

Note

Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?

I. INTRODUCTION

Much of the recent increase in antitrust litigation in the health care field is due to suits by health care professionals alleging antitrust violations when hospitals have denied them staff privileges.¹ In addition to individual physicians, non-physician health care providers such as podiatrists, clinical psychologists, nurse-midwives, nurse-anesthetists, and chiropractors seek hospital privileges and have legally challenged privilege denials.² The large number of cases indicates the strength of the competing interests involved.³ For a health professional, access to a hospital is vital to fully practice his profession. For a hospital, the ability to be selective in choosing its staff is vital to the quality of its service.

A plaintiff's allegation that the denial of privileges is an illegal group boycott and the hospital's assertion in defense that it must maintain its quality of care present special problems to an antitrust court. The variety and inconsistency of judicial approaches to analyzing quality of care as a justification for exclusion⁴ suggest the difficulty of reconciling these competing interests under the antitrust laws in a way that prevents anticompetitive abuses without interfering with the legitimate functioning of hospitals. In struggling with these cases, courts have not adequately distinguished between denial of privileges to an individual physician and exclusion of an entire group of non-physicians.⁵ However, there are clear

¹Nearly half of health care antitrust cases involve staff privileges. *Attempts to Gain Access to Hospitals Are Prevalent in Health Care Actions*, [Jan.-June] Antitrust & Trade Reg. Rep. (BNA) No. 1150, at 187 (Feb. 2, 1984).

²See, e.g., *Bhan v. NME Hosp., Inc.*, 772 F.2d 1467 (9th Cir. 1985) (nurse-anesthetist); *Wilk v. American Medical Ass'n*, 719 F.2d 207 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984) (chiropractors); *Kaczanowski v. Medical Center Hosp. of Vt.*, 612 F. Supp. 688 (D. Vt. 1985) (podiatrists); *Nurse Midwifery Assocs. V. Hibbett*, 54 F. Supp. 1185 (M.D. Tenn. 1982) (nurse-midwives); *Ohio Charges Accreditation Association with Preventing Competition in Provision of Psychological Care*, [Jan.-June] Antitrust & Trade Reg. Rep. (BNA) No. 948, at D-2 (Jan. 24, 1980) [hereinafter *Ohio Charges Accreditation Association*] (clinical psychologists).

³Enders, *Antitrust and Health Care: Reconciling Competing Values—Medical Staff Issues*, 6 WHITTIER L. REV. 737, 737 (1984).

⁴See *infra* notes 118-38 and accompanying text.

⁵See *infra* notes 118-44 and accompanying text.

differences between quality of care as a rationale for excluding an individual physician and as a justification for barring a group of non-physicians. Because of these differences, exclusion of a group merits heightened antitrust scrutiny.

Beginning with an overview of group boycott law, this Note discusses the issue of hospital privileges, focusing on specific non-physician groups seeking privileges. After examining a denial of privileges as a group boycott and quality of care as a defense, this Note surveys judicial approaches to such a defense. As this Note will show, there are significant differences between a quality of care rationale asserted against individuals and asserted against groups. Because of these differences, primarily the greater potential anticompetitive effects of excluding an entire group of competitors, this Note concludes with a recommendation that judicial scrutiny of quality of care as a defense be based on a substantial relation and least restrictive alternative test when quality is asserted as a justification for excluding a group. A court should demand that a quality standard invoked to deny privileges to non-physicians be substantially related to the procompetitive justification asserted for the standard and that the standard be the least restrictive alternative for achieving that procompetitive justification.

II. OVERVIEW OF ANTITRUST LAW

Section one of the Sherman Act states that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."⁶ Relatively early in the history of litigation under this provision, the United States Supreme Court decided that Congress could not have intended such a potentially broad proscription of trade.⁷ The Court, therefore, formulated the "rule of reason," declaring that only conduct that unreasonably restrains trade violates the Sherman Act.⁸ Under the rule of reason, a court analyzes in detail the challenged conduct in a specific market and weighs the procompetitive and anticompetitive effects. Where anticompetitive effects predominate, the conduct will be declared unreasonably restrictive of trade, thus illegal.⁹

Because applying the rule of reason consumed much judicial time and because certain practices were repeatedly found to be anticompetitive in various contexts, the Court has, over the years, declared certain trade

⁶15 U.S.C. § 1 (1982).

⁷*Standard Oil Co. v. United States*, 221 U.S. 1, 60 (1911). Because a contract to sell a product to one buyer effectively precludes others from buying that particular product, a literal reading of section one could conceivably bar all contracts to sell. *Id.*

⁸*Id.*

⁹*National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 690-92 (1978).

restrictions per se illegal.¹⁰ Having specific, clearly defined per se offenses conserves judicial time and enhances predictability in the conduct of business.¹¹ Because a per se offense includes a presumption of anticompetitive effect,¹² a plaintiff need not show the challenged conduct has an anticompetitive effect in a specific market, but only that a defendant did the act alleged.

One type of conduct that has been accorded per se status is a group boycott or concerted refusal to deal,¹³ recently defined by the Court as "joint efforts . . . to disadvantage competitors by 'either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle.'" ¹⁴ A group boycott is a somewhat amorphous offense because almost any joint conduct that results in denial of a business relationship to a competitor may be characterized as a group boycott.¹⁵ Therefore, the courts have not found that anything a plaintiff labels a group boycott is per se illegal, but have instead applied the rule of reason in certain contexts, so that only conduct with clearly anticompetitive effects would be found illegal.¹⁶ Group boycotts thus became a quasi per se offense. In *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.*,¹⁷ the Supreme Court attempted to clarify the confusion in group boycott law by declaring that only where a plaintiff can show that a defendant "possesses market power or exclusive access to an element essential to effective competition,"¹⁸ may a court find an alleged group boycott per se illegal.¹⁹ Where a plaintiff cannot make this showing, the alleged group boycott should be evaluated under the rule of reason.²⁰

¹⁰*Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 5 (1958) (listing price fixing, division of markets, group boycotts, and tying arrangements as per se offenses).

¹¹*Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 343-44 (1982).

¹²*Id.*

¹³*Silver v. New York Stock Exch.*, 373 U.S. 341, 347-48 (1963); *Klor's v. Broadway-Hale Stores*, 359 U.S. 207, 212 (1959).

¹⁴*Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 105 S. Ct. 2613, 2619 (1985) (quoting L. SULLIVAN, *LAW OF ANTITRUST* 261-62 (1977)).

¹⁵P. AREEDA, *ANTITRUST ANALYSIS* ¶ 370 (3d ed. 1981) ("boycotts are not a unitary phenomenon").

¹⁶*See, e.g.*, *Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1491-93 (D.C. Cir. 1984); *United States Trotting Ass'n v. Chicago Downs Ass'n*, 665 F.2d 781, 788-90 (7th Cir. 1981); *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 484-85 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981); *Hatley v. American Quarter Horse Ass'n*, 552 F.2d 646, 652-53 (5th Cir. 1977).

¹⁷105 S. Ct. 2613 (1985).

¹⁸*Id.* at 2621. "Market power" is "the capacity to act other than as a perfectly competitive firm would;" it often results from having a large market share. P. AREEDA, *supra* note 15, at ¶ 201.

¹⁹105 S. Ct. at 2621.

²⁰*Id.*

III. HOSPITAL STAFF PRIVILEGES

A. Overview of Staff Privileges

A health care provider must have staff privileges in order to admit his patients to a hospital and to care for them there.²¹ A hospital's decision whether to grant these privileges is typically made by a committee of the medical staff, physicians who have privileges at the institution, by applying criteria in the hospital's by-laws.²² This decision may be reviewed by the entire medical staff and is subject to approval by the hospital's board of directors or trustees.²³

The Joint Commission on Accreditation of Hospitals (JCAH), a private body formed and run by physicians and hospitals, is responsible for accrediting most of the hospitals in this country.²⁴ The JCAH has established several categories of hospital privileges. These categories include "clinical privileges," whereby a provider may not admit patients to a hospital but he may provide treatment there, as well as privileges providing for varying levels of participation on the medical staff itself.²⁵ The most advantageous category for a practitioner is full membership on the medical staff, with its attendant admission privileges and voting rights in setting medical policy.

Whether an applicant is granted privileges is critical to him, both professionally and economically.²⁶ If certain tasks of his profession, such as surgical procedures, must be done in a hospital, the lack of privileges means that his range of practice is significantly curtailed. If he has no privileges and one of his patients needs treatment that can only be provided in a hospital, he must refer the patient to a provider with privileges and he may never get the patient back. Furthermore, if patients

²¹JOINT COMM'N ON ACCREDITATION OF HOSPS., ACCREDITATION MANUAL FOR HOSPITALS, 1986 111 (1985).

²²*Id.* at 101-02, 107. See generally M. ROEMER & J. FRIEDMAN, DOCTORS IN HOSPITALS 43-46, 225 (1971).

²³JOINT COMM'N ON ACCREDITATION OF HOSPS., *supra* note 21, at 101-02, 114; see also M. ROEMER & J. FRIEDMAN, *supra* note 22.

²⁴Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C.L. REV. 835, 839 (1983).

²⁵For example, in addition to the "active medical staff," a hospital may establish an "associate medical staff," consisting of "physicians and dentists who are being considered for advancement to the active medical staff;" a "courtesy medical staff," with "privileges to admit and treat only an occasional patient;" and a "consulting medical staff" of physicians who are not in another category, but who come to the hospital to consult. JOINT COMM'N ON ACCREDITATION OF HOSPS., ACCREDITATION MANUAL FOR HOSPITALS 89-96 (1984); see also *Quinn v. Kent Gen. Hosp.*, 617 F. Supp. 1226, 1231 (D. Del. 1985) (physician appointed to consulting staff challenged exclusion from active medical staff where only active medical staff could admit patients); Jost, *supra* note 24, at 873.

²⁶Enders, *supra* note 3, at 737.

know the applicant cannot use a hospital, they may elect not to go to him at all.²⁷

There has historically been some degree of conflict between physicians on the medical staff, concerned primarily that the hospital provides the facilities, support staff, and equipment the doctors need, and the hospital administration, concerned primarily with budgetary and efficiency matters.²⁸ Recent economic changes in the market for health and hospital services are likely to intensify this conflict with regard to admission privileges. There is currently a surplus of some types of physicians, which is expected to increase in the future.²⁹ The resulting increased competition for patients may lead physicians on staff to deny privileges to unwanted competitors.³⁰ In addition, the recent change to a prospective payment method for federal Medicare payments to hospitals has led to empty beds because hospitals are discharging patients earlier.³¹ While hospitals may have an incentive to increase their medical staff to provide patients to fill the empty beds, hospitals must also appease the doctors already on staff to encourage them to admit more patients.³² Finally, the development of preferred provider organizations (PPO's) promises to increase price competition among hospitals. One commentator predicts this will only increase tension between the medical staff and hospital administration as physicians respond to the increased competition by trying to close the staff while administrators want a larger staff to increase business.³³

²⁷See *Wolf v. Jane Phillips Episcopal-Memorial Medical Center*, 513 F.2d 684, 686 (10th Cir. 1975).

²⁸M. ROEMER & J. FRIEDMAN, *supra* note 22, at 283.

²⁹Tarlov, *Shattuck Lecture—The Increasing Supply of Physicians, the Changing Structure of the Health Services System, and the Future Practice of Medicine*, 308 NEW ENG. J. MED. 1235, 1237-38 (1983).

³⁰Spivey, *The Relation Between Hospital Management and Medical Staff Under a Prospective-Payment System*, 310 NEW ENG. J. MED. 984, 984 (1984).

³¹*Patients Are Leaving Hospitals Sooner and Sicker, Study Says*, 85 AM. J. NURSING 828 (1985). Under the new prospective payment method, Medicare pays a hospital for a specified number of days of care based on a patient's diagnostic category. If the patient's hospitalization lasts longer than predicted based on his diagnosis, the hospital is not paid for the extra days. Conversely, if the patient is sent home in fewer than the established number of days, the hospital still receives the predetermined amount. Therefore, there is an incentive for hospitals to discharge patients quickly. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 84 DUKE L.J. 1071, 1077 n.14 (1984).

³²See Mechanic, *Some Dilemmas in Health Care Policy*, 59 MILBANK MEMORIAL FUND Q. 1, 4-5 (1981); Spivey, *supra* note 30.

³³Spivey, *supra* note 30. *But see* Enders, *supra* note 3, at 738-39. A preferred provider organization is an arrangement whereby a group of doctors or hospitals contracts with an insurer or other purchaser of health care to provide services to insureds at set (usually discounted) fees. The disadvantage to the provider of the lower fees is offset by increased business from participating in the PPO. Built-in financial disincentives discourage patients

B. *Non-Physicians and Hospital Privileges*

Until 1985, the Joint Commission on Accreditation of Hospitals required that medical staff membership be restricted to physicians and dentists.³⁴ However, partially because of antitrust suits against the JCAH by non-physician groups categorically denied staff privileges,³⁵ the JCAH relaxed its criteria and now permits each hospital to decide for itself whether to grant staff privileges to independent non-physician health care providers.³⁶ This change may encourage non-physicians to apply for privileges and to sue under the antitrust laws if privileges are denied.

Several specific non-physician groups desire hospital privileges and have legally challenged privilege denials in the past. One such group is podiatrists. Podiatrists receive four years of graduate level education in the diagnosis and medical and surgical treatment of diseases of the foot and are licensed in all states.³⁷ Podiatrists seek hospital privileges because some complex podiatric surgical procedures can best be performed in a hospital or because surgical patients have chronic medical diseases and require close monitoring and observation available only in a hospital setting.³⁸ Podiatrists compete with orthopedic surgeons in the market for foot surgery.³⁹

A major antitrust suit by a podiatrist who lost his hospital admitting and surgical privileges due to the previous JCAH restriction was *Levin*

from seeking care from other than a "preferred provider." See AMERICAN HOSP. ASS'N, LEGAL DEVELOPMENTS REPORT NO. 4, STATE REGULATION OF PREFERRED PROVIDER ORGANIZATIONS: A SURVEY OF STATE STATUTES iv (1984).

³⁴JOINT COMM'N ON ACCREDITATION OF HOSPS., *supra* note 25, at 89.

³⁵See, e.g., *Wilk v. American Medical Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984); *Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515 (D.C. Cir. 1965); *Health Care Equalization Comm. of the Iowa Chiropractic Soc'y v. Iowa Medical Soc'y*, 501 F. Supp. 970 (S.D. Iowa 1980); *New York v. American Medical Ass'n*, 1980-2 Trade Cas. (CCH) ¶ 63,456 (E.D.N.Y. 1980); *Ohio Charges Accreditation Association*, *supra* note 2. See generally AMERICAN HOSP. ASS'N, AN ANALYSIS OF THE REVISED MEDICAL STAFF STANDARDS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS 1-2 (1984); Beardon, *JCAH Adopts Revised Medical Staff Standards*, 2 THE HEALTH LAWYER 4, 4 (1984); Jost, *supra* note 24, at 912. One report estimated the potential antitrust liability of the JCAH and other medical organizations named as defendants in four pending antitrust actions at over \$300 million. *JCAH Is Weighing Wider Access to Staff Privileges in Hospitals*, 83 AM. J. NURSING 1260 (1983).

³⁶See JOINT COMM'N ON ACCREDITATION OF HOSPS., *supra* note 21, at 101. See generally AMERICAN HOSP. ASS'N. *supra* note 35, at 2-13.

³⁷Hollowell, *The Growing Legal Contest—Hospital Privileges for Podiatrists*, 23 ST. LOUIS U.L.J. 491, 492 & n.8 (1979).

³⁸See Podell, *Issues in the Organization of Medical Care: An Illustrative Case Study—Podiatry in the United States*, 284 NEW ENG. J. MED. 586, 587 (1971).

³⁹Skipper & Hughes, *Podiatry: Critical Issues in the 1980's*, 74 AM. J. PUB. HEALTH, 507, 507 (1984).

v. Doctors Hospital.⁴⁰ After Levin successfully joined the JCAH as a defendant,⁴¹ the suit was settled out of court. As part of the settlement, the JCAH established a separate category of clinical privileges for podiatrists whereby, at the discretion of the individual hospital, a podiatrist and a physician could collaborate on admitting and treating a podiatric patient.⁴² In the twenty years since *Levin*, podiatrists have succeeded in gaining some type of privileges at over fifty percent of the hospitals in this country.⁴³ However, two recent cases in which podiatrists lost antitrust challenges to the categorical denial of staff privileges attest to the continuing vitality of physicians' resistance to podiatrists obtaining hospital privileges.⁴⁴

Clinical psychologists, who compete with physician psychiatrists in the market for psychotherapy and treatment of mental illness, seek hospital privileges to admit and treat patients experiencing acute emotional crises or patients requiring constant protection against self-harm.⁴⁵ Psychologists have been less successful than podiatrists in getting a foot in the door regarding hospital privileges.⁴⁶ The major psychologists' privileges case was instituted by the Attorney General of Ohio, who alleged that the categorical denial of staff privileges to psychologists foreclosed

⁴⁰233 F. Supp. 953 (D.D.C. 1964), *rev'd per curiam sub nom. Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515 (D.C. Cir. 1965).

⁴¹*Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515 (D.C. Cir. 1965).

⁴²Hollowell, *supra* note 37, at 500-01 n.55.

⁴³AMERICAN PODIATRIC MEDICAL ASS'N, FOOT CARE: A MAJOR PRODUCT LINE FOR TODAY'S COMPETITIVE HOSPITAL MARKETPLACE 1 (1985).

⁴⁴*Kaczanowski v. Medical Center Hosp. of Vt.*, 612 F. Supp. 688 (D. Vt. 1985); *Cooper v. Forsyth County Hosp. Auth.*, 604 F. Supp. 685 (M.D.N.C. 1985), *aff'd*, 789 F.2d 278 (4th Cir. 1986). For earlier cases in which podiatrists challenged exclusion from hospitals on antitrust or constitutional grounds, see *Shaw v. Hospital Auth. of Cobb County*, 614 F.2d 946 (5th Cir.), *cert. denied*, 449 U.S. 955 (1980); *Feldman v. Jackson Memorial Hosp.*, 571 F. Supp. 1000 (S.D. Fla. 1983), *aff'd mem.*, 752 F.2d 647 (11th Cir.), *cert. denied*, 105 S. Ct. 3504 (1985); *Todd v. Physicians & Surgeons Community Hosp.*, 165 Ga. App. 656, 302 S.E.2d 378 (1983); *Settler v. Hopedale Medical Found.*, 80 Ill. App. 3d 850, 400 N.E.2d 577 (1980); *Davidson v. Youngstown Hosp. Ass'n*, 19 Ohio App. 2d 246, 250 N.E.2d 892 (1969). See also *Hospital Must Consider Podiatrists for Privileges*, [July-Dec.] Antitrust & Trade Reg. Rep. (BNA) No. 1238, at 742 (Oct. 31, 1985) (podiatrists successfully challenged denial of privileges by invoking state anti-discrimination statute); 50 Fed. Reg. 41,693 (1985) (consent agreement proposed Oct. 11, 1985, to settle complaint by Federal Trade Commission that a hospital's and medical staff's restrictions of podiatrists' surgical privileges restrained competition in violation of section 5 of Federal Trade Commission Act).

⁴⁵Tanney, *Hospital Privileges for Psychologists—A Legislative Model*, 38 AM. PSYCHOLOGIST 1232, 1233 (1983).

⁴⁶See McGuire & Moore, *Private Regulation in Mental Health: The JCAH and Psychologists in Hospitals*, 7 L. & HUM. BEHAV. 235 (1983); Zaro, Batchelor, Ginsberg & Pallak, *Psychology and the JCAH: Reflections on a Decade of Struggle*, 37 AM. PSYCHOLOGIST 1342 (1982).

consumer choice in the market for mental health care and stabilized prices at non-competitive levels.⁴⁷ The case became moot, however, when the Ohio legislature enacted a statute that restricted hospital admission privileges to physicians.⁴⁸

Another non-physician group interested in obtaining staff privileges is nurse-midwives.⁴⁹ Nurse-midwives are registered nurses who have completed six to twenty-four months of additional specialized training and who are certified to provide health care for women during all phases of the reproductive cycle and to deliver babies of women with low-risk pregnancies.⁵⁰ By statute, nurse-midwives must be supervised by physicians for some aspects of their practice.⁵¹ In 1982, nurse-midwives delivered only 1.8 percent of the babies born in the United States, but this proportion was an eighty percent increase from 1976.⁵² Nurse-midwives directly compete with obstetricians in the market for childbirth services. Legal battles involving hospital privileges for nurse-midwives have been reported in several states and the District of Columbia, although no antitrust case has yet been decided on the merits.⁵³

The most recent group to challenge denial of privileges under the antitrust laws is nurse-anesthetists. Nurse-anesthetists are registered nurses who receive a minimum of two years of additional training in administering anesthesia.⁵⁴ Like nurse-midwives, they must work under physician supervision.⁵⁵ Historically, nurses were the primary group responsible for administering anesthesia in this country, and nurse-anesthetists are still responsible for more than fifty percent of anesthetic procedures.⁵⁶ Today, nurse-anesthetists' primary competitors are physician anesthesiologists, and in a market with an increasing supply of anesthesia providers, the competition is intense.⁵⁷

⁴⁷*Ohio Charges Accreditation Association*, *supra* note 2.

⁴⁸OHIO REV. CODE ANN. § 3727.06 (Page Supp. 1985).

⁴⁹See generally Comment, *Hospital Privileges for Nurse-Midwives: An Examination Under Antitrust Law*, 33 AM. U.L. REV. 959 (1984).

⁵⁰Adams, *Nurse-Midwifery Practice in the United States, 1982*, 74 AM. J. PUB. HEALTH 1267, 1267 (1984); Levy, Wilkinson & Marine, *Reducing Neonatal Mortality Rate with Nurse-Midwives*, 109 AM. J. OBSTETRICS & GYNECOLOGY 50, 51 (1971).

⁵¹Levy, Wilkinson & Marine, *supra* note 50, at 51; see, e.g., CONN. GEN. STAT. ANN. § 20-86(b) (West Supp. 1986); N.J. STAT. ANN. § 45:10-8 (West 1978); OHIO REV. CODE ANN. § 4731.33 (Page 1977).

⁵²Adams, *supra* note 50, at 1267, 1270.

⁵³See *Nurse Midwifery Assocs. v. Hibbett*, 549 F. Supp. 1185 (M.D. Tenn. 1982); *CNM's Seek Test of Right to Compete with MD's*, 85 AM. J. NURSING 599 (1985); *CNM's Pursue Admitting Privileges*, 83 AM. J. NURSING 1261 (1983).

⁵⁴Adams, *Nurse Anesthetist Clarifies Group's Responsibilities*, Am. Med. News, May 10, 1985, at 6, col. 1.

⁵⁵*Id.*; see, e.g., OHIO REV. CODE ANN. § 4731.35 (Page 1977).

⁵⁶Adams, *supra* note 54; *CRNA's Battle a Trend to Phase Out Hospital Jobs*, 84 AM. J. NURSING 376, 386 (1984) [hereinafter *CRNA's Battle*].

⁵⁷*CRNA's Battle*, *supra* note 56, at 386, 390.

Neither nurse-anesthetists nor physician anesthesiologists actually admit patients to a hospital. They generally work under a contractual arrangement to provide anesthesia to surgical patients.⁵⁸ Consequently, the conflict has not been over staff privileges per se, but over potential anticompetitive abuses where contractual arrangements have been changed to replace nurse-anesthetists with physician anesthesiologists.⁵⁹ In Maine, the state attorney general accused anesthesiologists who attempted to close a nurse-anesthetist training program of violating antitrust law.⁶⁰ The physicians entered into a consent decree enjoining them from raising prices, negotiating exclusive contracts, and interfering with the employment or training of nurse-anesthetists.⁶¹ In West Virginia, the state attorney general also alleged antitrust violations where two hospitals changed their staff by-laws to block nurse-anesthetists from obtaining staff privileges, and also reached a settlement in which the anesthesiologists involved would not raise prices, enter into exclusive contracts, or jointly participate in any privileges decision regarding nurse-anesthetists.⁶² Finally, in a case from California, the Ninth Circuit declared that nurse-anesthetists compete with physician anesthesiologists despite a state statutory requirement that nurse-anesthetists be supervised by physicians, thus permitting a nurse-anesthetist barred from hospital practice to proceed with his antitrust suit.⁶³

Chiropractors are another group seeking access to hospitals, although chiropractors may not actually compete with physicians. At least one study suggests consumers do not view chiropractors' services as a substitute for physicians'.⁶⁴ Nevertheless, chiropractors have been challenging exclusionary behavior by the medical establishment for years.⁶⁵ Regarding

⁵⁸See Adams, *supra* note 54.

⁵⁹See *CRNA's Battle*, *supra* note 56, at 376-90.

⁶⁰State v. Anesthesia Prof. Ass'n, 1984-2 Trade Cas. (CCH) ¶ 66,081 (Me. Super. Ct. 1984).

⁶¹*Id.* See generally *Maine Aims AT Blow at MD's and Saves the Day for CRNA's*, 85 AM. J. NURSING 600 (1985) (reports background of the litigation).

⁶²*Anesthesiologists Will Hold Down Prices Under Settlement with Attorney General*, [Jan.-June] Antitrust & Trade Reg. Rep. (BNA) No. 1258, at 551 (March 27, 1986).

⁶³Bhan v. NME Hosp., Inc., 772 F.2d 1467 (9th Cir. 1985).

⁶⁴Yesalis, Wallace, Fisher & Tokheim, *Does Chiropractic Utilization Substitute for Less Available Medical Services?*, 70 AM. J. PUB. HEALTH 415 (1980).

⁶⁵See *Wilk v. American Medical Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984); *Ballard v. Blue Shield of S. W. Va.*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977); *Aasum v. Good Samaritan Hosp.*, 542 F.2d 792 (9th Cir. 1976); *Spears Free Clinic & Hosp. for Poor Children v. Cleere*, 197 F.2d 125 (10th Cir. 1952); *Chiropractic Coop. Ass'n of Mich. v. American Medical Ass'n*, 617 F. Supp. 264 (E.D. Mich. 1985); *Slavek v. American Medical Ass'n*, 1982-1 Trade Cas. (CCH) ¶ 64,509 (E.D. Pa. 1982); *Ballard v. Blue Shield of S. W. Va.*, 529 F. Supp. 71 (S.D. W. Va. 1981); *Health Care Equalization Comm. of the Iowa Chiropractic Soc'y v. Iowa Medical Soc'y*, 501 F. Supp. 970 (S.D. Iowa 1980); *New York v. American Medical Ass'n*,

hospital access, chiropractors do not necessarily want admitting privileges, but merely the ability to refer patients to a hospital's laboratory or x-ray facilities as an aid in diagnosis.⁶⁶ In the past, the JCAH has warned hospitals that cooperating with chiropractors even to this extent might threaten the hospital's accreditation.⁶⁷ In light of the recent relaxation of JCAH standards for privileges,⁶⁸ however, each individual hospital may now apparently decide whether to accommodate chiropractors. In general, chiropractors have not fared well in their legal efforts to gain access to hospitals,⁶⁹ although suits by chiropractors against medical associations may be partially responsible for the change in JCAH standards.

IV. HOSPITAL PRIVILEGE DENIALS AS A GROUP BOYCOTT

As a result of United States Supreme Court decisions in the 1970's and early 1980's, health care providers can challenge the denial of hospital privileges under the antitrust laws. In *Hospital Building Co. v. Trustees of Rex Hospital*⁷⁰ and *McLain v. Real Estate Board of New Orleans*,⁷¹ the Court relaxed its definition of interstate commerce, so that a plaintiff's showing that the challenged restraint affects the purchase of supplies out-of-state or the billing of out-of-state insurers is enough to satisfy the Sherman Act's interstate commerce requirement.⁷² More significantly,

1980-2 Trade Cas. (CCH) ¶ 63,456 (E.D.N.Y. 1980); *Kentucky Ass'n of Chiropractors v. Jefferson County Medical Soc'y*, 549 S.W.2d 817 (Ky. 1977); *New Jersey Chiropractic Soc'y v. Radiological Soc'y of N.J.*, 156 N.J. Super. 365, 383 A.2d 1182 (1978); *Boos v. Donnell*, 421 P.2d 644 (Okla. 1966).

⁶⁶See Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595, 675 (1982) [hereinafter Kissam & Webber]; Note, *Health Professionals' Access to Hospitals: A Retrospective and Prospective Analysis*, 34 VAND. L. REV. 1161, 1194 (1981).

⁶⁷*Wilk v. American Medical Ass'n*, 719 F.2d 207, 214 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984); see also *Aasum v. Good Samaritan Hosp.*, 395 F. Supp. 363, 370-71 (D. Ore. 1975), aff'd, 542 F.2d 792 (9th Cir. 1976).

⁶⁸See *supra* notes 35-36 and accompanying text.

⁶⁹See, e.g., *Aasum v. Good Samaritan Hosp.*, 395 F. Supp. 363 (D. Ore. 1975), aff'd, 542 F.2d 792 (9th Cir. 1976); *Boos v. Donnell* 421 P.2d 644 (Okla. 1966); cf. *Kentucky Ass'n of Chiropractors v. Jefferson County Medical Soc'y*, 549 S.W.2d 817 (Ky. 1977) (chiropractors not permitted to use services of medical laboratories).

⁷⁰425 U.S. 738 (1976).

⁷¹444 U.S. 232 (1980).

⁷²*Hospital Bldg. Co.*, 425 U.S. at 744; *McLain*, 444 U.S. at 242, 245. There is conflict among the federal circuit courts of appeal as to just how much *McLain* relaxed the definition, i.e. as to whether a plaintiff may show merely that a defendant's business activities in general affect interstate commerce or whether a plaintiff must show a nexus between the challenged restraint and interstate commerce. See *Shahawy v. Harrison*, 778 F.2d 636 (11th Cir. 1985); *Seglin v. Esau*, 769 F.2d 1274 (7th Cir. 1985); *Hayden v. Bracy*, 744 F.2d 1338 (8th Cir. 1984); *Cardio-Medical Assocs. v. Crozer-Chester Medical Center*, 721 F.2d 68 (3d Cir. 1983); *Furlong v. Long Island College Hosp.*, 710 F.2d 922

in *Goldfarb v. Virginia State Bar*⁷³ and in *Arizona v. Maricopa County Medical Society*,⁷⁴ the Court made it clear that professionals, including physicians, are not exempt from the antitrust laws.⁷⁵ These changes cleared the way for a deluge of antitrust suits challenging privilege denials, many of which were brought by individual physicians.⁷⁶ Because an excluded privileges applicant competes with physicians on the hospital's medical staff, the denial of hospital privileges can be characterized as a group boycott. The staff's recommendation to deny or terminate privileges is a joint decision by competitors that deprives the applicant of access to the hospital, a resource essential to his ability to compete.⁷⁷

Because a group boycott is a violation of section one of the Sherman Act, a critical issue in a hospital privileges suit brought on a group boycott theory is the existence of a conspiracy or concerted action by competitors. Some defendants have asserted that the denial of privileges resulted from merely unilateral action by the hospital; thus, there was not the combination or conspiracy required for a section one violation.⁷⁸ However, although the hospital board makes the final decision on whether to grant privileges, hospital boards almost always defer to the medical expertise of physicians and agree with the medical staff's or staff committee's recommendation.⁷⁹ According to one federal district court, the individual physicians on the staff or on the reviewing committee are more than the mere agents of the hospital in making this recommendation because the doctors have a personal economic interest in the outcome

(2d Cir. 1983); *Mishler v. St. Anthony's Hosp. Sys.*, 694 F.2d 1225 (10th Cir. 1981); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715 (10th Cir. 1981) (on reh'g en banc); *Capili v. Shott*, 620 F.2d 439 (4th Cir. 1980).

⁷³421 U.S. 773 (1975).

⁷⁴457 U.S. 332 (1982).

⁷⁵*Goldfarb*, 421 U.S. at 787-88; *Maricopa*, 457 U.S. at 348-49.

⁷⁶*Attempts to Gain Access to Hospitals Are Prevalent in Health Care Actions*, [Jan.-June] Antitrust & Trade Reg. Rep. (BNA) No. 1150, at 187 (Feb. 2, 1984). In October 1986, Congress effectively eliminated antitrust suits by individual physicians by providing immunity from damages liability for peer review committees, their members, and the hospital where restrictions in clinical privileges are based on review of a physician's competence or professional conduct. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, tit. IV. The statutory definition of immunized conduct refers only to "individual physician[s]," *id.* § 431(9), so presumably the statute does not cover applications for hospital privileges by non-physicians, nor does it preclude a physician seeking injunctive relief.

⁷⁷See *supra* notes 13-15 and accompanying text.

⁷⁸See *Weiss v. York Hosp.*, 745 F.2d 786, 814-17 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985); *Quinn v. Kent Gen. Hosp.*, 617 F. Supp. 1226, 1242 (D. Del. 1985); *Feldman v. Jackson Memorial Hosp.*, 571 F. Supp. 1000, 1009 (S.D. Fla. 1983), *aff'd mem.*, 752 F.2d 647 (11th Cir. 1985), *cert. denied*, 105 S. Ct. 3504 (1985); *Williams v. Kleaveland*, 534 F. Supp. 912, 920 (W.D. Mich. 1981).

⁷⁹Redisch, *Physician Involvement in Hospital Decision Making*, in *HOSPITAL COST CONTAINMENT* 217, 220-21 (M. Zubkoff, I. Raskin & R. Hanft eds. 1978).

of the privileges decision.⁸⁰ Therefore, the board's approval of this recommendation does not immunize the staff's action from antitrust scrutiny. In *Weiss v. York Hospital*,⁸¹ the Third Circuit held that as a matter of law, a medical staff is a combination of competitors.⁸² This court also noted the individual economic interest of staff members in the outcome of a privileges decision.⁸³ According to this view, the potentially illegal conspiracy is not between the staff and the hospital, but within the staff itself.

The absence on the reviewing committee of a direct competitor of an applicant should not mislead a court to conclude that there was no anticompetitive conduct.⁸⁴ Commentators have noted the immense power of the referral network among physicians.⁸⁵ Because physician specialists depend on their physician colleagues for patient referrals and for coverage on days off, there is great incentive for physicians to conform to their colleagues' wishes.⁸⁶ Peer pressure subtly exerted on the members of a reviewing committee could easily induce them to deny privileges to their colleagues' unwanted competitors.

Although a group boycott can be a per se antitrust offense,⁸⁷ most courts faced with hospital privileges cases have applied the rule of reason, on several bases. One basis is that hospital privileges decisions are a form of industry self-regulation.⁸⁸ Because industry self-regulation can have significant procompetitive benefits, whether a particular restraint is unreasonable can only be determined after detailed analysis under the rule of reason.⁸⁹ Also, although the Supreme Court in *Maricopa* made

⁸⁰*Robinson v. Magovern*, 521 F. Supp. 842, 907 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3rd Cir.), *cert denied*, 459 U.S. 971 (1982).

⁸¹745 F.2d 786 (3rd Cir. 1984), *cert denied*, 105 S. Ct. 1777 (1985).

⁸²*Id.* at 814.

⁸³*Id.* at 815-16.

⁸⁴Havighurst, *supra* note 31, at 1116-17.

⁸⁵*See, e.g.*, E. FREIDSON, PROFESSIONAL DOMINANCE—THE SOCIAL STRUCTURE OF MEDICAL CARE 72, 99, 190 (1970).

⁸⁶A clear example of how physicians can influence their colleagues' behavior without overt coercion appears in *Feminist Women's Health Center v. Mohammad*, where an obstetrician described how peer pressure induced him to sever his relations with an abortion clinic. 586 F.2d 530, 536-37 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

⁸⁷*Silver v. New York Stock Exch.*, 373 U.S. 341, 347-48 (1963); *Klor's v. Broadway-Hale Stores*, 359 U.S. 207, 212 (1959); *see also Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985) (denial of privileges to osteopaths held to be per se illegal group boycott).

⁸⁸*See, e.g.*, *Vuciecevic v. MacNeal Memorial Hosp.*, 572 F. Supp. 1424, 1428 (N.D. Ill. 1983); *cf. Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1491 (D.C. Cir. 1984) (rule of reason appropriate for evaluating professional association's exclusion of dentist based on application of standards).

⁸⁹*See, e.g.*, *Silver v. New York Stock Exch.*, 373 U.S. 341, 348-49 (1963) (rule of reason may be appropriate approach where proper procedures have been followed in stock exchange self-regulation under Securities Exchange Act); *Hatley v. American Quarter Horse*

it clear that per se rules may apply to learned professions,⁹⁰ dicta in this and other Supreme Court decisions suggest that the rule of reason is the proper approach when restraints of trade by a profession are premised on public service or ethical norms.⁹¹ A denial of privileges because the applicant fails to meet a quality standard has such a premise.⁹² Some courts have used the rule of reason because the judiciary lacks experience applying antitrust laws to the health care industry.⁹³ These courts are wary of per se condemnation of a particular industry practice until they can be more confident that the practice will almost always be anticompetitive.

Finally, despite the Supreme Court's recent statement in *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.*⁹⁴ that the per se rule may apply to a group boycott if the defendant has market power,⁹⁵ where the defendant hospital in a privileges case has market power, a trial court might use the rule of reason. Dicta in *Northwest Stationers* suggesting that "plausible arguments that [the restraints] were intended to enhance overall efficiency and make markets more competitive"⁹⁶ may weaken the per se rule's presumption of anticompetitive effect and make the rule of reason the appropriate judicial

Ass'n, 552 F.2d 646, 652 (5th Cir. 1977) (rule of reason appropriate where group boycott alleged in context of sports industry self-regulation); see also Ponsoldt, *The Application of Sherman Act Antiboycott Law to Industry Self-Regulation: An Analysis Integrating Nonboycott Sherman Act Principles*, 55 S. CAL. L. REV. 1, 33-34 (1981).

⁹⁰457 U.S. at 348-49.

⁹¹*Id.* (per se rule applicable where doctors' conduct "not premised on public service or ethical norms"); *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 696 (1978) ("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."); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788-89 n.17 (1975) ("The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently."); see also *Federal Trade Comm'n v. Indiana Fed'n of Dentists*, 106 S. Ct. 2009, 2018 (1986) ("we have been slow to condemn rules adopted by professional associations as unreasonable *per se*").

⁹²See, e.g., *Weiss v. York Hosp.*, 745 F.2d 786, 820 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985) (per se rule applied because "defendants have offered no 'public service or ethical norm' rationale"); *Pontius v. Children's Hosp.*, 552 F. Supp. 1352, 1369-70 (W.D. Pa. 1982); see also *Chiropractic Coop. Ass'n of Mich. v. American Medical Ass'n*, 617 F. Supp. 264, 269 (E.D. Mich. 1985) (defendant physicians' assertion that exclusion of chiropractors was motivated by quality of care invokes rule of reason).

⁹³*Vuciecevic v. MacNeal Memorial Hosp.*, 572 F. Supp. 1424, 1427 (N.D. Ill. 1983); *Pontius v. Children's Hosp.*, 552 F. Supp. 1352, 1368 (W.D. Pa. 1982); *Everhart v. Jane C. Stormont Hosp.*, 1982-1 Trade Cas. (CCH) ¶ 64,703, 73,897 (D. Kans. 1982).

⁹⁴105 S. Ct. 2613 (1985).

⁹⁵*Id.* at 2621.

⁹⁶*Id.* at 2620.

approach. Particularly in rural areas, a hospital may have market power simply because it is the only hospital in a county. Applying the per se rule when rural hospitals deny staff privileges while applying the rule of reason to the same practice by urban hospitals would be illogical and could deny rural hospitals necessary discretion to qualitatively screen individual applicants, for fear of per se antitrust liability.⁹⁷ Supreme Court dicta in an earlier hospital privileges case emphasizing “the hospital’s unquestioned right to exercise some control over the identity and the number of doctors to whom it accords staff privileges”⁹⁸ further support application of the rule of reason to a hospital privileges case, even where the defendant hospital has market power.

V. QUALITY OF CARE AS A DEFENSE

A. Overview

Under the rule of reason, a defendant may not justify a privileges denial merely by asserting that restricting hospital privileges to the most highly-qualified practitioners promotes the public health or welfare.⁹⁹ In *National Society of Professional Engineers v. United States*,¹⁰⁰ the Supreme Court emphasized that the rule of reason permits only justifications based on the procompetitive effects of an alleged restraint.¹⁰¹ The Court stated that to permit an antitrust defense based on protecting the public welfare would be “tantamount to a repeal”¹⁰² of the Sherman Act and suggested that such an argument is more properly directed to the legislature.¹⁰³

The Court recently repeated this position in *Federal Trade Commission v. Indiana Federation of Dentists*.¹⁰⁴ The Federal Trade Commission had found that a collective refusal by a group of dentists to submit dental x-rays to insurers to enable the insurers to assess the appropriateness of care was an unreasonable restraint of trade.¹⁰⁵ The dentists attempted to justify their boycott by asserting that they were protecting the quality of dental care.¹⁰⁶ The Supreme Court rejected this argument and reaffirmed its position in *Professional Engineers* that quality of service considerations unrelated to enhancing competition are not available as a justification under the rule of reason.¹⁰⁷

⁹⁷See *Pontius v. Children’s Hosp.*, 552 F. Supp. 1352, 1370, 1377 (W.D. Pa. 1982).

⁹⁸*Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 30 (1984) (dictum).

⁹⁹Havighurst, *supra* note 31, at 1095; Kissam & Webber, *supra* note 66, at 646.

¹⁰⁰435 U.S. 679 (1978).

¹⁰¹*Id.* at 688-92, 694.

¹⁰²*Id.* at 695.

¹⁰³*Id.* at 689-90.

¹⁰⁴106 S. Ct. 2009 (1986).

¹⁰⁵*Id.* at 2014-15.

¹⁰⁶*Id.* at 2015, 2020.

¹⁰⁷*Id.* at 2020-21. The Court hinted that there might be circumstances where quality

In *Wilk v. American Medical Association*,¹⁰⁸ a case in which chiropractors alleged antitrust violations in various exclusionary acts by organized medicine, the Seventh Circuit also emphasized that under the rule of reason, the effect of the challenged restraint on competition is the "critical and sole factor"¹⁰⁹ in determining whether a practice is illegal. Nevertheless, the Seventh Circuit, citing Supreme Court dicta regarding the application of the antitrust laws to professions, fashioned a new rule of reason defense for physicians where their exclusionary conduct is motivated by an ethical concern for their patients' well-being.¹¹⁰ Commentators have been critical of this judicial creation of a special rule, pointing out that the Supreme Court's suggestions that the antitrust laws might operate differently for the service and ethical aspects of a profession can be satisfied by a special sensitivity to the unusual features of competition in professional markets.¹¹¹ Such a unique rule for physicians threatens to undermine the basic premise of the rule of reason, that effect on competition is the sole yardstick for legality, and threatens to legitimize professional usurpation of the legislative function of deciding what is in the public interest.¹¹²

Under the rule of reason, an exclusion based on quality of care is defensible, however, because quality is a major competitive variable in the health care industry. Because third-party insurers pay such a large proportion of health care bills, patients are relatively unconcerned about price when they purchase health services, leading to minimal price competition among physicians or hospitals.¹¹³ Quality, instead of price, is a major factor patients and physicians use to select a hospital.¹¹⁴ Therefore, where an exclusion improves the overall quality of a hospital, the restriction is procompetitive and quality of care may be asserted as a defense.¹¹⁵

Where non-physicians have been excluded, quality of care as a justification has arisen primarily in cases involving podiatrists and chi-

of patient care could justify a restraint of trade. *Id.* at 2021. However, its focus here seems to be on situations where quality relates to ethical grounds or is otherwise "non-competitive." In a hospital privileges context, because hospitals compete with each other largely on the basis of quality, such a "loophole" in the rule of reason is unnecessary. See *infra* notes 113-15 and accompanying text.

¹⁰⁸719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984).

¹⁰⁹*Id.* at 225.

¹¹⁰*Id.* at 226-27 (citing *Professional Engineers*, 435 U.S. at 696; *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 n.17 (1975)).

¹¹¹Kissam, *Antitrust Boycott Doctrine*, 69 IOWA L. REV. 1165, 1214-15 (1984).

¹¹²*Id.*; see also Havighurst, *supra* note 31, at 1103-04 n.101.

¹¹³Salkever, *Competition Among Hospitals*, in COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 191, 201 (1978).

¹¹⁴*Id.*

¹¹⁵See, e.g., *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1355 (7th Cir. 1982); *Pontius v. Children's Hosp.*, 521 F. Supp. 1352, 1365 (W.D. Pa. 1982).

ropractors,¹¹⁶ although a similar rationale could apply to barring psychologists, nurse-midwives and nurse-anesthetists. The essence of this defense in a group context is that because physicians are the only group trained and licensed to independently diagnose and treat the whole person, only physicians should have hospital privileges.¹¹⁷ Granting privileges to less qualified providers would threaten the overall quality of care in the institution; thus, the exclusion is procompetitive.

B. *Judicial Approaches to Quality of Care as a Defense*

Courts have taken a variety of approaches in evaluating quality of care as a procompetitive justification for denying hospital privileges to individual physicians or to groups of non-physicians. Some courts have almost totally deferred to medical authority, labeling the privileges decision professional rather than commercial. For example, in *Hackett v. Metropolitan General Hospital*,¹¹⁸ a case brought by an individual physician under state antitrust law, the court, using federal antitrust concepts, stated, "[E]ven when serious anticompetitive effects exist[,] . . . professional decision-making relative to the quality or efficiency of health care should not be subject to antitrust constraints and, therefore, impeded."¹¹⁹ Similarly, in a suit by podiatrists challenging a categorical denial of hospital privileges, a federal district court granted a summary judgment for defendant hospitals, finding in the record "nothing by way of the Sherman Act to call upon the courts to intrude upon a responsibility reserved to medical decision-makers."¹²⁰ In addition to deviating from the rule of reason's mandate that the proper judicial focus is on the impact on competition, this approach ignores the fact that privileges decisions have both professional and commercial aspects and, in some cases, could be economic decisions disguised as professional.¹²¹

¹¹⁶See *Wilk v. American Medical Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984); *Chiropractic Coop. Ass'n of Mich. v. American Medical Ass'n*, 617 F. Supp. 264 (E.D. Mich. 1985); *Kaczanowski v. Medical Center Hosp. of Vt.*, 612 F. Supp. 688 (D. Vt. 1985); *Cooper v. Forsyth County Hosp. Auth.*, 604 F. Supp. 685 (M.D.N.C. 1985), *aff'd*, 789 F.2d 278 (4th Cir. 1986).

¹¹⁷See, e.g., *Cooper v. Forsyth County Hosp. Auth.*, 604 F. Supp. 685, 687 (M.D.N.C. 1985), *aff'd*, 789 F.2d 278 (4th Cir. 1986).

¹¹⁸465 So. 2d 1246 (Fla. Dist. Ct. App. 1985).

¹¹⁹*Id.* at 1252 n.3. This case defies easy categorization. The opinion approvingly cites a variety of approaches which, when blended, become very deferential.

¹²⁰*Kaczanowski v. Medical Center Hosp. of Vt.*, 612 F. Supp. 688, 697 (D. Vt. 1985); see also *Levin v. Doctors Hosp.*, 233 F. Supp. 953, 954-55 (D.D.C. 1964), *rev'd per curiam sub nom. Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515 (D.C. Cir. 1965).

¹²¹Although not a hospital privileges case, *Federal Trade Commission v. Indiana Federation of Dentists*, 106 S. Ct. 2009 (1986), illustrates this possibility. In this case, dentists' assertions that their boycott of insurers was aimed at protecting the quality of

Other courts have looked to whether the exclusionary decision was made in good faith or was not arbitrary or capricious. For example, the federal district court in *Williams v. Kleaveland*,¹²² a case involving an individual physician, invoked the professional-commercial distinction noted above and recognized a good faith defense, based on a bona fide concern for the public welfare.¹²³ A similar standard was used in a podiatrist's case in which the court granted a summary judgment for the defendant based on a "good faith judgment that high quality care requires that surgery . . . only be performed by physicians educated and trained to treat the whole person."¹²⁴ The court failed to consider the denial's impact on competition, although the court said it was applying the rule of reason.¹²⁵

A third judicial approach has been to require a mere rational relation between the decision to exclude and quality of care. The court in *Kaczanowski v. Medical Center Hospital of Vermont*,¹²⁶ a podiatrists' case, thought that "common sense dictates that the use of sensitive medical instruments, which may engage highly technical diagnostic equipment . . . should not be entrusted to applicants who fail to meet a high level of advanced medical training."¹²⁷ The court did not address the facts that the plaintiff podiatrists had spent several years in professional school learning how to use the sensitive instruments and that the state legislature had decided it was proper for podiatrists to perform the surgical procedures at issue.¹²⁸

Some courts have applied a higher level of scrutiny and required that a quality rationale for denial of privileges or other exclusionary conduct in a health care context be objectively reasonable. In *Feminist Women's Health Center v. Mohammad*,¹²⁹ the defendants were charged with a group boycott and other antitrust violations in persuading phy-

dental care were substantially undermined by statements of a boycott leader that "We are fighting an economic war The name of the game is money." *Id.* at 2013 n.1.

¹²²534 F. Supp. 912 (W.D. Mich. 1981).

¹²³*Id.* at 920.

¹²⁴*Cooper v. Forsyth County Hosp. Auth.*, 604 F. Supp. 685, 687 (M.D.N.C. 1985), *aff'd*, 789 F.2d 278 (4th Cir. 1986).

¹²⁵*Id.*

¹²⁶612 F. Supp. 688 (D. Vt. 1985).

¹²⁷*Id.* at 697. *See generally* Havighurst, *supra* note 31, at 1133-36, recommending a rational basis test for privileges denials based on quality maintenance, absent market power or a violation of section two of the Sherman Act. This recommendation is premised on the hospital's ultimate accountability to consumers for its business decisions. Such a premise may be questionable in light of the hospital's greater responsiveness to physicians than to consumers. *See infra* notes 162-65 and accompanying text.

¹²⁸*See* VT. STAT. ANN. tit. 7, § 321 (1975); *see also supra* note 37 and accompanying text.

¹²⁹586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

sicians not to work at an abortion clinic. Reversing (on other grounds) a summary judgment for the defendants, the Fifth Circuit stated that under the rule of reason, the tests for evaluating a defense based on maintenance of professional standards are "the genuineness of the defendants' justification, the reasonableness of the standards themselves, and the manner of their enforcement."¹³⁰ In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*,¹³¹ the Fourth Circuit found that a requirement that third-party payment for psychologists' services be billed through a physician was patently unreasonable as a quality assurance measure because it permitted supervision by any physician, not just those knowledgeable about mental illness.¹³² The court noted that "we are not inclined to condone anticompetitive conduct upon an incantation of 'good medical practice.'" ¹³³

In *Pontius v. Children's Hospital*,¹³⁴ a federal district court established the test under the rule of reason for evaluating termination of an individual physician's hospital privileges as "valid reasons supported by substantial evidence."¹³⁵ Because evaluating individual competence is largely subjective, the court stated it would not attempt to decide whether the privileges committee was correct, but would make sure there was substantial evidence to support the decision.¹³⁶ Perceptively noting a difference between exclusion of an individual and exclusion of a group of physicians, the court suggested that the validity of excluding a group on a quality basis is more capable of objective evaluation.¹³⁷ Although the court used the example of a categorical exclusion of a group of physicians from a specific medical school, exclusion of a group of non-physicians on a quality basis should be amenable to the same objective evaluation.

Finally, commentators and at least one court have advocated a "purpose-based rule of reason," requiring a dominant anticompetitive purpose for a denial of privileges to violate the Sherman Act.¹³⁸ One difficulty with purpose as the determinative criterion is that a hospital

¹³⁰*Id.* at 547.

¹³¹624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).

¹³²*Id.* at 485.

¹³³*Id.* On remand, however, the federal district court found that determining a remedy for the boycotted psychologists had become a moot issue because of a Virginia Supreme Court decision that the state statute under which the plaintiff psychologists were demanding insurance reimbursement was unconstitutional. 501 F. Supp. 1232 (E.D. Va. 1980) (citing *Blue Cross of Va. v. Commonwealth*, 221 Va. 349, 269 S.E.2d 827 (1980)).

¹³⁴552 F. Supp. 1352 (W.D. Pa. 1982).

¹³⁵*Id.* at 1372.

¹³⁶*Id.* at 1372-73.

¹³⁷*Id.* at 1370-71.

¹³⁸*Hackett v. Metropolitan Gen. Hosp.*, 465 So. 2d 1246, 1255-57 (Fla. Dist. Ct. App. 1985); Kissam & Webber, *supra* note 66, at 660-62.

staff might have mixed purposes for a particular privileges denial or might assert a purpose to maintain the quality of care while the covert purpose is to suppress competition. Uncovering the true or dominant purpose will necessarily require a lengthy trial.¹³⁹ A second problem with this approach is that it is inconsistent with the rule of reason's primary focus on anticompetitive effect. According to Justice Brandeis' classic statement of the rule of reason in *Chicago Board of Trade v. United States*,¹⁴⁰ "[t]he true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition."¹⁴¹ Justice Brandeis explained that a court may consider the purpose of the restraint, "not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences."¹⁴² Thus, while purpose is relevant, it is not determinative.¹⁴³

VI. DIFFERENCES BETWEEN DENIAL OF PRIVILEGES TO AN INDIVIDUAL AND TO A GROUP

In general, the lower courts have attempted to find a way to "guard against . . . anticompetitive abuses without disrupting the legitimate interests of hospitals and medical staffs in providing efficient and high quality medical care."¹⁴⁴ Except for the court in *Pontius v. Children's Hospital*, however, these courts have not clearly distinguished between denial of hospital privileges to individual physicians and denial to groups of non-physicians and have, therefore, applied the same variety of levels of scrutiny to both types of cases. There are at least four fundamental differences between denial of privileges to an individual and to a group: differences in the substantive validity of the quality rationale for exclusion, in the operation of due process, in procompetitive justifications, and in anticompetitive effects. Because of these distinctions, denial of privileges to a group merits antitrust scrutiny beyond a mere rational relation or good faith standard.

¹³⁹Havighurst, *supra* note 31, at 1109-10.

¹⁴⁰246 U.S. 231 (1918).

¹⁴¹*Id.* at 238.

¹⁴²*Id.*

¹⁴³See also *NCAA v. Board of Regents of the Univ. of Okla.*, 468 U.S. 85, 101 n.23 (1984) ("It is . . . well-settled that good motives will not validate an otherwise anticompetitive practice."); *Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1492-93 (D.C. Cir. 1984) (effect, and not intent, is controlling factor in a rule of reason inquiry); *Ponsoldt*, *supra* note 89, at 63 (lower courts often give great weight to defendants' intent despite Supreme Court declarations that intent is not controlling).

¹⁴⁴Kissam & Webber, *supra* note 66, at 597.

A. *Differences in the Substantive Validity of the Quality Justification*

In contrast to a quality of care justification for denying privileges to an individual physician, there are inherent weaknesses in a quality rationale when applied to exclude a group of non-physicians. Although physicians are probably best qualified to assess a fellow physician's skill, training, and experience, they are not necessarily experts about the capabilities of allied health practitioners. Members of the medical staff may have little experience with or knowledge about the group being excluded. For example, only twenty-seven percent of physicians questioned in one study knew that podiatrists receive four years of graduate level podiatry education in addition to undergraduate studies.¹⁴⁵ Most physicians underestimated the extent of podiatry training.¹⁴⁶ There may be reason to question the validity of physicians' opinions of podiatric care if physicians lack even basic knowledge about podiatrists' education. Furthermore, physicians' evaluations of the quality of care rendered by non-physicians may be biased by the physicians' professional ego.¹⁴⁷ Because the training and experience of doctors may lead them to believe in their own superiority, their ability to judge objectively the competence of a group with different or less training may be distorted.¹⁴⁸

There are also inherent weaknesses in the argument that allied groups should not obtain privileges because they are not qualified to treat the whole person.¹⁴⁹ Non-physicians do not necessarily want to treat the whole person; they want only to provide professional care within the scope of their licenses, whether it be care of the feet or the psyche.¹⁵⁰ As long as physicians are readily available to treat health problems beyond the scope of the non-physician's expertise, there is no reason to exclude the non-physician. Also, many physician specialists might fail to measure up to this "whole person" criterion. For example, a physician who has specialized in psychiatry for many years may no longer be competent to regulate insulin dosages in a newly diagnosed diabetic and would, as a matter of course, seek consultation from a more qualified physician. In an era of increasing specialization, there may be few health

¹⁴⁵Dixon, *Hospital Privileges for Podiatrists*, 24 HOSP. & HEALTH SERVICES AD. 63, 74 (1979).

¹⁴⁶*Id.*

¹⁴⁷*Cf.* Kissam & Webber, *supra* note 66, at 608 ("the professional pride of physicians often will be at stake . . . particularly when nonphysicians apply for privileges.").

¹⁴⁸E. FREIDSON, *supra* note 85, at 146-58.

¹⁴⁹*See* Cooper v. Forsyth County Hosp. Auth., 604 F. Supp. 685, 687 (M.D.N.C. 1985), *aff'd.*, 789 F.2d 278 (4th Cir. 1986) (court accepted this argument and upheld denial of privileges to podiatrists).

¹⁵⁰*Cf.* Dolan, *Antitrust Law and Physician Dominance of Other Health Practitioners*, 4 J. HEALTH POL. POL'Y & L. 675, 679 (1980).

care providers who are truly qualified to treat the whole person.¹⁵¹ Finally, this "whole person" argument is weakened by the fact that hospital privileges were available to dentists even under the pre-1985 JCAH standards.¹⁵² Dentists clearly are not trained to treat the whole person, but neither do they compete with physicians as directly as the excluded non-physician groups do.

Additionally, denying an entire professional group the opportunity to provide services for which it was trained and licensed has the effect of partially negating the licensure law. The courts have clearly declared that a license does not automatically give an individual the right to practice in any hospital.¹⁵³ A state licensure law is, however, a legislative determination that in general, people with the requisite training and knowledge can safely provide whatever service they are licensed to provide.¹⁵⁴ A hospital's denial of privileges to an entire licensed group on a quality basis is, in effect, a declaration that despite the legislature's judgment, no one with that particular license is competent to provide that service. The courts have been hostile to industry self-regulation that is so extensive that the industry acts as a private government and threatens to usurp the legislature's prerogative of determining what is in the public interest.¹⁵⁵

A quality rationale for excluding a group may be further flawed if research demonstrates the safety or effectiveness of treatment by non-physicians. Although there are few such studies of patient-outcomes, an assertion that an allied health group gives inferior care is inherently suspect if scientific investigations document the quality of care given by non-physicians.¹⁵⁶ Nurse-midwives are one group for which such outcome

¹⁵¹Tanney, *supra* note 45, at 1235.

¹⁵²JOINT COMM'N ON ACCREDITATION OF HOSPS., *supra* note 25, at 89.

¹⁵³Hayman v. City of Galveston, 273 U.S. 414, 416-17 (1927); Don v. Okmulgee Memorial Hosp., 443 F.2d 234, 239 (10th Cir. 1971); Stern v. Tarrant County Hosp. Dist., 565 F. Supp. 1440, 1447 (N.D. Tex. 1983); *rev'd on other grounds*, 778 F.2d 1052 (5th Cir. 1985), *cert. denied*, 106 S. Ct. 1957 (1986); Aasum v. Good Samaritan Hosp., 395 F. Supp. 363, 371 (D. Ore. 1975), *aff'd*, 542 F.2d 792 (9th Cir. 1976); Levin v. Doctors Hosp., 233 F. Supp. 953, 955 (D.D.C. 1964), *rev'd per curiam on other grounds sub nom.* Levin v. Joint Comm'n on Accreditation of Hosps., 354 F.2d 515 (D.C. Cir. 1965); Settler v. Hopedale Medical Found., 80 Ill. App. 3d 1074, 1075-76, 400 N.E.2d 577, 578 (1980).

¹⁵⁴See Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6, 6 & 25 (1976); Moore, *The Purpose of Licensing*, 4 J. LAW & ECON. 93, 104 (1961). These articles argue that even licensing, although ostensibly to protect the public from incompetence, is too restrictive and results in protecting the licensees from competition.

¹⁵⁵Fashion Originators' Guild of Am. v. Federal Trade Comm'n, 312 U.S. 457, 465 (1941); American Medical Ass'n v. United States, 130 F.2d 233, 245-49 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943). See generally 1 P. AREEDA & D. TURNER, ANTITRUST LAW ¶ 216b (1978).

¹⁵⁶Dolan, *supra* note 150, at 686.

studies exist. These studies consistently show no difference in patient-outcomes or even better outcomes when childbirth care is provided by nurse-midwives as compared with physicians.¹⁵⁷ Thus, any exclusion of nurse-midwives as a group on the basis that they give lower quality care would be highly questionable.

B. Differences in the Effects of Due Process

Courts deciding privileges cases should also be sensitive to the differences in the operation of due process when a group of non-physicians has been excluded as opposed to an individual physician. Notice of the reason for denial and an opportunity to be heard can serve as effective safeguards for an individual physician against competitive abuses. A hearing and an internal appeal procedure provide an individual physician threatened with denial or termination of privileges an opportunity to show how his personal qualifications meet a presumably valid standard.¹⁵⁸ In contrast, when privileges are limited to physicians, a non-physician applicant, no matter how expert in his own field, is automatically barred. He is faced with trying to persuade the medical staff not only that he is highly qualified, but that the standard should be changed. Thus, a hearing and an appeal procedure may be of little help to the non-physician when the barrier is the standard itself.¹⁵⁹

C. Examination of Procompetitive and Anticompetitive Effects

In applying the rule of reason to privilege denials and weighing the procompetitive and anticompetitive effects, courts must first recognize that there are three distinct markets involved: hospitals compete for patients, hospitals compete for providers, and providers compete for patients.¹⁶⁰ What is procompetitive in one market may be anticompetitive in another.¹⁶¹

Courts should also recognize that the structure of the market for in-patient hospital services creates a conflict of interest for physicians.

¹⁵⁷Levy, Wilkinson & Marine, *supra* note 50; Mann, *San Francisco General Hospital Nurse-Midwifery Practice: The First Thousand Births*, 140 AM. J. OBSTETRICS & GYNECOLOGY 676 (1981); Slome, Wetherbee, Daly, Christensen, Meglen & Thiede, *Effectiveness of Certified Nurse-Midwives*, 124 AM. J. OBSTETRICS & GYNECOLOGY 177 (1976).

¹⁵⁸See Drexel, *The Antitrust Implications of the Denial of Hospital Staff Privileges*, 36 U. MIAMI L. REV. 207, 227 (1982).

¹⁵⁹See, e.g., *Cooper v. Forsyth County Hosp. Auth.*, 604 F. Supp. 685, 687 (M.D.N.C. 1985), *aff'd*, 789 F.2d 278 (4th Cir. 1986) (granting staff privileges to plaintiff podiatrist would have required change in hospital by-laws); *cf.* Jost, *supra* note 24, at 907 (exclusion of a class of providers subject to criticism as denying procedural fairness).

¹⁶⁰See generally Rafferty, *Comment*, in COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 207, 208 (1978).

¹⁶¹See *infra* notes 168-71 and accompanying text.

Although the hospital sells its services to patients, the physician acts as the patient's agent in the decision to purchase hospital services.¹⁶² The physician decides whether the patient needs hospital care, what kind of care, and for how long. Aware that physicians thus control hospital utilization, hospitals compete for patients indirectly by competing for physicians.¹⁶³ Hospital decisions regarding what services to offer and who should offer them are aimed at making the hospital attractive to physicians.¹⁶⁴ On the other side of the hospital-patient transaction, physicians on the medical staff advise the hospital what services to offer. The power of physicians on both sides of this transaction creates a conflict of interest.¹⁶⁵ When a group of non-physicians is denied hospital privileges based on the advice of physicians on the medical staff, antitrust courts should be sensitive to this conflict of interest and scrutinize the extent to which the exclusion may serve the physicians' self-interest as well as or instead of the patient's interest.

1. *Differences in Procompetitive Justifications for Privilege Denials.*— One procompetitive justification for the denial of privileges to non-physicians that is no longer available to hospitals is that the denial is necessary to maintain the hospital's accreditation, which, in turn, is critical in qualifying for federal and private insurance payments.¹⁶⁶ The JCAH has recently changed its accreditation standards and no longer requires a hospital to restrict its staff to physicians and dentists to be accredited.¹⁶⁷

From the perspective of the hospital-provider market, there is no price competition among hospitals for physicians because hospitals do not pay physicians. The main competitive variables here are quality and amenities; physicians want to be on staff at a hospital with a reputation for quality and at a hospital offering the services and equipment that facilitate the physician's work.¹⁶⁸ Thus, an exclusion that maintains or enhances a hospital's quality is procompetitive in the hospital-provider

¹⁶²Reinhardt, *Comment*, in *COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE* 156, 157 (1978); Somers, *Comment*, in *COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE* 469, 469-70 (1978).

¹⁶³Redisch, *supra* note 79, at 231.

¹⁶⁴Havighurst, *supra* note 31, at 1081; Salkever, *supra* note 113, at 197-98.

¹⁶⁵E. FREIDSON, *supra* note 85, at 146-69; Havighurst, *supra* note 31, at 1104.

¹⁶⁶Jost, *supra* note 24, at 843; *see also* Havighurst, *supra* note 31, at 1087-88. For cases in which accreditation is discussed in this manner, *see, e.g.*, *Wilk v. American Medical Ass'n*, 719 F.2d 207, 214 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984); *Williams v. Kleaveland*, 1983-2 Trade Cas. (CCH) ¶ 65,486, 68,358 (W.D. Mich. 1983); *Levin v. Doctors Hosp.*, 233 F. Supp. 953 (D.D.C. 1964), *rev'd per curiam on other grounds sub. nom. Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515 (D.C. Cir. 1965).

¹⁶⁷*See supra* notes 34-36 and accompanying text.

¹⁶⁸Salkever, *supra* note 113, at 198.

market.¹⁶⁹ In addition, a hospital's decision to deny staff privileges to non-physicians may be procompetitive in this market because the exclusion makes the hospital more attractive to physicians by insulating them from whole groups of competitors in the provider-consumer market for in-patient services.¹⁷⁰ The purpose of the antitrust laws, however, is to promote competition to benefit consumers.¹⁷¹ A court faced with a privileges case should therefore focus on whether the denial is procompetitive from the consumer's viewpoint as well as from the physician's.

Other procompetitive justifications a hospital might assert for qualitatively screening individuals do not necessarily apply to the exclusion of entire groups of non-physicians. For example, because a hospital may be liable in tort for negligently screening or supervising members of its medical staff,¹⁷² any exclusion that decreases the hospital's potential liability for malpractice is procompetitive in that it decreases the hospital's costs of doing business.¹⁷³ This rationale would justify excluding any individual who the hospital has reason to believe is likely to practice negligently, such as a physician with a history of several malpractice suits against him or a physician who attempts to practice beyond the scope of his expertise. This rationale would not justify excluding an entire group of non-physicians where there is no evidence that the group is prone to malpractice. For example, the rate of malpractice suits against nurse-midwives is one-tenth of the rate of suits against obstetricians.¹⁷⁴ The low rate for nurse-midwives is no doubt partially because nurse-midwives deliver primarily low-risk patients and because some nurse-midwives do no deliveries at all.¹⁷⁵ Nevertheless, a hospital should not

¹⁶⁹Enders, *supra* note 3, at 742.

¹⁷⁰*Cf.* Kissam & Webber, *supra* note 66, at 610 (even with respect to fellow physicians, there is an incentive for physicians to want staff membership restricted to inefficient levels to increase excess capacity and physicians' own prestige and income).

¹⁷¹*NCAA v. Board of Regents of the Univ. of Okla.*, 468 U.S. 85, 107 (1984); *Marrese v. American Academy of Orthopaedic Surgeons*, 706 F.2d 1488, 1495 (7th Cir. 1983), *rev'd on other grounds*, 105 S. Ct. 1327 (1985).

¹⁷²*Crumley v. Memorial Hosp., Inc.*, 509 F. Supp. 531 (E.D. Tenn. 1978), *aff'd mem.*, 647 F.2d 164 (6th Cir. 1981); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); *Ferguson v. Gonyaw*, 236 N.W.2d 543 (Mich. Ct. App. 1975); *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

¹⁷³*Kaczanowski v. Medical Center Hosp. of Vt.*, 612 F. Supp. 688, 696 (D. Vt. 1985); *Williams v. Kleaveland*, 1983-2 Trade Cas. (CCH) ¶ 65,486, 68,358 (W.D. Mich. 1983); *Drexel*, *supra* note 158, at 231.

¹⁷⁴*Malpractice Crisis Leaves Nurse-Midwives Without Coverage*, 4 PROF. REG. NEWS, July 1985, at 6.

¹⁷⁵*Levy, Wilkinson & Marine*, *supra* note 50, at 51; *Adams*, *supra* note 50, at 1267. *But see id.* at 1270, noting increased involvement of nurse-midwives with complicated births.

be permitted to assert potential tort liability as a justification for excluding nurse-midwives.

This rationale may justify excluding chiropractors due to the hospital's potential liability for a chiropractor's misdiagnosis.¹⁷⁶ Orthodox health care providers do not agree with chiropractors that the cause of all disease is misalignment of the spine.¹⁷⁷ If, for example, a hospital x-ray for a chiropractor's patient revealed an operable tumor as the probable cause of the patient's symptoms, but the chiropractor proceeded to treat the patient by spinal manipulation, the hospital and its radiologist might be placed in a vulnerable position.¹⁷⁸

Several state statutes as well as accreditation bodies require members of a medical staff to conduct peer review.¹⁷⁹ Staff members might be discouraged from participating in peer review or being candid in evaluating their colleagues if an expelled provider institutes an antitrust suit against the members of a review committee that recommended termination of privileges.¹⁸⁰ This potential chilling of peer review by antitrust litigation is a proper judicial concern and a valid procompetitive justification in privileges cases involving individuals.¹⁸¹ Although this rationale might

¹⁷⁶Note, *supra* note 66, at 1194. Although there are no large scale studies of the quality of chiropractic care, there are assertions that chiropractic education is inadequate and that chiropractors tend to exceed the scope of their competence. See generally Ballantine, *Will the Delivery of Health Care Be Improved By the Use of Chiropractic Services?*, 286 NEW ENG. J. MED. 237 (1972); Firman & Goldstein, *The Future of Chiropractic: A Psychosocial View*, 293 NEW ENG. J. MED. 639 (1975); Silver, *Chiropractic: Professional Controversy and Public Policy*, 70 AM. J. PUB. HEALTH 348 (1980). There are also anecdotal reports of injuries caused by chiropractic treatment. See, e.g., Braun, Pinto, DeFilipp, Lieberman, Pasternack & Zimmerman, *Brain Stem Infarction Due to Chiropractic Manipulation of the Cervical Spine*, 76 S. MED. J. 1507 (1983); Schmidley & Koch, *The Noncerebrovascular Complications of Chiropractic Manipulation*, 34 NEUROLOGY 684 (1984).

¹⁷⁷Silver, *supra* note 176, at 348.

¹⁷⁸But cf. Kissam & Webber, *supra* note 66, at 608-09 (suggesting hospital may not be liable for chiropractor's treatment error as long as hospital has exercised proper care in selecting chiropractor). Regarding the difficulty a hospital might have in screening chiropractors, see *infra* notes 188-89 and accompanying text.

¹⁷⁹See, e.g., IND. CODE § 16-10-1-6.5 (a) & (c) (Supp. 1985); ME. REV. STAT. ANN. tit. 24, § 2503 (1984-85); MICH. COMP. LAWS ANN. § 333.21513 (West Supp. 1985); 63 PA. CONS. STAT. ANN. § 425.1 (Purdon Supp. 1985); JOINT COMM'N ON ACCREDITATION OF HOSPS., *supra* note 21, at 107-09, 113.

¹⁸⁰Where peer review is mandated by a state statute, staff members may have state action immunity to antitrust liability. *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 105 S. Ct. 3501 (1985); *Lombardo v. Sisters of Mercy Health Corp.*, 1985-2 Trade Cas. (CCH) ¶ 66,749 (N.D. Ind. 1985). But see *Jiricko v. Coffeyville Memorial Hosp. Medical Center*, 628 F. Supp. 329, 333 (D. Kan. 1985) (no state action immunity where publicly-owned hospital did not provide due process to demoted physician); *Quinn v. Kent Gen. Hosp.*, 617 F. Supp. 1226, 1236-40 (D. Del. 1985) (peer review not immune as state action because peer review statute does not reflect a legislative intent to displace competition with regulation).

¹⁸¹See *Pontius v. Children's Hosp.*, 552 F. Supp. 1352, 1376 (W.D. Pa. 1982); *Williams v. Kleaveland*, 534 F. Supp. 912, 920 (W.D. Mich. 1981). Indeed, concern with this chilling

justify a deferential judicial approach where individual physicians lost hospital privileges as a result of peer review, the rationale does not support excluding an entire group of non-physician providers. If the group were granted privileges, evaluation by physicians or peers could still be done on an individual basis.

Another procompetitive effect of denying privileges to less qualified practitioners is that a hospital would incur high costs in monitoring these people if it could not initially qualitatively screen privileges applicants.¹⁸² This rationale is another argument that does not, however, readily transfer from an individual to a group context because the rationale does not justify excluding an entire group unless there is some evidence that, in general, its members give inferior care.

If a specific non-physician group seeking privileges must have physician supervision of some aspects of its practice, the costs to the hospital of providing such supervision are a procompetitive justification for excluding the group.¹⁸³ Even the new, flexible JCAH standard restricts full medical staff membership to providers licensed to practice independently.¹⁸⁴ This justification would not apply, however, if the non-physician applicant has arranged for his own supervision by a doctor already on the staff. For example, although nurse-midwives legally require medical supervision for some types of services,¹⁸⁵ nurse-midwives challenging exclusion in *Nurse Midwifery Associates v. Hibbett*¹⁸⁶ had already arranged for the necessary supervision and did not ask the hospital to supply it.

Furthermore, even physicians require consultation with other physicians when they encounter an illness or clinical situation beyond their own fields of expertise. For example, a family physician may be required to call in an obstetrician when a maternity patient needs a caesarean section.¹⁸⁷ Although there is a distinction between medical supervision required by statute and consultation or back-up required by the hospital, hospitals and medical staffs have not found such cooperative arrangements unduly costly when only physicians were involved.

A hospital could assert, as a procompetitive justification for exclusion, that accommodating new types of staff members would create high

effect largely prompted Congress to enact, in late 1986, a statutory provision for antitrust damages immunity for peer review of individual physicians. See Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, tit. IV; see also *supra* note 76.

¹⁸²Drexel, *supra* note 158, at 232; Enders, *supra* note 3, at 743.

¹⁸³See Kissam & Webber, *supra* note 97, at 655.

¹⁸⁴JOINT COMM'N ON ACCREDITATION OF HOSPS., *supra* note 21, at 101.

¹⁸⁵See *supra* note 51 and accompanying text.

¹⁸⁶549 F. Supp. 1185 (M.D. Tenn. 1982).

¹⁸⁷See M. ROEMER & J. FRIEDMAN, *supra* note 22, at 284.

costs in developing standards and review mechanisms for the new group.¹⁸⁸ The key legal question, however, is whether these initial costs are outweighed by the benefit to the consumer of the increased competition from the new group. This argument might be a valid justification for excluding chiropractors because chiropractic is based on an entirely different theory of disease than orthodox medicine.¹⁸⁹ It is difficult to imagine how an institution, the hospital, based on a scientific-medical model of diagnosis and treatment could even begin to articulate standards for an alien ideology.

Consumers may have problems making informed choices in purchasing health or hospital care because information about the skill of a provider or the quality of a hospital is difficult for a lay person to obtain and evaluate.¹⁹⁰ Thus, in the hospital-patient market, the hospital's selectivity in staff membership is procompetitive because it reduces consumers' information search costs. The uninformed consumer can rely on the hospital's screening to provide at least some assurance that the hospital itself and the providers on its staff meet a professionally determined level of quality.¹⁹¹ As applied to groups of non-physicians, however, the hospital's screening serves this function only if the group excluded in fact gives low quality care.¹⁹² It is, therefore, reasonable to demand of a hospital that asserts this justification for excluding a group some qualitative evidence beyond the fact that the members of the group are not physicians.

Most of these procompetitive benefits are achievable by screening individuals and do not require excluding an entire group. Because the major factor on which hospitals compete with each other is quality, an antitrust ruling that decreases a hospital's ability to select among individuals on a quality basis would greatly diminish competition among hospitals. However, the consequences of prohibiting a hospital from

¹⁸⁸Kissam & Webber, *supra* note 66, at 655. Although not basing its decision on antitrust analysis, a New Jersey state court found that a hospital's inability to establish standards and supervise the care given by a new type of staff member was a reasonable basis for denying adjunct staff privileges to a certified psychiatric nursing specialist. *Wrable v. Community Memorial Hosp.*, 205 N.J. Super. 438, 501 A.2d 187 (1985). Broad application of this court's reasoning could make it impossible for any new category of provider to obtain privileges.

¹⁸⁹See *supra* note 177.

¹⁹⁰Pauly, *Is Medical Care Different?*, in *COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE* 19, 28-34 (1978).

¹⁹¹See *Quinn v. Kent Gen. Hosp.*, 617 F. Supp. 1226, 1239 (D. Del. 1985) (medical staff peer review "arguably procompetitive" by compensating for consumers' "relative lack of information about these matters"). See generally Jost, *supra* note 24, at 866-75 (while standards may thus reduce costs, they may also promote inefficiency if the standards are merely symbolic or force consumers to pay for something they don't need).

¹⁹²Jost, *supra* note 24, at 906.

excluding an entire group without substantive evidence of a quality deficiency would not be as destructive of competition. The hospital could still be selective as to individuals within the group.

2. *Differences in Anticompetitive Effects.*—From the consumer's perspective, there are clear differences between excluding an individual and excluding a group in terms of anticompetitive effects. Denial of hospital privileges to an entire group of non-physicians has a much greater effect in foreclosing consumer choice than denial of privileges to an individual physician. According to the Seventh Circuit, "[A] consumer has no interest in the preservation of a fixed number of competitors greater than the number required to assure his being able to buy at the competitive price."¹⁹³ In the consumer-health care provider market, such factors as personalization of care, convenience, and variations in treatment modalities may be added to price as the salient competitive variables. Where the excluded individual offers essentially the same array of services at a similar price as other physicians in the geographic market, the loss of one physician has a minimal anticompetitive effect.¹⁹⁴ However, where the excluded individual offers a different, but still reasonably substitutable package of services, and the exclusion means that consumers will be unable to select that package at all, the anticompetitive effect is much greater. For example, in a market where six obstetricians and one nurse-midwife compete to sell health care to pregnant women, the loss of the midwife, who may have been offering more personalized care, greater flexibility in choices for delivery, and more health education,¹⁹⁵ forecloses consumer choice much more drastically than the loss of one of the obstetricians. In a recent antitrust case involving dentists, the Supreme Court emphasized that it does not look favorably upon agreements among competitors that limit consumer choice, "absent some countervailing procompetitive virtue."¹⁹⁶

Also, the non-physicians who are barred from offering in-patient services generally charge less than the physicians with whom they compete. Podiatrists charge less than orthopedic surgeons,¹⁹⁷ psychologists charge

¹⁹³Marrese v. American Academy of Orthopaedic Surgeons, 706 F.2d 1488, 1497 (7th Cir. 1983), *rev'd on other grounds*, 105 S. Ct. 1327 (1985).

¹⁹⁴See Williams v. Kleaveland, 534 F. Supp. 912, 920 (W.D. Mich. 1981); Hackett v. Metropolitan Gen. Hosp., 465 So. 2d 1246, 1257 (Fla. Dist. Ct. App. 1985). See generally R. POSNER, ANTITRUST LAW—AN ECONOMIC PERSPECTIVE 123 (1976) ("the elimination of an individual potential competitor can be expected to have no competitive significance at all"). *But see* Havighurst, *supra* note 31, at 1143 (elimination of a single physician may have anticompetitive ramifications justifying judicial oversight).

¹⁹⁵See Comment, *supra* note 49, at 963 (describing physicians' childbirth services as technological and surgical in contrast with nurse-midwives' as natural and personalized).

¹⁹⁶Federal Trade Comm'n v. Indiana Fed'n of Dentists, 106 S. Ct. 2009, 2018-19 (1986).

¹⁹⁷AMERICAN PODIATRIC MEDICAL ASS'N, *supra* note 43, at 4 (podiatrists' charges are ten to fifty percent less than orthopedists').

less than psychiatrists,¹⁹⁸ nurse-midwives charge less than obstetricians,¹⁹⁹ and nurse-anesthetists charge less than physician anesthesiologists.²⁰⁰ Therefore, denying privileges to allied health groups has the anticompetitive effect of maintaining higher prices in the provider-consumer market. The same is not true of the exclusion of an individual physician whose prices may be similar to those of other physicians in the market.

Another anticompetitive effect of excluding a group of non-physicians that does not apply to the exclusion of an individual physician is that restricting hospital privileges to physicians stifles innovation in health care delivery. From the consumer's perspective, where services offered by non-physicians are reasonably substitutable for services by physicians, the two groups compete.²⁰¹ However, where non-physicians also offer treatments not generally used by physicians, denying privileges to non-physicians retards the development of alternative approaches, even where such treatments have been proven safe and effective.²⁰² For example, nurse-midwives are inclined to use natural childbirth techniques rather than anesthesia,²⁰³ and psychologists may offer biofeedback training rather than drugs as a treatment for chronic pain.²⁰⁴ In addition to limiting consumers' options, barring these groups from hospital practice slows the acceptance of these safe and effective alternatives.

Finally, although excluding a single physician from hospital practice has a minimal anticompetitive effect in the provider-consumer market, excluding an entire group of non-physicians protects the dominant group (physicians) from all competition from an alternative group offering reasonably substitutable services at lower prices. Defending such an exclusion under the rule of reason on a quality basis is, in effect, an assertion that non-physicians should not be allowed to compete in hospitals. This assertion comes close to arguing that competition itself is unreasonable, an argument the Supreme Court flatly rejected in *National Society of Professional Engineers v. United States*.²⁰⁵

¹⁹⁸Tanney, *supra* note 45, at 1233.

¹⁹⁹See *Nurse Midwifery Assoc. v. Hibbett*, 549 F. Supp. 1185, 1188 (M.D. Tenn. 1982) (excluded nurse-midwives alleged higher costs for maternity care in a market with only obstetricians).

²⁰⁰FTC, *Attorney General Come to Rescue of California CRNA*, 85 AM. J. NURSING 601, 601, 608 (1985).

²⁰¹See *Bhan v. NME Hosps., Inc.*, 772 F.2d 1467, 1471 (9th Cir. 1985); *FTC Addresses Key Question: Can Nurses and Doctors Compete?*, 4 PROF. REG. NEWS, Jan. 1985, at 2, 3.

²⁰²See Tanney, *supra* note 45, at 1235. See generally Ponsoldt, *supra* note 89, at 37-38 (analysis of how product standards created and enforced by dominant group of competitors result in eliminating competition from innovation).

²⁰³Comment, *supra* note 49, at 963.

²⁰⁴Tanney, *supra* note 45, at 1235.

²⁰⁵435 U.S. at 696; see also *NCAA v. Board of Regents of the Univ. of Okla.*, 468 U.S. 85, 117 (1984) (rejecting rule of reason defense based on premise that competition itself is unreasonable).

VII. SUGGESTED JUDICIAL APPROACH

A relatively deferential judicial approach might be appropriate in privileges cases involving exclusions of individual physicians.²⁰⁶ Physicians are better qualified than judges to evaluate other physicians. The content of the quality standard on which the exclusion is based, as the standard relates to training, experience, and expertise, is not suspect. Due process can effectively curb anticompetitive abuses. Most significantly for antitrust purposes, there is a minimal anticompetitive effect in any market.

However, because of the greater anticompetitive effect of precluding competition from an entire group, as well as other differences noted above, a quality of care standard invoked to exclude a group should be substantially related to the procompetitive justifications the hospital asserts.²⁰⁷ A court should not merely defer to physicians' subjective opinions or allow a good faith defense. It is not unreasonable to demand some evidence that in general, the group excluded in fact provides inferior care.²⁰⁸ Such a demand is consistent with the Supreme Court's recent decision in *Federal Trade Commission v. Indiana Federation of Dentists*.²⁰⁹ "[E]ven if concern for the quality of patient care could under some circumstances serve as a justification for a restraint of [trade],"²¹⁰ defendants must produce sufficient evidence that the restraint in fact improves the quality of care. Mere expert opinion testimony may not be enough.²¹¹

A court should also require that the exclusionary standard be the least restrictive way to achieve the particular procompetitive benefit used to justify the standard. The least restrictive alternative concept appears in several antitrust cases involving industry self-regulation. Evaluating the antitrust liability of stock exchange self-regulation in *Silver v. New York Stock Exchange*,²¹² the Supreme Court articulated "the principle that exchange self-regulation is . . . justified in response to antitrust charges *only to the extent necessary* to . . . [achieve] . . . the aims of the Securities Exchange Act[.]"²¹³ In a concurring opinion in *Professional*

²⁰⁶See Havighurst, *supra* note 31, at 1133-35; Kissam & Webber, *supra* note 66, at 613, 638-39; see also *supra* notes 76 & 181.

²⁰⁷*Cf.* Kreuzer v. American Academy of Periodontology, 735 F.2d 1479, 1494 (D.C. Cir. 1984) (test for application of the rule of reason to exclusionary conduct by health professionals when a quality defense is asserted is whether there is a close rational nexus between the standard and quality of care).

²⁰⁸See Pontius v. Children's Hosp., 552 F. Supp. 1352, 1370-72 (W.D. Pa. 1982) (demanding substantial evidence to support exclusion of individual physician).

²⁰⁹106 S. Ct. 2009 (1986).

²¹⁰*Id.* at 2021.

²¹¹*Id.* at 2020-21.

²¹²373 U.S. 341 (1963).

²¹³*Id.* at 361 (emphasis added).

Engineers,²¹⁴ Justice Blackmun found that even if one accepted a quality argument for the engineers' policy against competitive bidding, the "rule is still grossly overbroad."²¹⁵

The Court of Appeals for the District of Columbia Circuit cited these aspects of *Silver* and *Professional Engineers* in a case involving the exclusion of an individual from a health professional association and held that "even if evidence existed in the record to support the asserted justification that the [limitation] improved the quality of patient care, it must be shown that the means chosen to achieve that end are the least restrictive available."²¹⁶ Similarly, the Seventh Circuit, also citing *Silver* and *Professional Engineers*, has declared that where a patient care motive is used to justify exclusionary behavior by a health professional association, the defendant's conduct must meet a least restrictive alternative test.²¹⁷ Scholarly commentary also recommends a least restrictive alternative standard for potentially anticompetitive acts that result from industry self-regulation.²¹⁸

As applied to individual practitioners, denial of hospital privileges is the least restrictive alternative for achieving various procompetitive benefits. When a hospital has reason to believe that an individual will provide low quality care because of deficient training, poor references, or a history of malpractice suits, forcing the hospital to nevertheless grant privileges, but closely monitor the individual's practice, would generate costs and potential liabilities for the hospital.

However, there are methods other than categorical exclusion of a non-physician group that can safeguard the quality of hospital care without limiting competition. A hospital could be selective as to individual non-physician applicants just as it is with physicians. Instead of barring all non-physicians, the hospital could provide for non-physicians' privileges, but admit only the most highly qualified podiatrists or psychologists, for example. With regard to standards of training, the appropriate focus is not on whether the training is less than that of physicians, because non-physician applicants are not seeking to practice medicine.

²¹⁴435 U.S. 679 (1978).

²¹⁵*Id.* at 699 (Blackmun, J., concurring).

²¹⁶*Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1491 (D.C. Cir. 1984) (emphasis added).

²¹⁷*Wilk v. American Medical Ass'n*, 719 F.2d 207, 227 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984).

²¹⁸*Ponsoldt*, *supra* note 89, at 40-43, 59. A least restrictive alternative test is also recommended for scrutinizing exclusionary acts of joint ventures. Brodley, *Joint Ventures and Antitrust Policy*, 95 HARV. L. REV. 1521, 1536, 1568 (1982). A hospital and its medical staff may be characterized as a joint venture. See Kissam & Webber, *supra* note 66, at 656-59; see also Havighurst, *supra* note 31, at 1128-29 (recommending least restrictive alternative scrutiny of the hospital-medical staff joint venture, but focusing only on the structure, rather than the substance, of a privileges decision).

Rather, a court should consider whether the training is deficient in relation to what the applicant intends to do in the institution. For example, where podiatrists seek to perform more elaborate surgical procedures, a hospital could reasonably require advanced residency training or Board certification.²¹⁹

Another less restrictive alternative is for a hospital to grant staff membership to non-physician groups, but limit specific clinical privileges, a practice analogous to the current policy of some hospitals which permit family physicians to deliver babies but require that an obstetrician perform caesarean births.²²⁰ A court should be careful, however, that such limits are not so narrow as to be a sham. In *Davidson v. Youngstown Hospital Association*,²²¹ a podiatrist's privileges case brought on public policy grounds, podiatrists were permitted to cut toenails and trim callouses on a physician's order.²²² It is hard to believe that seven or eight years of professional education qualify podiatrists to do no more than cut toenails.²²³ Finally, to avoid institutional costs of providing medical supervision for legally dependent providers, a hospital could require that an applicant needing physician back-up arrange for his own medical supervision by a staff member.²²⁴

VIII. CONCLUSION

Hospital privileges cases have presented courts with the thorny problem of protecting against anticompetitive abuses while guarding the legitimate interest of hospitals in maintaining high quality care.²²⁵ A first step in resolving this problem is recognizing the clear differences between denial of staff privileges to an individual physician and denial to a group of non-physicians, differences in the substantive validity of the quality

²¹⁹Although podiatrists need only meet state licensure requirements in order to practice, podiatrists may obtain additional clinical training during a residency and demonstrate advanced knowledge by passing a Board examination. Of the 9,200 podiatrists in the United States, 2,400 are Board certified or Board eligible. AMERICAN PODIATRIC MEDICAL ASS'N, *supra* note 43, at 5. *But see* 50 Fed. Reg. 41,693, 41,695 (1985) (Federal Trade Commission charged that a hospital, in demanding that all podiatrists have a three-year residency without relating the residency requirement to specific surgical procedures, restrained competition in violation of the Federal Trade Commission Act).

²²⁰M. ROEMER & J. FRIEDMAN, *supra* note 22, at 284.

²²¹19 Ohio App. 2d 246, 250 N.E.2d 892 (1969).

²²²*Id.* at 252-54, 250 N.E.2d at 897.

²²³*See supra* note 37 and accompanying text.

²²⁴*Cf.* Reynolds v. Medical and Dental Staff of St. John's Riverside Hosp., 86 Misc. 2d 418, 382 N.Y.S.2d 618 (Westchester County Sup. Ct. 1976), *aff'd*, 55 A.D.2d 948, 391 N.Y.S.2d 382 (1977) (although hospital not obligated to directly employ a physician's assistant, it is obligated to provide appropriate privileges when assistant is employed by a physician staff member).

²²⁵Kissam & Webber, *supra* note 66, at 597.

rationale for exclusion, differences in the application of due process, differences in procompetitive justifications and differences in anticompetitive effects. A relatively deferential judicial approach to the exclusion of an individual physician might be appropriate. Because of these differences, however, when quality of care is invoked to justify excluding a non-physician group, judicial scrutiny should be based on a substantial relation and least restrictive alternative test. This approach would ensure that the rule of reason is not applied so deferentially as to insulate one powerful group of competitors from competition. In addition, this heightened scrutiny would uphold the fundamental principle that the purpose of the antitrust laws is to protect competition, not competitors.²²⁶

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²²⁶Brown Shoe Co. v. United States, 370 U.S. 294, 320 (1962).