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Daniel M. Warner
Western Washington University

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UNDERSTANDING AND DEFENDING AGAINST MEDICAL PROFESSIONAL PEER REVIEW ANTITRUST CLAIMS

Daniel M. Warner†

I. INTRODUCTION: THE RELATIONSHIP BETWEEN MEDICAL MALPRACTICE, PEER REVIEW, AND ANTITRUST

Observers dispute whether there really is a "crisis" in medical malpractice litigation and in the availability and cost of malpractice insurance.¹ It is not disputed, however, that Americans spend a large sum of money on health care. Such expenditures amounted to approximately 12% of the gross national product in 1989, up from 7.4% in 1970.² A deep-rooted perception is that a part of the increase in the cost of health care, maybe a large part, is caused by "explosive" increases in malpractice claims; doctors often perform redundant, exhaustive, and expensive tests to protect themselves from

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† B.A., 1971, University of Washington; J.D., 1975, University of Washington School of Law; M.A., 1977, Western Washington University. Associate Professor, Dept. of Accounting (Business Law), College of Business; Western Washington University, Bellingham, WA.


2. U.S. DEP'T OF HEALTH AND HUMAN SERVS., NATIONAL CTR. FOR HEALTH STATISTICS, PUBLIC HEALTH SERV. 425 (1991). Personal health insurance costs increased at an annual rate of 20.7% for the period 1980-85, and 11.1% for 1985-88. Id. at 430. The cost of health insurance for a typical employee and his or her dependents in Los Angeles was found to be $7,577 per year, compared to $3,197 per year in Glen Falls, New York, according to a survey undertaken by actuarial consultants Milliman & Roberson, Inc. Gene Koretz, Where Employers Can Find Sanctuary, Bus. Wk., December 16, 1991 at 20. The survey was based on typical group health insurance packages. Id. The total amount of Gross National Product spent on health care in the United States is estimated at $671 billion, or $2,660 per person (J. Ratner, The High Cost of Health, 13 G.A.O. 3).
potential liability. The perceived increase in malpractice claims has generated calls for better mechanisms to identify and weed out bad doctors. If successful, this would reduce malpractice and the necessity for defensive testing and procedures, thereby lowering malpractice insurance rates and ultimately reducing medical costs.

The mechanisms currently used to police the medical profession are the threat of malpractice claims, the regulating activities of state licensing boards, and peer review. One observer has asserted that neither the threat of malpractice claims nor state oversight are sufficient deterrents. Peer review usually involves a group of local doctors, and sometimes staff members, conducting a hearing to determine whether the subject physician has provided competent service. It does, however, have inherent weaknesses. Undoubtedly, many doctors are reluctant to criticize members of their own profession. As one commentator has observed, "physicians who serve on peer review boards make neither money nor friends." One thing reviewing physicians can make, however, is a tempting target for litigation by physicians subject to such review. Doctors facing disciplinary action may bring claims for various torts including defamation, denial of due process, and tortious interference with business relations. Even more potentially damaging are claims that peer reviewers are engaged in a conspiracy to restrain trade in violation of antitrust laws.

The antitrust claim which may be asserted is that the peer review boards are engaged in a conspiracy to drive the physician under review out of business in order to reduce competition. These "group boycott" claims are serious because the physician-defendants are

3. Adler, supra note 1, at 692-96. Robert Adler argues that the state boards are seriously underfunded, that many members of such bars are uncomfortable judging their peers, and the boards "rarely have good sources of information regarding lapses in physicians' services." Id. at 693-94. The threat of malpractice claims is an insufficient deterrent "because insurance, rather than physicians, usually pays claims, and because insurance premiums are typically based on type of practice rather than on any specific physician's litigation record." Id. at 695 n.3. Additionally, the forum courts that adjudicate such malpractice claims "have no direct authority to suspend or remove a physician from practice." Id.

4. Id. at 697.

5. See, e.g., Decker v. IHC Hosps., Inc., 982 F.2d 433, 434 (10th Cir. 1992) (involving suit by plaintiff doctor against peer review panel members and the hospital for "breach of various contractual and common law tort duties; violations of the Sherman Act, RICO, and the federal extortion statute; violations of similar Utah statutes; and conspiracy to deprive Dr. Decker of his civil rights"); Austin v. McNamara, 979 F.2d 728, 732 (9th Cir. 1992) (involving suit by plaintiff for "antitrust violations ... civil rights violations ... and pendent state law claims of conspiracy and intentional interference with prospective economic advantage").
subject to treble damages under antitrust laws, and because such damages are not covered by insurance. In response to the chilling effect such claims have on vigorous peer review, Congress adopted the Health Care Quality Improvement Act of 1986 to provide some degree of antitrust immunity by restricting the circumstances under which peer reviewers face the threat of antitrust liability.

This Article provides background on group boycott law and examines some antitrust implications of the physician peer review process in view of recent trends to change traditional group boycott analysis. Also considered are the impact of the Health Care Quality Improvement Act on peer review boycott cases and recent Supreme Court analysis of the Act. Finally, the Article discusses possible defenses to claims of antitrust violations brought against members of medical peer review committees.

II. PROFESSIONAL GROUP BOYCOTT CASES: THE EROSION OF TRADITIONAL PER SE ANALYSIS

A. Traditional Analysis

Until recently, the antitrust analysis used by the Supreme Court held that horizontal boycotts were illegal per se. A horizontal boycott consists of a concerted refusal to deal among competitors at the same level of market structure as the target of the boycott. Early Supreme Court cases went so far as to suggest that every restraint of trade was condemned by Congress with the passage of the Sherman Antitrust Act ("the Sherman Act"). No proof that competitive harm

7. Adler, supra note 1, at 699 n.82. The American Medical Association is noted as arguing that those alarmed at the Patrick v. Burget award were concerned that ""doctors who seek to discipline other doctors they consider incompetent should not be put at risk of huge damage awards for which insurance is not available, whenever a jury can be convinced their motives were not pure.""
11. See, e.g., United States v. Trans-Missouri Freight Ass'n, 166 U.S. 290, 312-13 (1897) (stating that the Sherman Act provides that "'every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states or with foreign nations'" is declared to be illegal).
resulted was needed in per se cases.\textsuperscript{12} Two well-known cases serve as examples.

In \textit{Klors, Inc. v. Broadway-Hall Stores, Inc.},\textsuperscript{13} the plaintiff owned a retail appliance store. He charged that the defendants (a competing appliance retailer, its manufacturers, and their distributors) had conspired not to sell appliances to him or to sell only on discriminatory and unfair terms.\textsuperscript{14} The defendants did not dispute the allegations, but "showed that there were hundreds of other household appliance retailers, some within a few blocks of Klors who sold many competing brands, including those the defendants refused to sell to Klors."\textsuperscript{15} The district court and the court of appeals then found that, notwithstanding the apparent conspiracy, there was still vigorous competition in the appliance business, no public harm, and therefore no Sherman Act violation.\textsuperscript{16} The Supreme Court reversed. The Court quoted from \textit{Standard Oil Co. v. United States},\textsuperscript{17} construing the Sherman Act to prohibit and denounce all "contracts or acts which ... had a monopolistic tendency,"\textsuperscript{18} and said this kind of group boycott had "long been held to be in the forbidden category"\textsuperscript{19} that could not be saved from illegality by showing that it regulated prices, or brought about no deterioration in quality. Such agreements "cripple[d] the freedom of traders and thereby restrain[ed] their ability to sell in accordance with their own judgment."\textsuperscript{20} Demonstration of an effect on prices is not essential to a Sherman Act violation.\textsuperscript{21}

The second familiar example is \textit{United States v. General Motors Corp.},\textsuperscript{22} which involved a more egregious restraint of trade. A number

\textsuperscript{12} Id. See also \textit{United States v. General Motors Corp.}, 384 U.S. 127, 146-47 (1966) (finding restraint of trade in violation of Sherman Act where General Motors collaborated with dealers and associations to eliminate competitors by terminating dealings between them and a minority of Chevrolet dealers and to deprive franchised dealers of the choice of dealing through discounters).

\textsuperscript{13} 359 U.S. 207 (1959).

\textsuperscript{14} Id. at 207-09.

\textsuperscript{15} Id. at 210.

\textsuperscript{16} Id.

\textsuperscript{17} 221 U.S. 1 (1911).

\textsuperscript{18} \textit{Klors, Inc. v. Broadway-Hall Stores, Inc.}, 359 U.S. 207, 211 (1959) (quoting \textit{Standard Oil Co. v. United States}, 221 U.S. 1, 57 (1911)).

\textsuperscript{19} Id. at 212.

\textsuperscript{20} Id. at 212 (quoting Kiefer-Stewart Co. v. Seagram and Sons, 340 U.S. 211 (1951)).

\textsuperscript{21} "This is not a case of a single trader refusing to deal with another, nor even of a manufacturer and a dealer agreeing to an exclusive distributorship. Alleged in this complaint is a wide combination consisting of manufacturers, distributors and a retailer. . . . It interferes with the natural flow of commerce." Id. at 212-13.

\textsuperscript{22} 384 U.S. 127 (1966).
of Los Angeles area General Motors (GM) dealers complained to the car manufacturer about "discount house" sales operations that were run directly or indirectly by franchised dealers.23 Such "discount houses" were, according to the complaining dealers, in breach of the "location clause" of the Dealer Selling Agreement, and the sale by discounters left the non-discounters with the burden of performing free new car warranty work (for which they were not compensated by GM) and time consuming "pre-conditioning" which was required by both GM and the market.24 GM obtained from each dealer in the area a promise not to do business with the discounters, and three dealer organizations undertook to police the agreement.25 They hired a professional investigator who was instructed to try to purchase new Chevrolets from the proscribed outlets, to tape record the transactions and to gather evidence to lay "at the doorstep of Chevrolet."26 The wayward dealers were forced to repurchase the cars and to promise to end their discount operations.27 A criminal trial against the defendants resulted in a not guilty verdict.28 Subsequently the civil trial court found for the defendants, but the Supreme Court reversed. Justice Fortas said:

> We have here a classic conspiracy in restraint of trade: joint, collaborative action by dealers, appellee associations, and General Motors to eliminate a class of competitors by terminating business dealings between them and a minority of Chevrolet dealers and to deprive franchised dealers of their freedom to contract through discounters if they so choose.29

The usual apologies for this kind of joint activity, which preserves the collaborators' profit margins or their distribution system, were sharply dismissed as wholly unacceptable. This kind of activity, the Court said, is per se illegal and falls into that category of agreements which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use. . . . The principle of these cases is that where businessmen concert their actions in order to deprive

23. Id. at 129-35.
24. Id. at 133.
25. Id. at 136.
26. Id. at 137.
27. Id. at 138.
28. Id.
29. Id. at 140.
others of access to merchandise which the latter wish to sell to the public, we need not inquire into the economic motivation underlying their conduct.\textsuperscript{30}

\textbf{B. The Erosion of Per se Analysis: Commodities}

The Court’s vigorous denunciation of concerted horizontal boycotts as being illegal per se has changed; the category of restraints to be considered using per se analysis is decreasing. With respect to commodity commerce, \textit{Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.}\textsuperscript{31} is a notable case. Northwest Wholesale Stationers was a purchasing co-operative made up of about 100 office supply retailers in the Pacific Northwest, acting as the primary wholesaler for the retailers.\textsuperscript{32} Although non-members could purchase wholesale supplies from Northwest, members received an end-of-the year percentage rebate;\textsuperscript{33} members, therefore, had a significant price advantage. In 1978 the membership of Northwest voted to expel Pacific Stationery.\textsuperscript{34} Pacific had apparently violated one or more of the “reasonable rules [co-ops] must establish in order to function effectively.”\textsuperscript{35} Pacific sued, contending that its expulsion from the co-operative without procedural safeguards was a group boycott and therefore a per se violation of section 1 of the Sherman Act.\textsuperscript{36} Finding no anticompetitive effects on the basis of the record as presented, the district court granted summary judgment for the defendants.\textsuperscript{37} The Court of Appeals for the Ninth Circuit reversed, finding “that the uncontroverted facts of this case support a finding of per se liability.”\textsuperscript{38}

The Supreme Court overturned the decision of the Ninth Circuit and held that the absence of procedural safeguards had nothing to do with antitrust violations. If the acts of the co-op amounted to a per se Sherman Act violation, “no amount of procedural protection would [have] save[d] it.”\textsuperscript{39} While it is clear that group boycotts were per se illegal,\textsuperscript{40} it is less clear what constitutes a group boycott. Usually the boycott involves a conspiracy to deny something a

\begin{footnotesize}
\begin{enumerate}
\item[30.] Id. at 146.
\item[31.] 472 U.S. 284 (1985).
\item[32.] Id. at 286.
\item[33.] Id.
\item[34.] Id. at 287.
\item[35.] Id. at 296.
\item[36.] Id. at 288.
\item[37.] Id.
\item[38.] 472 U.S. 274, 288 (quoting Pacific Stationary & Printing Co. v. Northwest Wholesale Stationers, Inc., 715 F.2d 1393 (9th Cir. 1983)).
\item[39.] 472 U.S. at 293.
\item[40.] See supra note 11.
\end{enumerate}
\end{footnotesize}
competitor needs to operate, such as denial of access to market information for a stockbrokerage, denial of required certification of a product for a stove-manufacturer, denial of sources of news to a news service, or denial of wholesale supplies to a retailer. In each of these types of cases, the likely anticompetitive animus may be presumed; the anticompetitive impact is great and the likely pro-competitive impact small. But expulsion from a wholesale co-operative does not necessarily imply anticompetitive animus; and unless the co-operative possesses market power or exclusive access to an element essential to effective competition, the conclusion that expulsion is virtually always likely to have an anticompetitive effect is not warranted. As stated by the Court:

A plaintiff seeking application of the per se rule must present a threshold case that the challenged activity falls into a category likely to have predominately anti-competitive impacts. The mere allegation of a concerted refusal to deal does not suffice because not all concerted refusals to deal are predominately anticompetitive.

C. The Erosion of Per se Analysis: Services

The “typical” antitrust violation involves commodities. The Clayton Act, for example, is specifically limited to “commodities in interstate commerce.” However, one of the defenses raised by the Bar Association when its minimum price list for attorneys’ services was challenged as violative of the Sherman Act was that “Congress never intended to include the learned professions within the terms ‘trade or commerce’ in section 1 of the Sherman Act, and therefore the sale of professional services is exempt from the Act.” The court of appeals had noted that “there has long been judicial recognition of a limited exclusion of ‘learned professions’ from the scope of antitrust laws” because such professions are state regulated. The Supreme Court, however, found no legislative support for the necessary exclusion of learned professions from the Sherman Act. The Court did, however, strongly suggest that antitrust violations of the Sherman Act, which might

42. Id. at 298.
44. 421 U.S. 773 (1975).
45. Id. at 786.
46. Id. at 779-80.
47. Id. at 786.
properly be viewed as a per se violation in a context other than a service industry, should be analyzed under the Rule of Reason:

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

Not only, then, have the kinds of restraints considered per se violative been decreasing in the context of commodities transactions, but in the very first case questioning the Sherman Act’s applicability in the area of professional services the Court narrowed the scope of the law by suggesting that per se analysis was inappropriate.

D. *Per Se Analysis in the Health Care Field*

In 1980 the Court of Appeals for the Fourth Circuit held that a ‘‘boycott’ characterization . . . avails us little in determining whether an agreement . . . is per se illegal. Because of the special considerations involved in the delivery of health services,’’ the court determined that a Rule of Reason analysis is appropriate. The Supreme Court specifically confirmed this holding in *FTC v. Indiana Federation of Dentists.* A group of Indiana dentists formed what they styled a ‘‘union’’ in order to promulgate a ‘‘work rule’’ that required members to withhold X-rays requested by dental insurers for use in evaluating claims. The Federal Trade Commission (FTC) issued a complaint against the Federation. The FTC claimed the dentists’ actions constituted a violation of section 5 of the Federal

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51. *Id.*
53. Insurers examined the X-rays to determine whether the dentists’ diagnostic and treatment decisions were the most cost-effective, and the practice was "viewed by some dentists as a threat to their professional independence and economic well-being." *Id.* at 449.
Trade Commission Act because they amounted to a conspiracy in restraint of trade and were therefore illegal as judged under the Supreme Court's interpretation of section 1 of the Sherman Act. The Court found that the conspiracy existed and that it had resulted in a restraint of trade. A restraint of trade, the Court observed, is only illegal, however, if it is per se unreasonable or "because it violates what has come to be known as the 'Rule of Reason.'" The Federation's policy could fairly be labelled a "group boycott," the Court observed, but that did not render it per se illegal:

Although this Court has in the past stated that group boycotts are unlawful per se, we decline to resolve this case by forcing the Federation's policy into the "boycott" pigeonhole and invoking the per se rule. . . . [T]he category of restraints classed as group boycotts is not to be expanded indiscriminately, and the per se approach has generally been limited to cases in which firms with market power boycott suppliers or customers in order to discourage them from doing business with a competitor—a situation obviously not present here. . . . [I]n general, [we have been reluctant] to extend per se analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious.

The maintenance of high quality medical services is traditionally policed by peer review groups. Physicians whose practices are substandard may be put on probation; in egregious cases, physician

56. Id. at 458-59 (citations omitted). Finding a Rule of Reason violation with these facts was "not a matter of any great difficulty," even without elaborate market-definition and market-power analysis (which the IFD insisted was needed), since there was no dispute that insurers in the locations "served" by the IFD were actually unable to obtain compliance with their requests for X-rays and, thus, could not possibly police costs: there were sustained adverse effects on competition in the areas where the IFD dentists predominated. Id. at 495. The IFD also claimed there could be no Rule of Reason violation without a finding that the result of the "conspiracy" was an increase in prices. Id. at 461-62. The Court disagreed: the withholding of information desired by consumers for determining whether a purchase is cost-justified was obviously likely to disrupt the market's price-setting mechanism, and no proof of price impact was needed. Id. The IFD's final assertion, that non-competitive "quality of care" justifications for the boycott of insurers should be considered was dismissed too. Id. at 462-64. The Court said this amounted to the argument that "an unrestrained market in which consumers are given access to the information they believe will be relevant to their choices will lead them to make unwise and even dangerous choices," which is "nothing less than a frontal assault on the basic policy of the Sherman Act." Id. at 463.
privileges are revoked upon recommendation by review committees.\textsuperscript{57} The reviewers in such a situation are, however, in a tenuous position. They usually compete with the doctor whose medical standards are in question. Not infrequently the doctor complains that the motivation to revoke his or her privileges is not the maintenance of high standards, but his or her removal as a competitor.\textsuperscript{58} The complaining physician then becomes the plaintiff in a federal antitrust case claiming a group boycott in violation of antitrust laws.

Medical malpractice is a more complex problem than cut-rate automobile selling, so group boycotts by peer review boards have never been subject to the somewhat simplistic per se analysis; peer-policing of malpracticioners is not automatically illegal. For example, in \textit{Goss v. Memorial Hospital System},\textsuperscript{59} a Rule of Reason analysis was applied where the plaintiff physician complained of being excluded from practice at hospitals by a denial of staff privileges. The Fifth Circuit confirmed the district court's finding that mere expulsion does not imply anticompetitive animus. The court agreed that the evidence failed to show that the hospitals possessed "market power or unique access to a business element necessary for effective competition"\textsuperscript{60} so that their boycotting of Dr. Goss denied him competitive opportunities.\textsuperscript{61}

If the medical peer review process escapes per se analysis, relegation to Rule of Reason proves dangerous for peer reviewer defendants. It is an onerous business to mount a Rule of Reason defense, as it requires a showing that the ostensibly anticompetitive activity had a valid non-anticompetitive purpose (i.e., the actors had good faith).\textsuperscript{62} Even if the defendants are successful, the threat of

\begin{itemize}
\item \textsuperscript{57} Peer review is one step in a long process by which unacceptable medical practices are monitored, checked and reviewed. The peer review committee is typically one of four committees involved. The final decision on hospital privileges is made by the governing board.
\item \textsuperscript{58} See \textit{Manion v. Evans}, 986 F.2d 1036, 1037 (6th Cir. 1993) ("physicians aggrieved by the results of peer review increasingly appeared in federal court claiming that the actions of their peers were anti-competitive and violate federal antitrust laws.").
\item \textsuperscript{59} 789 F.2d 353 (5th Cir. 1986).
\item \textit{Id.} at 355 (quoting \textit{Northwest Wholesale Stationers, Inc. v. Pacific Stationary & Printing Co.}, 472 U.S. 284, 291 (1985)).
\item \textsuperscript{60} \textit{Id.} at 355. The hospitals each had less than 6% of the total beds in the county. \textit{Id.}
\item \textsuperscript{61} \textit{Id.} at 355.
\item \textsuperscript{62} \textit{See, e.g., Theater Enters. v. Paramount Film Distribution Corp.}, 346 U.S. 537 (1954). The plaintiff, a suburban movie theater owner, sued Paramount alleging that its policy of restricting first-run motion pictures to downtown theaters was a conspiracy in restraint of trade. \textit{Id.} at 538. The distributors successfully defended themselves by adducing evidence of the economies of movie distribution: the necessity of an adequate population base (not found in suburban areas), available public transportation, and greater opportunities for advertising.
costly and traumatic litigation chills vigorous peer review, and therefore increases the likelihood of poorly policed medical practice, and increases malpractice insurance rates.

III. THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986 (HCQIA)

A. The Purpose and Background of the HCQIA

Since the effective date of the HCQIA in October 1989, participants in physician peer review processes who are acting in good faith have a better defense than the Rule of Reason. Congress adopted the HCQIA to encourage effective physician peer review by discouraging the threat of private antitrust action against critical reviewers. The Act provides a limited exception from antitrust liability to the peer review group, any person acting as a member or staff to the body, any person acting under contract with the body, and any person participating with the body. No immunity is provided, however, from actions by the Federal Trade Commission, the United States Department of Justice, or state or federal attorneys general. Immunity from malpractice actions is likewise not available. The Act also sets up a national clearinghouse for information regarding physicians.

Id. at 540. The Supreme Court affirmed a finding that refusal to grant first-run licenses to suburban theaters was — considering the “adequate explanation” — within the Rule of Reason. Id. at 540-42. Demonstrating such “adequate explanation” is of course time consuming and expensive. As to the evidence necessary to show “good faith” in the medical peer review arena, see section III.D., infra.


The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior. Under this bill, hospitals and physicians that conduct peer review will be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions meet the due process and other standards established in the bill. In addition, hospitals and physicians that discipline doctors will be required to report these disciplinary actions to the state medical boards. In turn, the state medical boards will be required to forward this information to the Secretary of the Department of Health and Human Services . . .

Id. at 6384.


65. Id. § 11111(a)(1).

66. Id. § 1133(c)(1).

67. Id. § 1134(b).
The United States House of Representatives Energy and Commerce Committee was primarily responsible for drafting the Act. The Committee reported as follows:

This bill is needed to deal with one important aspect of the medical malpractice problem in this country—inept and unprofessional physicians. It does not address the malpractice insurance crisis, which has extremely complex and controversial origins and cannot be solved through peer review. The bill's focus is on those instances in which physicians injure patients through incompetent or unprofessional service, are identified as incompetent or unprofessional by their medical colleagues, but are dealt with in a way that allows them to continue to injure patients.

Unfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so. Even when such bodies do act against bad physicians, these physicians find it all too easy to move to different hospitals or states and continue their practices in these new locations.68

The Committee specifically referred to the damaging effect on effective peer review of both the threat of antitrust litigation and high malpractice insurance rates:

The reporting system [proposed in this legislation], however, creates a major problem. Many people in the medical field told the Subcommittee on Health and the Environment that the reporting system would inevitably result in an enormous increase in litigation. The reason: faced with the certainty that they can no longer hide their past records, physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them. Based on recent experience, the Committee believes that many of these physicians will file antitrust lawsuits.

Even though defendants may often win these lawsuits, that may not be sufficient to guarantee enthusiastic, or even minimally adequate, peer review. . . . Doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review. The result would be to continue the possibility for abuse by bad doctors.69

69. Id. at 6385.
B. Application of the HCQIA

The Health Care Quality Improvement Act\textsuperscript{70} was interpreted for the first time in \textit{Austin v. McNamara}.\textsuperscript{71} At age 65, Dr. George Austin retired as Chairman of the Loma Linda University School of Medicine.\textsuperscript{72} He had spent his entire medical career as an instructor and professor of neurosurgery.\textsuperscript{73} Subsequently, he took up private practice at the Cottage Hospital in Santa Barbara, California.\textsuperscript{74} Within five years the Cottage Hospital Medical Executive Committee was concerned enough about Dr. Austin's performance to establish an ad hoc committee "to investigate concerns voiced by the staff that Plaintiff Dr. Austin was providing substandard care to his patients at the hospital."\textsuperscript{75} Dr. Austin was suspended from practicing at Cottage Hospital for seven months, after which he was reinstated subject to various conditions.\textsuperscript{76} Dr. Austin sued the hospital and five physicians, claiming they conspired to restrain him from competing against them.\textsuperscript{77}

The defendants moved for a summary judgment, claiming that the HCQIA immunized them from antitrust liability.\textsuperscript{78} The district court agreed. To invoke the Act's protection, a defendant must show three things: (1) that the professional review actions complied with standards set forth in 42 U.S.C. section 11112; (2) that the results of the professional review actions were properly reported to state authorities in compliance with the Act; and (3) that the actions occurred after November 14, 1986, the effective date of the Act.\textsuperscript{79}

For a professional review action to comply with the Act, section 11112(a) provides that it must be taken:

(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances,
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain

\textsuperscript{71} 731 F. Supp. 934 (C.D. Cal. 1990).
\textsuperscript{72} Id. at 935.
\textsuperscript{73} Id.
\textsuperscript{74} Id.
\textsuperscript{75} Id. at 936.
\textsuperscript{76} Id. at 937-38.
\textsuperscript{77} Id. at 935.
\textsuperscript{78} Id. at 938.
\textsuperscript{79} Id. at 939.
facts and after meeting the requirement of paragraph (3).80

There was no serious question in the case that the defendants satisfied every requirement. Summary judgment was therefore granted in their favor.

C. Limitations on Usefulness of the HCQIA

The HCQIA is no panacea for the problems of medical professional peer review. One commentator observed in an early review of the Act that it might have only limited utility:

The Act seems likely to affect only one aspect of malpractice problems—the severe or repeat offender, who is meant to be curtailed in her career prospects. All hospitals or other entities hiring a physician are required to check the data bank for information about that physician; what they do with the information is up to them. This duty means that, should a problem develop, employers who do not check may face a lawsuit at some future date for negligent failure to monitor physicians. . . . Otherwise, the Act contains no enforcement mechanisms. The Act may very indirectly affect quality more broadly through its encouragement of hospital peer review; it gives limited immunity from liability for participation in review activities.81

Indeed, prospects that the Act would encourage hospital peer review were dimmed by the first United States Supreme Court case to consider — albeit indirectly — the Act. The problem is that the Act gives limited immunity only; bad faith peer review is not protected. If the mere allegation that there has been bad faith review against a single doctor is sufficient to trigger federal antitrust jurisdiction, the prospects of vigorous peer reviews are chilled, for reviewers know they may face a daunting and expensive civil antitrust action.

Whether federal jurisdiction under the Sherman Act reaches the typical peer review case was considered by the Supreme Court in Summit Health Ltd. v. Pinhas.82 In that case, the Court held that

81. Bovbjerg, supra note 1, at 538. The United States Court of Appeals for the Sixth Circuit confirmed that the HCQIA provides only limited immunity when it ruled that the Act does not provide among its protections the right not to stand trial: “all the statutory language accomplishes with certainty is to shield peer reviewers from liability for payment of damages. . . . [It] does not confer a right not to stand trial . . . .” Manion v. Evans, 986 F.2d 1036, 1042 (6th Cir. 1993).
the Sherman Act did in fact apply. The Pinhas case involved Dr. Simon J. Pinhas, an eye surgeon, who became embroiled with the Midway Hospital Medical Center in a dispute about staffing levels. He was able to perform eye surgery more cheaply than his peers because he did not need an assistant and Medicare had stopped funding for the second doctor. To make Dr. Pinhas’s services as expensive as the other doctors’ (who used the second surgeon), the hospital presented him with what he called “a sham contract” to sign by which he would receive $36,000 (later orally increased to $60,000) a year for services he would not be asked to perform. Dr. Pinhas refused to execute the contract. Ultimately Dr. Pinhas’s staff privileges were suspended, and the suspension was affirmed by the Midway Executive Committee. He then sought and obtained a hearing by the Midway Judicial Review Committee, which upheld only one of the seven charges against him and recommended reinstatement subject to several special conditions. This decision was then appealed to the Governing Board of the Hospital, which affirmed the decision of the Judicial Review Committee, but imposed more stringent conditions upon Pinhas’s probationary period. Notice of Pinhas’s termination was disseminated to hospitals in California and throughout the entire country pursuant to 42 U.S.C. sections 11133 and 11135. Pinhas claimed that, as a result of this action, the hospital had effectively boycotted his practice and precluded him from continued participation in the marketplace; he thereafter brought a Sherman Act action against the hospital and the doctors who served on the review panel. The district court granted the defendant’s motion to dismiss on the pleadings and Dr. Pinhas appealed to the Ninth Circuit.

When the case reached the court of appeals, the hospital claimed the federal court lacked jurisdiction to hear the Sherman Act claim because there was no adequate showing of “a required nexus with interstate commerce.” The court noted that the test set out by the Supreme Court was whether “as a matter of practical economics” the Hospital’s activities have a ‘not insubstantial effect on the inter-

83. Id. at 1845.
84. Id.
85. Id.
86. Id.
87. Id.
88. Id. at 1846 n.5.
89. Id. at 1845.
90. Id.
91. Id. at 1843.
92. Id.
state commerce involved.'" 94 Construing this language, the court said:

Pinhas need not . . . make [a] more particularized showing of the effect on interstate commerce caused by the alleged conspiracy to keep him from working. He need only prove that peer-review proceedings have an effect on interstate commerce, a fact that can hardly be disputed. The proceeding affected the entire staff at Midway and thus affect the hospital’s interstate commerce. Appellees’ contention that Pinhas failed to allege a nexus with interstate commerce because the absence of Pinhas’s services will not drastically affect the interstate commerce of Midway therefore misses the mark and must be rejected. 95

From the adverse Ninth Circuit decision on the antitrust issue, the hospital sought and was granted certiorari to the Supreme Court. The Supreme Court examined whether Dr. Pinhas’s complaint satisfied the jurisdictional requirements of the Sherman Act. 96 Because the case came before the Court following the trial court’s granting a motion to dismiss on the pleadings, the truth of the allegations was assumed. Specifically, the Court assumed that Pinhas’s medical staff privileges were revoked after an unfair peer review process and that the hospital intended—under the HCQIA—to disseminate the peer review board’s conclusions about his unfitness so as to ‘‘preclude him from continued competition in the market place, not only at the defendant Midway Hospital [but also] . . . in California, if not the United States.’’ 97

In affirming the court of appeals, the Court noted the Sherman Act requires that complaints brought under its aegis allege that interstate commerce is affected by the conspiracy claimed. 98 The hospital argued that the boycott of a single surgeon has no significant effect on interstate commerce, the complaint alleged no lack of an adequate supply of other surgeons to perform the services, and there was then ‘‘no factual nexus between the restraint on this one sur-

94. Id. at 1031-32.
95. Id. at 1034. Dr. Pinhas had also sought a declaratory judgment that the Health Care Quality Improvement Act of 1986 (42 U.S.C. §§ 11101-11152) was unconstitutional under the Fourteenth Amendment. Id. at 1025. The district court had dismissed this claim, and the court of appeals affirmed, agreeing that the appellees ‘‘are not the appropriate parties to defend a constitutional challenge to the relevant . . . federal statutes,’’ because ‘‘the appellees had no interest in the enforcement of . . . the federal regulation.’’ Id. at 1034-35.
97. Id. at 1846 (alterations in original) (citations omitted).
98. Id.
The Court, however, held that the alleged restraint of trade, accomplished by misuse of a congressionally regulated peer review process, resulted in foreclosing Pinhas's access to the market for ophthalmological services provided by hospitals in the Los Angeles area and therefore "had a sufficient nexus with interstate commerce to support federal jurisdiction." The dissent, written by Justice Scalia and joined by Justices O'Connor, Kennedy and Souter, lamented the decision because it made federal jurisdiction turn not on the effect on commerce of the restraint, nor to the effect on commerce of the defendants' "infected activities," but "rather, it seems, to the effect on commerce of the activity from which the plaintiff has been excluded." The dissenters felt that the effect of this conspiracy, if successful, would not significantly impact interstate commerce. The proposed agreement, for example, would only have affected Dr. Pinhas's practice at Midway, and could have no effect on the larger Los Angeles market, much less interstate commerce. Klors also involved only one small player in a much larger field, but in Klors the conspiracy was broader than an "in-house" dispute; it involved manufacturers and distributors. Moreover, as Justice Scalia observed, the Klors Court specifically noted that the conspiracy "interfered with the free flow of commerce," whereas in this case, no such interference was ever alleged. Justice Scalia summed up his concern about the impact of the decision as follows:

Federal courts are an attractive forum, and the treble damages of the Clayton Act an attractive remedy. We have today made them available for routine business torts, needlessly destroying a sensible statutory allocation of federal-state responsibility and contributing to the trivialization of the federal courts.

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99. Id. at 1847.
100. Id. at 1848.
101. The term is from McLain v. Real Estate Bd. of New Orleans, 444 U.S. 232 (1980). Justice Scalia observed that the term had caused great disagreement among the courts. Pinhas, 111 S. Ct. at 1850. It is difficult, he wrote, to determine "which 'activities of the defendants' are 'infected'? Are they all the activities of the hospital? Only the activities of the eye surgery department? The entire practice of eye surgeons who use the hospital? Or, as the Ninth Circuit apparently found in this case, the peer review process itself?" Id. (citations omitted).
102. Id.
103. Id. at 1850-51.
105. Pinhas, 111 S. Ct. at 1851. Justice Scalia wrote: "The complaint does not begin to suggest that the conspiracy at Midway could have even the most trivial effect on interstate commerce." Id. at 1853.
106. Id. at 1854.
The HCQIA may be "two steps forward and one step back," but medical professionals confronting antitrust complaints have two other ditches to defend: increased use of summary judgment in their favor and the increased use of the absolute defense of state-action immunity. The former holds some promise; the latter is still no-man's land. Before considering these defenses, however, it is appropriate to examine a more immediately obvious defense. The HCQIA is not useless; it does afford some protection against antitrust suits provided, among other things, the professional review action was taken in the "reasonable belief that [it] was in the furtherance of quality health care." To act on a belief that they are furthering quality health care, however, the actors must have some standard against which to measure the caregiving expected by practitioners and the care actually delivered.

D. Showing "Good Faith:" The HCQIA's Defense

The claim made against the reviewers is typically that the board is unjustly pursuing a competent physician. The fact is there are bad doctors. Not all malpractice claims are frivolous; good practitioners and good hospitals are concerned about quality, and with good reason.

Of course, malpractice is not typical of what transpires in well-run hospitals. But no one doubts there are bad doctors, just as there are bad lawyers and bad roofers. A bad roofer's work may be evident because the finished job is unsightly, or because the roof leaks. A bad doctor's work is evident if his or her patients have a higher infection rate than others, if he or she uses more blood than the norm, if the patient makes an inadequate recovery from a procedure which does not usually result in such complications, or if the patient unexpectedly dies. But using more blood than usual, without more, is not proof of malpractice, nor is the death of the patient. What is needed are standards against which medical care can be measured to determine if substandard care has been provided.

1. Standards Against Which Hospital Care-Giving is Measured

a. The Joint Commission's Standards

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the industry's chief regulator. The Accreditation

108. See, e.g., WALT BOGDANICH, THE GREAT WHITE LIE: HOW AMERICA'S HOSPITALS BETRAY OUR TRUST AND ENDANGER OUR LIVES (1991). The book, carefully documented if somewhat sensationalist, draws on more than 15 years of reporting on the hospital industry to argue that incidence of serious malpractice by doctors, nurses, and staff are "not mere freak accidents or anomalies, [but] the direct result of systemic health care problems of enormous proportions." Id. at 10.
Manual for hospitals contains lists or schedules of standards and a
"1 to 5" scale for determining the degree of compliance with the
standards. Hospitals are subject to periodic inspection by accredi-
tation examiners, and must show adequate compliance with the
standards.

The problem with the JCAHO standards is that they are not
specific. For example, a typical standard is that "activities are
conducted to prevent and control infections in patients and person-
nel." Another standard states "adequate infection control devices
and supplies to be available in patient care areas." Exactly what
the procedures are, or how many units of contaminate bacteria may
be tolerated in a test swab, is not set out. A more specific type of
standard would be "Not more than 15 cc of blood should be used
during a routine appendectomy," but this type of standard is not
provided. Although the national boards for certifying specialists are
having increasing influence on the locally applied "normal" perfor-
formance limits, most hospitals develop their own standards.

Even specific standards, however, are not a perfect measure of
good care-giving. Suppose, for example, that a particular doctor has
an infection rate three times that of other doctors. Several factors
could be the cause: operative technique, hardware, use of antibiotics,
or perhaps post-operative treatment. Isolating the cause is not easy;
usually it is not one thing, but a systemic problem. A review of
patient care is of course necessary.

b. Hospital Quality Assurance Programs

Hospitals that have good quality assurance programs promulgate
standards of care usually in a document such as a Hospital Quality
Management Plan. The standards generally provide for on-going
reviews such as monitoring medical staff functions (i.e., review of
surgical cases, blood usage, medical records, drug usage), provisional
status review, and special (focused) reviews. A showing that peer
review procedures were conducted in good faith, as is required by
the HCQIA, is based on a demonstration that there are reasonably

109. 2 JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGS., ACCREDITATION MANUAL FOR HOSPS. (1994) [hereinafter JCAHCO MANUAL].
110. Interview with Dr. John S. Moore, Ph.D, President of the St. Joseph Hospital Board of Trustees, in Bellingham, WA (May 7, 1992); interview with Catherine Anderson, R.N., Director, Quality Management Services, St. Joseph Hospital, in Bellingham, WA (May 24, 1992 and September 8, 1994).
111. JCAHCO MANUAL, supra note 109, § IC 1.3.2, at 122.
112. Id. § IC 1.3.2.1.1, at 122.
113. Interview with Catherine Anderson, supra note 110.
114. JCAHCO MANUAL, supra note 109, § LD .4, at 34.
established standards and an on-going program to compare practice to the standards.

c. Computerized Statistical Quality Control

In progressive hospitals the results of on-going reviews are fed into computer files as data modules, numerically identified by the practitioner. The modules might include information on each physician’s blood usage for a particular surgical operation, infection control records, drug usage reviews, and information from the patient files such as procedures, diagnoses, consultants, and special studies. This information may be variously manipulated. For the purposes of quality assurance, it is abstracted and automatically compared to the hospital norms. A doctor’s practices that are outside the norms will be flagged by the program, and a review may commence.

2. Peer Review Procedures

If comparing a practitioner’s performance to the hospital norms raises concerns, peer review is appropriate. This process should follow a set procedure in order to avoid the appearance of any ad hoc activity. The record of on-going reviews should have noted any concerns, typically designated as “minor” (a practice outside the standard of care, with the risk of morbidity but not adverse outcome, or a problem without potential significant adverse effects), “moderate” (a practice resulting in avoidable patient morbidity, or a potential for significant adverse effects), or “major” (clearly outside the standards, that results or could result in significant morbidity or death). If the reviews reveal practices serious enough to warrant more than minor corrective suggestions, further investigation is undertaken. The practitioner is usually provided an opportunity to comment at this stage, and these comments become part of the review file. The procedure should provide for interdepartmental communication, disposition and confidentiality of the peer review records thus created, and of multiple review levels.

3. Use of Statistical Quality Control in the “Good Faith” Defense

The Joint Commission’s standards should be the basis for promulgation of more specific in-hospital quality care criteria. These

115. Interviews with John Moore and Catherine Anderson, supra note 110.
116. Id.
117. Id.
118. Id.
119. Id. See also Bovbjerg, supra note 1.
120. See JCAHCO MANUAL, supra note 109.
locally-developed standards may be statistically compared to the practitioner's delivery, and if the delivery is sub-standard, the record of the statistical quality control system may stand as evidence that peer review actions were taken in good faith. Such standards provide a defense based on well-documented criteria indicating incompetence.

IV. OTHER ANTITRUST DEFENSES: ANTITRUST IMMUNITY, INCREASED USE OF SUMMARY JUDGMENT

A. State Action Immunity: Use of Absolute Defenses

The Parker doctrine asserts that the Sherman Act does not apply to anticompetitive actions of a state. In Parker v. Brown,121 the petitioner was a raisin grower.122 He brought suit against the California Director of Agriculture to enjoin the enforcement of a marketing plan.123 The plan had been adopted under a state agricultural adjustment act and was designed to reduce competition among food producers in the state so as to stabilize prices.124 The Court created the Parker doctrine, consisting of a rigorous two prong test, to determine if the state action exemption would shield anticompetitive acts taken by private parties.125 Specifically, "the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy,'"126 and the anticompetitive act "must be 'actively supervised by the State itself.'"127 In Parker, the Court found no conspiracy because no contract was made by the state agency.128

One might expect that because medical peer review boards are established according to law and supervised by the Board of Medical Examiners129 and the state judicial system they would be within the

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121. 317 U.S. 341 (1943).
122. Id. at 344.
123. Id.
124. Id. at 346.
125. Id. at 350.
127. Id. (citations omitted).
128. Parker, 317 U.S. at 352.
129. See Bovbjerg, supra note 1 and text accompanying notes 84-92 regarding "legislative enactments" aimed at medical quality. For example, the Revised Code of Washington Annotated provides that a "state medical disciplinary board . . . [which] shall be an administrative agency of the state," and it has authority, under § 18.130.050 to investigate claims of medical malpractice, hold hearings, and deny, revoke, or suspend licenses to practice medicine under § 18.130.120. WASH. REv. CODE ANN. § 18.72.040 (West 1989). See also Patrick, 486 U.S. at 101 (noting that the State of Oregon actively supervises the peer review process through the State Health Division, the Board of Medical Examiners, and the judicial system).
Parker exemption. Surprisingly, the Supreme Court has held otherwise in a recent decision. In *Patrick v. Burget*, Dr. Timothy Patrick, petitioner, was an Astoria, Oregon, surgeon who declined an invitation by respondents to join them as a partner in the Astoria Clinic and instead began an independent practice in competition with them. The clinic doctors then effectively blackballed him: they shunned him, refused to refer patients to him, and "showed reluctance to assist petitioner with his own patients." They also refused to provide backup coverage for his patients, and criticized him for having none. Ultimately, at the request of one of the clinic surgeons, the executive committee of the Columbia Memorial Hospital voted to recommend the termination of Patrick's privileges because his patient care was "substandard." Columbia Memorial was the only hospital in Astoria, and a majority of its staff members were employees of the clinic. Patrick sued in federal court alleging a violation of the Sherman Act; the jury found for Patrick and awarded $650,000, which was trebled by operation of the Sherman Act's provision for treble damages. The Court of Appeals for the Ninth Circuit, while admitting that the respondents' treatment of Dr. Patrick was "shabby, unprincipled and unprofessional" nevertheless reversed. It found the respondents' actions within the Parker exemption because the State Health Division, the Board of Medical Examiners, and the state judiciary constituted active state supervision.

The Supreme Court disagreed. It found that the Oregon Health Division's authority only related to procedures and did not encompass ultimate authority over private privilege determinations. The Board of Medical Examiners' principal function was to regulate the licensing of physicians, and it had no power to disapprove private privilege decisions. The Court also found that the state judiciary did not exercise active supervision because all that Oregon case law allowed was a review to determine if due process requirements were met; thus, the judicial supervision fell "far short of satisfying the active supervision requirement." The Court recognized that fear of antitrust litigation might chill peer review activity, but observed that if

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131. *Id.* at 96.
132. *Id.*
133. *Id.*
134. *Id.* at 97.
135. *Id.* at 96.
136. *Id.* at 98.
137. *Patrick v. Burget*, 800 F.2d 1498, 1509 (9th Cir. 1986).
138. *Id.* at 1506.
140. *Id.* at 103.
141. *Id.* at 104.
antitrust laws are indeed not to apply to medical care, the legislature should make that determination, not the judiciary.\textsuperscript{142}

Shortly after \textit{Patrick} was decided, the Eleventh Circuit considered a similar case. In \textit{Bolt v. Halifax Hospital Medical Center} ("HHMC"),\textsuperscript{143} Dr. Bolt was denied privileges by three hospitals in the Daytona Beach, Florida area after he refused to undertake psychiatric counselling following allegations of wrongdoing.\textsuperscript{144} He sued the members of the peer review panels and the hospitals, alleging, \textit{inter alia}, an antitrust violation.\textsuperscript{145} The defendants raised the \textit{Parker} exemption as a defense.\textsuperscript{146} An appeals panel determined that in Florida there is sufficient judicial oversight of private peer review panels to constitute "state action": the courts will review the fairness of the procedures, the validity of the criteria used (compared to state policy), and the sufficiency of the evidence.\textsuperscript{147} The private hospital, the hospital special taxing district and members of their medical staffs involved in the peer review were immune.\textsuperscript{148}

The case was then heard en banc, and the full panel vacated the prior decision because the private party defendants formally withdrew any claim that they were immune from antitrust liability under the state-action doctrine.\textsuperscript{149} Thereafter, the panel reconsidered the case.\textsuperscript{150} At this second hearing, the HHMC withdrew its claim that it was immune as a private party, developing two new state action arguments. The hospital first argued that it was a state agency, or was entitled to the status of such because it was closely supervised by the state.\textsuperscript{151} The court found it was not a state agency.\textsuperscript{152} Moreover, it opined that even if it were a state agency, had it nevertheless engaged in a conspiracy, such would be outside the \textit{Parker} rule.\textsuperscript{153} Furthermore, the court determined that HHMC was not so actively super-

\begin{flushright}
\textsuperscript{142} \textit{Id.} at 105.  \\
\textsuperscript{143} 851 F.2d 1273 (11th Cir. 1988).  \\
\textsuperscript{144} \textit{Id.} at 1276-77.  \\
\textsuperscript{145} \textit{Id.} at 1277.  \\
\textsuperscript{146} \textit{Id.} at 1279 (citing \textit{Parker v. Brown}, 317 U.S. 341 (1943)).  \\
\textsuperscript{147} \textit{Id.} at 1283-84. \textit{Patrick}, however, would apparently require more than that. The Supreme Court said "active supervision mandates that the State exercise ultimate control over the challenged anticompetitive conduct." \textit{Patrick v. Burget}, 486 U.S. 94, 101 (1988). Review of procedure, validity of criteria, and sufficiency of evidence may result in a decision to overrule the peer review panel, but it is not really "ultimate control" over the decision. \textit{Id.}  \\
\textsuperscript{148} \textit{Bolt v. Halifax Hosp. Ctr.}, , 851 F.2d 1273, 1284 (11th Cir. 1988).  \\
\textsuperscript{149} \textit{Bolt v. Halifax Hosp. Medical Ctr.}, , 874 F.2d 755 (11th Cir. 1989) (en banc).  \\
\textsuperscript{150} \textit{Bolt v. Halifax Hosp. Medical Ctr.}, , 891 F.2d 810 (11th Cir. 1990).  \\
\textsuperscript{151} \textit{Id.} at 823.  \\
\textsuperscript{152} \textit{Id.}  \\
\textsuperscript{153} "When a state agency joins in a private anticompetitive agreement not required by the state, the agency loses its protected status under \textit{Parker}." \textit{Id.} at 823 n.23 (citing \textit{Goldfarb v. Virginia State Bar}, 421 U.S. 773, 790-92 (1975)).
\end{flushright}
vised by the state as to qualify for the special status of state sovereign.\textsuperscript{154} The hospital's second argument was that, even if it were not a state agency, it was the equivalent of a municipality and therefore exempt from antitrust laws under the \textit{Town of Hallie} doctrine.\textsuperscript{155} The court did agree that as a special county taxing district the HHMC had some quasi-municipal attributes, and recognized that the legislature's grant of peer review power to the Center contemplated some kind of boycott against doctors who were denied privileges.\textsuperscript{156} The court reasoned, however, that the allegations involved actions ultra vires and went beyond the protection afforded by \textit{Parker} and its progeny.\textsuperscript{157} HHMC, therefore, was not entitled to immunity.

In the \textit{Pinhas} case\textsuperscript{158} the defendant hospital also raised the "state action" defense.\textsuperscript{159} Applying the \textit{Patrick} test, however, the Ninth Circuit found inadequate active state supervision, and concluded, therefore, that acts of the hospital were not immune from challenge under the state action defense.\textsuperscript{160} The issue was not raised on appeal to the Supreme Court.

\subsection*{B. Increased Use of Summary Judgment}

The Supreme Court has enhanced defendants' prospects in group boycott antitrust actions, including medical professional actions, by effectively removing them from per se analysis. The Court eroded defendants' prospects under the Health Care Quality Improvement Act by allowing ready invocation of federal antitrust jurisdiction upon a mere claim of bad faith in the "group boycott" process. Attempts by non-public medical facilities to use the absolute defense

\begin{itemize}
  \item \textsuperscript{154} \textit{Id.} at 824.
  \item \textsuperscript{155} The \textit{Town of Hallie} doctrine provides "that when a municipality engages in anticompetitive conduct pursuant to 'a clearly expressed state policy', the conduct constitutes state action for the purposes of \textit{Parker} even without a showing of active state supervision." \textit{Id.} at 825 (quoting \textit{Town of Hallie v. Eau Claire}, 471 U.S. 34, 40 (1985)).
  \item \textsuperscript{156} \textit{Id.} at 825.
  \item \textsuperscript{157} \textit{Id.} The court found no evidence to support the community-wide conspiracy claim holding that: (1) evidence of parallel action by the hospitals proved nothing; (2) that inter-hospital communication about Dr. Bolt could have been for a legitimate independent business purpose; and (3) that the direct evidence that decision makers at the hospitals agreed among themselves to take concerted action to drive Dr. Bolt out of the Daytona Beach area could be interpreted as being nothing more than evidence that decision makers at each hospital based their decisions partly on matters that occurred at the other two hospitals. \textit{Id.} at 826-27. However, the court then held that the district court had erroneously prohibited Dr. Bolt from submitting other evidence of a community-wide conspiracy, and the case was remanded. \textit{Id.} at 827-28.
  \item \textsuperscript{158} See \textit{supra} text accompanying notes 82-107.
  \item \textsuperscript{159} \textit{Pinhas v. Summit Health Ltd.}, 894 F.2d 1024 (9th Cir. 1989).
  \item \textsuperscript{160} \textit{Id.} at 1029-30.
\end{itemize}
of government immunity have not received favorable judicial treatment.

There is, however, one last area to examine. The Supreme Court has eased the defendant’s burden by changing the criteria by which the plaintiff’s case can be dismissed on summary judgment. In *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*,161 respondents Zenith and other American manufacturers of consumer electronic products brought an action in district court in 1974 alleging that Matsushita and other Japanese firms were “dumping” televisions in the United States (i.e., selling them in the United States for less than the same product was sold for in Japan).162 After several years of discovery, the petitioners moved for summary judgment, upon which the district court directed the parties to file statements listing all the documentary evidence that would be offered if the case were tried.163 Finding that the bulk of the respondents’ evidence would be inadmissible and that what was left did not raise a genuine issue of material fact as to the existence of any conspiracy and that any inference of conspiracy was unreasonable, the district court granted petitioners’ motion.164 The court of appeals then reversed, finding that much of the excluded evidence would be admissible and that there was both direct and circumstantial evidence of a conspiracy sufficient to allow a reasonable fact finder to find a conspiracy to depress prices in the United States.165

The Supreme Court reversed the court of appeals, reinstating the district court’s summary judgment. The Court reviewed the requirements for successfully resisting a summary judgment: there must be a genuine issue of material fact as to whether petitioners entered into an illegal conspiracy that caused respondents to suffer a cognizable injury.166 But, the Court said, if the claims made by the respondents are simply implausible—if they make no economic sense—then respondents must come forward with more evidence to support their claim than would otherwise be reasonable in order to convince a court that there is a material issue of fact.167 To orchestrate a conspiracy among as many firms over as long a time as here alleged would be extremely difficult; it would require years of losses before there would be any profitable effect followed by years of high profits to recoup the losses.168 The Court noted that there was no evidence

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162. Id. at 577-78.
163. Id. at 578.
164. Id. at 578-79.
165. Id. at 580-81.
166. Id. at 585-86.
167. Id. at 587.
168. Id. at 589-90.
of the alleged conspiracy's success after 20 years: RCA and Zenith continued to hold the largest share of the color television market notwithstanding the alleged conspiracy and decreasing prices.\textsuperscript{169} If it had not worked after so long a period, the Court said, it probably never existed.\textsuperscript{170} Moreover, if the petitioners here had been selling their televisions at a low profit, it is possible that they were just better competitors; it would defeat the whole purpose of antitrust law if factfinders could infer conspiracies even where such inferences are implausible.\textsuperscript{171} On remand, the Court said that the court of appeals would be "free to consider whether there is other evidence that is sufficiently unambiguous to permit a trier of fact to find that petitioners conspired to price predatorily for two decades despite the absence of any apparent motive to do so,"\textsuperscript{172} but this evidence must "tend to exclude the possibility" that the underpricing was pro-competitive rather than an anti-competitive, "economically senseless conspiracy."\textsuperscript{173} The Ninth Circuit summarized the Supreme Court's \textit{Matsushita} decision in \textit{T. W. Electrical Service v. Pacific Electrical Contractors Ass'n.}\textsuperscript{174} The court stated:

Where an antitrust plaintiff's allegation of a conspiracy is based solely on indirect evidence that is capable of inferences of both lawful and unlawful behavior, the plaintiff must produce some evidence tending to exclude the possibility that the defendant acted independently. If the plaintiff does not produce such evidence or provide a reason for not doing so ... a grant of summary judgment in favor of the defendant is appropriate.\textsuperscript{175}

In the area of medical peer review, the mere fact that physicians who sit on peer review boards within a hospital may have the power to exclude direct competitors from that hospital will not inoculate the plaintiff's case against summary judgment dismissal. In \textit{Cooper v. Forsyth County Hospital Authority, Inc.},\textsuperscript{176} doctors Carlos T. Cooper, Jr. and E. Joseph Daniels brought a private antitrust action. The two were licensed podiatrists who had sought hospital privileges for the performance of certain surgical operations allowed under North Carolina licensing statutes.\textsuperscript{177} The bylaws of the hospital re-

\begin{itemize}
\item \textsuperscript{169} Id. at 591.
\item \textsuperscript{170} Id. at 592.
\item \textsuperscript{171} Id. at 593-94.
\item \textsuperscript{172} Id. at 597.
\item \textsuperscript{173} Id. at 597-98 (citation omitted).
\item \textsuperscript{174} 809 F.2d 626 (9th Cir. 1987).
\item \textsuperscript{175} Id. at 632.
\item \textsuperscript{176} 789 F.2d 278 (4th Cir. 1986).
\item \textsuperscript{177} Id. at 279.
\end{itemize}
stricted surgical privileges to physicians and dentists, excluding podiatrists. A hospital bylaws committee undertook hearings on whether the hospital bylaws should be amended. Orthopedic surgeons with surgical privileges participated in the hearings and objected to proposed amendments: "[i]n the event podiatrists were granted surgical privileges, podiatrists and orthopedists arguably would compete to perform certain surgical procedures." Although the evidence was clear that the orthopedists and the North Carolina Orthopedic Association discussed the issue, that orthopedists appeared before the bylaws committee and that the recommendation adverse to the podiatrists followed, this was not sufficient to overcome a motion to dismiss. The evidence was insufficient to support the inference of a conspiracy, and—as one might imagine—there were affidavits from the defendants denying any anti-competitive animus and asserting that their opposition to granting podiatrists surgical privileges was based on quality of patient care grounds.

V. CONCLUSION

Medical professionals confronted with a loss of hospital privileges by action of a peer review panel will not successfully invoke the traditional per se antitrust analysis. Per se analysis has clearly eroded, even when the line of commerce is commodities. It is certainly clear that "group boycotts" by professionals are not subject to per se condemnation; rather, they are judged by the Rule of Reason. While the Health Care Quality Improvement Act of 1986 immunizes good faith peer review actions, an allegation of bad faith is easy to make and apparently automatically qualifies a case for federal antitrust jurisdiction. The chilling effect of possible litigation, therefore, continues to hamper effective peer review activity. The Joint Commission on the Accreditation of Healthcare Organizations has recently revised its accreditation standards. These are inadequate to be useful in setting specific standards of care, but they do provide a framework within which more specific standards can be developed by hospitals. The rigorous adoption and policing of standards, augmented by computerized quality reporting can create a solid record of the quality of a physician's care-giving. If that record is poor, it prevents an objective and defensible method of demonstrating that any peer review action was taken in good faith.

178. Id.
179. Id.
180. Id.
181. Id. at 281.
182. Id. at 282.
183. JCAHCO MANUAL, supra note 109. It is considered revised compared to previous editions.
Non-public defendant hospitals have not been able to successfully invoke the "governmental immunity" antitrust exemption because courts have been unwilling to find that these health care facilities possess the required governmental attributes. Defendants may, however, prevail on a summary judgment dismissal if the plaintiff does not produce some admissible evidence which tends to exclude the possibility that there was a good faith reason for the boycott. Maintaining, policing and recording of standards remains the best insurance against incompetent and unprofessional care-giving, and the best defense against the threat of antitrust litigation.