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Antitrust Implications of Medical Peer Review: Balancing the Competing Interests

One of the greatest difficulties facing hospital-medical staff members today is the requirement of service on various hospital peer review committees. As a result, staff members must review the competency of fellow staff members. When faced with the prospect of "blowing the whistle" on colleagues, physicians are confronted with an array of potential legal actions that a disgruntled reviewee may assert. Most fearsome to the reviewing physician is the prospect of a federal antitrust suit with its attending treble damages award. In the past several years, both Congress and the federal courts have stepped up their efforts to assure physicians that their peer review activities, which are vital to safeguard the public against incompetent physicians, will be given the utmost protection. Recently, in a landmark decision, the Ninth Circuit Court of Appeals announced for the first time that peer review activities, whether or not conducted in bad faith, are immune from federal antitrust scrutiny.

I. INTRODUCTION

In an era of rising health-care costs,¹ the demand for physician participation on peer review committees² has never been greater. Growing concern over the quality of medical care has sparked the development of mandatory quality assurance programs³ throughout the health care industry. Unfortunately, the duty to participate in peer review⁴ has also spawned a number of lawsuits⁵ brought by phy-

1. USA Today, Feb. 16, 1987, at 10A, col. 1. (Doctors' fees, hospital bills, and prescription drugs rose 7.7% in 1986, meaning that the nation's medical bills rose seven times faster than the cost of all U.S. production in 1986). See also Lamm, *America's Inefficient Health Care: One Possible Cure Could Be Rationing*, L.A. Times, Feb. 1, 1987, § 5 (Opinion), at 1.

2. Peer review can be defined as "the evaluation by practicing physicians of the quality, efficiency and effectiveness of services ordered or performed by other physicians." W. ISELE, *THE HOSPITAL MEDICAL STAFF: ITS LEGAL RIGHTS AND RESPONSIBILITIES* 126 (1984). Peer review encompasses all medical review efforts, including utilization review, medical audit, the credential awarding function, periodic reappointment evaluations, and quality review activities. *Id.*

3. Lembecke, *Evolution of the Medical Audit*, 199 J. A.M.A. 543 (1967) (Formal peer review dates back to the early 20th century, when medicine was becoming an increasingly scientific discipline. The professional conscience was aroused by studies that found that most institutions were unable to meet any reasonable standard of care). See also Payne, *Continued Evolution of a System Medical Care Appraisal*, 201 J. A.M.A. 536 (1967).

4. Mandatory peer review is a prerequisite when professional services are paid for with public funds. 42 U.S.C. § 1320(c) (1983 & Supp. III 1986). More recently, peer review has been required for professional health services paid for with federal funds under the Professional Standards Review Organization. Peer review was formerly required under the Medicaid and Maternal Child Health and Crippled Children's service

sicians against peer review committee members who have reviewed them, and recommended that their privileges be terminated or suspended. For the most part, the decisions are inconsistent as to whether a cause of action should be recognized.⁶

The difficulty with a courts' failure to recognize antitrust claims⁷ under these circumstances, is that some physicians are subjected to peer review conducted in bad faith.⁸ Even though all the elements necessary to assert a legitimate antitrust claim may be present, physicians have been unable to succeed in both state⁹ and federal court actions.¹⁰

This comment will discuss the case law surrounding the peer review process and provide an overview of the applicable antitrust provisions. Finally, the comment will conclude that the public's interest

programs (Titles XIX and V of the Social Security Act). These requirements were amended in 1981, making such review optional among the states. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 2111-2113, 95 Stat. 357, 794-96 (1981) (codified as amended at 42 U.S.C. §§ 1320(c), 1396(a), 1396(b) (1983)).

5. Most of these suits allege defamation of character, tortious interference with business relations, violation of due process, and/or antitrust violations. See *Wright v. Southern Mono Hosp. Dist.*, 631 F. Supp. 1294 (E.D. Cal. 1986) (antitrust claim denied); *Ascherman v. Natanson*, 23 Cal. App. 3d 861, 100 Cal. Rptr. 656 (1972) (defamation claim denied); *Good Samaritan Hosp. Ass'n v. Simon*, 370 So. 2d 1174 (Fla. Dist. Ct. App. 1979) (defamation claim permitted); *Maimon v. Sisters of the Third Order of St. Francis*, 142 Ill. App. 3d 306, 491 N.E.2d 779 (1986) (libel claim denied); *Matviuw v. Johnson and Alexian Bros. Med. Center*, 70 Ill. App. 3d 481, 388 N.E.2d 795 (1979) (defamation claim permitted); *Hayden v. Foryt*, 407 So. 2d 535 (Miss. 1981) (*reh'g denied*) (slander claim permitted).

6. See cases cited *supra* note 5.

7. The statute commonly used in antitrust actions is the Sherman Act, 15 U.S.C. §§ 1-7 (1983 & Supp. III 1986). However, the Clayton Act, 15 U.S.C. §§ 12-27 (1983 & Supp. III 1986), the Federal Trade Commission Act, 15 U.S.C. §§ 41-48 (1983 & Supp. III 1986), and state antitrust laws may also apply.

8. Common to most state immunity statutes is the requirement that communications made to peer review committees be conducted in "good faith." Typical is the Maryland statute which first defines the nature and the function of medical review committees and then states:

A person who acts in *good faith* and within the scope of jurisdiction of a medical review committee is not civilly liable for any action as a member of the medical review committee or for giving information to, or participating in, or contributing to the function of the medical review committee.

MD. HEALTH OCC. CODE ANN. § 14-601(f) (1986) (emphasis added). See also OR. REV. STAT. § 41.675(4) (1985); CAL. CIV. CODE § 43.97 (West 1982 & Supp. 1986).

9. In response to the growing fear of potential antitrust suits, legislation has been enacted which gives some degree of immunity from suit to members of peer review committees. However, coverage differs from state to state, and each statute must be scrutinized to determine which activities and which persons are covered. This grant of immunity has made it impossible for the challenging physician to proceed past the pleading stages in his suit. Most claims are simply demurred to or dismissed on a summary judgment motion. Interview with Peter A. Schneider, Bonne, Jones, Bridges, Mueller & O'Keefe (March 27, 1987).

10. See *infra* notes 11-19 and accompanying text. The Seventh Circuit reached a similar result in *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).

in receiving quality health care outweighs the rights of physicians to assert even legitimate antitrust claims.

The Patrick Case

Patrick v. Burget is one of the most recent examples of a judicial determination in the area of antitrust and medical peer review.¹¹ In *Patrick*, an Oregon antitrust case, the Ninth Circuit Court of Appeals reversed a 2.1 million dollar jury award¹² that caused widespread fear that participation in peer review committees may be a basis for potentially burdensome liability.¹³

The court in *Patrick* was faced with allegations by a staff physician that adverse peer review recommendations were motivated by the desire to eliminate competition. Dr. Patrick alleged that his fellow staff members' lack of cooperation, their appeals to the Board of Medical Examiners, and their presence at hearings to revoke staff privileges, all amounted to unfair attempts by competitors to create a monopoly.¹⁴

The Ninth Circuit ruled that Oregon's mandatory medical peer review committees¹⁵ are immune from federal antitrust scrutiny under

11. 800 F.2d 1498 (9th Cir. 1986), *cert. granted*, (Oct. 5, 1987) (Docket No. 86-1145).

12. The jury awarded Dr. Patrick \$650,000 for antitrust violations, which the court then trebled. The jury also awarded \$20,000 in compensatory and \$90,000 in punitive damages. The court awarded Dr. Patrick \$228,600 in attorney's fees. *Id.* at 1505.

13. Rust, *Justice Says Peer Review Not An Antitrust Violation*, AM. MED. NEWS, Dec. 19, 1986, at 2, col. 1. In response to a request by the American Medical Association, the United States Department of Justice issued a letter making clear its position with respect to peer review proceedings and antitrust laws. Hoping to alleviate the "chilling effect" that high-profile antitrust suits have created across the country, the Department stated the following:

Antitrust laws do not stand in the way of physicians' participation in hospital peer review conducted to identify and restrain incompetence in the provision of health care. . . . To the contrary, because such peer review enhances both the quality and efficiency of services delivered in our nation's hospitals to the benefit of consumers, it furthers the antitrust goal of fostering competition in the health care marketplace.

Id.

14. *Patrick*, 800 F.2d at 1502.

15. The Oregon statutory scheme provides:

The governing body of each health care facility shall be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility. The governing body shall:

(a) Insure that all health personnel for whom state licenses or registration are required are currently licensed or registered;

(b) Insure that physicians admitted to practice in the facility are granted privileges consistent with their individual training, experience and other qualifications;

(c) Insure that procedures for granting, restricting, and terminating privi-

the “state action” doctrine.¹⁶ The court reasoned that the state had ordered the activity in a clearly articulated and affirmatively expressed statute,¹⁷ and that the regulation of the process belongs to the state alone—not the federal courts.¹⁸ The court further declared that physicians who feel they have been wronged by the peer review process may pursue their claims in state courts, but maintained that federal antitrust laws should not apply in state court actions.¹⁹

II. BACKGROUND

To fully understand and appreciate the impact of *Patrick v. Burget*,²⁰ it is helpful to examine the structure of a typical hospital medical staff and the functions of peer review committees. A review of the hospital structure also reveals why hospitals must exercise discretion in selecting their medical staffs.²¹

A. Organization of the Medical Staff

A hospital’s governing board has ultimate responsibility for maintaining quality patient care.²² The medical staff, however, bears the immediate responsibility to ensure that such care is actually administered.²³ To fulfill this obligation, the medical staff must establish and perform certain functions for monitoring and improving its medical

leges exist and that such procedures are regularly reviewed to assure their conformity to applicable law; and

(d) Insure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the professional practices of the facility for the purposes of reducing the morbidity and mortality and for the improvement of patient care.

OR. REV. STAT. § 441.055(3) (1985).

16. *Patrick*, 800 F.2d at 1507. See *infra* notes 49-62 and accompanying text.

17. See Oregon statute, *supra* note 15.

18. *Patrick*, 800 F.2d at 1507.

19. *Id.*

20. *Id.* at 1498.

21. The law has imposed upon health care facilities an increasing obligation to properly select and continually monitor their attending physicians under the doctrine of *corporate liability*. See *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 337-41, 183 Cal. Rptr. 156, 157-58 (1982); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966). See also Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship With the Staff Physician*, 9 CAL. W.L. REV. 429 (1973); Walkup & Kelly, *Hospital Liability: Changing Patterns of Responsibility*, 8 U.S.F. L. REV. 247 (1973).

22. JOINT COMMISSION ON ACCREDITATION FOR HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 49 (1987) [hereinafter JCAH]. (In August, 1987, this Commission changed its name to Joint Commission on Accreditation of Healthcare Organizations.) In *Matchett v. Superior Court*, 40 Cal. App. 3d 623, 115 Cal. Rptr. 317 (1974), the court took judicial notice of the nationwide standards describing the organization and functions of medical staffs and their committees in accredited hospitals. In a footnote, the court recited the JCAH credentials and recognized its accreditation and standards as a benchmark. *Matchett*, at 627 n.2, 115 Cal. Rptr. at 319 n.2.

23. JCAH at 109.

practice.²⁴ These functions include: surgical case review (tissue review), review of pharmaceutical and therapeutic activities, review of medical records, review of blood utilization, antibiotic usage reviews, and other patient-related medical activities.²⁵ One other important function is that of investigating the credentials of applicants for staff privileges.²⁶ In most hospitals with large medical staffs, these functions are performed by committees composed of members of the medical staff.²⁷ Of all the committees that are regularly set up, the "credentials committees" have routinely been targeted by antitrust claims.

It is the responsibility of the credentials committee to collect and review information on the professional competence and ethical practices of all applicants for medical staff privileges.²⁸ The committee makes recommendations to the staff's executive committee regarding approval or denial of applicants' privileges.²⁹ Although the governing board is responsible for the final decision with regard to all recommendations,³⁰ the executive committee can still exercise considerable influence over the extension of these privileges.³¹ This power to influence the ability of a physician to retain or obtain staff privileges provides a basis for the allegation that peer review committees engage in anticompetitive acts.

The credentials committee is also empowered to re-appraise all staff members on a regular and periodic basis to approve or deny re-appointment and to delineate the scope of a member's staff privileges.³² The committee reviews information concerning the professional performance, judgment, technical skill, and health of the physicians on staff.³³

Peer recommendation serves an important role in this evaluation process.³⁴ Significantly, the recognized purpose of peer review is the continued improvement in the care and treatment of patients through objective, candid, and sometimes brutally critical evaluation

24. *Id.* at 122.

25. *Id.* at 122-27.

26. *Id.* at 117-121.

27. *Id.* at 115.

28. *Id.*

29. *Id.* at 122.

30. *Id.*

31. *Id.* at 115.

32. *Id.* at 121.

33. *Id.*

34. *See id.* at 122.

of a physician's clinical practices.³⁵

B. The Antitrust Considerations

1. Background

The Sherman Act,³⁶ passed by the United States Congress in 1890, was designed to prohibit restraint of trade³⁷ and monopolization of the marketplace.³⁸ The aim of Congress in promulgating the Act was to promote "full and free competition" in the marketplace.³⁹ The United States Supreme Court stated in 1958 that:

[The Sherman Act] rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political and social institutions.⁴⁰

In pleading a cause of action under section 1 or 2 of the Sherman Act, the plaintiff must adequately allege the jurisdictional requirements of interstate commerce.⁴¹ The Seventh Circuit in *Williams v. St. Joseph Hospital*,⁴² established that "medical practice *per se* and without more is a local activity."⁴³ However, the Supreme Court has since embarked on an expanded interpretation of the interstate commerce requirement as applied to the health care field.⁴⁴ Thus, a complaint is now deemed adequate if it alleges facts sufficient to establish that the defendant's illegal conduct constitutes "interstate commerce" or has a "substantial adverse effect upon interstate commerce."⁴⁵ Under the "substantial effect" test, it has been held unnecessary for a plaintiff to show that the impact on interstate com-

35. See Firestone, *Malicious Deprivation of Hospital Staff Privileges*, 14 LEGAL ASPECTS OF MED. PRAC. 1 (May, 1986).

36. 15 U.S.C. §§ 1-7 (1982).

37. Section one of the Act establishes: "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 hereby declared to be illegal." *Id.* § 1.

38. Section two of the Act establishes: "Every 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 among the several States, or with foreign nations, shall be deemed guilty of a felony. . . ." *Id.* § 2.

39. See S. 3445 50th Cong. 2d Sess. § 1 (1888); *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 4 (1958) ("[t]he policy unequivocally laid down by the Act is competition"). For an excellent treatment of the legislative history of the Act, see Letwin, *Congress and the Sherman Antitrust Law: 1887-1890*, 23 U. CHI. L. REV. 221 (1956).

40. *Northern Pac. Ry. Co.*, 356 U.S. at 4.

41. See *infra* notes 42 and accompanying text.

42. 629 F.2d 448 (7th Cir. 1980).

43. *Id.* at 454 (citing *Polhemus v. American Med. Ass'n*, 145 F.2d 357, 359 (10th Cir. 1944)).

44. See Kissman, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CAL. L. REV. 595 (1982).

45. *McLain v. Real Estate Bd.*, 444 U.S. 232, 241-42 (1980); *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738, 743 (1976) (hospital that received out-of-state supplies and finances determined to be involved in interstate commerce).

merce has caused a business collapse, affected market prices, or that the defendant intended to affect interstate commerce.⁴⁶ In hospital cases, some well-recognized methods for demonstrating effect upon interstate commerce in antitrust litigation include: (1) treatment of out-of-state patients; (2) receipt of medicare; (3) receipt of medicaid and out-of-state insurance funds; and (4) purchase of medicine, equipment, and medical supplies from out-of-state retailers by the defendant hospital or physician or the plaintiff doctor.⁴⁷

2. Exemptions Under the Antitrust Laws

Over the years, courts have developed exemptions to the antitrust laws which prevent any inquiry into a defendant's allegedly anticompetitive actions. Although the exemptions are not statutory, they have nevertheless become well-defined through their evolution in case law. Significant to the health care field are the state action doctrine,⁴⁸ implied repeal,⁴⁹ and the McCarran-Ferguson Act.⁵⁰

a. The State Action Doctrine

The state action doctrine⁵¹ was first enunciated by the Supreme Court in *Parker v. Brown*.⁵² In *Parker*, the Court held that a California statute⁵³ which established state control over raisin production

46. *Hospital Bldg. Co.*, 425 U.S. at 745-46.

47. *Id.* at 744. See, e.g., *Weiss v. York Hosp.*, 745 F.2d 786, 824 n.63 (3d Cir. 1984) (osteopath denied staff privileges); *Hayden v. Bracy*, 744 F.2d 1338 (8th Cir. 1984); *Furlong v. Long Island College Hosp.*, 710 F.2d 922 (2nd Cir. 1983); *Mishler v. St. Anthony's Hosp. Systems*, 694 F.2d 1225 (10th Cir. 1981) (neurosurgeon excluded from emergency room referral list); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715 (10th Cir. 1981) (pathologist denied staff privileges); *Capili v. Shott*, 620 F.2d 438 (4th Cir. 1980); *Williams v. Kleaveland*, 534 F. Supp. 912 (W.D. Mich. 1981) (doctor denied reappointment to hospital staff).

48. See *infra* notes 51-65 and accompanying text.

49. See *infra* notes 66-77 and accompanying text.

50. 15 U.S.C. §§ 1011-15 (1982). This federal statute specifically exempts certain activities from federal antitrust scrutiny if the following requirements are met: (1) the practices challenged must involve the "business of insurance;" (2) the "business of insurance" must be regulated by state law; and (3) the conduct challenged must not involve an agreement to boycott, coerce or intimidate. *Id.* § 1012, 1013(b). Because peer review activities are not connected to the "business of insurance," the McCarran-Ferguson Act will not be discussed.

51. For an excellent review of the state action doctrine, see P. AREEDA, ANTITRUST LAW 206-20 (Supp. 1982); Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 HARV. L. REV. 435 (1981).

52. 317 U.S. 341 (1943).

53. California Agricultural Prorate Act, Act of June 5, 1933, ch. 754. The constitutionality of the Act was sustained by the California Supreme Court in *Agricultural Prorate Comm. v. Superior Court*, 5 Cal. 2d 550, 55 P.2d 495 (1936).

was immune from antitrust scrutiny.⁵⁴ This conclusion represents the Court's attempt to resolve the conflict between principles of federalism and the antitrust laws' goal of preserving and encouraging unfettered competition.⁵⁵ Relying on principles of sovereignty, the Court stated:

We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature. In 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.⁵⁶

A recent Supreme Court case concluded: "Thus, when a state legislature adopts legislation, its actions constitute those of the state . . . and *ipso facto* are exempt from the operation of the antitrust laws."⁵⁷

When the challenged activity is not undertaken directly by the legislature or the state supreme court, but rather is carried out by others pursuant to state authorization, closer analysis is required to determine if the state action doctrine applies.⁵⁸ It is imperative to ensure that the anticompetitive conduct of the state's representative was contemplated by the state.⁵⁹

To acquire immunity in these cases, the Supreme Court has stated two requirements for immunity to attach under *Parker*.⁶⁰ First, the challenged restraint must be a clearly articulated and affirmatively expressed state policy;⁶¹ second, the policy must be actively super-

54. *Parker*, 317 U.S. at 350.

55. *Id.* at 350-51.

56. *Id.* See P. AREEDA, ANTITRUST LAW, *supra* note 51 at 207-08.

57. *Hoover v. Ronwin*, 466 U.S. 558, 567-68 (1984).

58. *Id.* See also *New Motor Vehicles Bd. of Cal. v. Orrin W. Fox Co.*, 439 U.S. 96 (1978) (state board's enforcement of a clearly articulated, affirmatively expressed state regulation of automobile dealerships exempt under *Parker*); *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 413-15 (1978) (plurality opinion) (city's operation of electrical utility system exempt under *Parker* if state contemplated the action complained of when it authorized the city to operate in the area); *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977) (enforcement of clearly articulated disciplinary rules by state supreme court acting in its legislative capacity is exempt under *Parker*); *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976) (plurality opinion) (private utility company's regulation of light bulbs, approved by the state and required to be continued until a new tariff was filed, not exempt under *Parker*); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) (state bar association's enforcement of a minimum legal fee schedule not exempt under *Parker* because it was not compelled by the state).

59. *Hoover*, 466 U.S. at 568.

60. See *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

61. *Id.* at 105. To establish the "clearly articulated and affirmatively expressed state policy" prong of the state action exemption, the state legislature must authorize the challenged activity and must intend it to displace the federal antitrust laws. See P. AREEDA, ANTITRUST LAW *supra* note 51 at 212; see also *Community Communications Co. v. Boulder*, 455 U.S. 40 (1982); *Hybud Equip. Corp. v. City of Akron*, 742 F.2d 949 (6th Cir. 1984) *cert. denied*, 471 U.S. 1004 (1985).

vised by the state.⁶²

A peer review committee mandated by state law may fall within the state action exemption. In *Patrick*, the court found that "by compelling physicians to review their competitors affirmatively, [the State of Oregon] has expressed a policy to replace pure competition with some regulation."⁶³ The *Patrick* court also found that the peer review process was actively supervised by the state.⁶⁴ Crucial to this conclusion was the court's finding that supervision by the Board of Medical Examiners, a state agency, was the equivalent to supervision by the state.⁶⁵ Therefore, it may be concluded that if a peer review committee can establish that the state legislature contemplated that the peer review statute was intended to replace competition with regulation in the relevant market, and that a state agency supervises the peer review process, then the peer review activities are exempted from antitrust challenge under the state action doctrine.

b. Implied Immunity

Conduct that is mandated by federal legislation is covered by another exemption to the antitrust laws referred to as "implied immunity" or "implied repeal." This exemption is grounded on the theory that Congress intends an implied repeal of the antitrust laws when it passes subsequent legislation which directly conflicts with those laws.⁶⁶ In order to reconcile the two statutory schemes, the antitrust laws are considered repealed to the extent necessary to make the subsequent legislation effective.⁶⁷ However, implied immunity is not viewed favorably and "can be justified only by a convincing showing of clear repugnancy between the antitrust laws and the regulatory system."⁶⁸ The intent of Congress to repeal the antitrust laws must

62. *California Retail Liquor Dealers Ass'n.*, 445 U.S. at 105. In *Patrick*, the court found that internal review by the hospital, the Board of Medical Examiners, and by the courts constituted adequate supervision. *Patrick*, 800 F.2d at 1506. See *Hoover*, 466 U.S. at 572 n.22 (availability of judicial review evidence of state action); *Tambone v. Memorial Hosp.*, 635 F. Supp. 508, 514-15 (N.D. Ill. 1986) (no state supervision where record of peer review not automatically transmitted to state agencies).

63. *Patrick*, 800 F.2d at 1505-06.

64. *Id.* at 1506.

65. *Id.*

66. *National Gerimedical Hosp. & Gerontology Center v. Blue Cross*, 452 U.S. 378 (1981); *United States v. National Ass'n of Sec. Dealers*, 422 U.S. 694 (1975); *Gordon v. New York Stock Exch., Inc.*, 422 U.S. 659 (1975).

67. *Silver v. New York Stock Exch.*, 373 U.S. 341, 357 (1963).

68. *National Gerimedical*, 452 U.S. at 388; *National Ass'n of Sec. Dealers*, 422 U.S. at 719-20.

be clear and will most likely be found only when a regulatory agency has been empowered to supervise, authorize, or require the particular type of conduct under antitrust scrutiny.⁶⁹

*National Gerimedical Hospital & Gerontology Center v. Blue Cross*⁷⁰ was the Supreme Court's most recent consideration of implied immunity. In that case, National Gerimedical Hospital attempted to enter into a participating hospital agreement with Blue Cross, a nonprofit provider of health care reimbursement plans. Blue Cross refused to enter into the agreement on the basis that the hospital had failed to comply with the provisions of the National Health Planning and Resources Development Act of 1974 (hereinafter NHPDA).⁷¹ National Gerimedical then filed an antitrust lawsuit against Blue Cross, claiming that Blue Cross' refusal placed it at a competitive disadvantage.⁷²

The Supreme Court refused to find Blue Cross' acts exempted under the implied immunity doctrine.⁷³ The Court noted that action taken by Blue Cross was neither compelled nor approved by any government regulatory body.⁷⁴ The Court also found no inconsistency between the NHPDA and the antitrust laws which would necessitate a partial repeal of the antitrust laws to effectuate the Act.⁷⁵

The activities of federally mandated hospital peer review under the Health Care Quality Improvement Act⁷⁶ can be distinguished from the activities challenged in *National Gerimedical*. Unlike the activities questioned in *National Gerimedical*, the federal peer review law specifically mandates peer review activities. It may thus be argued that to the extent Congress intended to encourage peer review activities, Congress must have intended a partial repeal of antitrust laws that prohibit peer review. Therefore, those peer review activities required by federal law and supervised by the Department of Human Services may be exempted from antitrust scrutiny under the implied immunity doctrine.

69. *National Gerimedical*, 452 U.S. at 389.

70. *Id.* at 378.

71. 42 U.S.C. § 3001 (1983 & Supp. III 1986). Blue Cross relied on the hospital's failure to obtain approval for construction from the Mid-America Health Systems Agency [hereinafter MAHSA]. MAHSA was the local "health system agency" under the Act for health planning. The hospital did not seek approval of its construction because MAHSA had announced a policy that it would not approve any addition of acute care beds.

72. National Gerimedical claimed violations of sections 1 and 2 of the Sherman Act and violations of the Missouri antitrust laws. *National Gerimedical*, 452 U.S. at 382.

73. *Id.* at 393.

74. *Id.* at 389.

75. *Id.* at 393.

76. See *infra* notes 123-148.

3. Peer Review Under the Antitrust Laws

Even though peer review activities may be exempted from antitrust implications, they are still subject to scrutiny as to whether an illegal agreement among competitors is present. The Sherman Act prohibits agreements "between competitors, actual or potential, dealing in competing products in a relevant market."⁷⁷ Once it is determined that there is an agreement between competitors, the challenged agreement must be evaluated by either the *per se* rule or the rule of reason.

a. The Per Se Rule

The *per se* rule is a judicially created rule under which certain types of agreements are considered "so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality."⁷⁸ The *per se* rule has traditionally been applied to cases involving price-fixing,⁷⁹ group boycotts,⁸⁰ and tying arrangements⁸¹ are summarily treated because of their "pernicious effect on competition and lack of any redeeming virtue."⁸² A physician challenging committee actions faces difficult legal obstacles and very little favorable precedent unless the physician is able to categorize the challenged action as one of the traditional *per se* violations. Absent a finding of *per se* violations, courts resort to the rule of reason standard which almost invariably results in a ruling in favor of the health care agency.⁸³

The professional status of physicians and other health care providers may also be a basis for peer review committee members to escape antitrust liability. Although the Supreme Court has disavowed any total professional exemption from antitrust scrutiny,⁸⁴ it has indicated that antitrust laws might be applied less rigorously to profes-

77. *United States v. Columbia Pictures Corp.*, 169 F. Supp. 888, 893 (S.D.N.Y. 1959).

78. *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 692 (1978).

79. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). The *per se* analysis will apply even if the agreement would stabilize maximum prices. See *Albrecht v. Herald Co.*, 390 U.S. 145, 151-53 (1968); *Keifer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 213 (1951).

80. *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959).

81. *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1 (1958).

82. *Id.* at 5.

83. See *infra* notes 104-115 and accompanying text.

84. See *infra* note 93 and accompanying text.

sions than to trades or industries.⁸⁵

In *Goldfarb v. Virginia State Bar*,⁸⁶ the Supreme Court explicitly rejected an expansive professional exemption from antitrust scrutiny. *Goldfarb* involved a minimum-fee schedule for legal services relating to real estate transactions enforced by the Virginia State Bar.⁸⁷ A class action suit was brought, in which it was alleged that the minimum-fee schedule constituted price-fixing in violation of Section 1 of the Sherman Act.⁸⁸

The County Bar relied on two arguments in defending the case. First, it argued that Congress never intended to include the learned professions within the terms of Section 1 of the Sherman Act.⁸⁹ Second, it maintained that competition was inconsistent with the practice of a profession because enhancement of profit is not the goal of professional activities.⁹⁰

The Supreme Court rejected both of these arguments, finding that the nature of the occupation standing alone is insufficient to create an exemption from the Sherman Act⁹¹ and that the public service aspects of a profession are not controlling.⁹² However, the Court did not completely rule out the possibility that it may impose a less stringent standard on professionals. In a footnote, the Court cautioned:

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.⁹³

In subsequent decisions, the Court has continued to mention this more lenient standard for professionals but has refused to apply it. In *National Society of Professional Engineers v. United States*,⁹⁴ the Court was confronted with the legality of a canon of engineering ethics prohibiting competitive bidding among engineers.⁹⁵ The Court invalidated the canon because it completely precluded competitive prices among engineers.⁹⁶ In its defense, the Society relied heavily on *Goldfarb*, asserting that the canon sought to preserve traditional

85. *Id.*

86. 421 U.S. 773 (1975).

87. *Id.* at 776.

88. *Id.* at 778.

89. *Id.* at 786.

90. *Id.*

91. *Id.* at 787.

92. *Id.*

93. *Id.* at 788-89 n.17.

94. 435 U.S. 679 (1978).

95. *Id.* at 681.

96. *Id.* at 692-93.

fees for services while at the same time preventing "public harm which might be produced by unrestrained competitive bidding."⁹⁷ The Court conceded that professional services may differ significantly from other business services and ethical canons may serve to regulate and promote competition.⁹⁸ However, the Court found that the engineers' ethical canon, which resulted in a total ban on competitive bidding, was too broad and an improper reason for doing away with competition.⁹⁹

The most recent decision announced by the Court dealing with the application of the antitrust laws to a profession is *Arizona v. Maricopa County Medical Society*.¹⁰⁰ In *Maricopa*, the Court found maximum-fee agreements *per se* unlawful under Section 1 of the Sherman Act. The Court stated that doctors who are parties to price-fixing agreements will not be safeguarded from antitrust liability any more than nonprofessionals.¹⁰¹ Referring to *Goldfarb*, the Court noted that *Maricopa* was not a case where the agreements were premised on public service or ethical norms which may have permitted application of a less stringent standard.¹⁰² The Court also rejected the argument that the judiciary has too little experience with antitrust in the health-care industry to apply a *per se* rule.¹⁰³

The scope of the professional exemption is not yet clear. If the United States Supreme Court grants review in *Patrick*, it will have an excellent opportunity to address this principle outside a price-fixing setting. *Patrick*, unlike *Goldfarb*, *National Society*, and *Maricopa*, involves no allegations that would subject the parties to the traditional *per se* analysis. Also, the hospital peer review process contains elements of public service which the Court found lacking in *Maricopa*. Additionally, peer review does not constitute a total ban on competition, but merely regulates competition by encouraging only competent physicians to practice medicine. Therefore, the professional exemption may be found to attach in this setting. As a result, the reviewing court may apply a less stringent standard of review, provided the court determines that the inherent goal of peer review is to improve the quality of patient care.

97. *Id.* at 687.

98. *Id.* at 696.

99. *Id.*

100. 457 U.S. 332 (1982) (plurality opinion).

101. *Id.* at 349.

102. *Id.*

103. *Id.*

b. The Rule of Reason

The rule of reason is a common law doctrine which developed long before the enactment of the Sherman Act.¹⁰⁴ The legislative history of the Act indicates that Congress intended that common law principles should assist the courts in shaping the scope of the Act's broad proscriptions.¹⁰⁵ Thus, courts have consistently relied on the rule of reason to provide a flexible means of delineating the scope of the act.¹⁰⁶

The rule of reason focuses directly on the impact of the challenged restraint on competitive conditions.¹⁰⁷ However, "[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."¹⁰⁸ In *Standard Oil Co. of New Jersey v. United States*,¹⁰⁹ the Court enunciated a two-pronged test to determine if the challenged contracts "were unreasonably restrictive of competitive conditions."¹¹⁰ Under the test, unreasonableness can be found either: (1) based on the nature or character of the contracts; or (2) where the surrounding circumstances give rise to the inference or presumption that the contracts were intended to restrain trade or enhance prices.¹¹¹ The Court has adhered to the position that the inquiry mandated by the rule of reason is whether the challenged agreement is one that promotes competition or one that suppresses competition.¹¹²

Thus, in peer review cases, either an anticompetitive purpose or an anticompetitive effect would have to be found in order for the rule of reason to invalidate the denial or revocation of staff privileges.¹¹³ Anticompetitive purpose may be present where the peer review action is conducted by fellow physicians who wish to be insulated from additional competition. Suppression of competition might also be

104. The rule of reason developed from the case of *Mitchel v. Reynolds*, 24 Eng. Rep. 347 (1711). *Mitchel* involved the enforceability of a covenant not to compete for a limited time and within a limited area. The court upheld the covenant, finding that the benefits of enhancing marketability outweighed the temporary loss of competition. *Id.* at 350. *Mitchel* has been regarded as a standard for application of the rule of reason to covenants in restraint of trade which are ancillary to a legitimate transaction. See *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 689 (1977).

105. *National Soc'y of Professional Eng'rs*, 435 U.S. at 688 n.11.

106. *Id.* at 688.

107. *Id.*

108. *Id.*

109. 221 U.S. 1 (1910).

110. *Id.* at 58.

111. *Id.*

112. The rule of reason was further explained by the Court in *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49 (1977) as follows: "Under this rule, the factfinder weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition."

113. *Robinson v. McGovern*, 521 F. Supp. 842, 915 (1981).

found where a physician is given a poor peer review evaluation because of failure to join a medical society. However, under the rule of reason, the Court may look beyond this result and inquire whether the action taken by the peer review body is one that promotes or suppresses competition.¹¹⁴

Therefore, peer review action may be found to actually promote competition because effective review has the result of ensuring that only qualified physicians are permitted to practice medicine, which in turn results in increased competition among those physicians in practice. A court may also find that a hospital, acting through its peer review body, has legitimate reasons for denying or revoking a privilege, especially in light of new trends in hospital corporate liability.¹¹⁵

The application of the rule of reason to staff privilege revocation cases allows hospitals to be selective in their obligation to maintain control over the quality of its medical staff. If conducted properly, it is unlikely that review activities will be found to violate the antitrust laws under the rule of reason.

III. AN ANALYSIS OF THE COMPETING INTERESTS

The primary goal of the peer review process is to assure that health care is delivered in a competent manner.¹¹⁶ Protection of the public health, safety, and welfare is also of importance because the general public is correctly deemed incapable of monitoring the system themselves.¹¹⁷ At odds with these interests are those of a physician who has been subjected to a sham peer review evaluation conducted by his competitors.¹¹⁸ Analysis of the relative significance of the rights being protected, however, reveals that these competing interests are reconcilable.

The most significant interest protected is that of ensuring that the public receives quality health care from a competent physician.¹¹⁹ To facilitate this interest, "self-policing" is crucial because, in this author's opinion, nonprofessionals lack the capacity to judge the competency of a professional.¹²⁰ The result is that any peer review

114. See *supra* note 112 and accompanying text.

115. See *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).

116. See *Marrese v. Interqual, Inc.*, 748 F.2d 373, 595 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).

117. *Franco v. District Ct.*, 641 P.2d 922, 925 (1982).

118. See *Patrick v. Burget*, 800 F.2d 1498, 1503-04 (9th Cir. 1986), *cert. granted*, 107 S. Ct. 1345 (1987).

119. *Franco*, 641 P.2d at 925.

120. *Id.*

committee member must contemplate that his or her fellow staff members might conceivably complain or raise questions concerning his or her own competency.¹²¹

Inevitably, physicians charged with the duty of initiating a complaint will be personally acquainted with the staff member to be reviewed and will often be his competitor.¹²² However, the anticompetitive aspects of this process have been diluted because physicians who conduct the review are faced with the knowledge that what they include in their reports may be used against them in court.

IV. CONGRESSIONAL RESPONSE

In an effort to show its concern for the problems facing physicians called upon to recognize and root out incompetent practitioners, Congress enacted the Health Care Quality Improvement Act of 1986 (the Act).¹²³ Effective November 14, 1986, the Act provides to peer review committees¹²⁴ which act in good faith¹²⁵ immunity from state¹²⁶ and federal¹²⁷ antitrust suits as well as other actions.¹²⁸ The preamble of the Act indicates that Congress recognized that the fear of private

121. *Marrese*, 748 F.2d at 388.

122. *Id.* See Miles & Philp, *Hospitals Caught in the Antitrust Net: An Overview*, 24 DUQ. L. REV. 489 (1985). See Springer & Casale, *Hospitals and the Disruptive Health Care Practitioners—Is the Inability to Work With Others Enough to Warrant Exclusion?*, 24 DUQ. L. REV. 377 (1985).

123. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 1986 U.S. CODE CONG. & ADMIN. NEWS 100 Stat. 3784, codified as 42 U.S.C. §§ 11101-11152. The bill was introduced by Oregon Democratic Representative, Ron Wyden. For a comprehensive analysis of the Act, see *Health Care Quality Improvement Act of 1986*, 3 THE HEALTH LAWYER Winter, 1987, at 2.

124. Peer review committees fall within the definition of a "professional review body" defined in the statute as follows: "a health care entity and the governing body or any committee or a health care entity which conducts professional review activity, and includes any committee of the medical staff of such entity when assisting the governing body in a professional review activity." 42 U.S.C. § 11151(11).

125. Section 11112 of the Act enumerates the standards for professional review actions. Section 11112(a)(1) expressly states that in order to take advantage of the protections afforded by the Act, professional review must be grounded upon a "reasonable belief that the action was in furtherance of quality health care." *Id.* § 11112(a)(1).

126. Immunity from state law actions applies only for professional review actions taken on or after October 14, 1981. *Id.* § 11111(c)(1). States may by legislation elect to opt into the Act at an earlier date as authorized by section 11111(c)(2)(A) or opt out of the Act entirely pursuant to section 11111(c)(2)(B).

127. Immunity from federal claims applies to professional review activity commenced on or after November 14, 1986, the date the Act was enacted. *Id.* § 11111.

128. Expressly exempted from the Act are actions based on state or federal civil rights actions. *Id.* § 11111(a)(1). Specifically exempted are the Civil Rights Act of 1964, *Id.* § 2000(e); and the Civil Rights Acts, *Id.* § 1981. Therefore, exclusion of a physician on racial or ethnic grounds could not be defended by asserting the immunity provisions of the Act. *Id.* § 11111(a)(1).

Additionally, the provisions of the Act in no way limit the enforcement power of the state and federal governments. The Act is meant to apply only to private damage awards. This relief is further limited to liability for civil damages only. Defendants are not protected from claims for declaratory or injunctive relief. *Id.* § 11113(a).

money damages under the federal laws, specifically, potential liability for treble damages awards under the antitrust laws, had created a nationwide chilling effect on peer review activities.¹²⁹ Additionally, Congress expressed doubt in the ability of the individual states to remedy the national problem on their own.¹³⁰

To promote peer review activities, Congress granted the immunity to any professional review body, its staff members, anyone under contract or other formal agreement with the body, or any person who participates with or assists the review body.¹³¹ This protection is granted only to a peer review action taken in a reasonable belief that it was in furtherance of improving the quality of health care.¹³² Under the Act, peer review bodies are presumed to have conducted themselves in accordance with the Act unless the presumption is rebutted by a preponderance of the evidence.¹³³ If a suit is brought against a committee member, and at the conclusion of the action the committee member substantially prevails,¹³⁴ the Act provides for recovery of costs of the suit by that party, including reasonable attorney's fees if the claim was frivolous, unreasonable, without foundation, or in bad faith.¹³⁵

In return for the limited immunity conferred by the Act, various entities will be subject to stringent reporting requirements. Insurance companies are now required to report all malpractice judgments

129. Section 11101 provides as follows:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

Id. § 11101.

130. *Id.*

131. *Id.* § 11111(a)(1).

132. *Id.* § 11112(a).

133. *Id.*

134. If the plaintiff obtains an award for damages or for permanent or injunctive relief, the defendant will not be considered to have substantially prevailed. *Id.* § 11113.

135. *Id.*

or settlements to the national body¹³⁶ and to the state licensing boards¹³⁷ or risk payment of civil penalty fines of up to \$10,000.¹³⁸ Each state board of medical examiners will be required to report to the national body and the state licensing board all competency-related license revocations, suspensions, censures, or reprimands, or else risk losing the protection from antitrust suits.¹³⁹ Finally, the Act imposes an affirmative duty on hospitals, as opposed to other health care entities, to request information from the Secretary that has been reported.¹⁴⁰ Hospitals must request the information when a physician applies for membership on the medical staff. The hospital is also required to obtain information once every two years on all physicians who are currently members of its staff.¹⁴¹

For purposes of medical malpractice actions, if the hospital fails to meet its duty to affirmatively obtain the information described above, the hospital is presumed to have knowledge of any information that has been reported to the Secretary.¹⁴² However, once the hospital obtains the information in accordance with the Act, it cannot be held liable for reliance on the information provided.¹⁴³

The antitrust immunity provided by the Act appears much narrower than the protection afforded in *Patrick*.¹⁴⁴ In *Patrick*, the immunity was given to the peer review board although there was evidence that the procedure was conducted in bad faith.¹⁴⁵ In con-

136. The information must be reported at least monthly to the Secretary. The initial report must be submitted within one year of the date of the enactment. 42 U.S.C. § 11134.

137. *Id.* § 11134(c).

138. *Id.* § 11131(c). In California, insurance companies must report any judgment or settlement rendered against an insured physician for an amount of \$30,000 or greater. CAL. BUS. & PROF. CODE § 801(b) (West Supp. 1987). Section 11131 is much less lenient and requires that all judgments or settlements be reported. Not less than two years after the date of enactment, the Secretary will report to Congress on whether reporting small claims should continue to be required. 42 U.S.C. § 11131(d). This provision will have a substantial impact on settlement negotiations in medical malpractice actions. Under present California law, an incompetent physician may effectively avoid being reported to the Board of Medical Quality Assurance if a settlement can be reached wherein his insurance company will pay less than \$30,000 under the policy. The new provisions of the Act, however, will prevent an unfit physician from settling *any* lawsuit without the appropriate state or federal agency becoming aware of the circumstances surrounding the action.

139. 42 U.S.C. § 11132.

140. *See Id.* § 11134(a).

141. *Id.* § 11135. The obligation to request information applies not only to physicians, for whom reporting is mandatory, but also to other health care practitioners for whom reporting is discretionary. *Id.* § 11133. Reports by health care entities are first directed to state boards of medical examiners who are then required to forward the information to the Secretary. *Id.* § 11133(a)(1)(c).

142. *Id.* § 11135(b).

143. *Id.* § 11135(c). This protection is not extended, however, if the hospital has knowledge that the information provided was false.

144. 800 F.2d 1498 (9th Cir. 1986), *cert. granted*, 107 S. Ct. 1345 (1987).

145. In *Patrick*, the court noted that there was "substantial evidence" that the peer

trast, the Act provides immunity only to those actions conducted "in a reasonable belief that the action was in the furtherance of quality health care."¹⁴⁶ This obligation of the federal statute is similar to the "good faith" requirements of many state immunity statutes.¹⁴⁷

In summary, the Health Care Quality Improvement Act will likely be viewed as both a blessing and a hazard to physicians and health care entities across the nation.¹⁴⁸ It is clear, however, that as long as the requirements of the Act are complied with, the peer review committee can be confident that measures taken to increase the quality of patient care will not subject them to a federal antitrust lawsuit.

V. CONCLUSION

Peer review serves a vital societal function. There is no question that it should be afforded utmost protection. At stake is the public interest in receiving quality health care by competent practitioners. This goal can be achieved most effectively if physicians responsible for reviewing the competency of their colleagues are given absolute assurance that, in so doing, they will not become subject to a high-profile antitrust lawsuit.

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review proceedings were conducted in bad faith. However, the court stated that the issue of "bad faith" is generally a question for the state courts. *Patrick v. Burget*, 800 F.2d 1498, 1507 (9th Cir. 1986).

146. See *supra* note 135 and accompanying text.

147. See *supra* note 8 and accompanying text.

148. The Act states that information obtained by the Secretary is considered confidential. 42 U.S.C. § 11137(b)(1). The exceptions to the rule provide that with respect to medical malpractice actions, or professional review actions, the information will not be considered confidential. *Id.* However, just how much information a medical malpractice plaintiff will be able to obtain is uncertain at this time. This provision could be a very powerful tool for litigants wishing to establish that the hospital knew or should have known about an incompetent physician employed on its staff. *Id.* § 11137(b)(1).

