THE ANTITRUST LAWS AND THE HEALTH INDUSTRY

ROBERT P. BORSODY*

The health industry is one of the largest and fastest growing sectors of the nation's economy, yet in the past, trade regulation cases arising in this area have been disproportionately few. Today this is changing. The courts and regulatory agencies have increasingly held the attitude that if physicians and health care providers wish to reap the benefits of commercial activity they must bear the burden of competition, including trade regulation.

Moreover, many persons in positions of authority believe that restrictive trade practices such as price fixing agreements and boycotts of health care providers have caused increases in prices to consumers. Widespread public and governmental concern with these rapidly escalating costs has caused federal and state governments to search for methods to contain them. In addition to the proposals for "cost cap" programs by government and Blue Cross-Blue Shield and state rate review legislation, the enforcement of existing antitrust laws has been suggested and is being pursued as a means of holding down costs. Such enforcement requires little additional funding or legislative action, and for this reason too, many antitrust regulators have announced their determination to initiate aggressive enforcement efforts in the health care field.

---

*Partner, Epstein, Becker, Borsody & Green, New York, New York; Member New York Bar; LL.B., University of Virginia School of Law.

1 A study by the Council on Wage and Price stability concluded that the rise in health care costs was strongly influenced by lack of vigorous price competition and by restrictions on advertising. [1967] ANTITRUST & TRADE REG. REP. (BNA) No. 761 at A-18. Similar conclusions were reached by Sen. Hart's Subcommittee at hearings held in May of 1974. Hearings on Competition in the Health Services Market Before the Subcomm. on Antitrust and Monopolies of the Senate Comm. on the Judiciary, 93d Cong., 2d Sess. (1974).

2 In 1940, health care expenditures were 4.1% of the Nation's Gross National Product. In 1950, they climbed to 4.5% and in 1960 to 5.2%. In 1970, they reached 7.2% and in only five years the figure rose to 8.3%. Last year in 1977, with the figure at 8.6%, it was estimated that the average American family spent one-twelfth of its budget on health care costs. Put another way, the typical wage earner works one month out of twelve to pay for health care. MED. WORLD NEWS, Feb. 21, 1977 at 57. Secretary of HEW, Joseph Califano, Jr., testifying before the Senate Finance Subcommittee on Health, on S.1470, a cost containment bill, said that "the problem of rising costs is of . . . disastrous proportions."

3 Senator Edward M. Kennedy recently made the statement that "health care appears to be a fertile field for antitrust activity" at the National Leadership Conference on Controlling Health Care Costs. N.Y. Times, June 28, 1977, at 17, col. 6. The Senator, who then headed the Senate Health Subcommittee, announced that the Senate Antitrust Subcommittee, which he also then headed, would hold hearings on anticompetitive practices in the medical and hospital industries. Id.

The health care industry is vast and diverse, ranging from giant pharmaceutical houses to individual visiting nurses. This article will examine only the health delivery system and health insurance companies to survey the present application of the antitrust laws and, when pertinent, to describe the current status of some of the classical defenses available.

In perusing this survey the reader may well conclude that the health field has recently been engulfed by litigation. This writer would emphatically confirm such a conclusion and add that there is more court action to come. As noted, recent antitrust activity has occurred because of public concern with apparently restrictive practices in the industry contributing to the increasing cost of health care. The industry is ripe for regulation. This regulation will come about primarily through two forms of court action: (1) private actions initiated by competitors and pursued because of conflicting commercial interests, and (2) actions by state and federal agencies.

The number of cases actually litigated by governmental agencies, however, is very small. This is due primarily to Section 5(a) of the Clayton Act, which permits a private plaintiff to use a criminal conviction or a civil judgment, obtained by the government after a trial, as prima facie evidence of a violation of the antitrust laws. Section 5(a) specifically does not apply to consent decrees entered prior to trial. Hence, most government actions are settled by consent decree far in advance of trial. The use of a judgment in subsequent private actions is thereby avoided.

Section 4 of the Clayton Act gives a private party the right to sue for three times the damage caused to him by activity which violates any of the federal antitrust laws. The courts term such private parties "individual attorneys general," and in this sense these private plaintiffs can, through the precedential weight of their litigation and through the direct effect of injunctions they may secure, influence the practices of an entire industry. The major part of this article will examine these private antitrust actions.

I. THE ANTITRUST LAWS AND THE ENFORCEMENT AGENCIES

A. Federal Legislation

Before discussing the case law, it may be helpful to outline the major

6 Id. See Annot., 10 A.L.R. FED. 328 (1972). A consent decree is an agreement by the defendant to discontinue the challenged trade practice without admitting wrongdoing.
federal antitrust statutes and to describe the administrative agencies charged with the enforcement of governmental policy through these laws.

The first of the American antitrust laws is the Sherman Antitrust Act, enacted in 1890. Section 1 of this statute prohibits contracts, combinations, and conspiracies in restraint of trade or commerce. This includes all forms of agreements to fix prices and to allocate territorial markets. Most of the private litigants in the health care industry to date have alleged a violation of Section 1 of the Sherman Act. Section 2 of the Act makes it illegal to monopolize, to conspire to monopolize, or to attempt to monopolize. Significantly, an increasing number of private antitrust actions in the health field are premised, at least in part, on alleged violations of Section 2.

The Clayton Antitrust Act contains other legislative provisions which may become more familiar to health care providers, but which have as yet been sparingly invoked. Section 3 of this Act deals with "tie-in" sales agreements. A "tie-in" is a condition which requires that a purchaser buy one product in order to obtain a second. The sale of the first product is thus "tied" to the sale of the second, since the purchaser can obtain the second product only through the purchase of the first. Such an arrangement violates Section 3 only when no comparable substitute for the desired second product is available to the purchaser, and he is thus compelled to purchase the tied product. This showing of monopoly power is the crucial element of a Section 3 violation. For example, the only hospital in a town might require a patient to purchase drugs or prosthetic devices as a precondition to becoming or remaining a patient.

In medicine, quality control considerations often justify certain tie-in arrangements. Thus, a hospital may rightfully require certain minimum quality standards for prosthetic devices used on its premises as a reasonable safeguard consistent with patient safety and risk management programs. If the standards are such that only devices furnished by the hospital comply, however, the hospital could be in violation of Section 3. An illustration from industry is relevant: American Telephone and Telegraph (AT&T) for many years required that subscribers use only instruments furnished by the company in order to avoid possible damage to the network of switching and transmission equipment it maintained. With some prompting from

9 Id. at § 1.
10 Id. at § 2.
13 Thus, the Sherman Act can also be used to support a tie-in case. In the health care field this would be the usual approach since the Clayton Act covers trade involving the sale of goods and not the provision of services.
private litigants and regulatory agencies, AT&T has dropped this require-
ment and now permits the use of other electronically compatible equipment. 
Hospitals are in a similar situation. Before they rely on a "quality assurance" 
argument in tying products to services, cognizance should be taken of the 
dangers involved as evidenced by the AT&T example.

The third major relevant statute is the Federal Trade Commission 
Act.\textsuperscript{14} Section 5 of this act prohibits a broad variety of "unfair methods of 
competition."\textsuperscript{15} For example, a hospital might drive a clinic out of business 
by establishing a competing clinic across the street and attracting the com-
petitor's patients with a schedule of lower-than-cost charges. The hospital's 
other operations could subsidize the operation of its money-losing clinic 
until the competitor is driven out of business. At that point, the new clinic 
would raise its prices to a level exceeding the former competitor's original 
prices. The original clinic having been driven out of business, the public 
is thus faced with a monopoly, and is forced to pay the inflated monopoly 
prices.

This scheme has been used many times in mercantile or industrial 
enterprises but is not so readily adaptable to the health industry. Many 
unique characteristics distinguish the health industry from its mercantile 
or industrial counterparts. Some of these salient characteristics are con-
sumer ignorance concerning the comparative quality of health services, a 
prevalent perception of medical services as being personal and unique and 
not comparable on the basis of price alone, ignorance of price and avail-
ability of health services due to advertising constraints, consumer insensi-
tivity to cost considerations due to widespread third party reimbursement, 
and the consumer's unfamiliarity with the system due to the often episodic 
or emergent access to it.

Thus, in order to be effective in the health field, this particular scheme 
of predatory pricing would certainly require advertising, which to date has 
not been used. Even then, with third party coverage for most patients, 
the pricing scheme would possibly not be as effective as it has been in other 
areas of commerce and industry. However, with the current trend toward 
the approval of advertising which we have seen in some states (Arizona, 
for example) it may well be that the health industry will become somewhat 
more vulnerable to such predatory pricing tactics in the future.

Mergers with anticompetitive effects are barred by Section 7 of the 
Clayton Act.\textsuperscript{16} In the health industry, this Section would most likely be

\textsuperscript{15} Id. at § 45 (1976).
\textsuperscript{16} Id. at § 18.
applied to a merger of competing hospitals. It could conceivably be applied to the acquisition of an additional institution by one of the religious orders or large foundations which already operate a number of such institutions. However, Section 7 cases are rare in the health industry, primarily because the industry is so fragmented.

The antitrust offense occurring most frequently in the health field is the group boycott or concerted refusal to deal. Illegal under both the Sherman Act and the Clayton Act, depending on its factual background, it could occur in a number of circumstances in the health industry. Providers who agree to shun a third party reimbursement source, often for the purpose of inducing higher fees; insurers who refuse to include coverage for the services of a particular provider group; or physicians who boycott a hospital in a board-medical staff dispute, can run afoul of this antitrust principle. The essence of this offense is the agreement or conspiracy not to deal with the excluded group or entity. Individual providers, on the other hand, remain free to choose with whom they will do business, at least as far as the antitrust laws are concerned.

Most states have comparable antitrust statutes and regulations, although the degree to which they are enforced varies from state to state.\(^\text{17}\) The Attorney General of Ohio has proclaimed a vigorous campaign to use the state and federal antitrust laws to attempt to lower the cost of health care to Ohio citizens.\(^\text{18}\) Actions taken so far in Ohio include a suit against the state medical society and the Blue Shield plan of the state under sections 1 and 2 of the Sherman Act and Section 7 of the Clayton Act,\(^\text{19}\) and two antiboycott cases: one against a county medical society for attempting to prevent doctors from working for a health maintenance organization,\(^\text{20}\) and another against dentists for refusing to treat Medicaid patients until the rates were raised.\(^\text{21}\)

The Hart-Scott-Rodino bill, entitled the Antitrust Improvements Act of 1976, added a provision allowing state attorney generals to bring private treble damage actions on behalf of the citizens of their states.\(^\text{22}\) The Tunney Amendments, entitled the Antitrust Penalties & Procedures Act of 1974, changed violations of the federal antitrust laws from misdemeanors to felonies and increased the maximum penalties to three years imprisonment and fines of $100,000 for individuals and $1,000,000 for corporate offend-

\(^\text{17}\) A compilation of state antitrust laws can be found in 4 TRADE REG. REP. (CCH) ¶ 30,000.
\(^\text{18}\) See note 4 supra.
\(^\text{19}\) See note 143 infra; notes 203-205 and accompanying text infra.
\(^\text{20}\) See note 158 and accompanying text infra.
\(^\text{21}\) See note 169 and accompanying text infra.
ers. With these kinds of penalties, health providers are well advised to carefully consider the antitrust consequences of any planned activity which has significant economic or competitive impact.

B. Enforcement

As mentioned before, most of the antitrust case law derives from disputes between private parties. Criminal proceedings under the federal antitrust laws are the province of the United States Department of Justice. These actions are usually reserved for blatant offenses in the clearly defined areas of the law. Businessmen know they should not fix prices. If they are challenged by the Antitrust Division of the Justice Department, courts and juries have little sympathy for them. In the health field the guidelines are far less clear. Strong health policy arguments based on considerations of quality and ethics support what in another industry would be clearly labelled price fixing. Until civil cases and perhaps additional legislation clarify the gray areas of antitrust policy in the health industry, it is very unlikely there will be any criminal actions brought by the Justice Department.

Civil enforcement of the antitrust laws is the responsibility of both the Antitrust Division of the Justice Department and the Federal Trade Commission (FTC). The Clayton Act gives both agencies responsibility for enforcement of Sections 2, 3, 7 and 8. Although the Sherman Act gives authority for enforcement only to the U.S. Attorney General, the Supreme Court has held that restraints of trade in violation of the Sherman Act may also be found to be unfair methods of competition under Section 5 of the Federal Trade Commission Act.

The Federal Trade Commission is an independent regulatory body which was created in 1914 under the FTC Act. The responsibilities of the FTC extend beyond antitrust enforcement; it also has the power to enforce a variety of consumer protection statutes. The FTC's Bureau of Competition is concerned with preserving competition by enforcing Sec-

23 15 U.S.C. § 1-3 (Supp. 1977). Cases involving price discrimination under the Robinson-Patman Price Discrimination Act, id. at §§ 13, 13a, 13b, 21 (1976), are rare in the health field. Although there are a number of such cases involving the drug companies, only one has been found in the health care delivery sector. Abbot Labs., Inc. v. Portland Retail Druggists Ass'n, Inc., 425 U.S. 1 (1976).

24 The exact definition of price fixing as it occurs in the health industry is a problem which will be discussed later in connection with relative value scales. See text accompanying notes 173-77, infra.


26 Id. at § 4.


tion 5 of the FTC Act. In this enforcement the Bureau has great flexibility. It can conduct investigations, bring administrative proceedings before the Commission, or appear in court to conduct its own litigation. Penalties include heavy fines and injunctions. Cases can also be referred to the Department of Justice for prosecution.

Task force groups in both the FTC and the Justice Department's Antitrust Division have been investigating the need for enforcement and, when the decision is made to proceed, compiling evidence for prosecution of an action in the health area. Consequently, we may expect a series of enforcement proceedings in the next few years. The current activities of the task forces will be discussed further in this article.

II. The Laws Interpreted: The Case Law

As an introduction to the cases interpreting the statutes outlined above, the defenses most frequently raised to actions under those statutes will be discussed. This discussion will review most of the earlier cases in which these defenses were raised, often with great success. In recent times, they have more frequently been brushed aside by the courts.

A. Defenses

1. The Professional Exemption and the Effect on Interstate Commerce

The first cases to be considered deal with two defenses which are often raised together. The first, the interstate commerce defense, derives from the requirement of the federal laws that the illegal activity affect interstate commerce. The defendant in this instance argues that restraint of plaintiff's commerce does not substantially affect interstate commerce. The second defense, the professional exemption, stems from the fact that the antitrust laws apply only to a trade or business. Until recently, this requirement had been thought to exempt the learned professions from their scope. In raising this defense the defendant claims that the economic activity said to be restrained is in fact not a "business" but rather a profession and so exempt from the antitrust laws. Both defenses are usually raised by motion in advance of trial and must be considered and resolved in plaintiff's favor before a court can go on to deal with the merits of the action.

The interstate commerce defense is treated in various ways, depending upon the parties to the action and the allegations in the complaint. In cases where hospitals or other health institutions, as plaintiffs, claim the restraint, the defense has not often been successful. When an individual medical

29 These requirements of the federal laws are referred to in the shorthand of the legal profession as follows: The first requires that the offense be "in commerce" and the second, that it "affect trade or commerce."
practitioner claims a restraint, the defense has been more successful. Defendants in the first type of case often support this defense with the argument that hospital activities are strictly local in nature and do not constitute interstate commerce. However, in antitrust litigation the courts have generally held that once an offense is present, a surprisingly small effect on interstate commerce justifies a finding of federal jurisdiction.30 Hospitals, as administrators know, acquire supplies and products from interstate sellers which represent a significant expenditure. This, plus the care of patients from out of state, would be enough under recent case law to produce the necessary effect on interstate commerce.

Three leading cases have illustrated that courts are not likely to dismiss an action by an institutional plaintiff on the basis of the interstate commerce defense. The most recent case affirming the principle that restraint of the hospital business can affect interstate commerce is Hospital Building Co. v. Trustees of the Rex Hospital.31 In Rex, the petitioner, a small proprietary hospital, charged that respondents conspired to monopolize the hospital business in the community and to prevent petitioner's expansion by opposing plaintiff's application for a certificate of need. Defendants in the action were a voluntary hospital, its administrator, one of its trustees, and an official of the local health planning agency. The Supreme Court reversed the lower courts' failure to find the requisite effect on interstate commerce, holding:

Petitioner's purchases of out-of-State medicines and supplies as well as its revenues from out-of-State insurance companies would be thousands and perhaps hundreds of thousands of dollars less than they would otherwise be. Similarly, the management fees that petitioner pays to its out-of-State parent corporation would be less if the expansion were blocked. Moreover, the multimillion dollar financing for the expansion, a large portion of which would be from out of State, would simply not take place if the respondents succeeded in their alleged scheme. This combination of factors is certainly sufficient to establish a "substantial effect" on interstate commerce under the Act.32 Further the court noted that the plaintiff hospital served out-of-state patients.33

30 Although the statute requires a substantial effect on interstate commerce, if the offense is clear, the Supreme Court has sanctioned attack on local restraint when important in the local area even in the absence of such substantial effect. See Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219 (1948); United States v. Employing Lathers Ass'n of Chicago, 347 U.S. 198 (1954).
32 Id. at 744.
33 Id. at 741.
Similarly, in *Doctors, Inc. v. Blue Cross of Greater Philadelphia*, a Philadelphia proprietary hospital claimed that Blue Cross was monopolizing the business of financing health care in the city. The defendant's motion to dismiss on the basis of an insubstantial effect on interstate commerce was denied, the court finding that approximately $23 million in medical supplies were being shipped into the state annually. However, this case was later dismissed on the basis of another defense, the exemption of the insurance industry from the antitrust laws, which will be discussed herein.

The third case, *St. Bernard General Hospital, Inc. v. Hospital Service Association of New Orleans, Inc.*, was brought by a group of proprietary hospitals claiming a boycott by defendants, the Blue Cross Association and its member hospitals. The trial court dismissed the action on the basis that hospital services are local in character and do not affect interstate commerce. On appeal the Fifth Circuit Court of Appeals reversed.

There remains little doubt at this point that reliance can no longer be placed upon those older cases with holdings similar to the district court's ruling in *St. Bernard*. Rare indeed would be the hospital today whose activities would not have an effect on interstate commerce sufficient to sustain antitrust jurisdiction.

The interstate commerce defense has, however, been sustained in cases involving suits by single practitioners since their effect on interstate commerce will most likely be small in comparison to hospitals. In *Riggall v. Washington County Medical Society*, for example, the plaintiff physician brought an action under the Sherman Act, charging that he was wrongfully excluded from the defendant medical society. The court dismissed the action, upholding the interstate commerce defense. Passing on this jurisdictional issue, the court said:

> There is no allegation in the complaint remotely suggesting that the acts of the defendants cast any burden upon interstate commerce. The mere fact that plaintiff at his location in Arkansas may be treating patients from other states who must travel interstate does not result in practicing his profession in interstate commerce as the transportation of such patients is incidental.

The *Riggall* court then went on to describe and quote from a previous
case in which the defense was successfully asserted against a claim brought by a small hospital:

In Spears Free Clinic Hospital for Poor Children v. Cleeres, . . . [197 F.2d 125 (10th Cir. 1952)], action was brought against the Medical Society of Denver City and County, former and present members of the State Board of Health and former and present officials and trustees of the Medical Society based on alleged violations of Sections 1 and 2 of the Sherman Anti-Trust Act. There it was alleged that “numerous persons from all of the United States, and from many foreign countries” regularly came to the plaintiff institution for treatment . . . . Referring to these charges the court among other things said:

The practice of the healing arts in Colorado, including chiropractic, is wholly local in character. The alleged conspiracy and the acts alleged to have been done in furtherance thereof had for their purpose and object the monopolization and restraint of purely local activities. No price fixing or price maintenance for professional or other services was involved. There was no intent to injure, obstruct or restrain interstate or foreign commerce. The mere fact that a fortuitous and incidental effect of such conspiracy and acts may be to reduce the number of persons who will come from other states and counties to the Spears Hospital for chiropractic treatments does not create such a relation between interstate and foreign commerce and such local activities as to make them a part of such commerce.\[^{41}\]

Neither Riggall nor Spears is a recent case, being twenty and twenty-five years old, respectively. Indeed, the reasoning in Spears on the nature of interstate commerce was attacked as being outmoded in United States Dental Institute v. American Association of Orthodontists.\[^{42}\] However, in Dental Institute, the volume and type of business involved was quite different from that in Spears. Dental Institute involved a private dental school alleging antitrust violations by an orthodontist association. There was a substantial effect on interstate commerce due to large purchases of out-of-state orthodontic supplies.\[^{43}\] Indeed, in the Dental Institute case, Spears and other cases were distinguished on just that basis, the district court stating that they were: “cases in which the courts held that the rendering of medical services by a single hospital or a single physician, in a single state, was

\[^{41}\] Id. at 270. See also Elizabeth Hosp., Inc. v. Richardson, 269 F.2d 167 (8th Cir. 1959), cert. denied, 361 U.S. 884 (1959) (related case, same holding); Robinson v. Lull, 145 F. Supp. 134 (N.D. Ill. 1956) (Doctor excluded from medical society. Following Spears, the court found no effect on interstate commerce).


\[^{43}\] Id. at 578.
essentially local in character, despite the fact that some patients came from outside the state for treatment."  

Moreover, in a more recent case involving medical staff privileges, the Tenth Circuit Court of Appeals firmly held that the individual practice of medicine was intrastate in character. Reliance was placed on Spears and Riggall as precedent. In this case, Wolf v. Jane Phillips Episcopal-Memorial Medical Center, an osteopathic physician claimed an exclusionary boycott under Section 1 of the Sherman Act against two hospitals. The circuit court affirmed the district court's dismissal of the action for failure to establish a substantial effect on interstate commerce. The court conceded that there was an offense, saying: "The effect of the alleged conspiracy is clearly to restrain the plaintiff from practicing medicine and furnishing medical services as a member of the defendants' medical staff. The question arises, then, whether the defendants' conduct has substantially affected interstate commerce."

After reviewing the facts of both Spears and Riggall, the court concluded: "We reach the same conclusion in the case at bar; the facts alleged do not support the proposition that the restraint upon plaintiff's practice causes more than an insubstantial effect upon interstate commerce."

The court added a footnote which specifically narrowed the holding to individual practitioners:

Although we recognize that cases such as Oregon State Medical Society and Spears could be read as suggesting the proposition that state-wide professional organizations and their members do not engage in interstate commerce in any of their activities — or, at any rate, that they are somehow effectively exempt from the antitrust laws, we do not subscribe to that proposition in support of our decision in the instant case. We have referred to those cases, rather, for the more narrow propositions, that the plaintiff's business of practicing medicine and furnishing medical services is wholly intrastate in character.

It should be made clear that the interstate commercial activity which forms the jurisdictional basis for an antitrust action must be entirely that of the plaintiff and not of the defendants'. This was explained in the Wolf case as follows:

Plaintiff also seeks to establish jurisdiction by focusing upon the interstate nature of the defendants' business of providing hospital care

---

44 Id.
45 513 F.2d 684 (10th Cir. 1975).
46 Id. at 686.
47 Id. at 687.
48 Id. at 687 n.1.
services. Thus, relying on *Doctors, Inc. v. Blue Cross of Greater Phila-
delphia*, . . . he contends that jurisdiction is present in the instant
case. . . . We note first, that, aside from a general allegation that his
business involves interstate commerce, the plaintiff does not suggest
that the defendants' conspiracy threatens his purchase of interstate
goods or that the flow of such goods would be affected in any way
by his exclusion from the defendants' medical staff. . . .

Second, we note that the plaintiff, by his general allegation that the
defendants' business involves interstate commerce, has suggested that
that business has been affected by the defendants' conspiracy to exclude
plaintiff from their medical staff. Nonetheless, even were we to con-
cede, by *Doctors*, the interstate character of defendants' business, we
fail to perceive the relevance to the plaintiff's claim that the defendants
adopted a plan, that the plan limited or controlled the membership of
the defendants' own medical staff, and that the plan in a very con-
ceptual sense thereby affected the services which the defendants them-
selves might provide. The facts alleged by the plaintiff cannot support
the proposition that his exclusion from the medical staff has affected,
or threatens to affect, the defendants, their hospitals, or through them
interstate commerce. The facts do not support the existence of the
requisite nexus between the defendants' conduct and the interstate
commerce.  

No case has been reported in which an individual practitioner of
medicine was sued and raised the defense that any restraint caused by his
actions did not affect interstate commerce. In such a case the standards
applied by a court might well differ from those used in cases like *Wolf*
and *Riggall*, in which an individual practitioner sued and the defendants
showed that any restraint of plaintiff's practice failed to affect interstate
commerce.

These examples suggest that the defense of an insubstantial effect
on interstate commerce is indeed an uncertain assertion for a defendant
to rely upon in an era of rapid communication, mobile population, and
pervasive governmental regulation and financing of the health care industry.
The case of *Zamiri v. William Beaumont Hospital*, 50 may presage the future
status of this defense in the courts. In *Zamiri*, the plaintiff claimed that he
was the victim of a boycott when he was denied hospital privileges. The

49 Id. at 687-88. Accord American Medical Ass'n v. United States, 317 U.S. 519, 528-29
(1943); Friends of Animals, Inc. v. American Veterinary Medical Ass'n, 310 F. Supp.

50 430 F. Supp. 875 (E.D. Mich. 1977). In an even more recent case where a physician
claimed a boycott by a hospital, the court dismissed following *Wolf v. Jane Phillips Epis-
copal-Memorial Hospital*, although the plaintiff sought to rely on *Hospital Building Co. v.
Trustees of the Rex Hospital*. *Crane v. Intermountain Health Care, Inc. No. C 77-0113*
(D. Utah March 17, 1978). It did not appear, however, that the plaintiff had alleged loss
of Medicare and Medicaid funds as had been done in *Zamiri v. William Beaumont Hospital.*
court refused to dismiss the action on the grounds of failure to affect interstate commerce because the plaintiff physician alleged that defendant's restraint of his practice caused him to lose Medicare and Medicaid funds. The court distinguished this case from *Wolf v. Jane Phillips Episcopal-Memorial Hospital*, a case with quite similar facts, solely on the ground that there had been no allegation in *Wolf* that Medicare and Medicaid funds were affected.\(^{51}\)

The exemption of learned professionals from the antitrust laws is closely allied to and often argued simultaneously with the interstate commerce defense. In both instances, the defendant argues that the activity allegedly restrained does not constitute "trade or commerce" which affects interstate commerce. While the professional exemption has never been applied to a hospital, it has been successfully argued in a number of cases involving practicing physicians. When dealing with the professions the courts have generally applied different and less strict rules than in commercial cases. This principle is stated in *Jones v. N.C.A.A.*: "The prescriptions of the [Sherman] Act were tailored for the business world, not as a mechanism for the resolution of controversies in the liberal arts or in the learned professions."\(^{52}\)

An early case, decided in 1931, *Federal Trade Commission v. Raladam Co.*,\(^{53}\) exempted the medical profession from trade regulation. In *Raladam* the Supreme Court indicated that "medical practitioners . . . follow a profession and not a trade."\(^{54}\)

Perhaps the leading case establishing this exemption is *United States v. Oregon State Medical Society*,\(^{55}\) which squarely held that the "sale of medical services . . . within the State of Oregon is not trade or commerce within the meaning of Section One of the Sherman Antitrust Act."\(^{56}\) The Supreme Court went on to observe that:

> there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different from the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in

\(^{51}\) 430 F. Supp. at 876 n.4. *See also* Haddy v. Grass Valley Medical Quality Ass'n, No. S-77-461 TJU (E.D. Cal. Feb. 28, 1978) (where the interstate commerce defense was denied when plaintiffs alleged a boycott resulting from the requirement that all patients consent to binding arbitration for medical malpractice claims.)


\(^{53}\) 283 U.S. 643 (1931).

\(^{54}\) Id. at 653.

\(^{55}\) 343 U.S. 326 (1952).

\(^{56}\) Id. at 338.
the business world may be demoralizing to the ethical standards of a profession. Semler v. Oregon State Board of Dental Examiners, 294 U.S. 608.57

This principle was reaffirmed, the Oregon State Medical Society case cited and the above passage quoted in the landmark case which has gravely challenged the application of the professional exemption to all professions, Goldfarb v. Virginia State Bar.58 In Goldfarb, the plaintiff was unable to find a lawyer to represent him in the purchase of a home who would charge less than the one percent minimum fee contained in the fee schedule of the local county bar association. This prospective home buyer, an attorney with the Federal Trade Commission, felt this fee schedule constituted price fixing. The Supreme Court agreed. The Court found that the facts showed a:

fixed rigid price floor . . . [of] minimum fees to be charged in future transactions, and those minimum rates were increased over time. The fee schedule was enforced through the prospect of professional discipline from the State Bar. . . . [T]he motivation to conform was reinforced by the assurance that other lawyers would not compete by underbidding. . . . [H]ere a naked agreement was clearly shown, and the effect on prices is plain. . . . Respondents' activities constitute a classic illustration of price fixing.59

The Court struck down the learned profession defense, finding no basis for it in federal legislation and saying: "The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public service aspect of professional practice controlling in determining whether Section 1 includes professions."60

However, the Court made an important qualification of this holding in footnote seventeen:

The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in

57 Id. at 336 citing Semler v. Oregon, 294 U.S. 608 (1935).
59 Id. at 781-83.
60 Id. at 787.
another context, be treated differently. We intimate no view of any other situation than the one with which we are confronted today.63

Most courts considering the professional exemption defense after Goldfarb have concluded that professionals are no longer exempt from antitrust allegations.62 This was certainly the case in Ballard v. Blue Shield of Southern West Virginia, Inc.,63 a suit brought against the state's Blue Cross-Blue Shield insurers by a group of chiropractors claiming that the defendants boycotted them by refusing to provide coverage for chiropractic services. The court, relying on Goldfarb, denied a motion raising the professional exemption defense.64 The court also denied the interstate commerce and insurance exception defenses raised in the same motion.65

Veizaga v. National Board for Respiratory Therapy exhibits a more carefully reasoned approach to the current applicability of the professional exemption after Goldfarb.66 In its opinion the court dealt with the suggestion in footnote seventeen of Goldfarb and concluded:

Where professional organizations are alleged to have committed a per se offense, a two-step analysis is required. First, the court must determine whether the challenged activity is, by its nature and character, commercial. If the Court should find that it is commercial, the professional organization may be liable for a per se offense. However, if the court should find the activity to be noncommercial, it should then apply a rule of reason analysis, using the factors outlined in Board of Trade v. United States. . . . We believe that the second step is necessary to ensure that those professional activities, while noncommercial in their character, but unreasonable (in the antitrust sense) in their impact, are subject to the antitrust laws. This analysis satisfies the concern of the Court that professions should be subject to the antitrust laws but still be treated differently where the public service aspects of the profession are involved.67

63 Id. at 787 n.17.

62 The antitrust enforcers took a similar position. In a speech shortly after the Goldfarb decision, a representative of the Antitrust Division said:

The Supreme Court's clear unequivocal, and unanimous rejection of any idea that the learned professions are exempt from the antitrust laws is a clear signal to all professions. In the unlikely event that the signal is not clear, let me state that we regard the demise of the "learned profession" exemption as complete.


63 543 F.2d 1075 (4th Cir. 1976).

64 Id. at 1079.

65 Id. at 1078.


67 Id. at 70,870.
A per se offense, referred to by the court, is one which the courts have found to be by its very nature illegal under the antitrust laws. No showing of anticompetitive effect is necessary. Price fixing, tie-in agreements, and boycotts are examples of per se offenses. The rule of reason analysis, which applies in the absence of a per se offense, requires a showing of substantial adverse effect on competition within the industry. A sound business reason can, under the rule of reason, serve to justify the challenged practice if the reason is unrelated to anticompetitive purposes.

Another court has used a two-step approach, slightly different from the one in the Veizaga case, in a recent post-Goldfarb case, Feminist Women's Health Center, Inc. v Mohammad. In that case the court denied a preliminary injunction for lack of a showing of irreparable harm to plaintiffs. The court, however, analyzed the merits, noting that there existed a "substantial likelihood of success on the merits" regarding an alleged boycott of an abortion clinic by the defendant doctors and medical society. While this would otherwise be a per se violation of the Sherman Act, the court noted:

This case presents the problem of applying these historic antitrust doctrines in the area of a profession which is highly regulated by the state, and intimately concerns the public health and welfare. In its recent opinion of Goldfarb v. Virginia State Bar, . . . the Supreme Court intimated that due deference to the state's interest in controlling and regulating the professions must be given by the federal courts in applying the antitrust laws. Therefore, in the professional context the application of the historic antitrust doctrines may be somewhat different from the application of those doctrines in purely commercial settings. In other words, the professions are a special case under the antitrust regulating scheme, and the impact of state regulation and policy must be measured in any action against members of such profession. The question therefore arises whether the per se doctrine may be applied at all in an antitrust case brought against members of the medical profession and, if so, to what extent? In the court's view, the per se doctrine does have application in this case, although it must be harmo-

---

68 The courts define per se offenses as those which: "[b]ecause of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." Northern Pacific Ry. Co. v. United States, 356 U.S. 1, 5 (1958). See generally 16 Von Kalinowski BUSINESS ORGANIZATIONS: ANTITRUST LAWS AND TRADE REGULATION § 6.02(3a-f) (1978).
69 415 F. Supp. 1258 (N.D. Fla. 1976). This case was later dismissed on a motion for summary judgment by defendant doctors which was reversed on appeal, the Fifth Circuit agreeing with much of the District Court opinion discussed in the text. 586 F.2d 530 (1978).
70 Id. at 1270.
nized with the peculiarities of the profession involved and the dictates of state policy regarding the profession.\textsuperscript{71}

The court concluded that, because of the state’s authorization to the medical profession to organize themselves,\textsuperscript{72} “good intentions would be a defense to a per se violation.”\textsuperscript{73} The court described the distribution of the burden of proof in the case as follows:

Plaintiff, of course, carries the burden of proving jurisdiction under the Sherman Act. In addition, plaintiff must establish a case showing a combination or conspiracy in the nature of a boycott, and that such combination or conspiracy resulted in the interference with and damage to plaintiff’s business. But plaintiff need not prove that the restraint of trade occasioned by the combination or conspiracy was unreasonable, and that the conspirators had specific intent to violate the antitrust laws, nor that public harm ensued from the actions of the combinations. To this extent the application of the per se doctrine in this case is facile. If plaintiff establishes the elements outlined above, defendants must bear the burden of proof on the “good faith” defense.\textsuperscript{74}

The defense of good faith was explained by the court to require that defendants show that:

their action was motivated by a bona fide concern over the existence of satisfactory medical care rather than by concern over the economic impact of competition upon their medical practices. For only if they were motivated by such bona fides can their actions be deemed reasonable under the per se doctrine, if plaintiff has established a prima facie per se case.\textsuperscript{75}

In Feminist the court indicated that the defendants may not be able to sustain their burden of proof since “the mainspring of defendants’ action was economic.”\textsuperscript{76} In particular, a principal doctor defendant was shown to have voiced concern for the adverse effect on his own practice of the competition of plaintiff.\textsuperscript{77} Hence, notwithstanding their claims of public interest and concern for patient care, the court was of the opinion that the plaintiff could show at trial that the defendants were engaged in a restraint

\textsuperscript{71} Id. at 1262-63.
\textsuperscript{72} The court states at 1263 that FLA. STAT. § 768.131 (1975), authorizes the medical profession to organize.
\textsuperscript{73} Id.
\textsuperscript{74} Id.
\textsuperscript{75} Id.
\textsuperscript{76} Id. at 1270.
\textsuperscript{77} Id. at 1269.
of trade no different than that of a commercial interest which conspires to put a lower priced competitor out of business.\textsuperscript{78}

In both \textit{Goldfarb} and \textit{Feminist}, a determinative factor in the finding of an offense was a showing of defendants' obvious attempts to gain economic advantage by the use of a blatant anticompetitive device. In the first case, establishing fees at a certain minimum level fixed prices.\textsuperscript{79} In the second, a group boycott attempted to drive a lower priced competitor out of business. A similar showing in any future antitrust case is sure to preclude serious consideration of the professional exemption defense.

The \textit{Veizaga} and \textit{Feminist} cases, however, differ significantly in their interpretation and application of the defense. In \textit{Feminist}, proof of "good faith" by a professional would have been a solid defense against allegations of a per se offense. This good faith showing requires establishing a sound business reason under the rule of reason analysis. In \textit{Veizaga} on the other hand, if a per se offense were shown, there would have to be a finding that the activity is "noncommercial" before the rule of reason analysis could apply. Presumably, good faith would then be a defense under the rule of reason analysis and no good faith showing would be allowed the professional defendant.

The view utilized by \textit{Feminist} is more liberal because it implies that professionals can defeat any per se charge by a showing of good faith. In contrast, the \textit{Veizaga} view requires that the activity first be found non-commercial before the showing of good faith can be made. Even the interpretation used in \textit{Veizaga}, however, gives the professional the advantage of being able to demonstrate that the challenged activity is not commercial. Good faith would then be a complete defense.

In conclusion, professional persons and their organized activities continue to be in a somewhat favored position, although since \textit{Goldfarb} the circumstances in which the defense can be successfully asserted have been significantly circumscribed. The success of the argument may well depend to some degree on the particular court deciding the issue as well as whether

\textsuperscript{78} \textit{Id.}

\textsuperscript{79} In the \textit{Goldfarb} case, the Supreme Court punctured the public interest protestations of the defendants with the following footnote: "The reason for adopting the fee schedule does not appear to have been wholly altruistic. The first sentence in respondent State Bar's 1962 Minimum Fee Schedule Report states: 'The Lawyers have slowly, but surely, been committing economic suicide as a profession.'" 421 U.S. at 786 n.16.
the action is predicated upon federal or state statute. One thing is for sure, professionals can no longer ignore antitrust legislation with impunity.

2. The State Action Defense: *Parker v. Brown*

The state action defense is based on the premise that if the antitrust laws are intended to protect the public by preserving competition, which ensures low prices and high quality, they are not necessary in those highly regulated markets where state or federal regulatory authorities monitor and to some extent control price and quality. Allied considerations underlie the doctrine of "primary jurisdiction." Under this doctrine the antitrust enforcers may refrain from attacking trade restraints in heavily regulated industries such as shipping, the airlines, and the railroads, where primary jurisdiction over the industry is in an effective regulatory body.

There are parallels between the state action defense for institutional providers and the professional exemption defense for medical professionals. For many years both defenses have appeared to place the industry and the profession beyond the reach of antitrust enforcement. There were and are strong public policy reasons for both defenses, however, both seem to have been weakened by recent Supreme Court action. It seems logical for institutional health providers to rely on the state action defense because the health industry is one of the most intensely regulated of all industries. The current state of that defense will now be examined to ascertain the extent to which such continued reliance is justified.

The case associated almost interchangeably with the state action defense is *Parker v. Brown*. The litigation was brought to enjoin enforcement

---

80 It should be mentioned that a number of state courts have sustained the professional exemption defense under state antitrust laws. One of these cases was Willis v. Santa Ana Community Hospital Ass'n, 58 Cal. 2d 806, 26 Cal. Rptr. 640 (1962), a treble damage action by osteopaths against doctors in a hospital under the Cartwright Act (the California antitrust law) charging a conspiracy to monopolize the practice of medicine. The action was dismissed, the court holding that the state law did not apply to the professional practice of medicine. Another state case on this subject is Moles v. White, 336 So. 2d 427 (Fla. Dist. Ct. App. 1976), cert. dismissed, 345 So. 2d 516 (1978). In this case, the plaintiff doctor applied for open heart surgery privileges at the defendant hospital. When the application was denied, he brought an action claiming a conspiracy in violation of the Florida antitrust act, to deny him those privileges. The court dismissed the action holding that the Florida law did not apply to the practice of medicine.


82 See generally Report of the Attorney General's National Committee to Study the Antitrust Laws, Ch. VI (1955). Primary jurisdiction questions usually arise when there is a federal regulatory body in the picture and often the issue is resolved by a determination that the regulation does not preclude application of the antitrust laws. See, e.g., United States v. Radio Corp. of America, 358 U.S. 334 (1959); Silver v. New York Stock Exchange, 373 U.S. 341 (1963).

83 317 U.S. 341 (1943).
by California state officials of a clearly anticompetitive agricultural marketing program devised during the Second World War. Plaintiff, a private producer and packer, argued that the plan was inconsistent with federal law, in particular the Sherman Act, and hence invalid. Chief Justice Stone's opinion, holding there was no congressional intent to deprive the states of their freedom to regulate commerce, had come to be interpreted as insulating from the federal antitrust law all state sanctioned anticompetitive arrangements.

The many state regulated industries which had, through the years, taken the Parker v. Brown doctrine for granted were seriously concerned by the Goldfarb Court's apparent limitation of this defense. In Goldfarb, the defendant State Bar Association raised the defense on the ground that it had been designated by the State of Virginia as the administrative agency to enforce the code of ethics for attorneys in Virginia. In this capacity the bar had promulgated the challenged minimum fee schedule and declared it unethical for members of the Bar to ignore the schedule.\(^8\) In considering the state action defense the Supreme Court, citing Parker v. Brown, said: "The threshold inquiry in determining if an anti-competitive activity is state action of the type the Sherman Act was not meant to proscribe is whether the activity is required by the State acting as sovereign.\(^8\)\(^5\) The Court went on to observe that Virginia statutes relevant to the practice of law were silent on fee schedules and the state had never endorsed the defendant bar association's ethical opinions.\(^8\)\(^6\) Accordingly, there was no finding of state action regulating attorney fees, and the case was therefore factually distinguishable from Parker v. Brown. While Parker v. Brown was cited twice with approval and thus remains a viable precedent, the Court more precisely defined the requirements for state action by saying that the "anti-competitive activities must be compelled by direction of the State acting as a sovereign.\(^8\)\(^7\)"

The Supreme Court soon had another opportunity to consider Parker v. Brown and the status of the state action doctrine by way of dictum. In Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.,\(^8\) the Court held that a state statute forbidding the advertising of prescription drugs was constitutionally invalid as an infringement of the first amendment's guarantee of freedom of speech. The Court gratuitously added, however, that: "Virginia is free to require whatever professional

\(^8\)\(^4\) 421 U.S. 773, 776-77 (1975).
\(^8\)\(^5\) Id. at 790.
\(^8\)\(^6\) Id. at 790-91.
\(^8\)\(^7\) Id. at 791.
\(^8\)\(^8\) 425 U.S. 748 (1976).
standards it wishes of its pharmacists; it may subsidize them or protect them from competition in other ways." This dictum is consistent with the recognition in Goldfarb that "States have a compelling interest in the practice of professions within their boundaries" and that "the State may decide that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."

While these pronouncements may be interpreted as approving the police powers of a state to license and regulate, and thereby create exemptions from the federal antitrust laws, the Court has recently taken a more restrictive view.

In the landmark case Cantor v. Detroit Edison Co., the Supreme Court took a position limiting the availability of the state action defense. In Cantor, the plaintiff was a retail seller of electric light bulbs. The defendant, Detroit Edison, had provided "free" light bulbs for many decades to its customers. The plaintiff alleged that this bulb program was an unlawful "tie-in" agreement. The defendant claimed the protection of Parker v. Brown; being closely regulated by the state public utilities commission, it was required to submit the light bulb program for approval by the commission, had obtained that approval, and now could not discontinue the program without further approval by the commission. The Supreme Court denied the defense over a strong dissent, apparently limiting Parker v. Brown to suits against state officials and designating it thus inapposite to the case at bar. The Court also stressed that the challenged activity had originated with the defendant, that the state was neutral, only approving tariffs submitted to it, and that the state had never made "specific investigation" into it.

Justice Stevens, writing for the majority, discussed, without answering, two significant questions. The first was whether "private conduct required by state law is exempt from the Sherman Act." Goldfarb appeared to have answered this question in the affirmative. Dictum in Cantor supported this view: "it would be unacceptable ever to impose statutory liability on a party who had done nothing more than obey a state command." However, the

---

89 Id. at 770.
90 421 U.S. at 792.
92 Id. at 582-83.
93 Id. at 591-92.
94 Id. at 584-85.
95 Id. at 592.
96 See text accompanying notes 84-87 supra. This fact was also noted in Cantor, 428 U.S. at 604 (Burger, C.J., concurring).
97 428 U.S. at 592.
question remained unanswered in this case because Detroit Edison had itself initiated the challenged activity rather than acting in response to a command of the state.\(^9\)

The second question, more relevant to the current activities of the health industry, was whether the Sherman Act was intended to apply to a business "pervasively regulated" by the state under standards "fundamentally inconsistent" with the Act's purpose of fostering competition.\(^9\) Again, the disposition of the action did not necessitate an answer to the question, since the Court found that there was no specific regulation of the activity under consideration (the free light bulb program). But the Court again assumed, in dicta, that a successful defense would have been presented had the facts shown "pervasive regulation."\(^10\)

The Court in *Cantor* refused to articulate more definite guidelines for defining the extent of state regulation necessary for a successful defense as suggested by the dissent. The dissent argued for an antitrust exemption when a state agency both approved and compelled a private activity.\(^10\) The majority rejected this rule, fearing that many state agencies would "grant exemptions from an important federal law for reasons wholly unrelated either to federal policy or even to any necessary significant state interest."\(^10\) The Supreme Court thus wishes to reserve discretion to accept the state action defense on a case-by-case basis without affording the states an opportunity to carve out areas of exemption by affirmative legislative or agency action. This approach may be prudent. It is not inconceivable that a state regulated industry benefitting from a sympathetic political climate and a weak or even "captive" regulatory body could fashion an anticompetitive regulatory scheme impermeable to antitrust attack under the standard posed by the dissent in *Cantor*.

The Supreme Court recently considered the state action defense in *Bates v. State Bar of Arizona*.\(^10\) This case challenged the restraints on advertising imposed by the Supreme Court of Arizona on Arizona lawyers. In upholding the state action defense the court distinguished *Bates* from *Goldfarb* and *Cantor*, finding the advertising restraint in this case to be a clear command of the state acting through its highest court.\(^10\) However, the court went on to find the restraint to be repugnant to the first amend-

---

\(^9\) Id. at 593-95.
\(^9\) Id. at 595.
\(^10\) Id. at 595-97.
\(^10\) Id. at 603.
\(^10\) Id.
\(^104\) Id. at 359.
ment of the Constitution, which in its guarantee of the freedom of speech embraces the right to advertise and which overrides all antitrust policies and exemptions. Consequently, the restraint on advertising imposed by the Arizona Supreme Court on Arizona lawyers was struck down.

While Bates could be interpreted as restoring some vitality to the Parker v. Brown defense, it must be remembered that, although the state action doctrine was sustained, the plaintiff prevailed. It is interesting to speculate whether the plaintiff's antitrust claim without the first amendment claim would have sufficed to invalidate the advertising restraint. Changing the facts of Bates and replacing the advertising restraint with a court promulgated fee schedule, we have a case much more similar to Goldfarb and one in which the state action defense might not have fared as well.

Aside from Bates' apparent approval of the state action defense, this defense has been denied in both Goldfarb and Cantor, as previously noted, as well as in a host of lower court decisions. It appears, therefore, that the state action defense can be relied upon with certainty in only two circumstances — first, when the defendants are actually state officials, and second, when the challenged activity is compelled by state law. But if the defense is raised under any other circumstances, no matter how closely regulated the industry or activity challenged, it is likely to be denied.

This appraisal of the present utility of the state action defense may be translated into several practical prognostications for the health field. Officials of health planning agencies and Professional Service Review Organizations (PSRO's) should be immune from suit for territorial allocations and price fixing, respectively. Moreover, entities required to limit pro-

---

105 Id. at 363-84.
107 Cantor v. Detroit Edison, 428 U.S. 579, 591 (1976). See City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389 (1978). (State action defense denied when asserted by city, the Court holding that the defense could be successfully asserted only when the city was acting pursuant to state direction).
109 See 428 U.S. at 595.
110 But see Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976); text accompanying note 22 supra. The Rex Hospital case was considered by the Supreme Court only on the interstate commerce defense. It is not known whether the state action defense was raised at any stage of the proceedings by the planning agency official who was a defendant.
duction and refrain from expansion by state planning agencies, for example, under the National Health Planning and Resources Development Act of 1974, should be safe from antitrust attack, as should those health care providers whose rates are fixed by state agencies, since the regulatory activities of these agencies are mandated by federal and state statutory enactments. However, there is considerable question whether the state action defense would apply to voluntary cost containment efforts, including voluntary peer review, even if the actions are taken to forestall more onerous government controls.

3. The Insurance Exemption: The McCarran-Ferguson Act

There have been numerous antitrust cases against the various Blue Cross and Blue Shield plans and other health insurance companies. In these cases, the defense of the McCarran Act is usually raised, often successfully. This statute states that the business of insurance is exempt from the antitrust laws to the extent it is regulated by state law. As will be shown, this defense resembles the state action defense in principle, although it requires quite different conditions to attach.

Prior to the Supreme Court's decision in United States v. South-Eastern Underwriters Association, the insurance industry was not subject to federal regulation because it was not considered part of interstate commerce. Consequently, the regulation of the business of insurance was left entirely to the states. In South-Eastern Underwriters, however, the Supreme Court changed its position and held that insurance transactions were subject to federal regulation, including the antitrust laws, under the power to regulate interstate commerce. In reaction to this decision and in order to make clear its intent that the business of insurance should remain exclusively the province of state regulation, Congress passed the McCarran Act.

Section 1 of the McCarran Act acknowledges that "the continued

111 42 U.S.C. § 300K (Supp. 1977). Indeed, Justice Blackmun, in his concurring opinion in Cantor, noted that the defense should apply to state sanctioned schemes to "improve the performance of the market in fostering efficient resource allocation and low prices." 428 U.S. at 611. In a recent decision, an antitrust action brought under the Sherman and Clayton Acts against a regional planning agency and a group of hospitals by a plaintiff denied permission to construct a new hospital, it was held that health planning is exempt under the Parker v. Brown doctrine. Huron Valley Hospital, Inc. v. City of Pontiac, No. 872-7 (E.D. Mich. March 2, 1979).


113 322 U.S. 533 (1944).

114 Paul v. Virginia, 75 U.S. (8 Wall) 168 (1869).

115 322 U.S. at 539.
regulation and taxation by the several States of the business of insurance is in the public interest." The substantive provisions of the Act provide in pertinent part:

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance: Provided, That . . . the Sherman Act, . . . the Clayton Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

One exception to the McCarran Act is provided: "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."

Three conditions determine whether a particular activity is exempt from the antitrust laws by virtue of the McCarran Act. First, the Act applies only to the "business of insurance," and it is therefore necessary to determine whether the challenged activity falls within the scope of that statutory term. Second, the Act provides that the antitrust laws will apply to the business of insurance only if that business is not regulated by state law sufficiently to justify the exemptions. Therefore, even if defendant is found to be engaged in the insurance business, it is necessary to determine further whether its activities are regulated by the state. Third, the court must determine whether the challenged activity constitutes an agreement or act of boycott, coercion or intimidation which is expressly excepted from the Act's immunity.

The threshold question for the McCarran defense exemption is whether the business of insurance is involved. If this is established, together with state regulation, the defense is effectively asserted, unless the plaintiff can show a boycott. Thus, most of the cases concentrate on this first element of the defense.

The inquiry into the meaning of the term "business of insurance" is usually based on the Supreme Court's definition in SEC v. National Securities, Inc. In that case, the Supreme Court defined "business of insurance" as follows:

\[\text{References:}\]
117 Id. at § 1012(b).
118 Id. at § 1013(b).
The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policy-holder.\textsuperscript{120}

One of the first and leading cases to apply the McCarran Act to the health insurance field was \textit{Travelers Insurance Co. v. Blue Cross of Western Pennsylvania}.\textsuperscript{121} This was an action under Section 1 of the Sherman Act claiming that the uniform Blue Cross hospital contract excluded reimbursement for certain costs (hospital construction, uncollectible debts and health service provided to indigents), thus resulting in lower costs to Blue Cross and hence to its subscribers. Plaintiff, a competing commercial health insurance carrier, claimed that the Blue Cross reimbursement contract constituted an unlawful restraint of trade. The Third Circuit Court of Appeals found the negotiation of the contract and Blue Cross’s relationship with participating hospitals to be encompassed within the business of insurance.\textsuperscript{122} The court further found that the state vigorously regulated and in fact required the reimbursement arrangements under question.\textsuperscript{123}

A subsequent case, \textit{Anderson v. Medical Service of the District of Columbia},\textsuperscript{124} also asserted this defense with success. Plaintiff, a physician, challenged the participating provider plan of Blue Shield (Medical Service), claiming that it was a conspiracy among participating physicians and Medical Service to force nonparticipating physicians to adhere to medical fees fixed by Blue Shield. Under the plan, participating physicians were reimbursed directly by Medical Service for their usual charges, provided that these charges did not exceed the fees charged for the same service by ninety percent of the doctors in the community. The participating doctors agreed to accept the amount received from the insurer as payment in full for services rendered and to refrain from charging an excess to the patient. Physicians who did not agree to participate in the plan were not paid directly by the insurer. Under these circumstances, the insured patient was required

\begin{itemize}
\item \textsuperscript{120} \textit{Id.} at 460.
\item \textsuperscript{121} 481 F.2d 80 (3rd Cir. 1973), \textit{cert. denied}, 414 U.S. 1093 (1973).
\item \textsuperscript{122} 481 F.2d at 82-83.
\item \textsuperscript{123} The Court went on to remark that, even absent the McCarran defense, there was no Sherman Act violation because the defendant was just trying to "get the best deal possible." \textit{Id.} at 84.
\item \textsuperscript{124} 1976-1 \textit{TRADE CASES} (CCH) ¶ 60,884 (E.D. Va. 1976), \textit{aff’d}, No. 76-1438 (4th Cir. March 31, 1977).
\end{itemize}
to pay the physician's fee personally and then seek reimbursement from the insurer. The plaintiff physician claimed that this arrangement constituted a price fixing agreement.

In holding that the challenged practices involved the "business of insurance," immune from attack under the federal antitrust laws, the district court said:

This Court finds from the record here made that the McCarran-Ferguson Act exempts it [defendant] from the federal antitrust laws because its reimbursement methods, as set forth in its subscriber-participating physician contracts are part of the business of insurance. The business of insurance refers not only to the relationship between an insurer such as Medical Service and its policyholders, it refers also to those other activities which relate so closely thereto that they must be placed in the same class.\textsuperscript{125}

On similar facts the federal district court for the Northern District of California reached the same conclusion in \textit{Manasen v. California Dental Services}.\textsuperscript{126} Defendant, California Dental Services (CDS), contracted to reimburse the dental bills of subscribers by making direct payments to certain "participating" dentists. The contract also included a peer review system to help determine fees. Under the plan, CDS would compensate "participating" dentists according to a fixed fee schedule, submitted to and agreed upon with each dentist in advance, for services to be rendered to plan members. Any fee schedule submitted by a dentist for approval by CDS proposing fees above those charged by the dental community was allegedly rejected by the defendant, unless a committee of peers found the difference justified. Participating dentists were paid directly by the insurer and accepted such reimbursement as payment in full.

Plaintiffs alleged that when a subscriber to the plan sought care from a nonparticipating dentist, the policyholder would receive less than full

\textsuperscript{125} \textit{Id.} at ¶ 68,857. The court also said:

Participating physicians are in no way restrained from treating patients who do not subscribe to Medical Service or from selling their services to any other insurance carrier—they are in no way restrained from charging those entities whatever they wish. Further, they are in no way restrained from negotiating an agreed fee with those Medical Service subscribers without paid-in-full coverage or in collecting their fee in full.

Medical Service subscribers are in no way restrained from patronizing a non-participating physician—the allowance is the same regardless of whether the subscriber goes to the participating or non-participating physician—the subscribers are so advised.

Non-participating doctors are free to charge their patients, including Medical subscribers, whatever they deem proper. \textit{Id.} at ¶ 68,857-58.

\textsuperscript{126} 424 F. Supp. 657 (N.D. Cal. 1976). \textit{Contra}, Royal Drug Co. v. Group Life and Health Ins. Co., 556 F.2d 1375, 1386 (5th Cir. 1977), \textit{aff'd}, 47 U.S.L.W. 4203 (1979). This case, decided after this article was written, narrows the definition of the "business of insurance" and, consequently, casts doubt on the cases discussed in the text such as \textit{Procter} and \textit{Manasen}.
benefits. They also claimed that the agreements between the insurers and the participating dentists constituted a conspiracy "to fix the fees charged by all dentists in the state for dental care, by boycotting dentists who refuse to restrict their fees in the manner suggested by [the insurer] . . . ."\textsuperscript{127}

The major legal issue in the case was whether defendant's activities, including its referral of fee schedules to peer review panels and its agreements with participating dentists, were within the "business of insurance" for the purpose of the McCarran Act exemption. The court, relying in part on \textit{Anderson} and \textit{Travelers}, held that they were, stating:

\[A\] wide variety of activities which have a substantial effect on rate-making, including the settlement of claims and the limitations of costs, are embraced within the definition of "business of insurance."

Plaintiffs here contend that it is an antitrust violation for CDS to pay service providers prevailing rates for the services rendered to insured patients. It is undisputed that the level of dentists' fees are a major factor in determining policy premiums. CDS' payment arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act.\textsuperscript{128}

\textit{Manasen} discussed and relied upon a case in which the McCarran Act defense was also upheld, \textit{Nankin Hospital v. Michigan Hospital Service}.\textsuperscript{129} In \textit{Nankin}, a small hospital brought suit against Blue Cross under the Sherman Act when Blue Cross terminated its status as a participating institution on the basis that it was unnecessary and inefficient. The court held that contract negotiation with hospitals by the insurer, Blue Cross, constituted "acts in the conduct" of insurance business, hence within the scope of the McCarran Act exemption.\textsuperscript{130}

These cases and others have interpreted the McCarran Act to embrace many aspects of the relationship between carriers and providers of covered services, including the methods by which health insurance companies bargain with and determine rates of reimbursement for the medical providers who render services to subscribers and policyholders. This applies whether the provider is a hospital, as in \textit{Nankin} and \textit{Travelers}, or an individual medical professional, as in \textit{Anderson} and \textit{Manasen}.

\textsuperscript{127}424 F. Supp. at 659-60 (citations omitted).
\textsuperscript{128}Id. at 666-67 (citations omitted).
\textsuperscript{130}Id. at 1211.
The second element of the McCarran defense requires a showing that the activity under attack is regulated by state law. While this is the primary inquiry when the state action is argued to justify exemption, it is, in comparison, the least important element of the McCarran defense. Rarely discussed at length by the courts, a sufficient degree of state regulation is usually assumed once it is shown that the defendant is engaged in the business of insurance. This language from Proctor v. State Farm Mutual Automobile Insurance Co. indicates that courts are not inclined to reject the defense on the basis of an insufficient degree of state regulation.

In every McCarran Act case which has been reported, the pattern of state regulation has always been found sufficient to trigger the antitrust exemption. Such exemption is not affected by whether or not there is a conflict between the Federal antitrust laws and state regulations, whether or not the state enforces its regulations or whether such enforcement is effective. The mere existence of regulatory statutes capable of being enforced apparently is all that is required for the McCarran Act exemption to be applicable.

The third requirement of a successful defense based upon the McCarran Act involves a showing that the defendant's activities did not constitute a boycott within the meaning of the Act. The phrase "boycott, coercion or intimidation," which appears in the McCarran Act, was taken by Congress from the Supreme Court opinion in United States v. South-Eastern Underwriters Association, which first held that the business of insurance was "commerce," and thus subject to the federal antitrust laws. Congress passed the McCarran Act in reaction to this decision in order to confine its impact and to assure, among other things, that the federal antitrust laws would have no application to the insurance industry when regulated by the states, except when the particularly pernicious practices involved in cases such as South-Eastern Underwriters occurred.

The wrongful conduct in South-Eastern Underwriters followed the pattern of "boycotts" traditionally condemned under the antitrust laws. Companies writing fire insurance joined in an association to exclude competing nonmember insurance companies, their agents and other members of the association who did not adhere to the conspiracy, through coercive devices such as group refusals to deal with the competing nonmember companies and their customers.

---

134 322 U.S. 533 (1944).
135 Id. at 539-40.
As in *South-Eastern Underwriters*, the hallmark of every boycott condemned by the Supreme Court is the use of the coercive force of a collective refusal to deal. Thus, for example, in *Klors v. Broadway-Hale Stores, Inc.*, the Supreme Court defined a boycott as a "concerted refusal by traders to deal with other traders."\(^{136}\)

Until a recent Supreme Court decision,\(^{137}\) there was considerable disagreement concerning the proper interpretation of the phrase "boycott, coercion or intimidation." Many cases adopted a narrow construction of this exception, confining application of the exception to the boycott of other insurance companies or insurance agents.\(^{138}\) The other cases have employed a broader interpretation of the term, closer to the traditional antitrust usage: *i.e.*, the statutory language is intended to protect all health care providers and is not confined to the protection of competing insurance companies or their agents.\(^{139}\) The recent Supreme Court case on this point, *St. Paul Fire and Marine Insurance Co. v. Barry*, adopted the latter view and settled the dispute among the circuits.

In *Barry*, a physician plaintiff alleged that an agreement existed among medical malpractice insurance carriers to refrain from selling to physicians dissatisfied with the policies offered by their present insurers. This agreement, the plaintiff alleged, constituted a boycott within the meaning of the statutory exception, since the agreement amounted to "a concerted refusal to deal."\(^{140}\)

The trial court, on the defendant's motion, dismissed the action stating: "the purpose of the boycott, coercion, and intimidation exception was solely to protect insurance agents or other insurance companies from being 'blacklisted' by powerful combinations of insurance companies, not to affect the insurer-insured relationship."\(^{141}\) On appeal to the First Circuit, the decision was reversed, the court of appeals holding that the term "boycott"

---


140 98 S. Ct. at 2927.

141 Id.
should be given its "normal Sherman Act scope." The Supreme Court agreed, with Justices Stewart and Rehnquist dissenting. Justice Powell, speaking on behalf of the Court, made it clear that the word "boycott" as contained in Section 3(b) of the McCarran Act carries with it the meaning it had acquired during the years of antitrust litigation:

The language of § 3(b) is broad and unqualified; it covers "any" act or agreement amounting to a "boycott, coercion, or intimidation." If Congress had intended to limit its scope to boycotts of competing insurance companies or agents, and to preclude all Sherman Act protection for policy-holders, it is not unreasonable to assume that it would have made this explicit. While the legislative history does not point unambiguously to the answer, it provides no substantial support for limiting language that Congress itself chose not to limit.  

B. Antitrust Actions

1. Boycotts

The majority of private antitrust actions in the health field involve allegations of a boycott. In such suits, the plaintiff claims that a concerted refusal to deal with him resulted in his exclusion from some area of economic opportunity. Due to the early success of the defenses discussed above, resulting in dismissal of a case without consideration of the merits, few of the older cases contain extended discussion of the legality of the economic activity alleged to be a boycott. Since these procedural and jurisdictional defenses are not as successful as they were in the past, we can expect more cases to proceed to consideration of the merits of the alleged antitrust violations.

This section will first examine boycott cases involving professional practitioners of the healing arts, usually not medical doctors, who claim that they were excluded from membership in a state or county medical

142 555 F.2d 3, 8 (1st Cir. 1977).
143 98 S. Ct. at 2934. It should be noted that a danger in asserting the insurance exemption defense in cases involving non-carrier defendants is that the insurer defendant can be found to be insulated from attack and thus dismissed out of the action leaving a co-defendant behind. This happened in one of the cases brought by the Ohio State Attorney General. In that case, Ohio v. Ohio Medical Indemnity, Inc., 1976-2 TRADE CASES (CCH) ¶ 61,128 (S.D. Ohio 1976), the defense was successfully pleaded by the insurance company defendant but the state medical society remained in the case because it was not found to be involved in the business of insurance. The state claimed that the medical society controlled the insurer, Blue Shield, and prevented it from using its bargaining power to reduce physician's fees. See text accompanying note 203 infra. To the same effect is Pastor v. Hartford Fire Ins. Co., 1976-1 TRADE CASES (CCH) ¶ 60,783 (C.D. Cal. 1976). There the Los Angeles County Medical Association remained in the case because it was not found to be in the business of insurance after the insurance defense was asserted by the insurer. In the Pastor case, a conspiracy to restrain trade in doctors' malpractice insurance was alleged to exist between the medical society and the defendant insurance company.
society or denied the right to admit their patients to a hospital. Membership in a medical society is often required to obtain malpractice insurance, to obtain referral of patients from colleagues, and as a necessary prerequisite to hospital medical staff appointment. Thus, when a podiatrist, osteopath, or chiropractor is excluded from a medical society or refused admitting privileges at a hospital, he or she may have a cause of action under the antitrust laws, especially if the practitioner is being denied the right to practice as determined by the relevant licensure statute.

In *Riggall v. Washington County Medical Society*, discussed earlier, a physician argued that the defendant's refusal to admit him to membership constituted an illegal boycott. While the court found no effect on interstate commerce and dismissed the action without consideration of the merits, it made the following reference to plaintiff's boycott claim: "Plaintiff has not been prevented from practicing his profession, but in the final analysis his complaint is that he could practice it more profitably but for the acts of the defendants. The Sherman Anti-Trust Act was not primarily to protect the individual but to protect the general public economically . . . ." This statement illustrates an antitrust principle which must form a part of any successful action based upon boycott. The alleged antitrust offense must be shown to have injured some segment of the public and also to have injured the plaintiff, as part of that public. Unless plaintiff has sustained injury as a result of defendant's antitrust violation, he has no standing to sue.

In *Wolf v. Jane Phillips Episcopal-Memorial Hospital Center*, an osteopath claimed a boycott by two hospitals. The interstate commerce defense was successfully interposed. This same defense was also sustained in another boycott case, *Spears Free Clinic and Hospital for Poor Children*

---

144 249 F.2d 266 (8th Cir. 1957), cert. denied, 355 U.S. 954 (1958).
145 See text accompanying notes 39 and 41 supra.
146 249 F.2d at 268.
147 There are other antitrust cases in the health field illustrating a plaintiff's lack of standing. In Council for the Advancement of the Psychological Professions and Sciences, Inc. v. Blue Cross Ass'n, No. 623-73 (D.D.C. Nov. 5, 1974), the plaintiffs sued claiming that a provision of the Blue Cross contract covering their patients required prior referral by a medical doctor. While the case was dismissed as moot, the provision having been altered, the court said that the plaintiffs lacked standing for failure to show sufficient nexus between the alleged violation and plaintiff's practice. In *Meyer v. Massachusetts Eye & Ear Infirmary*, 330 F. Supp. 1328 (D.C. Mass. 1971), the plaintiff was a doctor who claimed that a condition requiring that he give free time to treat clinic patients was an antitrust restraint on his practice. He also raised a number of claims concerning the inadequacy of care rendered to patients he was required to treat arising from the free care requirements. The court dismissed the action, ruling that the plaintiff doctor lacked standing to raise the patient's rights. See also *Stern v. Lucy Webb Hayes Nat'l Training School for Deaconesses and Missionaries*, 367 F. Supp. 536 (D.D.C. 1973), supplemented, 381 F. Supp. 1003 (1974).
148 513 F.2d 684 (10th Cir. 1975); see text accompanying note 45 supra.
The boycott in *Spears* was by city, county and state medical societies against a chiropractic hospital.

Only two boycott cases have been reported in which the court has actually addressed the merits. The first of these is the well-publicized 1943 case, *American Medical Association v. United States* in which the Supreme Court held that the AMA had violated the Sherman Act in its efforts to oppose a prepaid medical plan. It is important to note that no showing of effect on interstate commerce was necessary in this case because the suit was brought under Section 3 of the Sherman Act, which extends the law to the District of Columbia. The defendant medical association had organized a boycott to prevent doctors associated with the newly formed Group Health Association of Washington, D.C., from securing hospital admitting privileges.

The second case in which the court considered the merits of a boycott claim also originated in the District of Columbia. In *Levin v. Doctors' Hospital*, a podiatrist, excluded from medical staff appointment at a hospital, claimed to be the victim of a boycott. The court, however, found that the alleged boycott was only an ancillary result of a hospital rule enacted for the internal regulation of the hospital. The rule was intended to raise ethical standards and enhance the quality of services rendered in the hospital.

---

140 197 F.2d 125 (10th Cir. 1952); see text accompanying note 41 supra.
150 317 U.S. 519 (1943).
152 This is the "quality defense" and is perhaps the most promising of all defenses for health industry defendants. Its application is also illustrated in *Nankin Hospital v. Michigan Hospital Services*, 361 F. Supp. 1199 (E.D. Mich. 1973), a case in which a McCarran defense was sustained. See text accompanying note 129 supra. The court there made a finding that the challenged standards were not adopted for anticompetitive reasons and said:

> When a non-profit corporation promulgates standards designed primarily to promote the public welfare and not to lessen competition, the resulting restraint, if any, is reasonable and therefore not violative of the Sherman Act. Board of Trade of the City of Chicago v. United States, 246 U.S. 231 (1918); Roofire Alarm Co. v. Royal Indemnity Co., 313 F.2d 655 (6th Cir. 1963), cert. denied, 373 U.S. 949. . . .

*Id.* at 1207.

In an accompanying footnote the court stated: "The District Court in Roofire Alarm Co. v. Royal Indemnity, *supra*, held that the Sherman Act is not intended to reach normal and usual contracts or combinations which are incidental to lawful purposes and are intended to further legitimate trade." *Id.* at 1207 n.26. As indicated in *Nankin*, the defense has its roots in the "rule of reason" set out in *Chicago Board of Trade*, 246 U.S. 231 (1918). In *Chicago Board of Trade*, the Court analyzed the price fixing effect of a Board rule specifying prices to be charged after the close of trading hours on the exchange according to the rule of reason. See also United States v. Columbia Pictures, 189 F. Supp. 153, 178 (S.D.N.Y. 1960). Like *Chicago Board of Trade* and *Columbia Pictures*, the effect of the restraint of trade in *Levin* and *Nankin* was found to be ancilliary to the primary and valid purpose of providing quality medical care. It would seem that, in the absence of anticompetitive intent
There are numerous “medical staff privileges” cases with similar facts which have not alleged a violation of antitrust legislation. Some of these cases are brought on constitutional grounds alleging a denial of due process\textsuperscript{153} and some are brought under civil rights statutes.\textsuperscript{154} It seems likely that there will be more medical staff privilege cases claiming under the federal or state antitrust laws\textsuperscript{155} as attorneys become more aware of possible applicability of the statutes to health care providers.

One notable boycott case which had all the earmarks of the classic restraint of trade was settled and therefore not reported. Dr. Edward B. Dietrich, an Arizona heart surgeon of international reputation, brought suit with the Arizona Heart Institute against local physicians, the AMA, and the county medical society. Dietrich and the Institute, which he had founded, charged defendants with engaging in a boycott, defamation, invasion of privacy, and violation of Dietrich’s civil rights in their effort to ruin him professionally and financially. Dietrich claimed that defendants had acted against him because the increasing volume of open heart surgery being performed at the Institute was reducing the practice of certain defendants. Dietrich showed that charges of incompetence and unethical conduct which defendants had brought against him had been dismissed by the state board of medical examiners. He also showed that the local planning authority, dominated by defendants’ supporters, had denied him the right to set up a free-standing heart institute. These and other proofs apparently impressed the defendants and persuaded them to settle the case for an amount reported to be in excess of a half million dollars.

\textsuperscript{153} See, e.g., Kentucky Ass’n of Chiropractors, Inc. v. Jefferson County Medical Soc’y, 549 S.W.2d 817 (Ky. 1977).

\textsuperscript{154} See, e.g., Assum v. Good Samaritan Hospital, 542 F.2d 792 (9th Cir. 1976).

\textsuperscript{155} Mention should be made of two boycott cases brought under state antitrust laws, although both were dismissed on the grounds of the professional exemption before the merits were reached. The first case is Willis v. Santa Ana Community Hospital Ass’n, 58 Cal. 2d 806, 376 P.2d 568, 26 Cal. Rptr. 640 (1962). Willis was a treble damage action by osteopaths against hospital doctors under the Cartwright Act (the California Antitrust Law) charging a boycott and a conspiracy to monopolize the practice of medicine. The action was dismissed, the court holding that the state law did not apply to the professional practice of medicine. The second case is Moles v. White, 336 So. 2d 427 (Fla. Dist. Ct. App. 1976), cert. dismissed, 355 So. 2d 516 (Fla. Sup. Ct. 1978). In Moles, the plaintiff, a medical doctor, applied for open heart surgery privileges at the defendant hospital. When the application was denied, he brought an action claiming a boycott and a conspiracy to deny him those privileges in violation of the Florida Antitrust Act. The court dismissed the action holding that the Florida law did not apply to the practice of medicine.
Currently, considerable enforcement activity by state and federal agencies involves alleged boycotts of health maintenance organizations (HMO). In *Ohio ex rel. Brown v. Mahoning County Medical Society,* for example, the Ohio Attorney General has brought an action against two medical organizations and several individual doctors charging that they have engaged in a boycott to prevent doctors from working for a new, union-sponsored HMO. The action is pending.

Further, the Federal Trade Commission has been vigorously investigating possible boycotts of HMO's. In pursuit of data, the Commission is surveying approximately two hundred HMO's to determine whether they encountered anticompetitive restraints during their period of development. The investigation, which began in April 1977, was prompted by a consent order entered into with the Spokane Blue Shield Plan in September 1976. The FTC had charged the Plan with refusing to deal with a small HMO in Deer Park and the doctors who worked for it. The similarity to the 1943 *American Medical Association v. United States* case discussed earlier is striking. When prepaid group practices such as Kaiser, Group Health Association of America in Washington, D.C., and Health Insurance Plan in New York were first developed in the 1930s and 1940s, organized medicine as represented by the AMA felt the threat of group practice. The suit brought by the Ohio Attorney General against a county medical society for boycotting an HMO shows that private practitioners of medicine are still fearful of prepaid medical care organizations. The recent growth of HMO's, however, is likely to proceed at the expense of the existing indemnity insurers like the Blue Shield Plans. Hence, history is repeating itself, with health insurers along with organized medicine as defendants.

The FTC has also been investigating the AMA for allegedly attempting to eliminate the chiropractic profession by boycott and for other actions violative of the antitrust laws. This inquiry began in late 1975 as a result of the disclosure of certain internal AMA documents to the House Oversight and Investigations Subcommittee by an anonymous informant within the AMA. In February 1976, the FTC also announced that it was investigating the nation's seventy-one Blue Shield Plans to determine if they were dominated and controlled by local medical societies. Another FTC investigation seeks to determine if there is any evidence that the AMA or any affiliates have restrained the supply of physicians or health services. In that investigation, the FTC is examining the AMA's role in the accredita-

---

tion of medical schools, recognition of medical specialties, licensure of allied health professions, and restriction of development of alternative modes of health care delivery. As part of this investigation, the FTC sent out subpoenas on December 27, 1976, to specialty boards for allergy and immunology, anesthesiology, family practice, internal medicine, nuclear medicine, otolaryngology, pathology, pediatrics, radiology, surgery and urology.

Exclusive contracts for the rendition of hospital-based specialty services have also raised the legal issue of boycott. In such arrangements a hospital or other health institution agrees to deal only with a designated physician or group of physicians in a designated specialty, thus closing the department to other qualified persons. The hospital usually justifies this as a way of ensuring quality, an argument strengthened by numerous cases which have imposed increasing responsibility on the corporate hospital for malpractice of the hospital's attending physicians.

Charges of boycott arising from such exclusive contracts fall into two categories. In the first, a hospital has an exclusive contract with A, and B sues, claiming an exclusion. In the second, the hospital terminates its contract with A, who sues, claiming an exclusion.\(^{158}\) Two examples of the first variety follow.

In *Powsner v. St. Joseph's Mercy Hospital*,\(^ {159}\) the defendant hospital had contracted with a group of cardiologists to provide diagnostic and therapeutic cardiological services to the hospital, including cardiac catheterizations. No other physicians could use the hospital equipment to perform the catheterizations. Plaintiff, a cardiologist, brought an action under the antitrust laws of Michigan claiming, among other allegations, that her exclusion was a restraint of trade and a boycott. The court noted that, under state restraint of trade laws, only unreasonable restraints were forbidden; hence, the "rule of reason" must be applied to the facts. Thus, the intent of the defendants was a restraint of trade and a boycott. The court found that, under state restraint of trade laws, only unreasonable restraints were forbidden; hence, the "rule of reason" must be applied to the facts. Thus, the intent of the defendants was of significance and exclusion of plaintiff was not a violation per se. This action was dismissed by the court, which said:

With respect to plaintiff's allegations of the statutory violation, the Court finds that the parties defendant herein neither singly nor in concert had any intent or purpose at any time to create, affect or maintain a monopoly or restraint of trade. The Court finds that at all relevant times the defendants' herein sole purpose and intent was to provide the highest quality of patient care available.

\(^{158}\) Cases challenging exclusive contracts have also been brought on grounds other than restraint of trade but without success. *See*, e.g., Bank v. Palo-Stanford Hospital, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).

The medical education system is the epitome itself of a selective process. Special and subspecialization is a further selective process. The provision of such services often dictates a high degree of selectivity in order to assure only those most qualified provide the services and direction and control. The process of specialization in all areas has increased as scientific and technological advances have been made.

The Court finds that whatever restraint may be incidentally occasioned by the subject contract, in the sense that all contracts affect trade, when weighted against the public benefits as outlined, it is reasonable.\footnote{\textit{Id.} slip op. at 55.}

Earlier litigation in Arizona on similar facts had reached the same result in \textit{Datillo v. Tucson General Hospital}.\footnote{23 Ariz. App. 392, 533 P.2d 700 (1975).} The hospital had an exclusive contract for nuclear medical services. The action was brought by an excluded specialist under the Arizona State antitrust laws. The plaintiff was awarded a $40,000 judgment in the trial court, but this was reversed on appeal.

The court of appeals of Arizona also applied the "rule of reason," approving the exclusive contract arrangement on the following grounds:

- such contracts were needed for control and standardization of procedure and effective, efficient operation of the department; that they give the Board of Trustees great ability to monitor the departments to ensure that the standard is being maintained because of the more limited number of people actually participating; better patient care is achieved because of better scheduling and higher quality of results; they operate more economically; they provide consistency of training of technicians; allow doctors to keep up with current cases in the field; and create a pool of medical knowledge available to all members of the staff to utilize.\footnote{\textit{Id.} at 704-05.}

This kind of argument, which uses considerations of the quality of care to justify what in another setting would be a clear restraint of trade, was discussed in \textit{Feminist Women's Health Center, Inc. v. Mohammad},\footnote{415 F. Supp. 1258 (N.D. Fla. 1976).} noted earlier,\footnote{See text accompanying note 75 supra.} and will be considered by the courts more frequently as they reach the merits of antitrust allegations involving health care providers.\footnote{The quality of care defense is discussed further in text accompanying note 153 supra.}

The second type of boycott case involving the termination of exclusive contracts is illustrated by \textit{Harron v. United Hospital Center, Inc.}\footnote{522 F.2d 1133 (5th Cir. 1975), cert. denied, 424 U.S. 916 (1976).} In this
case plaintiff, a physician, claimed that termination of his exclusive contract to operate the radiology department of a hospital violated both his federal civil rights and the federal antitrust statutes. The district court granted the physician a preliminary injunction. When the defendant appealed this ruling, the Fourth Circuit dismissed the action, stating:

Whatever may be the law of contracts, it is frivolous to urge that the employment of a single doctor to operate the radiology department of a hospital invokes the Sherman Act and the civil rights statutes pleaded.

On remand, the district court will be instructed to dismiss the complaint for want of a substantial federal question and a consequent lack of jurisdiction.107

Although the Harron case does not discuss the point, a distinction must be made between a unilateral refusal to deal and an agreement or concerted refusal to deal. The former is permitted under antitrust law and is illustrated by Harron. The latter is condemned by the antitrust laws as a boycott and is illustrated by the cases alleging that health care providers have agreed among themselves to withhold services from patients entitled to a particular source of reimbursement or those alleging refusal of third party reimbursement sources to deal with a particular class of providers.

An example of a provider boycott case is Ohio ex rel. Brown v. Alliance Dental Services,168 brought in Ohio against dentists who refused to treat Medicaid patients until the fees were raised. While these cases have been threatened widely for years by local government officials, few have been brought, perhaps because the situations that provoke the threats are so quick to arise—and collapse. An investigation is currently underway by the New York Attorney General under the state antitrust laws of a possible boycott by doctors in New York City and Long Island of patients whose fees are paid by workmen’s compensation and the no-fault laws.169

An example of the other side of the coin, a boycott of providers by an insurance company, is the case of Ballard v. Blue Shield of West Virginia,

107 Id. at 1134. A similar case brought under state due process laws for termination of an exclusive cardiac consultation contract was dismissed on quality of care grounds. Adler v. Montefiore Hospital Ass’n of Western Pa., 453 Pa. 60, 311 A.2d 634 (1973), cert. denied, 414 U.S. 1131 (1974).


169 Motions to quash subpoenas issued by the Attorney General were recently denied, the court finding that: “although medicine is a profession, the United States Supreme Court held that, individual physicians who engage in or foster a medical boycott, are subject to [the antitrust laws].” In re Hirshorn, 402 N.Y.S.2d 520 (1978).
2. Price Fixing

Price fixing is the classic restraint of trade. The Department of Justice has recently brought actions claiming that the use of relative value scales promulgated by various professional societies constitutes price fixing. These cases, *United States v. American Society of Anesthesiologists,*\(^{173}\) and *United States v. Illinois Podiatry Society,*\(^{174}\) are part of antitrust enforcement activity aimed at prohibiting the use of relative value scales. Such scales set forth a list of comparative values for designated surgical and medical procedures. The comparative values can be easily converted into monetary fees by the application of a dollar conversion factor. The similarity to the minimum fee schedule litigated in *Goldfarb* is apparent. The FTC has signed consent orders prohibiting further use of relative value scales with the American Academy of Orthopaedic Surgeons on May 28, 1976,\(^{176}\) with the American College of Obstetricians and Gynecologists on June 17, 1976,\(^{177}\) and with the American College of Radiology on September 13, 1976.\(^{178}\) Consent orders have also been entered with several state and local medical societies. Since most medical professional organizations have stopped using relative value scales, this type of enforcement activity should become less widespread.

Relative value scales or any type of “fee schedule” promulgated by the profession itself must be sharply distinguished from rate regulation by governmental authorities. When government regulates rates directly, the doctrine of *Parker v. Brown,* discussed earlier provides an exemption from

---


\(^{171}\) Text accompanying note 63 supra.

\(^{172}\) In addition, chiropractors have brought antitrust actions against the AMA and other medical associations on the grounds that acceptance and enforcement of the AMA Code of Ethics which proscribes voluntary association between medical doctors and chiropractors constitute a “restraint of trade.” New Jersey Chiropractic Soc’y v. Radiological Soc’y of N.J., 156 N.J. Super. 365, 383 A.2d 1182 (1978) (Summary judgment motion by defendants raising the usual jurisdictional defenses denied); Slavek v. AMA, No. 77-1726 (E.D. Pa. 1977).

A recent boycott case dismissed on McCarran grounds is St. Bernards Gen. Hospital, Inc. v. Hospital Serv. Ass’n of New Orleans, Inc., 1978-1 TRADE CASES (CCH) ¶ 61,868 (E.D. La., Oct. 17, 1978), where providers alleged that Blue Cross refused to deal with them. A prior dismissal of this same case on interstate commerce grounds was reversed by the Fifth Circuit. See note 38 and accompanying text supra.


\(^{174}\) Consent decree entered, 1977-2 TRADE CASES (CCH) ¶ 61,767 (December 6, 1977).


\(^{177}\) *In re The American College of Obstetricians and Gynecologists,* 88 F.T.C. 955 (1976).

allegations of antitrust violation. The State of Wisconsin, exhibiting a
degree of caution, recently requested review by the Department of Justice
of a proposed program to set prospective hospital rates. The program,
established under 1975 legislation, authorized Wisconsin's Department of
Health and Social Services to contract with the Wisconsin Blue Cross and
the Wisconsin Hospital Association to jointly review proposals by individual
hospitals for rate increases. Included in the program was a provision for
appeals and for the development of standards for determining the reasonableness
of rates. The Department of Justice approved the program.

The ethical prohibitions on advertising by members of the medical
profession is currently being challenged by both private parties and gov-
ernmental agencies. The FTC has filed a complaint against the American
Dental Association for its stricture against advertising, and has challenged
this basic premise of professionalism by attacking the AMA code of ethics
in the case of In re American Medical Association, filed December 19,
1975. The FTC argues that the prohibition of advertising is a violation of
Section 5 of the FTC Act, since the absence of advertising allegedly results
in price fixing and in the allocation of customers. Prices become fixed
because physicians have no incentive to compete on that basis to attract
patients, and customer allocation results from patients' lack of information
upon which to base their choice of physicians. Moreover, the medical pro-
fession's traditional prohibition on solicitation of patients exacerbates the
situation produced by the ban on advertising.

Health Systems Agency v. Virginia State Board of Medicine, a private
action, raised these same issues. The case arose from an attempt to compile
a listing of doctors and their fees for an area covered by the plaintiff Health
Systems Agency. The 1977 Supreme Court decision in Bates v. State Bar
of Arizona, holding that certain ethical restrictions on advertising by at-
torneys were unconstitutional, can be expected to have at least as much

178 See text accompanying note 111 supra.
179 Business Review Letter dated July 5, 1977. The Department has a business review pro-
cedure under which proposed actions can be submitted for review. 28 C.F.R. § 50.6 (1978).
The Department's procedure when "approving" a proposed action, such as the one described
in the text, is to state that it has "no present intention to institute enforcement proceedings"
against the proposed action.
180 See Canby, Gellhorn, Physician Advertising: The First Amendment and The Sherman Act,
182 F.T.C. Docket No. 9064 (Filed Dec. 19, 1975). A number of other professional prac-
tices and AMA rules are called into question in this procedure. They include prohibitions on
patient solicitation, "corporate practice" of medicine, and partnerships between physicians
and non-physicians.
effect on the medical profession as did Goldfarb. There now seems little legal basis for an ethical prohibition on the advertising of medical fees for first and follow-up visits, representative procedures, and of other basic facts about the practice of an individual or an institution.

A possible new area of litigation activity could develop challenging peer review, alleging that review of fees is tantamount to price fixing. A peer review committee reviews fees submitted to it to determine whether they are "usual, reasonable, and customary." In peer review, health insurance carriers submit their fees for review by a committee of "peers" — i.e., health care providers. With the increasing emphasis on peer review, whether voluntary or imposed by legislation like the Professional Services Review Organization legislation and Titles Eighteen and Nineteen utilization review for Medicare and Medicaid reimbursement, the providers subjected to the review process may counterattack with antitrust allegations. To date the only such cases have involved voluntary peer review, probably because a defense based on Parker v. Brown would very likely be valid and effective for peer review required by the legislature.

Several cases have been filed in which chiropractors have attacked the voluntary peer review of fees and quality of care conducted by a state or national society, usually joining insurance companies as defendants. The chiropractors claim in these cases that the peer review process fixes prices by putting an upper limit on fees. Two of the cases are Pireno v. New York State Chiropractors Association and Bartholomew v. Virginia Chiropractors Association. In Bartholomew a motion to dismiss on the usual jurisdictional basis was denied and the case was set down for trial, while in Pireno the action was dismissed on McCarran grounds, the court finding the peer re-

186 Id. at § 1395X(k).
187 Id. at § 1396 a(19), (26).
189 The Antitrust Division issued a Business Review Letter, dated March 2, 1977, with respect to the voluntary peer review program of a national chiropractic organization. The letter noted that the purpose of the peer review committee "is to act as mediators in disputes between third party reimbursement organizations and chiropractic care organizations by attempting to settle disputes over the amount of particular fees charged by providers" and that the "Committees act in a purely advisory capacity." While stating no intent to challenge the procedure, the letter added that the Antitrust Division "could change its decision" if future evidence disclosed "an intent to control or upwardly influence" fees charged.
191 77-0062(R) (W.D. Va. April 7, 1977).
192 Id.
view process encompassed within the "business of insurance." In another case, *Ettenson v. Dutchess Co. Medical Society*, a physician sought to enjoin the activities of a medical society's peer review committee as it applied to him. He claimed that the proper forum for reviewing the fee in question was arbitration under the state's no-fault law because the fee was for treatment of injuries sustained in an automobile accident. He also argued that the Committee's actions defamed him and violated the Sherman Antitrust Act. The doctor's suit was dismissed on the grounds of failure to exhaust administrative remedies. The court did not treat the merits of the antitrust argument in its opinion, merely observing that "no suggestion was made as to any specific monetary amount or any reference made to any fixed schedule" by the peer review committee. Should the *Bartholomew* case be decided the same way, on the merits, it is unlikely that there will be more of this type of action. However, should the federal courts take a different view and find that peer review indeed has the effect of fixing prices, the filing of this type of suit will be encouraged. One of the current doctrines of the nation's public health policy is that peer review can help contain the rapidly rising costs of health care. Peer review, therefore, has been widely encouraged. However, health providers who engage in this process could find themselves caught between the prohibitions of antitrust policy and those of public health policy if the plaintiffs prevail in any of the cases noted earlier.

3. Mergers, Tie-ins and Other Cases

The antitrust laws prohibit the elimination of competition by merger of competing entities. This tactic has not found much use in the health industry. The fragmentation of the industry, its multiplicity of providers, hospitals, and individual practitioners, would probably minimize the intended anticompetitive impact of any such merger. A few recent cases, however, have suggested that despite this fragmented nature, health industry mergers do have antitrust implications.

---

193 76 Civ. 4309 (S.D.N.Y. Mar. 15, 1979) appeal docketed, No. 79-7307 (2d Cir. Apr. 15, 1979). This decision was made after the Supreme Court's construction of this aspect of McCarran in *Royal Drug Co. v. Group Life*, 47 U.S.L.W. 4203 (1979). See note 126 supra.
194 N.Y.L.J. June 29, 1977, p.17, co.4 (Sup. Ct. Dutchess Co.).
195 See text accompanying note 192 supra. A final price fixing case should be mentioned. In *Webster County Memorial Hospital, Inc. v. United Mine Workers of America Welfare and Retirement Fund of 1950*, 536 F.2d 419 (D.C. Cir. 1976), the plaintiff hospital charged the defendant with price fixing under § 1 of the Sherman Act because the Fund had repeatedly refused, over a period of time, to pay the entire amount of price increases asked by plaintiff for services to the Fund's insureds. The court dismissed the action finding "no allegation of monopoly" and "nothing unreasonable in the actions of the Fund." *Id.* at 420.
196 See note 16 and accompanying text supra. Mergers may also be attacked under the Sherman Act. See, e.g., *United States v. Columbia Steel Co.*, 334 U.S. 495 (1948).
The leading case to date is *City of Fairfax v. Fairfax Hospital Association,* brought under Sections 1 and 2 of the Sherman Act, instead of Section 7 of the Clayton Act. The suit was filed by a group of doctors and a municipality that opposed the transfer of a proprietary hospital to a publicly operated hospital authority. They claimed that the merger into the authority would decrease competition and increase prices, thus adversely affecting future patients as well as causing a loss of property taxes to the city. The lower court dismissed the action on the basis that there was no substantial effect on interstate commerce and further because the doctrine of state action exempted the activity from antitrust attack. The lower court further found that the plaintiffs lacked standing to complain of the alleged injuries, which were found to be speculative and conjectural. The decision was rendered three weeks before the Supreme Court released its opinion in *Hospital Building Co. v. Trustees of Rex Hospital.* Accordingly, *Fairfax* was reversed on appeal on the authority of *Rex Hospital.* On writ of certiorari to the Supreme Court, the Fourth Circuit's judgment was vacated for reconsideration in light of *City of Lafayette v. Louisiana Power & Light Co.*

Another merger case, while merely an adjunct to a corporate conflict between an acquiring and a “target” corporation, resulted in the first judicial assessment of relevant market considerations in the health industry. The case, *American Medicorp v. Hummana, Inc.*, warrants careful analysis. Defendant made a tender offer to the shareholders of plaintiff. Plaintiff's management, hostile to the proposed acquisition, filed the antitrust action as a defensive measure, claiming that the merger would lessen competition. Both parties were in the same business, namely, the ownership or management of hospitals. The court denied a motion for a preliminary injunction by plaintiff. Plaintiff had argued that the merged entity would control 29.5% of all proprietary hospital short-term acute care beds in the country. The court found, however, that the new entity would only control 1.7% of all short-term acute care beds in community hospitals. The court reasoned that, in an industry characterized by large numbers of competitors, this

---

199 562 F.2d 280 (4th Cir. 1977). There is also a discussion of the state action defense in the Fourth Circuit opinion which, over two lengthy dissents on this issue, limits the defense to actions compelled by state agencies, as distinct from local government agencies.
201 445 F. Supp. 589 (E.D. Pa. 1977). A court, in considering the legality of a merger, must first determine the area of effective competition of the relevant market within which the merging entities operate, then the share of this market held by each entity and the resultant combined entity. It is this latter share that must be considered to determine if competition will be adversely affected by the merger.
percentage did not constitute a threat to competition. The court held that the disposition of this merger case did not require any distinction between the beds of a proprietary hospital and those of a voluntary, nonprofit hospital. In addition, the court noted that the local health systems agencies, established under the National Health Planning and Resources Development Act, regulated all construction of beds. After the denial of the preliminary motion, the defendant acquired a controlling interest in the plaintiff corporation.

In one of the cases initiated by the Ohio Attorney General as part of his program to enforce antitrust legislation in the health field, Ohio v. Ohio Medical Indemnity, Inc., a potentially far-reaching argument was made that the Ohio State Medical Association was in violation of Section Seven of the Clayton Act as well as Sections 1 and 2 of the Sherman Act by virtue of its control over the state Blue Shield Plan. The State of Ohio charged the Blue Shield Plan (the largest single payor of doctor bills in the state) with failure to effectively use its bargaining power to reduce the costs of physicians' services since the Board of Blue Shield was dominated by members of the Medical Association. The Blue Shield Plan successfully asserted the McCarran Act defense by claiming that it was engaged in the business of insurance. It was dismissed as a defendant. The Medical Association remained as the defendant in the action. On March 22, 1979, the lawsuit was settled, the Ohio State Medical Association relinquishing control of the Blue Shield Plan.

A tie-in agreement has been defined as: "an agreement by a party to sell one product, but only on the condition that the buyer also purchases a different (or tied) product." While tie-ins have been involved in some of the cases discussed above, as yet no case in the health industry has raised the issue squarely. In Boddicker v. Arizona State Dental Association, a

---

204 Id.
205 Plain Dealer, Mar. 23, 1979, at 1, col. 2. The Ohio State Medical Association agreed, as part of the settlement, to make a $1 million grant to the geriatric medicine programs at seven medical schools, to give the Ohio Attorney General the power to choose directors, only four of which may be doctors, and to accept $56,000 it paid for the stock more than 30 years ago without interest in return for relinquishing control. Id.
207 549 F.2d 626 (9th Cir. 1977), cert. denied, 434 U.S. 825 (1978). Another state court case held that there was no tying agreement when a Blue Shield Plan required member
group of Arizona dentists brought suit against the state dental association, which required that its members also belong to the national dental association. Such a stipulation has all the earmarks of a tie-in: the requirement of the purchase of an unwanted product or service as a condition of purchase of the desired item. The district court's dismissal of the action on professional exemption and interstate commerce grounds was reversed on appeal, and there has not yet been any decision by the lower court to which the case was remanded for consideration of the merits.

*United States Dental Institute v. American Association of Orthodontists* typifies a possible trend in private antitrust actions in the health industry. As such, it can be thought of as a potentially ominous sign or as an opportunity for righting wrongs, depending on one's perspective. In this case a private, for-profit educational institution and a number of practicing dentists brought suit against the American Association of Orthodontists, the American Dental Association, and a number of officers of both associations individually. The plaintiffs sought treble damages and injunctive relief under Sections 1 and 2 of the Sherman Act. The Dental Institute offered orthodontic courses and seminars to dentists in general practice so that they could become qualified as dental specialists without returning to a dental school for more traditional academic work. The Institute alleged that the defendants conspired to restrain and destroy its business in order to restrict the number of specialists and perpetuate the monopolistic position of specialists currently in practice.

The court's opinion on a motion to dismiss disposed of a number of procedural defenses, including the failure to affect interstate commerce and the claim that professionals were exempt from antitrust regulation. The court further refused to credit defendants' arguments "that they were motivated only by a sense of duty to protect the general practitioner dentists from substandard education and to protect the public from treatment by less than qualified practitioners," finding instead that the defendants' physicians to participate in all its service programs rather than those they chose. Connecticut State Medical Soc'y v. Connecticut Medical Service, Inc., 29 Conn. Supp. 474, 293 A.2d 794 (1971). See also Bogus v. American Speech & Hearing Ass'n, 582 F.2d 277 (3d Cir. 1978) (Tie-in of certification with professional association membership alleged, dismissal denied). Several cases have also recently held it permissible for a hospital to require an attending physician to have malpractice insurance as a condition of securing or retaining admitting privileges. See, e.g., Holmes v. Hoemako Hospital, 11 Ariz. 403, 573 P.2d 477 (1977). It is not known, however, whether or not such a requirement was challenged on antitrust grounds as a tying agreement.


*Note 209* Id. at 577.

*Note 210* Id. at 579.

*Note 211* Id. at 580. In this case the quality assurance defense failed to convince the court. On the quality assurance defense, see note 153 and accompanying text *supra*. 
actions operated "on the business and commercial aspects of the dental practice by preserving the orthodontists' special commercial interests."\textsuperscript{1}

On such a motion a court can neither evaluate the credibility of any of the plaintiff's allegations nor know if the plaintiff can provide sufficient evidence to support his claim on trial. Still, the court in United States Dental Institute took the position, as an increasing number of other courts are doing, that the evidence must be heard and weighed on the merits as in the trial of any other issue involving commercial interests. On the merits, the restraints imposed by professional associations, codes of ethics, and health care providers may be sustained due to the facts of the particular case, the needs of the industry or, simply, on broader grounds of public policy. However, they will be examined and tested by many of the usual and traditional standards applicable to trade regulation.

**CONCLUSION**

What course can be counseled for those guiding craft afloat on this rising tide of antitrust litigation? The same as for any business: seek counsel before embarking on a new venture of any economic substance which could, in any way, be deemed to violate the laws discussed above. In addition, existing arrangements and practices should also be reviewed.

From a broader social policy point of view there are likely to be serious problems in the future as the enforcement policies of the federal and state government trade regulation agencies or decisions in private antitrust actions conflict with public health policy as administered by the United States Department of Health, Education & Welfare (HEW) and the corresponding state agencies.

Conflict between the federal antitrust agencies, themselves, on how to regulate the health industry is not unknown. For example, the writer is defending one of the peer review cases mentioned above\textsuperscript{2} and has had occasion to speak with the FTC about the practice. In the eyes of the New York Regional Office, peer review was viewed as a suspect activity because of possible influence on prices. Shortly thereafter, the Antitrust Division issued an opinion in response to an inquiry from a national association giving a clean bill of health to the identical practice.\textsuperscript{3} HEW, also, sometimes appears to take divergent approaches to competition in the industry. The policy to promote HMO's is premised on their proliferation with con-

\textsuperscript{1} Id. at 581. Compare with text accompanying note 79 supra. As in the Feminist and Goldfarb cases, a claim of "good faith" or "quality assurance" is inconsistent with demonstrated self-interest.

\textsuperscript{2} See text accompanying note 190 supra.

\textsuperscript{3} See note 189 supra.
sequent competition between them and, hopefully, lower prices and higher quality. However, a cornerstone of national public health policy, as embodied in the National Health Planning and Resource Development Act of 1974\textsuperscript{215} is limitation of growth.

It is hard to know how to navigate in these waters astir with the treacherous cross-current of treble damage actions and lined with regulatory reefs. A single encounter with one of these perils could spell the end of even a substantial health facility. The dangers of losing a private action or an enforcement action are obvious. However, with the disruption, uncertainty and enormous defense costs of antitrust litigation, even a victory can be a Pyrrhic one.

Guidance is clearly needed in this area. This may come out of the joint hearings of the Senate Subcommittee on Health and the Subcommittee on Antitrust and Monopolies both announced by Senator Edward M. Kennedy who chaired both subcommittees.\textsuperscript{216} Given the Senator's well known and long time commitment to comprehensive national health insurance, his interest is likely to be in the direction of an industry more closely regulated by the federal government. While legislation purposed toward this end may also include some express or implied relief from the antitrust laws, it may not. One thing is certain, in order to preserve a viable health delivery system, the incessant enactment of federal and state laws restricting the competitive freedom of health providers cannot continue while the tempo of antitrust enforcement increases. There must be relief in one direction or the other.

\textsuperscript{215} 42 U.S.C. § 300K (Supp. 1977). Indeed, current proposed amendments would even extend the scope of the Act to include private physician's offices. However, these same amendments would also exempt HMO's from the Act, thus tempering the apparent inconsistency referred to in the text.

\textsuperscript{216} See N.Y. Times, June 28, 1977 at p. 17, col. 6.