

The Antitrust Challenge
to the Professional Paradigm
of Medical Care

Clark C. Havighurst

Wm. Neal Reynolds Professor of Law
Duke University

The 1990
Michael M. Davis Lecture

CENTER FOR HEALTH
ADMINISTRATION STUDIES
UNIVERSITY OF CHICAGO

THE SPEAKER

Clark C. Havighurst is the William Neal Reynolds Professor of Law at Duke University. He received his A.B. magna cum laude from Princeton University and his J.D. from Northwestern University. His scholarly writings include articles on most phases of regulation in the health services industry, the role of competition in the financing and delivery of health care, medical malpractice, and a wide range of antitrust issues arising in the health care field. He is a member of the Institute of Medicine of the National Academy of Sciences and of its Board of Health Care Services.

THE OCCASION

Mr. Havighurst delivered this lecture at the McCormick Center Hotel, Chicago, on May 4, 1990.

INTRODUCTION

The subject of this conference—the enforcement of the antitrust laws against health care providers—has certainly been one of the big stories in the health care industry in the last decade and a half. I hope that I will be forgiven for observing, however, that the institution that is hosting us today bears some indirect responsibility for the extra attention that health care providers have received from antitrust enforcers and plaintiffs' lawyers in recent years. The University of Chicago is, after all, the spiritual home of the revisionist school of antitrust economics that was in the process of narrowing the scope of modern antitrust law just as the health care industry was opening up as a fertile new field for antitrust litigation. Perhaps if the antitrust industry had not been suffering from acute overcapacity brought on by "Chicago School" antitrust analysis when the health care target of opportunity came into view, the antitrust revolution in health care would not have been as sudden or as far-reaching as it turned out to be.

In any event, what I want to explore in this lecture is some of the deeper meaning of the antitrust revolution for the medical profession and its institutions.

I. THE POLICY SIGNIFICANCE OF BRINGING ANTITRUST LAW TO BEAR ON HEALTH SERVICES

The sudden application of antitrust law to health care in the late 1970s had far-reaching implications for the course of national health policy. In the early 1970s, health policy makers faced only two basic alternatives: Either the medical profession would retain its customary responsibility for the operation of a mixed public/private health care system, or the government would assume primary responsibility for the system—either as a regulator or as the sole payer for medical care. The third broad policy option—reliance on market forces and consumer choice to guide the health care industry—was a nonstarter in the debates of that era. One reason why the market option was neglected was the common belief that competition was unworkable, due in large measure to the tendency of physicians to act in concert and to mount massive collective resistance to any private-sector

initiatives they did not like. In the absence of antitrust enforcement against physicians, the strategy of relying on market forces struck nearly everyone as a bit naive.

All that changed when the Supreme Court decided the *Goldfarb* case—*Goldfarb v. Virginia State Bar*—in 1975. Although that case involved directly only the legal profession, the Court's decision that the so-called "learned professions" are not implicitly exempt from antitrust laws had the effect of abruptly altering substantive public policy toward the health care industry. Whereas the implicit premise of previous policy had been that competition could have no place in the health care sector, *Goldfarb* suddenly made competition mandatory, at least in the sense that restraints of trade and monopolization were prohibited. That overnight change in substantive policy in turn significantly altered the dynamics of the industry with which health policy makers had to contend.

Even more importantly, the new availability of antitrust law to police competition in the health care field broadened the policy debate. Thus, when the Federal Trade Commission (FTC) launched its antitrust initiatives in health care in the late 1970s, it finally became credible to build future policy on the assumption that competition could operate in the industry. In 1979, Congress went rather far toward adopting the neglected third option in health policy by defeating the Carter administration's plan to regulate all hospital revenues, by inserting language favorable to competition in the health planning amendments of that year, and by seriously considering a spate of so-called "procompetition" bills. Intensified antitrust enforcement was an essential prerequisite of the policy shift toward relying primarily on the market to allocate private resources to medical care and concentrating on the prudent purchasing by government in the private marketplace to provide for public beneficiaries. The Reagan administration, when it came to power, subscribed wholeheartedly to this policy approach.

In this lecture, I wish to consider whether society has done all that it can do in enforcing the antitrust laws to realize the ideal of a competitive market that allocates resources to health care in accordance with consumer preferences. I will pose the challenge as being broader than just to stop physicians from agreeing not to compete in certain ways and from boycotting payers or others who act in ways they do not like. To my mind, the

task of antitrust law is to substitute a whole new way of thinking for the traditional professional model of medical care, which I shall call the professional "paradigm." After describing this paradigm, I will first discuss old business to show how far we have come in challenging it. I will then take up unfinished business, suggesting that there are several areas where the old paradigm of medical care still operates to blur antitrust analysis, with adverse effects on consumer welfare.

II. THE TRADITIONAL PROFESSIONAL PARADIGM OF MEDICAL DECISION MAKING

The medical profession has long maintained that medical care is not a commodity, that its content should be determined by science and not economics, and that, because consumers are ignorant of medicine's technical mysteries, decisions should be entrusted exclusively to physicians. One corollary of these nonmarket tenets is that individual physicians and the profession as a whole have heavy ethical obligations; although generally unassailable, this proposition serves to legitimize the assumption of dominant decision making responsibility by the suppliers of medical services. The disenfranchisement of consumers is also facilitated by the paradigm's insistence that medical care should be evaluated and distributed solely on the basis of safety, efficacy, and patient need; in order that cost considerations and ability to pay will not influence treatment, the paradigm dictates arrangements under which patient preferences are consulted only after price tags have, for the most part, been removed. The paradigm also denies a legitimate role in decision making to corporate intermediaries, even though a corporation might employ technically competent professionals as decision makers and might be fully accountable to consumers in the marketplace. Because the professional paradigm of how and on what basis societal choices concerning medical care should be made was so clearly at odds with the market paradigm underlying antitrust law, it should have been clear that the *Goldfarb* decision, in undercutting the elite status of the "learned professions," exposed physicians to, among other things, a severe culture shock.

The medical profession's paradigm of the medical care enterprise has long enjoyed a high degree of acceptance by the larger society. Although this acceptance was

always more *de facto* than *de jure*, the legal system did embrace the paradigm in a number of crucial respects. Professional licensure set physicians apart and gave them—more or less explicitly, depending upon the state—the prime responsibility for collectively regulating their own performance. The regulatory system also accepted organized medicine’s assumption of responsibility for determining how physicians should be trained and how medical specialties should be structured. Many courts inferred from licensure laws that only individuals, and not corporations, could sell professional services and determine the scope of services provided. Because consumers were thus prevented from holding physicians accountable through various corporate agents, state regulation and professional controls became the public’s main line of defense against bad practice and high costs. Courts administering the law of medical malpractice looked to customary medical practice to ascertain the legal standard of care—not because medical custom was the resultant of efficient market forces, but because physicians, as ethical professionals, were presumed generally to know and to do what was socially appropriate. In all these respects, the medical profession itself provided the benchmarks for the legal system and public policy to use in judging professional conduct. In accord with the professional paradigm, the supply side of the market rather than the demand side—that is, consumer choice—dictated the nature and configuration of the services provided.

Antitrust law itself embraced the professional paradigm of medical care for a long time by generally ignoring the “learned professions” and inviting the inference that they might be exempt. One theory—the currency of which was surprising in light of the lack of legal precedent for it—was that physicians were engaged in something more exalted than “trade or commerce” (the statutory terms) and were therefore beyond the reach of the Sherman Act. There were also hints that, even if the antitrust statutes applied, only special, softer rules would be appropriate for physicians. The most famous such hint was the Supreme Court’s dictum in a 1952 case involving the Oregon State Medical Society that “forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.”

Not every antitrust authority suffered from illusions about the medical profession, however, as demon-

strated by the criminal convictions in the late 1930s of the AMA and the Medical Society of the District of Columbia, for attempting to destroy an early HMO. Thurman Arnold, the iconoclastic head of the Justice Department’s Antitrust Division when it brought the case, subsequently opined that “John L. Lewis and Dr. Fishbein [the dominant figure in the AMA] are brothers under the skin.” Nevertheless, the *AMA* case stood almost alone for many years as an aberration from the conventional view that physicians could be trusted, in the aggregate, to respond to a calling higher than narrow self-interest.

The professional paradigm was manifest even in the *Goldfarb* decision itself—specifically, in the famous footnote 17, which said that “the public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.” Subsequent history confirms, however, that—as was noted by someone at the time—“footnotes are for losers.” Although the Supreme Court always left open in subsequent opinions the possibility that professionalism might sometime dictate a different antitrust result, its dicta to this effect were increasingly narrow, and the Court has yet to decide a case in favor of a professional group on such a basis. If the professional paradigm still influences antitrust law, as I think it does, it is not simply because the courts have relaxed the law’s clear dictates in favor of some softer rule whenever physicians or other professionals are involved.

III. EARLY ANTITRUST INITIATIVES IN THE HEALTH CARE SECTOR

Partly because of the professional paradigm, antitrust enforcers proceeded cautiously in their early encounters with the medical profession. The initial problem was to develop a sophisticated understanding of the medical marketplace itself with its many unusual features, including third-party payment, and a clear sense of how competition could and should operate—or, conversely, might be foreclosed—in such a market. It was also necessary to develop principled and factually supported responses to anticipated antitrust defenses based on the professional paradigm. The public agencies

also had to be particularly sure of their political ground before moving against physicians, a powerful interest group. The profession could claim, after all, not only that its members had been unfairly surprised but also that replacing the professional paradigm with the untested, and arguably inappropriate, market paradigm was an unjustified exercise of prosecutorial discretion.

A. *Naked Restraints and Per Se Rules*

The earliest antitrust initiatives in the health care sector naturally addressed violations of the more obvious kinds. With respect to these so-called “naked” restraints of trade, traditional antitrust doctrine provided such a clear warrant for proceeding that the professional paradigm engendered few compunctions in the agencies and presented relatively few political problems. Choosing its targets with such thoughts in mind, the FTC directed its initial attention to provisions in the medical profession’s code of ethics that set naked limits on the forms that competition among professionals could take.

Although it would have been hard to argue on narrow consumer welfare grounds that overturning the AMA’s restrictions on professional advertising deserved the highest enforcement priority, those restrictions seemed such a clear and naked agreement in restraint of trade that the FTC deemed them, tactically, a good starting point. Nevertheless, the professional paradigm very nearly operated to frustrate the FTC’s effort, because the Supreme Court affirmed the Commission’s action by only a 4-4 vote. Presumably, four of the justices would have accepted the AMA’s claim that it was a responsible professional organization and that, because it had mended its ways once it learned that it was on shaky legal ground, the FTC’s cease and desist order against it was unnecessary. Ironically, the FTC had itself deferred to the professional paradigm by allowing the AMA and its affiliated societies to retain a role in policing “deceptive” ads. This concession to the tradition of professional self-regulation, even in the face of the respondents’ record of adamant opposition to all but the most innocuous physician advertising, demonstrated the political difficulty, at the time, of using the free-market paradigm to trump the professional one. In the same case, the FTC also challenged other provisions in medical codes of ethics, including those condemning “contract practice”—that is, a physician’s marketing of his

professional services through a corporate intermediary, such as an HMO. It seems certain that the FTC’s early action against the AMA assisted delivery system reform by making it clear that antitrust law would not tolerate even ethically inspired boycotts aimed at keeping physicians from participating in selective, competitive medical plans or in other innovative arrangements.

Naked restraints of trade by medical professionals, particularly boycotts, have consistently yielded to antitrust attacks, although rarely without a nod in the direction of the professional paradigm. The application of basic antitrust principles to physicians was greatly simplified by the Supreme Court’s 1978 decision in *National Society of Professional Engineers*, which forcefully reiterated that antitrust law is concerned only with a practice’s effects on competition, and not with whether it serves the overall public interest—which the professional paradigm can plausibly claim to do. In that case, the engineers offered their own paradigm of professionalism—really, it was more of a parody than a paradigm—in claiming that price competition for engineers’ services, which they had sought to suppress, would induce customers to neglect quality, with the result that buildings, bridges, and other structures would regularly collapse. The Court ruled rather forthrightly that such defenses are not cognizable in an antitrust case. Indeed, being based as they are on another paradigm, they constitute, as the Court said, “a frontal assault on the basic policy of the Sherman Act.”

Perhaps the only serious modern departure from rigorous judicial insistence that competitive effects alone, rather than alleged worthy purposes, govern antitrust cases against professionals is the peculiar rule sketched by the U.S. Court of Appeals for the Seventh Circuit in its first opinion in *Wilk v. AMA*. The court fashioned a narrow exception—too narrow, as it proved, for the AMA to slip through—for professionals’ boycotts to suppress competitors if the boycotters’ intention is specifically to protect their patients, and not simply to impose their view of the larger public interest. It is most unlikely that lawyers today are counseling physician clients in reliance on the *Wilk* exception—the most prominent modern dictum embracing the paradigm’s view that professional organizations can safely be allowed to police the private sector with coercive sanctions as long as their motives remain strictly professional and pure.

One way in which the professional paradigm of

medical care has been acknowledged, without affecting antitrust outcomes, is in the apparent reluctance of antitrust enforcers and the courts to treat naked restraints of trade by health professionals as *per se* violations, even when they fall rather easily within the categories of restraints that have been condemned in other contexts without requiring specific evidence of harmful effects. The FTC, no doubt cognizant of the political risks it would run in relying on a seemingly arbitrary legal presumption instead of proving its case in full, elected not to invoke an available *per se* rule in proceeding against the Michigan State Medical Society. The Commission had little difficulty, however, in condemning the society for initiating an egregious physician boycott of a Blue Shield plan in an effort to obtain rescission of certain cost-containment actions to which the society's members objected. The Commission and the Supreme Court both took a similar approach in *Indiana Federation of Dentists*, a case condemning an agreement by dentists not to accommodate patients' requests that X-rays be submitted to their insurers for cost-containment purposes. Although the Supreme Court noted that "we have been slow to condemn rules adopted by professional associations as unreasonable *per se*," it gave very short shrift to all the dentists' defenses based on the professional paradigm, applying instead the market paradigm with considerable rigor. Indeed, the Court suggested, in response to the dentists' assertion that only they stood between their patients and insurers' disinterest in quality dental care, that competition could reasonably be expected to induce insurers to accommodate appropriately the inevitable trade-off between quality and cost.

The reticence of the courts and the FTC about applying *per se* rules to professional organizations need not be viewed only as a sign of their residual respect for professionalism. During the same years, the Supreme Court was receding generally from its previous willingness to fashion new *per se* rules and to give expansive interpretations to existing ones. Also during this period, the Rule of Reason became generally more flexible, allowing quick resolution of many cases once certain elements are found. Finally, the health care industry has enough unusual characteristics to warrant listening to any defendant's or respondent's claim that the facts of its case are distinguishable in some relevant way from

the precedents laying down the *per se* rule. At least until substantial experience with the health care industry was gained, it made some sense for politically accountable prosecutors and careful courts to walk circumspectly.

The case that might be viewed as marking the end of the period of pussyfooting around hard-core antitrust violations by health care professionals is *Arizona v. Maricopa County Medical Society*. In that case, Justice Stevens, writing for only a four-justice majority of the Supreme Court, asserted that "the argument that the *per se* rule must be rejustified for every industry that has not been subject to significant antitrust litigation ignores the rationale for *per se* rules." But even though Justice Stevens said that it was appropriate to apply the *per se* rule against price fixing to the setting of maximum physician fees in the *Maricopa* case, he actually took significant pains in his opinion to satisfy himself that the challenged arrangements were not procompetitive in fact. Despite what he said he was doing, his actual method was to take what is sometimes called a "quick look" under the Rule of Reason. So understood, the *Maricopa* case was not as aberrational as it seems.

In general, it is unlikely that the Rule of Reason, as now administered, will saddle plaintiffs alleging hard-core antitrust violations by health care professionals with any special burdens attributable solely to the elite status of the defendants. On the other hand, the professional paradigm may continue to make criminal prosecutions of physicians for such violations relatively rare. Despite recent declarations by enforcement authorities that they are now willing to seek criminal indictments of physicians whenever they find egregious conduct, it remains to be seen whether physicians will be put in jail as often or as long as asphalt contractors for similar offenses. On the other hand, professional status is no longer a certain shield. Although past hesitancy to use criminal remedies was justified by the fact that the rules changed greatly in 1975, by the need to develop bright-line rules through experience, and by the need to allow physicians time to learn what is expected of them in conforming to a new paradigm, there should be no question that criminal penalties are now sometimes appropriate. Such deterrence is needed in part because serious spontaneous restraints continue to appear in local markets, and the victims thereof—such as HMOs or other payers

—often find it difficult to bring private antitrust suits against physicians with whom they hope to continue to do business.

B. Physician-Controlled Financing

Antitrust enforcers faced much more difficult problems, both analytical and political, when they began to scrutinize other forms of collaboration by competing professionals for possible antitrust violations. Under the professional paradigm, the medical profession had assumed important collective responsibilities, and its efforts to perform these affirmative obligations were likely to be seen by the agencies' political overseers in a quite different light than the profession's naked restraints, which by definition were restrictive, coercive, and lacking in any procompetitive merit. The profession's many collective activities ranged from operating plans for financing medical care to the maintenance of programs dedicated to various kinds of quality assurance. The challenge faced by antitrust enforcers was to legitimize the application of antitrust tests and the market paradigm to activities that had theretofore been taken largely for granted as inherent functions of the profession in society.

Among the FTC's first major objects of study in the health care industry were Blue Shield and similar plans for financing medical care that operated under the control of the organized medical profession. One reason why this area especially invited the agency's scrutiny was that physician domination of these plans—and hospital domination of Blue Cross plans—had frequently been questioned on nonantitrust grounds. In addition to not being entirely sacred cows, some Blue Shield plans had very large market shares, making antitrust scrutiny logical. Moreover, because any insurance plan necessarily sets the terms of compensation of providers of insured services, provider control of the plans created an element of price fixing that further legitimized the FTC's interest. The FTC's published study and enforcement policy in this area, although they never produced much litigation, hastened a trend that diminished professional dominance in health care financing.

The professional paradigm did not present much of a problem to the FTC in pursuing Blue Shield plans, confirming that price questions do not implicate the

paradigm to the same degree as quality-of-care issues. On the other hand, the FTC's analysis did run into trouble with the professional paradigm when it began to call into question the legality of certain physician-controlled HMOs of the individual-practice-association variety. Some of these plans had been created—and even subsidized by the Department of Health, Education and Welfare—under the federal HMO act of 1973. Believing that these creatures of local professionals were useful in advancing the causes of both cost containment and HMO development whether or not they were consistent with antitrust principles, some observers attempted to get the FTC to rethink its position and not to deter powerful physician groups from undertaking reforms of the approved types. The impulse to make extra room for physicians to act collectively to reform the health care system and control costs was vintage paradigm. Another manifestation of the professional paradigm that occurred at about the same time was the so-called Voluntary Effort, which the medical profession offered as its alternative to regulation but on which antitrust enforcers, to their credit, did not sign off.

In time, the antitrust enforcers evolved rough analytical tools for identifying procompetitive joint ventures in financing and delivery—especially IPAs and PPOs—and for distinguishing them from anticompetitive collaboration. Their analysis was aided by the Supreme Court's drawing of similar distinctions in cases under section 1 of the Sherman Act during this same period. In particular, the Court's ruling in the *Maricopa County Medical Society* case was helpful in identifying those plans in which price agreements would be permitted as ancillary to an undertaking that was primarily procompetitive in its impact. The Court condemned the foundations for medical care in that case precisely because their physician members had not integrated their practices, shared no financial risks, and could demonstrate no significant efficiencies that could not be achieved through less anticompetitive arrangements.

Justice Stevens, writing for the majority in the *Maricopa County* case, substantially undercut an important feature of the professional paradigm in refusing to be impressed that the defendant physician organizations fixed only maximum fees, not minimum ones, and could therefore claim to be lowering prices rather than raising them. Although the dissenting justices took a contrary

view, the Court's decision deprived organized medicine of its ultimate paradigm-based worthy-purpose defense—the claim that, although a professional group's practice might restrain competition, it advanced the larger public interest in cost containment. Those who still question the *Maricopa* holding should consider that the defendants probably sought to lower the cost of lucrative, inefficient fee-for-service insurance only in order to discourage entry by more efficient HMOs and other plans that engaged in selective contracting for physicians' services. The entry barriers facing such plans are great enough that concerted efforts by dominant fee-for-service physicians to maintain entry-limiting prices through traditional insurance can be fairly penalized as being neither in the long-run public interest nor ultimately procompetitive.

IV. UNFINISHED ANTITRUST BUSINESS WITH RESPECT TO MEDICAL CARE

Once one gets beyond physician collaborations impacting directly on the price of physician services, the professional paradigm begins to loom somewhat larger as an obstacle to antitrust enforcement. The difficulties are not attributable exclusively to the professional status of the potential defendants but also reflect some failings in general antitrust analysis. I will devote the remainder of this lecture to some comments on two problem areas where I would like to see some clearer antitrust thinking about the precise role of physicians in the larger competitive system. In both areas the professional paradigm is in part to blame for the analytical failings I observe.

A. Ensuring Competition in the Production of Information

Many activities of the organized medical profession are appropriately viewed for antitrust purposes as the collective production of information and opinion on matters important to consumers and industry participants. Accreditation of medical schools, of graduate specialty training, and of training programs for the many allied health occupations all fit this characterization. So do profession-sponsored programs for certifying medical specialists and allied health personnel and

for accrediting institutional providers, such as hospitals. So also do efforts by professional organizations to assess new medical technologies, or to develop practice guidelines or “parameters” to assist physicians in treating particular medical conditions and payers in making judgments concerning what to pay for. Finally, various peer-review activities of broad-based medical organizations may be seen in the same essential light, as the issuance of informative labels on which other, independent decision makers may or may not choose to rely.

Because of the influence of the professional paradigm, it is common to describe many of the activities I have mentioned as instances of professional “self-regulation.” That terminology is misleading, however. Regulation involves not only the setting of standards but also the enforcement of those standards by coercive sanctions. In each of the areas of professional activity I have cited, the professional organization ordinarily does not impose any affirmative sanction—other than publishing in some form the fact of compliance or noncompliance—on those who do not comply with its standards. Indeed, if an organization were to organize a true boycott of those practitioners or institutions of which it did not approve, antitrust law would step in to penalize the naked restraint. But as long as the only direct consequence of noncompliance with professional standards is the publication of information to that effect, there is no obvious antitrust problem. Indeed, far from being anticompetitive, collaboration for the production of information and opinion is highly procompetitive. This is particularly true in health care markets, which are especially information-poor because of the free-rider problems associated with public goods. Under modern antitrust analysis, the law should leave competitor groups free to express their views on important issues while conceding to them no power actively to enforce those views.

When a professional group is sued for publishing information or an opinion harmful to a competitor, the professional paradigm might make things worse, not better, for the physician defendants, exposing them to greater litigation costs and liability risks than they would face under modern, Chicago School antitrust doctrine. Because the paradigm purports to assign professional organizations quasi-governmental responsibilities, their actions may seem to call for close judicial

scrutiny under public-interest standards similar to those employed in reviewing actions of public agencies. In addition, because the paradigm's influence may give a professional body's pronouncements decisive weight in the marketplace or with public authorities, antitrust courts might overlook the essential difference between a result that flows solely from independent decisions—in the marketplace or in the political process—and the same result achieved by short-circuiting the market process of independent decision making. In these ways, the professional paradigm may easily cause an antitrust court to revert to the pre-Chicago School view that its task in such cases is to verify the "reasonableness" of the standards or opinions promulgated. Moreover, some professional organizations might freely accept the burden of proving reasonableness, preferring to be defended in terms of the professional paradigm rather than the market one. Thus, a professional body might wish to be portrayed in court as a responsible public servant even though it might stand a better chance of getting the case dismissed quickly by asserting that "there can be no restraint of trade without a restraint." (Judge Frank Easterbrook, formerly of the University of Chicago and now of the Seventh Circuit Court of Appeals, recently relied upon this "truism" in upholding the publication by the American Academy of Ophthalmology of its skepticism regarding radial keratotomy, a new surgical procedure.)

Although a professional organization would have greater freedom to express itself under the market paradigm than under the professional one, modern doctrine might expose it to a new and hitherto unrecognized antitrust risk. Specifically, once the professional paradigm is set aside, a professional body might face antitrust scrutiny in cooperating with other professional organizations in efforts to arrive at common positions on debatable issues. Not only does the professional paradigm legitimize the medical profession's monopoly of information and opinion, but it invites concerted efforts to ensure that the profession speaks with one voice on important matters. Under the market paradigm, however, there is cause for concern when combinations or agreements between independent actors deny consumers the chance to hear a variety of competing views, giving them instead only a single authoritative opinion on a given subject. The professional paradigm notwithstand-

ing, there are many reasons why the medical profession might hide elements of the truth from consumers and their agents, thus denying them the ability to make informed choices concerning the services they buy. Concerted efforts to keep consumers in ignorance can create market power and should be subject to antitrust challenge.

In my view, the antitrust laws should be used to discourage joint ventures in the production of information by professional bodies that are each capable of acting independently in the affected field. Although there are good efficiency reasons for encouraging competing physicians to collaborate in accrediting, credentialing, certification, and scientific activities, there is much less justification for allowing independent professional organizations, which may have very different views on many of the questions in issue, to combine to ensure that only one view is finally issued to the public. I see no good reason why antitrust law should not seek to preserve attainable competition in the production of commercial information and opinion just as it does in the production of more private goods. Unless one is prepared to argue that the production of such information and opinion, despite being bought and paid for by a combination of application fees, membership dues, grants, and contracts, does not constitute "trade or commerce," there is no legal justification for not subjecting agreements to suppress competition in such production to some antitrust scrutiny.

Admittedly, it would not be easy to devise antitrust standards for appraising joint ventures in accrediting, certification, credentialing, technology assessment, and the development of practice guidelines. Usually, antitrust liability turns on whether the challenged conduct creates "market power," which is typically defined as the ability to raise price profitably by reducing output in the relevant market. But, because information and opinion of the kind in question are not bought and sold for profit, such price effects would probably not be detectable and are, in any event, not the central reason for wanting to preserve competition among producers. In addition, because information and opinion are public goods that, by definition, are published only once and not consumed in use, there is no way to calculate producers' market shares—usually a crucial indicium of market power. Although there are many other sources of

information to which consumers might turn, the influence of a professional organization may still be dominant, even if that dominance cannot be precisely measured.

Despite the difficulty of analyzing markets for public goods, a joint venture between two professional bodies, both of which are capable of expressing independent views and of credibly criticizing the views of others, represents an agreement to limit the diversity and output of information and opinion. Such combinations should not be permitted in the absence of either an efficiency justification—e.g., economies of scale or complementarity of inputs—or evidence that other equally reliable sources of information and opinion exist or will emerge if a vacuum is created. Even though there is no precedent for an antitrust campaign to preserve competition in the production of public goods, I believe that such a campaign should be mounted. Consumers lose a great deal in being denied access to a full range of professional opinions on crucial matters.

Assuming that the antitrust laws apply to agreements between professional organizations that reduce competition in the production of information and opinion affecting consumer decisions concerning medical care, there are numerous potential targets for attack. The Joint Commission on Accreditation of Healthcare Organizations is the most prominent of these, but there are many others, including the American Board of Medical Specialties and the various educational accreditors. Each of these joint ventures represents an agreement to resolve any controversies that may arise by negotiation and compromise in order that consumers (and governmental purchasers of medical care) will not hear the competing viewpoints and have an opportunity to choose between them. As a result of such collaborations, there is only one authoritative manual on what constitutes a good hospital, only one set of standards for each type of educational program, and a carefully worked out set of territorial arrangements among the medical specialty boards under which each concerns itself only with its own precisely defined field of medical practice. As an example of the medical profession's desire to suppress competition in the marketplace of technical ideas, the Council of Medical Specialty Societies recently held a national conference for the sole purpose of finding ways to resolve differences between professional organiza-

tions concerning the content of practice guidelines. It was noted with evident concern in floor discussions that if inconsistent guidelines coexisted—that is, if competition were allowed—a payer might choose to be guided by the standards that promised cheaper treatment.

Obviously, the resistance to enforcing the antitrust laws in this area springs in large measure from the professional paradigm of medical decision making, under which the organized profession, rather than informed consumers and their sophisticated agents, are expected to make all the important choices. In my view, the medical profession's current monopoly over crucial information and opinion deprives consumers of important opportunities to economize in purchasing health care. If antitrust law confines itself to addressing only restraints directly affecting price and organizational matters, it is neglecting a crucial source of professional power that undermines the efficiency of the health care marketplace.

B. Eradicating the Paradigm in Hospitals

The professional paradigm has also adversely affected antitrust reasoning with respect to hospital/physician relationships. Courts have generally handled cases involving hospital admitting privileges with the Joint Commission's model of the hospital exclusively in mind. Because that model was developed by a physician-dominated joint venture, it is not surprising that it embodies the paradigmatic view that all decisions relating to medical care in hospitals should be made by or in equal collaboration with the self-governing medical staff. There are several specific respects in which legal analysis of decision making in hospitals has been distorted by the professional paradigm, and has consequently failed to carry out the implications of the market model on which antitrust law is exclusively based.

Consider first how the so-called state-action exemption has been applied in staff privileges cases. In *Patrick v. Burget*, the Supreme Court held that the exemption was inapplicable because the State of Oregon had not provided for "active supervision" of hospitals' actions on staff privileges, thus failing to satisfy the second prong of the two-part *Midcal Aluminum* test for implied antitrust immunity. The question I want to raise,

however, has to do with the first prong of that test—the requirement that the state legislature must have “clearly articulated” an affirmative policy setting competition aside, in which event federal antitrust policy will give way to state policy as a matter of comity. In every staff-privileges case in which the state-action issue has arisen, it has been pretty much assumed that this requirement is satisfied if the state statute mandates hospital-based peer review of physicians and their practices. But I find nothing in such statutes that mandates or even expressly contemplates anything that is inconsistent with competition or federal antitrust principles. The Oregon statute, for example—which, incidentally, the Supreme Court did not construe in *Patrick* because the second-prong test was so obviously not satisfied—required merely that hospital governing bodies “be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility.” In addition, it required that physicians be “organized into a medical staff in such a manner as to effectively review the professional practices of the facility. . . .”

Does such a statute compel or even contemplate anything that would violate federal antitrust law? The Eleventh Circuit, in its recent *Bolt* decision, concluded that the Florida legislature, in passing a similar statute, “could foresee that [the hospital] would rely on recommendations made by a physician’s peers and refuse to deal with (i.e., boycott) that physician.” Only someone thoroughly blinded by the professional paradigm would automatically equate a hospital’s decision to terminate a physician’s staff privileges with an anticompetitive boycott engineered by his competitors. That equation reflects a conclusive presumption that hospitals could never be expected to act independently on their own responsibility in such matters. The Eleventh Circuit’s construction of the statute also reflects the view that taking a recommendation from a medical staff necessarily implies a conspiracy with the staff rather than independent action by the hospital. Not even the Joint Commission, which has always acknowledged the governing board’s ultimate legal responsibility for operating the hospital, would go so far as to deny the hospital’s freedom or ability to act on its own with information obtained not only from its medical staff but from the sources as well.

A sufficient predicate for state-action immunity would exist only if a state legislature took away all au-

thority from hospital governing boards and required that physicians alone be allowed to control their competitors’ access to hospital facilities. No state has done anything so radically anticompetitive, however. Indeed, all any state has done is to nudge hospitals to take more responsibility for the quality of care provided on their premises—something the legal system has encouraged since even before the *Darling* case. Only the professional paradigm has kept judges from appreciating (a) that physician domination of hospital actions affecting other physicians is not inevitable and (b) that making hospitals more responsible for overseeing staff physicians would strengthen competition, not restrain it.

Another issue relating to the internal affairs of hospitals also rewards discussion in light of the professional paradigm and its presumption that doctors, not lay persons or corporations, should be in charge of medical matters. In the *Bolt* case, the court held that the *Copperweld* principle regarding intra-enterprise conspiracies does not preclude finding a conspiracy between a hospital and its medical staff in withholding staff privileges. The contrary argument, which finds support in the earlier case of *Weiss v. York Hospital*, is that the medical staff is merely an administrative arm of the hospital, not an independent entity capable of conspiring with it. The only strength that this latter argument has derives directly from the professional paradigm’s tenet that a hospital’s organized medical staff should control everything having to do with patient care in the institution.

Under the market paradigm, a typical medical staff would be regarded as an independent entity fully capable of entering into anticompetitive agreements with the hospital. Far from being an integral part of the hospital, a medical staff comprises physicians who are independent contractors, not hospital employees, and is highly insulated from accountability to the governing board. Moreover, under the Joint Commission’s paradigmatic accreditation standards, medical staffs enjoy the extraordinary privilege of being self-governing. There is therefore no basis in antitrust theory for courts to insulate a medical staff’s exercise of powers delegated to it by the hospital from antitrust attack.

A Chicago School antitrust analysis would view a hospital and its medical staff as engaged in a classic, highly procompetitive joint venture. Analysis should not stop with recognition of the efficiencies gained by com-

binning the collaborators' complementary resources, however. Because such a collaboration can threaten competition by limiting the opportunities of competing physicians, the joint venture's internal operations must be subject to antitrust scrutiny to ensure that the venture's anticompetitive potential is minimized. Under the less-restrictive-alternative requirement of the antitrust Rule of Reason, a hospital's internal decision making should be structured so that the governing board, rather than the medical staff, is truly—not just on paper—in charge. Thus, if a hospital could demonstrate that it acted independently, consulting only its own commercial interests, in making a decision to terminate an individual's staff privileges, summary judgment terminating that individual's antitrust case would be appropriate. On the other hand, if the medical staff seemed to be a co-equal party to the decision, the staff/hospital conspiracy theory would be appropriately invoked, and the hospital's action would have to be defended on its business merits—at great legal expense.

There is an excellent opportunity here for the law finally to overcome one of the last bastions of the professional paradigm. A legal regime that gave close scrutiny to physician-dominated decisions and only very limited scrutiny to hospitals' unilateral decisions would yield a market in which an aspirant for hospital privileges would have to deal, not with his horizontal competitors, but with an entity standing in a vertical market relationship to him. That kind of market relationship, while not the one contemplated in the professional paradigm, is what antitrust law should foster.

V. CONCLUSION

The application of the antitrust laws to the health care industry has contributed significantly to the changes that have occurred in recent years in the way Americans regard medical care and its providers. But the professional paradigm of medical decision making has not yet been finally replaced by the market paradigm, under which the industry is driven and shaped by consumer choice rather than professional fiat. If antitrust law is to complete the intellectual revolution it has helped to begin, antitrust enforcers must think more deeply about the enterprise in which they are engaged on society's behalf. In particular, they should recognize

that the proper role of organizations of competing physicians is to advocate, but not to impose, their views and to leave to the marketplace the resolution of the many disputes and trade-offs that abound in the provision of medical services.

Perhaps we need to be more explicit about the goals of antitrust law in the health care industry. I see antitrust law as driving a peaceful revolution that is similar in many revealing respects to the revolutions that have recently occurred in central and eastern Europe. The law's immediate object in the health care industry, like the object of reform in those previously oppressed nations, should be to put an end to one-party rule by a powerful, self-appointed elite. The way to achieve this democratizing goal is by widening consumer choice, by encouraging market-driven *perestroika*, and by substituting *glasnost* for the current professional monopoly of information. Antitrust law has long embodied a paradigm of an unfettered, democratic marketplace—of ideas as well as goods and services—that could serve Americans better than the professional paradigm has done. It still remains, however, for antitrust enforcers and courts finally to discover, articulate, and give full effect to the law's implications as a charter of freedom in the health care sector of the economy.