intent, and purpose that John Coons once suggested for analyzing other kinds of anomalous antitrust behavior. Coons, *Non-Commercial Purpose as a Sherman Act Defense*, 56 NW. U.L. REV. 705, 709-12 (1962). Thus, by "motive" we mean the subjective aspect of an individual's will to do something. By "intent" we refer to the desire of individuals or groups to effect certain means in order to accomplish ultimate goals. And by "purpose" we refer to an individual's or group's ultimate goals, ends, objectives, or reasons for doing something. Cf. R. DICKERSON, THE INTERPRETATION AND APPLICATION OF STATUTES 87-88 (1975) (drawing a similar distinction between the concepts of legislative intent and legislative purpose). With this nomenclature, it does not make sense to speak of a hospital's motive to exclude practitioners, although evidence of an individual's motives may be relevant in determining the hospital's purpose for the exclusion. Similarly, it usually will not be controversial that the hospital intended to exclude certain practitioners, but whether the hospital's purpose was to punish competitors of its medical staff or to protect the quality of the hospital's services will often be the difficult question that antitrust courts must resolve.

5. See Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 CUM. L. REV. 684, 701-02 (1979).

6. See, e.g., Holoweiko, *FPs v. OBGs: a battle over babies*, Med. Econ., June 15, 1979, at 129-35; Sanders, *We primary-care doctors are in a bind—and that's great*, Med. Econ., Dec. 11, 1978, at 165, 168.

gery within the scope of their accredited training and state licenses.⁷ There may be justifications for these decisions, but on their face they will appear unfair to many and also inefficient because they exclude effective competitors of the hospital's present medical staff.⁸

The demand for legal settlement of these sorts of disputes is likely to increase dramatically in future years. The recent expansion of American medical schools will substantially increase the number of physicians in this country during the next several decades.⁹ At the same time, federal and state policies have been initiated to curb hospital growth as a means of limiting health care costs.¹⁰ These conflicting trends promise to raise the barriers to hospital access that some physicians already are experiencing. In addition, other health care practitioners such as clinical psychologists, podiatrists, chiropractors and nurse practitioners may suffer increasing frustration as their professional visions and interests grow while hospital privileges become increasingly scarce resources.¹¹

Antitrust law is concerned with ensuring that private markets allocate resources in an efficient and fair manner,¹² and is therefore relevant to hospital privilege issues. Historically, however, antitrust law was applied to privilege decisions in only a few instances, typically in cases where a denial of privileges was part of a broader effort by fee-for-service physicians to boycott third party health insurers such as health maintenance organizations (HMOs).¹³ Antitrust claims against

7. See *Shaw v. Hospital Auth.*, 614 F.2d 946 (5th Cir. 1980); *Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515 (D.C. Cir. 1965); Hollowell, *The Growing Legal Contest—Hospital Privileges for Podiatrists*, 23 ST. LOUIS U.L.J. 491 (1979).

8. See generally Dolan & Ralston, *supra* note 3, at 709-21; W. Lazarus, E. Levine & L. Lewin, *Competition Among Health Practitioners: The Influence of the Medical Profession on the Health Manpower Market*, at IV-1 to IV-66 (Report to the FTC, Feb. 1981).

9. See Katz, Warner & Whittington, *The Supply of Physicians and Physicians' Incomes: Some Projections*, 2 J. HEALTH POL., POL'Y & L. 227 (1977); U.S. Report Projects Oversupply of Doctors by 1990, N.Y. Times, April 14, 1980, at A-16.

10. These policies include certificate-of-need controls over entry, see *The Certificate-of-Need Laws in Health Planning*, 1978 UTAH L. REV. 1, and other federal and state laws that are designed to limit hospital revenues. See generally D.S. ABERNETHY & D.A. PEARSON, *REGULATING HOSPITAL COSTS: THE DEVELOPMENT OF PUBLIC POLICY* (1979); Lewin, Somers & Somers, *State Health Cost Regulation: Structure and Administration*, 6 U. TOL. L. REV. 647 (1975).

11. On the problems that physicians, particularly family practitioners and general practitioners, are experiencing in obtaining hospital privileges, see *supra* notes 6, 8. On the problems of nonphysicians, see Hollowell, *supra* note 7; Note, *Health Professionals' Access to Hospitals: A Retrospective and Prospective Analysis*, 34 VAND. L. REV. 1161, 1185-98 (1981); *Chiropractors: Pushing for a place on health-care team*, Med. World News, Dec. 11, 1978, at 57-72.

12. See generally *Antitrust Jurisprudence: A Symposium on the Economic, Political and Social Goals of Antitrust Policy*, 125 U. PA. L. REV. 1182 (1977). But cf. R. BORK, *THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF* 15-89 (1978) (arguing that consumer welfare is the only ultimate goal that is appropriate for antitrust law, although recognizing that fairness may be promoted as an incidental effect).

13. See *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *Group Health Coop. v. King County Medical Soc'y*, 39 Wash. 2d 586, 237 P.2d 737 (1951); Rayack, *Restrictive Practices*

other privilege decisions generally foundered on jurisdictional grounds, either because of the so-called "learned professions" exemption from antitrust law¹⁴ or, in federal cases, because of an insufficient connection between the privilege decision and interstate commerce.¹⁵

Recent developments suggest that both federal and state antitrust laws will begin to play a more significant role in policing the allocation of hospital privileges. The Supreme Court's recent antitrust decisions condemning the collective elimination of price competition by lawyers and professional engineers portend application of federal antitrust law to a broad variety of professional practices.¹⁶ Moreover, in 1976 the Court held that the local acts of a hospital may, at least in some circumstances, have a substantial effect upon interstate commerce for the purpose of establishing federal antitrust jurisdiction.¹⁷ These decisions have supported a number of lower court decisions which recognize that federal antitrust law should apply to privilege denials and that such acts may have a substantial effect upon interstate commerce.¹⁸ State antitrust courts need not follow the new federal cases concerning professional practices,¹⁹ but the trend toward increased state antitrust enforcement²⁰ suggests that some state antitrust laws as well may be

of *Organized Medicine*, 13 ANTITRUST BULL. 659, 677-97, 711-12 (1968). See generally Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303; Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 DUKE L.J. 487.

14. See *Wolf v. Jane Phillips Episcopal-Memorial Medical Center*, 513 F.2d 684, 686 (10th Cir. 1975); *Moles v. White*, 336 So. 2d 427 (Fla. Dist. Ct. App. 1976), cert. denied, 355 So. 2d 516 (Fla. 1978); *Willis v. Santa Ana Community Hosp.* Ass'n, 58 Cal. 2d 806, 376 P.2d 568, 26 Cal. Rptr. 640 (1962); cf. *Williamson v. Grant County Pub. Hosp. Dist.*, 65 Wash. 2d 245, 396 P.2d 879 (1964) (antitrust exemption for hospital privileges because of other state regulation).

15. See *Wolf v. Jane Phillips Episcopal-Memorial Medical Center*, 513 F.2d 684 (10th Cir. 1975); see also *Elizabeth Hosp., Inc. v. Richardson*, 167 F. Supp. 155 (1958), aff'd, 269 F.2d 167 (8th Cir.), cert. denied, 361 U.S. 884 (1959); *Riggall v. Washington Medical Soc'y*, 249 F.2d 266 (8th Cir. 1957), cert. denied, 355 U.S. 954 (1958); *Spears Free Clinic and Hosp. for Poor Children v. Cleere*, 197 F.2d 125 (10th Cir. 1952).

16. See *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). On the implications of these cases for other kinds of professional practices, see *Branca & Steinberg, Attorney Fee Schedules and Legal Advertising: The Implications*, 24 U.C.L.A. L. REV. 475 (1977); *Canby & Gellhorn, Physician Advertising: The First Amendment and the Sherman Act*, 1978 DUKE L.J. 543, 564-82; Havighurst, *supra* note 13; Kissam, *Antitrust Law, The First Amendment and Professional Self-Regulation of Technical Quality*, in *REGULATING THE PROFESSIONS: A PUBLIC POLICY SYMPOSIUM* 143 (R. Blair & S. Rubin eds. 1980) [hereinafter cited as Kissam, *The First Amendment*].

17. *Hospital Bldg. Co. v. Trnstees of Rex Hosp.*, 425 U.S. 738 (1976).

18. Compare *Crane v. Intermountain Health Care*, 637 F.2d 715 (10th Cir. 1981), *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981) and *Zamiri v. William Beaumont Hosp.*, 430 F. Supp. 875 (E.D. Mich. 1977) with *Capili v. Shott*, 620 F.2d 439 (4th Cir. 1980).

19. See, e.g., *Moles v. White*, 336 So. 2d 427 (Fla. Dist. Ct. App. 1976), cert. denied, 355 So. 2d 516 (Fla. 1978); *New York v. Roth*, 1981-1 Trade Cas. (CCH) ¶ 64,076 (N.Y. Apr. 2, 1981).

20. See *Developments in State Antitrust Activities*, in *THE POLITICAL ECONOMY OF ANTITRUST: PRINCIPAL PAPER BY WILLIAM BAXTER* 143-46 (R.D. Tollison ed. 1980); *State Enforcement "Oaks" Grow from "Acorns" Planted by Congress, ANTITRUST & TRADE REG. REP. (BNA)*, April 4, 1979, at D-1 to D-4. But cf. *Hope Dims for Further Federal Funding of State Antitrust*

applicable to privilege decisions.

Antitrust rules, of course, are not the only external standards that apply to privilege decisions,²¹ but the focus of antitrust law upon relationships between economic competitors promises to address factors that are of central significance to many of the more bitterly contested privilege disputes. The satisfactory resolution of these issues should also affect the costs of hospital care and the opportunities for effective competition among health care providers. In particular, costs might decrease because practitioners who are excluded from hospitals often promise to deliver health care at a lower price, in a more innovative mode, and more competitively than the incumbent physicians of a hospital's medical staff.²² The application of antitrust law to privilege disputes thus may 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.²³

As a threshold matter, the application of antitrust law to hospital privileges will raise issues of antitrust jurisdiction, including questions of how far federal antitrust law should extend into matters of profes-

Enforcement Programs, ANTITRUST & TRADE REG. REP. (BNA) No. 967, at D-6, D-7 (June 5, 1980). See generally Rubin, *Rethinking State Antitrust Enforcement*, 26 U. FLA. L. REV. 653 (1974).

21. A summary of nonantitrust standards that are applicable to hospital privilege decisions may be found in Southwick, *The Physician's Right to Due Process in Public and Private Hospitals: Is There a Difference?*, 6 Medicolegal News, Feb. 1981, at 4-8. Briefly, these standards include hospital accreditation requirements that applicants for privileges be provided with notice and an opportunity to be heard by the hospital, see JCAH MANUAL, *supra* note 1, at 53-54, constitutional and common law requirements that privilege applicants be provided with fair process, see Shaw v. Hospital Auth., 614 F.2d 946 (5th Cir. 1980); Sosa v. Board of Managers of Vol Verde Memorial Hosp., 437 F.2d 173 (5th Cir. 1971); Griesman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963); Cray, *Due Process Considerations in Hospital Staff Privileges Cases*, 7 HASTINGS CONST. L.Q. 217 (1979); McCall, *A Hospital's Liability for Denying, Suspending and Granting Staff Privileges*, 32 BAYLOR L. REV. 175 (1980), particular state statutes that grant procedural or substantive rights to certain groups of privilege applicants, see, e.g., CAL. ADMIN. CODE, tit. xxii, R. 70706.1 (1980) (privilege applications from nonphysicians must be considered); N.Y. PUB. HEALTH LAW § 2801-b (McKinney 1973) (privileges may not be denied without giving reasons), and various contract and tort doctrines that may be particularly relevant to decisions not to renew existing privileges, see, e.g., Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1st Dist. 1965); Margolin v. Morton F. Plant Hosp., 342 So. 2d 1090 (Fla. Dist. Ct. App. 1977); Burkhardt v. Community Medical Center, 432 S.W.2d 433 (Ky. 1968).

22. See, e.g., Blackstone, *The A.M.A. and the Osteopaths: A Study of the Power of Organized Medicine*, 22 ANTITRUST BULL. 405 (1977); Dolan & Ralston, *supra* note 3, at 709-21.

23. The Reagan Administration's basic policy on health care appears to be based on the idea of promoting economic competition among medical insurers and hospitals. See *Health Chief Gives Plans to Cut Costs—Schweiker Asserts Administration Seeks to Restore Competition by Hospitals and Insurers*, N.Y. Times, June 12, 1981, at B-6. See generally Enthoven, *Health Care Costs: Why Regulation Fails, Why Competition Works, and How to Get There from Here*, 11 NAT'L J. 885 (1979); Enthoven, *Consumer Choice Health Plan*, 298 NEW ENG. J. MED. 650, 709 (1978); Havighurst, *supra* note 13; Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716, 736-48 (1970).

sional self-regulation and local affairs, which traditionally have been left to state regulation and frequently are closely regulated by state law. On these issues, the Supreme Court's current penchant for a case-by-case extension of federal antitrust law without principled justification offers some general guidance but fails to provide clear standards for the resolution of many specific questions.²⁴

Privilege issues also raise important questions about the rules of fair play among physicians and within the larger communities of hospitals, patients, and health professionals who work within a hospital setting. Antitrust law can contribute to the resolution of these disputes by requiring virtually all hospitals to provide a fair procedure to privilege applicants.²⁵ Although many hospitals are obligated under other standards to provide fair procedures,²⁶ antitrust law could extend this obligation to additional hospitals, require more rigorous procedures, and help enforce this obligation through the availability of treble damages for antitrust victims.²⁷ Antitrust law also could be used to police the many substantive criteria for privilege decisions that may have adverse effects upon competition among physicians, other health care professionals, and hospitals.²⁸ In addition, some restrictive privilege decisions are the result of accreditation and certification standards that are promulgated by professional organizations; antitrust law might be used to attack these standards and other extrahospital behaviors that unfairly obstruct the award of privileges to health care practitioners.²⁹

On substantive issues, the most direct problem for antitrust analysis will be the need to reconcile arguments about medical quality with arguments about promoting competition by providing hospital access to physicians and other practitioners who can provide lower cost and more innovative kinds of services. In other words, there will be a need to reach an accommodation between the goals of antitrust law and the practical and legal effects of medical malpractice law and its "*Darling doctrine*," which increasingly are being used to impose liability upon hospital corporations for their failure to ensure that staff physicians provide high quality medical care.³⁰ This central problem appears within virtually all substantive antitrust issues dealing with privileges,

24. See *infra* Part III.

25. See *infra* text accompanying notes 255-68.

26. See *supra* note 21.

27. See *infra* text accompanying notes 255-68.

28. See *infra* text accompanying notes 225-391.

29. See *infra* text accompanying notes 392-428.

30. The so-called *Darling doctrine* stems from a 1965 decision by the Illinois Supreme Court, which held a hospital corporation liable for its failure to supervise the medical care provided by a staff physician who was a private practitioner and not a hospital employee. *Darling v. Charlestown Comm. Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966). See generally Harty & Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485, 491-94 (1978); McCall, *supra* note 21, at 205-13.

and its successful resolution may be hampered by two kinds of rather cumbersome antitrust precedents and traditions. One is the overly broad antitrust rule against tie-in arrangements, in which a seller conditions the sale of one product or service upon the purchase of a second product or service.³¹ A more significant problem, however, may be the prevailing tendency of antitrust courts to resolve antitrust issues by an ad hoc balancing of anticompetitive and procompetitive effects, rather than by the application of categorical rules to broadly defined types of behavior.³² In the area of hospital privileges, this ad hoc balancing approach could leave hospitals uncertain about the legality of almost all significant privilege decisions, and this in effect would turn antitrust courts and hospital attorneys into public utility regulators with the power to make these decisions for hospitals. We shall argue that such a case-by-case approach is inappropriate as a matter of antitrust law and can be avoided by careful analysis and application of existing antitrust rules.³³

In brief, our analysis will suggest that antitrust law can play a useful role in policing hospital privileges, particularly if antitrust courts will focus upon drawing some relatively distinct lines between legal and illegal privilege decisions. The lines that we suggest may be drawn on the basis of antitrust precedents, and these lines would help guard against blatant anticompetitive behavior by hospitals, their medical staffs, and other professional groups. At the same time, our suggested approach would leave hospitals and their medical staffs with ample freedom to engage in robust discussion and actions that are legitimately designed to promote quality medical care.

II. PHYSICIAN-HOSPITAL RELATIONSHIPS

Antitrust challenges to privilege decisions will raise several issues of fact and law that will be resolved, either explicitly or implicitly, by the judicial characterization of the relationship between a hospital and its medical staff in the making of the privilege decision. One such issue is whether any particular denial of privileges may be said to result from an "agreement" between the medical staff and the hospital corporation, or whether it should be treated as a unilateral decision by a single corporate entity. The former characterization will support analysis of the decision as a "contract, combination . . . or conspiracy" that may be a "restraint of trade" and thus violate section 1 of the Sherman Act.³⁴ Restraint of trade analysis will have two major advantages for plain-

31. See *infra* text accompanying notes 342-54.

32. See *supra* note 3 and accompanying text.

33. See *infra* Part IV.

34. 15 U.S.C. § 1 (1976).

tiffs. It will focus antitrust analysis upon a possibly suspect decision by the medical staff to exclude competitors and, in some cases, it will obviate the need to establish the defendants' market power as an element of the antitrust violation.

The existence of an agreement, in turn, presents the possibility of making a further distinction based on a characterization of the interests involved in the privilege decision. If the privilege decision is based only on medical staff interests, it may be appropriate to characterize the decision as that of a "physician cartel." This characterization would support application of antitrust's per se rule against horizontal boycotts or, in other words, the rule that a concerted refusal to deal with others because of their status as competitors is illegal in itself.³⁵ Application of the per se rule would substantially diminish the plaintiff's burden of proof, since the excluded practitioner would need to establish only that physicians on the medical staff had agreed to exclude a competitor or competitors because of their competitive status. The plaintiff would not have to show the specific anticompetitive effects of this decision. The per se rule also would eliminate consideration of affirmative justifications by the defendants. On the other hand, if the hospital has a substantial or independent interest in the decision, it may be appropriate to characterize the privilege decision as one made by a "joint venture" between the hospital and its medical staff physicians, or even as a decision made solely by the hospital. In this event, antitrust's Rule of Reason or "balancing" approach would be used to analyze the decision, with the plaintiff carrying the burden of proving that the anticompetitive effects of the decision outweigh its procompetitive or legitimate business effects.³⁶

If no agreement can be shown, the privilege decision will be characterized as a unilateral act of a hospital board. In that case, the plaintiff will face the more difficult task of proceeding under section 2 of the Sherman Act and proving that the privilege decision was an act of "monopolization" or an "attempt to monopolize" by the hospital.³⁷ This sort of claim is unlikely to be very significant in the area of hospital privileges because the excluded practitioner and the excluding party, the hospital, will not be in direct competition with each other in many situations.

The analysis of physician-hospital relations also may affect the resolution of other antitrust issues, including the determination of a defendant's market power and the assessment of a hospital's claim that a particular restrictive policy is in fact procompetitive. It is reasonable to

35. See *infra* text accompanying notes 269-300.

36. See *infra* text accompanying notes 301-70.

37. 15 U.S.C. § 2 (1976).

expect that antitrust courts in privilege cases will tend to measure a defendant's market power by using readily available and "objective" data such as the hospital's share of all hospital beds in some geographical area.³⁸ Yet this method may be a particularly insensitive measure of any hospital's effective market power and attractiveness to practitioners. On these issues, attention should be paid to the relations among physicians as well as to the relations between a medical staff and its hospital corporation. Physicians (particularly specialists) are heavily dependent upon referral-and-consulting networks among physicians, and these networks today are often centered among hospital medical staffs. These networks provide the individual physician with a source of patients and a pool of consultants who are able to assist on complex medical problems. Accordingly, the nature of the referral-and-consulting network at a particular hospital may be an important explanatory factor in considering the hospital's market power as well as its value to particular physicians.³⁹

The nature of this network at a particular hospital may also be relevant to the separate antitrust issue of assessing a claim that a particular restrictive policy is in fact procompetitive. For example, a requirement that only board-certified physicians be granted privileges might result either from the anticompetitive interests of the medical staff in excluding competitors or from the legitimate interest of the hospital in raising its privilege standards to help build an effective "network" that is capable of attracting a good medical staff.⁴⁰

The legal, political, and economic relationships among members of a medical staff and the hospital as a corporate entity are complex, to say the least, and untangling these relationships does not promise to be an easy task. For one thing, the legal, administrative, and economic relations between hospitals and their medical staffs vary a great deal among hospitals, depending upon the hospital's legal structure, market power, and administrative philosophy.⁴¹ For another, the recognized legal relationships between hospitals and medical staffs often seem to be at odds with, or else describe inaccurately, the administrative and economic relationships between these entities. With these caveats in mind, we shall analyze three ways of looking at physician-hospital rela-

38. See, e.g., *Hyde v. J. Jefferson Parish Hosp. Dist.* No. 2, 1981-1 Trade Cas. (CCH) ¶ 63,932 (E.D. La. Jan. 26, 1981). See generally Landes & Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937 (1981).

39. See *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981); Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1458 (1980); Salkever, *Competition Among Hospitals*, in FEDERAL TRADE COMMISSION, *COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT AND FUTURE* 191, 195 (1978). See generally M. ROEMER & J. FRIEDMAN, *DOCTORS IN HOSPITALS: MEDICAL STAFF ORGANIZATION AND HOSPITAL PERFORMANCE* (1971).

40. Cf. *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981).

41. See M. ROEMER & J. FRIEDMAN, *supra* note 39.

tions and then draw some tentative conclusions about these relationships for the purposes of antitrust analysis.

A. A Formal View

On a formal or legal plane, medical staff physicians may be the owners or salaried employees of a hospital, but in most antitrust cases the medical staff will consist mainly or entirely of "attending physicians." Attending physicians are not salaried employees but rather unique kinds of independent contractors, who obtain the privilege of admitting and treating patients in the hospital in return for a commitment to perform some hospital work (for example, supervising or teaching residents, peer review, and providing clinic care for indigent patients) and the important but usually implicit undertaking to bring fee paying patients to the hospital.⁴²

The relationship between attending physicians and hospitals is also given definition by the hospital's bylaws. These vary from hospital to hospital, but there is good reason to believe that most hospital bylaws concerning staff and clinical privileges will, at a minimum, conform to the accreditation standards of the Joint Commission on Accreditation of Hospitals (JCAH).⁴³ The basic JCAH standard on privileges provides that the hospital's governing board "shall delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants" and, further, that the board "shall hold the medical staff responsible for making recommendations" to the board on privilege issues.⁴⁴ The JCAH's interpretation of this standard notes that the board has "the responsibility" for privilege decisions but notes also that whenever a board disagrees with its medical staff, a joint board-medical staff committee should "review" the issue before the board reaches its "final" decision.⁴⁵ In practice, the medical staff's functions in this area are typically carried out by a credentials committee and an executive committee of the medical staff, which evaluate and make recommendations on privilege matters to the hospital board of trustees.⁴⁶

In essence, these formal relationships between hospitals and attending physicians depict two "legal" roles for physicians. On the one hand, they are independent contractors, engaged primarily in providing

42. See *id.* at 44-45.

43. On the influence of JCAH standards upon hospital bylaws, see JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, JCAH MONOGRAPH: MEDICAL STAFF BYLAWS 5 (1978). See also Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROBS. 305 (1970).

44. JCAH MANUAL, *supra* note 1, at 53 (Standard IX).

45. *Id.* at 53-54.

46. See Note, *Physician-Hospital Conflict: The Hospital Staff Privileges Controversy in New York*, 60 CORNELL L. REV. 1075, 1076-77 (1975).

services to their patients as independent economic actors. On the other hand, at times the attending physician must participate in medical staff activities such as peer review or privilege decisions, and in this role the attending physician is at least formally acting as an agent of the hospital corporation. For the purposes of medical malpractice law, these two roles often may be treated separately because the roles are typically significant in different situations. Thus, hospitals may not be vicariously liable for the malpractice of attending physicians who provide services to patients as independent contractors rather than as agents of the hospital.⁴⁷ At the same time, members of the medical staff arguably should not be liable for violations of the hospital's responsibility to supervise medical care, because physicians participate in this supervision as agents of the hospital rather than as independent actors who should be held independently responsible to the patients of other physicians.⁴⁸

It does not follow that these two roles can or should be treated separately in an antitrust analysis of privilege decisions. The private economic and political interests of attending physicians may be affected by many decisions that a hospital makes with regard to privileges for other physicians and health care practitioners.⁴⁹ It seems inevitable that the interests of attending physicians as independent contractors will often influence their judgment as members of the medical staff who participate in hospital privilege decisions. Indeed, this confusion of roles seems to be reflected in the JCAH accreditation standards on the role of the medical staff in privilege decisions. These standards are remarkably vague about the true locus of decisionmaking authority. They mandate delegation of the evaluation function to the medical staff and yet, on the other hand, they appear to lodge "final decisions" on privileges with the hospital's governing board, at least as long as the board agrees with its staff.⁵⁰ This very real ambiguity about the locus of decisionmaking authority will deserve careful attention in many antitrust attacks upon privilege decisions.

B. Political Analysis

From a political point of view, medical staffs generally seem to

47. See e.g., *Cramer v. Hoffman*, 390 F.2d 19, 23 (2d Cir. 1968); *Mayers v. Litow*, 154 Cal. App. 2d 413, 418, 316 P.2d 351, 354 (2d Dist. 1957). See generally Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 385 (1980).

48. Compare *Horty & Mulholland*, *supra* note 30 (the medical staff should not be liable for the hospital's failure to supervise medical care of attending physicians) with Comment, *supra* note 47 (staff physicians with supervisory responsibilities should be held liable for the failure to supervise with due care). On the general issue of when agents of a corporate enterprise should be held liable for corporate misconduct, see Stone, *The Place of Enterprise Liability in the Control of Corporate Conduct*, 90 YALE L.J. 1, 28-35 (1980).

49. See *infra* text accompanying notes 51-65.

50. See *supra* text accompanying notes 44-45.

control privilege decisions, or at least to share the ultimate authority over these issues with hospital governing boards. Historically, governing boards rarely have departed from medical staff recommendations on privilege issues.⁵¹ This may be explained by the deference historically accorded to the presumed technical expertise of physicians, as well as deference accorded to them because of their cultural authority and political power within local communities.⁵² To be sure, the balance of power between hospital administrations and medical staffs has seemed to shift toward hospital administrations in recent years, but this appears to be related primarily to administrative requirements that have been imposed upon hospitals by new government regulations, new technologies, and the health care financing system.⁵³ This trend need not apply to the more "technical" issues of hospital care, since the presumption of professional expertise will be stronger in situations that directly involve the patient-physician relationship than in those matters of "economic organization" that have merely indirect effects upon the patient-physician relationship.⁵⁴ Privilege decisions will fall on the technical side of this distinction in most cases, a fact suggesting that hospital managers may continue to defer to physicians on privilege issues. The technical nature of privilege decisions also suggests that the professional pride of physicians often will be at stake in these matters, particularly when nonphysicians apply for privileges. Physicians thus may be especially unwilling to surrender their traditional authority over this area of hospital operations.

The landmark malpractice case of *Darling v. Charlestown Community Memorial Hospital*⁵⁵ undoubtedly has encouraged hospital trustees to take a more active interest in privilege questions, because hospitals can now be held liable for negligence in the organizational supervision of medical care. This interest, however, does not ensure that actual control over privilege decisions will shift into the hands of hospital governing boards. In fact, this new interest may provide incumbent medical staffs with increased opportunities to impose restrictive standards upon the award of privileges. The *Darling* doctrine requires that governing boards act reasonably in granting privileges and establishing im-

51. Harty & Mulholland, *supra* note 30, at 487-88.

52. See generally Starr, *Medicine and the Waning of Professional Sovereignty*, 107 DAEDALUS 175 (1978).

53. See *id.* at 177-79, 182-91.

54. On the distinction between "technical" and "organizational" aspects of professional work and the potential usefulness of this distinction in developing public policy toward the medical profession, see E. FREIDSON, *PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE* 23-46 (1970). On the potential role for this distinction in applying antitrust law to the professions, see Kissain, *supra* note 16, at 146-56.

55. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966). On the current development of the *Darling* doctrine, see McCall, *supra* note 21, at 205-13.

tramural systems of medical care supervision, but the doctrine does not make hospitals vicariously liable for all negligent acts of attending physicians.⁵⁶ Properly read, therefore, the *Darling* doctrine imposes no substantive requirement on hospital boards to grant privileges only to "highest quality" practitioners in order to protect the hospital from the risk of additional malpractice liability.⁵⁷ Nonetheless, this doctrine does impose a procedural requirement that hospital boards apply standards of some kind to privilege questions. In this context, it seems likely that governing boards will establish additional standards on privileges but defer to their medical staffs on the content of these standards.

In summary, this brief political analysis suggests that medical staffs may continue to control most privilege decisions, a markedly different conclusion from that suggested by the formal legal relationships between hospitals and medical staffs.

C. Economic Analysis

An economic view of physician-hospital relationships may be the most appropriate for antitrust analysis. The discipline of economic science, after all, is concerned with the behavior of firms and their economic efficiency, and our previous analysis suggests that either a complex firm or a complex set of firms is engaged in the hospital's decision to grant or deny privileges. As suggested by the work of Mark Pauly and Michael Redisch, it seems useful to think initially of a hospital and medical staff as joint producers of "hospitalization services."⁵⁸ These services include both the medical services provided by physicians and the complementary services that are provided by a hospital's employees and facilities. These jointly produced services presumably are what the patient is interested in buying, even though separate charges for physician and hospital services have been established in this country due to complex reasons of professional ethics and power.⁵⁹

The work of Pauly and Redisch also seems to suggest that it is useful to think of the medical staff itself as a cooperative venture of profit-maximizing physicians, who are interested in establishing a medical staff of a size and quality that maximizes their individual incomes, leisure, prestige, and satisfaction from high quality work.⁶⁰ Importantly, this view implies that a medical staff of fee-for-service physicians will have an interest in maintaining a smaller staff and more

56. See McCall, *supra* note 21, at 205-13.

57. Dolan & Ralston, *supra* note 3, at 718-19.

58. Pauly & Redisch, *The Not-for-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87, 88 (1973).

59. See *id.*; Harris, *The Internal Organization of Hospitals: Some Economic Implications*, 8 BELL J. ECON. 467, 472-75 (1977).

60. Pauly & Redisch, *supra* note 58, at 88-90.

excess hospital capacity than would exist if the hospital were hiring staff physicians at a market salary rate or allocating privileges on some other competitive basis. In this cooperative venture model, incumbent physicians will act to ensure that the hospital has enough slack capacity to provide the highest possible quality care for their patients in terms of available beds, nursing staff, turnaround time for x-rays, and laboratory tests.⁶¹ By contrast, a more competitive system for awarding privileges presumably would result in the elimination of those minimal quality gains in hospital services that are desirable to individual physicians but of high cost to the hospital, patients, and society.⁶²

The cooperative venture model indicates that economic reasons exist for medical staff recommendations on privilege issues to be generally biased against a competitive and efficient allocation of privileges. In other words, any significant privilege decision is likely to engage the economic interests of the entire medical staff, not merely the interests of physicians in the particular specialty involved. The model thus provides a good reason for antitrust courts to regard medical staff recommendations on privilege questions as suspect and deserving of careful judicial scrutiny.

The cooperative venture model, however, will not always provide a complete picture of the interests involved in privilege decisions. This is particularly so in view of such modern forces as the increasing control of third party insurers over hospital revenues and the expanding liability of hospitals for medical malpractice stemming from their failure to supervise medical care.⁶³ These forces suggest that hospital trustees and administrators may begin to participate substantially in privilege decisions that affect the hospital's independent interests in the costs and quality of hospitalization services. Thus, Jeffrey Harris' "dual firm" model of hospitals may often provide a more complete analysis of the economic and political interests that are relevant to privilege decisions.⁶⁴ This model views the medical staff as a firm (or division) that demands services to complement the medical care provided by physicians and the hospital administration as another firm (or division) that supplies these services, with the two firms locked into a rather indeterminate and ongoing bargaining situation. The model suggests that hospital administrations may have frequent if not pervasive interests in privilege decisions. Of course, this model will be most relevant to rela-

61. *Id.* at 90-93.

62. See generally Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medicare Care: The Role of PSROs*, 70 Nw. U.L. Rev. 6 (1975). Of course, a hospital that established a competitive privileges system might discover that its patients and physicians are willing to pay for the availability of slack capacity and the highest possible quality of care. This may be particularly likely in view of the general availability of insurance for most hospital services.

63. See *supra* text accompanying note 53.

64. Harris, *supra* note 59.

tively complex and sophisticated hospital organizations that have the resources and incentives to bargain with, if not actually control, their medical staffs on privilege issues.⁶⁵

Under the dual firm model, however, it often will be unclear whether a medical staff has controlled a particular privilege decision or whether the hospital corporation has asserted its own independent interest on the issue. Moreover, it will be difficult to detect assertions of independent hospital interests with regard to privilege decisions. This is because the hospital's policy on privileges often may have a restrictive orientation that coincides with the medical staff's recommendation. For example, a hospital administration may wish to increase its standards on privileges in order to improve its position vis-à-vis other hospitals in the competition for high quality physicians and their patients.⁶⁶ Similarly, the hospital may be interested in increasing standards and denying privileges in order to guard against perceived malpractice risks or to limit the size of its medical staff as a means of controlling costs, improving peer review, or allowing for a more rational expansion of hospital services. In summary, economic analysis suggests a useful framework for analyzing physician-hospital relationships on privileges but it cannot, as any theory cannot, provide conclusive answers to the actual influences that may play on any particular decision.

D. Some Working Hypotheses

At this preliminary stage, a useful hypothesis about physician-hospital relations appears to be that the interests and power of a hospital and the interests and power of its medical staff may relate to each other in three different ways. Some privilege questions may be determined entirely by the medical staff, and we will refer to this kind of decision-making as that of a "physician cartel." For example, when physicians are denied privileges because of their association with a non-hospital-based HMO that threatens the business of fee-for-service physicians, the economic interests of the medical staff would appear to be para-

65. The usefulness of the dual firm model for analyzing privilege decisions will increase if the current plans of the Reagan Administration for increasing competition among health insurers, *see supra* note 23, are successfully implemented. Cost-conscious health insurance plans presumably would employ many sorts of devices to establish greater cost-consciousness among hospitals. *See* Havighurst, *supra* note 13, at 321-26. The general effect of these devices would be to increase the hospital's resources and incentives to bargain with and control its medical staff on issues affecting excess capacity. With greater incentives and resources to address excess capacity, hospital administrations would have a corresponding incentive to award privileges on a more competitive basis than the medical staff would like.

66. On the prevalence of competition among hospitals to obtain physicians, see *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981); Joskow, *The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital*, 11 BELL J. ECON. 421, 432, 445-46 (1980); Salkever, *supra* note 39, at 195.

mount and there would appear to be no legitimate interest of the hospital at stake.⁶⁷ To be sure, if a non-hospital-based HMO were taking income-generating patients from the hospital or represented a potential competitor for inpatients, the hospital might be said to have an independent interest in denying privileges to the other institution's physicians. For antitrust purposes, however, this interest is so well merged with the possible anticompetitive interests of the medical staff that it does not appear worth distinguishing this situation from one in which only the physicians fear the HMO.

In other situations, both the medical staff and hospital may have significant interests that are of different kinds, even though these interests support the same result. We will label this form of decisionmaking as that of a "joint venture" between the hospital and its medical staff. Examples here may include such questions as whether specialty board certification should be relied upon to delineate physician privileges,⁶⁸ whether physician assistants or nurse practitioners should be granted privileges,⁶⁹ and whether "mid-level" independent health professionals such as clinical psychologists, podiatrists, and chiropractors should be extended privileges or other kinds of access to hospital services.⁷⁰ In these cases, members of the medical staff may be interested in protecting themselves (and other physicians who can provide reciprocal support on other occasions) from economic competition for both patients and hospital services. On the other hand, hospital administrations may be interested in promoting any of several quality and efficiency goals.⁷¹ In this kind of situation, it often will be difficult or impossible to tell which set of interests has controlled the privilege decision since both interests will support the same restrictive result.⁷²

A third type of privilege decision is where the interest of the hospital in the quality of care or efficiency of hospital operations appears paramount and any separate anticompetitive interests of the medical staff in general are relatively weak. We will refer to this situation as the "employer hospital" form of decisionmaking regarding hospital privileges. An example here might be a decision to grant exclusive privileges to a partnership of radiologists or pathologists who are responsible for operating a hospital's capital equipment, supervising large numbers of hospital employees, and providing support services to

67. See Kissam, *supra* note 13, at 503-08.

68. See, e.g., *Armstrong v. Board of Directors*, 553 S.W.2d 77 (Tenn. Ct. App. 1976); *Holoweiko*, *supra* note 6.

69. See, e.g., *Reynolds v. St. John's Riverside Hosp.*, 86 Misc. 2d 272, 382 N.Y.S.2d 618 (Sup. Ct. 1976). See generally Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 KAN. L. REV. 1 (1975).

70. See *supra* text accompanying note 11.

71. See *supra* text accompanying note 66.

72. *Id.*

other physicians and their patients.⁷³ In this case, the interests of most medical staff members are more likely to coincide with the hospital interests in efficiency and quality rather than with the possible anticompetitive interests of the specialists who have obtained the exclusive privileges contract. A second example might be where an individual practitioner is excluded on grounds of professional incompetence.⁷⁴ In both examples it is likely that the hospital corporation (and perhaps medical staff) will have such strong and legitimate interests in the quality and costs of providing hospital services that the governing board would make the privilege decision independently of any private interests of the medical staff in restraining competition.

The characterization of a privilege decision as one of these three types is likely to carry substantial explicit or implicit weight in the resolution of several antitrust issues. Our examples of the different types, however, are not intended to serve as a general or permanent characterization of these kinds of privilege decisions. For example, the facts surrounding a particular exclusive privileges contract with radiologists may support characterization of the privilege decision as physician cartel behavior rather than as an employer hospital decision. This would be the case if the hospital can provide no good reason for granting the contract (other than pleasing the incumbent radiologists) and the radiologists have obtained their contract by threatening to withdraw their services from the hospital.⁷⁵ Our three forms of privilege decisionmaking are thus intended for use only as organizing principles, that is, as *prima facie* assumptions about the appropriate characterization of physician-hospital relationships.

III. JURISDICTION ISSUES

Antitrust challenges to hospital privilege decisions will raise three kinds of significant jurisdictional defenses. Two of these may apply to either federal or state actions and the third will apply only in federal cases. These defenses are the claim that an antitrust exemption for "noncommercial" professional activities should be recognized and applied to privilege decisions; the claim that other law regulates the privilege decision and establishes a "state action" exemption for the decision; and, in federal cases, the claim that the privilege decision does not have a connection with interstate commerce that is sufficient to establish federal antitrust jurisdiction. In this Part we analyze these complex technical issues. Our basic conclusions are first, that there may be substantial justification for exempting privilege decisions from some

73. See M. ROEMER & J. FRIEDMAN, *supra* note 39, at 124-26.

74. See, e.g., Robbins v. Ong, 452 F. Supp. 110 (S.D. Ga. 1978).

75. Cf. *infra* note 290 (FTC complaint that five physicians threatened to withdraw their services from hospital if it hired another physician).

state antitrust laws but not from federal law. There also are some cases in which direct state regulation of privilege decisions may exempt these decisions from federal antitrust law. In addition, the interstate commerce defense may be persuasive in federal cases that involve relatively isolated kinds of privilege decisions.

Our conclusions are unstable, however, in view of the unprincipled and poorly justified development of modern antitrust doctrine on some of these jurisdictional issues. This doctrinal elasticity suggests to us that many of these jurisdictional issues may be decided in fact on the basis of an antitrust court's tentative impressions about the merits of the underlying substantive claim. For example, if a court is willing to characterize a particular privilege decision as "physician cartel" behavior, it may be more likely to decide difficult jurisdictional issues in favor of the plaintiff. On the other hand, if the court characterizes the decision as an "employer hospital" decision, it may be more likely to decide such issues on behalf of the defendants. We do not suggest that this is an appropriate way to determine jurisdictional issues, but this kind of decisionmaking is a possible consequence of the current confusion about the jurisdictional doctrines to be discussed in this Part.

A. "Professional" and "Noncommercial" Exemption Claims

In *Goldfarb v. Virginia State Bar*,⁷⁶ the Supreme Court rejected a claim that price fixing by lawyers should be exempt from the Sherman Act because of its professional character. The Court rejected such a "sweeping" exemption for three reasons: the absence of any statutory language or legislative history to support such an exemption, the "heavy presumption" against implicit or judicially recognized exemptions from federal antitrust law, and the "business" or "commercial" aspect of exchanging professional services for money.⁷⁷ The language of the Court's opinion and the obvious business aspects of price-fixing have suggested to some that application of the Sherman Act to professional behavior should be limited to cases that involve the sale of professional services.⁷⁸ This would allow recognition of a limited antitrust exemption for "noncommercial" professional activities, and this exemption might be applied to hospital privilege decisions.⁷⁹

It is unlikely, however, that federal courts will recognize an antitrust exemption that covers privilege decisions. The *Goldfarb* Court's

76. 421 U.S. 773 (1975).

77. *Id.* at 785-88.

78. For a suggestion of this sort, see Rigler, *Professional Codes of Conduct after Goldfarb: A Proposed Method of Analysis*, 29 ARK. L. REV. 185 (1975).

79. See Selman v. Harvard Medical School, 1980-2 Trade Cas. (CCH) ¶ 63,371 (S.D.N.Y. May 21, 1980) (medical school admissions decisions are exempt from Sherman Act); Rigler, *supra* note 78, at 189.

rationale for its holding on the exemption issue, the Court's subsequent decision in *National Society of Professional Engineers v. United States*,⁸⁰ and the close relationship between privilege decisions and the sale of professional services suggest that federal antitrust law should be applied to privilege decisions when other jurisdictional conditions are satisfied.

In *Goldfarb*, the Court's denial of an antitrust exemption for price fixing by professionals was based on both the absence of statutory language and legislative history to support a learned professions exemption and the presumption against implicit exemptions. These reasons also argue against an antitrust exemption for privilege decisions. In addition, privilege denials appear to have substantial "business" or "commercial" aspects that are somewhat similar to those of professional pricing decisions, since they can preclude or substantially limit health care practitioners from selling services in particular communities.⁸¹ It is arguable, therefore, that all the reasons for not recognizing an antitrust exemption for professional price fixing also apply to privilege decisions.

On the other hand, privilege decisions typically will involve quality determinations by and about professionals that appear to have a substantially different nature than professional pricing choices. Hospital privilege decisions in general will be more closely related to the "technical" aspects of professional work and the exercise of professional expertise than are the "economic" decisions of price setting.⁸² It does not follow, however, that privilege decisions should be exempt from antitrust scrutiny. The technical and economic aspects of professional practices can be treated differently under antitrust law without recognizing an exemption for technical practices. This may be done, for example, by limiting the use of antitrust's per se rules to the economic practices of professionals and employing antitrust's Rule of Reason balancing approach exclusively in those cases that involve technical professional practices.⁸³ This would have the effect of imposing a more substantial burden of proof upon antitrust plaintiffs who attack professional practices of a technical nature.

The rejection of an antitrust exemption for noncommercial profes-

80. 435 U.S. 679 (1978).

81. Dolan & Ralston, *supra* note 3, at 712-14.

82. See *supra* note 54 and accompanying text.

83. See *Veizaga v. National Bd. for Respiratory Therapy*, 1977-1 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill. Jan. 27, 1977) (per se antitrust rules apply only to the "commercial" practices of professionals); see also Note, *The Professions and Noncommercial Purposes: Applicability of Per Se Rules Under the Sherman Act*, 11 U. MICH. J.L. REF. 387 (1978). Cf. *Feminist Women's Health Center, Inc. v. Mohammad*, 415 F. Supp. 1258, 1263, 1269 (N.D. Fla. 1976) (professionals may advance a "good faith" defense to allegations of per se antitrust violations), *rev'd on other grounds*, 586 F.2d 530 (5th Cir. 1978).

sional practices also is supported by dictum in the *Professional Engineers* case. As did *Goldfarb*, this case involved the collusive elimination of price competition among professionals, but the Court here faced the additional claim that price competition among civil engineers would cause deterioration in the quality of their services. Once again the Court refused to recognize "a broad exemption under the Rule of Reason for learned professions."⁸⁴ More generally, the Court stated 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."⁸⁵ While this view does not necessarily dispose of all exemption claims for professional practices, it certainly implies that any professional "ethical" standard or judgment, commercial or noncommercial, deserves antitrust scrutiny under the Rule of Reason in order to determine whether the standard or judgment "promotes" or "suppresses" competition.⁸⁶

Since the *Goldfarb* decision, lower federal courts in general have followed this line of reasoning and have been unwilling to recognize an antitrust exemption for noncommercial professional practices.⁸⁷ The one apparent exception is *Selman v. Harvard Medical School*,⁸⁸ in which a district court held that the Sherman Act does not apply to the "noncommercial" practice of establishing medical school admissions criteria. The *Selman* court followed a 1970 decision by the District of Columbia Court of Appeals, in which that court had refused to apply the Sherman Act to a college accreditation program in the absence of "an intent or purpose to affect the commercial aspects of the [education] profession."⁸⁹ The continuing validity of this 1970 case as antitrust precedent seems doubtful, however, in view of the implications of *Goldfarb* and *Professional Engineers*.

Federal precedents thus support application of antitrust law to hospital privilege decisions. State courts, however, still may choose to reject *Goldfarb* and recognize a "learned professions" exemption from

84. 435 U.S. at 696.

85. *Id.*

86. *Id.* at 691.

87. See, e.g., *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir.), cert. denied, 434 U.S. 825 (1977); *Veizaga v. National Bd. for Respiratory Therapy*, 1977-1 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill. Jan. 27, 1977); *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), cert. denied, 444 U.S. 924 (1979).

88. 1980-2 Trade Cas. (CCH) ¶ 63,371 (S.D.N.Y. May 21, 1980).

89. *Marjorie Webster Junior College, Inc. v. Middle States Ass'n of Colleges and Secondary Schools, Inc.*, 432 F.2d 650, 654 (D.C. Cir.), cert. denied, 400 U.S. 965 (1970).

state antitrust laws.⁹⁰ As an alternative, state courts may limit the application of their antitrust laws to the sale of professional services, recognizing an exemption for noncommercial professional activities.⁹¹ Either approach could protect privilege decisions from scrutiny under state antitrust laws, although a state antitrust exemption for "professional" activities conceivably might not apply to privilege decisions because of their corporate setting.

There are several arguments that would support a state antitrust exemption for noncommercial or all professional activities. First, there may be a specific provision in the state antitrust statute that exempts professional activities, although such provisions are not universal.⁹² Another justification could be statutory language or legislative history which indicates that the state legislature did not intend the state's antitrust law to apply to the professions. For example, the statute might contain specific language that limits the act's jurisdiction to the sale of goods and services.⁹³ Or the state antitrust law may apply to "trade and commerce" but have been enacted subsequent to other nonantitrust statutes that apply explicitly to "trade, business and the professions."⁹⁴

More general arguments also may support a state antitrust exemption for noncommercial or all professional activities. One is a rather broad argument from history or "legislative history." Around the turn of the century, when most states initially enacted their antitrust laws,⁹⁵ the states also were developing extensive licensure regulation of the professions.⁹⁶ Although licensure laws limit competition by controlling entry into a profession, antitrust law is not logically incompatible with this type of regulation. The enactment of professional licensure laws, however, arguably constitutes a general declaration by the legislature that competition in professional services is inappropriate—because competition harms consumers or adversely affects the income of profes-

90. See *Moles v. White*, 336 So. 2d 427, 429 (Fla. Dist. Ct. App., 1976), cert. denied, 355 So. 2d 516 (Fla. 1978); *New York v. Roth*, 1981-1 Trade Cas. (CCH) ¶ 64,026 (N.Y. Apr. 2, 1981).

91. See *Rigler*, *supra* note 78, at 189-98.

92. See *Rubin*, *supra* note 20, at 714; cf. *UNIF. ST. ANTITRUST ACT* § 4, 4 TRADE REG. REP. (CCH) ¶ 30,101 (exemptions only for labor, agricultural and horticultural organizations).

93. See, e.g., ARK. STAT. ANN. § 70-101 (1979 Replacement).

94. See *Willis v. Santa Ana Community Hosp. Ass'n*, 58 Cal. 2d 806, 809, 376 P.2d 568, 569-70, 26 Cal. Rptr. 640, 641-42 (1962). But see Note, *Should the Medical Profession be Exempt from California Antitrust Law?* *Willis v. Santa Ana Community Hospital Association Reexamined*, 7 W. ST. U.L. REV. 91, 102-03 (1979) (arguing that the nonantitrust statute relied upon in *Willis* provided weak evidence of legislative intent to exempt the professions from the state's antitrust law, because the reference to the professions in the nonantitrust statute was introduced in a recodification enacted in the same year as, rather than before, the antitrust law).

95. Rubin, *supra* note 20, at 657-58.

96. See Friedman, *Freedom of Contract and Occupational Licensing 1890-1910: A Legal and Social Study*, 53 CALIF. L. REV. 487, 489 (1965).

sional workers.⁹⁷ The existence of this alternative regulatory scheme, of which state legislators certainly were aware as they enacted antitrust laws, thus supports the claim that a state antitrust law was not intended to apply to the professions or at least not to their "noncommercial" activities.⁹⁸

Another argument for a professional or noncommercial exemption is the principle that criminal statutes (and statutes with criminal-like sanctions, such as treble damages) should be interpreted narrowly, to ensure that criminal behavior is defined by a majoritarian decision of the state legislature and that citizens have fair notice of prohibited acts.⁹⁹ This argument, of course, might have been applied to federal antitrust law, although it does not seem to have been raised in the *Goldfarb* case. Perhaps this principle is not to be taken (or should not be taken) as seriously in the federal arena, where criminal laws are not as central to governmental activity.

It may be argued that the Sherman Act's prohibitions against "restraints of trade" and "inonopolizing" behavior were intended to incorporate existing common law rules,¹⁰⁰ and that these rules had been applied to the professions prior to the passage of the Sherman Act.¹⁰¹ While this argument may be persuasive with regard to the Sherman Act and state laws that employ the same common law terms, it should be irrelevant to the many state antitrust laws that use different statutory language.

Finally, the case for a state antitrust exemption for noncommercial or all professional activities may be enhanced by arguments that other specific acts of the state support recognition of an exemption for hospital privilege decisions. In particular, state courts that have adopted a particularly rigorous version of the *Darling* doctrine¹⁰² may be sympathetic to the plea that courts should not insist, simultaneously, upon more restrictive privilege standards under *Darling* and more liberal or procompetitive standards under the state antitrust law. Antitrust law and the *Darling* doctrine are not logically inconsistent,¹⁰³ but it would not be unreasonable for a state court to weigh the underlying policies of the malpractice law so heavily that it precludes all antitrust scrutiny of

97. On the basic purposes of professional licensure laws, see Frech, *Occupational Licensure and Health Care Productivity: The Issues and the Literature*, in *HEALTH MANPOWER AND PRODUCTIVITY* 119-20 (J. Rafferty ed. 1974); Friedman, *supra* note 96, at 499-502.

98. See *New York v. Roth*, 1981-1 Trade Cas. (CCH) ¶ 64,026 (N.Y. Apr. 2, 1981); *In re Estate of Freeman*, 34 N.Y.2d 1, 311 N.E.2d 480, 355 N.Y.S.2d 366 (1974).

99. See *Willis v. Santa Ana Community Hosp. Ass'n*, 58 Cal. 2d 806, 809, 376 P.2d 568, 570, 26 Cal. Rptr. 640, 642 (1962).

100. See, e.g., P. AREEDA, *ANTITRUST ANALYSIS* ¶ 144 (3d ed. 1981).

101. See *United States v. American Medical Ass'n*, 110 F.2d 703, 709-11 (D.C. Cir.), *cert. denied*, 310 U.S. 644 (1940).

102. See *supra* text accompanying note 30; *McCall*, *supra* note 21, at 205-13.

103. See *supra* text accompanying notes 55-57.

hospital privileges. Other arguments of this sort also may be advanced, but these in effect will raise "state action" claims as the basis of the exemption and we consider these in the next section.

B. State Action Defenses

Generally, antitrust law applies only to the anticompetitive behavior of private parties that is directed at other private parties. Under the *Parker v. Brown* doctrine, federal antitrust law does not apply to anticompetitive acts that are mandated by state governments.¹⁰⁴ The "implied immunity" doctrine of antitrust law recognizes antitrust exemptions for private acts that are subject to regulation under other laws of the same jurisdiction, at least if the exemption is "necessary" for the effective implementation of the other regulatory scheme.¹⁰⁵ In addition, under the *Noerr-Pennington* doctrine, antitrust law does not apply to the efforts of private parties to petition government for anticompetitive governmental acts, as long as the petitioning is legitimate and not a "sham" or "cover" for private acts that are aimed directly at other private parties.¹⁰⁶ Each of these doctrines may be relevant to antitrust challenges against private decisions, and we shall analyze the applicability of these doctrines to three sets of circumstances.

I. State Regulations

The first set of circumstances involves claims that privilege decisions should be exempt from antitrust law because the decisions are otherwise regulated by state law. Hospitals are licensed by state governments to help ensure quality medical care,¹⁰⁷ and in some states there are specific licensure regulations or other laws that apply to hospital privilege matters. State regulations may require that hospitals develop peer review plans for submission to or approval by a state licensing agency,¹⁰⁸ that particular medical procedures be restricted to

104. See *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 103-05 (1980); *New Motor Vehicle Bd. v. Orrin W. Fox Co.*, 439 U.S. 96, 109 (1978); *City of Lafayette, La. v. Louisiana Power & Light Co.*, 435 U.S. 389, 413 (1978); *Bates v. State Bar*, 433 U.S. 350, 359 (1977); *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 589 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 (1975); *Parker v. Brown*, 317 U.S. 341, 350-51 (1943).

105. See, e.g., *Silver v. New York Stock Exch.*, 373 U.S. 341, 357-61 (1963). See generally Handler, *Regulation Versus Competition*, 44 U. CIN. L. REV. 191, 194-206 (1975); Shuman, *The Application of the Antitrust Laws to Regulated Industries*, 44 TENN. L. REV. 1, 16-28 (1976).

106. See *California Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 509-11 (1972); *United Mine Workers v. Pennington*, 381 U.S. 657, 669-70 (1965); *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 136-38 (1961). See generally Fischel, *Antitrust Liability for Attempts to Influence Government Action: The Basis and Limits of the Noerr-Pennington Doctrine*, 45 U. CHI. L. REV. 80, 104-10 (1977).

107. See *Worthington & Silver*, *supra* note 43, at 308-10.

108. *Id.* at 319 (discussing Michigan's 1970 hospital licensure law).

board-certified physicians,¹⁰⁹ that the number of physicians performing certain procedures be limited in order to ensure frequent physician performance,¹¹⁰ or that medical staffs participate in privilege decisions, with "legal immunity" for staff members who act in good faith.¹¹¹ State regulation of hospital rates also could impinge upon the grant of privileges. For example, a state rate agency might encourage hospitals to award exclusive privilege contracts in various specialties in order to reduce the costs of operating hospital capital equipment.¹¹²

These sorts of regulations are not likely to protect many privilege decisions from federal antitrust law under the current formulation of the *Parker* doctrine. Private behavior qualifies for the state action exemption only if certain limiting conditions are satisfied. The Supreme Court's most recent statement of these conditions, in *California Retail Liquor Dealers Association v. Midcal Aluminum*, provides that "the challenged restraint [of trade] must be 'one clearly articulated and affirmatively expressed as state policy' . . . [and] the policy must be 'actively supervised' by the State itself."¹¹³ Under this test, California's system of resale price maintenance for wine was found to violate the Sherman Act because, although the policy was clearly articulated, the state did not actively supervise what was described as "essentially a private price fixing arrangement."¹¹⁴ The conditions outlined in this case seem unobjectionable if they are designed merely to delineate the distinction between legitimate state regulation and state regulation that attempts to authorize a violation of the federal antitrust laws. On the other hand, these conditions have been stated in rather sweeping terms, which seem to invite "judicial activism" in the use of federal antitrust law to preempt state regulations that are legitimate but deemed to be unwise.

The likelihood of judicial activism that preempts legitimate, albeit anticompetitive, state regulations is supported as well by the fact that the current version of the state action doctrine was drawn from several

109. See *id.* at 318 n.56 (discussing New York's 1969 hospital licensure regulations promulgated by the state health department).

110. In the early 1970s, the New York state and city health departments were interested in employing hospital licensure laws to enforce this kind of quality of care measure. Personal experience of Philip Kissam with New York City's Health Services Administration, 1970-73. A similar policy apparently is being employed today in Rhode Island to reduce the number of physicians with privileges to perform open heart surgery in Rhode Island hospitals. Phone conversation between Philip Kissam and Ralph Giamma, Rhode Island attorney, Nov. 1980.

111. See, e.g., FLA. STAT. ANN. § 395.065(2) (West Supp. 1981).

112. Cf. Horan & Nord, *supra* note 5, at 702 (discussing benefits of exclusive privilege contracts with physicians).

113. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

114. *Id.* at 106.

earlier state action decisions of the Supreme Court.¹¹⁵ This means, presumably, that the earlier cases may be relied upon to help define what constitutes "clear articulation" and "active supervision" of a state policy.

In particular, this suggests that the troublesome test of *Cantor v. Detroit Edison Co.*¹¹⁶ may still be relevant to many state action issues. In *Cantor*, the Court appeared to hold that a regulatory agency's approval or requirement of private behavior would not establish a state action defense for the private activity, unless the agency had played the "dominant" role in the regulatory decision and the agency decision was "necessary in order to make the regulatory Act work 'and even then only to the minimum extent necessary.'"¹¹⁷

This test is troublesome for two reasons. First, it would appear to be quite difficult to apply in many regulatory situations. The continuous relationship between regulatory agencies and regulated parties will often obscure the issue of which party played the "dominant" role in a particular regulatory decision, while the complexity of many regulatory schemes will similarly obscure the question of whether a regulatory decision is "necessary" to make the scheme work. Second, the "necessity" aspect of the test appears to invite antitrust courts to second-guess regulatory agencies on their decisions about how best to carry out their statutory responsibilities. In our view, since Congress never indicated an intent that the antitrust laws be used to preempt legitimate but anticompetitive state regulations, such judicial activism would constitute undue interference with the federal structure of American government.¹¹⁸

The *Cantor* test thus should be limited to cases that are closely analogous to the facts of that case, in which a public utility commission

115. See *id.* at 103-06.

116. 428 U.S. 579 (1976).

117. *Id.* at 592-98.

118. See Verkuil, *State Action, Due Process and Antitrust: Reflections on Parker v. Brown*, 75 COLUM. L. REV. 328, 329-58 (1975). A lively academic debate has been conducted on the appropriateness of using federal antitrust law to preempt state laws that have substantial anticompetitive effects. For a sampling of this debate, compare Posner, *The Proper Relationship Between State Regulation and the Federal Antitrust Laws*, 49 N.Y.U. L. REV. 693 (1974), with Handler, *The Current Attack on the Parker v. Brown State Action Doctrine*, 76 COLUM. L. REV. 1 (1976) (other contributions to this debate are listed in note 3 of the latter article). Our preference for the nonactivist position espoused by Professors Handler and Verkuil is based fundamentally on our view that relevant constitutional values should be employed to help resolve open questions of statutory interpretation. See *infra* text accompanying notes 179-86. To be sure, the "state action" issue in antitrust law superficially involves a conflict between the supremacy clause and the federalism provisions of the Constitution. But legitimate state regulations, even if anticompetitive in effect, clearly implicate the federalism values of the Constitution. The same cannot be said for the supremacy clause because Congress has not expressly indicated that the federal antitrust laws should be used to preempt anticompetitive state regulations. See *Parker v. Brown*, 317 U.S. 341, 350-51 (1943).

had approved the free distribution of light bulbs by a public utility as part of the commission's general approval of the company's tariff schedule. So limited, the *Cantor* decision may be characterized as a refusal to extend the state action exemption to peripheral state regulations for which the state has offered no rational justification. Until the Court clearly limits *Cantor* in this way, however, the case remains a potential instrument for using federal antitrust law to upset legitimate regulatory decisions by state agencies.¹¹⁹

It thus appears that only specific and statewide requirements about hospital privileges may support a federal antitrust exemption, and even these regulations may be subject to question under the "dominant role" and "necessity" tests that might be applied to regulatory orders under the *Cantor* doctrine. For example, a health department's regulation that only board-certified physicians may perform certain procedures in hospitals probably would exempt identical decisions by licensed hospitals.¹²⁰ In contrast, the availability of a state action defense would not be at all clear if an individual hospital obtained health department approval of the hospital's decision to limit procedures to board-certified physicians. More general state regulations, such as one that medical staffs must participate in privilege decisions, would appear to be compatible with the application of antitrust law and should not support a state action exemption from the federal law.¹²¹

State antitrust courts may follow the federal precedents and limit the "state action" exemption for privilege decisions to those commanded by state regulations. This would have the advantage of extending the state's competition policy to its ultimate extent. On the other hand, at the state level there may be good reasons for recognizing a broader antitrust immunity for hospital privilege decisions in order to avoid all possible conflicts between the state's antitrust policy and policies that underlie other regulations. The state action defense as a matter of federal law involves questions of federalism and constitutional structure, of how far our national competition policy should be extended to cover local matters that are regulated by the states. In this context, a relatively broad scope for federal antitrust law and a correspondingly narrow reading of the *Parker* doctrine may be appropriate if federal antitrust policies are believed to outweigh the values of

119. In *Bates v. State Bar*, 433 U.S. 350, 359-63 (1977), the Court distinguished *Cantor* in ways that suggest support for the argument in the text, but the Court did not disown either of the two parts of the *Cantor* test.

120. Cf. *id.* (a state court's regulation that prohibits advertising by lawyers is exempt from federal antitrust law).

121. Cf. *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530, 541-45 (5th Cir. 1978) (dismissing a medical staff's claim that a state-imposed responsibility to review staff privileges supported a *Noerr-Pennington* defense for the staff's conspiracy against physicians associated with an abortion clinic), cert. denied, 444 U.S. 924 (1979).

federalism.¹²²

As a matter of state law, however, the state action issue involves the different question of establishing an accommodation between two laws that have been enacted by the same legislature. This accommodation need not be based upon an a priori presumption in favor of the state's competition policy. It may be appropriate for a state court to conclude that the state's competition policy is less important than a competing state policy to promote the "highest quality" medical care through medical staff and hospital control over privilege decisions, as expressed in the state's hospital licensure law and perhaps in the state's version of the *Darling* doctrine as well. In this event, a state court would be justified in finding an implied antitrust immunity for privilege decisions if it also concludes that any application of antitrust law to privilege decisions might jeopardize the "highest quality" policy. To be sure, antitrust law in theory may be applied to privilege decisions without jeopardizing "highest quality" decisions.¹²³ Yet courts are imperfect decisionmakers, and the possibility that antitrust courts may make more relative errors than hospitals and other regulatory agencies might well cause a state court to conclude that a total antitrust immunity for state regulated privilege decisions is justified.¹²⁴ This result also would be supported, of course, by any provision in a state antitrust statute that exempted actions "permitted, prohibited or regulated" by state regulatory bodies.¹²⁵

2. Public Hospitals

A second circumstance in which a state action defense might be raised is where the privilege decision is made by a public hospital. Such a privilege decision could be characterized as a "regulatory act" by a state agency and thus arguably be exempt from antitrust law under the *Parker* doctrine. But two Supreme Court decisions suggest that this defense will be a difficult one to maintain.

In *City of Lafayette v. Louisiana Power & Light Co.*,¹²⁶ private and publicly owned utility companies filed antitrust claims against each

122. See *supra* note 118 and accompanying text.

123. See *infra* Part IV.

124. See generally Komesar, *In Search of a General Approach to Legal Analysis: A Comparative Institutional Alternative*, 79 MICH. L. REV. 1350 (1981).

125. WASH. REV. CODE ANN. § 19.86.170 (1978). See N.J. STAT ANN. § 56:9-5 (West Supp. 1981); VA. CODE § 59.1-9.4 (1981 Supp.). Williamson v. Grant County Pub. Hosp. Dist. No. 1, 65 Wash. 2d 245, 396 P.2d 879 (1964), held that Washington's antitrust law was inapplicable to an osteopathic physician's suit against a public hospital and its medical staff for a denial of staff privileges. The court relied upon a general immunity provision in the state's antitrust law for "permitted, authorized or regulated" activities, WASH. REV. CODE ANN. § 19.86.170 (1978), and upon a state statute which recognized that the management of hospital patients was subject to approval of the hospital's medical staff. *Id.* § 70.44.160 (1978).

126. 435 U.S. 389 (1978).

other, and the publicly owned companies raised the state action defense to protect their activities from antitrust scrutiny. The Court rejected this argument, although a majority could not agree upon the reasons for doing so. Four Justices concluded that the state action exemption applies only if the state has "authorized or directed" anticompetitive conduct by a political subdivision. Such authority need not be "specific" or "detailed," but would exist "when it is found 'from authority given a governmental entity to operate in a particular area, that the legislature contemplated the kind of activity complained of.'"¹²⁷ Chief Justice Burger concurred in the judgment, although he relied on the different theory that the state action exemption should not apply automatically to "proprietary" activities of political subdivisions.¹²⁸

Anticompetitive privilege decisions by public hospitals would appear subject to antitrust scrutiny under either of *Lafayette*'s tests. First, under the plurality approach, it is unlikely that the state will have "authorized or directed" anticompetitive privilege decisions by public hospitals. When state legislatures enacted enabling legislation for public hospitals, they presumably did not contemplate the possibility of anticompetitive privilege decisions. The concern about the possibility of such decisions is a recent phenomenon, and, in fact, enabling legislation for public hospitals often may fail to contain any specific mention of privileges.¹²⁹ Second, public hospitals typically have private entrepreneurs on their medical staffs, and a decision to deny privileges also may damage the private medical sector. These facts would support classification of public hospitals as "proprietary" enterprises under the Chief Justice's approach.¹³⁰ One might try to distinguish privilege decisions by public hospitals from the anticompetitive acts of publicly owned utilities by arguing that privilege decisions by public hospitals will cause no harm to competing private hospitals. This distinction, however, would ignore the role of the public hospital's medical staff in making anticompetitive privilege decisions. An anticompetitive decision is likely to inflict harm on practitioners who compete with the medical staff in the private sector. This would seem to be a good reason for treating the public hospital as a "proprietary" enterprise for antitrust purposes.¹³¹

127. *Id.* at 413-17 (plurality opinion).

128. *Id.* at 418-26.

129. See, e.g., KAN. STAT. ANN. §§ 13-14b01 to 13-14b15 (1975 & Supp. 1980).

130. See 435 U.S. at 418-20. The Chief Justice in *Lafayette* did not spell out a test for "proprietary" activities, but he did rely upon both profitmaking and competition with private enterprise as indicia that could be used to establish the proprietary nature of government enterprises. *Id.*

131. See also Note, *The Antitrust Liability of Municipalities Under the Parker Doctrine*, 57 B.U.L. REV. 368, 384-86 (1977) (supporting an approach that is similar to the Chief Justice's approach in *Lafayette*, and arguing the proprietary municipal enterprises should be those that

Our conclusion that antitrust law is likely to apply to privilege decisions by public hospitals is strengthened by the Supreme Court's most recent decision on the state action issue. In *Community Communications Company, Inc. v. City of Boulder*,¹³² a majority of five Justices adopted the plurality approach in *Lafayette* toward the use of the state action defense by political subdivisions of a state. They held that a grant of general power under Colorado's home rule statute did not constitute sufficient authorization or direction to a city to regulate cable television in an anticompetitive manner, thus leaving the regulation subject to antitrust scrutiny.¹³³ Enabling legislation for public hospitals that grants broad power to a public hospital's board of trustees to manage the hospital in the public welfare¹³⁴ would seem analogous to the grant of powers to municipalities under home rule statutes. Thus, privilege decisions by public hospitals are likely to be subject to the same kind of antitrust scrutiny as cable television regulation by local governments.¹³⁵

3. Noerr-Pennington Claims

A third circumstance in which a state action claim might be raised occurs when a public hospital and its medical staff claim that the staff's participation in a privilege decision is immune from antitrust law because the staff is petitioning a government agency—the public hospital.¹³⁶ If the privilege decision is a physician cartel or joint venture action, however, petitioning may be an incorrect characterization of the medical staff's role. Petitioning is a form of speech which implies that another party is listening and subsequently takes full responsibility for the ultimate decision.¹³⁷ In physician cartel and joint venture decisions, medical staff participation consists of "making the decision" as well as petitioning the hospital board. The *Noerr-Pennington* doctrine protects only efforts to communicate with a governmental body, and

provide the same services as private entities and are capable of aggregating and exercising the kinds of power that are the concern of antitrust law when exercised by private parties).

132. 102 S. Ct. 835 (1982).

133. *Id.* at 42-43.

134. See, e.g., KAN. STAT. ANN. § 13-14b11 (1975 & Supp. 1980) (the board of trustees of a hospital established by a first class city "shall have exclusive control of the management and operation of the hospital and shall make and adopt such rules and regulations for the government of the hospital as may be deemed expedient for the economical and proper conduct thereof").

135. We do not mean to endorse the Supreme Court's decision in *Community Communications Co.*, which strikes us as an instance of judicial activism under the state action doctrine that is not particularly desirable. See *supra* text accompanying notes 113-19. See generally Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 HARV. L. REV. 435 (1981).

136. See Dolan & Ralston, *supra* note 3, at 773-77; Note, *Physician Influence: Applying Noerr-Pennington to the Medical Profession*, 1978 DUKE L.J. 701, 715-19.

137. See *supra* note 106 and accompanying text.

not agreements by private parties that are aimed at competitors.¹³⁸ On the other hand, characterization of a medical staff's role as mere petitioning may be appropriate in employer hospital decisions and in instances where individual physicians offer their opinions but are not responsible for the medical staff's recommendation. The use of the *Noerr-Pennington* doctrine to protect these forms of speech from antitrust analysis would recognize that the physicians in these cases are acting either as legitimate agents of the hospital or as private petitioners, rather than in the mixed role of entrepreneur and agent who suffers from a conflict between private interests and public or hospital interests.¹³⁹

Two arguments might be made against use of the *Noerr-Pennington* doctrine in these latter situations,¹⁴⁰ although we find neither of these arguments to be persuasive. One is the contention that the *Noerr-Pennington* defense should not apply to petitioning that is designed to influence the "commercial" activities of government institutions.¹⁴¹ This argument is subject to two objections. First, the petitioning of government on commercial matters often may involve an attempt to influence government policy decisions as well as the purchase or sale of goods. Consider, for example, a physician's request that a public hospital not grant admitting privileges to chiropractors. In this situation, the speech would appear to have a "political" character that would clearly support application of the *Noerr-Pennington* doctrine. Second, the notion that the *Noerr-Pennington* doctrine should not apply to commercial matters was developed prior to the Supreme Court's recognition of first amendment protection for commercial speech in 1976.¹⁴² The first amendment may provide "lesser protection" for commercial speech than for political speech,¹⁴³ but the Court has held that any valid governmental restriction on commercial speech that neither misleads nor advertises illegal activities "must be designed carefully to achieve the State's goal."¹⁴⁴ This incorporates the idea that

138. See, e.g., *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530, 541-45 (5th Cir. 1978), cert. denied, 444 U.S. 924 (1979).

139. On the nature of this mixed role, see *supra* Part II.

140. See *In re Airport Car Rental Antitrust Litig.*, 474 F. Supp. 1072 (N.D. Cal. 1979), *rev'd on reassignment*, 1981-1 Trade Cas. (CCH) ¶ 63,983 (N.D. Cal. Apr. 16, 1981).

141. See *George R. Whitten, Jr., Inc. v. Paddock Pool Builders, Inc.*, 424 F.2d 25 (1st Cir.), cert. denied, 400 U.S. 850 (1970), *on remand*, 376 F. Supp. 125 (D. Mass.), *aff'd*, 508 F.2d 547 (1st Cir.), cert. denied, 421 U.S. 1004 (1975); *In re Airport Car Rental Antitrust Litig.*, 474 F. Supp. 1072 (N.D. Cal. 1979), *rev'd on reassignment*, 1981-1 Trade Cas. (CCH) ¶ 63,983 (N.D. Cal. Apr. 16, 1981); *Dolan & Ralston*, *supra* note 3, at 774-76.

142. Compare *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976) with *George R. Whitten, Jr., Inc. v. Paddock Pool Builders, Inc.*, 424 F.2d 25 (1st Cir.), cert. denied, 400 U.S. 850 (1970).

143. *Central Hudson Gas & Elect. Corp. v. Public Serv. Comm'n*, 447 U.S. 557, 562-63 (1980).

144. *Id.* at 564.

"if the governmental interest could be served as well by a more limited restriction on commercial speech, the excessive restrictions cannot survive."¹⁴⁵ In the case of anticompetitive privilege decisions that have been influenced by physician petitioning (rather than by an agreement between the physicians and hospital), the government's antitrust interest in the efficient and fair allocation of privileges should be sufficiently served by providing remedies against the public hospital itself rather than against the petitioning physicians, and the *Noerr-Pennington* doctrine should protect the petitioning physicians from antitrust liability.

The second argument against use of the *Noerr-Pennington* doctrine in these situations is that it would be somehow anomalous and unfair to exempt the petitioning for an anticompetitive act and, at the same time, to subject the public hospital to antitrust scrutiny.¹⁴⁶ In cases where physicians are mere petitioners, however, it does not seem anomalous to us to subject a public hospital to antitrust remedies while immunizing the physicians from personal liability. This distinction is supported by free speech values, the special obligation of public officials and public institutions to comply with the law, and the fact that staff physicians will suffer when their hospital loses resources due to an illegal act. We conclude that the *Noerr-Pennington* defense for medical staff participation in public hospital privilege decisions may be appropriate in some instances, but only in cases of employer hospital decisions and where individual physicians are petitioning the public hospital outside of their official roles as voting medical staff members.

This analysis of the *Noerr-Pennington* defense suggests a distinction that could have relevance in the application of antitrust law to many hospital privilege decisions. A medical staff physician clearly may participate in privilege decisions from any of several different positions: as an advice-giving citizen, as a mere agent of the hospital with no personal interests at stake, as an entrepreneur with nothing but personal interests at stake, or in a mixed role as both entrepreneur and agent. In view of this complex set of possibilities, antitrust analysis might benefit from the willingness of courts to treat medical staffs as groups of independent entrepreneurs for the purpose of restraint of trade analysis and, at the same time, to treat these physicians as individual citizens or as agents of the hospital for the purpose of imposing liability for antitrust damages. Thus, in many cases (particularly joint venture privilege decisions), antitrust courts could find the requisite agreement between hospital and medical staff for applying restraint of trade analysis under section 1 of the Sherman Act, and yet limit the

145. *Id.*

146. See *In re Airport Car Rental Antitrust Litig.*, 474 F. Supp. 1072 (N.D. Cal. 1979), rev'd on reassignment 1981-1 Trade Cas. (CCH) ¶ 63,983 (N.D. Cal. Apr. 16, 1981).

liability for any damages to the hospital.¹⁴⁷

Admittedly, joint venture privilege decisions that violate the anti-trust laws may be based upon a finding of "anticompetitive purpose" among the hospital and medical staff.¹⁴⁸ Yet characterization of the decision as a joint venture suggests that the determination of an anticompetitive purpose may often be difficult, with questions remaining about the possibly legitimate aspects of the defendant physicians' participation in the decision. This differential treatment of physicians on different antitrust issues should not, however, apply in all cases. Physicians may deserve personal liability for their participation in physician cartel decisions, where their role is more clearly like that of an entrepreneur with nothing but personal interests at stake.¹⁴⁹ And in employer hospital decisions, the role of the medical staff may be protected from antitrust scrutiny by the *Noerr-Pennington* doctrine or by an analogous first amendment defense for the medical staffs of private hospitals.¹⁵⁰

C. The Interstate Commerce Test

In order to invoke federal antitrust law, a plaintiff will need to show some connection between the denial of privileges and interstate commerce. In general, there are two ways to determine whether a defendant's acts affect interstate commerce sufficiently to support application of the Sherman and Federal Trade Commission Acts.¹⁵¹ A defendant's anticompetitive behavior is subject to these laws if it has occurred "within the flow of interstate commerce" or if it has "substantially affected interstate commerce."¹⁵² The flow-of-commerce test covers the case where a defendant restrains or monopolizes trade in some multistate market. Because physicians and hospitals usually offer their services in local markets, this test will not be relevant to many privilege

147. Cf. Stone, *supra* note 48, at 28-35 (on the need for complex adjustments in decisions that impose liability on corporate agents for enterprise misconduct).

148. See *infra* text accompanying notes 301-31.

149. See *infra* text accompanying notes 269-300.

150. See generally Kissam, *Applying Antitrust Law to Medical Credentialing*, 7 AM. J. L. & MED. 1, 12-22 (1981); Kissam, *The First Amendment*, *supra* note 16, at 156-66.

151. Sections 1 and 2 of the Sherman Act prohibit restraints of trade and monopolizing behavior that affect "trade or commerce among the several states, or with foreign nations." 15 U.S.C. §§ 1, 2 (1976). Similarly, section 5 of the Federal Trade Commission Act prohibits unfair methods of competition "in or affecting . . . commerce among the several states or with foreign nations." 15 U.S.C. §§ 44, 45(a)(1) (1976). These acts are the federal antitrust laws that are most likely to be applied to hospital privilege decisions. The Clayton and Robinson-Patman Acts deal only with specific kinds of anticompetitive behavior, and in any event, the interstate commerce test for the application of these laws is narrower than the interstate commerce test under the Sherman and Federal Trade Commission Acts. See L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 233 (1977).

152. *Las Vegas Merchant Plumbers Ass'n v. United States*, 210 F.2d 732, 739 n.3 (9th Cir.), cert. denied, 348 U.S. 817 (1954).

cases. The question usually will be whether a denial of privileges has some "substantial effect" upon interstate commerce. This test allows federal antitrust law to reach relatively far into local communities. As Justice Jackson remarked, "[i]f it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze."¹⁵³

Nevertheless, application of the substantial effect test to hospital privilege denials presents some analytical problems of both precedent and principle. Through 1975, federal antitrust courts had refused to find any substantial connection between interstate commerce and privilege denials or similar acts by medical care institutions. In that year, for example, the Tenth Circuit held that the denial of privileges to an osteopathic physician by two hospitals in Bartlesville, Oklahoma, had no more than an "insubstantial effect upon interstate commerce" and was "wholly intrastate in character."¹⁵⁴ The common theme in this and earlier medical antitrust cases was the search for a "direct" or "intended" effect of the alleged antitrust violation upon interstate commerce.¹⁵⁵ At the same time, however, the Supreme Court was shedding this restrictive view of the interstate commerce requirement in other antitrust cases,¹⁵⁶ and in 1976 the Court was provided a clear opportunity to review the "direct" or "intended" effect test in medical antitrust cases.

In *Hospital Building Co. v. Trustees of Rex Hospital*,¹⁵⁷ the Court rejected the idea that the effect on interstate commerce must be direct or purposeful and held that indirect effects of antitrust violations, if proved to be substantial, would satisfy the interstate commerce test. This holding clearly has expanded the opportunity to apply federal antitrust law to hospital privileges. The specific implications of this decision for privilege issues are unclear, however, and there is still perhaps room for leaving numerous privilege decisions outside the scope of federal antitrust law.

In *Rex Hospital*, a private hospital in Raleigh, North Carolina, alleged that Rex Hospital had conspired with others to block expansion

153. *United States v. Women's Sportswear Mfrs. Ass'n*, 336 U.S. 460, 464 (1949).

154. *Wolf v. Jane Phillips Episcopal-Memorial Medical Center*, 513 F.2d 684, 686 (10th Cir. 1975).

155. *Id.*; see *United States v. Oregon State Medical Soc'y*, 343 U.S. 326, 337-39 (1952); *Riggall v. Washington County Medical Soc'y*, 249 F.2d 266, 268 (8th Cir. 1957), cert. denied, 355 U.S. 954 (1958); *Spears Free Clinic and Hosp. for Poor Children v. Cleere*, 197 F.2d 125, 126 (10th Cir. 1952); *Elizabeth Hosp., Inc. v. Richardson*, 167 F. Supp. 155, 160 (W.D. Ark. 1958), aff'd, 269 F.2d 167 (8th Cir.), cert. denied, 361 U.S. 884 (1959). But see *Doctors, Inc. v. Blue Cross*, 490 F.2d 48 (3d Cir. 1973).

156. E.g., *Burke v. Ford*, 389 U.S. 320, 322 (1967); *United States v. Women's Sportswear Mfrs. Ass'n*, 336 U.S. 460, 464 (1949); see Note, *The Medical Profession and the Sherman Act: Wolf v. Jane Phillips Episcopal-Memorial Medical Center*, 1976 UTAH L. REV. 196, 200-02.

157. 425 U.S. 738 (1976).

of the plaintiff's hospital from 49 to 140 beds. To establish jurisdiction, the plaintiff alleged that the conspiracy would have an adverse effect upon its purchase of supplies from other states, its billings to national insurance companies and the federal Medicaid and Medicare programs, its out-of-state patients, its management service contract with an out-of-state parent corporation, and its planned capital borrowing from out-of-state lenders for a large part of the planned four million dollar expansion.¹⁵⁸ Seizing upon four of these effects, all except those on out-of-state patients and Medicaid or Medicare revenues, the Court ruled that "this combination of factors" was "certainly sufficient to establish a 'substantial effect' on interstate commerce"¹⁵⁹

Rex Hospital has lessened the plaintiff's burden of demonstrating a nexus between the defendant's behavior and interstate commerce. Yet the Court's reliance upon "this combination of factors" does not answer the difficult question of where the line should be drawn between substantial and insubstantial effects upon interstate commerce. There is no principled distinction between the cluster of factors deemed relevant in *Rex Hospital* and any one factor, such as the purchase of supplies from out of state by an individual physician. Is there, then, a difference for purposes of Sherman Act jurisdiction between the plaintiff hospital in *Rex* and an individual practitioner who has been denied hospital privileges? Admittedly, the dollar amounts involved will differ, but where can a line be drawn?

Furthermore, is it significant that the Court failed to include Medicaid and Medicare revenues within the "combination of factors" that might satisfy the interstate commerce test? On the one hand, it could be argued that the interstate flow of funds from public health insurance programs is not "commerce" within the meaning of the Sherman Act, which was aimed at the evils of private combinations. On the other hand, these public health programs purchase services from private sellers and employ private insurance companies as agents to administer their day-to-day operations.¹⁶⁰ The Sherman Act should be used to attack anticompetitive behavior that increases the costs of operating these already expensive federal programs.¹⁶¹ In any event, resolution of questions like these may be decisive in cases that involve hospital privileges, since it is unlikely that many health care practitioners will be able to allege that a denial of privileges to them would affect a volume of interstate commerce that is similar in quantity to that affected in *Rex Hospital*.

The uncertainty surrounding this issue is reflected in recent lower

158. *Id.* at 741.

159. *Id.* at 744.

160. See, e.g., S. LAW, BLUE CROSS: WHAT WENT WRONG? 31-58 (1976).

161. See Havighurst, *supra* note 23, at 780-81.

court decisions on the connection between hospital privileges and interstate commerce. In *Zamiri v. William Beaumont Hospital*,¹⁶² a district court refused to dismiss a physician's antitrust action against a hospital on summary judgment, although the physician offered to prove only that the denial of privileges affected interstate commerce by causing his Medicare and Medicaid patients to switch to other doctors. This court held that

[P]laintiff must prove that a significant proportion of his potential patients receive medicare or medicaid benefits. A more complete explication of the facts may lead to the conclusion that the effect of defendant's conduct upon plaintiff's participation in interstate commerce is in fact insignificant. However, in antitrust cases summary dismissal is to be used sparingly.¹⁶³

In *Robinson v. Magovern*,¹⁶⁴ a second district court refused to dismiss a physician's antitrust suit against a hospital and a partnership of cardiothoracic surgeons on the ground that the interstate commerce test was not satisfied. The plaintiff alleged that the denial of privileges to him and others by reason of an exclusive dealing arrangement with the cardiothoracic surgeons would affect the prices paid by Medicare, Medicaid, and out-of-state private insurers, and would also affect the hospital's purchase of surgical equipment in interstate commerce. The court held that plaintiff had satisfied the liberal pleading standard in antitrust law, but it noted that there was "an alleged conspiracy aimed at a market which limits not only the competition from Dr. Robinson, but whose effects could transcend those relating to his services alone."¹⁶⁵

More recently, the Fourth and Fifth Circuits have upheld the dismissal of hospital privilege antitrust suits on the ground that plaintiff physicians had failed to satisfy the interstate commerce test.¹⁶⁶ Yet on apparently similar facts, the Tenth Circuit en banc has held that a pathologist should have the opportunity to prove at trial that the denial of privileges would substantially affect the prices paid by out-of-state insurance companies and the government, as well as affect the hospital's purchase of supplies from interstate commerce.¹⁶⁷ This decision reversed an earlier decision of a Tenth Circuit panel, which had tried to

162. 430 F. Supp. 875 (E.D. Mich. 1977).

163. *Id.* at 877.

164. 456 F. Supp. 1000 (W.D. Pa. 1978), *subsequent decision after trial*, 521 F. Supp. 842 (W.D. Pa. 1981).

165. *Id.* at 1005.

166. *Moles v. Morton F. Plant Hosp., Inc.*, 617 F.2d 293 (5th Cir. 1980), *cert. denied*, 449 U.S. 919 (1980); *Capili v. Shott*, 620 F.2d 439 (4th Cir. 1980).

167. *Crane v. Intermountain Health Care*, 637 F.2d 715 (10th Cir. 1981). *Accord Mishler v. St. Anthony's Hosp. Sys.*, 1981-82 Trade Cas. (CCH) ¶ 64,342 (10th Cir. Nov. 2, 1981); *McDonald v. St. Joseph's Hosp. of Atlanta*, 524 F. Supp. 122 (N.D. Ga. 1981); *Malini v. Singleton & Assocs.*, 516 F. Supp. 440 (S.D. Tex. 1981); *Feldman v. Jackson Memorial Hosp.*, 509 F. Supp. 815 (S.D.

distinguish the pathologist's case from *Rex Hospital* and had held that the suit should be dismissed.¹⁶⁸

These and other cases can perhaps be reconciled by some rather narrow factual distinctions that might be drawn along a spectrum of quantitative effects. On the basis of the alleged restraint's quantitative effects upon interstate commerce, the situation in *Robinson v. Magovern* appears to be most analogous to *Rex Hospital*. In *Robinson* the alleged conspiracy would have excluded other cardiothoracic surgeons besides the plaintiff. *Zamiri v. William Beaumont Hospital* might come next on this spectrum, since the plaintiff there alleged that "many" or a "significant proportion" of his patients were receiving Medicare or Medicaid funds that come ultimately from Washington, D.C. Similarly, the plaintiffs in other cases, who alleged merely that privilege denials to them would affect insurance prices and the purchase of supplies, can perhaps be distinguished from each other with regard to the volumes of their alleged effects. Yet such quantitative distinctions would certainly be imprecise guidelines, and they are unsatisfactory, in any event, because they offer no good reason why an antitrust court should hear one case and not another.

Further confusion about the interstate commerce test has been introduced by the Supreme Court's most recent decision on this issue. In *McLain v. Real Estate Board of New Orleans*,¹⁶⁹ the Court held that activities of real estate brokers in New Orleans that were "infected" by the brokers' price-fixing activities could have an effect upon interstate commerce sufficient to establish Sherman Act jurisdiction.¹⁷⁰ This holding rejected the narrower view that the alleged violation itself must have an effect upon interstate commerce, with the Court reasoning that an alleged violation may not have any effect and thus could not be reached under the Sherman Act if only the violation's effects were considered on the jurisdictional issue.¹⁷¹ Unfortunately, there also is language in *McLain* which suggests that a plaintiff need only show that a defendant's total activities, independent of the alleged violation, have a substantial effect upon interstate commerce—if that language is read outside the context of the full opinion.¹⁷² This reading of *McLain*, which has been followed by some lower courts,¹⁷³ would in essence eliminate the interstate commerce test from antitrust law, since the total

Fla. 1981); *Denver v. Santa Barbara Comm. Dialysis Center*, 1981-1 Trade Cas. (CCH) ¶ 63,946 (C.D. Cal. Feb. 26, 1981).

168. *Crane v. Intermountain Health Care, Inc.*, 1980-1 Trade Cas. (CCH) ¶ 63,122 (10th Cir. Jan. 8, 1980), *rev'd on rehearing en banc*, 637 F.2d 715 (1981).

169. 444 U.S. 232 (1980).

170. *Id.* at 242, 246.

171. *Id.* at 244-45.

172. *See id.* at 246.

173. *See Western Waste Serv. v. Universal Waste Control*, 616 F.2d 1094, 1097 (9th Cir.),

activities of virtually any defendant, no matter how local its business, are likely to have some effects upon interstate commerce. Yet this reading is based upon an abstraction of language from its rightful context, and is unnecessary to justify *McLain* or any other Supreme Court decision on this issue.¹⁷⁴ This suggestive language should thus be viewed as casual dicta at worst or simply an inadvertent expression that has been wrongly torn from its context by other lawyers and judges.¹⁷⁵

The confusion that remains after *Rex Hospital, McLain*, and these lower court decisions on hospital privileges is not unique to medical antitrust cases, because the Supreme Court in general has failed to articulate a principled test for determining substantial effects upon interstate commerce for purposes of federal antitrust jurisdiction.¹⁷⁶ There are, however, two tests that might be used to resolve this issue on a more principled basis. Phillip Areeda and Donald Turner have suggested that Sherman Act jurisdiction should be recognized as coextensive with the power of Congress to regulate interstate commerce under the Constitution.¹⁷⁷ This would recognize that all local activities have some ultimate effect upon interstate commerce and would abandon the attempt to determine whether an alleged violation, or activities "infected" by the violation, have a substantial effect upon interstate commerce. Instead, these commentators would change the jurisdictional test to whether an alleged violation is a "substantial" or "de minimis" violation of national competition policy. Their test would question only whether it is worth employing federal judicial resources to review the challenged behavior.¹⁷⁸ The authors offer no criteria for this new test, but presumably it would depend upon some qualitative assessment of the harm to competition in a relevant market, no matter how local the market may be. That is, this test would focus upon anticompetitive effects, qualitatively measured, rather than upon the alleged violation's quantitative effects on interstate commerce.

A major problem with the Areeda and Turner approach is that it ignores the constitutional principle of federalism, which arguably should be applied to limit the reach of federal laws when Congress has not indicated an explicit intent to regulate local activities.¹⁷⁹ This prin-

cert. denied, 449 U.S. 869 (1980); Feldman v. Jackson Memorial Hosp., 509 F. Supp. 815, 819-21 (S.D. Fla. 1981).

174. *Crane v. Intermountain Health Care*, 637 F.2d 715 (10th Cir. 1981); *Malini v. Singleton & Assocs.*, 516 F. Supp. 440 (S.D. Tex. 1981).

175. See *Crane v. Intermountain Health Care*, 637 F.2d 715 (10th Cir. 1981). But cf. *infra* text accompanying notes 177-78 (a proposal to abolish the interstate commerce test in antitrust law, which the broad reading of *McLain* would accomplish implicitly).

176. See P. AREEDA & D. TURNER, ANTITRUST LAW § 232 (1978).

177. See *id.* ¶ 232e.

178. *Id.*

179. See L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 5-8 (1978). See also Dworkin, *Hard*

ciple, and the fact of congressional silence on the intended reach of the Sherman Act into local affairs, support the occasional expression of judicial unease about recognizing a scope for the Sherman Act that is as broad as the commerce power of Congress.¹⁸⁰ To be sure, the Supreme Court has stated that "Congress wanted to go to the utmost extent of its Constitutional power"¹⁸¹ in applying the Sherman Act, but this frequently quoted statement was made in support of a decision that interstate insurance services were in fact "commerce and trade" and thus subject to the Sherman Act.¹⁸² How far the Act should extend in regulating purely local activities that in 1890 were certainly not considered to fall under the commerce power is a different question, and it is a question to which the federalism principle seems relevant.¹⁸³

A second principled approach to the interstate commerce issue could be developed by an explicit weighing of the different constitutional values that are implicated in attempts to apply federal antitrust law to essentially local activities. This would involve moving beyond the current slogan of "substantial effect" upon interstate commerce, to an express consideration of the basic purposes of the commerce clause, the federalism principle, and other constitutional values that may be implicated in particular cases. Under this approach, federal antitrust law should not be applied to essentially local activities unless one or more of the "national" constitutional values specifically outweighs the federalism principle that local affairs should be left to state regulation or nonregulation.¹⁸⁴

The basic purposes of the commerce clause are understood to be the authorization of Congress to regulate interstate commerce in the national interest¹⁸⁵ and the protection of interstate commerce from self-interested or parochial regulation by state governments that favors lo-

Cases, 88 HARV. L. REV. 1057, 1085-87 (1975), reprinted in R. DWORKIN, TAKING RIGHTS SERIOUSLY 81, 107-09 (1977).

180. See, e.g., Doctors, Inc. v. Blue Cross, 490 F.2d 48, 53-54 (3d Cir. 1973).

181. United States v. Southeastern Underwriters Ass'n, 322 U.S. 533, 558 (1944).

182. *Id.*

183. The Supreme Court relied upon the idea that the Sherman Act had been extended to its "utmost extent" in the recent *McLain* decision on the interstate commerce issue. See *McLain v. Real Estate Bd.*, 444 U.S. 232, 241 (1980). This reliance was not necessary for the decision, however, and the better reading of the Court's use of this concept in interstate commerce cases is to view this reference merely as support for the judicial broadening of Sherman Act jurisdiction "along with expanding notions of congressional power," *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738, 743 n.2 (1976), rather than as a holding that Sherman Act jurisdiction is identical to the commerce power. The Supreme Court precedents on the interstate commerce issue thus continue to leave room for employment of the federalism principle.

184. For a good discussion of the judicial weighing of competing legal principles, see Dworkin, *The Model of Rules*, 35 U. CHI. L. REV. 14 (1967), reprinted in R. DWORKIN, *supra* note 179, at 14.

185. See, e.g., *Perez v. United States*, 402 U.S. 146 (1971).

cal interests at the expense of interstate interests.¹⁸⁶ The former purpose will not usually be implicated in hospital privilege cases or other cases that involve essentially local activity. The failure of Congress to indicate an intent to extend the Sherman Act to the farthest reaches of the commerce power¹⁸⁷ constitutes a national judgment that interstate commerce and the national interest will not suffer significantly from occasional adverse effects upon interstate commerce that result indirectly from local activities.

On the other hand, in some hospital privilege cases, the challenged restraint may have an inherent effect, even though unintended, of favoring in-state economic interests to the disadvantage of the interstate movement of goods and persons. Thus, if the alleged antitrust violation is part of an ongoing or patterned opposition to economic competition, as was alleged in *Robinson v. Magovern*,¹⁸⁸ the purpose of the commerce clause to guard interstate commerce against "local protectionism" would seem to be implicated. In particular, the interstate migration of physicians to seek new positions might suffer because of the economic interests of incumbent medical staff physicians.¹⁸⁹ Similarly, an implicit concern with local protectionism that specifically harms the movement of goods and persons in interstate commerce may help explain the decisions on the interstate commerce issue in both *Rex Hospital* and *McLain*.¹⁹⁰ To be sure, the local protectionism in these cases may result from unregulated private behavior rather than from state regulation, but the effects are the same. In cases of local protectionism, then, there is a sound argument for extending federal antitrust law into relatively local activities.

Other constitutional values may be implicated in particular hospital privilege cases, and the weight to be attributed to these values also may overcome the weight of the federalism principle. For example, the denial of privileges to a particular physician because of that physician's propensity to engage in competitive advertising would implicate the

186. See, e.g., *Raymond Motor Transp., Inc. v. Rice*, 434 U.S. 429 (1978).

187. See *supra* text accompanying notes 179-83.

188. See *supra* text accompanying notes 163-64.

189. In addition, the personal right to interstate travel is implicated by this type of privilege decision. On the nature of this right, see *Shapiro v. Thompson*, 394 U.S. 618 (1969).

190. In *Rex Hospital*, a nonprofit hospital and major provider of health services in Raleigh, North Carolina, was alleged to have conspired with other members of the local health planning agency to block the expansion of a profit-making hospital that was managed and financed by out-of-state companies. Since nonprofit hospitals traditionally have been established and supported by leaders in the local community, and also have been extremely wary of price competition from profit-making hospitals, which frequently are operated by interstate corporations, the implication of "local protectionism" in this case seems relatively clear. Similarly, in *McLain*, the Court could discover a sufficient nexus between the alleged price fixing by real estate brokers in New Orleans and interstate commerce because of out-of-state home purchasers and out-of-state mortgage money which might be adversely affected by the higher purchase prices from such price fixing in a major metropolitan community.

first amendment value of free speech. Or, privileges might be denied to a physician who serves substantial numbers of Medicare patients, as was alleged in *Zamiri v. William Beaumont Hospital*,¹⁹¹ thus affecting the efficient administration of a federal program that is authorized by the spending power of Congress. In these cases there also would appear to be sound reasons for extending federal antitrust law into local affairs.

In contrast, if the alleged antitrust violation merely affects an individual practitioner, or a relatively few practitioners who are already in the community, there will be no national value deserving of special weight, and the federalism principle would justify the denial of federal antitrust jurisdiction. Such cases, which may be numerous, would include the denial of privileges to a practitioner on the grounds of individual incompetence, the establishment of geographical boundaries for medical staff membership, and privilege decisions that affect mainly existing staff members.¹⁹² This second approach would have the inelegant property of merging questions of constitutional value with the jurisdictional issue of interstate commerce. On the other hand, this approach would have the considerable virtues of preserving recognition of the federalism value in antitrust law and explaining why federal courts should assume jurisdiction over some antitrust cases and not others.

Let us consider the way in which current precedents and these two principled tests might be applied to three types of antitrust attacks on privilege denials. One situation would be where privilege denials are aimed at discouraging competition from a medical care institution, such as an HMO or ambulatory surgical center. Here there should be no problem in applying federal antitrust law. The institution is likely to have interstate contacts which approximate those that were held to be substantial in *Rex Hospital*.¹⁹³ It also will be arguable that HMOs and similar insurers compete within an interstate insurance market.¹⁹⁴ Privilege denials against an HMO's physicians thus may satisfy the "within-the-flow-of-commerce" test that does not require the showing of quantitative effect.¹⁹⁵

A second situation would be where the privilege decision will have an ongoing exclusionary effect upon groups of health care practitioners, as where all podiatrists are denied privileges or all physicians are re-

191. See *supra* text accompanying notes 162-63.

192. Examples of this latter type of privilege decision would include bylaws that restrict use of hospital radiological equipment to radiologists and similar bylaws respecting pathologists.

193. See *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530, 539-41 (5th Cir. 1978) (interstate commerce affected by an alleged boycott against an ambulatory abortion clinic), cert. denied, 444 U.S. 924 (1979).

194. See *Kissam*, *supra* note 13, at 502.

195. See L. SULLIVAN, *supra* note 151, § 233a n.12.

quired to join the partnerships of existing staff members. In this situation, too, there should be little problem in applying federal antitrust law, although *Rex Hospital* does leave some lingering traces of uncertainty. Nevertheless, the district court decision in *Robinson v. Magovern*,¹⁹⁶ the logical implications of *Rex Hospital*, and both of the principled tests would appear to support the finding of federal antitrust jurisdiction on these facts. Under our recommended "constitutional values" test, patterned opposition to a type of health care practitioner would implicate both the right of interstate commerce to move in freedom from "local protectionism" and the right of persons to interstate travel.¹⁹⁷

Privilege denials that affect only individual practitioners or local communities of practitioners raise the most difficult cases for the interstate commerce test, and these cases invite different results under different approaches. The current case law appears to be more or less split on this matter, apparently depending upon the presence or absence of some special quantitative contact with interstate commerce. Under the Areeda and Turner approach, jurisdiction might be recognized in many of these cases, wherever it can be shown that the exclusion of an individual practitioner may be significant to competition in some relevant economic market, no matter how small or local the market may be. Under the approach that we have suggested, Sherman Act jurisdiction would not be recognized in cases that involve only individual practitioners or limited kinds of privilege disputes within an existing community of practitioners, unless a specific constitutional value like the right to advertise is implicated.

IV. SUBSTANTIVE ISSUES

In this Part we consider the important issues of substantive antitrust law that promise to figure in antitrust challenges to hospital privilege decisions. We discuss first the critical issue of proving an "agreement" between the hospital and medical staff to make the decision. Thereafter we consider three other kinds of issues: the application of restraint of trade analysis to privilege decisions, the application of monopolization analysis to privilege decisions in which hospitals themselves may have an anticompetitive interest, and finally, the opportunities for antitrust attacks on professional behavior outside the hospital that influences privilege decisions in an anticompetitive manner. Our primary emphasis will be upon the "agreement" and "restraint of trade" issues, since these promise to be central issues in most

196. 456 F. Supp. 1000 (W.D. Pa. 1978).

197. See *supra* text accompanying notes 184-89.

antitrust privilege disputes.¹⁹⁸

A. Proving an Agreement

Whether antitrust defendants have engaged in a "contract, combination or conspiracy" to restrain trade is a question of fact that will be determined by the jury or trial court judge.¹⁹⁹ Generalizations about this issue necessarily must be of a looser and more flexible nature than generalizations about questions of law, because so much will depend upon the specific facts that surround a particular privilege decision, including the perceived character and demeanor of witnesses. Nonetheless, it appears possible to develop a general theory about the arguments that are likely to be made on this issue.

In some instances the existence of an agreement will be obvious, as for example, where a hospital grants exclusive privileges by contract to an individual physician or partnership for the practice of a given specialty or procedure. In most cases, however, establishing the requisite agreement for restraint of trade analysis will not be as easy. To be sure, most privilege decisions will involve both a medical staff's recommendation to the governing board and a subsequent decision by the board that is consistent with this recommendation. Yet the hospital and medical staff may advance two arguments to support characterization of the decision as a decision by a single entity rather than as an agreement between independent economic actors. Both are based on the idea that physicians participating in medical staff roles are acting merely as agents of the hospital. One argument is that any agreement between hospital and medical staff is an "intraenterprise" conspiracy, which for antitrust purposes should be treated as the decision of a single economic entity.²⁰⁰ The second argument is that the medical staff's recommendation, in accordance with JCAH standards and the hospital's bylaws, is merely an "advisory" communication to the hospital board, which is ultimately responsible for making the privilege decision.²⁰¹

If the privilege decision can fairly be characterized as one that has been made by an employer hospital, rather than by a joint venture of hospital and physicians or by a physician cartel, the treatment of the decision as a unilateral one may be appropriate.²⁰² Such instances

198. See *supra* text accompanying notes 34-37.

199. See *Theatre Enters. v. Paramount Film Distrib. Corp.*, 346 U.S. 537, 541-42 (1954); *Interstate Circuit v. United States*, 306 U.S. 208, 221 (1939).

200. See *Robinson v. Magovern*, 521 F. Supp. 842, 906-07 (W.D. Pa. 1981); *Moles v. Morton F. Plant Hosp.*, 1980-81 Trade Cas. (CCH) ¶ 63,600, at 77,188-90 (M.D. Fla. May 10, 1978), *aff'd*, 617 F.2d 293 (5th Cir.), *cert. denied*, 449 U.S. 919 (1980). See generally L. SULLIVAN, *supra* note 151, § 114.

201. See *supra* text accompanying notes 43-46.

202. See *Harron v. United Hosp. Center*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976); *Robbins v. Ong*, 452 F. Supp. 110, 116 (S.D. Ga. 1978); *Moles v. Morton F. Plant*

might include, for example, a medical school's decision to limit privileges at a teaching hospital to faculty members, particularly if the faculty is paid largely on a salaried basis.²⁰³ Other examples might be a decision to condition privileges upon a physician's acquisition of substantial malpractice insurance,²⁰⁴ or a denial of privileges because the applicant does not meet the hospital's criteria for individual skills, competence, and future contribution to the hospital's operations.²⁰⁵ In these cases the hospital would appear to have a strong interest in maintaining a high quality medical school, adequate malpractice protection, or general quality of hospital operations, and these interests are likely to be substantially independent of any anticompetitive concerns among the medical staff. On facts such as these, it may be appropriate to treat the medical staff's role in the privileges decision as merely an advisory one which does not involve an agreement with the hospital corporation, or alternatively as part of an intraenterprise conspiracy.

On the other hand, in the situations that we have labeled physician cartel and joint venture decision-making, the privilege decision typically results from an agreement between independent actors who possess quite different interests.²⁰⁶ In these cases, there are persuasive reasons for rejecting the arguments about intraenterprise conspiracy and a purely advisory role for the medical staff. The concept of an intraenterprise conspiracy focuses upon the incontestable fact that a corporation, for these purposes, is merely officers and employees. To invade this identity by applying restraint of trade analysis would do violence to the basic legislative intent underlying section 1 of the Sherman Act, to prohibit collusive behavior between two or more independent actors.²⁰⁷ Attending physicians, however, are independent contractors with the hospital for other legal purposes and most of them also provide ambulatory services that are outside the scope of their hospital roles.²⁰⁸ Such independent physician behavior suggests that the

Hosp., 1980-81 Trade Cas. (CCH) ¶ 63,600 (M.D. Fla. May 10, 1978), *aff'd*, 617 F.2d 293 (5th Cir.), *cert. denied*, 449 U.S. 919 (1980); Pollock v. Methodist Hosp., 392 F. Supp. 393, 398 (E.D. La. 1975). These cases involved the denial of privileges to physicians either because of the physicians' personal incompetence or because of an exclusive privileges contract with other physicians in a hospital-based specialty. These are the paradigm situations of an employer hospital privilege decision. *See infra* text accompanying notes 332-70.

203. *But cf.* Hayden v. Stanford Univ. Hosp., No. P32039 (Cal. Super. Nov. 8, 1977), discussed in Rich, *supra* note 3, at 678-79 (ordering that a radiologist be given privileges at a teaching hospital and concluding that the hospital "may still close its staff in the appropriate circumstances, but not without limitation").

204. *See* Pollock v. Methodist Hosp., 392 F. Supp. 393, 398 (E.D. La. 1975).

205. *Cf.* Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981) (denial of privileges for failure to meet hospital's criteria upheld as reasonable, without need to address the agreement issue).

206. *See supra* text accompanying notes 67-75.

207. L. SULLIVAN, *supra* note 150, § 114.

208. *See supra* text accompanying notes 42-48.

relationship between medical staff members and a hospital is more analogous to the relationship between a corporation and its "outside agents"—lawyers, accountants, advertising firms, and consultants—than to the relationship between a corporation and its salaried employees. Physicians thus may be treated as "outside agents" of the hospital, if not as independent entrepreneurs.²⁰⁹ Significantly, the precedents are clear that outside agents are separate enough from the corporations they do business with to be treated as co-conspirators under the Sherman Act.²¹⁰ Moreover, in the case of physician cartel decisions, there is no independent interest of the hospital, and thus the intraenterprise conspiracy defense would seem to be entirely spurious. The physicians are not acting even arguably as agents, but rather as entirely independent actors who desire to use the hospital for their own anticompetitive purposes.²¹¹

The "advisory role" defense for medical staff participation in physician cartel and joint venture decisions also is misplaced, although less easily dismissed. The basic issue raised by this defense will be whether the courts, in assessing the existence of an "agreement," will rely on some notion that the formal legal authority for the decision rests with the hospital's governing board or, rather, will be willing to recognize the actual power relationships and economic interests of the actors.²¹² The history of medical staff control over privilege decisions,²¹³ the general economic interests of medical staff members in restrictive privilege policies,²¹⁴ and the accreditation standards of the JCAH all suggest that an agreement exists.

The primary JCAH standard on privileges provides that the governing board shall "delegate" to the medical staff "the authority to evaluate" applicants for hospital privileges and that the staff shall make "recommendations" to the board on all privilege issues. Although the board has "the responsibility" for staff appointments, a board that disagrees with its medical staff is expected to establish a joint committee of the board and staff to "review" the issue before a "final" decision is reached by the board.²¹⁵ This standard certainly suggests that governing boards of hospitals are expected to share authority over privileges with medical staffs, if not to surrender this authority entirely. First, the standard seems to contemplate that the hospital governing

209. See *Robinson v. Magovern*, 521 F. Supp. at 907 (personal stake of physicians in outcome of a privileges decision may be sufficient to overcome intraenterprise conspiracy defense).

210. E.g., *Poller v. Columbia Broadcasting Sys.*, 368 U.S. 464, 469-70 (1962); *Brehm v. Goebel Brewing Co.*, 1953 Trade Cas. (CCH) ¶ 67,431 (W.D. Mich. 1953).

211. See *infra* text accompanying notes 269-300.

212. See *supra* Part II.

213. See *supra* text accompanying notes 51-57.

214. See *supra* text accompanying notes 58-62.

215. See *supra* text accompanying notes 43-46.

board will review and share authority with its medical staff in a manner that is analogous to judicial review of administrative agencies. That is, because the medical staff, like an agency, has "the authority" to evaluate applicants for privileges, the hospital board functions as a reviewing court that recognizes substantial discretion in the staff and upholds the staff's decision if it is supported by any "rational basis" or "substantial evidence."²¹⁶ Second, joint committees rarely make a recommendation without some sense that their parent bodies will accept the recommendation. Indeed, this tendency is even more likely to occur in the relatively intimate setting of a hospital. These considerations suggest that the JCAH standards, if not contradicted by specific hospital bylaws or other practices, should be sufficient to support a finding of agreement between hospital and medical staff in any physician cartel or joint venture privilege decision by a JCAH accredited hospital.²¹⁷

In any individual case, an agreement also may be inferred from more specific evidence. For example, there may be a pattern of consistent exclusionary behavior, as when several osteopaths rather than only one have been denied privileges.²¹⁸ There may be evidence of external anticompetitive influences, such as a medical society resolution that recommends the denial of privileges on some ground that bears only a specious relationship to the quality of hospital care.²¹⁹ A specific hos-

216. *Cf.* O'Keeffe v. Smith, Hinchman & Grylls Assocs., 380 U.S. 359 (1965); O'Leary v. Brown-Pacific-Maxon, 340 U.S. 504 (1951); Universal Camera Corp. v. NLRB, 340 U.S. 474 (1951) (reviewing courts should uphold administrative agency determinations if they are based on substantial evidence or have a rational basis).

217. In joint venture situations, where the hospital and medical staff may have different interests in the privilege decision, *see supra* text accompanying note 71, a hospital might argue that its decision to deny privileges in light of the medical staff's similar recommendation is merely an example of "conscious parallelism" that is not enough to establish the fact of agreement. *See* Theatre Enters. v. Paramount Film Distrib. Corp., 346 U.S. 537, 540-41 (1954). This argument is unpersuasive in view of the "other factors" that are likely to be present, including the JCAH standards and specific hospital bylaws that provide for coordination of privilege decision-making by the hospital board and medical staff. *See supra* text accompanying notes 212-16.

218. On the identity of medical training for osteopathic and allopathic physicians, and on patterns of exclusion of osteopaths from allopathic hospitals, see Blackstone, *supra* note 22, at 408-14. To be sure, osteopaths tend to be oriented toward general practice rather than specialization, and in general osteopaths receive somewhat shorter, less expensive, and less specialized training than today's highly specialized allopathic physicians. *Id.* at 408-10. This may justify limitations on the privileges of osteopaths that are similar to limitations imposed upon general practice M.D.s and family practitioners, but it would not seem to justify the total exclusion of osteopaths, particularly when they are licensed in many states to perform the same medical services as allopathic physicians. *See id.* at 411.

219. *See, e.g.*, *Florida Medical Group Faces Charges of Boycotting Doctors Working for HMO*, ANTITRUST & TRADE REG. REP. (BNA), A-16, -17 (Nov. 30, 1978) (Justice Department complaint alleged that a county medical society publicly advocated the lack of need for an HMO in the county, while at the same time the credentials committee of the county hospital was denying privileges to physicians who contemplated affiliation with the HMO). This case subsequently was settled. *United States v. Halifax Hosp. Medical Center*, 1981-1 Trade Cas. (CCH) ¶ 64,151 (M.D. Fla. June 24, 1981) (consent agreement).

pital bylaw, or more informal practices, also may indicate the existence of an agreement by which the hospital board has surrendered authority over privilege questions to its medical staff.

In this general context, it would seem appropriate for antitrust courts, as a matter of law, to recognize a rebuttable presumption of agreement between the governing board and medical staff.²²⁰ This would reallocate the burden of proof on the agreement issue, forcing the hospital and medical staff to prove that the privilege decision is not based upon an agreement rather than requiring the plaintiff to prove the existence of such an agreement. Antitrust law in general has not recognized presumptions of this sort,²²¹ but sound arguments from antitrust and evidentiary policy would support the recognition of this presumption. The specific economic interests of medical staff members in maintaining a staff of less than efficient size makes their participation in privilege decisions suspect from an antitrust point of view, and the "probability of violation" is one reason for recognizing a presumption that increases the chance of proving actual violations.²²² The plaintiff's burden of proving a specific agreement is also likely to be unduly onerous, since the direct evidence of an agreement will usually be under the control of the hospital board and staff members, who are defendants in the action.²²³ And finally, the best circumstantial evidence about an agreement is likely to be whether there are substantial hospital interests in the privilege question;²²⁴ on this issue, too, the hospital and medical staff will have the best access to the available evidence.

B. Restraint of Trade Analysis

If it can be established that a privilege decision results from an agreement, the next step will be to apply the relevant precedents of antitrust law under section 1 of the Sherman Act to determine whether a violation has occurred. Our analysis of this issue is divided into several parts. We discuss first the implications of the leading antitrust cases on professional self-regulation. We then consider whether antitrust law should require hospitals and medical staffs to provide procedural due process to privilege applicants and the desirable extent of such a requirement. Thereafter we analyze the application of restraint

220. See generally Note, *A Suggested Role for Rebuttable Presumptions in the Antitrust Restraint of Trade Litigation*, 1972 DUKE L. J. 595, 605-24.

221. See Liebenluft & Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927, 945-50 (1981); Note, *supra* note 220, at 595-97.

222. See Note, *supra* note 220, at 605.

223. A second reason for the recognition of a rebuttable presumption is a need to place the burden of producing evidence on parties who control the evidence. *Id.*

224. See *supra* text accompanying notes 67-75.

of trade law to several different types of privilege decisions—physician cartel, joint venture, and employer hospital.

1. Implications of the Leading Cases

Restraint of trade analysis in general involves the balancing of anticompetitive and procompetitive effects under antitrust's so-called Rule of Reason.²²⁵ Typically, an antitrust plaintiff will have the burden of showing that the anticompetitive effects of the challenged behavior are likely to outweigh its legitimate or procompetitive effects. In some cases plaintiffs can rely upon antitrust's rules of per se illegality, which have been established for types of conduct that are believed to be almost always anticompetitive. These per se rules merely require proof of a certain type of conduct, thereby dispensing with the difficult weighing of specific effects and also eliminating the opportunity for defendants to show that their conduct is reasonable because of its procompetitive or other good effects. Antitrust's per se rules include prohibitions against the collusive elimination of price competition,²²⁶ against group boycotts of competitors, or in other words, concerted refusals to deal with parties because of their status as competitors,²²⁷ and against "tie-in" sales, in which a firm with some degree of market power over one product requires that another product be purchased along with the first.²²⁸

There is substantial uncertainty about whether antitrust analysis of professional behavior should be different from the analysis of industrial and commercial affairs. Stimulated by a reference in *Goldfarb* to the possibility that the professions may be "treated differently" than other occupations,²²⁹ and by a subsequent statement in *Professional Engineers* that professional services may "differ significantly from other business services,"²³⁰ various proposals have been advanced to support special antitrust treatment of professional activities. These have included suggestions to exempt noncommercial professional activities from antitrust law,²³¹ to apply per se rules only to the commercial ac-

225. See *supra* note 3.

226. See *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940); *United States v. Trenton Potteries Co.*, 273 U.S. 392 (1927).

227. See *United States v. General Motors Corp.* 384 U.S. 127 (1966); *Silver v. New York Stock Exch.*, 373 U.S. 341 (1963); *Radiant Burners Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656 (1961); *Klor's v. Broadway-Hale Stores*, 359 U.S. 207 (1959); *Eastern States Retail Lumber Dealers' Ass'n v. United States*, 234 U.S. 600 (1914).

228. See *United States Steel Corp., v. Fortner Enters.*, 429 U.S. 610 (1977); *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1 (1958).

229. 421 U.S. at 788 n.17.

230. 435 U.S. at 696.

231. See *supra* text accompanying notes 76-103.

tivities of professionals,²³² to use antitrust's alternative Rule of Reason or "balancing" approach exclusively,²³³ and to establish a special test for professional or nonprofit activities that would permit acts which are "anticompetitive" but are intended to correct for the market failures that occur so often in the professional context.²³⁴

In our view, sufficient guidance on this issue may be obtained from an analysis of *Goldfarb*, *Professional Engineers*, and one earlier Supreme Court case involving professional self-regulation, *Silver v. New York Stock Exchange*.²³⁵ The major implication of these cases is that antitrust's full Rule of Reason or balancing approach is likely to be employed in the analysis of most hospital privilege questions, but there also is support in these cases for the application of per se rules to egregious anticompetitive behavior by hospitals and medical staffs.

Goldfarb held that a price-fixing agreement among lawyers violated section 1 of the Sherman Act, although the Court did not clearly apply antitrust's per se rule against price fixing.²³⁶ The Court also issued its broad and gentle dictum that "the public service aspect, and other features of the profession, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently."²³⁷ These are the features of *Goldfarb* that have been primarily responsible for spawning the variety of proposed special tests for antitrust analysis of professional behavior.

Professional Engineers provides some clarification. This case affirmed a lower court decision that had applied antitrust's per se rule against price fixing to a professional society's prohibition of price competition by civil engineers.²³⁸ The Supreme Court's approval of this per se approach was perhaps "not totally explicit,"²³⁹ but the proper

232. *Veizaga v. National Bd. for Respiratory Therapy*, 1977-1 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill. 1977).

233. *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977); *Bauer, Professional Activities and the Antitrust Laws*, 50 NOTRE DAME LAW. 570, 584-92 (1975); Note, *The Professions and Noncommercial Purposes*, *supra* note 83.

234. Note, *Antitrust and Nonprofit Entities*, 94 HARV. L. REV. 802 (1981). See also Liebenluft & Pollard, *supra* note 221 (professional behavior that would be subject to per se condemnation in other industries should be only presumptively illegal in order to allow procompetitive professional self-regulation for which there is no less restrictive alternative).

235. 373 U.S. 341 (1963).

236. See 421 U.S. at 780-83. The Court referred to the defendant's activities as "a classic illustration of price fixing," *id.* at 783, but the defendants did not put forward any affirmative justification for this price-fixing and thus the full test of the per se rule (the refusal to consider affirmative justifications) was not satisfied in this case.

237. 421 U.S. at 788 n.17.

238. *United States v. National Soc'y of Professional Eng'rs*, 389 F. Supp. 1193, 1199-200 (D.D.C. 1974), *aff'd*, 555 F.2d 978, 981-84 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679 (1978).

239. *Arizona v. Maricopa County Medical Soc'y*, 643 F.2d 553, 564-65 (9th Cir. 1980) (dissenting opinion), *cert. granted*, 450 U.S. 979 (1981). In *Professional Engineers* the Supreme Court appeared to hold that the professional society's ban on competitive bidding was illegal "[o]n its face," 435 U.S. at 692-93, a clear reference to antitrust's per se rule against price fixing. On the

reading of *Professional Engineers* is that the Court is now willing to apply antitrust's per se rule to price fixing by professionals.²⁴⁰ In any event, the Court's explicit rationale for rejecting the engineers' claim that price competition would harm engineering services was that antitrust law does not recognize defenses based "on the assumption that competition itself is unreasonable."²⁴¹ In other words, the Court held that antitrust analysis of professional behavior must be limited to the consideration of a restraint's "impact on competitive conditions," that is, to whether a restraint serves to "regulate and promote" or to "suppress" competition.²⁴² This apparent approval of a per se rule, combined with the Court's tough-minded rationale, certainly suggests that antitrust's standards, including its other per se rules, are not likely to be relaxed in favor of a special test for the professions.

On the other hand, in *Professional Engineers* the Court did indicate that antitrust courts should be sensitive to any special facts of professional behavior that may distinguish the professions from other occupations for the purposes of antitrust analysis. In its interpretation and restatement of the dictum in *Goldfarb*, the Court suggested that

[w]e adhere to the view expressed in *Goldfarb* that, by their nature, professional services may differ significantly from other business serv-

other hand, some uncertainty about the application of this per se rule to professional behavior may remain because the Court went on to conclude that the professional society's affirmative defense (that price competition would harm the quality of engineering services) "confirms rather than refutes the anticompetitive purpose and effect of its agreement." *Id.* at 693. As Judge Larson noted in his dissenting opinion in *Maricopa County*, this brief look at purpose and effect may constitute something of a "truncated rule of reason" approach rather than a straightforward application of the per se rule. 643 F.2d at 563.

Commentators differ on whether *Professional Engineers* applied a Rule of Reason or a per se approach. The basic issue in *Professional Engineers* was whether the professional society should have the opportunity to advance its affirmative defense that price competition would harm the quality of engineering services. On this issue, the Court held that antitrust's Rule of Reason did not allow recognition of the defense that competition itself was unreasonable. 435 U.S. at 692-96. If this reference to the Rule of Reason is a reference to the paradigm of all antitrust reasoning, as we believe, *see supra* note 3, then this holding would be consistent with the subsequent application of a per se rule that merely represents one kind of analysis under the Rule of Reason. *Accord* *Havighurst, supra* note 13, at 348 n.194; *Kissam, supra* note 16, at 149-50; *see supra* note 3. On the other hand, if the Court's reference to the Rule of Reason was meant to indicate that the Court was applying antitrust's alternative approach to per se analysis, as others seem to believe, *see* *Liebenluft & Pollard, supra* note 221, at 938 n.64; *Sullivan & Wiley, Recent Antitrust Developments: Defining the Scope of Exemptions, Expanding Coverage, and Refining the Rule of Reason*, 27 U.C.L.A. L. Rev. 265, 322-25 (1979), then the Court in *Professional Engineers* was perhaps avoiding the application of per se analysis to professional behavior.

240. *See Arizona v. Maricopa County Medical Soc'y*, 643 F.2d 553, 564-65 (9th Cir. 1980) (dissenting opinion), cert. granted, 450 U.S. 979 (1981). The justification for this prediction is that any affirmative defense of price fixing behavior will necessarily involve some claim that price competition is unreasonable. *See P. AREEDA, supra* note 100, §§ 306-11 (discussing possible social justifications for price fixing by competitors). In *Professional Engineers*, the Court was very clear that this type of claim is untenable under the antitrust laws. *See* 435 U.S. at 692-96.

241. 435 U.S. at 696.

242. *Id.* at 687-92.

ices, and, accordingly, the nature of competition in such services may vary. Ethical norms may serve to regulate and promote this competition and thus fall within the Rule of Reason.²⁴³

Most hospital privilege decisions probably can be characterized as "ethical norms" of the medical profession, since the Court seems to have used this term as a reference to market restraints that may potentially protect the public from harm without destroying competition.²⁴⁴ The Court's adjuration that antitrust decisions should be sensitive to special professional facts would thus appear to establish a presumption in favor of applying antitrust's full Rule of Reason or "balancing" approach to privilege questions and similar professional behavior.

Another implication of *Professional Engineers* follows from the preceding discussion. The decision indicates that any affirmative justification or defense of a particular privilege decision apparently must be framed in "procompetitive" terms.²⁴⁵ This means that an affirmative justification, to be deserving of weight, must show how the particular privilege decision helps to improve the competitive working of some market, for example, by increasing a provider's efficiency, by improving the quality of a provider's product, or by providing consumers with the opportunity to make better informed choices among providers. In other words, it no longer will suffice to defend privilege decisions merely by references to "the public welfare" or "consumer protection." In Kenneth Elzinga's helpful terms, one must show how a privilege decision promises to be "output expanding" rather than "output restricting" in order to establish a persuasive antitrust defense.²⁴⁶ For example, a decision to limit privileges to surgeons who are affiliated with a medical school may not be defensible simply as an act to promote "the public welfare," but rather must be shown to be part of a well-developed hospital plan to attract high quality physicians who will make the hospital more competitive with other hospitals in the region.²⁴⁷

Goldfarb and *Professional Engineers* thus appear to say that antitrust's rules should not be changed for the professions, although the rules should be applied with a special sensitivity to unique facts that may be involved with the delivery of professional services. Such "fact sensitivity" suggests in particular that a full Rule of Reason analysis may at times be appropriate in analyzing professional behavior even when a per se approach might be indicated by the precedents from

243. *Id.* at 696.

244. See *id.*, especially n.22.

245. *Id.* at 690-92.

246. See Elzinga, *The Compass of Competition for Professional Services*, in R. BLAIR & S. RUBIN, REGULATING THE PROFESSIONS 107 (1980).

247. See *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981).

other industries.²⁴⁸

This general position is supported by the *Silver* case, in which the Court held that collective action by members of a stock exchange to exclude a competitor would constitute a per se violation of the Sherman Act "absent any justification derived from the policy of another statute or otherwise."²⁴⁹ The question in *Silver* concerned whether the collective exclusion of a competitor was justified by federal securities law. The Court's reference to other justifications for industrial self-regulation, however, has been used by lower courts to establish the principle that legitimate industrial or professional self-regulation should be given a full Rule of Reason analysis.²⁵⁰ Yet this general standard, like the broad implications of *Goldfarb* and *Professional Engineers*, actually says little about what constitutes legitimate self-regulation. It should not preclude the application of per se rules to obvious instances of illegitimate self-regulation.

Lower court antitrust decisions involving the professions have tended to apply the full Rule of Reason balancing approach, or to entertain a "good faith" defense in cases that would have been subject to per se rules if the restraints had occurred in other industries.²⁵¹ This hesitancy to apply per se rules is perhaps justified on the ground that the professions are somehow "different" from other occupations.²⁵² On the other hand, this hesitancy also may be explained as part of the antitrust tradition that per se rules should be applied to new industries only after the accumulation of judicial experience with the special facts of

248. For other instances in which antitrust courts have displayed such "fact sensitivity," see *Broadcast Music v. Columbia Broadcasting Sys.*, 441 U.S. 1 (1979) (per se rule against price-fixing not applicable to an apparently unique market in the licensing of copyrighted material to broadcasters); *White Motor Co. v. United States*, 372 U.S. 253 (1963) (application of per se rule to a new fact situation should not be established on a motion for summary judgment); *United States v. Jerrold Elec. Corp.*, 187 F. Supp. 545 (E.D. Pa. 1960), *aff'd per curiam*, 365 U.S. 567 (1961) (recognizing "infant industry" exception to the per se rule against tie-in sales).

249. 373 U.S. at 348-49 (emphasis added).

250. See *Hatley v. American Quarter Horse Ass'n*, 552 F.2d 646, 651-54 (5th Cir. 1977); *United States Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 487 F. Supp. 1008, 1014-16 (N.D. Ill. 1980); *McCreery Angus Farms v. American Angus Ass'n*, 379 F. Supp. 1008, 1018 (S.D. Ill.), *aff'd*, 506 F.2d 1404 (7th Cir. 1974); *Denver Rockets v. All-Pro Management, Inc.*, 325 F. Supp. 1049, 1064-65 (C.D. Cal. 1971). See also *Bird, Sherman Act Limitations on Nonecommercial Concerted Refusals to Deal*, 1970 DUKE L.J. 247, 288-292; Note, *The Professions and Noncommercial Purposes*, *supra* note 83.

251. See, e.g., *Arizona v. Maricopa County Medical Soc'y*, 643 F.2d 553 (9th Cir. 1980) (rule of reason approach should be applied to maximum price fixing by physicians), *cert. granted*, 450 U.S. 979 (1981); *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977) (Rule of Reason approach should be used to analyze an alleged tie-in by professionals); *Veizaga v. National Bd. for Respiratory Therapy*, 1977-1 Trade Cas. (CCH) ¶ 61,274 (per se rules should only apply to "commercial" professional behavior); *Feminist Women's Health Center, Inc. v. Mohammad*, 415 F. Supp. 1258 (N.D. Fla. 1976) (recognizing a "good faith" defense to the claim of a per se illegal boycott), *rev'd on other grounds*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

252. See *supra* text accompanying notes 229-34.

competition in the industry.²⁵³ Another explanation may be the inherent difficulty in characterizing joint behavior by competitors as either a horizontal boycott or some more legitimate form of joint venture.²⁵⁴ These latter explanations appear more attractive to us, particularly in view of the Supreme Court's apparent approval of the *per se* rule against price fixing and the Court's exclusive focus upon a restraint's competitive impact in the *Professional Engineers* decision.

2. Procedural Due Process

The special problems of professional self-regulation have prompted courts to go beyond the Rule of Reason analysis and develop due process requirements to govern the activities of professional regulatory bodies. JCAH accreditation standards, state statutes and regulations, and various constitutional and common law doctrines already require that many hospitals provide a fair procedure to applicants for hospital privileges.²⁵⁵ All hospitals are not covered by these requirements, however, and these standards and their sanctions are variable and often ineffectual in ensuring that applicants are provided with a meaningful hearing.²⁵⁶ Application of antitrust law to privilege decisions, by contrast, could require that all hospitals provide privilege applicants with a "basic" but significant procedural due process. This would mean providing notice, an opportunity to be heard, a right to counsel, and reasons for the decision. Furthermore, if antitrust law requires due process, the treble damage remedies available to injured antitrust victims²⁵⁷ should be an effective sanction that would help ensure that procedural due process is provided as a matter of course.

In the *Silver* case, the Supreme Court recognized that self-regulation by members of a stock exchange might be exempt from antitrust law because the self-regulation was required by a federal securities statute. The Court held, however, that a violation of basic due process by the self-regulators placed their exclusion of a competitor outside the

253. See, e.g., *Mackey v. National Football League*, 543 F.2d 606 (8th Cir. 1976); Note, *The Professions and Noncommercial Purposes*, *supra* note 83, at 397 n.32.

254. See L. SULLIVAN, *supra* note 151, §§ 86-88.

255. See *supra* note 21.

256. For example, the JCAH accreditation requirement of procedural due process is a very general one. It fails to provide for the rights to confront adverse evidence and cross-examine adverse witnesses and only notes the possibility of "the role, if any, of legal counsel." It also fails to speak to the question of providing an impartial decisionmaker. See JCAH MANUAL, *supra* note 1, at 92. These rights may be particularly crucial in view of the possible bias of medical staff members in general, see *supra* Part II, as well as the obvious importance of the chief of service in any decision to deny privileges, see JCAH MANUAL, *supra* note 1, at 83. In addition, the JCAH does not expect full compliance with all standards and guidelines by accredited hospitals, *id.* at xvii, and therefore violations of this due process standard will not necessarily be sanctioned by the JCAH.

257. 15 U.S.C. § 15 (1976).

scope of this exemption. Three reasons were given for this rule: that a fair hearing would not defeat any policy of the securities law, that the duty to give reasons and afford an opportunity to answer would help ensure that self-regulators worked within the intended purposes of the securities law and antitrust exemption, and that the hearing would contribute to the effective functioning of antitrust courts by providing the court with better evidence of the self-regulators' purposes.²⁵⁸

By analogy, the *Silver* rule seems clearly applicable to hospital privileges. A fair hearing will not defeat those exclusionary privilege decisions based on legitimate hospital policies that are aimed at providing better quality, lower cost services, or more effective competition in the sale of hospital services. These policies can be characterized as procompetitive or output expanding and are the best antitrust justification for exclusionary decisions. A fair hearing will also help maintain the hospital's focus on the procompetitive purposes of privilege decisionmaking and contribute to the effective functioning of an antitrust court that reviews the privilege decision. A fair hearing at the hospital, in contrast to a court suit, should provide a better opportunity for the free and full airing of the many different views and interests of hospital administrators, physicians, and other health care practitioners.

A fair hearing requirement will raise questions of what constitutes adequate procedural due process for antitrust purposes. Some informality in procedures undoubtedly is appropriate, in view of the nature of a hospital organization and the technical issues that may be involved.²⁵⁹ The possible anticompetitive interests of the medical staff, however, should support recognition of a substantial package of procedural rights. Hospital privilege cases decided under the due process clause of the fourteenth amendment²⁶⁰ may provide useful guidance in this regard. In particular, the Fifth Circuit's recent decision in *Shaw v. Hospital Authority of Cobb County*²⁶¹ appears to provide a good model for balancing the applicant's and hospital's interests in a privilege hearing. In *Shaw*, a podiatrist was provided with "meaningful hearings," which included the right to counsel and the right to confront all adverse evidence and witnesses, before both the medical staff and hospital

258. 373 U.S. at 361-63.

259. Cf. *Board of Curators of Univ. of Missouri v. Horowitz*, 435 U.S. 78 (1978) (a medical school's informal and ex parte procedures for excluding a medical student on academic grounds satisfy the due process requirement of the United States Constitution). On the need to balance interests of the decisionmaking organization against the needs of an applicant for a particular kind of hearing in determining due process as a constitutional matter, see *id.*; *Mathews v. Eldridge*, 424 U.S. 319 (1976); see also *Cray*, *supra* note 21, at 246-49 (balancing the interests of the hospital against those of privilege applicants as a constitutional matter).

260. U.S. CONST. amend. XIV, § 1. For discussion of hospital privilege cases decided under this provision, see *Cray*, *supra* note 21; *McCall*, *supra* note 21, at 188-95.

261. 614 F.2d 946 (5th Cir. 1980).

board.²⁶² These rights, together with a right to the most impartial decisionmakers feasible, seem essential when many participants in the decisionmaking process may be substantially biased against the privilege applicant.²⁶³

The *Silver* rule, however, should not be expanded to justify "rigorous" or "close" judicial scrutiny of the *reasons* that hospitals may give for privilege decisions that exclude health care practitioners. The reviewing court, in other words, should be willing to accept reasons that are only arguably legitimate and should avoid making an independent judgment about the validity or legitimacy of the hospital's reasons.²⁶⁴ To be sure, the concept of a fair procedure in its fullest sense includes giving satisfactory reasons. If antitrust courts use a due process rationale to evaluate the reasons for privilege decisions on an independent basis, however, the analytical process will move towards the realm of "substantive due process," including the specter of inappropriate judicial interference with a hospital's managerial prerogatives. To illustrate, consider that many privilege denials may be based on allegedly technical but rather general grounds, such as that the applicant is "incompetent," "unqualified," or "unable to function smoothly with the staff."²⁶⁵ Careful scrutiny of these reasons by antitrust courts would eliminate the possibility of using subjective judgments to promote effective teamwork and the functioning of "health care teams" within the hospital's walls.²⁶⁶ Both constitutional and antitrust courts appear to have been sensitive to these considerations, generally refraining from requiring more than a "basic" or "minimum" procedural due process from hospitals and other professional institutions that need to explain exclusionary decisions.²⁶⁷ Of course, if there is other evidence of antitrust abuse and the vague reasons are merely a cover for a decision to exclude the practitioner for anticompetitive purposes, a different issue is presented. In that case, a more careful analysis of the privilege decision will be justified under other rules of antitrust law that apply to the substance of exclusionary behavior rather than its procedure.

For the purpose of analyzing exclusionary privilege decisions

262. *Id.* at 951.

263. See *supra* note 256.

264. Cf. Gunther, *Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1 (1972) (courts should not question the particular ends of government on economic and social policy issues).

265. See, e.g., Robbins v. Ong, 452 F. Supp. 110 (S.D. Ga. 1978); Sosa v. Board of Managers, 437 F.2d 173, 176-77 (5th Cir. 1971); Miller v. Eisenhower Medical Center, 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980).

266. See Ludlam, *Physician-Hospital Relations: The Role of Staff Privileges*, 35 LAW & CONTEMP. PROBS. 879, 885-88 (1970).

267. See, e.g., Board of Curators of Univ. of Missouri v. Horowitz, 435 U.S. 78 (1978); Shaw v. Hosp. Auth., 614 F.2d 946 (5th Cir. 1980); Robbins v. Ong, 452 F. Supp. 110 (S.D. Ga. 1978); Miller v. Eisenhower Medical Center, 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980).

under these other rules, privilege decisions may be divided usefully into the categories of physician cartel decisions, joint venture decisions, and the decisions of an employer hospital.²⁶⁸ Each of these categories deserves a different kind of antitrust analysis, and these are developed in the following sections.

3. Physician Cartel Decisions

When hospitals and medical staffs agree or act consistently to deny privileges to other physicians because of their status as competitors, physician cartel behavior is indicated and the situation may be characterized as a group boycott of competitors, or "horizontal boycott." This situation seems indistinguishable from the facts in *American Medical Association v. United States*,²⁶⁹ in which the Supreme Court held that a concerted refusal by fee-for-service physicians to deal with HMO physicians violated the Sherman Act. Physician cartel decisions on privileges also are indistinguishable from the line of more recent Supreme Court cases that have held group boycotts against competitors *qua* competitors to be per se antitrust violations.²⁷⁰ To be sure, the application of antitrust's per se rules to professional behavior remains an open question.²⁷¹ Yet it is unlikely that physician cartel decisions will survive any antitrust approach, whether per se, balancing of effects, or some intermediate analysis, because of a cartel's clear harms to competition and the absence of any procompetitive justification for these kinds of decisions.

At least three types of privilege decisions appear to fall within the category of physician cartel behavior. Two others, which at first appear to be cartel behavior, are better analyzed as joint venture decisions. The first type of physician cartel behavior includes any decision to exclude physicians because of their association with HMOs, ambulatory surgical centers, or other medical care institutions that provide services in direct competition with fee-for-service physicians on the hospital's medical staff. There is no procompetitive justification for this kind of decision. The defendants may argue that they are helping to ensure an adequate quality of medical care in the community by refusing to cooperate with "low quality" institutions,²⁷² but the quality of other institutions will not affect the quality and costs of hospital services. This defensive argument should be addressed to the public authorities that are responsible for regulating medical care in the community rather

268. See *supra* text accompanying notes 67-75.

269. 317 U.S. 519 (1943).

270. See *supra* note 227 and accompanying text.

271. See *supra* text accompanying notes 229-54.

272. See, e.g., *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530 (5th Cir. 1978), cert. denied, 444 U.S. 924 (1979).

than to a hospital and antitrust court. Antitrust law in general does not recognize the defense that a private group has assumed responsibility for a governmental function.²⁷³

There may be some difficult borderline issues that relate to this type of physician cartel behavior. A hospital may deny various kinds of special access to competing medical care institutions, an occurrence which in form appears analogous to the denial of privileges to that institution's physicians. Suppose, for example, that privileges are granted to an HMO's physicians but not to the HMO's nurse practitioners, who have been trained and licensed to manage low-risk pregnancies under the supervision of the HMO's obstetricians.²⁷⁴ Or, suppose that a hospital refuses to enter into a backup services arrangement to provide inpatient care for complications that may develop in patients at an ambulatory surgical center.²⁷⁵ These cases will require a preliminary analysis of the hospital's quality of care claims,²⁷⁶ although we suspect that such claims often may fail to implicate the independent interests of the hospital in the quality and costs of its operations. If these latter interests are implicated, however, then the decision to deny special access to the competing institution should be analyzed as a joint venture decision by the hospital and medical staff as discussed in the next section.

A second type of physician cartel behavior would be the enactment of a bylaw or some pattern of privilege decisions that limits hospital privileges to physicians who join the existing partnerships of medical staff physicians.²⁷⁷ Exclusive privilege contracts in hospital-based specialties such as radiology may be justified by independent hospital interests,²⁷⁸ but there is no procompetitive justification for general hospital-wide exclusive privileges or for exclusive privileges that result merely from an individual physician's bargaining power. Any quality control that may be claimed for this system (for example, experienced partners evaluating and supervising the new ones) could be established just as easily as part of the hospital's intrainstitutional peer review. Moreover, competition among physicians in the community may be se-

273. *Fashion Originators' Guild of America v. FTC*, 312 U.S. 457, 465-66 (1941).

274. See Kissam, *supra* note 13, at 504-08.

275. See *Feminist Women's Health Center v. Mohammad*, 415 F. Supp. 1258, 1265 (N.D. Fla. 1976), *rev'd on other grounds*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

276. Cf. *Doctors' Maximum Fee Agreements With Approved Insurers are Subject of Supreme Court Argument*, ANTITRUST & TRADE REG. REP. (BNA) No. 1038, at DD-2 (Nov. 5, 1981) (argument by the United States Solicitor General that antitrust courts should undertake a "preliminary inquiry" or "quick look" to determine whether a price-fixing agreement, which appears to be per se illegal on its face, may be an integral part of a "procompetitive" joint venture and thus deserving of further examination at trial under antitrust's Rule of Reason approach).

277. On the apparent prevalence of this type of exclusionary behavior, see Horan & Nord, *supra* note 5, at 701-02.

278. See *id.* at 702; *infra* text accompanying notes 332-70.

verely damaged by such exclusive privileges, even if the same number of physicians should enter the market as would have entered under a more liberal privileges system.²⁷⁹ Enforced entry into existing partnerships will reduce the number of economic decision-makers in each specialty market, and this will increase the possibilities for collusive economic behavior by the sellers in each market.²⁸⁰ In addition, enforced entry into existing partnerships is likely to reduce the competitive ardor and instincts of new physicians, since incumbent physicians will be able to manage the development of the new physicians' practices.²⁸¹

A system of exclusive privileges in each specialty would give each partnership the power to veto competitors who seek to join the hospital's staff. This situation is difficult to distinguish from the facts in *Associated Press v. United States*.²⁸² The Court there held that an Associated Press bylaw, which allowed AP members to veto membership for newspapers serving the same communities, violated section 1 of the Sherman Act without any need to establish the bylaw's specific effects upon newspaper competition.²⁸³ Admittedly, a factor in the *Associated Press* decision was the market power (but not monopoly power) enjoyed by the AP in the gathering and dissemination of news.²⁸⁴ Hospitals and their medical staffs, however, often may possess similar market power because of a hospital's location, its relatively unique services, and other special factors such as the religious affiliations of its physicians and patients.²⁸⁵ In view of the substantial anticompetitive effects and lack of procompetitive justification for hospital-wide exclusive privileges, the *Associated Press* case and its progeny should be sufficient precedent to hold that such a system is a per se violation of the Sherman Act.²⁸⁶

279. One may doubt that the same number of physicians will enter a particular market when a hospital only grants privileges to physicians who join existing partnerships of staff physicians. Under this privilege system, the partnerships will have a veto over privilege applicants in their specialty, and there is no reason to believe that medical partnerships will want to expand at an optimal rate to meet market demand. Cf. Pauly & Redisch, *supra* note 58 (physician control over hospital privileges may result in a suboptimal use of hospitals).

280. On the possibilities for price fixing by physicians who practice in the same local market, see Havighurst & Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, 4 J. HEALTH POL., POL'Y & L. 48, 54-56, 63-65 (1979). On collusive behavior by oligopolists in general, see R. POSNER, *supra* note 3, at 39-77.

281. We owe this point to Stanley Wallack, Director of the Center for Health Policy and Research at Brandeis University.

282. 326 U.S. 1 (1945).

283. *Id.* at 12.

284. *See id.* at 12-14.

285. *See supra* text accompanying notes 38-39.

286. For a recent case on point, see Tyson's Corner Regional Shopping Center, 85 F.T.C. 970 (1975) (a lease provision allowing a commercial tenant to veto any applicant for another tenancy in the shopping center is per se illegal).

A third category of physician cartel decisions consists of other opposition to physicians and groups of physicians that can be explained only by a desire on the part of the medical staff (or individual members) to punish competitors and eliminate competition. Such decisions might include consistent opposition to osteopaths,²⁸⁷ to general practitioners,²⁸⁸ or to physicians who advertise and otherwise seek clients in an aggressive manner.²⁸⁹ This category also would include instances of opposition to medical specialists, who have more training than current members of the staff and thereby threaten to take away patients by reason of their greater training.²⁹⁰ This residual category should also include any decision to limit privileges because the community has "enough" physicians,²⁹¹ or to limit privileges to physicians who can obtain references from members of the hospital's medical staff.²⁹² Another form of physician cartel behavior occurs when a hospital denies privileges or other kinds of access to nonphysicians without giving any reason that relates to the hospital's interests in the quality and efficiency of hospital services.²⁹³

The exclusion or severe limitation of privileges for physician assistants and physician-supervised nurse practitioners²⁹⁴ might appear to be a fourth type of physician cartel decision. On the one hand, this limitation might be viewed as a medical staff's (partial) refusal to deal with competitor physicians who would employ and supervise the work of these new health practitioners. This view would be supported by the fact that the quality of work of these allied health professionals is controlled both by state licensure and by the moral, economic, and legal responsibilities of their supervising physicians.²⁹⁵ At least in theory, hospitals need not have any independent concern or interest in the

287. See *supra* note 218 and accompanying text.

288. See Sanders, *supra* note 6.

289. Cf. American Medical Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 50 U.S.L.W. 4313 (U.S. Mar. 23, 1982) (the AMA's ethical rule against physician advertising violates federal antitrust law).

290. Cf. *In re Sherman A. Hope, M.D.*, 3 TRADE REG. REP. (CCH) ¶ 21,791 (FTC consent order, Aug. 5, 1981) (settlement of an FTC complaint that five doctors threatened to boycott a Texas hospital for offering employment to a board certified obstetrician-gynecologist).

291. See *supra* note 219. Attempts to control the number of physicians who serve a community, like attempts to control the quality of medical care in the community at large, should be the responsibility of public authorities rather than hospitals. See *supra* text accompanying notes 272-73.

292. Cf. Ascherman v. St. Francis Memorial Hosp., 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1st Dist. 1975) (requirement of three references from staff physicians is unreasonable and violates the common law standards of fair procedure).

293. A case of this sort is discussed *infra*, text accompanying notes 396-99.

294. See generally THE NEW HEALTH PROFESSIONALS (A. Bliss & E. Cohen eds. 1977); Kissam, *supra* note 69.

295. See Kissam, *supra* note 69, at 20-29, 31-34.

quality of care provided by these "dependent" medical care practitioners.

On the other hand, the employment of these practitioners does in some elemental way change the quality of hospitalization services, or certainly the perception of quality, if not its fact. It also may increase the administration or transaction costs of hospitals, which will need to establish new procedures for ensuring that the physician assistants and nurse practitioners 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.²⁹⁶ In this view, the change of quality by the use of physician assistants or nurse practitioners 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.

A fifth possible kind of physician cartel decision might be the establishment of geographical boundaries for the granting of privileges, which give a preference or exclusive privileges to physicians whose primary offices are in the same county as the hospital or within a certain number of miles from the hospital.²⁹⁷ This device could be used simply to limit the number of physicians who have privileges or, more specifically, to limit the competition for patients between hospital-based physicians and general practitioners in outlying communities. In this view, geographical limits on the granting of privileges would be analogous to group boycotts and market division agreements, which are both per se violations of section 1.²⁹⁸ On the other hand, it is possible that a hospital might establish this kind of limitation in order to ensure the availability of physicians in the case of patient emergencies. Or a public hospital might employ a geographical limitation to allocate a greater proportion of its services to local taxpayers, who subsidize the hospital's operations.²⁹⁹ This conduct, together with the other devices that can be used to prevent "overcrowding" in a hospital, is perhaps better analyzed as joint venture decisionmaking.³⁰⁰

296. On the issue of malpractice liability for nurse practitioners, see Note, *A Revolution in White—New Approaches in Treating Nurses as Professionals*, 30 VAND. L. REV. 839-855-79 (1977).

297. Cf. *Sams v. Ohio Valley Gen. Hosp. Ass'n*, 413 F.2d 826 (4th Cir. 1969) (hospital's requirement that all medical staff members practice within county violates fourteenth amendment).

298. The leading group boycott cases are cited *supra* note 227. On the per se rule against market division agreements, see *United States v. Topco Assocs., Inc.*, 405 U.S. 596 (1972); *United States v. Associated Patents, Inc.*, 134 F. Supp. 74 (E.D. Mich. 1955), *aff'd per curiam sub nom. Mac Inv. Co. v. United States*, 350 U.S. 960 (1956).

299. See *Sams v. Ohio Valley Gen. Hosp. Ass'n*, 413 F.2d 826, 830-32 (4th Cir. 1969) (dissenting opinion).

300. This issue is discussed *infra* at text accompanying notes 330-31.

4. Joint Venture Decisions

Many privilege decisions that may have substantial anticompetitive effects seem to result from "joint venture" decisions by hospitals and medical staffs, in the sense that a hospital and medical staff happen to agree upon the decision on the basis of their own independent interests.³⁰¹ Some of these decisions, characterized here as "technical", will exclude certain categories of health care providers. They include reliance upon specialty board certification to delineate privileges for different groups of practitioners,³⁰² the exclusion or limitation of privileges for independent practitioners such as clinical psychologists, independent nurse practitioners, podiatrists, and chiropractors,³⁰³ and the exclusion or limitation of privileges for dependent practitioners such as physician assistants and nurse practitioners who work under a supervising physician.³⁰⁴ Joint venture decisions also may include "economic" restrictions that are designed to limit the general size or nature of the medical staff, such as "moratoriums" on the grant of new privileges³⁰⁵ and geographical limitations of the kind described immediately above. All of these decisions may exclude significant competitors of incumbent staff members, but there is room in these cases for legitimate and independent quality of care and efficiency claims by the hospital administration, acting as a representative of its community and as an independent entity that is concerned about marketing hospital services and reducing its exposure to malpractice liability. In the discussion that follows, we look first at the relevant joint venture precedents in antitrust law and then consider their application to both "technical" and "economic" joint venture decisions on hospital privileges.

The term "joint venture" is a business term that is too general to serve much use in antitrust law, except as used here to distinguish be-

301. See *supra* text accompanying notes 67-75.

302. The JCAH accreditation standards encourage the use of specialty board certification "as an excellent benchmark to serve as a basis for privilege delineation." JCAH MANUAL, *supra* note 1, at 84.

303. JCAH accreditation standards provide that hospitals "may" grant limited clinical privileges to podiatrists, but these privileges are subject to consultation rules that include the requirement that podiatrists may admit and discharge patients only upon the concurrence of a physician. *Id.* at 85. These standards also permit more limited kinds of privileges to be granted to "specified professional personnel," who may only work under the "supervision or direction" of a physician member of the medical staff who has "ultimate responsibility" for the patient. *Id.* at 86. These latter kinds of privileges are presumably worthless for most independent allied health practitioners such as clinical psychologists or chiropractors.

304. The JCAH standards described *supra* note 303 appear to contemplate that physician assistants and nurse practitioners who are supervised by physicians may work in hospitals that desire to allow such practitioners.

305. On the use of privilege "moratoriums" to relieve overcrowding in hospitals, see *Guerrero v. Burlington County Memorial Hosp.*, 70 N.J. 344, 360 A.2d 334 (1976); *Walsky v. Pascack Valley Hosp.*, 145 N.J. Super. 393, 367 A.2d 1204 (Ch. Div. 1976); *Davis v. Morristown Memorial Hosp.*, 106 N.J. Super. 33, 254 A.2d 125 (Ch. Div. 1969).

tween broadly defined categories of collective behavior.³⁰⁶ In antitrust law the term usually denotes a group of independent economic actors who have joined together, in part, to provide a common product or service. These activities are usually analyzed under antitrust's Rule of Reason balancing approach, and joint ventures generally have been upheld if there are "legitimate business reasons" for the activity.³⁰⁷ Under this approach, plaintiffs challenging joint venture privilege decisions may have a rather substantial burden of proof, since they will have to show how the (often speculative) anticompetitive effects in some market for medical services are more significant than the (often speculative) procompetitive effects that might be realized by allowing a hospital to maintain its current quality of care. To be sure, the hospital decision may be quite conservative and based only on opinion rather than upon "objective" data that measures the quality of care.³⁰⁸ Nevertheless, antitrust plaintiffs will be contending with the traditional reluctance of antitrust courts to second-guess decisions by business enterprises,³⁰⁹ as well as the apparent reluctance of antitrust courts to second-guess professional decision-making on matters that seem to affect the technical aspects of professional practice.³¹⁰

Plaintiffs may attempt to use two arguments to discredit the defendants' joint venture characterization of the "technical" and "economic" privilege decisions discussed in this section. One would be that these decisions are in fact analogous to a group boycott, in which retailers (the medical staff) request a manufacturer or wholesaler (the hospital) to refuse to deal with competitors of the retailers.³¹¹ The short answer to this argument should be that the hospital, unlike the manufacturer in the boycott situation, has a substantial interest of its own that both explains and justifies the hospital's participation in the exclusionary decision.³¹² Of course, if there is no such independent interest present, the decision should be characterized as a physician cartel and

306. See Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin*, 82 HARV. L. REV. 1007, 1007 (1969).

307. See *id.* at 1018.

308. Most measures of health care quality focus upon input and process characteristics rather than health outcomes. See, e.g., Williams & Brook, *Quality Measurement and Assurance*, HEALTH & MED. CARE SERV. REV., May-June 1978, at 1. Thus, even where hospital privilege denials are based on professionally recognized standards of quality, there is likely to be a very significant subjective element in the decision. See also Dolan & Ralston, *supra* note 3, at 728-31, 733-34.

309. See, e.g., Cooper, *Attempts and Monopolization: A Mildly Expansionary Answer to the Prophylactic Riddle of Section Two*, 72 MICH. L. REV. 373, 440-41 (1973).

310. See Kissam, *supra* note 16, at 146-56.

311. See Robinson v. Magovern, 521 F. Supp. 842, 904-13 (W.D. Pa. 1981); Dolan & Ralston, *supra* note 3, at 752-56. The leading cases that discuss this boycott theory are United States v. General Motors Corp., 384 U.S. 127 (1966); Radiant Burners v. Peoples Gas, Light & Coke Co., 364 U.S. 656 (1961); Klor's v. Broadway-Hale Stores, 359 U.S. 207 (1959).

312. See Robinson v. Magovern, *supra* note 311, at 842, 907-13.

the group boycott analogy would be appropriate.³¹³

The second argument would be that the hospital constitutes a "bottleneck" or "essential facility" and is therefore obligated to provide its services to privileged applicants and their patients.³¹⁴ Either of two responses may be appropriate to this sort of argument. The relatively easy one, which will not do in all cases, is to observe that this doctrine requires the defendant to have virtually a total monopoly over some service before the defendant is obligated to provide its services to all comers.³¹⁵ The second response is that the precedents for this doctrine are limited to two situations that are inapposite to joint venture privilege decisions. One is where a monopolist refuses an essential facility or service to its competitor,³¹⁶ a characterization that generally will not apply to the relationship between a hospital and a privilege applicant since they are not in direct competition. The other situation is where a joint venture of competitors has excess capacity and excludes sellers of services that are identical to those sold by the joint venture or its members. In two such cases, the Supreme Court has ordered joint ventures to grant membership or extend service to excluded competitors. The facts of these cases, however, suggest that they may be distinguished from the general type of joint venture hospital privilege decision.

*United States v. Terminal Railroad Association*³¹⁷ involved a group of railroads that controlled the only effective railroad access across the Mississippi River into St. Louis. *Associated Press* concerned an international newsgathering service that was owned by "an overwhelming majority of American [newspaper] publishers."³¹⁸ Both joint ventures clearly possessed substantial market power. More importantly, both were excluding competitors whose services were identical to those sold by members of the joint venture, they both had unused capacity. These circumstances supported findings of anticompetitive purpose and effect, because the defendants could not argue that the exclusion of competitors was necessary to allocate scarce resources or to maintain a given level of quality. The excess capacity and identity of the producers also made the issue of remedy a relatively easy one, since the excluded com-

313. See *supra* text accompanying notes 269-300.

314. See *Robinson v. Magovern*, *supra* note 311, at 913; *Calvani & James*, *supra* note 3, at 81-83; *Dolan & Ralston*, *supra* note 3, at 744-48. The leading case that would support this theory is probably *Hecht v. Pro-Football*, 570 F.2d 982, 992-93 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978).

315. See *Otter Tail Power v. United States*, 410 U.S. 366, 377-78 (1973); *Hecht v. Pro-Football*, 570 F.2d 982, 988-92 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978); *Robinson v. Magovern*, 521 F. Supp. at 913.

316. See *Otter Tail Power v. United States*, 410 U.S. 366, 377-78 (1973); *Hecht v. Pro-Football*, 570 F.2d 982, 988-92 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978); *United States v. Standard Oil Co.*, 362 F. Supp. 1331, 1341 (N.D. Cal. 1972), *aff'd*, 412 U.S. 924 (1973).

317. 224 U.S. 383 (1912).

318. *Associated Press v. United States*, 326 U.S. 1, 17 (1945).

petitors could be admitted to the joint venture on the same terms as existing members. In contrast, the joint venture privilege decisions considered in this section will typically involve the exclusion of providers who offer qualitatively different services from the hospital's incumbent medical staff, or else they will involve exclusions based on a hospital's claim that it does not have excess capacity that is sufficient to support the award of additional privileges. In either situation, it would be a mistake to simply follow the "essential facility" or "bottleneck" precedents and award hospital privileges to the applicants without a more careful analysis of the competing interests, purposes, and effects.

Joint venture activities are usually analyzed under the Rule of Reason balancing approach,³¹⁹ but joint venture privilege decisions have some unique aspects that call for a modified version of this analysis. Privilege decisions that address "technical" concerns and delineate privileges on the basis of specialty board certification, or exclude allied health practitioners such as psychologists, nurse midwives, and physician assistants, will be based largely upon the accreditation and certification standards of organized medicine. These standards will provide the basis for the hospital's judgment that its quality of care will be improved by these exclusionary decisions. Many of these standards, however, are based solely upon professional opinion about good quality care rather than upon objective studies that document the quality enhancing effects of the standards in terms of improved health outcomes.³²⁰ In this important way, professional credentialing standards are unlike the certification standards for industrial products, which typically are based upon some objective documentation of output quality.³²¹ It thus may appear that the reliance of hospitals upon these professionally-sponsored standards should be suspect and deserving of careful antitrust scrutiny.

We question, however, whether antitrust courts should second-guess the decisions of hospitals to rely upon opinion-based standards of professional quality. The general tendencies of antitrust courts to defer to enterprise decision-making and to professional judgments on the technical aspects of professional behavior, as well as the leading precedents on joint ventures, suggest instead that antitrust courts should approach these sorts of privilege decisions rather cautiously. In our view, antitrust courts should be unwilling to condemn "technical" joint venture privilege decisions without obtaining persuasive evidence that a particular decision has a sole or dominant anticompetitive purpose and that the hospital possesses substantial market power.

319. See *supra* note 307 and accompanying text.

320. See *supra* note 308.

321. See, e.g., *Structural Laminates, Inc. v. Douglas Fir Plywood Ass'n*, 261 F. Supp. 154 (D. Or. 1966), *aff'd*, 399 F.2d 155 (9th Cir. 1968), *cert. denied*, 393 U.S. 1024 (1969).

The purpose-based rule we suggest deserves some extended discussion, since it is not clearly expressed in the leading precedents although it may be drawn from them.³²² First, the term "anticompetitive purpose" is meant to focus analysis upon the ultimate goals or objectives of the hospital's privilege decision rather than upon the obviously intended effect to exclude someone as a means to a desired end.³²³ Also, the "motives" of particular staff members may be relevant evidence in determining the hospital's purposes, but evidence of individual motives should not detract antitrust courts from focusing upon the overall purposes of the collective institution.³²⁴ Furthermore, the anticompetitive purpose should be the "sole" or "dominant" purpose for the privilege decision, in order to ensure that antitrust courts provide appropriate deference to hospital and staff judgment about the hospital's need for a certain technical quality.³²⁵ In theory it might be preferable to con-

322. The leading cases, *Associated Press* and *Terminal Railroad Association*, are discussed *supra* in the text accompanying notes 301-02. See also *Gamco, Inc. v. Providence Fruit & Produce Bldg.*, 194 F.2d 484, 488 (1st Cir.), cert. denied, 344 U.S. 817 (1952) (the conjunction of economic power and a motive to exclude, when the exclusion is not "justified by reasonable business requirements, establishes a *prima facie* case of the purpose to monopolize"). *Gamco* uses § 2 analysis to condemn the exclusion of a tenant from a valuable commercial location, but the building was owned jointly by several of the tenant's competitors and *Gamco* may be viewed as a joint venture case as well.

In addition, two courts of appeals have dealt with the exclusion of podiatrists and psychologists from "joint ventures" of physicians and hospitals. These decisions also suggest that a clear anticompetitive purpose and substantial market power of the hospital may be required for antitrust condemnation of joint venture privilege decisions. In *Levin v. Joint Comm'n on Accred. of Hosps.*, 345 F.2d 515 (D.C. Cir. 1965), a podiatrist claimed that the JCAH and a hospital had conspired to deprive him of clinical privileges at the hospital. The District of Columbia Court of Appeals reversed the district court's summary judgment for the hospital, but it did so on the ground that summary procedures are to be used sparingly in complex antitrust litigation and that the defendants' affidavits had left "some uncertainties as to the fact and extent of agreement, as well as to the parties, purposes and motivations involved." *Id.* at 518. Then in *Virginia Academy of Clinical Psychols. v. Blue Shield*, 642 F.2d 476 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981), the Fourth Circuit held that two Blue Shield plans had violated the Sherman Act by refusing to reimburse clinical psychologists directly, when the plans did reimburse physicians for psychologist services provided under physician control. This court relied in part upon the "dominant" position of the Blue Shield plans in the Virginia medical insurance market. *Id.* at 485. It also relied upon evidence that the refusal to provide direct reimbursement had resulted from concerted action by psychiatrists and other physicians to refuse to deal with "independent" psychologists. This latter evidence included the fact that physicians controlled the Blue Shield plans, that each plan had provided direct reimbursement to clinical psychologists at other times, and that the "quality of care" claim about the need for medical supervision of psychologists' services was inconsistent with the plans' reimbursement of psychologist services through *any* physician, psychiatrist or general practitioner. *Id.* at 478-81, 484-86. In other words, it is fair to conclude that this court found that the Blue Shield plans, as corporate entities, had no independent interest in the decision to exclude clinical psychologists and that the decision was essentially the result of a physician cartel that had market power and acted with a clear anticompetitive purpose.

323. See *supra* note 4.

324. *Id.*

325. Our suggestion that antitrust courts employ a purpose-based test to grant deference to hospital enterprises is analogous to the requirement that some racially motivated purpose is necessary before facially neutral government acts with discriminatory impact on racial minorities may

demonstrates privilege decisions only if the "sole" purpose were anticompetitive, but in practice there will be multiple possible purposes for any institutional action, and some balancing of possible purposes to determine which is the "sole" purpose would seem inevitable. It thus would be conceptually more straightforward to recognize this inevitable balancing and use a "dominant" anticompetitive purpose as the standard for condemning joint venture privilege decisions.

Second, the requirement that the hospital possess substantial market power will help ensure appropriate judicial deference to the enterprise and professional judgments of the hospital in several ways. This requirement, of course, will help measure the anticompetitive effects of any particular exclusion, thus limiting judicial inquiry to those joint venture decisions where substantial anticompetitive effects are likely. In addition, the requirement of substantial market power will reinforce the validity of the findings of anticompetitive purpose, since an anticompetitive purpose is more likely when a hospital and medical staff know that they can effectively exclude competitors from some relevant market. And finally, the requirement of market power will help limit the adverse social consequences that may follow from antitrust courts making mistakes in their judgments about the dominant purposes of joint venture privilege decisions.³²⁶

It may be objected that this purpose-based approach would be inconsistent with the antitrust tradition of balancing anticompetitive effects against procompetitive effects, while using evidence of good and bad purposes only to help "interpret" effects.³²⁷ Yet a purpose-based rule for technical joint venture decisions would be consistent with this tradition; the quality-enhancing and restrictive effects of professional credentialing standards would appear to be quite incomensurable, and any attempt to balance these effects on an ad hoc basis would seem to be a rather incoherent undertaking, at least in practice if not in theory.

For example, suppose that a community hospital were to require that only board certified obstetricians could deliver babies. Suppose also that the immediate effect of this bylaw is to exclude a new family practitioner who is interested in developing a substantial obstetrics practice, and a few general practitioners who occasionally have delivered babies in the past. The immediate beneficiaries in economic terms

be treated as racial classifications subject to strict judicial scrutiny under Equal Protection doctrine. *See Washington v. Davis*, 426 U.S. 229 (1976). This constitutional test is also designed to limit judicial activism in the review of enterprise decisionmaking. *See Mishkin, Equality*, 43 LAW & CONTEMP. PROBS. 51, 52-54 (Summer 1980).

326. Cf. Cooper, *supra* note 309, at 400-01 (retaining the "substantial market power" requirement in the law of attempts to monopolize would yield the benefits noted in this paragraph).

327. *See Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918); *see also supra* note 3.

are the several board-certified obstetricians on the hospital's staff. In this situation, it would seem difficult if not impossible for an antitrust court to determine, without clear evidence of purpose, if the potential anticompetitive effects in terms of reduced choice and possibly higher prices for consumers outweigh the bylaw's procompetitive effects in terms of allowing the hospital to offer higher quality services that attract both physicians and patients to the hospital. In this kind of situation, the requirement that antitrust courts must find a dominant anticompetitive purpose to establish a violation may be viewed as a device to ensure that the courts use convincing evidence of purpose to "interpret" what is otherwise an irresolvable conflict between effects.

In the somewhat analogous area of product certifications by trade associations, antitrust courts at times have insisted upon a finding of evil purpose before condemning product certification efforts that rather clearly had substantial anticompetitive effects.³²⁸ Moreover, by comparison with an ad hoc balancing approach, a purpose-based rule would have the considerable advantage of establishing a relatively clear standard. This would leave hospitals substantial freedom to manage their own enterprises without frequent interference by antitrust lawyers and antitrust courts on privilege matters. Under the balancing approach, the intervention of antitrust law could easily turn into a form of public utility regulation, which required hospitals to rely on their attorneys and the courts to make any significant privilege decision or, in the alternative, to provide privileges to virtually any competent licensed health care practitioner.³²⁹

Other joint venture privilege decisions will raise issues that are more closely related to the economic organization of hospital services than to the technical aspects of patient care. We suggest that the same antitrust rule be applied to these decisions as to technical joint venture decisions, although in these economic cases antitrust courts should feel

328. See *Structural Laminates v. Douglas Fir Plywood Ass'n*, 261 F. Supp. 154, 159 (D. Or. 1966), *aff'd*, 399 F.2d 155 (9th Cir. 1968), *crrt. denied*, 393 U.S. 1024 (1969) (no antitrust violation despite the association's five-year delay in approving plaintiff's new form of plywood, which was based on new technology not immediately available to most competitors and had passed performance tests for certified plywood but did not satisfy a structural definition used in the association's existing standard); *Hughes Tool Co. v. Motion Picture Ass'n*, 66 F. Supp. 1006, 1011 (S.D.N.Y. 1946) (no antitrust violation despite the association's withdrawal of its seal of approval from a successful commercial film on account of some mildly scandalous advertising, apparently largely because the district judge was unwilling to interfere with the association's purpose to establish and maintain the highest possible "moral and artistic" standards in motion picture production).

329. This latter alternative would be possible if hospital attorneys should give "conservative" legal advice and hospital managers should adopt "conservative" positions in order to avoid possible antitrust liability in the face of the substantial legal uncertainty that would result from an ad hoc balancing approach to hospital privilege decisions. In our experience, the attorneys and managers of nonprofit organizations are often prone to adopt conservative strategies in the face of legal uncertainty. Perhaps this is because these organizations (including government) are highly sensitive to public criticism and the negative publicity of law suits.

more comfortable and less deferential in assessing the purposes of exclusionary decisions. Privilege "moratoriums" that are declared for the ostensible purpose of relieving hospital overcrowding and geographical limitations on the award of privileges are examples of this kind of joint venture decision. The quality of care claims and other defenses for these decisions will be more analogous to issues that arise in industrial and commercial contexts, and antitrust courts may be less deferential to hospital judgments of this kind.

For example, in assessing privilege moratoriums, there will be the "objective" standards of occupancy rates, utilization review procedures, and patient scheduling techniques at other hospitals that can be used to determine if the moratorium is reasonably related to patient care, or rather, is merely a disguised attempt to exclude physicians from the medical staff.³³⁰ Moreover, antitrust courts would not be breaking new ground by applying careful scrutiny to economic joint venture decisions. Under the common law doctrine that hospitals serve a public trust, New Jersey courts already have started to take a rather careful look at some suspiciously anticompetitive privilege moratoriums.³³¹

5. Employer Hospital Decisions

At least two types of exclusionary privilege decisions deserve to be characterized as decisions of an "employer hospital"—exclusive dealing contracts with certain hospital-based specialists, and the denial of privileges to individual physicians who do not meet hospital standards. An "exclusive dealing contract" exists when a hospital awards exclusive privileges in some specialty to an individual physician or partnership of physicians.³³² The antitrust danger here is that the physician or group may have sought the contract in order to eliminate competition by foreclosing other physicians in the specialty from obtaining access to the hospital. On the other hand, at least in cases involving specialists like radiologists and pathologists, a hospital is likely to have valid independent interests in contracting with a single group in order to ensure quality and reduce the costs of its internal operations. These interests include the facilitation of good administrative relationships within the department and between the department and the rest of the hospital, the assurance of continuous and immediate consulting services to other physicians, lower hospital costs through enhanced hospital

330. See Rich, *supra* note 3, at 679-80.

331. See *supra* note 305.

332. See *supra* text accompanying notes 73-74. Hospital-based specialties today include anesthesiology, pathology, radiology, and perhaps some of the specialties that emphasize newer medical technologies such as nuclear medicine, cardiothoracic surgery, and intensive renal dialysis. See Feldman, Sloan & Paringer, *Compensation Arrangements Between Hospitals and Physicians*, 12 BELL J. ECON. 155, 156 (1981).

control, and perhaps higher quality through more frequent practice by a limited number of physicians.³³³

Exclusive dealing contracts are generally analyzed under antitrust's balancing approach, with the plaintiffs bearing the burden of proving that the anticompetitive effects of a contract outweigh its procompetitive effects in helping the parties provide more efficient services.³³⁴ This approach and the leading precedents suggest that several factors may be considered to help determine whether a plaintiff has met this burden.³³⁵ These factors include the market power of the hospital, whether the physicians or hospital initiated the contract, the length of the contract, and whether the hospital has extensive capital equipment involved, which would support its claims of quality and efficiency. The method by which the physicians are compensated also may be relevant, since compensation that is controlled by the hospital as opposed to straight fee-for-service compensation would suggest an independent hospital interest in efficiency. Another factor may be whether there is an industry-wide practice of exclusive contracts in the specialty,³³⁶ although answers to this question can be seen as subtly cutting both ways. On the one hand, an industry-wide practice suggests that hospitals in general may have valid independent reasons for making exclusive contracts in the specialty. On the other hand, an industry-wide practice of exclusive privileges, or at least a local practice among hospitals in the region, will make it more difficult for new physicians to obtain privileges and arguably would support more careful scrutiny of exclusive contracts. The best case for an antitrust plaintiff thus would be created by a local practice of exclusive dealing, together with the absence of an industry-wide practice; such a combination might suggest a local conspiracy among the incumbent specialists at the region's hospitals. Conversely, the best case for defendants would be a national practice of exclusive contracts in the specialty, but a relative absence of such contracts among hospitals in the region.

Although the factors discussed above figure in the traditional balancing approach to exclusive dealing contracts, they also are relevant to a purpose-based approach. This approach would be just as appropriate for analyzing exclusive contracts with hospital-based specialists as it is for analyzing joint venture decisions. That is, antitrust courts should insist upon proof of both a dominant anticompetitive purpose and substantial market power of the hospital in the medical specialty involved before they condemn exclusive contracts with hospital-based specialists, at least in such specialties as radiology and pathology. In these

333. See, M. THOMPSON, *supra* note 3, at 149-61; Horan & Nord, *supra* note 5, at 702.

334. See *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 325-29 (1961).

335. See M. THOMPSON, *supra* note 3, at 149-61.

336. See *Standard Oil Co. v. United States*, 337 U.S. 293, 309 (1949).

and perhaps other hospital-based specialties,³³⁷ the existence of substantial hospital-owned equipment and numerous hospital employees who are supervised by the physicians would appear to create a *prima facie* case that the hospital has a strong independent interest at stake and should be allowed to manage its affairs as it wishes.³³⁸ In contrast, in cases that involve exclusive privileges for physicians in other specialties, the presumption of an independent hospital interest should not exist, and courts need not be as concerned with showings of market power as long as an anticompetitive purpose is evident. Indeed, these cases often may look more like a hospital-wide system of exclusive privileges, and thus deserve treatment as a physician cartel without any inquiry into market power at all.³³⁹

In any event, exclusive privilege contracts tend to be employed most frequently in hospital-based specialties,³⁴⁰ and these contracts generally have survived legal attacks to date, including all antitrust challenges.³⁴¹ This seems appropriate because hospitals appear to have strong independent interests in this kind of privilege decision. Moreover, the possible anticompetitive motives among the medical staff are likely to be weak and, in any event, to be disregarded by the hospital's governing board. The real agreement in these cases is the one between the hospital and specialists involved, not among the entire medical staff, and there is therefore less reason for antitrust concern about these contracts.

In a recent case, however, the award of exclusive privileges to a group of anesthesiologists was attacked as a "tie-in" arrangement in which the hospital was tying the group's anesthesiology services to the sale of other hospital services.³⁴² The district court ultimately held that this contract did not violate antitrust's *per se* rule against tying arrangements, but it had to struggle to reach this conclusion once it had characterized the contract as a tie-in. The court correctly pointed out that

337. See *supra* note 332.

338. Both functionally and historically, pathologists and radiologists seem to have enjoyed the closest relationships to internal hospital operations, as evidenced by the fact that these specialists frequently have worked for hospitals on a salaried rather than fee-for-service basis. M. ROEMER & J. FRIEDMAN, *supra* note 39, at 63-69. Anesthesiologists have more frequently worked on a fee-for-service basis, *id.*, which indicates that there may be a less intense relationship between anesthesiologists and internal hospital operations in general. We conclude from this distinction only that "sham" cases of exclusive privilege contracts, *see supra* text at note 75, may be more likely with anesthesiologists and other hospital-based specialists than with radiologists or pathologists.

339. See *supra* text accompanying notes 277-86.

340. See M. ROEMER & J. FRIEDMAN, *supra* note 39, at 63-69; Feldman, Sloan & Paringer, *supra* note 332, at 156.

341. See M. THOMPSON, *supra* note 3, at 149-61; Borsody, *The Antitrust Laws and the Health Industry*, 12 AKRON L. REV. 417, 452-54 (1979); Rich, *supra* note 3, at 75-77.

342. Hyde v. J. Jefferson Parish Hosp. Dist. No. 2, 1981-1 Trade Cas. (CCH) ¶ 63,932 (C.D. La. 1981); *see also* Dolan & Ralston, *supra* note 3, at 756-63.

tie-ins are per se illegal only when the seller has some market power over the first or "tying" product. The court went on, however, to interpret the precedents as requiring a "dominant position" in the market for the tying product and to hold that the hospital's thirty percent share of all hospital patients from its township was not "sufficient economic power with respect to the tying produce [surgical services] to appreciably restrain free competition in the market for the tied product [anesthesiology services]"³⁴³ These conclusions appear to be based on some rather strained reasoning. The Supreme Court's most recent statement on tie-ins held that the per se rule applies if there is merely some "appreciable economic power" over the tying product, a standard which does not require "that the defendant have a monopoly or even a dominant position throughout the market for a tying product."³⁴⁴ Furthermore, if the district court was interpreting this standard correctly, it is unclear why the hospital's thirty percent share of patients from the township, and its admitted locational advantage as the only hospital in the township,³⁴⁵ did not provide the "appreciable economic power" over the tying product that is necessary for application of the per se rule.

A better approach would have been to hold that the medical staff and hospital jointly provide only one product, hospitalization services,³⁴⁶ and therefore that the tie-in characterization is inappropriate for exclusive contracts with hospital-based specialists. This would be consistent with the teaching of *Professional Engineers* that antitrust courts should be sensitive to the special facts of professional situations.³⁴⁷ It also would be consistent with antitrust precedents that have refused to treat the sale of closely related items as the sale of two products, where the purchasers did not discriminate between the items³⁴⁸ or where economic efficiency and technical quality were significantly served by providing the items in one package.³⁴⁹ The advantage of this approach would be to recognize a relatively clear and sound rule of antitrust law with regard to exclusive privilege contracts for hospital-based specialists. By contrast, under the tie-in approach, exclusive con-

343. Hyde v. J. Jefferson Parish Hosp. Dist. No. 2, 1981-1 Trade Cas. (CCH) ¶ 63,932 (C.D. La. 1981).

344. United States Steel Corp. v. Fortner Enters., Inc., 429 U.S. 610, 611-20 (1977).

345. 1981-1 Trade Cas. (CCH) ¶ 63,932.

346. See *supra* text accompanying note 58.

347. See *supra* text accompanying notes 229-48.

348. Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 613-14 (1953).

349. See Siegel v. Chicken Delight, 448 F.2d 43, 48 (9th Cir. 1971), cert. denied, 405 U.S. 955 (1972); Dehydrating Process Co. v. A.O. Smith Corp., 292 F.2d 653, 655 (1st Cir. 1961); Automatic Radio Mfg. Co. v. Ford Motor Co., 242 F. Supp. 852, 855-58 (D. Mass. 1965); United States v. Jerrold Elecs. Corp., 187 F. Supp. 545, 559-60 (E.D. Pa. 1960), aff'd per curiam, 365 U.S. 567 (1961). See generally Ross, *The Single Product Issue in Antitrust Tying: A Functional Approach*, 23 EMORY L. J. 963 (1974).

tracts could be held illegal simply on the basis of a finding that a hospital has substantial market power, a concept that is not very clear as a matter of antitrust law.³⁵⁰ This result would not be sound either, because all hospital corporations, even those with market power, can have legitimate reasons for granting exclusive privileges to hospital-based specialists. Furthermore, in view of the substantial insurance for hospital services, hospitals would not appear to be in a position to obtain extra monopoly profits from the exercise of monopoly power by the medical group that is granted exclusive privileges.³⁵¹ The hospital's motives are thus likely to be procompetitive, which also suggests the inappropriateness of applying the *per se* rule.

Antitrust courts nevertheless may hold that the services of at least some hospital-based specialists are a separate product from other hospital services, in view of the separate billing for these services and instances of other hospitals in which "open" departments in the same specialty are maintained.³⁵² In this event, a hospital might try to defend its exclusive privileges contract against the *per se* rule by showing that there is no less restrictive alternative under which the hospital could obtain the same quality in the delivery of hospitalization services. The Supreme Court has dismissed this "good will" defense rather casually in two cases involving salt and computer punch cards as the tied products, observing that the lessors of salting machines and computers (the tying products) could as easily have protected the quality of their machines by requiring that a particular grade of salt and particular quality of punch card be used with the machines.³⁵³ Nonetheless, this good will defense is available in principle,³⁵⁴ and the specification of standards for hospital-based specialists and their supervision of hospi-

350. See generally Landes & Posner, *supra* note 38.

351. We see no reason why any monopoly power of the hospital that is inherent in the situation could not be exploited by the hospital as easily under contracts with several groups of hospital-based specialists as under one contract with a single group.

352. *See Hyde v. J. Jefferson Parish Hosp. Dist. No. 2*, 1981-1 Trade Cas. (CCH) ¶ 63,932 (C.D. La. 1981) (relying on these factors to justify the conclusion that a hospital's anesthesiology services were separate from other hospital services). Separate billing by the seller and separate sales by competitors are two of the four factors in the frequently cited *Jerrold Electronics* "test" for determining whether there is one or two products in an alleged tying situation. *United States v. Jerrold Elecs. Corp.*, 187 F. Supp. 545, 559 (E.D. Pa. 1960), *aff'd per curiam*, 365 U.S. 567 (1961). The problems with this test include its failure to focus upon cost savings that may be generated by particular couplings of items, *see Ross*, *supra* note 349, at 1006-08, and, as admitted by the *Jerrold Electronics* court itself, the ambiguity of several of these factors in determining the fundamental issue, 187 F. Supp. at 559-60 (for example, separate billing for different items may have been used because each set of services is "custom made" for a purchaser who is only interested in acquiring a "single" product).

353. *International Salt Co. v. United States*, 332 U.S. 392, 397-98 (1947); *International Business Machines Corp. v. United States*, 298 U.S. 131, 139-40 (1936).

354. R. POSNER, *supra* note 3, at 181. Cf. *Dehydrating Process Co. v. A.O. Smith Corp.*, 292 F.2d 653, 655 (1st Cir. 1961) (substantial good will defense justifies classification of silo and silo unloader as "one product").

tal personnel would not appear to be as feasible an alternative to a "tying arrangement" (the exclusive privileges contract) as the specification of standards for salt and computer punch cards.

A second important category of employer hospital decisions consists of the denial of privileges to practitioners because of their personal incompetence or other individual failure to satisfy the legitimate standards of a hospital.³⁵⁵ It is possible that courts may not find an "agreement" in these cases, since there may be good reasons to hold that the hospital as a corporate entity has made the decision itself.³⁵⁶ In any event, as long as procedural due process is provided under the *Silver* rule, one senses that antitrust courts are unlikely to scrutinize this kind of hospital decision very closely if there is no other evidence of possible antitrust abuse.³⁵⁷ We suggest that the appropriate test for antitrust violations in this situation should be the same as that suggested for all joint venture and other employer hospital decisions—a dominant anticompetitive purpose and possession of substantial market power by the hospital.

The recent decision after trial in *Robinson v. Magovern*³⁵⁸ suggests the usefulness of our framework for analyzing hospital privilege decisions. In this case, a seemingly well-qualified cardiothoracic surgeon³⁵⁹ was denied privileges at a relatively large hospital in Pittsburgh, Pennsylvania. The hospital, Allegheny General, was engaged in a planned effort to improve its programs by attracting academically inclined physicians to its medical staff and by developing and maintaining AMA-approved residency programs in several specialties, including cardiothoracic surgery.³⁶⁰ Another major actor in the case was Dr. Magovern, the chief of cardiothoracic surgery, who had taken this position with the understanding that he would have substantial discretion and responsibility for developing the hospital's residency program and services in cardiothoracic surgery.³⁶¹ Dr. Magovern recommended that the hospital deny privileges to Dr. Robinson on two basic grounds: he did not possess the academic credentials and interests that the hospital and cardiothoracic surgery department required,³⁶² and his history and interview with Magovern suggested that Robinson might not be an effective supervisor of residents.³⁶³ Dr. Magovern, however, also was the senior partner in a partnership of physicians that performed more than

355. See *supra* text accompanying notes 73-74.

356. See *supra* text accompanying notes 202-05.

357. See *supra* text accompanying notes 255-68.

358. 521 F. Supp. 842 (W.D. Pa. 1981).

359. See *id.* at 848-49.

360. *Id.* at 859-62.

361. *Id.* at 851-52.

362. *Id.* at 871.

363. *Id.*

ninety-five percent of all cardiothoracic surgery at Allegheny General.³⁶⁴ Thus, the case potentially presented aspects of a physician cartel decision in which Dr. Magovern's partnership had conspired to drive away a competitor.³⁶⁵ There were also aspects of a de facto exclusive privileges contract between the hospital and partnership,³⁶⁶ and of a privileges denial by an employer hospital because the applicant failed to satisfy the hospital's standards for the development of its medical staff.

The court held for the defendants, finding that Allegheny General was justified in denying privileges to Dr. Robinson because of his failure to satisfy the hospital's standards of academic and professional quality, because of the evidence concerning his inability to work effectively with all kinds of physicians, and because of the hospital's current shortage of facilities for cardiothoracic surgery.³⁶⁷ The court found its way to this conclusion, however, only after a careful analysis of several of the issues that we have discussed in this section. After noting that the hospital had provided Dr. Robinson with procedural due process,³⁶⁸ the court rejected the applicant's boycott or conspiracy theory by focusing upon the fact that the hospital's decision rested upon substantial reasons that were independent of any possible anticompetitive motives of Dr. Magovern.³⁶⁹ Thereafter, the court rejected a multitude of antitrust theories raised by the plaintiff on essentially one common ground, the absence of an anticompetitive purpose of the hospital in denying privileges to Dr. Robinson.³⁷⁰ This search for independent hospital interests and the hospital's overall purpose, of course, is consistent with the fundamental analytic technique that we have proposed throughout this section.

6. *A Final Word on Restraints of Trade*

The foregoing suggests that some distinct and helpful lines between legal and illegal privilege decisions can be drawn under antitrust

364. *Id.* at 852.

365. The main thrust of the plaintiff's antitrust theory was that Dr. Magovern, his professional corporation, and the hospital had conspired to boycott other cardiothoracic surgeons who applied for or were using privileges at Allegheny General, a boycott that allegedly included specific attempts to discourage other cardiothoracic surgeons from obtaining or exercising privileges. *See* Robinson v. Magovern, 521 F. Supp. 842, 892-913 (W.D. Pa. 1981).

366. Although the defendants did not pursue this theory at trial, the fact that Dr. Magovern's professional corporation performed almost all the cardiothoracic surgery at the hospital, 521 F. Supp. at 852, and Dr. Magovern's extensive powers over all cardiothoracic surgeons at the hospital in his role as Director of Surgery, *see* 521 F. Supp. at 851-52, 860-62, suggest that the hospital had granted de facto exclusive privileges to Dr. Magovern and his associates.

367. 521 F. Supp. at 927-28.

368. *Id.* at 853.

369. *Id.* at 891-96.

370. *Id.* at 893-903.

law. Antitrust courts can do this by requiring, for proof of an antitrust violation, that there be convincing evidence that the privilege decision has been motivated by a dominant anticompetitive purpose. This evidence might consist of the objective facts of a physician cartel decision (that is, no independent hospital interest) or, in apparent joint venture and employer hospital situations, of more direct evidence that an anticompetitive purpose of the medical staff has overwhelmed any putative separate interest of the hospital as a corporate entity. To be sure, antitrust in general does not require proof of an evil purpose, but it does employ such evidence to help interpret and predict effects. In joint venture and employer hospital privilege decisions, requiring evidence of bad purpose would appear to be especially helpful as a mechanism by which antitrust courts may avoid undue interference with the managerial prerogatives of hospital administrations.

If this purpose-based approach were adopted, the application of antitrust law to hospital privileges would promote important public policies without creating unfavorable side effects. Tendencies among medical staffs to use hospital privileges as a means to keep competitors out of town, or more generally as a means of ensuring excess hospital capacity, would be minimized although undoubtedly not eliminated. This result would serve the central antitrust policies of promoting competition and economic efficiency. The important antitrust policy of fairness also would be served by prohibiting concerted refusals by physicians to deal with groups of other practitioners simply because of their competitive status. At the same time, the basic requirement that there be a dominant anticompetitive purpose in order to establish a violation would give notice to hospitals that they remain free to base privilege decisions on any arguable quality of care concern that they choose to pursue.

Antitrust courts might apply more rigorous scrutiny to privilege decisions, by trying to weigh the anticompetitive and procompetitive effects of particular decisions.³⁷¹ Justifications for adopting this approach include the self-interested nature of medical staff recommendations on privilege questions,³⁷² the frequent difficulty of proving specific anticompetitive purposes in a professional setting,³⁷³ and a desire to promote the values of competition and efficiency to their fullest extent. In our opinion, however, this approach would suffer both from the judicial hubris of second-guessing hospital managers and physicians on technical medical questions and from the specter of antitrust courts becoming public utility regulators of privilege decisions. This

371. For proposals of this sort, see Calvani & Janies, *supra* note 3; Dolan & Ralston, *supra* note 3.

372. See *supra* text accompanying notes 58-62.

373. See Bird, *supra* note 250, at 281-82.

approach is likely to involve antitrust courts in a morass of case-by-case decisions on privilege issues, which would leave hospitals uncertain about the legality or illegality of almost any privilege decision. Hospitals would need to turn to the courts and to private antitrust attorneys at almost every step in the privilege decision process, and this, in effect, would constitute the courts and private lawyers collectively as a regulatory agency acting under the guise of antitrust law.

In view of this legal uncertainty, moreover, hospital attorneys could give "conservative" advice and hospital managers adopt "conservative" positions in order to avoid possible liability from antitrust actions. This, in effect, could turn the hospital into a public utility that grants admitting privileges to all health practitioners who are competent within the terms of their licenses. We believe that this result, as well as the more general effect of courts and lawyers becoming a regulatory agency, should be established by legislative action rather than by the intervention of antitrust courts. The regulation of hospitals as public utilities to serve all health care professionals would appear to be a major public policy issue, of the kind that is best reserved for the action of legislatures in a democratic society.³⁷⁴ It thus seems appropriate that antitrust courts should concentrate instead on developing a few purpose-based rules on hospital privileges, which attempt to guard against clear antitrust abuses while leaving hospitals ample room to manage their own affairs.

C. Other Issues, Other Theories

Some hospital privilege cases will raise either of two antitrust issues that may require a different analysis than that presented in the previous section. One consists of acts by hospitals that may "monopolize" particular medical service markets. The other consists of professional behavior that occurs outside the hospital setting but is intended to influence the privilege decisions of hospitals in a restrictive manner. We shall consider these types of antitrust issues in this section.

I. Hospital Monopolization Tactics

A hospital may require that its attending physicians deal exclusively with that hospital,³⁷⁵ thus denying these physicians and their patients to competing hospitals.³⁷⁶ Or, a hospital may require its medical

374. See *Associated Press v. United States*, 326 U.S. 1, 25 (1945) (Douglas, J., concurring); *International News Serv. v. Associated Press*, 248 U.S. 215, 262-63 (1918) (Brandeis, J., dissenting).

375. Cf. M. ROEMER & J. FRIEDMAN, *supra* note 39, at 110 (discussing a hospital's bylaw requirement that all members of the medical staff must conduct the "major portion" of their hospital practice at the hospital).

376. A requirement that physicians deal exclusively with one hospital may represent one of

staff to use specific hospital services that the physicians might otherwise provide to their patients on an outpatient basis.³⁷⁷ Hospitals may also deny privileges to practitioners who are associated with other health care institutions like HMOs that are direct or potential competitors of the hospital in question.³⁷⁸ There may be anticompetitive or procompetitive explanations for the hospital's actions in each of these situations.

In some instances, a hospital's anticompetitive interest in blocking the growth of competing institutions may be indistinguishable from similar anticompetitive interests among the hospital's medical staff. If the exclusionary behavior results from an "agreement" between the hospital and medical staff, the restraint of trade analysis discussed in the previous section will be appropriate in these cases as well. The antitrust result would then depend upon the hospital's ability to show that the exclusionary act is justified by some independent procompetitive interest of the hospital. For example, a requirement that attending physicians deal exclusively with one hospital may promote the hospital's legitimate interests in efficient planning and in ensuring that physicians are continuously available for patient care, peer review, and the supervision of residents. In addition, many hospitals may invest substantial resources in the training and supervision of their medical staff physicians, and these hospitals could claim that exclusive dealing arrangements are necessary to allow them to reap all the economic benefits from these investments.³⁷⁹ As another example, the requirement that a medical staff use hospital services rather than alternative outpatient services may be justified by a hospital's interest in ensuring high quality care or in operating hospital services at a scale sufficient to reduce per unit costs and maintain profitability.³⁸⁰

the relatively few kinds of cases in which exclusive dealing might be used to monopolize a particular economic market. In the usual exclusive dealing situation, a supplier's promise to deal exclusively with one buyer is unlikely to harm other buyers, who remain free to purchase services from other suppliers and to encourage new suppliers to enter the market. In the hospital privileges situation, however, physicians with existing practices in a community often may be relatively unique suppliers of patients to hospitals. Competing hospitals, which are faced with an exclusive dealing requirement imposed by one hospital, may not easily be able to substitute equivalent physician suppliers for those foreclosed to them by the exclusive dealing. *See generally* R. Posner, *supra* note 3, at 201-03.

377. *See, e.g.*, Cobb County-Kennestone Hosp. Auth. v. Prince, 242 Ga. 139, 249 S.E.2d 581 (1978) (physicians required to use the hospital's computer assisted tomoscope (C.A.T.) scanner on all hospital inpatients needing this x-ray procedure).

378. *See* Havighurst, *supra* note 23, at 760-61; Kissam, *supra* note 13, at 512-13.

379. The contrary argument will be that some medical staff physicians and the hospital want the exclusive dealing requirement merely to ensure an adequate flow of patients to their medical network and hospital rather than to competing hospitals. *See supra* note 376 and accompanying text.

380. *See, e.g.*, Cobb County-Kennestone Hosp. Auth. v. Prince, 242 Ga. 139, 249 S.E.2d 581 (1978). The contrary argument, of course, will be that the hospital has imposed its exclusive use

If the exclusionary behavior does not result from an agreement, the hospital still may be charged with violating section 2 of the Sherman Act by its unilateral action.³⁸¹ This claim will require proof that the hospital has monopoly power, or at least some substantial degree of market power, and that the hospital has engaged in some purposeful conduct that was intended to maintain or help acquire monopoly power.³⁸² In formal terms, a plaintiff who alleges monopolization by a hospital will need to establish the separate elements of market power and purposeful conduct. Practically speaking, however, a very substantial quantum of one element often may substitute for a lesser quantum of the other element under both monopolization³⁸³ and attempt to monopolize³⁸⁴ theories. Consistent with our emphasis upon a purpose-based antitrust analysis, we would urge antitrust courts to avoid the merging of these two elements in analyzing unilateral acts by hospitals of the sort discussed in this section. The courts should concentrate on documenting both the requisite degree of market power and an anticompetitive purpose as the dominant reason for the exclusionary behavior. This conservative approach to section 2 claims would be justified, in our view, by the difficulty of judicial decision-making on these issues,³⁸⁵ and by the same analytic considerations that support a purpose-based analysis of restraints of trade in the field of hospital privileges.³⁸⁶

To illustrate the potential for section 2 analysis of privilege decisions, consider two cases. Suppose that the only hospital in a cominu-

requirement simply in order to monopolize the provision of certain medical services in the community. *See id.*

381. Section 2 of the Sherman Act provides that “[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several states” shall be guilty of a felony. 15 U.S.C. § 2 (1976). For our purposes, the relevant portions of this act are the “monopolization” and “attempt to monopolize” violations that may be committed by single persons. “Conspiracies to monopolize” require an agreement, and the substantive analysis of conspiracies does not differ much from that of restraints of trade under § 1 of the Sherman Act. *See L. SULLIVAN, supra* note 151, § 49.

382. On monopolization, the standard test today appears to be “(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.” *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). On attempts to monopolize, the current standard is more elusive but appears to require a “specific intent to monopolize” and the fact that a defendant “has come dangerously near to unlawful monopolization.” *See Cooper, supra* note 309, at 375.

383. *See, e.g., United States v. Aluminum Co. of America*, 148 F.2d 416 (2d Cir. 1945) (substantial market power substituted for purposeful conduct).

384. *See, e.g., Lessig v. Tidewater Oil Co.*, 327 F.2d 459, 474 (9th Cir.), *cert. denied*, 377 U.S. 993 (1964) (purposeful conduct substituted for market power).

385. Compare *supra* text accompanying notes 379-80 (possible procompetitive justifications for a hospital’s “monopolization” tactics) with *supra* notes 376, 379-80 (possible anticompetitive purposes and effects of the same tactics).

386. *See supra* text accompanying notes 301-74.

nity refuses privileges to physicians who would associate with a new ambulatory surgical center. This hospital presumably would have substantial market power, and the hospital itself could have a dominant anticompetitive purpose if the ambulatory center threatened to draw substantial numbers of inpatients and outpatients from the hospital.³⁸⁷ The ambulatory center also might threaten the economic interests of important groups on the hospital's medical staff but section 2 analysis would obviate the need to prove an "agreement" between the hospital and its medical staff or the concerned groups. A more difficult case would be presented if the same hospital required that all inpatients must obtain x-ray or other radiology services from the hospital's radiology department.³⁸⁸ This requirement could have substantial anticompetitive effects upon the hospital's physicians who owned and operated competing radiology equipment in their offices.³⁸⁹ The hospital could claim, however, that the requirement was necessary to ensure a high quality of care for its inpatients and to obtain economies of scale in the operation of its radiology department.³⁹⁰ A judicial attempt to balance these effects would appear to be just as difficult as the balancing of effects in a joint venture privilege decision,³⁹¹ and thus the requirement of a dominant anticompetitive purpose in order to establish a section 2 violation by the hospital would seem to make good sense in this situation as well.

2. *Extrahospital Behavior*

The second category of different antitrust issues involves collective professional behavior that occurs outside the hospital setting but influences privilege decisions, either directly or indirectly. These external influences may include resolutions and lobbying by local medical societies desiring to influence the privilege decisions at particular hospitals.

387. Such competition between hospitals and ambulatory surgical centers is likely to increase in the future. The availability of medical insurance for surgical procedures and investment tax credits for physician owners of capital equipment, as well as regulatory attempts to discourage costly inpatient stays, are likely to encourage the development of ambulatory clinics that compete with hospitals on many services that traditionally were only provided on an inpatient basis.

388. See, e.g., Cobb County-Kennestone Hosp. Auth. v. Prince, 242 Ga. 139, 249 S.E.2d 581 (1978) (hospital resolution that patients be required to use hospital facilities for any procedure, test, or service routinely offered by the hospital).

389. See, e.g., *id.* (neurosurgeons operating their own C.A.T. scanner in an ambulatory facility to serve inpatients at the hospital).

390. See, e.g., *id.* (these claims are the "pre-eminent" reason for finding that the hospital's requirement is reasonable). To be sure, some inpatients probably could be moved to ambulatory facilities for radiology services without harm. But the hospital's need to monitor the choice of patients who could be moved would increase the hospital's transaction costs, as well as creating the possibility of error. Moreover, it is not clear that hospitals could safely escape all responsibility for malpractice injuries that might occur in the course of providing outside radiology services to inpatients.

391. See *supra* text accompanying notes 327-29.

tals.³⁹² They also may include the standards and judgments of accreditation and certification programs that pertain to quality of care standards for hospitals, residency programs, and the medical specialists who are trained in residency programs.³⁹³ These external activities may provide evidence that is relevant to a particular privilege decision by a hospital,³⁹⁴ or they may themselves be the subject of a direct antitrust attack, on the theory that the external activity constitutes a restraint of trade by competitors.³⁹⁵

In some instances, the external activity of professionals may be an integral part of a conspiracy to deny privileges to an applicant or may be used as a cover for such a conspiracy. Consider, for example, the rather unhappy tale of Dr. Aasum and the Good Samaritan Hospital in Corvallis, Oregon.³⁹⁶ Dr. Aasum, a chiropractor, had been obtaining hospital laboratory tests and reports on his patients for about ten years, when the executive director of Good Samaritan received a "recommendation" by telephone from the Oregon physician licensing board that the hospital should limit the use of its laboratory to the patients of physicians. Relying upon this recommendation, and on a written opinion from the JCAH that also disapproved such access for chiropractors, the Good Samaritan Hospital terminated Dr. Aasum's access to its laboratory. Both a federal district court and court of appeals subsequently held that this did not violate Dr. Aasum's fourteenth amendment rights under the Constitution, although neither court addressed the possibility of an antitrust violation.

Suppose that Dr. Aasum had filed an antitrust suit against the hospital, and the hospital had claimed that its action was necessary to protect its accreditation by the JCAH. Two observations may be made about this defense. First, as suggested by the case of Dr. Aasum, an accrediting agency's communications on particular privilege decisions may not always represent a legitimately adopted or official position of the agency. Rather, an accrediting agency official simply may be conspiring with the hospital to exclude chiropractors.³⁹⁷ Second, the JCAH in general does not require hospitals to comply with all of its

392. See, e.g., *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *supra* note 219.

393. On professional accreditation and certification programs in medicine in general, see R. STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST (1971).

394. See, e.g., *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *infra* text accompanying notes 396-99.

395. See *Levin v. JCAH*, 354 F.2d 515 (D.C. Cir. 1965) (JCAH standard against privileges for podiatrists allegedly violates the Sherman Act); *Ohio v. JCAH*, No. C-2-79-1158 (S.D. Ohio filed Dec. 14, 1979) (JCAH standard against independent admitting privileges for clinical psychologists allegedly violates the Sherman Act). See generally *Kissam*, *supra* note 150.

396. *Aasum v. Good Samaritan Hosp.*, 395 F. Supp. 363 (D. Or. 1975), *aff'd*, 542 F.2d 792 (9th Cir. 1976).

397. Cf. *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530, 547-51 (5th Cir. 1978) (remand for trial on the issue of whether the executive director of the state licensing board

standards,³⁹⁸ nor does the JCAH profess to require that accredited hospitals must choose between accreditation and violating the law.³⁹⁹ Thus, there is "slack" in these standards, and hospitals may appropriately be required by antitrust courts to demonstrate their independent interests in exclusionary privilege decisions. In other words, the fear of sanctioning by an accrediting agency may in some cases be merely a "possible" purpose of the privilege decision and an anticompetitive purpose the "dominant" one. In these types of situations, the external professional activity may be ignored or may be treated as part of a conspiracy to deny privileges, depending upon the specific facts of the case.

In other cases, the external activity of a local medical society or professional credentialing organization will consist simply of a public statement about privileges, which apparently concerns the quality of care in a hospital or hospitals and is otherwise unconnected with the privilege decision or decisions in question.⁴⁰⁰ This kind of statement by a professional society would be analogous to efforts by trade associations to certify the quality of industrial products. This suggests that the professional society's statement should be analyzed under the antitrust precedents that concern product certifications by trade associations.⁴⁰¹ This analogy also suggests that a first amendment defense may be available to protect these kinds of statements from antitrust scrutiny.⁴⁰²

The antitrust standard that generally has been applied to product certification efforts by trade associations is the broad one of "reasonableness,"⁴⁰³ and any attempt to formulate a more precise characterization of this law would be difficult. Some courts seem to have applied a very lenient standard of "minimum rationality," one which would uphold any product certification effort that appears to generate any potentially useful information, notwithstanding evidence of substantial anticompetitive effects and apparently anticompetitive purposes as

had acted outside the scope of his authority and conspired with other defendants to violate the Sherman Act), *cert. denied*, 444 U.S. 924 (1979).

398. JCAH MANUAL, *supra* note 1, at xvii ("Accreditation need not require one-hundred-percent compliance with every item in the standards that is applicable to a given hospital. Accreditation decisions will be based on a careful and reasonable assessment of each individual case.")

399. *See id.* at 81 ("Medical staff membership shall be limited, unless otherwise provided by law, to individuals who are currently fully licensed to practice medicine and, in addition, to be licensed dentists.").

400. *See, e.g., supra* note 219.

401. *See generally* G. LAMB & C. SHIELDS, TRADE ASSOCIATION LAW AND PRACTICE 86-96 (1971).

402. *See Kissam, supra* note 16; Kissam, *supra* note 150; Comment, *Anticompetitive Data Dissemination in the Medical Profession: The Conflict Between the Sherman Act and the First Amendment*, 1980 DUKE L. J. 1142.

403. *See G. LAMB & C. SHIELDS, supra* note 401; J. VON KALINOWSKI, 11 ANTITRUST LAWS & TRADE REGULATION § 75.04 (1980).

well.⁴⁰⁴ Other courts have subjected the defendants' conduct to a more careful examination that would appear to approximate the typical balancing approach under the Rule of Reason.⁴⁰⁵ This test would weigh the apparent usefulness of the trade association's statement about product quality against its exclusionary effect upon competitors. Notwithstanding such scrutiny, product certification efforts usually have survived antitrust attacks in the absence of associated noncommunicative acts such as price fixing or group boycotts of competitors.⁴⁰⁶ Moreover, in the future, all antitrust courts may move toward application of the "minimum rationality" standard in order to avoid addressing the constitutional issue of the nature of protected commercial speech in product certification statements.⁴⁰⁷

In our view, a standard that offers similar protection to most professional society statements about hospital privileges and medical quality can be derived directly from the first amendment.⁴⁰⁸ Professional society statements about hospital privileges and medical quality would appear to constitute a collective form of speech, in which the professional society and its members are stating an argument or an opinion that a particular form of medical care is of adequate or inadequate quality. Perhaps this speech may be characterized as "mere" commercial speech, since it is intended to have commercial effects through the actions of other institutions and persons. It is nonetheless speech of a classical sort, and in recent years the Supreme Court has begun to recognize a relatively rigorous doctrine of first amendment protection for commercial speech.⁴⁰⁹

Specifically, in *Central Hudson Gas & Electric Corp. v. Public Service Commission*,⁴¹⁰ the Court held that government may regulate commercial speech that neither misleads nor provides information about an unlawful activity only if there is "a substantial [governmental] interest to be achieved by restrictions on commercial speech," and then only if "the regulatory technique [is] in proportion to that interest."⁴¹¹ To satisfy this proportionality test, the regulation must "directly advance" the state interest and "the governmental interest could [not] be served by a

404. See *supra* note 317 and accompanying text.

405. See *United States v. Johns-Manville Corp.*, 1967 Trade Cas. (CCH) ¶ 72,184 (E.D. Pa. July 13, 1967); *United States v. Johns-Manville Corp.*, 259 F. Supp. 440 (E.D. Pa. 1966).

406. See J. VON KALINOWSKI, *supra* note 403; Jacobs, *Statistical, Standardization and Research Activities*, 6 A.B.A. SEC. ANTITRUST L. 80, 83-86 (1955).

407. Kissam, *supra* note 16, at 164.

408. For a more detailed statement of this argument, see Kissam, *supra* note 16; Kissam, *supra* note 150.

409. See *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n*, 447 U.S. 557 (1980); L. TRIBE, *supra* note 179, § 12-15; Barrett, "The Uncharted Area"—Commercial Speech and the First Amendment, 13 U.C.D. L. REV. 175 (1980).

410. 447 U.S. 557 (1980).

411. *Id.* at 564.

more limited restriction on commercial speech.⁴¹² An antitrust attack upon a professional society's statement that gives some quality of care reason for pursuing a particular course on hospital privileges, no matter how controversial that reason may be, would not be the most "direct advance" on the governmental goal of increased competition. Antitrust attacks on privilege decisions themselves would be a more direct attack. In addition, the goal of increased competition could be served by more limited restrictions on professional speech, by simply requiring the professional society to provide a fuller account of the issue in its standards, judgments, resolutions, and press releases.⁴¹³ In short, the application of antitrust law to condemn a professional society's mere expression of opinion—even if the opinion has the effect of inducing others to behave in ways that have anticompetitive effects—would restrict rather than increase the flow of potentially useful information to the public. The first amendment is designed to prevent this kind of application of statutory law.⁴¹⁴ Of course, if the professional society's statement about hospital privileges can be shown to have a dominant anticompetitive purpose, then it may be treated as "sham" speech and condemned as an attempted group boycott of competitors.⁴¹⁵

An antitrust and first amendment analysis of all medical credentialing activities that may affect hospital privileges would be beyond the scope of this essay. A discussion of the State of Ohio's recently filed antitrust suit against the JCAH on the issue of privileges for psychologists⁴¹⁶ may serve, however, to illustrate the potential application of

412. *Id.*

413. In other words, the government could choose to monitor incomplete medical society resolutions by regulating these statements in the same way that the Federal Trade Commission regulates false and misleading advertising. *See generally* G. ROBINSON, E. GELLHORN & H. BRUFF, THE ADMINISTRATIVE PROCESS 469-72 (2d ed. 1980) (discussion of the elements of a false advertising case).

414. *See* L. TRIBE, *supra* note 179, § 12.

415. *See* California Motor Transp. Co. v. Trucking Unlimited, 404 U.S. 508 (1972). In the absence of a dominant anticompetitive purpose, it might be argued that professional society statements about medical care quality do not deserve first amendment protection because they are "misleading" or "more likely to deceive the public than to inform it." Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n, 447 U.S. 557, 563 (1980). *See* Friedman v. Rogers, 440 U.S. 1, 13, 15-16 (1979); Ohralik v. Ohio State Bar Ass'n, 436 U.S. 447, 464-65 (1978). This argument would be that the statement is likely to harm consumers by "misleading" health care institutions, physicians, and consumers into providing and purchasing medical services that are either unnecessarily expensive or furnished by unduly limited types of providers. This argument, however, would oversimplify the concept of false or misleading advertising, whose gravamen appears to be the making of some misrepresentation of fact that limits the opportunities of listeners to make an independent judgment about the purchase of services. *See* G. ROBINSON, E. GELLHORN & H. BRUFF, *supra* note 413, at 469-72. By contrast, a professional society's statement about the quality of medical care—even if technically worthless—is likely to be based upon sincere opinions about the maintenance of high quality medical care. Thus, if these statements are free from conscious misrepresentations of fact, or a dominant anticompetitive purpose, it seems unlikely that courts would characterize them as misleading advertising. *See* Kissam, *supra* note 150, at 19.

416. Ohio v. Joint Comm'n on Accred. of Hosps., Civ. Action No. C-2-79-1158 (S.D. Ohio

antitrust law in this field. The current JCAH manual provides that medical staff membership should be limited to licensed physicians and licensed dentists "unless otherwise provided by law."⁴¹⁷ It also provides that members of the medical staff must supervise the admission and discharge of patients from the hospital,⁴¹⁸ and further provides that clinical privileges shall be granted only to podiatrists and other professional personnel who work under the responsibility and supervision of a member of the medical staff.⁴¹⁹ These standards clearly discourage accredited hospitals from granting independent admitting privileges to state-licensed clinical psychologists, who understandably may desire access to hospital resources in order to provide inpatient care to their patients.

In developing its antitrust attack upon these standards, the State of Ohio presumably will attempt to prove that the JCAH standards are in some sense part of a physician boycott of clinical psychologists. One relatively easy line of attack might be to pursue Clark Havighurst's "linkage" theory, which would relate the particular speech of a professional group (in this case, the JCAH) to any relatively uniform and anticompetitive behavior by professionals that occurs in response to the speech (in this case, privilege decisions by hospitals). Professor Havighurst argues that uniform and anticompetitive professional behavior that occurs in response to public statements by professional societies ought to be sufficient to link the speech and subsequent behavior as integral parts of a group boycott against competitors. This linkage, in his view, should allow antitrust condemnation of the group speech even if it has some quality of care merit and does not specify any "enforcement mechanism" for the supposed boycott.⁴²⁰

The theory that professional statements alone, because of professional solidarity, may often induce uniform behavior by other professionals may be correct as an empirical proposition. In our view, however, the legal conclusion that such professional statements may be condemned under the antitrust law incorrectly reverses the appropriate

filed Dec. 14, 1979). This complaint is summarized in 1980 ANTITRUST & TRADE REG. REP. (BNA), at D-2 (Jan. 24, 1980).

417. JCAH MANUAL, *supra* note 1, at 81.

418. *See id.* at 85-86.

419. *Id.*

420. *See* Havighurst, *supra* note 13, at 344-49, 355-62. Professor Havighurst specifically discusses professional society statements that condemn cost reduction methods instituted by medical insurance plans but do not specify any enforcement mechanism against the insurance plans. *See id.* at 317-18. In the case of JCAH standards, there is in one sense an "enforcement mechanism" built into the statement since the failure to comply with a standard may result in the loss of a hospital's accreditation. This should not be thought of as a true enforcement mechanism, however, because the loss of accreditation for the failure to comply with JCAH standards may be a voluntary act by the hospital and because the loss of accreditation also may be viewed as an integral part of the JCAH's communicative act to tell the public about good quality hospital care.

priority between the first amendment and statutory law. This conclusion would turn first amendment analysis of professional speech into nothing more than a balancing of antitrust values in economic competition against the possible social values of the speech.⁴²¹ This would condemn the speech of professional groups merely for its "bad tendencies" to influence others to act in ways that produce anticompetitive effects. Yet the First Amendment is designed to be a constraint upon the application of statutory law, rather than merely an occasion for the judicial balancing of free speech and statutory values.⁴²² With a few notable exceptions (for example, pornography), the "bad tendency" doctrine of first amendment law has appropriately become a relic of historical interest.⁴²³

In our opinion, the JCAH standards and the relatively uniform denial of privileges to clinical psychologists, without more, should not be sufficient to condemn the JCAH standards under the antitrust laws. These standards appear to have at least arguable quality of care justifications, and they do not specify enforcement mechanisms in order to ensure that hospitals comply. It is possible, after all, that hospitals may provide a higher overall quality of care if they grant independent admitting privileges only to medically trained psychiatrists and not to clinical psychologists.⁴²⁴ The JCAH standards thus would not appear to constitute a "sham" and, without more, should benefit from a first amendment defense.

A more successful line of attack, but a more difficult one to maintain, may be to demonstrate that some identifiable group of physicians (probably the American Medical Association) has controlled both the setting of the JCAH standards and the enforcement of these standards, by Residency Review Committees⁴²⁵ and other professional groups that are not acting in the interests of quality when they apply and enforce the JCAH standards.⁴²⁶ Suppose, for example, that Ohio can

421. See *id.* at 356.

422. See L. TRIBE, *supra* note 179, § 12-1,2.

423. On the historical beginnings of the bad tendency doctrine in first amendment law, see Rabban, *The First Amendment in Its Forgotten Years*, 90 YALE L.J. 514, 533-39, 543-49 (1981).

424. Unlike psychologists, psychiatrists are licensed to prescribe drug therapies and also trained to identify and treat the related medical problems of their patients.

425. Residency Review Committees are sponsored by the American Medical Association and other interested professional organizations, and completion of a residency program approved by one of these committees is necessary for a physician to become board certified in her specialty. See R. STEVENS, *supra* note 393, at 389-96. Residency Review Committees report to the Liaison Committee on Graduate Medical Education, another AMA-sponsored organization, which is the formal accrediting body for hospital residency programs in all specialties. See *Medical Education in the United States 1977-1978*, 240 J. A.M.A. 2809, 2837 (1978) (AMA Annual Report).

426. In June, 1969, the AMA's House of Delegates approved a "joint statement of the AMA and American Hospital Association" on the issue of hospital privileges for physicians and non-physicians. This statement closely parallels the JCAH's current standards on privileges. Compare AMA HOUSE OF DELEGATES, RESOLUTION—MEDICAL STAFF MEMBERSHIP AND STATUS OF AL-

prove that all or most Residency Review Committees would withdraw (or better yet, have withdrawn or threatened to withdraw) their approval of residency programs at hospitals that grant admitting privileges to a clinical psychologist. It is difficult to see how a hospital's decision to grant privileges to psychologists could possibly affect the quality of a hospital's residency programs in such specialties as radiology, pathology, or anesthesiology. In these and other specialties, a Residency Review Committee's action to apply the JCAH standards on psychologists and cut off the supply of residents to a hospital might appear to be an integral part of a group boycott against psychologists.⁴²⁷ Such coercive acts of enforcement would be a "sham" form of speech and would be appropriately characterized as noncommunicative behavior that is outside the scope of first amendment protection. Alternatively, suppose it can be shown that the motives for promulgation of the JCAH standards were anticompetitive and designed to elicit enforcement behavior from hospitals, medical staffs, and Residency Review Committees. In that event, the JCAH speech itself could be characterized as the means to a group boycott, and therefore would also fall outside the scope of the first amendment. It thus is difficult to predict the outcome of Ohio's case against the JCAH, but it is worth noting that an earlier antitrust challenge to JCAH standards that excluded podiatrists from accredited hospitals resulted in a significant settlement in the podiatrists' favor.⁴²⁸

CONCLUSION

This study has demonstrated, we believe, that a reasonable accommodation between the values of antitrust law and the professional values of hospital privilege decisions is possible. This accommodation, however, may require some moderate restructuring of currently accepted antitrust doctrines and tests in several areas. On jurisdictional issues, antitrust courts will need to attend to the continuing constitutional value of federalism and to the legitimate needs of other regulatory schemes that apply to privilege decisions. This attention would limit the intervention of federal antitrust courts to cases that involve

LIED HEALTH PROFESSIONALS IN HOSPITALS (1969) with JCAH MANUAL, *supra* note 1, at 81-86. The AMA's resolution did not give reasons for its recommended standards on privileges, but neither did it specify sanctions or other enforcement mechanisms for physicians and hospitals that fail to comply with these standards.

427. These facts would make this case similar to the dress manufacturers' boycott of the so-called "style pirates" in *Fashion Originators' Guild of America v. FTC*, 312 U.S. 457 (1941). In that case, original design dress manufacturers had refused to sell their dresses to retail stores that carried copied dresses that were manufactured by "style pirates."

428. See Hollowell, *supra* note 7, at 500-01, especially n.55. This settlement included the issuance of a statement by the JCAH that recognized the appropriateness of hospital privileges for podiatrists who admit patients with the concurrence of physicians. *Id.*

significant threats to national values and are unregulated by state government.⁴²⁹ As a matter of state law, this attention would limit antitrust intervention to privilege decisions that are unregulated by other state agencies⁴³⁰ and, in states with particularly rigorous hospital regulation, an antitrust exemption for all privilege decisions might be justified.⁴³¹

With regard to substantive antitrust issues, a relatively consistent application of a few purpose-based rules would achieve the most reasonable accommodation between antitrust values and the legitimate economic and medical values that are inherent in the pursuit of high quality medical care by hospitals and medical staffs. This approach can be drawn from the existing antitrust precedents, although some re-interpretation and judicial sensitivity to the particular facts of hospital and medical care may be necessary in order to achieve this accommodation in full.⁴³² In general, our suggested rules may be viewed as a moderate and feasible mode of limited "judicial deregulation" in the antitrust field. These rules would leave hospitals with adequate room to promote their complex interests in efficient and high quality services. At the same time, these rules would eliminate instances of blatant anticompetitive conduct, and they would strengthen the position of hospital managers in their continual bargaining with medical staffs over all aspects of hospital operations.

To be sure, our suggested approach would not root out all anticompetitive consequences or economic slack that may result from the interests of medical staff members in controlling the excess capacity of hospitals and protecting their status as high quality professional workers. Antitrust law, however, would seem to be a rather cumbersome instrument for achieving these goals. The elimination of economic slack in the award of privileges is more likely to be achieved by a national policy of promoting effective competition among hospital insurance plans⁴³³ than by a rigorous antitrust campaign on privilege decisions. Effective competition among insurance plans presumably would create adequate incentives for the plans to explore the diverse possibilities of contractual arrangements with both providers and subscribers that might encourage hospitals to operate at optimal efficiency.⁴³⁴

This analysis of hospital privileges also indicates a new direction for the development of more effective antitrust doctrine. Our consider-

429. See *supra* text accompanying notes 104-96.

430. See *supra* text accompanying notes 122-25.

431. *Id.*

432. See *supra* text accompanying notes 301-428.

433. On the possibility of such a policy, see *supra* note 23 and accompanying text.

434. On the possibilities for such incentives, see Havighurst, *supra* note 13.

ation of jurisdictional issues has suggested a role for greater judicial reliance upon constitutional principles,⁴³⁵ and our analysis of substantive antitrust issues has proposed that the courts should rely upon purpose-based rules in order to mitigate the current uncertainty in conventional doctrine.⁴³⁶ The common element in these proposals is their focus upon antitrust law as a set of standards that is designed primarily to protect "individual rights" to fair treatment rather than to promote "social policies" that serve the collective welfare.⁴³⁷ This focus upon rights is obvious when constitutional values are implicated in antitrust issues. The same focus also underlies our proposals for purpose-based rules, however, in that these kinds of rules are well designed to protect both the moral and legal rights of individuals to fair behavior by others.⁴³⁸

In the past several decades of American law, the prevailing tendency among "legal realists" in general, and antitrust lawyers in particular, has been to view the law as the pursuit of policies or collective social goals.⁴³⁹ Two issues we have discussed are illustrative: the application of a rigid *per se* rule against tie-in arrangements,⁴⁴⁰ and the invitation under the Rule of Reason to use an ad hoc balancing ap-

435. See *supra* text accompanying notes 99, 136-45, 151-97. Cf. *supra* text accompanying notes 408-28 (a possible first amendment defense against antitrust attacks upon professional credentialing activities).

436. See *supra* text accompanying notes 301-70.

437. On the important distinction between "rights" and "policies" in the adjudication of hard cases, see Dworkin, *Hard Cases*, *supra* note 179, reprinted in R. DWORKIN, *TAKING RIGHTS SERIOUSLY* 81 (1977). In brief, Dworkin argues that the making of social policy lies primarily in the domain of legislatures and that judicial decisions in civil cases "characteristically are and should be generated by principle not policy." Arguments of "policy" attempt to justify a government decision by showing that it would serve the collective welfare, in general. Arguments of "principle" are arguments from standards that justify a government decision by showing that the decision would secure "some individual or group right." Thus, when no settled rule disposes of a case, a party may nevertheless have a right to win because of preexisting legal principles that support the party's claim. See Dworkin, *Hard Cases*, *supra* note 179, at 1058-60, reprinted in R. DWORKIN, *TAKING RIGHTS SERIOUSLY* 81-84.

438. A major instance of the connection between individual rights and purpose-based legal analysis is, of course, the *mens rea* concept in criminal law. See H.L.A. HART, *PUNISHMENT AND RESPONSIBILITY* (1968); cf. I. KANT, *FOUNDATIONS OF THE METAPHYSICS OF MORALS* 16-18 (L. Beck trans. 1959) (fundamental morality, and fairness toward others, is obtained by acting in accordance with duties that are specified by principles of universal applicability; thus, moral worth and moral rights depend primarily upon "the principle of volition by which the act is done" rather than upon the effects of actions).

439. On the history of legal realism and the realists' treatment of law as social policy, see Woodard, *The Limits of Legal Realism: An Historical Perspective*, 54 VA. L. REV. 689 (1968). See also Summers, *Pragmatic Instrumentalism in Twentieth Century American Legal Thought—A Synthesis and Critique of Our Dominant General Theory About Law and Its Use*, 66 CORNELL L. REV. 861 (1981). For good examples of the realist view of antitrust law, see R. BORK, *supra* note 12; C. KAYSEN & D. TURNER, *ANTITRUST POLICY* (1959); R. POSNER, *supra* note 3.

440. See *supra* text accompanying notes 342-54.

proach in analyzing hospital privilege decisions.⁴⁴¹ At first glance, these areas of doctrinal confusion and uncertainty appear to have radically different causes. The strict antitrust treatment of tie-ins results from several Supreme Court decisions that were undertaken in the "political" antitrust tradition of promoting a decentralized economy and greater opportunities for small traders.⁴⁴² By contrast, the tendency of antitrust courts to engage in ad hoc balancing under the Rule of Reason has been substantially enhanced by the competing and now dominant tradition of analyzing antitrust issues solely from the point of view of economic efficiency and consumer welfare.⁴⁴³

Both doctrinal problems, as well as the uncertainty on issues of antitrust jurisdiction, may stem fundamentally from the same conceptual error—the judicial pursuit of social policies rather than concern for individual rights that have been granted by constitutional and statutory provisions. Thus, the "political antitrusters" have pursued interpretations of antitrust law that have focused upon restructuring the American economy and providing greater opportunities for small businesses in general, rather than upon protecting the rights of individual consumers and businesses to fair treatment.⁴⁴⁴ At the same time, "efficiency analysis" in antitrust law has focused upon promoting consumer welfare as a general policy, without particular regard for the rights of trad-

441. See *supra* note 3 and accompanying text; *supra* text accompanying notes 371-74; *supra* text accompanying notes 375-428.

442. See, e.g., *Fortner Enter. v. United States Steel Corp.*, 394 U.S. 495 (1969); *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1 (1958); *International Salt Co. v. United States*, 332 U.S. 392 (1947). For criticism of this approach, see R. POSNER, *supra* note 3, at 171-84.

443. On the substance of this "economic" tradition in antitrust law, see R. BORK, *supra* note 12; R. POSNER, *supra* note 3. On this tradition's apparent ascendancy at the current time, see *Continental T.V. v. GTE Sylvania*, 433 U.S. 36 (1977); Williamson, *Commentary, On the Political Economy of Antitrust: Grounds for Cautious Optimism* in R. TOLLISON, *supra* note 20, at 77. To be sure, the economic tradition of antitrust analysis does not logically require ad hoc judicial balancing as the preeminent analytic method, and in the hands of masters this tradition may indeed be capable of generating categorical rules of some clarity and generality. See, e.g., R. POSNER, *supra* note 3, at 171-211. Yet, if the ultimate purpose of antitrust law is efficiency, it may be unreasonable to expect that lawyers and judges in general will hew to a few efficiency-based rules and avoid the temptation to look at each case on its facts to determine which antitrust result will promote efficiency in the particular case. This seems to be one of the practical dilemmas of any Rule Utilitarianism, which instructs persons to follow rules for the purpose of achieving the greatest utility even though a particular application of the rule may not have (or appear to have) the desired result. See generally R. SARTORIUS, *INDIVIDUAL CONDUCT AND SOCIAL NORMS* 11-18 (1975).

444. See, e.g., *Blake & Jones, In Defense of Antitrust*, 65 COLUM. L. REV. 377 (1965). The focus of the political antitrusters on policies of decentralizing the American economy and expanding opportunities for small traders, at the expense of efficiency, has made this tradition a relatively easy target for efficiency-minded analysts of antitrust law. This is because it can be argued persuasively that antitrust law has not prevented the growth of big business by methods that are beyond the reach of the antitrust laws and, furthermore, that encouraging monopolies might be the best way to expand opportunities for small traders in general. The political antitrusters' policies can thus be condemned as unrealistic, inconsistent, and perhaps counterproductive as well. See, e.g., R. POSNER, *supra* note 3, at 18-22.

ers and consumers who have been wronged by the unfair acts of economic enterprises.⁴⁴⁵

Our final and most sweeping conclusion is thus that antitrust law in general may benefit from some new thinking about the individual rights that have been granted (or not granted) by Congress in its enactment of the various antitrust statutes.⁴⁴⁶ In particular, the Sherman Act would seem to be a fruitful target for this rethinking. The extreme generality of the Act appears to invite the policy-laden analyses that have produced so much apparent uncertainty and inefficiency in antitrust decisionmaking. At the same time, there is evidence suggesting that Congress primarily intended the Act to provide the federal courts with jurisdiction to enforce the rights of traders and consumers to fair treatment under the common law standards on restraints of trade and monopolies.⁴⁴⁷ This is not to say that antitrust courts should try to freeze the Sherman Act into a set of specific common law rules that may have existed as of 1890, but to suggest that the legislative history of the Sherman Act would support a new antitrust focus upon individual rights. One probable result of this focus, we suspect, would be an increasing recognition of purpose-based antitrust rules to help specify fair and unfair economic behavior towards consumers and traders.

445. See, e.g., R. BORK, *supra* note 12; R. POSNER, *supra* note 3.

446. Cf. *Discussion: Public-Choice Aspects of Antitrust in THE POLITICAL ECONOMY OF ANTITRUST*, *supra* note 20, at 125-26 (discussion between Kenneth Dam and Victor Goldberg of a "social property right" that legislatures and antitrust courts have recognized in situations in which the property values of small businesses are adversely affected).

447. See H. THORELLI, *THE FEDERAL ANTITRUST POLICY* 181-84 (1954). But see R. BORK, *supra* note 12, at 50-71.