1986

Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges

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Robert J. Enders*

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I. INTRODUCTION

In response to an increasing physician surplus and a more competitive hospital marketplace, hospitals in recent years have refocused decisionmaking criteria regarding medical staff privileges. As hospitals have begun to compete more vigorously for patients and preferred status under insurance plans, considerations such as which physicians or groups of physicians will be cost effective in servicing patients or which will be more likely to fill the hospital's beds have become crucial in staffing decisions. A hospital's exclusion of a physician from access to its facilities may result in substantial economic damage sufficient to motivate the physician to file a lawsuit. Indeed, in recent years no single health care industry practice has been the target of more antitrust lawsuits than hospital denial of medical staff privileges.

Antitrust challenges to medical staff privilege decisions typically occur in one of three situations. In the first factual setting, the

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defendant hospital uses a committee of staff physicians to evaluate potential candidates for admission to the medical staff and to reevaluate current members of the staff for continued appointments. The applicant denied hospital access or the physician whose privileges are suspended or revoked may allege that the denial resulted from a conspiracy because the hospital adopted the recommendations made by the medical staff peer review or credentials committee.

A second pattern involves allegations that physicians on the hospital's medical staff have conspired to exclude the applicant from practicing in the facility. In this situation, unlike the first, the hospital is not necessarily named as a co-conspirator. In fact, the hospital itself may be a victim. For example, where the physicians on staff threaten the hospital with retaliation if the hospital grants privileges to the applicant deemed unacceptable by the existing medical staff, both the hospital and the applicant are victims of the conspiracy.

A third potential antitrust challenge involves the existence of an exclusive arrangement or contract between the hospital and a group of physicians for the provision of a specialized service to the hospital. A physician excluded by such an agreement from practicing in the hospital may allege unlawful exclusive dealing and the existence of an illegal tying arrangement.

Regardless of which factual pattern is alleged, the plaintiff must overcome a series of significant legal hurdles before a court will allow a jury to consider whether there has been a violation of federal antitrust law. This article will first address the jurisdictional obstacles which a physician plaintiff must overcome. The article will then discuss the issue of conspiracy as it relates to the activities of medical staffs, peer review committees and hospitals. Next, the article will address the topics of concerted refusals to deal, exclusive dealing, and tying arrangements in the context of the denial of medical staff privileges. Finally, the article will address the continued viability of medical staff privilege antitrust cases.

II. THE JURISDICTIONAL REQUIREMENT: AN EFFECT ON INTERSTATE COMMERCE

Section I of the Sherman Act prohibits every contract, combination, or conspiracy "in restraint of trade or commerce among the several States . . . ." In order to establish jurisdiction under the

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Sherman Act, a plaintiff therefore must allege either that the challenged activity is directly involved in interstate commerce (the "in commerce" test)\(^2\) or, if it is local in nature, that the activity has a not insubstantial effect on interstate commerce (the "effect on commerce" test).\(^3\)

Because hospital activities are primarily local in nature,\(^4\) it is extremely difficult to establish federal jurisdiction for medical staff cases under the "in commerce" test. Thus, plaintiff physicians usually establish jurisdiction under the "effect on commerce" test, by alleging a connection between the hospital’s activities and some effect on interstate commerce.\(^5\) There exists uncertainty, however, as to the precise criteria that the plaintiff must satisfy to establish federal jurisdiction.\(^6\)

The United States Supreme Court first discussed the jurisdictional requirements of a hospital antitrust case in *Hospital Building Co. v. Trustees of Rex Hospital*\(^7\). The Court held that the interstate commerce nexus required by the Sherman Act will be established only if the hospital’s conduct has a *substantial* adverse effect on interstate commerce.\(^8\) Clarifying its holding, the Court stated that the substantial effect requirement can be established by an impact that "falls far short of causing enterprises to fold or affecting market prices,"\(^9\) and that it is not essential that the defendant intend its

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1. id. at 743.
2. id. at 745; Cardio-Medical Assoc. v. Crozer-Chester Medical Center, 721 F.2d 68, 74 (3d Cir. 1983).
3. What is relevant is the presence in interstate commerce of transactions that, as a
conduct to directly affect state commerce.\textsuperscript{10} It is significant that the \textit{Hospital Building} Court did not consider the overall business activities of the defendant hospital. To the contrary, the Court made it clear that only the specific activities challenged by the plaintiff will be considered in applying the jurisdictional analysis.\textsuperscript{11}

The Supreme Court again considered the issue of Sherman Act jurisdiction in \textit{McLain v. Real Estate Board of New Orleans, Inc.}\textsuperscript{12} The Court required the plaintiff to establish that the alleged illegal activities had a "not insubstantial" effect on interstate commerce.\textsuperscript{13} Although \textit{McLain} did not involve the health care industry, the Court based its reasoning, in part, on the \textit{Hospital Building} decision.\textsuperscript{14} Differing interpretations of \textit{McLain} have led to the current uncertainty regarding jurisdictional requirements in antitrust cases involving the denial or termination of medical staff privileges.\textsuperscript{15}

\begin{quotation}
result of the anticompetitive conduct, are "substantially" different from the transactions that would otherwise have occurred. They may be differences in the overall number of volume of such transactions, but they may also be differences in the terms of the transactions, or the parties thereto. Such transactions "burden" interstate commerce because they are the result, directly or indirectly, of conduct that violates federal antitrust policy. They are a burden not on the volume of trade but on the freedom of trade.
\end{quotation}

\textit{Id.}

\begin{quotation}
10. "[T]he fact that an effect on interstate commerce might be termed 'indirect' because the conduct producing it is not 'purposely directed' toward interstate commerce does not lead to a conclusion that the \textit{conduct at issue} is outside the scope of the Sherman Act." 425 U.S. at 744 (emphasis added).

11. In focusing on the challenged activity, the Court stated: "As long as the \textit{restraint in question} 'substantially and adversely affects interstate commerce,' . . . the interstate commerce nexus required for Sherman Act coverage is established." 425 U.S. at 743 (quoting \textit{Gulf Oil Corp. v. Copp Paving Co.}, 419 U.S. 186, 195 (1974)) (emphasis added).


13. The Court in \textit{McLain} stated:

[I]t is not sufficient merely to rely on identification of a relevant local activity and to presume an interrelationship with some unspecified aspect of interstate commerce. To establish jurisdiction a plaintiff must allege the critical relationship in the pleadings and if these allegations are controverted must proceed to demonstrate by submission of evidence beyond the pleadings either that the defendant's activity is itself in interstate commerce or, if it is local in nature, that it has an effect on some other appreciable activity demonstrably in interstate commerce.

\textit{Id.} at 242. Also, the Court declared, "To establish federal jurisdiction in this case, there remains only the requirement that respondents' \textit{activities which allegedly have been infected} by a price-fixing conspiracy be shown 'as a matter of practical economics' to have a \textit{not insubstantial effect} on the interstate commerce involved." \textit{Id.} at 246 (citing \textit{Hospital Building Co. v. Trustees of Rex Hosp.}, 452 U.S. 738, 745 (1975)) (emphasis added).


15. See \textit{infra} notes 16-37 and accompanying text.
A. The "General Business Activities" Test

In *Western Waste Service Systems v. Universal Waste Control*, one of the first cases to apply the Supreme Court's ruling in *McLain*, the Ninth Circuit interpreted *McLain* to mean that as long as the defendant's general business activities, independent of the challenged conduct, have an effect on interstate commerce (the "general business activities" test), federal jurisdiction exists under the Sherman Act. In order to demonstrate the requisite connection between the defendant's general business activities and a "not insubstantial" effect on interstate commerce, one plaintiff physician alleged that the defendant hospital received a large number of payments through the Medicare system, that the hospital treated patients who traveled in from out-of-state, that a large percentage of the supplies and equipment purchased by the hospital came from out-of-state, that a significant number of physicians on the hospital staff also practiced out-of-state, and, finally, that improvements and additions to the hospital were federally funded.

Although the Ninth Circuit is considered the source of the "general business activities" test, as articulated in *Western Waste*, another panel of the Ninth Circuit chose not to follow this test in

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17. *Id.* at 1097. The rationale for the Ninth Circuit's interpretation is apparently derived from the following passage in *McLain*:

> To establish the jurisdictional element of a Sherman Act violation it would be sufficient for petitioners to demonstrate a substantial effect on interstate commerce generated by respondents' brokerage activity. Petitioners need not make the more particularized showing of an effect on interstate commerce caused by the alleged conspiracy to fix commission rates, or by those other aspects of respondents' activity that are alleged to be unlawful. The validity of this approach is confirmed by an examination of the case law. If establishing jurisdiction required a showing that the unlawful conduct itself had an effect on interstate commerce, jurisdiction would be defeated by a demonstration that the alleged restraint failed to have its intended anticompetitive effect. This is not the rule of our case.... A violation may still be found in such circumstances because in a civil action under the Sherman Act, liability may be established by proof of either an unlawful purpose or an anticompetitive effect.

444 U.S. at 242-43 (citations omitted). However, it seems that the Supreme Court was not drawing a distinction between general and specific activities of the defendant when it referred to a "more particularized showing." Rather, it is more likely that the Court was indicating that a plaintiff need not be required to prove an anticompetitive effect to gain jurisdiction. A court could find that jurisdiction exists as long as a plaintiff alleges an unlawful purpose for the challenged activity.

19. *See supra* notes 16-17 and accompanying text.
**Hahn v. Oregon Physicians’ Service,** a suit brought by podiatrists against providers of prepaid health insurance. In reviewing the district court’s finding that the plaintiffs failed to meet jurisdictional requirements, the court of appeals stated that the district court had erred by focusing its inquiry exclusively on the nature and extent of the plaintiffs’ interstate commerce contacts. After discussing *McLain*, the court of appeals held that jurisdiction may be established by a showing that the defendants’ activities affect interstate commerce through their effect on plaintiffs’ interstate activities or by a showing that the defendants’ activities themselves directly affect interstate commerce. The court did not specify whether the defendants’ general business activities were the proper focus; in fact, the court omitted any reference to the *Western Waste* decision. However, the court did say that on remand, the district court should consider the “relevant insurance activities” of the defendant and whether they have a “not insubstantial effect” on interstate commerce. The statement suggests that this panel of the Ninth Circuit believes judicial analysis should be based on the defendant’s challenged conduct rather than on its general business activities. Two cases involving medical staff privileges, decided after *Hahn* by district courts within the Ninth Circuit, have either explicitly or implicitly rejected the *Western Waste* opinion. In

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20. 689 F.2d 840 (9th Cir. 1982).
21. *Id.* at 844.
22. “[T]he jurisdictional requirement may be satisfied by showing that defendants’ activities affect interstate commerce through their effect on plaintiffs’ interstate activities ... However, if the plaintiffs’ interstate contacts are insubstantial, jurisdiction may also be established directly by the defendants’ activities.” *Id.*
23. The court in *Hahn* seemed to implicitly adopt the “infected activities” test interpretation of *McLain*, see infra notes 26-37 and accompanying text, when it stated:

> We thus remand for identification of a relevant aspect of interstate commerce and a determination whether defendants’ relevant insurance activities, taking into account their overall effect on interstate commerce and not simply their effect on the particular plaintiffs before the court, have, as a matter of practical economics, a “not insubstantial effect” on interstate commerce.

689 F.2d at 844 (emphasis added).

> There are two difficulties with reading *Western Waste* and its successors as rejecting an infected activities test: first, such a holding was never articulated and, second, all of the cases cited are consistent with an infected activities test. When the defendant’s entire business is “infected” by the allegedly illegal activity, then under both tests, that entire business will be examined for a nexus with interstate commerce.

*Id.* at ¶ 67,475.
doing so, they have de facto adopted the specific or "infected" activities test used by the majority of courts.

B. The "Infected Activities" Test

Most federal courts faced with antitrust cases involving medical staff privileges have interpreted McLain's jurisdictional requirements as mandating a connection between the defendant's challenged conduct and interstate commerce. In Crain v. Intermountain Health Care, Inc., the Court of Appeals for the Tenth Circuit for the first time applied the McLain rationale to an antitrust case arising in the health care industry.

The court in Crain specifically rejected the "general business activities" test, stating that where the defendant's overall business impacts interstate commerce, "the challenged activity may in every practical economic sense be unrelated to interstate commerce." The court found that the general business test, impermissible under McLain, left the court to "presume" a connection between the challenged conduct and interstate commerce. The Tenth Circuit instead adopted the "infected activities" test. Under this test, the relevant inquiry is whether the defendant's activities that have been "infected" by unlawful behavior have the requisite effect on interstate commerce.

Since Crain, the Courts of Appeals for the Second, Third, Aron, the court dismissed the action for lack of subject matter jurisdiction. The court stated that, "[t]he [jurisdictional] requirement is met by demonstrating that the defendant's activity is itself in interstate commerce, or if it is local in nature, that it has a substantial effect on interstate commerce." Id. (citing McLain v. Real Estate Board of New Orleans, Inc., 444 U.S. 232 (1980); Hospital Building Co. v. Trustees of Rex Hosp., 452 U.S. 738 (1975); see supra notes 7, 12 and accompanying text.) Moreover, the court said, "it is still necessary for a plaintiff to prove either that the [defendant's] business activities occurred in commerce or have a substantial impact on it." Aron, 600 F. Supp. at 485 (citing Feldman v. Jackson Memorial Hosp., 571 F. Supp. 1000, 1006 (S.D. Fla. 1983), aff'd mem. 752 F.2d 647 (11th Cir.), cert. denied, 105 S. Ct. 3504 (1985)).

26. 637 F.2d 715 (10th Cir. 1980) (en banc). After McLain, the Tenth Circuit Court of Appeals granted a rehearing en banc to reconsider an earlier decision by a panel of that court which affirmed the district court's dismissal of Dr. Crane's suit for lack of jurisdiction. The dismissal by the district court was primarily based on Wolf v. Jane Phillips Episcopal-Memorial Medical Center, 513 F.2d 684 (10th Cir. 1975), where a link between the defendant's alleged activities and an effect on interstate commerce was required to establish Sherman Act jurisdiction.

27. 637 F.2d at 724.
28. Id.
29. Id.; see McLain, 444 U.S. at 242.
Sixth,\textsuperscript{32} Seventh,\textsuperscript{33} Eighth,\textsuperscript{34} and Eleventh\textsuperscript{35} Circuits have also interpreted \textit{McLain} as requiring the use of the “infected activities” test. These courts have held that plaintiffs must allege facts sufficient to demonstrate that the hospital’s \textit{challenged activity} will have a not insubstantial effect on interstate commerce. In determining whether a physician’s complaints satisfy the jurisdictional requirements of the Sherman Act, courts have relied upon the effect of the challenged conduct on interstate activities such as the hospital’s treatment of out-of-state patients; receipt of Medicare, Medicaid and out-of-state insurance payments; and the purchase of medicines, equipment and medical supplies from out-of-state vendors.\textsuperscript{36} Some courts have found that interstate commerce jurisdiction exists in such cases, thus refuting contentions that the use of the “infected activities” test creates an insurmountable barrier to antitrust plaintiffs in medical staff privilege cases.\textsuperscript{37}

\textbf{C. Comments on the Jurisdiction Issue}

The clear trend in the federal appellate courts, when faced with the question of Sherman Act jurisdiction in a medical staff privilege case, is to interpret \textit{McLain} as requiring the plaintiff to plead that the defendant’s alleged illegal activities have a “not insubstantial effect” on interstate commerce. A careful reading of \textit{McLain} supports this position as the most appropriate approach to deciding this question.

\textsuperscript{33} Seglin v. Esau, 769 F.2d 1274 (7th Cir. 1985); Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984).
\textsuperscript{34} Hayden v. Bracy, 744 F.2d 1338 (8th Cir. 1984).
\textsuperscript{36} See, e.g., Marrese v. Interqual, Inc., 748 F.2d 373, 382 (7th Cir. 1984); Cardio-Medical Assoc. v. Crozer-Chester Medical Center, 721 F.2d 68, 76 (3d Cir. 1983). These factors are similar to those referred to by other courts when applying the "general business activities" test. See \textit{supra} note 18 and accompanying text. However, when the “infected activities” test is utilized, the courts focus on the effect of the challenged restraint rather than whether these factors, in general, generate sufficient contacts to interstate commerce to create the requisite jurisdictional nexus.
The "general business activities" approach used by the Ninth Circuit in Western Waste stretches the jurisdiction of the Sherman Act to its constitutional limits. The mere showing that the defendant's general business activities have an effect on interstate commerce virtually eliminates a meaningful interstate commerce limitation on the jurisdictional reach of the Sherman Act. Proponents of the "general business activities" test, however, contend that, when properly applied, the test does not eliminate the interstate commerce nexus because McLain's "not insubstantial effect" requirement will still prevent the finding of jurisdiction where the defendant's general business activities have only an insignificant effect on interstate commerce.38 However, in practical terms, a physician denied access to a hospital medical staff will almost always be able to satisfy the jurisdictional requirements of the Sherman Act under the "general business activities" test.

The availability of treble damages and attorneys' fees provides a powerful incentive for a disgruntled physician to allege an antitrust cause of action. It is unfair, however, to subject hospitals to potentially prolonged and costly antitrust litigation every time a medical staff decision is made. The prospect of constant litigation places an unwarranted burden on a hospital legitimately exercising its right to decide who should be a member of its medical staff. Therefore, it is appropriate that the "general business activities" test is being abandoned in medical staff privilege cases in favor of the more stringent "infected activities" test. The latter test, by imposing a meaningful jurisdictional requirement, will, it is hoped, reduce the volume of this kind of nonmeritorious antitrust litigation.

III. The State Action Doctrine

A second threshold issue which may confront an antitrust plaintiff in a medical staff privilege case is the state action doctrine. Successful use of this doctrine by the defendant hospital and medical staff immunizes challenged conduct from federal antitrust laws, resulting in a dismissal of the complaint. The state action doctrine was first articulated by the United States Supreme Court in Parker v. Brown,39 wherein the Court held that the Sherman Act was not intended to prohibit a state, acting as sovereign, from imposing re-

strains on competition. While Parker involved an antitrust action against a state official, the application of the state action immunity has been extended, in appropriate circumstances, to antitrust suits brought against private parties.

A. The Midcal Test

In California Retail Liquor Dealers' Association v. Midcal Aluminum, Inc., which the Supreme Court announced a two-pronged test that outlines the circumstances under which the state action immunity is available to private party defendants. The challenged conduct "must be . . . 'clearly articulated and affirmatively expressed as state policy' " and the conduct "must be 'actively supervised' by the State itself." When evaluating the potential application of this immunity to the activities of private parties or state regulatory agencies (where the state is not acting as sovereign), the state's intention to displace competition in a particular field with some regulatory scheme must be considered.

In Southern Motor Carriers Rate Conference v. United States, the Supreme Court confirmed that the state's intention is an important consideration in state action cases and, in addition, held that "a state policy that expressly permits but does not compel, anticompetitive conduct may be 'clearly articulated' within the meaning of Midcal." Therefore, in order to satisfy the first prong of

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40. Id. at 368.
42. Id. at 105.
43. See, e.g., Hoover v. Ronwin, 104 S. Ct. 1989 (1984), an antitrust challenge to the bar examination grading policies of the Arizona Committee on Examinations and Admissions and the Arizona Supreme Court. The United States Supreme Court concluded that when the challenged activity is being carried out by such entities, pursuant to some state authorization:

   it becomes important to ensure that the anticompetitive conduct of the State's representative was contemplated by the State . . . . If the replacing of entirely free competition with some form of regulation or restraint was not authorized or approved by the State then the rationale of Parker is inapposite. As a result, in cases involving the anti-competitive conduct of a nonsovereign state representative the Court has required a showing that the conduct is pursuant to a "clearly articulated and affirmatively expressed state policy" to replace competition with regulation.

   Id. at 1995 (citations omitted).
44. 105 S. Ct. 1721 (1985).
45. Id. at 1729 (emphasis in original). The petitioners, private rate bureaus composed of motor common carriers operating in four states, submitted joint rate proposals to each state's public service commission for approval or rejection. This collective rate making process was permitted, but not compelled, by the states involved. The Supreme Court held that this private activity was immune from federal antitrust liability under the state action doctrine. The activity was taken pursuant to a "clearly articulated state pol-
the *Midcal* test, the state policy need not compel a state agency or a regulated private party to act in an anticompetitive fashion; it may simply permit the state agency or the private party to engage in such conduct in order to achieve the underlying goals of the state.

The question of what constitutes adequate state supervision under the second prong of the *Midcal* test has not been completely answered by the Supreme Court. In *Town of Hallie v. City of Eau Claire*, the Court required the presence of "active state supervision" in order for actions of private parties to be deemed immune under the state action doctrine. The Court did not, however, offer any guidance regarding the required extent of such supervision.

**B. The Medical Staff Privilege Case**

In *Marrese v. Interqual*, a medical staff privilege decision was immunized from federal antitrust law pursuant to the state action doctrine. In *Marrese*, the plaintiff orthopedic surgeon filed an antitrust and civil rights suit against an Indiana hospital and members of the medical staff peer review committee. The committee had recommended revocation of the plaintiff’s medical staff privileges based on an audit of the surgeries he had performed.

Indiana law, for the purpose of improving the quality of care, required the hospital’s medical staff to review its practices and procedures in order to evaluate the quality and necessity of treatment.
provided to patients.\textsuperscript{50} Indiana law further authorized the establishment, by hospitals, of peer review committees to conduct these evaluations.\textsuperscript{51} Committee members were immunized from civil liability for good faith decisions and recommendations.\textsuperscript{52} In addition, the statutory scheme provided that the State Medical Licensing Board was to review the committees' records and determinations regarding individual physicians, in order to enforce standards of competent medical practice.\textsuperscript{53} The State Board of Health Hospital Licensing Council, which periodically reviewed hospitals for relicensure, was allowed to review the peer review committee records to ensure that each hospital was providing quality medical care.\textsuperscript{54}

The hospital's revocation of Dr. Marrese's privileges, based on the recommendation of the peer review committee, was held to be immune from a federal antitrust suit under the state action doctrine. In order to satisfy the first ("clear state policy") prong of the \textit{Midcal} test, the court evaluated whether the state legislature had

\begin{itemize}
  \item \textbf{50.} \textit{IND. CODE ANN.} § 16-10-1-6.5 (Burns 1982) provides in part:
  
  The governing board of the hospital shall be the supreme authority in the hospital, responsible for . . . the appointment of the members of the medical staff with the advice and recommendations of the medical staff consistent with their individual training, experience, and other qualifications. . . . The medical staff of a hospital . . . shall be responsible to the governing board . . . and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and the improvement of the care of patients in the hospital.


  \item \textbf{51.} \textit{IND. CODE ANN.} § 34-4-12.6-1 (Burns 1982) (Indiana's medical peer review statute).

  \item \textbf{52.} \textit{IND. CODE ANN.} § 16-10-1-6.5 (Burns 1982), provided in part: "The members of any medical staff committee organized for the purpose of conducting medical review . . . shall have an absolute immunity from civil liability for . . . reports and recommendations made by the committee . . . ." In 1983, this section was amended to provide similar immunity to members of the hospital governing board. \textit{IND. CODE ANN.} § 16-10-1-6.5(b) (Burns Supp. 1985).

  \textit{IND. CODE ANN.} § 34-4-12.6-3(c) (Burns 1982) provides in part: "The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care . . . ." \textit{See also} \textit{IND. CODE ANN.} § 34-4-12.6-1(f) (Burns 1982) (definition of "good faith").

  \item \textbf{53.} \textit{IND. CODE ANN.} § 16-10-1-6.5(b) (Burns Supp. 1985) provides in part:
  
  The governing board shall report, in writing, to the Indiana medical licensing board the results . . . of any final, substantive, and adverse disciplinary action taken by the governing board regarding a physician on the medical staff, or an applicant for the medical staff if the action results in . . . nonappointment, revocation or significant reduction of clinical privileges . . . .

  \textit{See also} \textit{IND. CODE ANN.} §§ 25-22.5-2-7, 25-22.5-6-2.1, 34-4-12.6-2(b) (Burns Supp. 1985).

  \item \textbf{54.} \textit{IND. CODE} §§ 16-10-1-9, 16-10-1-12, 16-10-1-13, 16-10-1-17 (1982); \textit{see also} \textit{410 IND. ADM. CODE} § 15-1-8(1)(c) (1979).
\end{itemize}
intended to displace competition by regulation of hospitals and health care practitioners. The court held that legislative intent to displace antitrust laws exists if the defendant's challenged conduct "is a necessary consequence of engaging in the authorized activity."\textsuperscript{55} The denial or revocation of medical staff privileges, subsequent to the recommendations of peer review committees, was deemed by the court to be a necessary and reasonable consequence of the Indiana statutory scheme, a scheme created to protect consumer welfare and ensure the quality of medical care.\textsuperscript{56} In effect, the court in \textit{Marrese} determined that the state legislature anticipated that the peer review process would deny hospital staff privileges to some medical practitioners who might be in direct competition with members of the peer review committee.

Addressing the second ("active supervision") prong of the \textit{Mid-}
\textit{cal} test,\textsuperscript{57} the court found that the responsibilities assigned to the State Medical Licensing Board and the State Board of Health Hospital Licensing Council constituted sufficient state supervision of the peer review process.\textsuperscript{58} The court addressed a number of concerns in reaching this decision.\textsuperscript{59} Relying upon the principle of federalism, the court held that the state had the right to set up a peer review system to ensure the quality of medical care and to protect consumer welfare.\textsuperscript{60} Moreover, the court expressed concern about the overload of federal courts which might result if an antitrust suit could be filed against the hospital and the peer review committee every time a physician was denied staff privileges.\textsuperscript{61} The court stated that physician plaintiffs already had sufficient means to press their grievances through the state court system.\textsuperscript{62}

Finally, the court was concerned with the trend toward holding hospitals accountable for the competency of their medical staffs. Allowing antitrust suits for the denial of medical staff privileges based on peer review committee recommendations could, according to the court, place hospitals in a difficult position. The court noted that hospitals under such circumstances either risk a lengthy

\textsuperscript{55} 748 F.2d at 386 n.18.
\textsuperscript{56} The court stated: "As a necessary and reasonable consequence of this state mandated medical peer review process, hospital staff members must review the medical treatments, diagnostic procedures, and surgical procedures of competing staff members and, when required, recommend the revocation of staff privileges." \textit{Id.} at 388.
\textsuperscript{57} \textit{See supra} notes 46-47 and accompanying text.
\textsuperscript{58} 748 F.2d at 391.
\textsuperscript{59} \textit{Id.} at 393-94.
\textsuperscript{60} \textit{Id.} at 395.
\textsuperscript{61} \textit{Id.} at 394.
\textsuperscript{62} \textit{Id.}
and expensive antitrust suit as a consequence of privilege denial decisions or, by admitting marginally qualified or incompetent practitioners, create the potential for negligence suits for failure to maintain a competent medical staff.63

In a subsequent medical staff privilege case, Quinn v. Kent General Hospital,64 a hospital raised the state action doctrine as an affirmative defense. A federal district court held that the Delaware medical peer review statute at issue could not serve as the basis for exempting the defendant hospital and credentials committee from liability under the federal antitrust law.65 Unlike the Indiana statutes at issue in Marrese,66 the Delaware statute simply provided immunity from all liability to individual members of peer review committees for good faith actions taken as members of those committees. It did not compel the creation of peer review committees or institute a state supervisory program to review the actions of those committees. The court did not find any indication that the state legislature "intended to displace competition in the market for hospital facilities" when it drafted the statute.67 Moreover, in contrast to the findings in Marrese, the court in Quinn did not view restrictions on physician competition as a necessary consequence of such a peer review statute.68

The court also found that the state's supervision of peer review

63. Id.
65. 24 DEL. CODE ANN. § 1786(a) (1981) provided in part:

The Board of Medical Practice, the Medical Society of Delaware, their members, or the members of any committees appointed thereby, and members of . . .
a professional standards review committee or organization established under federal law (or other peer review committee or organization) . . . shall not be
subject to, and shall be immune from, claim, suit, liability, damages or any other recourse, civil or criminal, arising from any act or . . . decision or determination undertaken . . . or recommendation made so long as such member acted in good faith . . . .
66. See supra notes 50-54 and accompanying text.
68. The district court in Quinn took specific exception to the Marrese court holding on this issue:

In Marrese the court was greatly concerned that denial of an antitrust exemption would frustrate the policy of the peer review statute by making physicians reluctant to serve on peer review committees. The court finds this concern misplaced, since the relevant inquiry is not whether the exemption would foster the purpose of the statute but whether restriction of competition is a necessary consequence of engaging in the activity promoted by the statute. In most instances, these two conditions would probably converge, but in the case of peer review statutes it appears they may not.

Id. at 1239 n.10. Contra supra text accompanying notes 55-56.
committees did not meet the requirements of *Midcal.* Delaware's Board of Medical Practice did not review the proceedings of peer review committees, nor did it receive notification if such a committee declined to admit a physician to a hospital's staff. The Delaware State Board of Health, which was responsible for the licensing of hospitals, did not take an active part in the supervision of the peer review process. Unlike its Indiana counterpart, the Delaware State Board of Health was neither directed nor authorized by statute to review the decisions of hospital peer review committees.

C. Comments on the State Action Doctrine

The state action doctrine is potentially available as an affirmative defense to a federal antitrust suit brought by a physician who has been denied medical staff privileges or terminated from the hospital's medical staff pursuant to a recommendation of his peers. In order to satisfy the first prong of the *Midcal* test for invocation of the doctrine, there must be a state statutory scheme that requires, or at a minimum permits, the creation of peer review committees. The statute or its legislative history must indicate that the legislature's intention in creating the statutory scheme was to ensure that patients received quality medical care. Furthermore, the statute or its ancillary documentation should specifically acknowledge that some potentially anticompetitive results (for example, exclusion of certain physicians from hospital medical staffs) may occur and will be deemed acceptable as necessary and reasonable consequences of the statute's implementation. Finally, the statutory program must require some type of active supervision of these peer review committees by a specific state department or agency, such as a state department of health or board of medical quality assurance.

Although the scope of the requisite supervision has yet to be comprehensively addressed by courts evaluating antitrust challenges in the medical staff privilege context, the involvement of state authorities seems essential for the successful application of the state action doctrine to medical staff decisions involving a nongovernment hospital.

Absent such state-mandated regulation...
and supervision of medical staffing decisions, the state action doctrine will probably not exempt private hospitals and the physicians on their medical staff committees from federal antitrust suits.

IV. THE "CONSPIRACY" ISSUE

Section 1 of the Sherman Act declares illegal "every contract, combination . . . or conspiracy in restraint of trade or commerce . . . ."\(^{72}\) Since the existence of an agreement is essential for a section 1 violation, a plaintiff in a medical staff privilege case must prove that the adverse decision concerning his privileges was a result of an agreement between two or more separate entities.\(^{73}\) For example, two otherwise competing hospitals might agree to deny or revoke a physician's medical staff privileges at both hospitals. This agreement between noncommonly owned hospitals would provide the plurality of actors required for a section 1 conspiracy claim. However, medical staff privilege decisions rarely result from an agreement between hospitals. Rather, the typical physician staff privilege case involves the allegation of other conspiracy patterns, generally involving variations of four conspirator combinations: (1) the hospital and its medical staff (as a separate entity); (2) the hospital and individual members of its medical staff (who may also have administrative positions or committee responsibilities); (3) individual members of the hospital's existing medical staff, conspiring among themselves to deny or revoke privileges of a potential competitor; and (4) the hospital and an incorporated group of specialized physician practitioners (for example, radiologists or anesthesiologists) with whom the hospital has an exclusive contractual relationship.

A. The Medical Staff as a Co-conspirator

One conspiracy theory advances the proposition that the hospital conspires with its medical staff as a whole, rather than with individual members of the staff, when it denies staff privileges to an

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\(^{73}\) Unilateral action, even if anticompetitive, will not violate section 1 of the Sherman Act. See United States v. Colgate & Co., 250 U.S. 300 (1919).
applicant. There is little case law concerning this proposition. However, at least one federal appellate court has held that, as a matter of law, the medical staff is incapable of conspiring with the hospital. On the other hand, if the medical staff is a legal entity, that is, if it is incorporated separately from the hospital, and thus has standing to sue or be sued, logically it has the capacity to be a co-conspirator with the hospital.

The Federal Trade Commission (the "FTC") has apparently de facto adopted the latter view in appropriate circumstances. In a complaint prepared by the FTC in connection with a proposed consent order, the owner-operator of a hospital and the hospital's medical staff were named as the two respondents. The complaint alleged that the medical staff had enacted unreasonable restrictions to prevent podiatrists from using the hospital and that the hospital had approved or enforced these restrictions. However, since the FTC action involved a consent order, it is not especially useful in clarifying whether naming the medical staff itself as a conspiring party will ultimately be successful in antitrust litigation.

B. Can Peer Review Committees and Administrator-Physicians Conspire with the Hospital?

More often, antitrust plaintiffs in medical staff privilege cases argue that either the members of the hospital's credentials or peer review committee, the committee itself or physician-administra-

74. See infra notes 76, 77 and accompanying text.
77. Medical staffs have also been "recognized" as legal entities in other cases brought by the FTC. While these cases did not involve the medical staff and the hospital as co-conspirators, the fact that the FTC took action against the medical staff as a group may indicate a willingness on the part of the FTC to consider a medical staff a potential conspirator in future cases. See, e.g., In re Medical Staff of John C. Lincoln Hosp. & Health Care Center, 3 TRADE REG. REP. (CCH) ¶ 22,271 (July 16, 1985) (FTC charged hospital's medical staff with threatening a boycott of the hospital if the hospital opened and operated a nearby urgent-care center which conceivably would have reduced the medical staff physicians' incomes); In re Sherman A. Hope, 98 F.T.C. 58 (1981); see infra note 93 and accompanying text; In re Forbes Health System Medical Staff, TRADE REG. REP. (CCH) ¶ 21,587 (June 27, 1979) (FTC prohibited medical staff from rejecting applicants either because they are associated with a health maintenance organization or because they do not practice on a fee-for-service basis). Cf. Maryland v. Medical Staff of Hartford Memorial Hosp., 1981-2 Trade Cas. (CCH) ¶ 64,430 (Cir. Ct. Md. Oct. 29, 1981) (state court prohibited hospital medical staff, as a group, from engaging in anticompetitive conduct, under state antitrust laws, even thought it recognized that the medical staff was an unincorporated group of physicians).
tors, who have been delegated the responsibility for recommending the plaintiff's admission to or removal from the defendant hospital's medical staff, are conspiring with the hospital in violation of section 1 of the Sherman Act. Defendants often respond to such suits by arguing that the hospital and its committees and physician-administrators are legally incapable of conspiracy. This defense relies upon rulings that officers, agents, or employees of a corporation or business entity usually are incapable of conspiring with the corporation or among themselves to violate federal antitrust law. Consistent with this principle, some courts have found that the medical staff, its committees, and individual physicians in various administrative capacities were actually agents or subdivisions of the hospital when they made medical staff privilege decisions. Under this view, no antitrust conspiracy could have occurred since the requisite multiple parties for a finding of conspiracy were missing.


79. See Copperweld Corp. v. Independence Tube Corp., 104 S. Ct. 2731 (1984). The Supreme Court, discussing the "intra-enterprise conspiracy" doctrine, stated:

"[I]t is perfectly plain that an internal "agreement" to implement a single, unitary firm's policies does not raise the antitrust dangers that § 1 was designed to police. The officers of a single firm are not separate economic actors pursuing separate economic interests, so agreements among them do not suddenly bring together economic power that was previously pursuing divergent goals. Coordination within a firm is as likely to result from an effort to compete as from an effort to stifle competition. In the market place, such coordination may be necessary if a business enterprise is to compete effectively. For these reasons, officers or employees of the same firm do not provide the plurality of actors imperative for a § 1 conspiracy.

Id. at 2741; see also id. at 2741 n.15 (citing other federal court decisions that stand for this proposition).

80. See, e.g., McMorris v. Williamsport Hosp., 597 F. Supp. 899 (M.D. Pa. 1984). The court agreed that the medical staff could not conspire with the hospital to boycott the plaintiff physician by replacing him as the head of the nuclear medicine department.

It is generally agreed that officers, agents and employees of a business "are legally incapable of conspiring among themselves or with their firm in violation of section 1." . . . [I]t appears that the medical staff acted as a unit or an "arm" of
However, a conspiracy may exist if an officer or agent has an "independent personal stake" in the corporation's ultimate decision. If any of the individual physicians, either on the medical staff committee or serving in a hospital administrative capacity, are direct competitors of the applicant, courts can apply this "independent personal stake" concept in medical staff privilege cases to find that these physicians, along with the hospital, satisfy the "plurality of actors" requirement of section 1.

Nevertheless, while some courts explicitly or implicitly find that the medical staff committees, their members, and administrator-physicians are capable of conspiring with the hospital for purposes of the Sherman Act, most of these courts have been reluctant to infer that such a conspiracy exists. Most courts will recognize the existence of a conspiracy only where the plaintiff has alleged facts sufficient to convince the court that the medical staff privilege decision was actually the result of an agreement reached between the hospital and either the medical staff committee or individual physicians acting on their own behalf or as independent contractors.

Id. at 914 (quoting Note, "Conspiring Entities" under Section 1 of the Sherman Act, 95 Harv. L. Rev. 661, 661 (1982)).


Courts have recognized a narrow exception to the general rule that no violation occurs when a corporation conspires only with its officers, agents or employees. This exception provides that a violation can occur if the officer, agent or employee has an independent personal stake in achieving the object of the conspiracy.

Id. at 907 (citing H&B Equipment Co., Inc. v. International Harvester Co., 577 F.2d 239, 244 (5th Cir. 1978); Greenville Publishing Co. v. Daily Reflector, Inc., 496 F.2d 391 (4th Cir. 1974)).

82. See, e.g., Robinson v. Magovern, 521 F. Supp. 842, 907 (W.D. Pa. 1981), aff'd mem. 688 F.2d 824 (3d Cir.), cert. denied, 459 U.S. 971 (1982). The Robinson court found that the director of the surgical department to which the plaintiff had applied, although an agent of the hospital, had such a direct personal interest in whether a potential competitor was admitted to the hospital medical staff that he was legally capable of conspiring for purposes of section 1 of the Sherman Act. In this case, however, the plaintiff failed to prove the existence of such a conspiracy. But see Pontius v. Children's Hosp., 552 F. Supp. 1352, 1374 (W.D. Pa. 1982), in which the individual defendants' interests were found to be identical to the defendant hospital's interests. The court found no personal interest sufficiently independent of the hospital's interests to warrant invocation of the "independent personal stake" exception to find a conspiracy.

physicians.\textsuperscript{84}

**C. Members of the Medical Staff as Co-conspirators**

A somewhat different conspiracy pattern relies on the proposition that individual members of the medical staff or one of its committees are, without hospital complicity, conspiring among themselves in violation of section 1 of the Sherman Act. This theory has rarely been argued in medical staff privilege cases. However, this approach was successfully used in \textit{Weiss v. York Hospital},\textsuperscript{85} a class action brought by an osteopath against a hospital and its medical and dental staff. In finding that a conspiracy existed, the court reasoned that each physician member of the staff was a potential competitor of the applicant and fellow staffers.

Recognizing the reality of medical practice patterns, the court held that members of the medical staff committee could conspire to create a horizontal boycott. The court found that the staff's recommendation against amending the hospital bylaws to allow osteopaths to have full staff privileges was, in effect, an agreement among competitors to exclude other potential competitors and, therefore, a per se violation of section 1 of the Sherman Act.\textsuperscript{86} To date \textit{Weiss} appears to be the only medical staff privilege case to find that a conspiracy existed within the medical staff without encom-

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\textsuperscript{84} Proving an agreement in restraint of trade, however, probably requires more than a judicial finding that the hospital's decision is consistent with the recommendations of the medical staff committee and/or the director of the department involved. The court in \textit{Feldman v. Jackson Memorial Hosp.}, 571 F. Supp. 1000 (S.D. Fla. 1983), \textit{aff'd}, 752 F.2d 647 (11th Cir.), \textit{cert. denied}, 105 S. Ct. 3504 (1985), commenting on the plaintiff's attempt to show a conspiracy between the defendant orthopedic surgeons and the hospital, stated that "[p]roof of conspiratorial behavior requires a showing of some agreement or concerted activity to achieve an unlawful goal. Borrowing a phrase from the law of contracts, this agreement involves a 'meeting of the minds' by the defendants." \textit{Id.} at 1008, 1008 n.14. The court stated that "[t]he fact of parallel behavior, standing alone, unequivocally does not prove the existence of a conspiracy." \textit{Id.} at 1008; \textit{see also} \textit{McMorris v. Williamsport Hosp.}, 597 F. Supp. 899, 914 (M.D. Pa. 1984) (plaintiff must show that the alleged conspirators "had a conscious commitment to a common scheme designed to achieve an unlawful objective," quoting \textit{Edward J. Sweeney & Sons, Inc. v. Texaco, Inc.}, 637 F.2d 105, 111 (3d Cir. 1980)).


\textsuperscript{86} The court stated:

\textit{We believe that the actions of the York medical staff are the actions of a combination of the individual doctors who make it up. In substance, the medical staff is a group of individual doctors in competition with each other and with other physicians... who have organized to regulate the provision of medical care at York Hospital. Where such associations exist, their actions are subject to scrutiny under section 1 of the Sherman Act...}

\textit{Id.} at 816.
passing the hospital as a co-conspirator. 87

Even after Weiss, however, it may be argued that members of the medical staff committee are not capable of engaging in a conspiracy unless the committee has as a member at least one direct competitor of the physician applicant. Courts might be persuaded to view competition among medical practitioners as occurring solely within specialty or subspecialty areas of practice (for example, an orthopedic surgeon may be the direct competitor of a podiatrist, but not a cardiovascular surgeon). If courts adopt this view of competition, they may be unwilling to characterize the entire membership of the medical staff committee as being in actual or potential competition with the applicant or one another without further inquiry into each member's area of practice. However, where peer review or credentials committees include, as they often do, physicians who practice in the same specialty area as the applicant, those members should be viewed as being capable of conspiracy.

D. Group Medical Practices as Conspiring Entities

It seems clear that a group of physicians, organized into a medical group practice, constitutes an economic and legal entity capable of conspiring with a hospital in violation of section 1 of the Sherman Act. 88 Indeed, the contract by which the medical group usually deals with the hospital demonstrates the presence of an agreement between the two entities. The existence of an agreement between two parties is not, in such circumstances, usually the subject of dispute. 89

E. Comments on the "Conspiracy" Issue

The physician plaintiff seeking antitrust redress as a result of an adverse privileges decision faces many formidable obstacles to the successful prosecution of a Sherman Act section 1 claim. Because the medical staff privilege decision occurs in a complex hospital environment with a multitude of players involved, a variety of conspiracy combinations could apparently form the basis for finding the requisite "agreement." However, since most state laws explic-

87. The FTC has found conspiracy within a hospital medical staff without the hospital being named as a co-conspirator. See supra note 77 and accompanying text.
88. See Jefferson Parish Hosp, Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984). However, the individual members of this group practice will be incapable of conspiring among themselves under the Sherman Act. See supra notes 79-84 and accompanying text.
89. Antitrust issues that arise in such cases typically involve application of "tying arrangement" or "exclusive dealing" standards. See infra notes 158-82 and accompanying text.
Itly or implicitly reserve to the hospital’s governing board the authority to grant, revoke or suspend medical staff privileges, it will usually be necessary for the physician plaintiff to include the hospital, via its governing board, as an alleged co-conspirator. This is because, absent hospital involvement as a co-conspirator, the physician plaintiff will likely be unable to prove that another conspiracy pattern (one not involving the hospital as a co-conspirator) was the actual cause of his antitrust injury, that is, the adverse medical staff privilege decision. Perhaps this dilemma explains why so many privilege cases involve allegations that the hospital conspired with individual physicians of the medical staff, especially those members holding administrative positions in the hospital’s organization. Such a conspiracy allegation, however, is legally tenuous.

The antitrust principle which generally precludes capacity to conspire between a corporation and its agents is one formidable obstacle for the staff privileges plaintiff. The application of the “independent personal stake” exception, in appropriate circumstances, to find physician-administrators legally capable of conspiring with the hospital is theoretically sound. Nevertheless, there is relatively little case law regarding this concept in the context of hospital staff privileges. The extent to which courts will adopt the “independent personal stake” concept in an antitrust claim involving medical staff decisions is still uncertain and may well be critical to the future of such cases.

Even when the physician plaintiff has convinced the court that alleged co-conspirators have the capacity to conspire, actual proof that an agreement has occurred between such parties has often been the plaintiff’s downfall. For example, even if competitor members of the medical staff agree to urge the hospital to deny privileges to an applicant, such urgings should not be considered the equivalent of agreement between the hospital’s governing board and the physicians. Thus, even if the hospital governing board normally uses the input and adopts the recommendations of individual staff physicians, its credential or peer review committees, its department head, or all of them, the use of such input does not necessarily constitute an agreement.

While agreements can be inferred for antitrust purposes from circumstantial evidence, the plaintiff bears the burden of establishing the existence of such an agreement. A hospital medical staff privilege decision will ordinarily be consistent with the hospital’s own legitimate interests. Thus, convincing the trier of fact that the medical staff privilege decision was the result of an agreement
rather than a unilateral decision on the part of the hospital is a formidable challenge—and one where physician plaintiffs have frequently failed.

**V. GROUP BOYCOTTS OR CONCERTED REFUSALS TO DEAL**

Medical staff privilege antitrust cases typically involve allegations of a group boycott or concerted refusal to deal. Group boycott situations are either horizontal or vertical in nature. If the refusal-to-deal agreement is horizontal, that is, among competitors, the boycott has traditionally been viewed as a per se violation of section 1 of the Sherman Act.\(^9\) The practical effect of per se characterization is that the plaintiff need not prove any anticompetitive intent on the part of the defendants or any anticompetitive effects resulting from the defendants' agreement. Moreover, the defendants are ordinarily denied the opportunity to justify their actions.\(^9\)

A court ruling that a per se violation exists is the goal of every plaintiff bringing an action under section 1 of the Sherman Act.

Failure to establish that the agreement warrants per se treatment forces the plaintiff to argue, in the alternative, that the agreement between noncompeting entities constitutes an unreasonable restraint of trade. This affords the defendants the opportunity to demonstrate the procompetitive justifications for their agreement. Only after balancing the alleged anticompetitive effects against the proffered justifications can the court determine if the agreement is an unreasonable restraint of trade. This framework for analysis is referred to as the "rule of reason" standard.\(^9\)

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90. See, e.g., United States v. General Motors Corp., 384 U.S. 127 (1966); see also Fashion Originators' Guild v. FTC, 312 U.S. 457 (1941); Eastern States Retail Lumber Dealers Ass'n v. United States, 234 U.S. 600 (1914).


92. See Chicago Bd. of Trade v. United States, 246 U.S. 231 (1918), where Justice Brandeis described the rule of reason:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

*Id.* at 238. The rule of reason requires the fact finder to decide whether, under all the circumstances, the challenged restraint imposes an unreasonable restraint on competi-
A. Horizontal Group Boycott/“Per Se” Analysis

A horizontal group boycott may arise in the medical staff privileges context in several different ways: (1) hospitals may collectively agree not to grant privileges to an individual applicant, (2) physicians may collectively threaten a hospital with a group boycott if the hospital grants a particular applicant medical staff privileges, or (3) physicians, in their capacities as private practitioners, may agree among themselves not to deal with an individual within the hospital setting.

The first two fact patterns rarely occur. However, in In the Matter of Sherman A. Hope, the FTC alleged the existence of a horizontal boycott when a group of physicians threatened to boycott the hospital's emergency room if the hospital contracted with a recruited physician. The case exemplifies the “physician cartel” horizontal conspiracy model of medical staff privilege decisions. Under this model, the economic interests of the physicians on the existing medical staff are the sole reason for the hospital’s refusal to deal with the individual physician. In this situation, where the denial of staff privileges by the hospital occurs because of a collective threat by the medical staff, the hospital finds itself a co-victim of the boycott. This type of agreement among competitors to exclude a potential competitor should be analyzed under the per se rule.

In Robinson v. Magovern, the plaintiff cardiovascular surgeon alleged an unlawful group boycott and argued that per se treatment was appropriate because a group of cardiovascular surgeons had engaged in a horizontal conspiracy to prevent his admission to the hospital medical staff. The court ruled that the plaintiff failed to establish a conspiracy between two or more of the defendants. However, the court stated that if the incorporated group of cardio-

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93. 98 F.T.C. 58 (Aug. 5, 1981). The defendant staff physicians tried to prevent the hospital from recruiting new physicians for the staff, regardless of their medical qualifications, where the contracts contained financial terms to which the defendants objected. See supra note 77 and accompanying text.


95. But see Vucievevic v. MacNeal Memorial Hosp., 572 F. Supp. 1424 (N.D. Ill. 1983) (district court rejected use of the per se rule, in favor of rule of reason analysis, where defendant physicians may have made their decision not to admit the plaintiff because of fear of losing patients to him).


97. Id. at 896.
vascular surgeons had conspired with the hospital to prevent the plaintiff from obtaining staff privileges, "a group boycott with horizontal effects [would have] occurred." The court thus implied that per se analysis would be appropriate in such circumstances.99

The per se rule may also be applied in cases where entire classes of nonphysician health care professionals are denied medical staff privileges. For example, in Weiss v. York Hospital,100 the Third Circuit Court of Appeals focused on the composition of the medical staff committee and held, as a matter of law, that the members' agreement to disallow privileges to osteopaths was a horizontal group boycott.101 The court applied the per se rule and determined that the defendant's actions—denying medical staff privileges to all osteopathic physicians—were a violation of section 1 of the Sherman Act. The court found that osteopaths received education and training similar to that of allopathic physicians102 and that the defendant physicians offered no justification for their exclusion of all osteopaths from the hospital medical staff.103

98. The court obviously considered the hospital and the incorporated group of cardiovascular surgeons as two independent entities, capable of conspiring with one another to restrain the plaintiff in the practice of his profession. See supra notes 88-89 and accompanying text.

99. 521 F. Supp. at 906. Having rejected all of the plaintiff's per se claims, the court went on to find, under rule of reason analysis, that the plaintiff had presented insufficient evidence to demonstrate that any antitrust violation had occurred.

100. 745 F.2d 786 (3d Cir. 1984), cert. denied, 105 S. Ct. 1777 (1985); see supra notes 85-86 and accompanying text.

101. The court stated that, "as a matter of law, the medical staff is a combination of individual doctors and therefore . . . any action taken by the medical staff satisfies the 'contract, combination, or conspiracy' requirement of section I." Id. at 814; see supra notes 85-87 and accompanying text.

102. Testimony was received during trial that since at least the mid-1960's there have been no significant differences between the medical training provided to graduates of osteopathic medical schools and that provided by allopathic (the "regular" system of medical practice) medical schools. 745 F.2d at 792 nn.3,4; see also Stern v. Tarrant County Hosp. Dist., 565 F. Supp. 1440, 1443 (N.D. Tex. 1983), a medical staff privileges case not decided on antitrust grounds but involving exclusion from the staff based on postdoctoral training. The court recognized that differences in education and training between osteopaths and allopathic physicians were largely historical in nature and are virtually nonexistent today.

103. The court, explaining why the per se rule applied, stated:

We recognize, therefore, that in many cases involving exclusion from staff privilege, courts will, more or less openly, have to utilize a rule of reason balancing approach. This case is different, however, because York [the defendant hospital] has not contended that osteopaths as a group are less qualified than M.D.'s. . . . In the absence of such a contention, or another legitimate explanation for the discrimination [against osteopaths], we conclude a per se rule should be applied, since the effect of the practice is identical to that of the traditional boycott, and plainly anticompetitive.

745 F.2d at 820.
In *Wilk v. American Medical Association*,104 another case involving nonphysician health care practitioners, the plaintiffs alleged that the defendant organizations, the American Medical Association, the American Hospital Association, the Joint Commission on Accreditation of Hospitals and others, had engaged in a concerted effort to eliminate the practice of chiropractic. The plaintiffs' appeal from an adverse jury decision was based in part on the contention that the jury was not adequately instructed as to when to apply the per se rule. The court of appeals held that the trial court erred in allowing the jury the option of finding a per se violation because evidence of the "patient care motive" (the justification offered for the defendants' actions) required application of rule of reason analysis. Therefore, while *Weiss* and *Wilk* both involved nonphysician health care practitioners alleging horizontal group boycotts, the courts differed on the appropriateness of application of the per se standard.106

**B. "Rule of Reason" Analysis**

Despite the Supreme Court's application of the per se rule to agreements between physicians in *Arizona v. Maricopa County Medical Society*,107 lower courts are reluctant to apply the per se rule in health care antitrust cases that do not involve price-fix-

104. 719 F.2d 207 (7th Cir. 1983).

105. *Id.* at 221. The court stated:

When a conspiracy of this sort is alleged in the context of a profession, the nature and extent of its anticompetitive effect are too uncertain to be amenable to per se treatment, as contrasted with treatment under the rule of reason.

Moreover, assuming the case were otherwise amenable to per se treatment, the presence of substantial evidence of [the patient care motive] rendered the case inappropriate for per se treatment.

*Id.; see also* Kaczanowski *v.* Medical Center Hosp., 612 F. Supp. 688 (D. Vt. 1985) (rule of reason should be applied where all podiatrists were banned from the staff of the hospital under the bylaws of the hospital's medical and dental staff).

106. The probable reason for the difference in approach in the two cases is that the court in *Wilk* was apparently convinced that there are significant differences in the education and training of a physician and a chiropractor. This argument was advanced by the various medical associations as their reason for refusing to deal with chiropractors. The court considered these differences significant enough to qualify as a "public service or ethical norm" justification. *See infra* note 114 and accompanying text. The court in *Weiss*, on the other hand, could find no differences in the education and training received by osteopaths and allopathic physicians, and the defendant physicians made no attempt to justify their actions. *See supra* note 102 and accompanying text.

107. 457 U.S. 332 (1982). In *Maricopa*, the Supreme Court made it clear that the per se rule can be applied to antitrust cases in the health care industry. The Court held that maximum price-fixing agreements among competing physician members of the medical societies were per se violations of section 1 of the Sherman Act.
ing. This reluctance may be based, in part, on traditional judicial hesitation to apply the per se rule in areas where the courts have little experience. Moreover, there exists considerable uncertainty as to the continued vitality of the per se rule in boycott cases as a result of the Supreme Court's recent decisions involving nonprice horizontal restraints.

As exemplified by Wilk, lower courts confronting medical staff antitrust cases have rejected per se analysis in favor of the rule of reason approach if the defendants offer any plausible procompetitive justification for their agreement to deny or revoke the plaintiff's staff privileges. Generally, the defendant hospital claims


109. In Maricopa, 457 U.S. at 348-54, the defendants made the following traditional arguments against application of the per se rule: (1) the courts have little antitrust experience with the health care industry, (2) procompetitive justifications existed for the price agreement at issue in that case, and (3) the involvement of a "learned profession" requires that agreements that might otherwise invite application of the per se rule be subjected to a more comprehensive market analysis to determine their reasonableness.

110. See Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 105 S. Ct. 2613 (1985); National Collegiate Athletic Ass'n v. Board of Regents, 104 S. Ct. 2948 (1984). In the non-price horizontal restraints area, the Supreme Court has employed a truncated analysis of the actual or potential market effects of the challenged horizontal restraint before deciding whether the per se or rule of reason standard of analysis is applicable. Under this approach, the Court first assesses the challenged restraint's potential impact on competition. If the restraint is at least potentially procompetitive, the Court applies a rule of reason analysis, even when the horizontal agreement at issue (e.g., concerted refusal to deal) traditionally has been subjected to the per se rule.

111. See supra notes 104-05 and accompanying text.

112. See, e.g., Vucicevic v. MacNeal Memorial Hosp., 572 F. Supp. 1424 (N.D. Ill. 1983) (physician denied privileges because of potential competition; court rejected per se analysis because of unfamiliarity with its use in the health care industry and the involvement of a profession); Stone v. Beaumont Hosp., 1983-2 Trade Cas. (CCH) ¶ 65,681 (E.D. Mich. Oct. 18, 1983) (physician denied privileges for legitimate hospital business and medical reasons could not invoke a per se standard of analysis); Pontius v. Children's Hosp., 552 F. Supp. 1352 (W.D. Pa. 1982) (physician discharged from medical staff because of alleged incompetence; per se analysis rejected because actions were based on concern for patients' well-being); McElhinney v. Medical Protective, Inc., 549 F. Supp. 121 (E.D. Ky. 1982) (defendants would not refer patients to the plaintiff physician because he was alleged to be a "troublemaker"; rejection of per se rule justified by concern for maintenance of professional standards), remanded mem. 738 F.2d 439 (6th Cir. 1984), 1984-1 Trade Cas. (CCH) ¶ 66,054 (6th Cir. June 5, 1984) (opinion not recommended for full-text publication); Everhart v. Stormont Hosp., 1982-1 Trade Cas. (CCH) ¶ 64,703 (D. Kan. Feb. 18, 1982) (physician denied privileges because of possible personality difficulties and weak references; court rejected the per se rule because of a reluctance to invoke its use in health care field and because the case involved a profession); Williams v. Kleaveland, 534 F. Supp. 912 (W.D. Mich. 1981) (physician's privileges revoked be-
that the denial is justified on the basis of maintaining or improving the overall quality of medical care delivered to patients.\textsuperscript{113} Even imprecise justifications, such as "public service" or "ethical norms," have been found acceptable.\textsuperscript{114} On the other hand, where the defendants offer no justifications for the challenged action, the case will generally be resolved under the per se rule.\textsuperscript{115}

Courts struggle to find legal authority for their decisions not to apply the per se rule to what appears to be concerted action by physician members of a hospital's medical staff (and the hospital) to deny or revoke staff privileges. On occasion, these courts rely upon the reasoning of \textit{Silver v. New York Stock Exchange}.\textsuperscript{116} In
that case, the Supreme Court listed three requirements which justify discarding the per se rule and invoking the rule of reason approach in analysis of cartel-like horizontal restraints. These requirements are: (1) a mandate for industry self-regulation; (2) challenged action consistent with the policy justifying the self-regulation and no more extensive than necessary; and (3) application of procedural safeguards.117

In Vucievic v. MacNeal Memorial Hospital,118 a federal district court applied Silver's rationale to a medical staff privilege case. The court held that the hospital board's rejection of the plaintiff orthopedic surgeon should be analyzed under the rule of reason instead of the per se rule because the three prongs of the Silver test had been met. The mandate for self-regulation was present, according to the court, because hospitals have an obligation under state law to ensure that all staff physicians are competent, and hospitals must rely upon the recommendations of medical professionals in making determinations of competency.119 The court found that physicians already on staff were in the best position to evaluate the competence of the physician applicants, and that the board's rejection of the plaintiff was consistent with the policy justifying self-regulation and was not more extensive than necessary. The second prong of Silver was, therefore, met.120 Finally, the court found that the hospital and the medical staff had adopted procedural safeguards (the physician was provided with adequate notice of hearings concerning his application and a fair opportunity to respond to any alleged deficiencies) adequate for the protection of medical staff applicants, thus meeting the third prong of the Silver test.121 The court therefore ruled that the challenged actions should be analyzed, not under the per se approach, but under the rule of reason.122

The plaintiff proceeding under a rule of reason analysis must

117. 373 U.S. at 358-63.
119. Id. at 1428.
120. Id. at 1428-29.
121. Id. at 1429.
122. The first requirement of Silver might also be satisfied by the existence of state medical peer review statutes like that in Marrese v. Interqual, 748 F.2d 373 (7th Cir. 1984), cert. denied, 105 S. Ct. 3501 (1985). See supra notes 50-54 and accompanying text. The second and third requirements would then be met if the denial of medical staff privileges was recommended by such a state-mandated credentials or peer review committee and the denied applicant had ample opportunity to rebut the findings of this committee before the committee itself or the ultimate decisionmaking body of the hospital. See supra note 71 and accompanying text.
prove that there exists an actual adverse impact upon competition that is unreasonable under the circumstances.\textsuperscript{123} In a typical medical staff privilege case, the judicial analysis and subsequent outcome under the rule of reason standard should reflect a balancing of procompetitive and anticompetitive effects, in a relevant market, of the defendants' denial of the requested staff privileges.

In order for the court to evaluate this impact, both the relevant "product/service" market and "geographic" market must be identified.\textsuperscript{124} The relevant "product/service" market is the range of products or services that are reasonable substitutes for one another.\textsuperscript{125} For example, "adult open heart surgery"\textsuperscript{126} may be considered a relevant service market for a physician applicant who practices in that area (that is, a cardiovascular surgeon).\textsuperscript{127} The relevant geographic market is that area in which patients can realistically obtain the relevant services, the geographic area in which the provider markets the relevant services, or both.\textsuperscript{128} In the typical medical staff privileges case, the relevant market is the provision of physician services, of the type provided by the applicant, in the geographic area(s) where competition occurs between the applicant and the defendants who have denied him staff privileges.\textsuperscript{129}

\textsuperscript{123} "The plaintiff has the burden of showing the unreasonableness of the restraint . . . . When proceeding on a rule of reason claim, as opposed to a per se claim, the plaintiff also must prove that the restraint actually harmed the public by reducing competition." Robinson v. Magovern, 521 F. Supp. 842, 915 (W.D. Pa. 1981).
\textsuperscript{124} The definition of these two relevant markets is determined by the trier of fact. See id. at 876-86.
\textsuperscript{127} Other cases have discussed the relevant product or service market. In McElhinney v. Medical Protective, Inc., 549 F. Supp. 121, 134 (E.D. Ky. 1982), remanded mem. 738 F.2d 439 (6th Cir. 1984), 1984-1 Trade Cases (CCH) ¶ 66,054 (6th Cir. June 5, 1984), the district court found that,

[T]he nature of the services or product involved is the furnishing of medical services and supplies by the hospital and the individual doctors as a joint venture in the market area described above. The defendant doctors argue that the product or competitive market is that for a general surgeon, while the defendant hospital contends that the product or competitive market is the services and supplies of a hospital. The court, in considering the evidence most favorable to plaintiff, adopts the more expanded market.

See also Feldman v. Jackson Memorial Hosp., 571 F. Supp. 1000, 1010 (S.D. Fla. 1983) (court assumed that plaintiff podiatrist could have defined the relevant product market as "surgical services below the knee" but he failed to produce any evidence that the defendant had monopoly power in this market), aff'd mem. 752 F.2d 647 (11th Cir.), cert. denied, 105 S. Ct. 3504 (1985); Pontius v. Children's Hosp., 552 F. Supp. 1352, 1366 (W.D. Pa. 1982) (court determined relevant service market to be "pediatric thoracic cardiovascular surgery").

\textsuperscript{129} See Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984); Pontius
As the relevant market narrows, the plaintiff's chances of establishing an anticompetitive effect improve. On the other hand, a more expansive relevant market (for example, a nationwide market in the service), decreases the plaintiff's ability to prove the anticompetitive effect necessary to prevail. In medical staff privilege cases, plaintiffs have often argued that a single hospital is the relevant geographic market. Courts have uniformly rejected this argument, however, holding that a single hospital cannot be considered the relevant market.

Under most relevant market definitions, the plaintiff's burden of proving the anticompetitive effects of the defendants' agreement is a difficult one. However, if the plaintiff is unable to sufficiently narrow the relevant markets, the task of winning on the merits becomes almost impossible. If a plaintiff demonstrates anticompetitive effects, the defendant must rebut that showing by demonstrating that the restraint in question was necessary to achieve significant procompetitive effects. In other words, the defendant has the opportunity to demonstrate to the court that its

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130. The court in Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981) struck a compromise concerning the relevant geographic market by rejecting both the defendants' proposal of a nationwide geographic market for adult open heart surgery and the plaintiff's proposal of a two county submarket. Instead, the court chose a sixteen county area. Id. at 885. The plaintiff's failure to convince the court to accept the narrower characterization of the relevant geographic market probably resulted in the court's finding that the defendants' agreement (denial of staff privileges) did not result in a discernible anticompetitive effect and, therefore, was not an unreasonable restraint on trade. Id. at 919.


132. Plaintiffs have failed to prevail on the merits in all medical staff privilege antitrust cases analyzed under the rule of reason. See, e.g., Feldman v. Jackson Memorial Hosp., 571 F. Supp. 1000, 1010 (S.D. Fla. 1983) (the trial court judge directed a verdict for the hospital where the plaintiff podiatrist failed to prove staff surgeons were acting on personal motives when they denied his application for staff privileges), aff'd mem. 752 F.2d 647 (11th Cir., cert. denied, 105 S. Ct. 3504 (1985); McElhinney v. Medical Protective, Inc., 549 F. Supp. 121 (E.D. Ky. 1982) (directed verdict for defendants because plaintiff physician failed to show defendants' actions had more than a de minimis effect on the relative competitive market for medical services), remanded mem. 738 F.2d 439 (6th Cir. 1984), 1984-1 Trade Cas. (CCH) ¶ 66,054 (6th Cir. June 5, 1984); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981) (plaintiff physician failed to carry his burden of proof of conspiracy; defendants' actions were reasonable). But see Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984) (court of appeals, using per se rule, upheld jury verdict in favor of class of osteopaths, and included individual osteopaths, by finding evidence sufficient to demonstrate an antitrust violation by the medical staff), cert. denied, 105 S. Ct. 1777 (1985).

actions were reasonable because they enhanced competition and that, therefore, the actions did not violate section 1 of the Sherman Act.

The defendant hospital’s procompetitive justifications for excluding the physician plaintiff from its medical staff will be acceptable if they further legitimate hospital objectives. Maintenance or improvement of the quality of care delivered by the hospital is often accepted as a justification for denial of staff privileges. For example, a hospital, acting on the recommendations of a medical staff committee, can reasonably deny or revoke medical staff privileges on the grounds of professional incompetence. Often, however, the applicant is an otherwise qualified physician who claims to have been denied privileges as a result of physician-hospital agreements. The defendant hospital may then justify its denial of staff privileges to a competent practitioner by claiming that admission of the physician to the medical staff would be inconsistent with the hospital’s other legitimate concerns.

For example, denial of medical privileges can be defended as being both procompetitive and business-justified in light of a hospital’s defined statement of policy or “competitive strategy.” Two cases provide especially good examples of this justification. In Robinson v. Magovern, the court, applying a rule of reason analysis, placed significant reliance upon the fact that denial of medical staff privileges to an otherwise competent physician was consistent with an overall marketing plan formulated to improve the hospital’s competitiveness. The hospital had adopted privileges criteria which required an applicant to demonstrate a strong interest in teaching and research. Although the applicant was otherwise qualified as a cardiovascular surgeon, he was considered to have insufficient interest in these two areas and was therefore denied privileges. At trial, the court found that the hospital’s staff privileges criteria were consistent with a previous defined “competitive strategy” designed to improve the reputation of the hospital as a teaching and research center. These criteria reasonably ad-

134. See Pontius v. Children’s Hosp., 552 F. Supp. 1352, 1359 (W.D. Pa. 1982), in which the plaintiff was denied reappointment to the medical staff based on the recommendation of the credentials committee. The committee determined that he did not meet “the minimal standards necessary to ensure continued competency in cardiovascular surgery.”
136. Id. at 858-63.
137. Id. The defendant hospital began to develop institutional objectives in 1967. In March, 1968 the board of trustees formally approved a statement of objectives which
advanced the hospital’s legitimate interest in improving its competitive position in the local market for the provision of secondary and tertiary medical services. The court held further that the denial of privileges to the applicant did not impose an unreasonable restraint on physician competition and that it was consistent with other personnel decisions the hospital had made in accordance with its marketing plan.\textsuperscript{138}

The hospital may also justify denial of medical staff privileges to an otherwise competent physician applicant on grounds of efficiency.\textsuperscript{139} In \textit{Stone v. William Beaumont Hospital},\textsuperscript{140} the defendant hospital developed a “physician profile” which every applicant had to meet in order to be considered for medical staff privileges. This profile was developed in response to the hospital’s concern with the overburdening of cardiac catheterization facilities.\textsuperscript{141} The hospital denied medical staff privileges to the plaintiff cardiologist principally because he did not fit the physician profile. The court found that adherence to profile criteria was not anticompetitive because there were legitimate medical and business reasons, related to the efficient use of hospital facilities, for development of physician profiles.\textsuperscript{142} In addition to the efficiency concerns, the hospital was concerned about the applicant’s lack of proximity to the hospital would serve as the basis for the hospital’s competitive strategy. The plaintiff’s application for staff privileges was denied in October 1976.

138. \textit{Id.} at 919.

139. A number of efficiency-related benefits could result from limitations in staff privileges. These possible benefits include: (1) greater control and standardization of procedures, resulting in lower operating costs; (2) better scheduling of facilities and support staff; (3) fewer machinery breakdowns and maintenance problems because of fewer equipment users; (4) easier monitoring of medical quality standards; (5) better work routines and teamwork resulting from physicians, nurses and technicians working together more often; (6) greater physician competence due to more frequent performance of particular procedures; and (7) higher commitment among the physicians to an efficient institution. Each of the above propositions is entirely consistent with an institution’s rational decision to limit the granting of staff privileges. Adequate documentation of the causal link between the asserted justifications and the privilege limitations will increase the likelihood that the limitations will withstand antitrust scrutiny. See Pollard, \textit{Antitrust in the Health Profession: An FTC Policy Planning Issues Paper} (Fed. Trade Office of Planning July 1981).


141. \textit{Id.} at ¶¶ 69,477-78.

142. \textit{Id.} at ¶ 69,483; see also Smith v. Northern Mich. Hosps., Inc., 703 F.2d 942 (6th Cir. 1983), where the court found that the defendant hospital could, based on an efficiency rationale, legitimately justify contracting with an independent group of emergency medicine specialists to staff its emergency room facilities rather than continuing to utilize physicians with admitting privileges. The plaintiff physicians had staffed the emergency room on a part-time, rotating basis while maintaining full private practices. The court found no antitrust violation because the hospital had created a method of providing emergency room services “in an effective, efficient and medically prudent manner.” \textit{Id.} at 953.
and the availability of backup coverage if he were unavailable to care for his patients. These latter concerns focused on a quality of care issue—the applicant's ability to care for his patients in cases of emergency.\textsuperscript{143} The \textit{Stone} court ruled that the hospital's efficiency and quality of care concerns were legitimate interests which justified the denial of medical staff privileges to the applicant.\textsuperscript{144}

Several cases have considered the legitimacy of a hospital's concern for staff harmony as a justification for rejecting an otherwise qualified physician applicant. For example, in \textit{Robinson}, the defendant director of surgery feared that the applicant might have a negative attitude toward the teaching program and therefore have trouble working with some of the residents he would be expected to supervise.\textsuperscript{145} The court accepted staff harmony as a legitimate concern related to the quality of medical care.\textsuperscript{146} In other cases, the defendants' perceptions that the applicant might be a disruptive influence in the hospital were also deemed to be legitimate concerns.\textsuperscript{147} Maintenance of staff harmony is a legitimate means of fostering efficient hospital operation, and a valid consideration in rejecting an otherwise qualified applicant.\textsuperscript{148}

\textsuperscript{143} \textit{Stone}, 1983-2 Trade Cas. (CCH) at ¶ 69,484. The physician profile required the physician to be at the hospital full time. The plaintiff pointed out that other part-time physicians had been appointed to the medical staff. The court found, however, that in contrast to the plaintiff, the other physicians were associated full time with hospitals near the defendant hospital and had sufficient emergency backup to ensure that the quality of care was not compromised.

\textsuperscript{144} \textit{Id.}

\textsuperscript{145} \textit{Robinson}, 521 F. Supp. at 864.

\textsuperscript{146} \textit{Id.} at 918. The court expressed its concern about staff harmony by stating:

Dr. Robinson's alleged inability to work harmoniously with his fellow surgeons, the residents and the support personnel could have had an impact on the hospital's effort to achieve its primary objective, which is to provide outstanding patient care.

Dissension or conflict among the operating room personnel undoubtedly would distract the participants from the task at hand, thus increasing the risk to the patient. Therefore, the hospital is acting indirectly to further the quality of medical care when it considers personality as one of its criteria for staff selection.

\textsuperscript{147} \textit{Id.}

\textsuperscript{148} \textit{See Everhart v. Stormont Hosp.}, 1982-1 Trade Cas. (CCH) ¶ 64,703 (D. Kan. Feb. 18, 1982). \textit{Cf. McElhinney v. Medical Protective, Inc.}, 549 F. Supp. 121 (E.D. Ky. 1982), remanded mem. 738 F.2d 439 (6th Cir. 1984), 1984-1 Trade Cas. (CCH) ¶ 66,054 (6th Cir. June 5, 1984) (opinion not recommended for full-text publication), wherein the plaintiff alleged that other physicians on staff refused to refer patients to him because they considered him a "troublemaker" and an instigator of malpractice suits. The defendants claimed that the refusal to deal with the plaintiff was not the result of a conspiracy. The trial court directed a verdict for the defendants, and the appellate court dismissed the appeal for lack of jurisdiction.

\textsuperscript{148} In dicta, the court of appeals in Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), \textit{cert. denied}, 104 S. Ct. 1777 (1985), discussed the restriction of medical staff privi-
C. Concerted Refusals to Deal with Nonphysician Health Care Practitioners

The denial of full medical staff privileges to otherwise qualified nonphysician health care practitioners raises potentially troublesome antitrust issues. Economic incentives of physician staff members can form the basis for findings of both horizontal conspiracy and anticompetitive intent. Even when nonphysician health care practitioners are licensed by the state to perform services that limited medical staff privileges would allow, hospitals denying such privileges routinely make a quality-of-care argument. The denied applicant invariably claims that the denial of staff privileges is in fact motivated by the economic interests of either the medical staff physicians or both the medical staff and the hospital itself.

In response to allegations of this type made by podiatrist plaintiffs, two courts have upheld the defendants' arguments that they had a duty to ensure the quality of the care they provided to their patients (a "public service and ethical norms" justification). Moreover, one court stated that hospitals may exclude podiatrists from their medical staffs under the quality-of-care rationale whenever the hospitals have acted in "good faith."

leges because of professional conduct: "In sum, doctors who have trouble getting along with other people will reduce efficiency, thereby reducing the hospital's competitive position, and, therefore, exclusion of such doctors is procompetitive and permissible under the rule of reason." Id. at 821 n.60.

149. See supra notes 85-87, 100-06 and accompanying text.
150. See supra notes 104-06 and accompanying text; infra notes 152-53 and accompanying text.
151. See supra notes 85-87, 100-06 and accompanying text; infra notes 152-53 and accompanying text.

The court ... concludes that defendant's actions were taken in good faith and were not an unreasonable restraint on trade under the circumstances .... The court finds that, as the governing body of Forsyth Memorial, the Board of Trustees and its delegated committees had a duty to insure that the hospital provide quality patient care and that the actions by the Board ... [were] in response to this duty.

Cf. Feldman v. Jackson Memorial Hosp., 571 F. Supp. 1000 (S.D. Fla. 1983), aff'd mem. 752 F.2d 647 (11th Cir.), cert. denied, 105 S. Ct. 3504 (1985). The plaintiff podiatrist claimed that the orthopedic surgeons and the hospital conspired to deny him privileges. The court held that the orthopedic surgeons were acting only within their roles as members of the medical staff in recommending denial of privileges to the plaintiff. Moreover, the plaintiff failed to prove that the surgeons were actually competitors, that a conspiracy existed, and that the defendants' actions had the requisite market impact. But cf. Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), cert. denied, 104 S. Ct. 1777 (1985), where
In cases involving nonphysician health care practitioners, courts allow a quality-of-care justification to prevail even when such practitioners are in full compliance with all state regulations governing training and education. Courts will probably continue to accept this justification as a legitimate reason for denial of staff privileges, largely because it is easily shown that nonphysician practitioners have relatively less training and education than their physician competitors.154

D. Comments on the Group Boycott Issue

If the antitrust plaintiff succeeds in demonstrating the existence of a conspiracy in a medical staff privilege case, the defendants must counter by offering quality-of-care, efficiency, or other procompetitive justifications for the concerted action taken. By proffering such justifications, defendants may ensure application of the rule of reason, under which defendants consistently prevail in antitrust medical staff privilege cases. Defendants' successes result from two factors. First, plaintiffs find it difficult to demonstrate more than a de minimis anticompetitive effect in any relevant market. Second, courts give substantial deference to the purported justifications set forth by the defendants. Maintenance or improvement of the quality of care provided by an institution to its patients and increased efficiency in the delivery of that care have both been accepted as legitimate justifications for denial of staff privileges since attainment of these objectives improves the reputation and enhances the competitive position of the hospital in the relevant hospital market.

Consistent with the Robinson155 and Stone156 cases, a hospital may be able to muster an adequate defense to an antitrust claim brought by an otherwise competent physician who has been denied

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154. The exclusion of incompetent nonphysician health care practitioners, on an individual basis, should pose no significant antitrust problems. See Weiss v. York Hosp., 745 F.2d 786, 820 (3d Cir. 1984), cert. denied, 104 S. Ct. 1777 (1985), where the court stated, “[t]he Medical Staff is, however, entitled to exclude individual doctors, including osteopaths, on the basis of their lack of professional competence or unprofessional conduct.”

155. See supra note 135 and accompanying text.

156. See supra note 140 and accompanying text.
medical staff privileges, if its denial of these privileges is consistent with a previously determined competitive marketing strategy or statement of policy. It is important that these policy determinations be solely that of the hospital administration or board of trustees, not the medical staff or credentials committee who will directly evaluate the applicant, so that the hospital is not readily accused of "rubber stamping" all medical staff decisions. Anticompetitive intent may be inferred if the policy was developed by the direct competitors of any potential applicant. If the trier of fact determines that the real decision regarding these policies was made at the medical staff level, a horizontal agreement is more easily inferred. Medical staff committee recommendations must, therefore, be seen as serving the hospital's overall interests, not merely the personal, economic interests of the member physicians.\footnote{157}

The virtually unanimous success of the defendants in medical staff privilege cases evaluated under the rule of reason demonstrates the paramount importance to the antitrust plaintiff of successfully characterizing the conspiracy as being at least in part horizontal in nature, and rebutting \textit{in toto} the defendants' purported justifications. Only by meeting this burden can the plaintiff prevail.

\textbf{VI. EXCLUSIVE DEALING/TYING ARRANGEMENTS}

Another common situation involving denial of medical staff privileges to an otherwise competent physician arises when a hospital enters into an exclusive contract with a group of physicians who specialize in a particular area. The contract between the separately incorporated medical group and the hospital clearly satisfies the conspiracy or combination requirement of section 1 of the Sherman Act.\footnote{158}

The physician plaintiff denied medical staff privileges as a result of such an exclusive contract will often allege a section 1 violation

\footnote{157. Contributions to the formulation of physician profiles and competitive marketing strategies by physicians who would be considered direct competitors of a potential applicant are not likely to pose a significant antitrust problem as long as the resultant plan serves the hospital's best interests and is not designed to serve only the competing physicians' interests by reducing competition in their particular areas of practice. Often, it may be both necessary and desirable to include such physicians in the design of institutional objectives because of their expertise. If these plans plainly serve legitimate, precompetitive hospital interests, then they should in most cases be considered reasonable restraints of trade. \textit{See} Pontius v. Children's Hosp., 552 F. Supp. 1352, 1376 (W.D. Pa. 1982).}

\footnote{158. \textit{See supra} notes 88-89 and accompanying text.}
under an "exclusive dealing" theory, an illegal "tying" arrangement theory, or both. If the plaintiff alleges only exclusive dealing, courts will engage in a rule of reason analysis to determine the outcome, often treating the case as a vertical combination. However, if the plaintiff is able to convince a court that a tying agreement exists, the defendant's actions may constitute a per se violation if two additional conditions are met. First, two separate services must be involved. Second, the seller of these services must possess sufficient market power in one service (the tying service) so that consumers (patients) are forced to purchase a second service (the tied service) that they either did not want at all or might have purchased elsewhere or under different terms. If the seller does not possess sufficient market power to create this "forcing," then the per se rule does not apply and the defendant's antitrust liability will be determined under a rule of reason analysis.

A. The Hyde Decisions

The seminal case evaluating exclusive dealing and tying agreement claims in the context of medical staff privileges is Jefferson Parish Hospital District No. 2 v. Hyde. In Hyde, a plaintiff anesthesiologist sought a declaratory judgment that an exclusive contract between the hospital and an anesthesiology group practice was unlawful under section 1 of the Sherman Act. The plaintiff alleged that the contract was an illegal tying arrangement because it required every patient admitted for surgery in the defendant hospital to use the services of one of the four anesthesiologists in the

159. See infra notes 160-61 and accompanying text.
160. See, e.g., Smith v. Northern Mich. Hosps., Inc., 703 F.2d 942 (6th Cir. 1983) (staff physicians challenged contract between hospital and group of full-time emergency medical specialists for provision of exclusive emergency room services; plaintiff physicians retained all staff privileges except emergency room practice, and, as a group, could have, but failed to, submit a bid to provide these services on a full-time basis; court analyzed the case under rule of reason); Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982) (plaintiff anesthesiologist alleged unlawful exclusive dealing between defendant hospital and anesthesia group; court characterized hospital-physician agreement as vertical combination to be analyzed under rule of reason); Rockland Physicians Assoc. v. Grodin, 616 F. Supp. 945 (S.D.N.Y. 1985) (plaintiff anesthesiology group brought exclusive dealing and price-fixing claims against defendant hospital and another anesthesiology group which replaced plaintiff group; court analyzed under rule of reason).
162. Id. at 1572.
163. Id. at 1558-59.
164. See supra notes 107-10 and accompanying text for a discussion of the Supreme Court's truncated analysis of an alleged horizontal restraint.
group. The plaintiff further alleged that the exclusive contract illegally restrained competition among anesthesiologists.\textsuperscript{166}

The Court began its analysis by finding that the contract involved two services—hospital operating room services (the tying services) and anesthesiology services (the tied services)—and that the defendant hospital had consolidated the sales of these two services into a single transaction.\textsuperscript{167} Distinguishing anesthesiology from other hospital services, the Court noted that professional anesthesiology services traditionally had been billed separately from hospital services and that patients (or their surgeons), in the absence of an exclusive contract, had often requested the services of specific anesthesiologists.\textsuperscript{168}

After deciding that the case involved more than one service, the Court considered the issue of whether patients were forced to purchase the group's anesthesiology services as a result of the defendant hospital's market power.\textsuperscript{169} In the absence of such forcing, the Court stated, the combining of two separate services by the defendant hospital would not be illegal because patients would be free to choose a competing hospital for their surgery and, therefore, to use anesthesiologists who were not members of the group.\textsuperscript{170}

The Court noted that the market power necessary to create "forcing" may exist in several situations, for example: (1) where the government has granted the seller a patent, license, or similar monopoly over the tying service, (2) where a seller offers a unique product or service that competitors are not able to offer, and (3) where a seller has a large market share.\textsuperscript{171} Since neither of the first two situations existed in \textit{Hyde}, the Court analyzed the defendant hospital's market power by focusing on its market share. Relying on the district court's finding that seventy percent of the

\textsuperscript{166} Id. at 1553.
\textsuperscript{167} Id. at 1565. However, the mere combination of two distinguishable services does not create antitrust liability.
\textsuperscript{168} [T]he fact that this case involves a required purchase of two services that would otherwise be purchased separately does not make the contract illegal . . . .
\textsuperscript{169} [T]here is nothing inherently anticompetitive about packaged sales. Only if the patients are forced to purchase [anesthesiology] services as a result of the hospital's market power would the arrangement have anticompetitive consequences.
\textsuperscript{170} If no forcing is present, patients are free to enter a competing hospital and to use another anesthesiologist instead . . . .
\textsuperscript{171} Id.; see also \textit{infra} notes 169-74 and accompanying text.
\textsuperscript{168} 104 S. Ct. at 1564.
\textsuperscript{169} Id. at 1566.
\textsuperscript{170} Id. at 1564-65.
\textsuperscript{171} Id. at 1560-61.
patients residing in Jefferson Parish used hospitals other than the
defendant hospital, the Court rejected Dr. Hyde's assertion that
the single hospital constituted a market for antitrust purposes.\textsuperscript{172}
Rather, the Court agreed with the district court's finding that the
relevant geographic market consisted of the entire metropolitan
New Orleans area.\textsuperscript{173} Having thus defined the market, the
Supreme Court agreed with the lower courts that the defendant's
thirty percent share of the Jefferson Parish hospital market was
insufficient to force patients to purchase the anesthesiology services
provided in the defendant hospital.\textsuperscript{174} Therefore, the Court held
that the per se rule did not apply to the alleged tying arrangement.\textsuperscript{175}

Even if a defendant hospital lacks market power in the tying
product sufficient to result in a per se violation, a hospital's exclu-
sive contract with a physician group may still be an unreasonable
restraint of trade.\textsuperscript{176} However, once it has been determined that
the defendant's lack of market power makes application of the per
se rule inappropriate, the antitrust analysis must proceed under the
rule of reason standard normally applied to exclusive contract ar-
rangements.\textsuperscript{177} The Court in \textit{Hyde} found that the record lacked
any evidence that the exclusive contract had an actual adverse ef-
fect on competition in the relevant product markets. There was
also no evidence that patients living in Jefferson Parish who desired
a choice in the selection of an anesthesiologist were denied that
choice by reason of the exclusive contract.\textsuperscript{178} Without the requisite
showing of an adverse effect on competition in the market for anes-
thesiology services, the Court held that the linkage between the
delivery of anesthesiology services and the "sale" of other hospital

\textsuperscript{172} \textit{Id.}; see \textit{supra} note 131 and accompanying text.
\textsuperscript{173} 104 S. Ct. at 1566.
\textsuperscript{174} \textit{Id.} at 1566-67.
\textsuperscript{175} \textit{Id.} at 1567. The court of appeals, contrary to the district court, concluded that
the relevant geographic market was not the entire New Orleans metropolitan area but the
East Bank of Jefferson Parish. The court of appeals determined that the defendant hospi-
tal's market share alone was insufficient to create the requisite market power for a per se
violation. Nevertheless, the Fifth Circuit held that the hospital had sufficient market
power to justify a per se condemnation of the tying arrangement because of the presence
of "market imperfections." These imperfections included the prevalence of health insur-
ance which eliminates patients' incentives to compare costs, inadequate information for
patients comparing quality, and family convenience which tends to magnify the impor-
tance of hospital location. \textit{Id.} at 1555-56. The Supreme Court rejected the Fifth Cir-
cuit's conclusion that these factors generate the kind of market power that justifies per se
\textsuperscript{176} \textit{Id.} at 1567-68.
\textsuperscript{177} See \textit{infra} note 180 and accompanying text.
\textsuperscript{178} 104 S. Ct. at 1568-69.
services, created as a result of the exclusive contract, was not the type of activity prohibited by section 1 of the Sherman Act.\textsuperscript{179}

In subsequent cases factually similar to \textit{Hyde}, courts have consistently rejected per se treatment in favor of the rule of reason approach.\textsuperscript{180} In each case, the plaintiff has failed to demonstrate an adverse effect on competition and the exclusive contracts at issue have, therefore, not been found to violate section 1 of the Sherman Act.\textsuperscript{181}

\textbf{B. Comments on Exclusive Dealing/Tying Arrangements}

Where the hospital has entered into an exclusive contract with a group of specialized medical practitioners, a physician plaintiff denied medical staff privileges as a result of the contract will in most instances fail to prove the existence of an illegal tying arrangement or exclusive dealing. There are, however, very limited factual settings in which such an argument may succeed. For example, where the hospital is the only hospital in the region or where it offers unique services, the single hospital may constitute the entire relevant market, and an antitrust violation may be found.\textsuperscript{182} Similarly, if the contracted-for service (which could also include non-physician services such as laboratory services) is separate and distinct from general hospital services and no competing sources of this service are reasonably available to patients, an illegal tying arrangement or anticompetitive exclusive dealing may exist. In the absence of such fact patterns, however, it is unlikely, after \textit{Hyde}, that plaintiffs will be able to challenge successfully their exclusions

\begin{footnotes}
\item[179] Id. at 1568.
\item[180] See Gonzalez v. Insignares, 1985-2 Trade Cas. (CCH) ¶ 66,701 (N.D. Ga. June 27, 1985) (court granted defendants' motion for summary judgment in case involving exclusive anesthesiology services contract); Mays v. Hosp. Auth., 582 F. Supp. 425 (N.D. Ga. 1984) (court granted defendant hospital's motion for summary judgment as to plaintiff's exclusive dealing and illegal tying arrangement claims regarding exclusive contract for radiology services; plaintiff radiologist, in light of \textit{Hyde}, conceded this was not a per se violation and failed to show adverse effect on competition); Aviani v. Sisters of St. Mary, No. 82-2966 (N.D. Ill. June 14, 1985) (available June 1, 1986, on LEXIS, Genfed Library, Dist. file) (court granted defendant's motion for judgment on the pleadings, based on \textit{Hyde} decision, in antitrust challenge to exclusive contract for anesthesiology services); see also \textit{supra} note 160 and accompanying text.
\item[181] Cf. Konik v. Champlain Valley Physicians Hosp. Medical Center, 733 F.2d 1007 (2d Cir.), cert. denied, 105 S. Ct. 253 (1984). The contract at issue was not exclusive (like that in \textit{Hyde}) because the defendant hospital offered the plaintiff anesthesiologist the same contract for her services as it had offered the defendant anesthesiology group. Therefore, the plaintiff could have practiced in the hospital under the same terms as the group anesthesiologists. Because the plaintiff could have agreed to the contract terms, there was no adverse effect on competition.
\item[182] See \textit{infra} notes 201-11 and accompanying text.
\end{footnotes}
from hospital medical staffs on the basis of exclusive dealing or tying arrangement claims.

VII. THE CONTINUED VIABILITY OF MEDICAL STAFF PRIVILEGE ANTITRUST CASES

Physician plaintiffs, alleging Sherman Act section 1 violations as the cause of the denial or revocation of their medical staff privileges, have an abysmal record of succeeding in antitrust litigation. Proving the requisite nexus between the defendant’s activities and interstate commerce and avoiding application of the state action exemption are crucial jurisdictional obstacles to the successful pursuit of a Sherman Act section 1 case. Those plaintiffs who succeed in avoiding these barriers next face significant difficulty in convincing courts that the hospital is legally capable of conspiring with its staff physicians or that the members of the medical staff credentials and peer review committees can conspire with each other. The plaintiff’s inability to prove the existence of an agreement between parties adjudged legally capable of conspiracy has been the sine qua non in a number of medical staff privilege antitrust cases. Confronted with all of these hurdles, plaintiffs rarely survive defendants’ summary judgment motions.

In the few medical staff privilege cases that have actually proceeded to trial, the rule of reason standard has invariably been invoked. The physician bearing the burden of proving anticompetitive effect in a relevant market faces a virtually impossible task. Given the disappointing success rate for such physi-

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183. See supra notes 1-71 and accompanying text.
184. See supra notes 72-89 and accompanying text.
186. Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), cert. denied, 105 S. Ct. 1777 (1985), is the only medical staff privilege case where the plaintiff eventually prevailed on the merits. See supra note 186 and accompanying text.
cian plaintiffs, is there any future for plaintiffs in antitrust suits based upon denial of medical staff privileges? FTC consent orders and dicta in several cases indicate that the physician plaintiff has a viable case if he can prove that the denial of staff privileges was based solely on the anticompetitive motives of physicians already on staff. However, hospitals and their committees are increasing their efforts not only to document quality, utilization and other criteria for medical staff privileges, but also to articulate legitimate procompetitive reasons for restricting medical staff access.

In view of the continued trend toward documentation of criteria, adherence to those criteria, and provision of due process to those physicians adversely affected by staff privilege decisions, it seems increasingly likely that medical staff privilege cases brought under section 1 of the Sherman Act will continue to fail. However, while this conclusion may be true with regard to the "typical" case, recent developments in the health care industry are prompting situations where medical staff privilege decisions are being premised, at least in part, on new criteria. These criteria may lead to new antitrust cases far different from the "typical" case seen thus far. Following is a discussion of the new restrictions and their potential antitrust implications.

A. Staff Privileges Related to Practice Patterns

The antitrust laws have never been successfully utilized to afford medical staff privileges to unqualified or incompetent physicians. In fact, hospitals that fail adequately to monitor the performance of staff physicians have been found liable to patient victims of physician malpractice.

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188. See supra note 76 and accompanying text.
191. See supra note 71 and accompanying text.
The emergence of cost containment efforts, including diagnostic-related groups ("DRG's"), per diem, and other prospective payment systems, creates new economic incentives for the hospital to monitor even more closely the composition of its medical staff. These payment mechanisms encourage hospitals and physicians to reduce the length of hospital stays while providing the fewest number of services still consistent with quality health care. This creates an incentive for the hospitals to attract and retain physicians whose hospital utilization patterns result in the greatest profitability for the hospital. Moreover, since certain types of procedures may be more profitable than others for hospitals under DRG payment systems, such hospitals will benefit economically from granting staff privileges to physicians who admit relatively high numbers of patients requiring these procedures.

What are the antitrust consequences when a hospital modifies its medical staff privileges policy to take into account physician admission patterns and utilization records? May a hospital deny or revoke medical staff privileges if a physician does not admit a predetermined number of patients over a certain period, or if the physician's utilization pattern exceeds norms determined by the hospital or some third-party payor? To say that a hospital cannot utilize such criteria in making staffing decisions is tantamount to saying that a hospital has no control over the use of its facilities. Clearly, a hospital should have the right to decide what services it will provide, to control utilization through medical staff credentials, and to establish reasonable competency standards for the medical staff.

Furthermore, a hospital has the right to protect its economic

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(1982), wherein the court held that the defendant hospital could be held liable to a patient under the doctrine of corporate negligence for negligent conduct of independent practitioners who were members of its medical staff and availed themselves of the hospital facilities, but who were neither employees nor agents of the hospital.

193. See 50 Fed. Reg. 35,707 (Sept. 3, 1985). Under traditional cost-based reimbursement systems, a hospital's economic incentives were, arguably, to prolong hospital stays and provide tests and services that may have been only marginally effective or required. These practices were subject only to the occasional disqualification of reimbursement based on the finding that "medically unnecessary services" had been provided. See also 42 C.F.R. §§ 405.301(k), 405.451(c)(3) (1980).

194. This article is limited to the antitrust consequences of such criteria and does not address state law constraints on hospital decisions regarding medical staff privileges.

195. It is possible that disciplinary action may be imposed for over-utilization which directly and adversely affects patient care. See Lewin v. St. Joseph Hosp., 82 Cal. App. 3d 368, 146 Cal. Rptr. 892 (1978). If a physician prescribes medically unnecessary services, this may raise questions regarding the physician's competence, even if the additional services pose no immediate risk of physical harm to the patient.
well-being. A pattern of over-utilization adversely affects the hospital if the hospital is not using a cost-based reimbursement system. If over-utilization leads to financial losses, the hospital must recoup those losses by increasing the charges to other patients or for other services. If over-utilization is not controlled, and the hospital is one of a number of competing facilities in the area, its long-range financial viability may be jeopardized.

Accordingly, logic dictates that a hospital must be permitted to make medical staff privilege decisions which promote its economic viability. Moreover, from an antitrust perspective, a hospital should be able to condition medical staff privileges on adherence to factors such as minimum admissions standards, since these factors reflect the hospital’s legitimate procompetitive concerns. Hospitals may enhance efficiency and, arguably, even patient care by restricting the number of physicians, overall and within each specialty, who will have medical staff privileges. When the excluded physician’s antitrust lawsuit is evaluated under rule of reason analysis, it is unlikely that anticompetitive effects in the relevant hospital or physician market will be sufficient to overcome the defendant’s proffered justifications for the physician’s exclusion.


197. Use of such criteria may conflict with standards articulated by the Joint Commission on Accreditation of Hospitals: “Professional and ethical criteria, uniformly applied to all medical staff applicants or members, shall constitute the basis for granting medical staff membership and clinical privileges . . . .” Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 90 (1984). On the other hand, disciplinary action imposed because the physician is an over-utilizer is arguably application of both “professional” and economic criteria.


199. See, e.g., Aron v. Michigan Health Care Corp., 1985-1 Trade Cases (CCH) ¶ 66,513 (D. Nev. June 29, 1984). Aron involved provisions in a hospital’s bylaws which required that the work of provisional staff members be observed for one year and that preference in emergency room referrals be given to active staff members. The provisions were found to be reasonable and legitimate means of controlling the quality of service offered by the hospital. The court found that the provisions constituted neither illegal monopolization nor an unreasonable restraint of trade. Id. at ¶ 66,557.

Significant anticompetitive effects may, however, be present when the hospital is the only available facility at which the physician can practice his profession, that is, when the hospital is the relevant market for antitrust purposes. This may occur where the hospital is geographically isolated (the one-hospital town) or where the hospital has unique facilities or services not available in other area hospitals. A physician denied medical staff access to such a hospital may seek an antitrust remedy through use of the “essential facility” doctrine. This doctrine provides that “where facilities cannot be practically duplicated by would-be competitors, those in possession of them must allow them to be shared on fair terms. It is an illegal restraint of trade to foreclose the scarce facility.”

In one antitrust case concerning medical staff privileges, a physician challenged a contract between a competing group of anesthesiologists and the hospital by alleging that the hospital was an essential facility because it was the only major medical facility in a tri-county area. The plaintiff, however, failed to establish that the contract between the defendants was an exclusive dealing contract. The antitrust claims were, therefore, dismissed.

The outer boundaries of the essential facility doctrine are un-
clear. In *Hecht v. Pro-Football, Inc.*,205 the Court of Appeals for the District of Columbia stated that “to be essential, a facility need not be indispensable; it is sufficient if duplication of the facility would be economically unfeasible and if denial of its use inflicts a severe handicap on potential market entrants.”206 Yet undue expansion of the essential facility doctrine would conflict with the fundamental premise of American jurisprudence that any party has the unilateral right to refuse to deal with another.207 Even the court in *Hecht* warned that the essential facility doctrine “must be carefully delimited: The antitrust laws do not require that an essential facility be shared if such sharing would be impractical or would inhibit the defendant’s ability to serve its customers adequately.”208

Thus, even the essential facility doctrine apparently considers the legitimate concerns of an antitrust defendant. A hospital defendant, relying upon the language of *Hecht*, might successfully argue that unlimited access to its medical staff would be impractical or that it would adversely affect the hospital’s efficiency, administration or quality of care. Nevertheless, the essential facility theory may in some instances provide a plausible antitrust case for the competent and otherwise qualified physician where the defendant hospital comprises the relevant hospital market. The plaintiff’s argument may be bolstered by *Aspen Skiing Co. v. Aspen Highland Skiing Corp.*,209 a case in which the Supreme Court upheld a jury finding of monopolization under section 2 of the Sherman Act when the owner of skiing facilities at three of the four skiing mountains in Aspen, Colorado, refused to continue a joint ticketing arrangement with the rival facility.210 In finding liability, the Court focused on the second element of the monopolization offense: “the willful acquisition, maintenance or use of monopoly power in a relevant market by anticompetitive or exclusionary means or for an-

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205. 570 F.2d 982 (D.C. Cir. 1977).
206. *Id.* at 992; *see also* Helix Milling Co. v. Terminal Flour Mills Co., 523 F.2d 1317, 1320 (9th Cir. 1975), *cert. denied*, 423 U.S. 1053 (1976).
208. *Hecht*, 570 F.2d at 992-93.
210. The Supreme Court did not rely upon the “essential facilities” doctrine in its *Aspen* ruling. The Tenth Circuit, however, relied upon this principle in finding that the defendant operator of the three facilities had monopoly power and thus had to grant other competitors or potential competitors access on reasonable terms to competitively essential facilities in the defendant’s control. *Aspen Highlands Skiing Corp. v. Aspen Skiing Co.*, 738 F.2d 1509, 1520-21 (10th Cir. 1984).
ticompetitive or exclusionary purposes." However, the Court clearly stated that even under the essential facility doctrine, an exclusionary policy which has efficiency or other legitimate justifications may be sufficient to deflect Sherman Act section 2 charges.

The hospital's conditioning of physician staff privileges on a minimum number of admissions and acceptable utilization standards will ordinarily not result in antitrust liability to the affected physicians. Where, however, the hospital conditions staff privilege decisions upon the physician's agreement not to admit patients to, or perform services at, competing hospitals, additional antitrust concerns arise.

The hospital's demand for even this increased level of physician loyalty will usually not result in antitrust liability. This conclusion, however, is subject to several qualifications. Conditioning staff privileges on a physician's agreement to admit patients to only one hospital could subject that hospital to a Sherman Act section 2 monopolization claim by competing hospitals. This type of restriction may be characterized as the "act of monopolizing" if the hospital already has monopoly power, or it may provide evidence of the intent to monopolize if the hospital does not have existing monopoly power but has the possibility of obtaining it. A hospital already dominant in its area by virtue of its reputation, comprehensive or specialized facilities, or other attractive attributes, may be especially vulnerable to antitrust claims if it imposes such restrictions. Moreover, the physician's explicit or implicit agreement to the restrictions as a condition to staff privileges provides the necessary "contract" for a Sherman Act section 1 claim.

Competing hospitals are the probable antitrust plaintiffs in this situation. It is also possible that a physician, subject to a restriction such as "not performing services elsewhere that could be pro-

211. 105 S. Ct. at 2854.
212. But see supra notes 201-11 and accompanying text.
213. See, e.g., Cobb County-Kennestone Hosp. Auth. v. Prince, 242 Ga. 139, 249 S.E.2d 581 (1978), wherein the hospital required the use of its facilities for any procedure, test or service routinely offered by the hospital.
216. Under either Sherman Act section 1 or section 2 allegations, definition of the relevant market and establishment of market power by the hospital imposing the restriction would be prerequisites to a finding of liability. See Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984).
vided in the hospital," may have standing as well. Physicians, as owner-managers of independent surgi-centers, sometimes compete with the hospital’s operating room.\(^{218}\) They suffer economic injury, not necessarily as physicians providing services, but in their capacities as owners of these facilities.

Other kinds of staff restrictions could engender even more categories of antitrust plaintiffs. For example, if a hospital participating in a preferred provider organization ("PPO") conditions its medical staff privileges upon a physician’s agreement to participate in the hospital-sponsored or endorsed PPO, the competitive impact of such a restriction could affect the hospital, physician, and third-party payor markets. Arguably, a restriction that mandates a physician's participation in the hospital's PPO does not exclude the physician from participating in other PPO's and thus does not create significant antitrust risk. On the other hand, if a hospital conditions its medical staff privileges on a physician's agreement not to affiliate with other PPO's, such a restriction forecloses competing hospital-sponsored PPO's, as well as payor-sponsored PPO's, from access to these physicians. In concentrated hospital markets, where only one or a few hospitals exist, such a restriction would create antitrust liability to payors, in addition to physicians and competing hospitals. As de facto buyers of both hospital and physician services, third-party payors who incur higher costs because of such a restriction may have the requisite standing to assert both Sherman Act section 1 and section 2 claims.\(^{219}\)

**B. Hospital-Imposed Physician Fee Restrictions**

As health care marketing has expanded, hospitals have been forced to compete for preferred provider and exclusive contracts with third-party payors. Hospitals compete in part by offering favorable prices to such payors for services provided to their subscribers. While the hospital component of health care services continues to account for the greatest percentage of overall health care costs,\(^{220}\) physician fees are beginning to attract cost containment

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218. A surgi-center is a small, independent facility set up primarily to handle elective surgery on an ambulatory basis. These centers may also handle some limited emergency surgery. The patients most likely to utilize a surgi-center are those patients who will not require significant postoperative care.


attention. Thus, a hospital seeking preferred or exclusive provider status with payors might attain a competitive advantage if it can offer services at a favorable price and also guarantee to the payor that physician fees for in-hospital services will not exceed designated maximum rates. To achieve this competitive advantage, a hospital might condition its staff privileges upon physician adherence to a maximum fee schedule.

This proposal, like many of the other medical staff restrictions previously discussed, would create significant political and other dilemmas for the hospital with regard to its medical staff relations. Nevertheless, assuming no state law prohibitions, a key question will be whether such a restriction is acceptable under the antitrust laws. To date, there has been no reported decision involving such a medical staff restriction.

In Konik v. Champlain Valley Physicians Hospital Medical Center, however, the Seventh Circuit addressed a somewhat similar fact pattern. In Konik, the plaintiff anesthesiologist argued that a contract between the hospital and an anesthesiology group, which provided that fees charged by the anesthesiologists were to be no greater than those charged for similar procedures in other parts of the state, constituted unlawful vertical price-fixing. The court found that the contract provision setting the maximum fees constituted evidence of a vertical price restraint. However, the court concluded that the plaintiff anesthesiologist had not presented any evidence that she was injured by reason of the price ceiling. The court therefore dismissed the vertical price-fixing claim. It is not clear from the Konik opinion whether the court

222. This discussion assumes that the fee schedule is determined by a non-physician controlled hospital and is not the subject of a horizontal agreement between physicians. A horizontal fee schedule, absent financial or productive integration, is probably subject to the per se rule. See Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982).
224. The contract provision read as follows: "Fees charged by the parties of the second and third parts shall be no greater than those charged by other anesthesiologists for similar work situations in Upstate New York." Id. at 1019.
225. Id.
226. In doing so, the court referred to Monsanto Co. v. Spray-Rite Service Corp., 104 S. Ct. 1464 (1984). However, the Court's reference to Monsanto may be misplaced. That case involved a terminal distributor who alleged that Monsanto and other complaining dealers were engaged in a combination or conspiracy to fix resale prices in violation of section 1 of the Sherman Act. The narrow issue before the Court was whether an inference of concerted action could be drawn from the fact that the dealer was terminated after Monsanto had received complaints from other dealers. Thus, the Monsanto decision was essentially concerned with evidentiary standards for establishing a conspiracy.
would have found the vertical price restraint unlawful had the plaintiff proved injury, and, if so, whether it would have made its determination under the per se or rule of reason standard.

Because physicians are not reselling products or services purchased from the hospital, it is not clear whether hospital-imposed restrictions on physician charges to third-party payors or patients constitutes vertical price-fixing. Where privity of contract exists between the hospital and the payor, and between the physician and the payor, there is usually no buyer-seller relationship between the hospital and the physician for the physician's services. In those circumstances where the hospital charge to the patient or third-party payor includes both the hospital and physician components, such joint billing may be an administrative convenience or it may reflect the fact that the physician has sold his or her services to the hospital which, in turn, has resold those services to the patient or payor. Neither of these fact patterns coincides with the typical antitrust resale price maintenance restraints governed by the per se rule.\textsuperscript{227} If the rule of reason applies, a hospital lacking market power may be able to survive an antitrust challenge by establishing procompetitive justifications for use of physician fee restrictions as a condition to medical staff privileges.

VIII. CONCLUSION

No definite conclusions can be drawn regarding the antitrust legality of economically motivated restrictions imposed as conditions to hospital staff membership. As health care cost containment and competitive pressures increase, hospitals have heightened financial incentives to maximize physician loyalty. As a result, new conditions will be imposed on medical staff privileges which will raise difficult questions under the antitrust laws. Although courts thus far have not been inclined to rule in favor of physician plaintiffs who allege that the denial of staff privileges was the result of an unlawful conspiracy, it would be imprudent to conclude that economically motivated conditions may be imposed on medical staff

Moreover, the factual pattern involved could be viewed as traditional resale price maintenance whereby the seller of a product (or service) requires the buyer to resell according to a prescribed pricing schedule. Despite continued criticism, the Supreme Court has consistently reaffirmed that resale price maintenance is a per se violation of section 1 of the Sherman Act. See, e.g., Dr. Miles Medical Co. v. John D. Park & Sons, 220 U.S. 373 (1911).

\textsuperscript{227} However, if a physician, in selling his services to the hospital, agrees with the hospital on the amount to be charged by the hospital to the patient for the physician's services, a pattern susceptible to vertical price-fixing charges could exist.
members with impunity. This is in part because there is relatively little case law regarding appropriate evaluation of such restrictions under the antitrust laws. Furthermore, the precedential value of existing case law may decrease as new restrictions generate additional categories of antitrust plaintiffs, such as third party payors and competing hospitals, who may be more successful than physician plaintiffs in proving damages and anticompetitive effects. While the antitrust future for health care providers remains clouded because of these uncertainties, one thing is clear. Hospitals imposing economically justified conditions on the granting of medical staff privileges must undertake risk-benefit analyses that consider the potential application of federal antitrust laws to these new restrictions.

228. "Restricting doctors for cost reasons is highly controversial and legally untested. Experts expect legal challenges if staff privileges are terminated on economic grounds." Wall St. J., Jan. 19, 1984, at 33, col. 5.