Antitrust Law, Immunity, and Medical Peer Review Boards

Valerie S. Biebuyck

Follow this and additional works at: https://digitalcommons.law.buffalo.edu/buffalolawreview

Part of the Medical Jurisprudence Commons

Recommended Citation
Available at: https://digitalcommons.law.buffalo.edu/buffalolawreview/vol37/iss3/11

This Comment is brought to you for free and open access by the Law Journals at Digital Commons @ University at Buffalo School of Law. It has been accepted for inclusion in Buffalo Law Review by an authorized editor of Digital Commons @ University at Buffalo School of Law. For more information, please contact lawscholar@buffalo.edu.
Antitrust Law, Immunity, and Medical Peer Review Boards

I. INTRODUCTION

The medical profession has undergone a subtle yet dramatic evolution that has distinctly affected the manner in which doctors perceive themselves. This change is nowhere more evident than in the realm of medical peer review, where physician self-regulation has given way to legislative mandates which delineate the bounds of such regulatory activities, and the entire peer review process is subject to the scrutiny of antitrust law. Recent cases have focused attention on the extent to which medical peer review boards are, or should be, subject to federal antitrust liability. These developments and their implications for both physicians and patients are the subject of this Comment.

The recent Supreme Court decision in *Patrick v. Burget* epitomizes what many physicians perceive to be an infuriating irony: while attempting to obey a state mandate to expel fellow physicians deemed incompetent to practice medicine, a group of doctors was found to have engaged in illegal anticompetitive behavior when one such physician was ousted from their midst.1 The specific circumstances of the *Patrick* case will be examined at length below. For now, it suffices to point out that although the holding must be narrowly construed as an interpretation of only one specific state statute, the case highlights the tensions amidst which peer review boards must try to function.

Generally comprised of staff physicians and hospital administrators, peer review boards evaluate the credentials of potential staff members to determine if privileges should be extended to them. The boards also assess the performance of current staff members to determine whether these individuals are entitled to a continued grant of privileges.2 Any time a negative decision is rendered against the subject of a review, such boards become vulnerable to allegations of anticompetitive activity.

Primarily two groups have been responsible for bringing such suits. The first consists of individual physicians whose professional access to

---

hospitals has been revoked or barred. The second group is comprised of allied health professionals (such as chiropractors, nurse-midwives, nurse-anesthetists, podiatrists, and psychologists) who have been prohibited from treating their patients in and using hospital facilities. Disgruntled health-care providers may aver that members of the board engaged in an anticompetitive conspiracy against them in violation of the Sherman Act, and thereby expose the peer review board to a lengthy and expensive antitrust suit.

Several developments have converged to focus the spotlight on physician peer review. Hospital admitting privileges have become increasingly important in recent years because the practice of medicine is now highly specialized and replete with sophisticated technology. The importance of admitting privileges varies depending on the type of specialty in which various health care professionals are engaged. Many specialists, such as surgeons and radiologists, are heavily dependent on access to hospitals. Even those who are not dependent upon hospital facilities and personnel benefit from the extension of hospital privileges. These specialists may wish to admit patients for testing, observation, or other diagnostic purposes. If privileges are denied, the specialist may be forced to refer patients to physicians who already have privileges. Additionally, specialists who do not have admitting privileges may be placed at a competitive disadvantage because of the perception that they are not as skilled as those professionals who have been granted privileges.

At the same time that the medical profession routinely was becoming the target of antitrust challenges, physicians were calling upon legislators to reduce the cost of malpractice insurance and contain the rising tide of malpractice litigation. In response, many state legislatures passed laws requiring hospitals to engage in greater scrutiny of doctors who apply for staff privileges, and increased investigation and prosecution of


6. Id. at 713-14.

7. See infra notes 90-113 and accompanying text.
professional misconduct. The danger of being charged with anticompetitive conduct exists any time members of a particular profession collectively decide whether a colleague—who is also a competitor of the decisionmakers—may be part of that group, or whether he should be excluded. This is precisely the position in which peer review boards across the country find themselves.

In recognition of this irony, doctors turned to an antitrust defense known as the "state action" doctrine to insulate peer review boards acting in compliance with state mandates from antitrust challenges. Protection was conferred erratically, however, and peer review boards continued to perform their legislatively required functions under the threat of antitrust liability. Many health-care providers were disappointed with the Supreme Court's decision in *Patrick v. Burget.* Although it only indicated that the particular state statute involved in the case was insufficient to confer immunity on the defendant peer review board, those involved in the peer review process had hoped for a more absolute declaration on their behalf. The result is that many doctors still fear that vigorous enforcement of statutory requirements to evaluate their peers will tempt the filing of an antitrust suit against them.

Section II of this Comment provides an overview of the evolution of the application of antitrust law to the professions, and to the health care field in particular. Section III describes the rise to prominence of the peer review process as an integral part of a legislative package to contain medical malpractice litigation. It also discusses state action immunity from antitrust litigation for peer review boards acting in compliance with state mandates, and examines the implications of the Supreme Court's holding in *Patrick v. Burget.* Section IV explores solutions which would allow hospitals to freely engage in effective peer review while being insulated from federal antitrust liability. Both state and federal legislators have given a vote of confidence to peer review by drafting statutes compelling its use. This Comment asserts that in order to make such review effective, reliable protection must be afforded to the physicians conducting it.

8. *See infra* notes 90-113, 147-68 and accompanying text.
10. *See infra* notes 146-72 and accompanying text.
11. For examples of different interpretations of the state action doctrine by different states, see Bolt v. Halifax Hosp. Medical Center, 851 F.2d 1273 (11th Cir. 1988); Marrese v. Interqual, 748 F.2d 373 (7th Cir. 1984), cert. denied, 472 U.S. 1027 (1985); Quinn v. Kent General Hospital, 617 F. Supp. 1226 (D. Del. 1985).
Without immunity from federal antitrust litigation, peer review will exist in form only, and the goals it was supposed to achieve will remain unfulfilled.

II. THE EVOLUTION OF ANTITRUST ACTIONS AGAINST THE PROFESSIONS

Many of the antitrust suits against hospital peer review boards are brought under section 1 of the Sherman Act, which prohibits "every contract, combination . . ., or conspiracy in restraint of trade or commerce." The law was enacted by the federal government after the Civil War to regulate trusts and monopolies which had begun to restrain interstate commerce. The intended targets of regulation were "trade" and "commerce," terms which included activities such as the transportation of goods and passengers, the purchase and sale of commodities, dealings in intangibles, commercial services, and other business activities for gain. Antitrust law was not initially intended to apply to the professions.

The manner in which the term "trade or commerce" was originally interpreted implicitly excluded the professions and many service industries. Even before passage of the Sherman Act, the distinction between a trade and a profession had been formulated. In 1834, Justice Story stated in *The Schooner Nymph* that, "[w]herever any occupation, employment, or business is carried on for the purpose of profit, or gain, or a livelihood, not in the liberal arts or in the learned professions, it is constantly called a trade." Almost a century later, in *FTC v. Raladam Co.*, the Supreme Court stated that "medical professionals . . . follow a profession and not a trade."

In addition to the difficulty of fitting the professions into traditional notions of "trade or commerce," the Sherman Act also requires that the activity at issue have an effect on interstate commerce. This, too, contributed to the idea that the professions were not meant to come under the purview of commercial antitrust laws. For example, in *Federal Baseball Club v. National League of Professional Baseball Clubs*, the Supreme Court.

---

13. 15 U.S.C. § 1 (1982). Such suits may also be brought under § 2, which states that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce" is guilty of a felony. 15 U.S.C. § 2 (1982).
15. 18 F. Cas. 506, 507 (C.C.D. Me. 1834) (No. 10,388).
Court stated that "a firm of lawyers sending out a member to argue a case ... does not engage in ... commerce because the lawyer ... goes to another State." 18

Aside from the problems posed by the particular language of the Sherman Act and the manner in which it was interpreted, a number of factors distinguish a profession from a trade or other occupations, and contribute to the difficulty of applying commercial laws to it. According to one commentator, the core characteristics of a profession are "a prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation." 19 Other characteristics are derived from this core and further emphasize the profession's autonomy. The profession determines its own standards of education and training; professional practice is often legally recognized by some form of licensure, the procedures of which are run by members of the profession; most legislation affecting the profession is shaped by that profession, itself; and the practitioner is relatively free of lay evaluation and control. 20

Not only is medicine imbued with these qualities, but its authority is particularly persuasive because of the "therapeutic" definition of the physician's role. The power of the profession stems in large part from its fundamental endeavor to preserve and promote health. 21 The value of this substantial undertaking to individuals and society, and the expertise held by physicians allows them wide latitude in making decisions regarding patient care and the role of allied health professionals in hospital settings.

Accepting the autonomy of quality-assurance bodies such as peer review boards was a natural extension of the popular perception that doctors should be left alone to make their own decisions regarding patient care, free from interference of the lay public. While quality-assurance activities exist in the commercial realm as well as in the professions, the independence inherent in the concept of professional peer review distinguishes it from the manner in which it is conducted in industry. 22 According to one pair of experts:

The autonomy accorded health professionals, in particular members of the medical profession, represents a general societal recognition that to be car-

---

20. Id.
ried out effectively, the work of health professionals must be conducted in an environment of patient-provider confidentiality and mutual trust. The autonomy of health professionals is not something won through the industriousness and determination of individual professional groups. Rather, it represents the willingness of society to grant that autonomy, if assured that its interests will be protected by self-regulatory or peer review monitoring of the professions’ members. In other words, the expectation is that health professionals will ultimately be accountable for their own actions.23

Because of the especially revered and respected position occupied by physicians in our society, the advent of the application of commercial antitrust laws to health care providers must have come as a particularly rude shock to those in the field. Such litigation meant that the medical profession would have to answer to laypersons and others outside of their professional enclave, and to incorporate commercial concerns into many aspects of health care planning.24

One of the earliest applications of antitrust law to the medical profession came in 1943, when the Supreme Court upheld a conviction of the American Medical Association (AMA) for violating the Sherman Act by attempting to put out of business Group Health Association (GHA), a nonprofit cooperative organized to provide medical care to prepaying subscribers.25 Before even addressing the issue of their allegedly anticompetitive activities, the American Medical Association argued that the Sherman Act should not apply since neither the practice of medicine nor the business of GHA could be considered “trade” as the term is used in the Sherman Act.26

The Court dodged the task of confronting this issue directly.27 Instead, it focused its analysis on the structure and function of GHA, itself. It described the “corporate activity” of GHA as “the consummation of the cooperative effort of its members to obtain for themselves and their families medical service and hospitalization on a risk-sharing prepayment basis.”28 The Court found that the activities of the health cooperative were within the “sphere of business,” and “the calling or occupation of the individual physicians charged as defendants is immaterial if the purpose and effect of their conspiracy was such obstruction and restraint of

23. Id. at 114.
26. Id. at 527.
27. Id. at 528.
28. Id.
the business of Group Health." Although the Court’s decision made it clear that a pre-paid health plan like GHA could be considered a trade or business entitled to protection from antitrust activity, it left unanswered "the question whether a physician’s practice of his profession constitutes trade under . . . the Sherman Act."

The Court’s decision implicitly recognized that doctors, like any other provider of services or goods, are sensitive to prices charged by their competitors. The opinion actually stated that:

In truth, the petitioners represented physicians who desired that they and all others should practice independently on a fee for service basis where whatever arrangement for payment each had was a matter that lay between him and his patient in each individual case of service or treatment. . . . These independent physicians, and the two petitioning associations which represent them [the American Medical Association and the Medical Society of the District of Columbia] were interested solely in preventing the operation of a business conducted in corporate form by Group Health.

However, the Court fell short of actually characterizing the medical profession as a “trade” within the meaning of the Sherman Act, even though this passage indicates it was certainly aware of the commercial and economic interests motivating the physicians’ actions. This case opened the door to the realm of professional antitrust liability, but an outright recognition of the commercial aspects of medical practice was still taboo.

The Supreme Court explicitly included the learned professions as a legitimate target of antitrust litigation more than thirty years later in Goldfarb v. Virginia State Bar. Petitioners attempted to find an attorney to perform a title examination for them for less than the fee prescribed in a minimum fee schedule published by the county bar association. When they failed, they sued the Virginia State Bar for enforcing behavior that allegedly constituted price-fixing in violation of the Sherman Act. Goldfarb is significant for a number of reasons. First of all, it was the most expansive reading to date of the Sherman Act’s interstate commerce requirement. The Fourth Circuit Court of Appeals had held that the legal services at issue were performed wholly intrastate and were es-

29. Id.
30. Id.
31. Id. at 536.
33. Id. at 776.
34. Id. at 778.
35. M. Handler, H. Blake, R. Pitosky, & H. Goldschmid, Cases and Materials on Trade Regulation 158-59 (1983) [hereinafter M. Handler, Trade Regulation].
sentially local in nature. The Supreme Court disagreed. Indicating that a significant portion of the funds for purchasing homes in Fairfax County, Virginia came from outside of the state, the Court concluded that "the transactions which create the need for the particular legal services in question frequently are interstate transactions." The Court found a link between interstate commerce and the minimum fee schedule because the schedule affected a legal service—title examination—which is an integral part of real estate transactions—an interstate commercial activity.

Goldfarb also began to define the limits of the state action doctrine, which will be discussed more fully in Section III, below. State action immunity is generally available to individuals engaging in anticompetitive activity pursuant to a state statute. The Court here made a distinction between general regulatory activities the state conducts with respect to the legal profession, and direct supervision. It concluded that "it cannot fairly be said that the State of Virginia through its Supreme Court Rules required the anticompetitive activities of either respondent." The case is also significant both for its expansion of the Sherman Act to explicitly include the professions, and for the restriction the Court placed on that expansion in the very same opinion. In what now has become a famous footnote, the Supreme Court recognized that professions ought to be treated differently than "other business activities." The Justices admitted that "[t]he 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." The Court neglected to provide any concrete guidance regarding how to weigh self-regulation by a profession, as opposed to such regulation by a business. Subsequent decisions at times seem to belie the fact that a reservation for the professions exists at all.

In the words of one commentator:

There is the inevitable difficulty of determining where the line is to be drawn. If professional groups cannot regulate maximum or minimum prices, cannot forbid advertising, encroachment, or solicitation, and if, con-

37. Id. at 783-84.
38. Id.
39. See infra notes 146-72 and accompanying text.
41. Id. at 788 n.17.
42. Id.
43. See infra notes 45-88 and accompanying text.
ceivably, even disciplinary action authorizing expulsion for unethical behavior may partake of a group boycott, what remains of the Goldfarb reservation? 44

Very little of the reservation remained in 1978 when the Supreme Court considered an antitrust challenge to the regulatory activities of a profession in National Society of Professional Engineers v. United States. 45 The Society, which consisted of approximately 69,000 members, was organized to regulate the nontechnical aspects of engineering practice. 46 The Society’s Code of Ethics prohibited the disclosure of prices to potential customers until after negotiations had resulted in the initial selection of an engineer, ostensibly for fear that allowance of such bidding would lead to deceptively low bids, and would thereby tempt individual engineers to do inferior work which might cause a public safety hazard. 47

The United States challenged the Code on the grounds that it suppressed price competition and deprived customers of the benefits of free and open competition. 48

The Court found that the Society’s asserted defense, itself, confirmed the existence of a prima facie violation of the Sherman Act: the Society’s justification for nondisclosure of prices “rests on the assumption that the agreement will tend to maintain the price level,” 49 and any action that has a direct price effect usually is considered a per se violation of the Sherman Act. 50 While condemning the restriction as a per se violation, it clarified the rule of reason standard, stating that “[c]ontrary to its name, the Rule does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint’s impact on

46. Id. at 682.
47. Id. at 684-85.
48. Id. at 684.
49. Id. at 693.
50. There are two basic approaches to examining acts accused of being anticompetitive: the “rule of reason” analysis and the “per se” analysis. The rule of reason, formulated in Standard Oil Co. of N.J. v. United States, 221 U.S. 1 (1911), asks whether the challenged activity is unreasonably restrictive of competitive conditions. As a part of this inquiry, the anticompetitive and procompetitive effects of the activity may be examined. The per se rule was developed in Northern Pac. Ry. Co. v. United States, 356 U.S. 1 (1958). According to that decision, certain acts or practices have such a pernicious effect on competition that they are conclusively presumed to be unreasonable, and no elaborate inquiry into the precise harm they have caused is necessary. Any agreements among competitors relating to price maintenance are usually condemned per se. Defendants in National Society attempted to utilize a rule of reason analysis, arguing that the restraint on price competition ultimately benefits the public.
competitive conditions."

Justice Stevens directly confronted the seeming contradiction with the Goldfarb "learned profession" defense that had given professionals a glimmer of hope. According to Stevens, he and his fellow Justices:

adhere to the view expressed in Goldfarb that, by their nature, professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote this competition, and thus fall within the Rule of Reason. But the Society's argument in this case is a far cry from such a position.

Thus, the Court ruled that nondisclosure of prices could not be justified on the grounds of protecting public safety, at least within the engineering profession. It said nothing about whether other professions would be held to the same finding, and did little to clear up the murkiness left by Goldfarb's vague and noncommittal language regarding the different standards which should apply to a profession. The Court reduced the issue to one of competition: if the regulation cannot be said to promote competition, even if there are other justifications for it, then it will not pass the rule of reason test. This statement is ambiguous for it ultimately rests on a definition of "competition" which the Court failed to provide. By the time this case was decided, the term had come to encompass a variety of different activities. The Court's formulation seems to favor a simplistic model of competition in which prices are reduced and output increased. Under this approach, actions which directly affect price must either be shown to reduce price or increase output in order to qualify for rule of reason analysis, rather than suffer auto-

52. Id. at 696 (citations omitted).
53. See Handler, supra note 44, at 1366-69.
54. H. HOVENKAMP, ECONOMICS AND FEDERAL ANTITRUST LAW 129 (1985). One of the great debates in the field of antitrust law focuses on defining what, exactly, the Sherman Act is intended to achieve. The basic premise of the law is to preserve and promote "competition." Underlying this is the assumption that competition is desirable because it will keep prices of competing goods and services low, and their quality high.

The question of how the Sherman Act is meant to operate must necessarily turn to a definition of what is meant by "competition." A traditional model envisions many small businesses vying for customers, and doing whatever is necessary to make a better, cheaper product in order to attract them. However, what if a situation exists in which the best and cheapest product is manufactured by a company with extraordinary market power? Should the company be disbanded because it has concentrated market power, even if this would mean that consumers will be forced to buy more expensive products of lower quality? This decision is just one example of the complexity inherent in the word "competition" and in the application of the Sherman Act, itself. For an overview of the history and goals of antitrust policy, see M. HANDLER, TRADE REGULATION 1-20.
55. H. HOVENKAMP, supra note 54, at 129.
The breadth of the antitrust net continued to expand in *Arizona v. Maricopa County Medical Society.* Respondent medical foundations, by agreement of their member doctors, established maximum fees doctors could claim in full payment for health services provided to policyholders of specified insurance plans. Participating doctors agreed not to charge more than a certain price for services, and participating insurance companies agreed to pay the full costs of the services provided. The arrangement was designed to offer a substantial savings to patients, who otherwise would have had to make a copayment with the insurance company for the treatment rendered.

Because the agreement had a direct effect on price, the court applied the per se rule. However, there were a number of factors which distinguished *Maricopa* from more typical price-fixing cases, and which supported arguments in favor of a rule of reason analysis. The most obvious of these was the fact that the arrangement did, indeed, reduce medical costs. The facts suggested that doctors who did not participate in the plan were charging rates that were the same as or higher than those charged by participating doctors—strong evidence that the plan was actually reducing health care costs. Moreover, the arrangement was nonexclusive: participating physicians could come and go as they pleased, and they were free to treat any patients they wished, including those who did not subscribe to insurance policies partaking of the arrangement. If this were a true cartel, no such independent activity would be permitted.

In addition to these factors, the nature of the insurance industry

---

56. *Id.*
58. *Id.* at 341.
59. *Id.* at 342.
60. *Id.* at 354. The Court justified use of the per se rule by arguing that maximum price-fixing could be used as a disguise for minimum price-fixing. *Id.* at 348.
61. See Hovemkamp, *supra* note 54, at 133.
62. See *id.*
63. See *id.*
64. *Id.* at 133-34. A cartel is "an agreement among perfect competitors to sell all their output at the same, agreed upon price. By entering such an agreement the firms acting in concert can reduce output and earn monopoly profits just as a single-firm monopolist." H. Hovemkamp, *supra* note 54, at 83. A cartel will only be successful if all of its members play by the agreed-upon rules. There is tremendous temptation to cheat, as the interests of individual cartel members may differ substantially from one another. Nonetheless, "if enough cartel members cheat . . . the cartel will fall apart." *Id.* Thus, the independence accorded physicians participating in the arrangement in *Maricopa* is wholly inconsistent with the behavior necessary to maintain a cartel.
undercut the Court's condemnation of the maximum price-fixing agreement as a disguise for a minimum price-fixing agreement. If the arrangement actually were an illegal minimum price-fixing agreement, then it would make no economic sense for insurance companies to participate in the plan since insurers want to avoid price increases that increase their insured risk. Although the doctors stand in a horizontal relationship to each other, and the Court declared horizontal price-fixing agreements per se illegal, the insurance companies stand in a vertical relationship with the doctors. The vertical relationship is inconsistent with a minimum price-fixing agreement among the doctors because the insurance companies earn more money when doctors charge less. Thus, not only the nature of the medical profession, itself, but the manner in which third-party payors factor into the equation, make appropriate application of the antitrust laws in this arena difficult. At the very least, the Court's analysis would have been more accurate and thorough had they used the rule of reason test, rather than condemning the arrangement per se.

The problem of how best to deal with the role of insurance companies in the scheme of health care delivery arose once again in 1986 in Federal Trade Commission v. Indiana Federation of Dentists. The Federation forbade members to submit x-rays to dental insurers in connection with insurance claims forms. The insurance companies insisted that they needed access to these records in order to ensure that benefits would be paid only for the "least expensive yet adequate treatment." Dentists feared that the practice might lead to a reduction of costs at the expense of the proper treatment, so they withheld the x-rays from evaluation by individuals who worked for the insurance companies.

In 1978, the Federal Trade Commission issued a complaint against the Federation, alleging the practice to be an unfair method of competition and a violation of the Sherman Act. After a full evidentiary hearing before an administrative law judge, the Commission ordered the Federation to cease and desist from further efforts to keep their member dentists from submitting x-rays to insurers. Upon judicial review, the United States Court of Appeals for the Seventh Circuit vacated the order.

66. See H. HOVEMKAMP, supra note 54, at 133.
67. Id.
69. Id. at 449.
70. Id. at 449-50.
71. Id. at 451.
72. Id.
ANTITRUST LIABILITY

Among other findings, the court held that there was no evidence that
dentists would compete for patients by offering cooperation with the in-
surance companies in the absence of a restraint. Further, the Commis-
sion failed to establish that the Federation had the power to effect the
alleged restraint of competition. Finally, the court criticized the Com-
mission for failing to find that the alleged restraint had actually resulted
in higher dental costs to patients and insurers. The Supreme Court
granted certiorari to determine whether applicable antitrust principles
had been applied correctly, and whether the Court of Appeals had mis-
applied the substantial evidence test.

The Court first found that the evidence was sufficient to support the
Commission's findings. It then turned to the question of whether the
Federation's collective refusal to cooperate with insurers' requests for x-
rays constituted an unreasonable restraint of trade in violation of the
Sherman Act. It noted similarities between the Federation's activities
and group boycotts, which are usually condemned per se. The Court then
made a perfunctory concession to Goldfarb by stating that "we have been
slow to condemn rules adopted by professional associations as unreas-
nable per se." However, it still condemned the arrangement using a rule
of reason analysis.

In so doing, the Court sidestepped direct consideration of noncom-
petitive "quality of care" justifications for the Federation's activities, ac-
knowledging that the FTC had considered them and had found that no
such justification had been established. It viewed as unwarranted the
implication that "an unrestrained market in which consumers are given
access to the information they believe to be relevant to their choices will
lead them to make unwise and even dangerous choices." Once again,
while insisting that it believed that the special problems of the health care
field somehow merit different treatment where antitrust law is concerned,
the Court's decision indicated that it was inappropriate to apply that phi-
losophy, at least in this particular case. While the Court acknowledged

73. Id. at 453. The Seventh Circuit seems to have been particularly amendable to the "quality of
care" defense, at least in the early 1980s. See infra notes 82-88.
74. 476 U.S. at 453.
75. Id.
76. Id.
77. Id. at 455-57.
78. Id. at 458.
79. Id. at 464.
80. Id. at 463.
the existence of the "quality of care" defense, it continued to politely ignore it.\textsuperscript{81}

The elements of another "quality of care" defense were articulated recently by the Seventh Circuit Court of Appeals. In \textit{Wilk v. American Medical Association}, a group of chiropractors sued a number of medical organizations, alleging that these groups had attempted to eliminate the chiropractic profession through the promulgation of certain anticompetitive principles which were expected to be adhered to by organizational members.\textsuperscript{82}

At trial, the jury returned a verdict for the defendants.\textsuperscript{83} On appeal, the Seventh Circuit Court of Appeals remanded the case and clearly delineated each party's burden of proof, outlining specific elements of what was dubbed the "patient care defense." If the plaintiffs met their burden of showing that the effect of the defendants' actions had been to restrict competition, the defendants could then come forward with the patient care defense, which requires the establishment of four elements. The defendants must show: (1) that they genuinely entertained a concern for what they perceive as scientific method in the care of each person with whom they had entered into a doctor-patient relationship; (2) that this concern was objectively reasonable; (3) that this concern was the dominant motivating factor in engaging in anticompetitive activity; and (4) that this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition.\textsuperscript{84}

On remand, the court found that defendants had failed to satisfy all the elements of the patient care defense. The AMA did not convince the district court that its concern for the scientific method was objectively reasonable throughout the duration of the boycott.\textsuperscript{85} However, the judge was careful to stop short of validating chiropractic as a health-care science, stating that "[t]his finding... should not be construed as a judicial endorsement of chiropractic."\textsuperscript{86} The court also determined that the AMA could have satisfied its concern for the use of scientific method in patient care through means less restrictive than a nationwide boycott of

\textsuperscript{81} \textit{See} Palmer, \textit{High Court Hands Professionals Antitrust Setback}, \textit{LEGAL TIMES}, July 7, 1986, at 22.

\textsuperscript{82} 719 F.2d 207 (7th Cir. 1983), rev'd on remand, 671 F. Supp. 1465 (N.D. Ill. 1987) modifying Docket No. 76 C 3777 (N.D. Ill., Aug. 27, 1987) (Memorandum and Order of District Judge Susan Getzendanner) [hereinafter Memorandum and Order].

\textsuperscript{83} Memorandum and Order at 3.

\textsuperscript{84} \textit{Id.} at 4-5.

\textsuperscript{85} \textit{Id.} at 35.

\textsuperscript{86} \textit{Id.}
the chiropractic profession. The judge issued an injunction ordering the AMA to modify its policy to indicate it is ethical for a doctor to associate with a chiropractor "[provided] the physician believes [the association] is in [the] best interests of the patient."

The decision is unusual in that economic gain was not found to be the predominant motive behind the allegedly anticompetitive behavior; rather, concern for patient care was the primary impetus. In any event, the AMA had changed its policy in 1980 to indicate that it was not unethical for physicians to associate with chiropractors, so the decision would have little, if any, practical effect on physicians or their patients.

Although the defendants did not prevail, Wilk seems to be the farthest any court has come with regard to evaluating allegedly anticompetitive activities in light of quality-of-care justifications.

III. THE RISE OF PEER REVIEW AND THE NEED FOR IMMUNITY

A. Attempts to Curb Medical Malpractice Litigation in New York

During the same period in which the application of antitrust laws to the learned professions evolved, physicians were becoming embroiled in a medical malpractice and insurance litigation crisis. In the 1970s, insurance companies began pulling out of the medical malpractice market because of the sharp increase in the number of such suits brought, and the exorbitant damage awards and settlements offered. A number of factors contributed to the proliferation of such suits, including unrealistic patient expectations regarding their treatment; an increase in the number of individuals obtaining medical treatment due to the availability of public and private insurance; deterioration of the traditional, personal and long-lasting physician-patient relationship resulting from specialization by doctors and fragmentation of patient care; increased awareness of consumers' rights; and use of experimental technology with an attendant increase in exposure to unknown risks. Physicians began to call upon

87. Id. at 36.
88. 671 F. Supp. at 1507.
91. Note, Insurance Crises, supra note 90, at 773.
92. Note, Reform Act, supra note 90, at 138.
state legislatures to take action to contain the spiral of insurance premiums and malpractice suits being brought against them.93

In New York, early attempts to deal with the problem focused on the suits, themselves. In 1974, the state legislature created pre-trial screening and mediation panels to evaluate medical malpractice claims and attempt to resolve them before resorting to a full-blown trial.94 The panels proved ineffective since their rulings were nonbinding and panelists only served on a voluntary basis.95

The following year, the focus shifted to ensuring that malpractice insurance would be available to physicians despite the exodus of private carriers from the market.96 New York's primary medical malpractice insurer, Employer's Insurance of Wausau, had withdrawn just the previous year.97 The legislature created a joint underwriting association to act as a temporary malpractice insurer, and mandated detailed reporting of claims to state officials.98 It also made admissible as evidence at malpractice trials the opinion of a medical malpractice panel if at least three panel members agreed on the question of liability.99 Additionally, the law created a State Board for Professional Medical Conduct with the Department of Health.100

The law was ill-received by medical professionals.101 While some doctors criticized it for not going far enough to reduce insurance premiums, others faulted its failure to address what was arguably at the root of the entire insurance and litigation dilemma: patient injuries caused by substandard medical care. One commentator summed up this sentiment as follows:

[E]ven a casual survey of the rash of malpractice reforms enacted to date shows the inordinate attention devoted to insurance and legal system concomitants compared to recommended improvements in health system quality controls, injury prevention, and the like. It is as though the legislatures, in their headlong rush to "get something on the books," ignored the indisputable precipitating cause of the entire problem—medical injury—preferring instead to deal with better-understood and more manageable issues. . . . [O]ur greatest need is to re-think the malpractice problem from a broader

94. Id. at 85.
95. Id.
96. Note, Reform Act, supra note 90, at 139-140.
97. 30 Rec. A.B. City of N.Y. 336 (1979) [hereinafter Committee Reports].
99. Id.
100. Id.
101. T. Lombardi, supra note 93, at 46.
vantage point. If malpractice claims are attributable primarily to maloccurrences in the treatment process, should we not be devoting more attention to the development of health system quality controls that will reduce their frequency? Is it possible to build into the present (fault-based) malpractice system a better assortment of rewards and sanctions so that substandard practices are prevented more effectively. . .?102

Thus, rather than emphasizing policies which attempted to minimize damage to a doctor once a malpractice suit has been brought, some experts preferred to channel efforts toward preventing malpractice in the first place.

This approach was recommended in a report published by a committee of the Association of the Bar of the City of New York, which studied the medical malpractice insurance crisis in 1975.103 The committee found that “the Board of Regents has not exercised sufficiently its statutory authority to police the profession,”104 and recommended that the New York State Medical Society be authorized “to participate more actively in the disciplinary process.”105 The committee also suggested that hospitals be required to notify the Board of Regents of the suspension, revocation, or curtailment of any physician's hospital privileges,106 and that health care institutions establish “medical injury prevention programs” to study common injuries and develop means of minimizing their risks.107 The report concluded with a general recommendation that “[g]reater emphasis on prevention of medical injuries” be adopted.108

These criticisms and recommendations were incorporated into New York's second attempt to confront the medical malpractice crisis in 1985. The state's new Medical Malpractice Reform Act, in addition to attempting to contain both malpractice awards and the number of cases tried, goes much farther than its predecessor in imposing requirements designed to actually reduce the incidence of malpractice.109 The legislature found that hospitals should establish medical and dental malpractice prevention programs, as well as increase scrutiny of doctors and dentists prior to granting privileges.110 Once privileges have been granted, hospi-

102. Bernzweig, Foreword to T. LOMBARDI, supra note 93, at xi-xii.
103. Committee Reports, supra note 97, at 336.
104. Id. at 358.
105. Id.
106. Id.
107. Id. at 359.
108. Id. at 360.
110. Reform Act, ch. 294, § 1.
tals should allocate increased resources to the investigation and prosecution of professional misconduct. 111

The Reform Act also mandates that every hospital maintain a program to identify medical malpractice. 112 Each such program must consist of, among other things, a quality assurance committee which periodically reviews credentials and competence as part of an evaluation of staff privileges. The committee is authorized to implement sanction procedures to aid in enforcement of its decisions. Prior to renewing or granting professional privileges or association, the hospital must obtain information from the doctor regarding the individual’s prior professional affiliations, and any professional misconduct or malpractice proceedings against him or her. Additionally, anyone who, in good faith, provides information to further the malpractice prevention program or participates on the quality assurance committee cannot be subject to an action for civil damages or other relief as a result of such activity. 113

B. Patrick v. Burget 114

At the same time, on the other side of the country, peer review was receiving quite different treatment. In the early 1980s in the small Oregon town of Astoria, a physician was in the process of suing a sizable portion of the town’s doctors on antitrust grounds for terminating his hospital privileges. The physician, Timothy Patrick, won his jury trial and was awarded $650,000 115 for the antitrust violations, which the court trebled as provided by the Sherman Act. 116 He also was awarded $20,000 in compensatory damages, $90,000 in punitive damages, and $228,600 in attorney’s fees, 117 for a total award of nearly $2.3 million. By the time the litigation ran the full course of its appeals during the next eight years, the jury’s verdict would be reversed by a Court of Appeals, and reinstated by the Supreme Court.

1. The Facts and Circumstances of Patrick v. Burget. Patrick v. Burget is practically a case study in how not to conduct peer review. In 1972, Dr. Patrick came to Astoria to practice medicine. The medical needs of the town’s 9,500 residents were served primarily by Columbia

111. Id.
115. 800 F.2d at 1504-05.
116. Id. at 1505.
117. Id.
Memorial Hospital\textsuperscript{118} and the Astoria Clinic,\textsuperscript{119} a partnership of eleven physicians. The Clinic needed a surgeon and hired Dr. Patrick under a one-year employment contract. After the contract had expired, he was invited to become a partner, but he refused and established his own practice in general and vascular surgery which competed directly with the clinic.\textsuperscript{120} 

According to Dr. Patrick, the doctors at the Astoria Clinic resented him for starting a competing practice. He claimed that they refused to refer patients to him, and even sent some emergency cases fifty miles away in order to avoid giving Patrick a referral.\textsuperscript{121} Patrick also complained that Clinic physicians refused to provide cross-coverage for his patients when he was out-of-town.\textsuperscript{122} Nonetheless, Dr. Patrick’s practice did well, and he continued to perform surgery at Columbia Memorial Hospital.\textsuperscript{123} 

In the fall of 1979, a patient named Leroy Willie was operated on by Dr. Patrick. After the surgery, Patrick had to leave town for a medical meeting, and asked his recently-hired associate, Dr. Weber, to care for the patient in his absence.\textsuperscript{124} Dr. Weber, himself, had to leave for a medical meeting the next day, so the doctors arranged for an independent family practitioner to cross-cover for both of them during the estimated six hours that both Patrick and Weber would be out-of-town simultaneously.\textsuperscript{125} The patient’s condition worsened during this interval, and he died while being transported to another hospital.\textsuperscript{126} 

On November 15, 1979, the Executive Committee of Columbia Memorial Hospital referred an investigation of Dr. Patrick’s handling of this case to the Board of Medical Examiners (BOME), which has complete regulatory authority over the practice of medicine in Oregon.\textsuperscript{127} The investigative committee of the BOME was chaired by Dr. Russell, one of

\textsuperscript{118} The hospital has sixty-five beds and between twenty and twenty-five doctors on staff. Petitioner’s Brief at 3, Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986) (No. 86-1145), rev’d, 108 S. Ct. 1658 (1988) [hereinafter Petitioner’s Brief]. 

\textsuperscript{119} Most doctors in Astoria belonged to the Astoria Clinic. Astoria Clinic physicians consistently constituted about a two-thirds majority of the Columbia Memorial Hospital Executive Committee. Id. at 3-4. 

\textsuperscript{120} Id. at 5. 

\textsuperscript{121} Id. 

\textsuperscript{122} Id. at 10. 

\textsuperscript{123} Id. at 6. 

\textsuperscript{124} Id. at 16. 

\textsuperscript{125} Id. 

\textsuperscript{126} Id. at 16-17. 

the members of the Astoria Clinic.128 The Board issued a letter of reprimand and constructive criticism to Dr. Patrick,129 and at the same time sent a letter to the hospital criticizing it for, among other things, lax grant of surgical privileges.130 Dr. Patrick admitted that the Board’s criticism of his handling of the Willie case was fair, but questioned the BOME’s actions in reviewing charts of his other patients since he had not been given an opportunity to review and discuss these.131 After subsequently reviewing these charts, the Board declined to modify its reprimand letter.132 Dr. Patrick then filed a Petition for judicial review of the determination along with a civil claim for damages against the BOME.133 In December of 1981, the Board withdrew its reprimand letter.134

One month earlier, however, Dr. Patrick performed an operation which would incite yet another round of investigative activity directed against him. Dr. Patrick removed the appendix of a 15-year-old boy, Stuart Snodgrass, on the basis of the diagnosis of a Coast Guard physician who had referred the patient.135 The patient did not recover, so Dr. Patrick operated a second time to check for infection.136 The boy still failed to recover, and a hospital urologist later diagnosed the boy as having testicular cancer.137

The Executive Committee of Columbia Memorial Hospital formed an investigative committee which reviewed Dr. Patrick’s practice. They granted Dr. Patrick a hearing, after which they decided that his privileges should be terminated.138

Pursuant to the Hospital’s bylaws, Dr. Patrick requested a hearing regarding the decision.139 During the seventeen sessions and sixty hours of testimony which comprised the hearing,140 one expert testified that the Snodgrass case involved a “major misdiagnosis” which there was “no

129. Respondent’s Brief at 8.
130. Id. at 9.
131. Id. at 9-10.
132. Id. at 13.
133. Id.
134. Id.
136. Id.
137. Id.
138. Respondent’s Brief at 15. Patrick is reported to have said that his only mistake in the Snodgrass case was “being caught.” Id. at n.2.
139. Id. at 15.
140. Id. at 16.
way to defend.” Another expert concluded that, given the errors Dr. Patrick had committed, the Hospital was obligated “to put him on probation and compel him to participate in consultation on elective surgery and in post-consultations on emergency cases.” The expert testified that the Snodgrass episode, alone, warranted probation. After the hearing, Dr. Patrick terminated the review process before taking the internal appeals provided by the hospital’s bylaws, and brought suit in federal court on antitrust grounds against members of the Astoria Clinic. The jury found for Dr. Patrick and awarded him nearly $2.3 million.

2. The Appeals. On appeal, the defendants’ primary argument focused on the fact that the state of Oregon requires medical peer review activities by statute; as such, they asserted, peer review falls within the purview of the state action exemption from antitrust challenges. Oregon requires that its health care facilities be licensed. To maintain that license, these facilities must have procedures for granting or restricting privileges of the medical staff, and for staff review of each other’s practices in order to reduce morbidity and mortality and to improve patient care. Any licensed health care facility that fails to con-

141. Id. at 17.
142. Id.
143. Id. at 18.
144. Id. at 19.
145. See supra notes 115-17 and accompanying text.
146. The state action doctrine was established in 1943 by the Supreme Court in Parker v. Brown, 317 U.S. 341 (1943). Parker involved a suit by raisin growers to prevent enforcement of a raisin marketing program adopted under California law. The marketing program restricted competition among growers and maintained prices in the distribution of their commodities to packers. The Court held that the Sherman Act never was intended to restrain action by state officers or legislatures. Id. at 350-51. According to the Court, “[i]n a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress.” Id. at 351. Although a state may not immunize violators of the Sherman Act by explicitly authorizing them to violate it, actions taken pursuant to state regulations could be immune from antitrust liability. Id.
148. OR. REV. STAT. §§ 441.030, 441.055(3) (c)-(d).
duct peer review as mandated, or that conducts peer review improperly is in violation of Oregon's health laws.149

Dr. Patrick's argument focused on the manner in which the proceedings were conducted. The Court of Appeals agreed that there was substantial evidence that the "defendants acted in bad faith in the hospital's peer review process and in the BOME proceedings."150 Patrick was convinced that he could not obtain a fair hearing from either the hospital investigatory committee or the BOME, since partners in the Astoria Clinic were members of both.151 To bolster this claim, Patrick pointed out that other doctors who had engaged in unprofessional conduct were treated much more leniently, or were not disciplined at all. For example, an orthopedic surgeon at Columbia Memorial Hospital, reportedly suffered a nervous breakdown while performing a simple operation.152 The incident was never reported to the BOME.153 This physician also admitted to being drunk while working in the emergency room.154 Neither his alcoholism, nor any specific incidents were the subject of any disciplinary proceeding within the hospital, nor were they reported to the BOME.155 Dr. Patrick argued that the Oregon statute immunizes only good faith peer review activity, and that the state action doctrine does not immunize bad faith conduct.156

The Court of Appeals found that Patrick's interpretation misconstrued the nature of the doctrine. According to the Court, "[o]nce we have determined that a state has acted to replace competition with regulation in a given market, out of respect for the sovereignty of the state, federal antitrust laws simply are displaced. The subjective motivations of the individual actors are irrelevant."157 Moreover, "[t]he fact that Oregon only immunizes good faith conduct demonstrates that Patrick had a state law remedy for any actions taken against him in bad faith," but the fact remains that the challenged actions are those of the state.158 The Court thus reversed the judgment on the antitrust claims.

149. Respondent's Brief at 41. Thus, Dr. Patrick could have filed a complaint with the State Health Division regarding the propriety of the peer review proceedings at Columbia Memorial Hospital.
150. 800 F.2d at 1507.
151. Id. at 1504.
152. Petitioner's Brief at 13-14.
153. Id. at 14.
154. Id.
155. Id.
156. 800 F.2d at 1507.
157. Id. (citations omitted).
158. Id.
The Supreme Court reversed the Ninth Circuit’s decision on appeal.\(^{159}\) The Court framed the issue as “whether the state-action doctrine of *Parker v. Brown* protects physicians in the State of Oregon from federal antitrust liability for their activities on hospital peer-review committees.”\(^{160}\) It did not consider the significance of the evidence indicating that the peer review activity in this case was conducted in bad faith. Instead, the Court zeroed in on a rigorous two-pronged test to determine whether the anticompetitive conduct of private parties is state action and thus exempt from antitrust scrutiny.\(^{161}\)

Two conditions must be met in order to pass the test. First, “the challenged restraint must be ‘one clearly articulated and affirmatively expressed as state policy.’”\(^{162}\) Second, “the anticompetitive conduct ‘must be actively supervised by the State itself.’”\(^{163}\)

The Court did not reach the “clear articulation” prong of the *McCal* test because it found that the “active supervision” requirement was not satisfied.\(^{164}\) The Court asserted that a state is not considered to actively supervise the termination of hospital privileges “unless a state official has and exercises ultimate authority over private privilege determinations.”\(^{165}\) Oregon did not bestow this power upon its State Health Division. Because the Division was not authorized “to review private peer review decisions and overturn a decision that fails to accord with state policy,”\(^{166}\) the activities of the Health Division do not qualify as state action. Nor does the Oregon BOME actively supervise private peer review decisions. Although the Board must be notified of a hospital’s decision to terminate or restrict privileges, it does not have the power to disapprove private privilege decisions.\(^{167}\)

The respondents’ last claim that state supervision exists via the state judiciary system was also rejected. The Court refused to confront the question directly, saying that “[t]his case . . . does not require us to decide the broad question whether judicial review of private conduct ever

---


\(^{160}\) *Id.* at 1160(citations omitted).

\(^{161}\) *Id.* The test was formulated in California Retail Liquor Dealers Ass’n v. Mideal Aluminum, Inc., 445 U.S. 97 (1980). See supra note 146.

\(^{162}\) 108 S. Ct. at 1163 (quoting California Retail Liquor Dealers Ass’n v. Mideal Aluminum, Inc., 445 U.S. at 105).

\(^{163}\) *Id.* at 1163 (quoting California Retail Liquor Dealers Ass’n v. Mideal Aluminum, Inc., 445 U.S. at 105).

\(^{164}\) *Id.* at 1163.

\(^{165}\) *Id.* at 1164 (emphasis added).

\(^{166}\) *Id.*

\(^{167}\) *Id.*
can constitute active supervision, because judicial review of privilege-termination decisions in Oregon, if such review exists at all, falls far short of satisfying the active supervision requirement."

Although the decision was anxiously awaited by the health care and legal communities, the opinion was disappointing from several perspectives. Advocates of peer review perceived the holding as a severe blow to the peer review system. Although the Court only interpreted one state’s laws, many fear that the decision will make peer review panelists think twice before attempting to discipline an incompetent colleague for fear of the potentially devastating antitrust consequences. The Court at least recognized that there are valid policy arguments for taking steps to protect the peer review process, although it declined to take those steps, itself; such arguments “essentially [challenge] the wisdom of applying the antitrust laws to the sphere of medical care, and as such [are] properly directed to the legislative branch.”

C. Congressional Encouragement of Peer Review

In 1986, partly as a response to the Patrick litigation, which was en route to the Supreme Court, Congress recognized the need to facilitate the work of peer review boards. To further this end, it passed the Health Care Quality Improvement Act (HCQIA), the purpose of which was “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.” Unlike New York’s medical malpractice reform legislation, which used peer review as a means of reducing the incidence of medical malpractice, the federal bill was not intended to be a direct solution to the medical malpractice crisis. Rather, it was

168. Id. at 1165. For an example of a decision holding that the state judiciary can be considered an appropriate supervisory authority for the purposes of the state action doctrine, see Bolt v. Halifax Hosp. Medical Center, 851 F.2d 1273, 1282 (11th Cir. 1988).

169. See, e.g., Snow, supra note 9, at 26; Riffer, Antitrust Law and Peer Review Remain at Odds, HOSPITALS, Feb. 5, 1986, at 58.

170. See N.Y. Times, May 17, 1988, § A, at 1, col. S. Kirk B. Johnson, general counsel of the American Medical Association, was disappointed that the Court allowed “the atom bomb of the antitrust laws” to be used against peer review panels. Johnson admitted that the AMA “did not defend the way peer review was done in this particular case,” but was concerned that “the threat of giant Federal lawsuits” will have a “chilling effect” on efforts to discipline incompetent doctors. Id., May 17, 1988 & § D, at 24, col. 6.

171. Id.


174. Id.
designed "to deal with one important aspect of the medical malpractice problem in this country—incompetent and unprofessional physicians."\textsuperscript{175} The primary objective of the HCQIA is to ensure that physicians who have already been identified as incompetent or unprofessional will not be able to move to a locale where their reputation is unknown, and continue to practice bad medicine.

In order to accomplish the dual goals of identifying incompetent doctors and then keeping them away from patients, the bill provides guidelines for conducting peer review, including due process safeguards for subjects of review;\textsuperscript{176} immunity for individuals engaging in peer review activity in the "reasonable belief" that such activity is in furtherance of quality health care;\textsuperscript{177} and a central clearinghouse to which all actions taken against physicians will be reported so that such doctors will not be able to hide from a past record of poor performance.\textsuperscript{178} All states have the option of adopting the HCQIA, or drafting their own legislation providing peer review immunity and opting out of the federal statute by October 14, 1989.\textsuperscript{179}

The guidelines for professional review actions are grounded in a "reasonable belief" standard. The drafters considered using a "good faith" standard, but ultimately rejected it for fear that it could be misinterpreted as requiring no more than a test of the subjective state of mind of the physicians conducting the peer review activity.\textsuperscript{180} Instead, they settled upon the more objective "reasonable belief" test, which "will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients."\textsuperscript{181} While this standard will be more difficult to meet than one requiring only good faith, the statute provides a presumption that all professional review actions are taken with the reasonable belief that they will further the attainment of quality health care, unless a plaintiff can rebut the presumption by a preponderance of the evidence. However, it is important to note that the statute does not provide absolute immunity. If a jury concludes that a peer review body had disciplined a doctor in order

\begin{thebibliography}{99}
\bibitem{175} Id.
\bibitem{176} Health Care Quality Improvement Act, 42 U.S.C. § 11112 (1986).
\bibitem{177} Id. Section 11111 (immunity for participants).
\bibitem{178} Id. Sections 11132-11135.
\bibitem{179} Id. Section 11111(c); see \textit{HCQIA: CA Doctors Decide to Opt Out}, HOSPITALS, July 5, 1988 at 56 [hereinafter \textit{CA Doctors Opt Out}].
\bibitem{180} H.R. REP. NO. 903, \textit{supra} note 173, at 10.
\bibitem{181} Id. at 6393.
\end{thebibliography}
to eliminate a competitor, it can award antitrust damages.\textsuperscript{182}

The statute also outlines the steps necessary to ensure a fair hearing during peer review.\textsuperscript{183} Among other requirements, the physician must be given notice of the proposed action and the reasons therefore,\textsuperscript{184} and must be informed of his right to request a hearing on the proposed action.\textsuperscript{185}

The requirements relating to the conduct of hearings are more difficult to satisfy. The statute offers three alternatives from which to choose the composition of the hearing board: (1) an arbitrator mutually acceptable to the physician and the health care entity;\textsuperscript{186} (2) a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved;\textsuperscript{187} (3) a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved.\textsuperscript{188} Standard due process rights such as the right to representation by counsel, to have a record made of the proceedings, and to examine and cross-examine witnesses, are also required by the statute.\textsuperscript{189}

In some settings, it will be difficult, if not impossible to find a hearing officer or panel of individuals who are not in “direct economic competition with the physician involved.”\textsuperscript{190} This is especially true with peer review activity taking place in a small hospital or medical community.\textsuperscript{191} According to a chief of obstetrics/gynecology at such a hospital, “[a]ttempts at constructive criticism turned confrontational. I felt I was in a situation where there was no way out.”\textsuperscript{192} Another obstetrician/gynecologist agreed that “[w]hen you work in a small hospital, it’s difficult to blow the whistle on your peers.”\textsuperscript{193} It was precisely this dilemma which contributed to the trouble in which the Astoria Clinic found itself in \textit{Patrick v. Burget}.\textsuperscript{194}

\begin{itemize}
\item \textsuperscript{182} Savage, \textit{Peer Review Teams That Censure Doctors Can Be Sued for Damages, Justices Hold}, L.A. Times, May 17, 1988, § 1, at 12, col. 1.
\item \textsuperscript{183} Health Care Quality Improvement Act, Section 11112(a).
\item \textsuperscript{184} Health Care Quality Improvement Act, Section 11112(b)(1)(A)(i), (ii).
\item \textsuperscript{185} Id. § 11112(b)(1)(B)(1).
\item \textsuperscript{186} Id. § 11112(b)(3)(A)(i).
\item \textsuperscript{187} Id. § 11112(b)(3)(A)(ii).
\item \textsuperscript{188} Id. § 11112(b)(3)(A)(iii).
\item \textsuperscript{189} See id. § 11112(b)(3) (C) (1)-(v).
\item \textsuperscript{190} Id. § 11112(b)(3)(A) (ii)-(iii).
\item \textsuperscript{191} Koska, ACOG Program Eases Peer Review Conflicts, HOSPITALS, April 20, 1988, at 58.
\item \textsuperscript{192} Id.; see also Holthaus, Federal Law Offers Protection for Peer Review, HOSPITALS, July 5, 1988, at 46. For potential solutions to this problem, see \textit{infra} notes 194-215 and accompanying text.
\item \textsuperscript{193} See supra notes 114-72 and accompanying text.
\item \textsuperscript{194} CA Doctors Opt Out, supra note 179, at 56.
\end{itemize}
IV. SOLUTIONS, ALTERNATIVES, AND CONCLUSIONS

Although advocates of peer review predicted dire consequences for their cause as a result of the Supreme Court's decision in *Patrick v. Burget*, the case must be kept in perspective. The Court's ruling was extremely narrow: although it determined that Oregon's laws did not confer immunity on its peer reviewers, the Court was only considering the laws of one state. Other states, with different state statutes, or with the federal HCQIA, may have incited a different result under circumstances otherwise identical to those in *Patrick*.

The Supreme Court's holding is most useful for the message it conveys regarding the degree of state supervision it expects before it will declare an activity immune under the state action doctrine. In addition to heeding this message, there are a number of steps that state legislatures and health care entities can take to protect peer review boards from antitrust liability.

States that have elected to opt out of the HCQIA would be well-advised to ensure that their immunity provisions are airtight. California, for example, has decided to opt out. According to the California Medical Association, the state has a "good system of immunity that has been tested in court. There isn't much of an advantage for us to opt into the HCQIA."195 States that opt out should bear in mind that peer review activities mandated by individual statutes are still susceptible to lawsuits brought against them under state law.196 The language of their laws should leave no doubt that the state legislature has made a decision to allow private parties to engage in behavior that would be considered anticompetitive under ordinary circumstances because of other overriding policy considerations.

States that opt out have the advantage of being able to tailor their requirements for enabling a peer review body to discipline a physician. Statutes should provide ample due process safeguards, including the right to adequate notice, a written record of the proceedings, counsel, and confrontation and cross-examination of adverse witnesses, among others. If a state sincerely intends to protect the activities of peer review boards, so that they may conduct their investigations free from the fear

---

195. *Id.* But see *Physician Wins Reinstatement of Sherman Act Conspiracy Claim*, Antitrust & Trade Reg. Rep. (BNA) Vol. 57, No. 1428 at 190 (Aug. 10, 1989) (physician who alleged that suspension of his staff privileges violated the Sherman Act won a reprieve from the U.S. Court of Appeals for the Ninth Circuit, which held that the challenged conduct was not shielded by the state action doctrine. Pinhas v. Summit Health, Ltd., No. 87-6530 (9th Cir. July 26, 1989)).
196. *See supra* notes 180-82 and accompanying text.
of expensive and lengthy antitrust litigation, then its laws should reflect standards of evidence and burdens of proof that facilitate this goal. For example, a state might require that peer review activity be conducted in "good faith," the standard that was rejected by the federal legislation in favor of the more stringent "reasonable belief" standard.197

One problem with opting out of the federal statute, however, is that unless a state has immunity provisions that have already proven successful in court, there is no guarantee that they will withstand a challenge to the state action doctrine. A state legislature may have intended to supplant competition with state regulation, but it may not have succeeded in conveying that intent in the language of its statutes. For example, the state action doctrine was rejected as an affirmative defense in a 1986 Delaware medical staff privilege case, Quinn v. Kent General Hospital.198 The court in Quinn conceded that state law provided immunity from liability to individual members of peer review boards for "good faith" actions taken during review proceedings,199 but rejected the contention that the state action doctrine shielded them from antitrust attack. The state did not mandate the creation of such boards, nor did it supervise review activities.200 As the Delaware court interpreted the "clear articulation" test:

[It] is true that the . . . test does not require that the legislature 'expressly state in a statute or its legislative history that it intends for the delegated action to have anticompetitive effects,' . . . [but] there is not even a hint in the Delaware statute that the peer review process will be promoted by conferring a monopoly upon those physicians with entrenched positions on hospital staffs. Nor is there any reason why promotion of the peer review process should require any additional restriction of competition.201

Federal courts can also play an important role in ensuring the success of state action immunity for peer review boards operating pursuant

198. Id. at 1234. According to the Delaware statute:
   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. . . .
200. Id. at 1240.
201. Id. at 1239 (citations omitted).
to state statutes. The courts can simply dismiss\textsuperscript{202} antitrust claims if the state legislature has clearly expressed an interest in conferring state action immunity.\textsuperscript{203} The courts can also impose sanctions on attorneys who insist on bringing such suits in federal court despite the state legislature's intent.\textsuperscript{204}

In addition, the courts, themselves, may qualify as an appropriate supervisory authority for the purposes of the "active state supervision" requirement. According to the Eleventh Circuit in \textit{Bolt v. Halifax Hospital Medical Center}:\textsuperscript{205}

The purpose of the active state supervision requirement is to ensure that the conduct in question is in fact the product of state regulation. A state may choose to regulate private economic activity through a state agency; it may just as readily choose to regulate such activity through its courts. Indeed, regulation through the judiciary may be more likely to ensure accurate implementation of the state's policy, for courts are especially well suited to divine, interpret, and enforce legislative policy.\textsuperscript{206}

Hospitals, themselves, can also protect and promote their peer review activities. Hospital bylaws should provide for fair hearings with due process safeguards, which must be adhered to strictly and applied evenly to everyone. According to one health law expert, "[t]he best evidence you're following good faith is that you're following the rules."\textsuperscript{207}

One way in which hospitals can solve the problem of finding peer reviewers who are not in direct economic competition with the subject of a review is to enlist an outside, impartial peer review team. Such a program was formulated by the American College of Obstetricians and Gynecologists (ACOG) in 1986 in order to avoid the personal and legal conflicts that can arise from peer review, especially in the setting of a small health care facility.\textsuperscript{208} One drawback of such an approach is its cost: the ACOG program charges $20,000 to $25,000 for a team of three

\textsuperscript{202} Battaglia, \textit{The State of Peer Review in Delaware Today}, DEL. MED. J., April, 1988, at 238.

\textsuperscript{203} See Marrese v. Interqual, 748 F.2d 373 (7th Cir. 1984), \textit{cert. denied}, 105 S. Ct. 3501 (1985).

\textsuperscript{204} Id.

\textsuperscript{205} 851 F.2d 1273 (11th Cir. 1988). \textit{But see} Shahawy v. Harrison, 875 F.2d 1529 (11th Cir. 1989) (applying the Supreme Court's analysis in \textit{Patrick v. Burget}, the Court of Appeals held that state action doctrine does not shield a Florida hospital from antitrust claim of physician denied privileges because neither a state agency nor the state judiciary actively supervises the peer review process).

\textsuperscript{206} Id. at 1282.

\textsuperscript{207} Holthaus, \textit{Federal Law Offers Protection for Peer Review}, HOSPITALS, July 5, 1988, at 46; \textit{see also} Proper Procedures Are Key to Review Legality Experts Say, HOSPITALS, June 20, 1988, at 65 [hereinafter \textit{Proper Procedures}].

\textsuperscript{208} Koska, \textit{supra} note 191, at 58.
physicians and one nurse to visit a hospital and conduct a peer review. However, when compared to the potential price of an antitrust suit brought by a disgruntled physician, the money may be well spent.

A similar approach to ensuring impartial peer review is to institute a proctoring system within the hospital. Proctoring involves an objective evaluation of a physician’s clinical competence by a monitor, or proctor, who represents and is responsible to the medical staff. Proctors may be particularly appropriate in evaluating new applicants to a hospital. Proctors will actually observe the new physician performing procedures, and will discuss the applicant’s proposed treatment plans for particular patients.

The California Medical Association (CMA) has recommended that all medical staff institutes implement proctoring systems in their hospitals. The CMA’s guidelines for establishing a successful system require inclusion of proctoring rules in the hospital’s bylaws, and the careful selection of a proctor who is free from conflict of interest. If necessary, the proctor can be “borrowed” from another hospital or county medical society. In addition, the CMA recommends that proctors not receive a fee for their services.

Because of the unique nature of medicine—including factors such as the traditional independence accorded the regulation of physicians by their peers, and the presence of insurance companies as third-party payors—the profession as an industry does not respond neatly to traditional economic forces. Nor does it fit into a tidy antitrust package. It is contradictory, at best, to insist in one breath that physicians must monitor their colleagues, and then in another breath to allow disciplined physicians to sue their reviewers.

209. Id.
210. In 1981, for example, a Pennsylvania hospital spent over two million dollars in a successful defense against a surgeon who sued on antitrust grounds after his staff privileges were revoked. Otto, Flam & Silverman, An Approach to Limiting Antitrust Review of Hospital Peer Review Decisions, 55 INS. COUNSEL. J. 457, 462 n.38 (1986).
211. Baker, Taking Care of the Doctors: The Hospital’s Duty to Evaluate, Monitor, and Discipline its Medical Staff, 13 JOURNAL OF QUALITY ASSURANCE—QUALITY REVIEW BULLETIN, 88 (1987); Is There a Proctor in the House?, HOSPITALS, June 20, 1988, at 65 [hereinafter Proctor in the House]. Baker cautions that the proctor’s role must be carefully limited and described in order to avoid liability for breach of a potential duty of care owed to the patients of the physician being evaluated. Baker, at 89-90.
212. Proctor in the House, supra note 211, at 65.
213. Baker, supra note 211, at 89.
214. Proctor in the House, supra note 211, at 65.
215. Id.
The treble damages that accompany antitrust liability are grossly out of proportion to offenses that a peer review body attempting to perform its function can commit, and may result in harm that far outweighs its potential deterrent effect.\footnote{216} If a peer review board misbehaves or violates the trust that the public has placed in it to fairly and honestly evaluate its profession, other avenues of redress exist. Individuals with legitimate grievances can bring suit in state court for loss of income or other remedies that may accompany a finding that a state law was violated.

Peer review boards should not be given free reign to do whatever they please; \textit{Patrick v. Burget} is evidence of the kind of abuse that such boards are capable of. However, it is also evidence of a situation in which legitimate peer review could have saved lives. The whole point of peer review seems to have become obscured amidst the accusations of anticompetitive conspiratorial activity. The fact remains that Dr. Patrick committed serious, avoidable errors that cost patients their lives.\footnote{217} The fact also remains that other doctors in the community committed similarly egregious acts which went unpunished.\footnote{218} From a simplistic economic perspective, the unequal treatment of doctors in this community was admittedly unfair. The point that is so easily forgotten, however, is that the primary purpose of peer review is to protect the patient, not the doctor.

\textbf{Valerie S. Biebuyck}