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Antitrust Conspiracy Doctrine and the Hospital Enterprise

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ANTITRUST CONSPIRACY DOCTRINE AND THE HOSPITAL ENTERPRISE

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The smoke-filled room is a poor metaphor for the formal, clinical atmosphere associated with hospital decision making. Nevertheless, the routine decisions of a hospital and its doctors to grant, deny, or revoke medical staff admitting privileges can result in charges of antitrust conspiracy and anticompetitive conduct.[1] The prospect that hospitals and

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[1] Only recently have courts begun to apply antitrust analysis to the health care industry. Prior to Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), courts had held that learned professions, such as law, medicine, and engineering, did not constitute "trade or commerce" and thus enjoyed an exemption from the antitrust laws. In *Goldfarb*, however, the United States Supreme Court unequivocally rejected this notion. *Id.* at 786-88. Subsequent cases have confirmed the applicability of antitrust law to the health care industry. *See, e.g.*, FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 465-66 (1986) (upholding FTC decision that dentists' agreement to withhold X-rays from insurers violated antitrust law); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 29-31 (1984) (applying federal antitrust law to exclusive contract between anesthesiologists and hospital); Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 348-49 (1982) (condemning price-fixing agreement among physicians); *see also* Thomas E. Kauper, *The Role of Quality of Health Care Considerations in Antitrust Analysis*, LAW & CONTEMP. PROBS., Spring 1988, 273, 285 ("The Supreme Court's trilogy of health care antitrust cases following *Goldfarb*—[*Maricopa, Jefferson Parish*, and *Indiana Federation*]—leaves little doubt about the general applicability of the antitrust laws to health care activities and considerable doubt about how they are applied.").

Goldfarb also is important for its conclusion that the anticompetitive restraints in the market for professional services can substantially affect interstate commerce so as to justify federal jurisdiction. *Goldfarb*, 421 U.S. at 783-86 (noting the volume of commerce involved and the link of the services in question to interstate commerce); *see also* Clark C. Havighurst, *A Comment: The Antitrust Challenge to Professionalism*, 41 MD. L. REV. 30, 31 (1981) (arguing that lack of jurisdiction, rather than the nonapplicability of antitrust law to professionals, was the primary reason for the professions' longstanding antitrust immunity). The "interstate commerce" jurisdictional require-

physicians might face treble damages for credentialing decisions has generated concerns that patients might be endangered because staff physicians and hospitals would hesitate to curtail the privileges of incompetent practitioners.[2] On the other hand, access to hospital facilities is essential for modern medical practice, and excluded health care providers have offered credible allegations of anticompetitive conduct in the peer review process.[3]

Antitrust claims arise out of staff privileges decisions because of the way hospitals are organized. Generally, a hospital's governing board delegates the right to make decisions about clinical privileges and other medical matters to the physicians serving on the hospital's medical staff. The justification for this division of authority within the hospital is that only trained professionals should make judgments about medical matters, and especially about the performance or qualifications of a physician. For antitrust purposes, however, medical staff physicians are not merely professional colleagues, but also independent practitioners with their own economic interests to protect. Some of them may even be in direct competition with the practitioners whose competence they are evaluating.[4] In

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ment is no longer a significant obstacle to plaintiffs in staff privileges-related antitrust cases. Summit Health, Ltd. v. Pinhas, 111 S. Ct. 1842, 1847 (1991) (holding that alleged restraint's effect on interstate commerce should be "measured, not just by a particularized evaluation of [the physician's] own practice, but rather, by a general evaluation of the impact of the restraint on other participants in the market from which he has been excluded"); Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 741 (1976) (finding plaintiff's complaint alleged a sufficient nexus to interstate commerce when hospital, among other things, received a substantial portion of its supplies, revenue, and patients from out-of-state sources).

[2] To alleviate the fear among physicians of antitrust litigation, Congress enacted the Health Care Quality Improvement Act of 1986 (HCQIA), Pub. L. No. 99-660, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11101-11152 (1988 & Supp. III 1991)) (limiting damages when professional review process conforms to specified guidelines). Because potential plaintiffs may view the immunity that the HCQIA grants to be quite limited, the legislation apparently has not significantly decreased litigation against hospitals and physicians. *See* Clark C. Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117, 1162-63 (1986) (noting that the HCQIA "create[s] some new opportunities for litigating at length the true motives of peer reviewers").

[3] The claims presenting the most obvious anticompetitive motivations have been those involving nonphysician practitioners. *See, e.g.*, Nurse Midwifery Assocs. v. Hibbett, 918 F.2d 605 (6th Cir. 1990) (nurse midwives), *cert. denied sub nom.* Nurse Midwifery Assocs. v. Hendersonville Community Hosp., 112 S. Ct. 406 (1991); Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984) (osteopaths), *cert. denied*, 470 U.S. 1060 (1985).

[4] Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1076 (noting the increasing competition among physicians).

these situations, it is not difficult for an excluded physician to raise the specter of anticompetitive activity.

Despite the potential for anticompetitive activity inherent in the staff privileges decision-making process, several federal courts of appeals have held that a hospital and its staff physicians are incapable of concerted action—"antitrust conspiracy"—under § 1 of the Sherman Act[5] because concerted action, by definition, implies group conduct.[6] These courts typically have compared medical staff participation in hospital decision making with the role executive officers play in conventional firms, where intrafirm decision making by multiple persons has been held not to destroy the unilateral nature of firm conduct.[7] Accordingly, most courts

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[5] Section 1 of the Sherman Act provides: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1 (1988).

[6] The Third, Fourth, and Sixth Circuits have held that medical staff members are capable of antitrust conspiracy among themselves, but that the hospital is incapable of engaging in concerted action with its medical staff in the peer review process. Oksanen v. Page Memorial Hosp., 945 F.2d 696, 702-08 (4th Cir. 1991) (en banc), *cert. denied*, 112 S. Ct. 973 (1992); *Nurse Midwifery Assocs.*, 918 F.2d at 614; *Weiss*, 745 F.2d at 813-17.

The Eleventh Circuit recognizes both the capacity of medical staff members to conspire among themselves and the capacity of the hospital to engage in concerted action with medical staff members. Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810, 819 (11th Cir.) (criticizing *Weiss*), *cert. denied*, 495 U.S. 924 (1990). The Ninth Circuit has held that medical staff members are capable of antitrust conspiracy among themselves. Pinhas v. Summit Health, Ltd., 894 F.2d 1024, 1033 (9th Cir. 1989), *aff'd on other grounds*, 111 S. Ct. 1842 (1991).

Inability to conspire is one of several grounds upon which courts have rested dismissal of staff privileges-related antitrust complaints against the health care industry. In addition to dismissing claims for lack of jurisdiction, *see supra* note 1, courts have also used the state action doctrine to dismiss cases on the theory that medical staff decision making in the hospital embodies state regulatory policy. *E.g.*, Doe v. St. Joseph's Hosp., 788 F.2d 411, 416 (7th Cir. 1986) (upholding dismissal of antitrust claim when hospital suspended physician's staff privileges pursuant to state peer review statute). The Supreme Court, however, has held that immunity under the state action doctrine requires significant state control over the peer review decisions of private hospitals. Patrick v. Burget, 486 U.S. 94, 102-03 (1988) (finding state action doctrine inapplicable when state officials could not and did not exercise ultimate authority regarding hospital privileges). However, public hospitals, particularly those with the characteristics of a "municipality," may have a stronger claim under the state action doctrine. *See* Todorov v. DCH Health Care Auth., 921 F.2d 1438, 1459-62 (11th Cir. 1991) (dismissing antitrust claim when public hospital's charter expressly recognized power of hospitals to make anticompetitive decisions).

[7] *See, e.g., Oksanen*, 945 F.2d at 703 (suggesting that medical staff worked as hospital's agent in implementing hospital's policies); *Weiss*, 745 F.2d at 817 (comparing role of medical staff to corporate officers and noting that the staff, as an entity, had no interest in competition with the hospital).

have held that a so-called "vertical" agreement between the hospital and its medical staff does not constitute concerted action.[8] The same courts have also usually held that "horizontal" agreements among medical staff physicians rarely amount to concerted conduct if the agreement occurs within regular hospital channels for making staff privileges decisions.[9]

This Article evaluates antitrust conspiracy doctrine in medical staff privileges litigation. Its thesis is that given the typical economic and managerial independence of physicians from hospitals, courts are usually wrong to view hospital decision making regarding medical staff privileges as the equivalent of decision making within a single, integrated firm. Except in the unusual case when staff physicians' medical practices and hospital operations are significantly integrated,[10] traditional hospital governing structures create the risk of anticompetitive physician conduct. In the typical case, hospital decisions involving medical staff participation should escape scrutiny under § 1 of the Sherman Act only if it can be demonstrated that the medical staff acted in a purely advisory role.[11]

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[8] *See supra* note 6.

[9] *Bolt*, 891 F.2d at 819; *see Oksanen*, 945 F.2d at 706 (finding no conspiracy when staff members' actions occurred in peer review process); Cooper v. Forsyth County Hosp. Auth., 789 F.2d 278, 282 n.14 (4th Cir. 1986) ("That the challenged conduct of the appellants is consistent with legitimate activities also weighs against inferring a conspiracy."); *infra* note 82.

The mere fact that physicians act through the existing structures of the peer review process in denying staff privileges should not preclude a finding of concerted conduct. The conclusion that medical staff members are capable of conspiracy with each other necessarily suggests that they are separate economic actors whose joint decisions should be seen as the product of concerted conduct. As Part I of this Article suggests, the relevant issue is whether actors with divergent economic interests are engaged in concerted decision making.

[10] Market trends encouraging physicians and hospitals to network their services are producing more integration and risk-sharing among hospitals and their staff physicians. *See* Howard S. Zuckerman et al., *Principles of Health Care Facility Organization and Management*, *in* HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION 2-22 to 2-23 (Mark A. Hall ed., 1993) (describing new models of medical staff organization).

[11] This Article does not attempt to delineate the appropriate standard for analyzing staff privileges decisions under the applicable antitrust law. For a thorough discussion of this issue, see 2 JOHN J. MILES, HEALTH CARE & ANTITRUST LAW § 10.05[4] (1992); James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, LAW & CONTEMP. PROBS., Spring 1988, at 7, 78-82; Havighurst, *supra* note 4, at 1108-39; Philip C. Kissam et al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CAL. L. REV. 595, 643-71 (1982).

I. PIERCING THE ENTERPRISE VEIL:[12] ANTITRUST CONSPIRACY DOCTRINE AND DECISION MAKING IN HOSPITALS

Conspiracy is a feature of substantive antitrust law only because the Sherman Act treats multiple parties who restrain trade differently than single entities who do so.[13] Plaintiffs must bring claims against a single actor under § 2 of the Sherman Act[14] and cannot succeed unless the challenged restraint threatens "actual monopolization."[15] Plaintiffs alleging concerted action, on the other hand, must bring claims under § 1, which requires a showing that the alleged activities unreasonably restrain trade.[16]

Recognizing that it is easier to prove that a challenged restraint is unreasonably anticompetitive than that it threatens monopolization, lawyers representing antitrust plaintiffs sometimes attempt to attribute the conduct of a single firm to the concerted activity of intrafirm decision makers. They may argue, for example, that agreements between a firm and its corporate division or subsidiary amount to concerted action subject to scrutiny under § 1.[17] In *Copperweld Corp. v. Independence Tube*

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[12] *See* Edward B. Rock, *Corporate Law Through an Antitrust Lens*, 92 COLUM. L. REV. 497, 506-11 (1992) (citing examples of antitrust law's willingness to look behind formal corporate structures).

[13] *See* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 769 (1984) (justifying distinction because of increased risk that concerted behavior will have anticompetitive effects).

[14] Section 2 of the Sherman Act provides: "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." 15 U.S.C. § 2 (1988).

[15] *Copperweld*, 467 U.S. at 767; *see also* Spectrum Sports v. McQuillan, 113 S. Ct. 884, 890 (1993) (citing *Copperweld*).

[16] *Copperweld*, 467 U.S. at 768. It is somewhat surprising that the legality of anticompetitive conduct frequently depends on whether the conduct is the product of unilateral, as opposed to concerted, action. The anticompetitive effect of a particular restraint is less a function of the number of firms implementing it than of the firm or firms' aggregate power in the market. A single, powerful firm imposing a restraint is more likely to restrain trade than a group of firms with less aggregate market influence instituting the same practice. *See id.* at 774 (noting that the distinction between concerted action and unilateral action may be arbitrary). Nevertheless, the Sherman Act gives greater latitude to single firms than it does to combinations of competitors because concerted action may signal anticompetitive behavior and because subjecting the day-to-day activities of a single firm to antitrust scrutiny may dampen the firm's "competitive zeal." *Id.* at 767-68.

[17] *See, e.g.*, Schwimmer v. Sony Corp. of Am., 677 F.2d 946, 953 (2d Cir. 1982) (alleging conspiracy among corporate executives); Cliff Food Stores, Inc. v. Kroger, Inc., 417 F.2d 203 (5th Cir. 1969) (alleging conspiracy between grocery chain and its wholly-owned, unincorporated sales division).

Corp.,[18] the United States Supreme Court recognized that permitting plaintiffs to bring § 1 claims against single firms on the basis of "intraenterprise" conspiracies threatened to undermine Congress's intent to treat concerted and unilateral activity differently.[19] Consequently, the Court held that § 1 analysis is inappropriate when there is a complete unity of economic interest between a parent firm and intraenterprise actors and when the parent may assert full control at any time.[20] Applying this test to staff privileges decisions, a hospital would be incapable, as a matter of law, of conspiring with its medical staff only when: (1) the two share a unity of economic interest; and (2) the hospital could exert full control over decisions about staff admitting privileges.[21]

A. *Conflicts of Economic Interests Within the Hospital Enterprise*

The *Copperweld* inquiry focuses first on whether there is a conflict of economic interests among the parent firm and the alleged conspirators.[22] In the ordinary business firm, intraenterprise decision makers do not have a separate presence in markets affected by firm activities. The decision makers have no personal incentive not to pursue the firm's best interests. Thus, it makes good economic sense to treat their decisions as those of the corporate entity acting alone. When, however, decision makers retain an independent presence in a market affected by firm activities, they may be tempted to skew firm decision making to further their personal interests. The presence of economic conflict among the firm and the decision makers justifies removing the presumption that decisions reflect solely the firm's interests and permitting judicial scrutiny of the reasonableness of any resulting restraint under § 1.

The success of hospitals and medical staff physicians in persuading courts to view medical staff decision making as the hospital's unilateral

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[18] 467 U.S. 752 (1984).

[19] *Id.* at 776.

[20] *Id.* at 771; *see also* Blumstein & Sloan, *supra* note 11, at 39-41 (suggesting that *Copperweld* requires both full control and unity of interest for immunity under § 1).

[21] In Oksanen v. Page Memorial Hosp., 945 F.2d 696 (4th Cir. 1991) (en banc), *cert. denied*, 112 S. Ct. 973 (1992), the Fourth Circuit noted that a "unity of interest is present in the relationship between the hospital and its staff, both of which seek to upgrade the quality of patient care." *Id.* at 703. The Supreme Court's emphasis on economic interests, however, suggests that this type of "unity" is not sufficient. *Cf. Copperweld*, 467 U.S. at 769 (noting the danger of the "sudden joining of *economic* resources" when two firms conspire (emphasis added)); *id.* at 771 (stating that "[t]he officers of a single firm are not separate *economic* actors pursuing separate *economic* interests, so agreements among them do not suddenly bring together *economic* power that was previously pursuing divergent goals" (emphasis added)). Although a hospital and its medical staff may share the goal of improving patient care, the appropriate inquiry in terms of unity of interest must focus on possible economic motivations that may create divergent incentives between the two entities. *See infra* part I.A.

[22] *Copperweld*, 467 U.S. at 770-72.

conduct is remarkable given the historic independence of physicians and the tradition of de facto physician control over hospital decision making.[23] An important theme in the history of the American health care industry has been the medical profession's efforts to preserve the economic independence of physicians.[24] Although government control has

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[23] Most studies suggest that effective control over hospital decisions is exercised exclusively by medical staff physicians or jointly by administrators and physicians. *See* PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 213-24 (2d ed. 1983); CHARLES E. PHELPS, HEALTH ECONOMICS 233 (1992); Jeffrey A. Alexander et al., *Effects of Competition, Regulation and Corporatization on Hospital-Physician Relationships*, 27 J. HEALTH & SOC. BEHAV. 220 (1986); Robert C. Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980); Kenneth W. Clarkson, *Some Implications of Property Rights in Hospital Management*, 15 J.L. & ECON. 363 (1972); Amitai Etzioni, *Alternative Conceptions of Accountability*, 55 HOSP. PROGRESS 34 (1974); Martin S. Feldstein, *Hospital Cost Inflation: A Study of Nonprofit Price Dynamics*, 61 AM. ECON. REV. 853 (1971); Marsha Goldfarb et al., *Behavior of the Multiproduct Firm: A Model of the Nonprofit Hospital System*, 18 MED. CARE 185 (1980); Jeffrey E. Harris, *The Internal Organization of Hospitals: Some Economic Implications*, 8 BELL J. ECON. 467 (1977); Philip Jacobs, *A Survey of Economic Models of Hospitals*, 11 INQUIRY 83 (1977); Maw Lin Lee, *A Conspicuous Production Theory of Hospital Behavior*, 38 S. ECON. REV. 48 (1971); Joseph P. Newhouse, *Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital*, 60 AM. ECON. REV. 64 (1970); Mark V. Pauly, *Medical Staff Characteristics and Hospital Costs*, 13 J. HUM. RESOURCES 77 (Supp. 1978); Mark V. Pauly & Michael Redisch, *The Not-for-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87 (1973); Michael A. Redisch, *Physician Involvement in Hospital Decision Making*, *in* HOSPITAL COST CONTAINMENT 217 (Michael Zubkoff et al. eds., 1978); Noralou P. Roos, *Influencing the Health Care System: Policy Alternatives*, 22 PUB. POL'Y 139 (1974); Richard B. Saltman & David W. Young, *The Hospital Power Equilibrium: An Alternative View of the Cost Containment Dilemma*, 6 J. HEALTH POL., POL'Y & L. 391 (1981); Sol S. Shalit, *A Doctor-Hospital Cartel Theory*, 50 J. BUS. 1 (1977).

[24] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 3-29 (1982); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 445-47 (1988); Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697, 700-05 (1986) [hereinafter Havighurst, *Changing Locus*]; Clark C. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 307-19.

Organized medicine has advanced physicians' interests largely through the medical profession's "private regulation" of the health care industry. This private and professional regulation of health care includes: (1) "the medical profession's power to specify the training required and other criteria for public or private recognition as a qualified practitioner or technician," Havighurst, *Changing Locus, supra*, at 700, through state licensing requirements, which incorporated the profession's standards; (2) "professional advocacy of legal, and enforcement of ethical, bans on contract practice by physicians and the corporate practice of medicine, which effectively discouraged hospitals from employing physicians and retailing their services," *id.* at 703; (3) specification of "the details of hospital organization and operation," *id.* at 704,

constituted the most obvious threat to physician autonomy,[25] the prospect of corporate control through the commercialization of medicine has been a source of constant concern to the profession.[26] In an effort to resist control by hospitals, insurance companies, and other corporations, the profession adopted ethical guidelines—which were frequently incorporated into state law—designed to ensure that physicians would not become subservient to corporate managers. For example, professional codes of ethics forbade the "contract practice of medicine," thereby preventing physicians from entering into contractual or employment relationships through which lay middlemen might profit from the delivery of medical services.[27] The profession justified these ethical proscriptions on the ground that lay intervention in the physician-patient relationship might lead to consumer exploitation.[28] However, such proscriptions

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through the Joint Commission on Accreditation of Health Care Organizations, a physician-dominated organization; (4) restrictions on physician supply, *id.*; and (5) establishing, and maintaining control over, financing mechanisms and suppression of possible alternatives, *id.* at 705.

In 1975, the Supreme Court held that professional activities were not exempt from antitrust scrutiny. Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975). This appeared to be the end of systematic professional regulation of the health care industry. Shortly after *Goldfarb*, the FTC successfully challenged professional ethical prohibitions against advertising, solicitation, and contract practice. American Medical Ass'n v. FTC, 638 F.2d 443, 453 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982). Courts have sustained government challenges to other manifestations of physician regulation, such as boycotts of nonphysician providers, Wilk v. American Medical Ass'n, 671 F. Supp. 1465 (N.D. Ill. 1987), physician control of health insurance plans, Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 276 (4th Cir. 1980), and price fixing, Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982); *see* Clark C. Havighurst, *The Contributions of Antitrust Law to a Procompetitive Health Care Policy, in* MARKET REFORMS IN HEALTH CARE 306-16 (Jack A. Meyer ed., 1983) (discussing successful antitrust challenges that have undermined the market power of health care providers). Nevertheless, the collective power of physicians in hospitals generally remains intact despite frequent challenges in antitrust suits involving the denial of clinical privileges to individual practitioners.

[25] *See, e.g.*, STARR, *supra* note 24, at 280-89 (recounting the history of organized medicine's opposition to national health insurance in the 1940s).

[26] *Id.* at 24-29.

[27] *See* Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 458-67 (1987) (examining the development of the corporate practice doctrine and recounting the history of the profession's ethical restraints on corporate practice).

[28] *Id.* at 467 (stating that commentators "generally advance three considerations" supporting ethical proscriptions against the corporate practice of medicine: "(1) lay control over professional judgment; (2) commercial exploitation of the medical practice; and (3) division of the physician's loyalty between patient and employer"); *see also American Medical Ass'n*, 638 F.2d at 453 (prohibiting the American Medical Association from imposing restraints on certain advertising, solicitation, and contrac-

amounted to professionally enforced agreements among physicians not to compete with each other by "wholesaling" their services at less than prevailing prices.[29]

Professional ethical standards also prohibited physicians from participating in health insurance plans that were not open to every physician in a given community.[30] The ethical principle ostensibly defending the consumer's "free choice of provider" prevented insurance companies from using their bargaining strength to subvert physicians' independence. It prevented price competition by requiring that "each public or private health insurer must deal with all [physicians] as a guild, and could not split them into competing groups."[31] For consumers, the effect of the contract practice and free choice rules was to prevent both hospitals and insurance companies from offering integrated packages of health care and financial protection.[32] In the absence of integrated delivery systems, the consumer's usual point of entry into the health care system was the independent physician. As a result, physicians could exert leverage over hospitals by threatening to take their patients elsewhere.[33]

Although the proscriptions against contract practice and the requirement of free choice of provider are now of markedly diminished legal and practical importance,[34] the professional independence they helped foster remains ingrained in the organizational structure of most American hospitals. In most hospitals the medical staff is composed of independent practitioners who devote their primary attention to, and receive primary

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tual practices of physicians); Hall, *supra* note 24, at 514-16 (criticizing courts that employ policy arguments to enforce the prohibition of corporate practice).

[29] Courts also enforced the restrictions through the legal doctrine forbidding the "corporate practice of medicine." *See* Hall, *supra* note 24, at 509-18 (discussing the history of the corporate practice of medicine doctrine).

[30] Charles D. Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1356 (1984).

[31] *Id.*

[32] *Id.* at 1355-59.

[33] The physician's role as gatekeeper was crucial to professional power. *See* STARR, *supra* note 24, at 26-27 ("The profession's [gatekeeping] authority puts at its disposal the purchasing power of its patients.... [T]he physician's authority to decide whether and where to hospitalize patients gives doctors great leverage over hospital policy.").

[34] *See American Medical Ass'n*, 638 F.2d at 453 (prohibiting the American Medical Association from imposing restraints on certain advertising, solicitation, and contractual arrangements by physicians); Chase-Lubitz, *supra* note 27, at 475-88 (enumerating reasons for the decline of the corporate practice doctrine); Weller, *supra* note 30, at 1374 (arguing that fundamental restructuring in the health care industry has overwhelmed traditional free choice and ethics proscriptions). *But see* Hall, *supra* note 24, at 516-18 (suggesting continued legal viability of the corporate practice of medicine doctrine).

economic benefit from, their private medical practices.[35] Independent physicians have economic interests that sometimes diverge sharply from those of the hospital. A physician's medical practice, his specialty, or the profession generally, may benefit from the exclusion of a given practitioner or class of practitioners from a hospital.[36] Such exclusions may not always be in the hospital's best interests.[37]

At most hospitals (i.e., those with medical staffs comprised largely of independent physicians), then, the analogy between staff physicians and conventional intraenterprise decision makers may be flawed because physicians have independent market interests that they may advance through their decision-making role within the hospital enterprise. This is not to say that all—or even a significant portion of—the decisions of a medical staff comprised of independent physicians restrain trade illegally. In order to violate § 1 of the Sherman Act, concerted decision making must result in an unreasonable restraint of trade.[38] If a credentialing decision promotes the hospital's legitimate, procompetitive interests, such as quality assurance, there is no serious doubt about its legality. Nevertheless, such decisions, if made in whole or in part by independent physicians, should not escape judicial scrutiny altogether.

B. *The Role of the Governing Body in Medical Staff Decision Making*

Intraenterprise decision making with respect to hospital staff privileges may also fail the second requirement of the *Copperweld* exemption test—that the parent firm have the ability to control decision making by its agents.[39] Staff physicians typically play a dual role within the hospital.

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[35] In some settings, such as teaching hospitals or hospitals owned by a staff model health maintenance organization, the staff physicians may effectively be employees of the hospital entity. *See* Blumstein & Sloan, *supra* note 11, at 42.

[36] *See* Kissam et al., *supra* note 11, at 651-69 (discussing various forms of "physician cartel behavior").

[37] *Id.*

[38] Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 767-68 (1984) (discussing the reach of § 1).

[39] *Id.* at 771-72; Blumstein & Sloan, *supra* note 11, at 40-41. Although the *Copperweld* opinion emphasizes the substantive nature of the analysis required in order to determine whether a court should treat the actions of putative conspirators as facilitating the acts of a single economic entity, the mandated inquiry into "full control" seems primarily concerned with management's formal ability to impose its policies if it chooses to do so. *Copperweld*, 467 U.S. at 772. The Court emphasized that antitrust law should determine neither the organizational structure of the firm, *id.* at 773, nor the extent of supervision management may choose to exert over subordinate departments, *id.* at 771-72.

In reality, independent staff physicians may exercise political and economic leverage that imposes a significant barrier to a governing body's exercise of formal decision-making power. *See* Kissam et al., *supra* note 11, at 607-11 (discussing control of privilege decisions); Saltman & Young, *supra* note 23, at 407-09 (illustrating the role

The physician's primary role is to provide patient care, usually with little ongoing hospital supervision.[40] Staff physicians also serve, however, in certain managerial capacities within the hospital. It is within this context that their decisions may give rise to antitrust claims. Hospital governing bodies typically delegate important quality assurance functions, including primary responsibility for credentialing decisions, to the hospital's medical staff.[41] As a medical staff member, the individual physician participates in the staff and committee meetings in which credentialing

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and control of the physician in the hospital). However, the *Copperweld* exemption requires a complete unity of economic interest between the hospital and the medical staff in addition to requiring that the hospital have the formal power to reverse medical staff decisions. *See supra* text accompanying notes 13-21. Thus, in those cases when staff physicians' personal economic interests create a motive for them to make use of political or economic leverage to prevent the hospital from asserting its formal power, the *Copperweld* exemption from scrutiny will not be available because the requisite unity of economic interest is not present. If physicians took steps outside the peer review process to coerce the hospital governing body to accept their "recommendations," the *Copperweld* defense would not apply because the physicians would not be acting in their formal capacity as agents for the hospital. *Cf.* Oltz v. St. Peter's Community Hosp., 861 F.2d 1440, 1450 (9th Cir. 1988) (stating that physician not acting as agent of hospital had sufficiently independent interests to permit a finding of concerted conduct).

[40] Traditionally, physicians and hospitals have operated independently in most respects. *See* Blumstein & Sloan, *supra* note 11, at 15-16. Thus, they bill separately for their respective services, *id.* at 16-17, and in many cases neither party is liable for the other's negligence in connection with the delivery of services within the hospital, *see* Albain v. Flower Hosp., 553 N.E.2d 1038, 1046 (Ohio 1990) (explaining that a physician's negligence does not automatically impose liability on the hospital). *But see* Helaine W. Heydemann et al., *Medical Malpractice*, *in* 2 TREATISE ON HEALTH CARE LAW § 12.01[3][a], at 12-10 to 12-11 (Michael G. Macdonald et al. eds., 1991) (discussing hospital's liability for negligence in conferring staff privileges and monitoring physician performance, and discussing vicarious hospital liability for hospital-based physicians). Physicians may be liable for acts of hospital employees in some circumstances under the "borrowed servant" doctrine. *See id.* § 12.01[2][c], at 12-8 to 12-10. However, hospital liability for corporate negligence has expanded steadily over time, and prospective payment and managed care have recently encouraged hospitals actively to attempt to influence physicians' practice patterns. *See* Blumstein & Sloan, *supra* note 11, at 17-18 (discussing the reduction of physician power relative to hospitals). Nevertheless, treatment decisions are still made largely within the context of an independent physician/patient relationship. *See* John D. Blum, *Economic Credentialing[:] A New Twist in Hospital Appraisal Processes*, 12 J. LEG. MED. 427, 434, 459 (1991) (discussing the role of the medical staff in the credentialing process); Peter M. Mellette, *The Changing Focus of Peer Review Under Medicare*, 20 U. RICH. L. REV. 315, 316 (1986) (stating the importance of the physician's role in patient treatment decisions). Thus, hospitals do not typically exercise full control over independent practitioners in their patient care function.

[41] Blum, *supra* note 40, at 434.

decisions are made.[42] Unless the hospital governing body has the ability to reverse decisions that fail to comport with hospital interests, *Copperweld*'s full control test[43] suggests that they should not be exempt from § 1 scrutiny.

1. Regulatory Constraints on Governing Body Control

The hospital's power over medical staff decision making is a complex issue of fact.[44] In conventional firms, formal decision-making control is vested in a board of directors representative of, and accountable to, the corporation's shareholders.[45] Similarly, hospital control is nominally vested in the institution's governing body representing either the public, in the case of a nonprofit or public hospital, or shareholders, in the case of a proprietary hospital.[46] However, the countervailing authority of the medical staff limits the hospital governing body's managerial power. Typically, the respective bylaws of the medical staff and the governing body formally delegate important aspects of hospital management to the medical staff and, strikingly, permit the medical staff to operate on a self-governing basis.[47]

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[42] *Id.* at 434-35.

[43] *Copperweld*, 467 U.S. at 772.

[44] As suggested more fully below, it is inappropriate for courts to conclude that hospital management is always in control of staff privileges decisions without careful examination of the hospital's decision-making process. *See infra* part I.B.3.

[45] *See* REVISED MODEL BUSINESS CORP. ACT §§ 8.01, 8.08 (1984).

[46] Hospital governance resembles that of other corporations in that managerial authority is initially vested in a board of directors. *Id.* However, most courts have held that a hospital board can limit its plenary managerial power contractually by approving medical staff bylaws that cede certain prerogatives to the medical staff. *See* McElhinney v. William Booth Memorial Hosp., 544 S.W.2d 216, 218 (Ky. 1976) (noting that a public or private hospital must act in accordance with its charter and bylaws); Berberian v. Lancaster Osteopathic Hosp. Ass'n, 149 A.2d 456, 459 (Pa. 1959) (stating that staff bylaws, approved by the board of directors, are an integral part of the contractual relation between the hospital and members of the medical staff); St. John's Hosp. Medical Staff v. St. John Regional Medical Ctr., 245 N.W.2d 472, 475 (S.D. 1976) (holding that medical staff bylaws, which were approved by medical center and which delegated adoption of new bylaws to medical staff, were binding upon the medical center). Some cases reject the characterization of medical staff bylaws as a contract between the hospital and its medical staff by relying on a narrow interpretation of bylaw provisions. *See, e.g.*, Munoz v. Flower Hosp., 507 N.E.2d 360, 365 (Ohio Ct. App. 1985) (stating that staff bylaws can form a binding contract between the doctors and the hospital only when an intent by both parties to be bound is found in the bylaws); Weary v. Baylor Univ. Hosp., 360 S.W.2d 895, 897-98 (Tex. Civ. App. 1962) (stating that medical staff bylaws did not limit the governing board's authority concerning physician reappointments, but also rejecting *Berberian*).

[47] *See infra* notes 57-72 and accompanying text.

Determining whether the governing board is capable of exerting full control[48] over hospital decisions requires a precise, case-by-case understanding of the nature and extent both of the governing body's delegation of managerial duties to the staff and of medical staff self-governance. Each hospital adopts its own medical staff and governing body bylaws; there is no prescribed form.[49] Nevertheless, many states will not license a hospital unless the hospital permits the medical staff to operate on a relatively autonomous basis.[50] Even in states where licensing laws impose no such requirement, medical staff independence may be a practical necessity. As discussed below, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO or Joint Commission), through its accreditation criteria, requires hospitals to vest significant decision-making power in their medical staffs.[51] JCAHO accreditation is effectively mandatory. The licensing laws of various states incorporate the JCAHO standards, and Joint Commission accreditation is a precondition for participation in many private and public third party insurance programs.[52]

The Joint Commission denies that it has any interest in using its accreditation authority to affect the balance of power between hospital governing boards and staff physicians.[53] Nevertheless, the JCAHO standards

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[48] *See* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 771-72 (1984) (requiring only that management be capable of exerting full control over decisions made by alleged conspirators, not that it actually do so).

[49] The California Medical Association has promulgated model medical staff bylaws. *See* CALIFORNIA MEDICAL ASSOCIATION, MODEL MEDICAL STAFF BYLAWS (1985) [hereinafter CMA MODEL BYLAWS], *reprinted in* 1 HOWARD S. ROLAND & BEATRICE L. ROLAND, HOSPITAL LEGAL FORMS, CHECKLISTS, AND GUIDELINES exhibit 16-1 (1986). At one time, the Joint Commission was in the process of preparing standard bylaws, but this project was abandoned in the late 1970s.

[50] Hall, *supra* note 24, at 529. For example, California law requires that the medical staff "be self-governing with respect to the professional work performed in the hospital." CAL. HEALTH & SAFETY CODE § 32128 (West 1973 & Supp. 1993). Although there are undoubtedly varying degrees of medical staff self-governance, it is unlikely that California hospitals will permit the degree of governing body authority required for a finding of unilateral action under *Copperweld*. *See* CMA MODEL BYLAWS, *supra* note 49.

[51] *See infra* notes 57-72 and accompanying text.

[52] Although accreditation by the Joint Commission is theoretically voluntary, it "is either explicitly or implicitly a requirement for participation in many private or public licensing, certification and financing programs." Timothy S. Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 843 (1983) (examining the organization and history of the JCAHO and analyzing its standards and accreditation programs); *see id.* at 843-45; 2 JOINT COMMISSION ON ACCREDITATION OF HOSPITALS 1993, ACCREDITATION MANUAL FOR HOSPITALS 26 [hereinafter AMH].

[53] Joint Commission President Dennis O'Leary, M.D. has disclaimed any intention on the part of the JCAHO to use the accreditation process to foster physician power: "In a patient-centered [accreditation] manual, standards would be meant to create

appear to reflect the larger political struggle within the health care industry over hospital control.[54] Even though the hospital industry is well represented, the Joint Commission is composed predominantly of representatives from physician groups,[55] and it has apparently responded to pressure from the medical profession to preserve medical staff power within hospitals on at least two occasions.[56]

Accreditation requirements that divide decision-making authority between hospital management and the medical staff reflect the organizational tension within the Joint Commission.[57] The JCAHO standards require, for example, that medical staff bylaws "establish a framework for self-governance of medical staff activities *and* accountability to the governing body."[58] In credentialing decisions, the governing body is "responsible for the final decision,"[59] but that decision must be "based on" the recommendation of the medical staff,[60] which "has overall responsibility for the quality of professional services provided by individ-

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protections for patients but not for anybody else. People who have a stake in how a hospital is run—physicians, executives, even governing body members—should not be turning to the Joint Commission for protection." *Dennis O'Leary: Toward Integrated Leadership*, TRUSTEE, Apr. 1988, at 10, 12 [hereinafter *O'Leary*].

[54] Both the hospital industry and the medical profession have been concerned about the balance of power within hospitals. In 1984, the American Hospital Association and the American Medical Association brought together ten lawyers representing industry and professional interests who issued a report "written for those who recognize that the unique and complex aspects of health care delivery in the hospital setting frequently prevent application of traditional 'organizational chart' solutions to many . . . issues that may arise" and also for those "who believe that a cooperative approach to problem solving, consistent with the discharge of legal responsibilities, is preferable and necessary in today's environment." AMERICAN MEDICAL ASSOCIATION-AMERICAN HOSPITAL ASSOCIATION JOINT TASK FORCE REPORT (1985), *reprinted in* CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 556 (1988). The Report specifically denies any intention to set forth the legal rights between the hospital and medical staff with respect to hospital governance. However, it contains a remarkably specific allocation of decision-making authority with respect to a wide range of hospital decisions. *See id.*

[55] *See* Jost, *supra* note 52, at 840 (describing the membership of the JCAHO).

[56] *See AMA Convention Medical Staff Highlights*, HOSPITALS, Aug. 5, 1987, at 58; *see also* 1 AMH, *supra* note 52, ¶ MS.3.1, at 58 (medical staff power over bylaws); *O'Leary*, *supra* note 53, at 10 (self-governance of medical staff). Dr. O'Leary described the conflict between the hospital industry and the medical profession over the JCAHO standards as "a classic situation in which a standard could be justified on the basis of promoting high-quality care but could also be suspected of serving the interests of physicians." *Id.*

[57] 1 AMH, *supra* note 52, ¶ MS.3.1, at 58 (stating that neither the medical staff nor the governing body "may unilaterally amend the medical staff bylaws").

[58] *Id.* ¶ MS.3.2, at 58 (emphasis added).

[59] *Id.* ¶ MS.2.12, at 56.

[60] *Id.*

uals with clinical privileges, as well as the responsibility of accounting therefor to the governing body."[61] Thus, the JCAHO does not overtly require either that the hospital or the medical staff be the substantive decision maker with respect to medical staff privileges decisions.[62] Instead, the formal balance of power within each hospital turns on the more specific accreditation requirements with respect to procedures for granting clinical privileges, as these requirements are interpreted in hospital and medical staff bylaws.[63]

Accreditation requirements clearly contemplate that the credentialing process will begin with medical staff evaluation of the applicant.[64] Although the medical staff's action with respect to applications for clinical privileges is merely a "recommendation,"[65] one should not infer that the governing body can freely disregard the staff's action. The scoring guidelines promulgated by the Joint Commission in conjunction with accreditation standards may be fairly read to limit the governing body's ability to make its own independent factual investigations.[66] Moreover, while the JCAHO acknowledges that "[t]he governing body is not bound by the medical staff recommendations but has the ultimate authority to render a decision,"[67] it states that the governing body's decision "must be guided by legitimate patient care considerations, medical staff bylaws,

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[61] *Id.* ¶ MS.1, at 53.

[62] *Id.*

[63] *Id.* ¶ MS.2.1, at 53.

[64] *Id.* ¶ MS.2.12, at 56 (stating that governing body makes its "final decision, based on medical staff recommendation").

[65] *Id.*

[66] 2 *id.* at 26 ("Scoring Guidelines"). These guidelines clarify the intent of ¶ MS.2.12, which provides that "[t]he governing body is responsible for the final decision, based on medical staff recommendations, regarding an individual's appointment or reappointment to the medical staff" *Id.* at 25. According to the Scoring Guidelines, under ¶ MS.2.12 the governing body should "review recommendations made by the medical staff executive committee, the documentation on which recommendations are based, and records of any hearings or appeals addressing adverse decisions for the applicant." *Id.* at 26. Apparently this statement does not preclude the governing body's consideration of additional facts. However, the next sentence states that "[t]he governing body's decision is based on the information submitted." *Id.* Although there is no explicit requirement that the decision be based *wholly* on such information, this sentence could be read to preclude the governing body's reversal of a medical staff decision based on matters extraneous to the documentation submitted by the medical staff. Presumably such a decision would not be sufficiently "based on" medical staff recommendations.

Although the statements appearing above are found in the Scoring Guidelines, they are apparently binding since they appear as expressions of the intent behind the JCAHO standards, and thus they would not have the nonbinding character of the scoring guidelines. *See id.* at vi (stating that the intent of the standards must always be met).

[67] *Id.* at 26.

and rules and regulations"[68] and may be "neither arbitrary, capricious, discriminatory nor contrary to the bylaws."[69] Finally, in a particularly noteworthy expression of medical staff power, accreditation requirements provide that if the governing body rejects a medical staff recommendation, the difference of opinion must be "resolved within a reasonable period of time,"[70] usually by a joint conference committee consisting of representatives of both the medical staff and the governing body.[71] If medical staff bylaws constrain governing body review of medical staff decision making by limiting governing body review to the record generated by the medical staff and the policies and procedures set forth in medical staff bylaws, the hospital board may not be capable of making an independent decision in the hospital's interests. Instead, the board may serve merely as a procedural check against medical staff misconduct in the credentialing process. Indeed, a common view is that the governing body's role should be limited in precisely this way.[72] If hospital and med-

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[68] *Id.* The Scoring Guidelines also suggest that the hospital may inject its own "reasonable" criteria into the credentialing process:

> The hospital may elect to add other reasonable criteria, such as the ability to provide adequate facilities and support services for the applicant and the applicant's patients, and patient care needs for additional staff members with the applicant's skill and training, current evidence of adequate professional liability insurance, and the applicant's geographic location. When additional criteria are specified in the medical staff bylaws, their uniform application is documented in credentials files.

Id. at 9. The last sentence of this quotation suggests that the criteria added by the hospital need not be included in the medical staff bylaws. This provision is significant since incorporation of such standards into the medical staff bylaws would require medical staff approval. 1 *id.* ¶ MS.3.2, at 58. Thus, the accreditation standards do not appear to require the medical staff's consent to additional criteria that are deemed "reasonable" by the Joint Commission. If the provision permitting hospitals to add "reasonable" criteria is read together with the requirement that governing body decisions be "guided by legitimate patient care considerations, medical staff bylaws, and rules and regulations," 2 *id.* at 26, it may be inferred that the "reasonableness" of hospital requirements not approved by the medical staff is determined solely by reference to patient care considerations. It is unclear whether "patient care considerations" encompass consideration of the financial well-being of the hospital. Given the prominence of economic credentialing in current discussions about hospital governance, it seems unlikely that the ambiguity is inadvertent. *See infra* text accompanying notes 76-77 (discussing economic credentialing).

[69] 2 *id.* at 26.

[70] *Id.*

[71] *Id.*

[72] An American Hospital Association publication prepared specifically for dissemination to hospital trustees described governing body and medical staff roles as follows:

> Appointment and privilege delineation are separate processes in which the board and medical staff work together to reach decisions that are in the best interest of the hospital and the community. The medical staff is responsible for assessing

ical staff bylaws restrict the governing body's role in credentialing decisions to procedural review, *Copperweld*'s full control requirement will not be satisfied.

2. Regulatory Constraints and Hospital Interests

The degree to which accreditation requirements may constrain the governing body's ability to make its own decisions on staff privileges matters may be illustrated by examining whether a hospital board operating in accordance with the JCAHO standards could decide to implement two widely discussed innovations in credentialing: (1) the use of external peer reviewers; and (2) the use of measures of the economic effects of physician practice patterns on the hospital as a criterion for privileges decisions.

The JCAHO standards may fairly be read to prohibit a governing body's unilateral decision to retain an external peer reviewer in order to obtain additional information about a medical staff applicant. Under the standards, a hospital board may not base credentialing decisions on information the medical staff has not reviewed. The governing board may base its decision on external review only if provided for in the medical staff bylaws and only if the results of the external review were considered by the staff in its recommendation to the governing body.[73] One important use of outside evaluators is to review medical staff decisions in circumstances in which the board suspects possible anticompetitive motivation on the staff's part.[74] The board may reasonably wish to reserve the right to use outside personnel in such instances without prior medical staff review.[75] JCAHO standards, however, would appear to prevent it from doing so.

Joint Commission standards may also effectively prevent the use of measures of the economic effects of physician practice patterns on the hospital without prior approval from the medical staff. As long as third-

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each applicant's professional competence, performance, character and fitness and making a recommendation to the governing board. *It is the board's responsibility to ensure that the medical staff has established and adhered to a meaningful, objective procedure.*

James E. Orlikoff & Mary K. Totten, *Medical Staff Appointments and Privileges: Key Role of the Governing Board*, TRUSTEE, Apr. 1988, at 14 (emphasis added); *see also* Blum, *supra* note 40, at 434 ("[T]he actual credentialing decisionmaking functions are carried out by the medical staff with the board's role being that of an overseer of the process."); Mary K. Totten et al., *Using Criteria for Medical Staff Reappointment*, TRUSTEE, Sept. 1990, at 13 (arguing that the board's most important quality assurance responsibility is to ensure the appointment and retention of a qualified medical staff).

[73] *See supra* notes 64-72 and accompanying text.

[74] *See* Havighurst, *supra* note 4, at 1120.

[75] *Cf.* Blumstein & Sloan, *supra* note 11, at 64 n.434 (suggesting that external peer reviewers might reasonably be employed at the "appeals stage" envisioned under the HCQIA).

party payors reimbursed hospitals solely on the basis of the "reasonable costs" incurred in the provision of hospital services, hospitals had little reason for concern over the utilization patterns of staff physicians. With the advent of prospective payment, however, a physician who practices inefficiently can cost a hospital significant sums of money.[76] JCAHO standards suggest that a hospital needs prior medical staff approval before implementing credentialing criteria that take into account the hospital's economic interests.[77] Given the apparent conflict of interests for staff physicians, requiring medical staff consent presents a clear obstacle to the implementation of a strategy designed to further legitimate hospital interests.

3. Evaluating the Effect of Regulatory Constraints

Courts should not merely assume that a hospital governing body does or does not effectively control medical staff peer review decisions on the basis of proof-texts found in accreditation requirements or in medical staff or governing body bylaws.[78] Instead, judges should examine the practical effect of bylaw provisions on the nature of the governing body's review and on the information available to the board during the review process.[79] A court should also consider the nature of any obligation of the governing body to account to the medical staff for a decision reversing the staff's judgment.[80] If such a process restricts the governing body's ability to assert itself in credentialing decisions, or significantly delays[81] or otherwise threatens implementation of governing body policy, then the hospital board lacks the control needed to justify immunity from antitrust scrutiny under *Copperweld*.

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[76] *See, e.g.*, Blum, *supra* note 40, at 429-30 (arguing that hospitals can lose profits if physicians deliver inefficient medical care); Mary T. Koska, *Hospital CEOs Divided on Use of Economic Credentialing*, HOSPITALS, Mar. 20, 1991, at 42, 48 (noting that single physician's cases cost a hospital $215,000 annually in losses).

[77] *See supra* note 68.

[78] For example, a court may seize upon language to the effect that the governing body is "responsible for the final [staff privileges] decision," 1 AMH, *supra* note 52, ¶ MS.2.12, at 56, to support a finding that the hospital exercises full control over privileges decisions.

[79] *See supra* part I.B.1. Some hospital governing bodies wishing to take a more aggressive posture in hospital governance may elect not to comply with all accreditation standards concerning the peer review process or may interpret them liberally. The Joint Commission does not require full compliance with each and every standard in its *Accreditation Manual* as a condition for accreditation. 1 AMH, *supra* note 52, at xxiv.

[80] *See* 2 AMH, *supra* note 52, at 26.

[81] *See* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 771-72 (1984) (noting that a parent "may assert full control *at any moment* if the subsidiary fails to act in the parent's best interests" (emphasis added)).

To summarize, evaluating whether it is appropriate to treat intrahospital decision making by the medical staff as the unilateral action of the hospital under *Copperweld* involves two factual inquiries. The first inquiry asks whether medical staff physicians have market interests separate from those of the hospital, which in general might affect medical staff decision making. When the staff consists primarily of independent physicians, the divergence of economic interests is sufficiently plausible to justify scrutiny of resulting restraints for their anticompetitive effects. The second inquiry involves careful investigation of the control the hospital board exerts over the credentialing process. Because hospital bylaw provisions purporting to place the "final decision" for staff privileges in the hands of the governing body may actually hide the medical staff's influence, a court should make a careful examination of the credentialing process with a focus on the governing body's ability to make its own decision for its own reasons. If the hospital board lacks this fundamental power, the control required by *Copperweld* is absent, and hospital credentialing decisions should not enjoy the presumption that they represent the unilateral interests of the hospital firm.[82]

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[82] As discussed earlier, *see supra* note 6, courts are divided in their application of intraenterprise conspiracy analysis to hospital decision making. Most courts that have considered the issue have held that a hospital and its medical staff are incapable of "vertical" conspiracy, but that medical staff members can conspire "horizontally" among themselves.

The Fourth and Eleventh Circuits distinguish between horizontal conspiracies occurring within formal peer review proceedings and those that occur outside the peer review process. For example, the Eleventh Circuit stated that it perceived "no basis for holding that a hospital is legally incapable of conspiring with the members of its medical staff." Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810, 819 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990). Nevertheless, it held that votes within the medical staff committee structure did not constitute concerted action. The court stated:

> That the members of the committees could conspire with each other and with their hospital does not mean . . . that every action taken by the committees and hospital satisfies the contract, combination or conspiracy requirement of section 1 of the Sherman Act. To satisfy that requirement, Dr. Bolt must also prove that the members *actually did conspire*.

Id. (emphasis added). To prove the existence of a conspiracy, plaintiffs must "produce evidence that tend[s] to exclude the possibility that the alleged co-conspirators acted legitimately and independently" in making the peer review decision. *Id.* at 820; *see also* Boczar v. Manatee Hosps. & Health Sys., Inc., 993 F.2d 1514, 1519 (11th Cir. 1993) (holding that evidence of misconduct in peer review process supported inference of conspiracy).

The *Bolt* test is derived from the Supreme Court's holding in Monsanto Co. v. Spray-Rite Serv. Co., 465 U.S. 752, 764 (1984). The *Monsanto* test was formulated for use in cases when there is only indirect or ambiguous evidence of concerted conduct. *Bolt*, 891 F.2d at 819. There is no such ambiguity, however, when there is direct evidence of the medical staff's concerted action in the form of votes taken in the peer review process. Nor can staff physicians' participation in the peer review process be

II. HOSPITALS AS JOINT VENTURES: THE IRRELEVANCE OF INTRAENTERPRISE CONSPIRACY

Courts and commentators often assume that courts should employ *Copperweld*'s intraenterprise conspiracy analysis in evaluating staff privileges cases under § 1.[83] *Copperweld*, however, is arguably an inappropriate starting point in the concerted action inquiry. Instead, the first issue should be whether the hospital is sufficiently integrated to be classified as a "single entity" for antitrust purposes. If the hospital is a combination rather than a single actor, there is no reason to pursue the *Copperweld*

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said to be unilateral in any meaningful sense. Indeed, no single staff physician would typically have the power to exclude a physician from staff privileges without the agreement of at least some of his colleagues. Moreover, there is no precedent for concluding that decisions taken within formal structures, if made on the basis of "independent" votes, are not subject to antitrust scrutiny. *Cf.* NCAA v. Board of Regents of the Univ. of Okla., 468 U.S. 85, 99 (1984) (holding that conspiracy resulted from actions of NCAA committee).

Putting aside the lack of precedent for the proposition that independent market actors do not conspire when their agreements take the form of votes in an existing structure, the relevant issue for the purposes of *Copperweld* is not whether an agreement is "outside" the peer review process in the sense that it was not made during a meeting held under the hospital's auspices. Instead, it is the subject matter of the decision that is important. *Copperweld* applies only to decisions that are made by intraenterprise actors in their capacity as agents for a firm. *Copperweld*, 467 U.S. at 769. Thus, if independent medical staff physicians engage in concerted conduct unrelated to managerial duties undertaken on behalf of the hospital, there is no basis for concluding that *Copperweld* could serve to exempt their concerted action from scrutiny. Such conduct would be "outside" of the peer review process in the relevant sense of being unrelated to the physicians' responsibilities as hospital agents. If the subject matter of the agreement at issue relates to matters within the scope of the medical staff's managerial authority, however, it should be irrelevant whether the agreement was reached by vote in the formal setting of a medical staff committee meeting or by handshake in some other setting. The relevant issue is whether actors with divergent economic interests are engaged in concerted decision making. If so, there is cause for concern about the potential anticompetitive consequences of their decisions regardless of the process through which the decisions are made or the subjective good faith of the individual participants. Conversely, when there is a complete unity of economic interest between the medical staff and the hospital, and when the hospital can, in any event, reverse decisions it finds unsatisfactory, informal consultation among the decision makers should not be chilled by the prospect of antitrust scrutiny.

[83] *But see* Weiss v. York Hosp., 745 F.2d 786, 812-13 (3d Cir. 1984) (holding a medical staff a combination as a matter of law for purposes of § 1, but that a hospital may not legally conspire with the staff); Havighurst, *supra* note 4, at 1110 n.120 (noting that "[t]he conspiracy element of the offense would seem hard to disprove as a preliminary matter").

inquiry; hospital actions would be subject to scrutiny under § 1 regardless of the mechanics of intraenterprise decision making.[84]

A. *The Hospital as Joint Venture*

Antitrust law treats most business organizations as single, integrated entities because once a firm begins to do business, its organizers and employees usually retain no significant presence in the markets in which the firm operates.[85] The firm's conduct is seen as unilateral and thus exempt from § 1 scrutiny.

In contrast, unintegrated associations, such as trade associations and cartels, are frequently organized and controlled by competitors to advance the competitors' common interests. Each competitor retains an individual presence in the market at which the association's activities are aimed, and the organization typically involves neither significant integration of members' operations nor the introduction of any new product or service. As a result, antitrust law disregards the formal unity of the association entity and treats its actions as the concerted conduct of its members.[86]

Organizations in a third category, the joint venture, share characteristics with both integrated firms and unintegrated associations. Like associations, such organizations are usually competitor-controlled, but they also partly integrate their owners' operations and typically introduce a new product or service.[87]

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[84] Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210, 214-15 (D.C. Cir. 1986) (holding *Copperweld* inapplicable when legally separate entities reach an agreement), *cert. denied*, 479 U.S. 1033 (1987).

[85] 7 PHILLIP E. AREEDA, ANTITRUST LAW ¶ 1476 (1986).

[86] *See* Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 356-57 (1982) (characterizing nonprofit medical foundation as a "combination" of member physicians and the maximum fee schedule as "an agreement among hundreds of competing doctors"); National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 692 (1978) (characterizing professional society's ethical canon as "an agreement among competitors"); Goldfarb v. Virginia State Bar, 421 U.S. 773, 783 (1975) (describing bar association's minimum fee schedule as "a classic illustration of price fixing"); *see also* Rock, *supra* note 12, at 508 (describing antitrust law's "disregard for organizational form" and willingness to find conspiracy when "members of trade groups, professional societies or standard-setting organizations are competitors").

[87] *See* Compact v. Metropolitan Gov't, 594 F. Supp. 1567, 1574 (M.D. Tenn. 1984) (defining a joint venture as a separate enterprise with integrated operations and subject to control by its parent firms); 1 ABA ANTITRUST SECTION, ANTITRUST LAW DEVELOPMENTS 372 (3d ed. 1992) (stating that a joint venture generally "embod[ies] collaboration among business firms accompanied by some integration of resources, management, and risk"); 7 AREEDA, *supra* note 85, ¶ 1478 ("Although it lacks precise meaning or antitrust consequences, 'joint venture' usually refers to a research, production or marketing enterprise created by several persons other than ordinary inves-

Actions taken by joint ventures, like those of unintegrated associations, are treated as the concerted conduct of the venturers.[88] In practice, however, courts are less likely to find a joint venture's activities to be anticompetitive than they are those of unintegrated associations. Because joint ventures typically involve the introduction of new products or services, courts tend to judge their activities deferentially, examining any alleged restraints of trade in light of the venture's overall procompetitive effects.[89] In antitrust parlance, restraints imposed by joint ventures are treated as ancillary to the larger competitive purpose of the venture.[90] Thus, antitrust challenges to joint venture decisions are unlikely to succeed.

When a hospital is managed in part by ceding power over medical matters to independent staff physicians, it may be plausibly characterized as a joint venture between the hospital firm and the medical staff,[91] and its activities are thus subject to continuing scrutiny under § 1. Medical staff

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tors. The creators may be actual competitors, potential competitors, potential buyer and seller, or otherwise in 'related' businesses.").

[88] *See* NCAA v. Board of Regents of the Univ. of Okla., 468 U.S. 85, 99-102 (1984) (sports league); Broadcast Music, Inc. v. CBS, Inc., 441 U.S. 1, 8 (1979) (venture selling blanket licenses to musical compositions); United States v. Topco Assocs., Inc., 405 U.S. 596, 608 (1972) (venture developing private label grocery products); United States v. Sealy, Inc., 388 U.S. 350, 351-54 (1967) (venture licensing rights to bedding label); Associated Press v. United States, 326 U.S. 1, 11-13 (1945) (newsgathering venture). *But see Maricopa County Medical Soc'y*, 457 U.S. at 356-57 (dictum) (characterizing hypothetical productive joint venture as "single firm"); 7 AREEDA, *supra* note 85, ¶¶ 1477-78 (proposing that joint ventures be treated as single entities "[t]o the extent they are buying and selling in their own right").

[89] *See NCAA*, 468 U.S. at 113-15 (analyzing restraints imposed by sports league in light of procompetitive effects); *Maricopa*, 457 U.S. at 356-57 (distinguishing joint ventures from a naked price-fixing agreement); *Broadcast Music*, 441 U.S. at 23 (stating that joint ventures are not usually unlawful as price-fixing schemes when a price agreement is necessary to market a new product). *But see Topco*, 405 U.S. at 608 (treating joint venture's territorial allocation as a per se antitrust violation); *Sealy*, 388 U.S. at 356 (treating joint venture's price-fixing as per se violation); *see also* Havighurst, *supra* note 4, at 1093 (stating that the hospital/staff arrangement is efficient and thus has a procompetitive effect).

[90] *See* Rothery Storage & Van Co. v. Atlas Van Lines, 792 F.2d 210, 224-30 (D.C. Cir. 1986) (finding that ancillary restraints created by a joint venture did not violate § 1), *cert. denied*, 479 U.S. 1033 (1987); United States v. Addyston Pipe & Steel Co., 85 F. 271, 280 (6th Cir. 1898) ("To be ancillary, and hence exempt from a *per se* rule, an agreement eliminating competition must be subordinate and collateral to a separate, legitimate transaction."), *modified*, 175 U.S. 211 (1899).

[91] *See generally* Havighurst, *supra* note 4, at 1126-31 (arguing for limited judicial scrutiny of decisions made by hospital/physician joint ventures if they can prove that physicians do not dominate decision making).

bylaws can be seen as the equivalent of a joint venture agreement,[92] the terms of which are roughly as follows: In exchange for the grant of clinical privileges and hospital collaboration in treating patients, individual physicians agree to form a self-governing, unincorporated association whose purpose is to supply managerial services to the hospital, drawing on the unique expertise of the staff physicians.[93]

From a formal organizational perspective, characterizing the hospital enterprise as a joint venture is counterintuitive. Joint venturers are usually co-owners of a business, whereas the medical staff in a hospital enterprise usually has no ownership interest. Even without formal ownership, however, staff members have traditionally reaped tangible returns on hospital capital.[94] Most significantly, the value of the time a physician spends on medical staff duties may be small compared with the value of access to a hospital's capital-intensive facilities to treat patients.

Moreover, under the bylaws "contract" between the hospital and staff, physicians are not subordinate to hospital management. Instead, a collaborative relationship exists. For example, a hospital usually must either obtain physician consent or permit the medical staff to make an investigation before divesting a physician of clinical privileges.[95] Although physician and hospital services are incompletely integrated, the time and expertise physicians expend in connection with hospital managerial duties

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[92] *See supra* note 46 (describing medical staff bylaws as a contract between the hospital and medical staff).

[93] Alternatively, one might characterize the hospital as a single entity that has contracted with the medical staff as an "outside agent" to provide managerial expertise. Principals and their outside agents are capable of antitrust conspiracy. *See* Belfiore v. New York Times Co., 826 F.2d 177, 182 (2d Cir. 1987) (holding that whether agent is capable of conspiring with principal depends on "the number and nature of the agent's functions, . . . whether the agent acts in its own interests . . . and whether the alleged coconspirators are in reality under the control of a single individual or entity"), *cert. denied*, 484 U.S. 1067 (1988); Victorian House, Inc. v. Fisher Camuto Corp., 769 F.2d 466, 469 (8th Cir. 1985) (holding that an agent can engage in an antitrust conspiracy if the agent is acting for its own benefit); Tamaron Distrib. Corp. v. Weiner, 418 F.2d 137, 139 (7th Cir. 1969) (holding that the existence of an agency relationship does not foreclose a violation of § 1). When hospitals, however, do not retain plenary power to reverse medical staff decisions, the "outside agent" characterization seems less plausible. *But see* Brown v. Donco Enter., 783 F.2d 644, 646-47 (6th Cir. 1986) (stating that attorneys can be held liable for conspiracy if they exceed advisory role).

[94] *See* Clark, *supra* note 23, at 1435-37 (explaining that physicians seek to maximize their incomes when deciding how hospital facilities are to be used); Pauly & Redisch, *supra* note 23, at 88 (assuming physician control of the hospital to develop a model in which the hospital operates to maximize each physician's income).

[95] *See supra* text accompanying notes 57-72 (discussing division of control between board and medical staff generally).

creates competitive advantages for the hospital.[96] The collaborative relationship between the hospital and its medical staff suggests that some hospitals could be aptly characterized as joint ventures.

The medical staff entity itself also is properly analyzed as a joint venture.[97] As noted above, the staff is a separate organization of physicians who have organized themselves, at the behest of the hospital, for the purpose of providing managerial and technical services.[98] Staff physician practices are not integrated with the staff's managerial activities. Nevertheless, the medical staff provides managerial and information services that might not be provided in the absence of collaboration among staff physicians.[99] Thus, medical staff activities are properly considered the concerted conduct of staff members, although any resulting restraints should be judged in light of the procompetitive aspects of the venture.[100]

B. *Vicarious Liability for Medical Staff Misconduct*

Ironically, once the medical staff is recognized as a combination of potential conspirators, it may be unnecessary to decide whether the hospital is a single entity or a joint venture.[101] If medical staff decision making causes unreasonable anticompetitive effects, the hospital will not escape responsibility in either case. If the hospital is a joint venture, it follows that staff privileges decisions are the product of the venturers' concerted conduct and are thus subject to § 1 scrutiny.[102] Alternatively, if the hospital is a single entity, then a medical staff that is the substantive decision maker in staff privileges matters is acting as the hospital's agent.[103] Under vicarious liability principles, hospitals are responsible for any unreasonably anticompetitive restraints their agents impose.[104]

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[96] Havighurst, *supra* note 4, at 1093.

[97] *Id.* at 1092-94.

[98] This conception of the hospital/medical staff relationship is confirmed by recent proposals providing for more explicit separation of the medical staff organization from the hospital entity. *See* Stephen M. Shortell, *The Medical Staff of the Future: Replanting the Garden*, 1 FRONTIERS HEALTH SERVICE MGMT. 3 (1985).

[99] A hospital might hire full-time physician-administrators to perform the functions of the medical staff, but there arguably are benefits to be gained from the more direct input of physicians practicing in the various hospital departments provided by the medical staff structure.

[100] Havighurst, *supra* note 4, at 1093 & n.63 (characterizing restraints imposed by medical staff as ancillary).

[101] It may also be unnecessary to decide whether the hospital and its medical staff are capable of entering into a "vertical" conspiracy.

[102] *See supra* notes 91-93 and accompanying text.

[103] *See* Havighurst, *supra* note 4, at 1118 (noting vicarious liability of medical staff).

[104] *See* American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp., 456 U.S. 556, 570-76 (1982) (holding a professional society vicariously liable for antitrust violations committed by its agents in the course of standard setting activity). *See generally*

Vicarious liability is justified because of the potential for anticompetitive activity that results when the hospital delegates authority over staff privileges matters to the medical staff.[105] Hospitals can greatly minimize the potential for anticompetitive conduct by ensuring that the medical staff review process is designed to further hospital interests, specifically by asserting the governing board's prerogative to make decisions independent of the staff.[106] If the hospital management elects to delegate decision-making authority to the staff without supplying checks on possible anticompetitive behavior, it should be accountable for resulting misconduct.[107]

III. BACK TO BASICS: INDEPENDENT CONDUCT AS A DECISIVE FACTOR IN ANTITRUST CONSPIRACY ANALYSIS

I argued in Part I that the intraenterprise conspiracy doctrine articulated in *Copperweld* is an inappropriate basis for dismissing most antitrust actions arising out of hospital staff privileges decisions. The per se exemption from scrutiny implicit in *Copperweld* should not be available primarily because most medical staff physicians participating in peer review have an independent market interest that might tempt them to skew hospital decision making to their own advantage.[108] Moreover, as noted in Part II, the *Copperweld* inquiry may be irrelevant when the hospital is appropriately characterized as a joint venture between management and the medical staff.

Staff privileges decision making need not always be treated as concerted conduct, however. In some hospitals the medical staff may play a

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Dean M. Harris, *Vicarious Antitrust Liability in the Health Care Field*, 5 CAMPBELL L. REV. 61, 105-12 (1982) (discussing the development of vicarious antitrust liability and its application to the health care field). The characterization of the hospital as a joint venture rather than a single entity would presumably be relevant when there is no basis for vicarious liability because the medical staff did not make the credentialing decision. If the hospital were a joint venture, the decision would be the product of concerted conduct, but it would be evaluated as an ancillary, rather than a naked, restraint. *But see infra* text accompanying notes 110-11 (arguing that joint venture characterization is weakened when medical staff does not share decision-making authority).

Characterizing the medical staff as an independent contractor would not relieve the hospital of liability either. *See* Havighurst, *supra* note 4, at 1118 n.144 (noting that a hospital probably has a nondelegable responsibility to prevent antitrust violations).

[105] *See Hydrolevel*, 456 U.S. at 571 (justifying vicarious liability because standard-setting organizations are "rife with opportunities for anticompetitive activity").

[106] *See id.* at 570-71 (supporting the imposition of vicarious liability because the principal placed its agents in a position to frustrate competition in an industry).

[107] If courts only imposed liability on the hospital if it ratified the staff's decision, it could avoid liability by purposefully remaining ignorant of staff conduct. *See id.* at 573 (noting that such a rule would promote anticompetitive ends).

[108] *See supra* part I.A.

truly advisory role in credentialing decisions, with the board making substantive decisions with an exclusive focus on the hospital's interests. In such cases, it is reasonable to view the resulting decision as unilateral, not because concerted conduct was legally impossible, but because it did not occur in fact. Mere advisory recommendations of the staff do not create any "agreement" between the hospital and the governing body.[109] Moreover, a medical staff recommendation that the hospital board is under no obligation to accept cannot be the effective cause of competitive injury.[110]

Similarly, when the medical staff serves in a purely advisory capacity, the characterization of the hospital as a joint venture becomes less plausible. Co-venturer status implies a co-equal rather than a subordinate managerial role for the medical staff. When hospital management makes its own decisions for its own reasons, the characterization of the hospital as operating to serve the economic interests of both management and staff physicians is likewise significantly weakened.[111]

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[109] *See* 2 MILES, *supra* note 11, § 10.05[2], at 10-49 to 10-50 (noting that having the capability to conspire does not mean the participants did conspire, unless a conspiracy is shown in fact); Blumstein & Sloan, *supra* note 11, at 72-73 n.509 (citing White v. Rockingham Radiologists, Ltd., 820 F.2d 98, 102 (4th Cir. 1987)). *But see* Havighurst, *supra* note 4, at 1126 ("[T]he evidence of decisionmaking independence that would allow a hospital to escape application of the essential-facilities doctrine would not normally be sufficient to overcome an allegation of a hospital/staff conspiracy."); *id.* at 1126 n.177 ("Even though a hospital decision might be independent in the sense that it was not delegated to the medical staff, it would not necessarily be wholly unilateral.").

[110] The Fourth Circuit has made an argument deceptively similar to the one in this Article: "To speak of a conspiracy among a medical staff during the peer review process is not very meaningful in antitrust terms if the staff lacks the final authority to implement any agreement that it does reach." Oksanen v. Page Memorial Hosp., 945 F.2d 696, 706 (4th Cir. 1991) (en banc), *cert. denied*, 112 S. Ct. 973 (1992). The court's statement begs the important question whether the board had the authority to implement unilaterally a privileges decision of *its* own choosing. *See supra* part I.B.1. If not, then the board and the staff would be jointly responsible for the decision. Facts in *Oksanen*, such as the board's threat that it would unilaterally evaluate Dr. Oksanen's privileges if disciplinary action was not instituted, suggest that the hospital board may, in fact, have made an independent decision. *Oksanen*, 945 F.2d at 701.

The Eleventh Circuit has noted that the mere fact that the board subsequently acted on a recommendation from the medical staff does not necessitate a conclusion that concerted action was present. Todorov v. DCH Healthcare Auth., 921 F.2d 1438, 1459 (11th Cir. 1991). Nevertheless, the court devoted little attention to determining whether the facts before it were more consistent with an independent board decision or a joint decision of the medical staff and the board. *See id.* at 1459 n.34.

[111] As long as physicians can use the purchasing power of their patients as leverage in negotiations with hospitals, hospitals are likely to accommodate physician interests in the course of pursuing hospital interests. Such accommodation does not differ materially from other arm's length relationships. Shifts toward integration of health

A. *The Significance of Hospital Independence*

In *Pennsylvania Dental Ass'n v. Medical Service Ass'n*,[112] the Third Circuit focused on the independence of decisions taken by the board of directors of Pennsylvania Blue Shield when the board had received advice from health care providers with a potential competitive stake in those decisions.[113] The case involved a challenge to the price setting mechanism that Blue Shield employed in connection with its prepaid dental services plan.[114] Under the plan, the company had agreed to pay for dental services pursuant to a formula based on the "usual, customary and reasonable" (UCR) charges of its providers.[115] The plaintiffs,[116] several dental associations and individual providers, alleged that dentists comprising a majority of two Blue Shield policy committees "conspired and acted through Blue Shield, as their agent, to establish and implement the UCR system."[117] In essence, they characterized Blue Cross as a conduit through which the conspiring dentists effectuated their scheme to fix prices.[118]

The Third Circuit accepted the plaintiffs' analytical framework, noting that "[t]o the extent that Blue Shield's establishment of the UCR reimbursement system might disguise or embody an agreement among competing providers, its actions would come within the purview of § 1."[119] It held, however, that the facts of the case would not support this characterization.[120] Blue Shield's board was not composed primarily of health care

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care finance and delivery are thus likely to reduce physician influence in hospitals. *See supra* part I.A.

[112] 745 F.2d 248 (3d Cir. 1984).

[113] *Id.* at 258.

[114] *Id.* at 253.

[115] *Id.* at 254.

[116] Actually, the claim against Blue Shield was asserted as a third party claim by one group of parties and a counterclaim by another. *Id.* at 258. For convenience, this Article refers to all the parties asserting price fixing claims against Blue Shield as the plaintiffs.

[117] *Id.* at 256.

[118] The court called the theory a "structural horizontal conspiracy with a vertical link." *Id.* This conspiracy depended "upon proof that participating dentists, through their majority membership on the two Blue Shield committees, *actually controlled* the establishment of the UCR system implemented by Blue Shield." *Id.* (emphasis added); *see also* Ratino v. Medical Serv., 718 F.2d 1260, 1270-71 (4th Cir. 1983) (stating that physician control of plan, if proven, could indicate concerted action); Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 481 (4th Cir. 1980) (affirming finding that physician control of Blue Cross plan was sufficient to subject activities to scrutiny under § 1). A hospital medical staff that makes the real decisions in the peer review process could be characterized as a "structural horizontal conspiracy" effectuated through the "vertical link" of the hospital.

[119] *Pennsylvania Dental*, 745 F.2d at 257.

[120] *Id.* at 258.

providers,[121] and only two of thirty-two members were dentists.[122] The court conceded that if the dentist-controlled committees had been dominant in the policy-making process, a conspiracy would have resulted. It noted, however, that "majority membership on a committee, without more, does not make out a prima facie case of structural economic conspiracy. The power and authority of that committee must be analyzed."[123] Upon such analysis, the court concluded that the committees "were advisory only, that they were constituted and utilized as a resource to the board, that they participated in no activities anathematic to antitrust precepts, and rendered advice only when particularly solicited by the board."[124]

Pennsylvania Dental thus suggests that when analysis of the power and authority of a hospital medical staff reveals that the staff's function was truly advisory to the hospital board, no concerted action exists under § 1. Dismissal of a § 1 claim would be appropriate under such circumstances even though *Copperweld*'s "complete unity of economic interest" requirement is unmet.[125] The capacity for concerted action between the hospital and the staff would be present in such a case, but concerted conduct does not occur since the staff's recommendation is without actual effect.[126]

The significance that the Sherman Act attaches to the distinction between concerted and unilateral activity forms the basis for the holdings of both *Copperweld* and *Pennsylvania Dental*. There are subtle differ-

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[121] *Id.*

[122] *Id.*

[123] *Id.*; *see supra* part I.B.1.

[124] *Pennsylvania Dental*, 745 F.2d at 258. The plaintiffs had elicited the testimony of a Blue Shield official who "could not remember any occasion when the policy committee's recommendation was not accepted by the board." *Id.* The court found this evidence insufficient to foreclose summary judgment on the price-fixing claim because the Blue Shield board nevertheless appeared to be pursuing its independent interests. *Id.* Two of the three committee decisions, which formed the basis of the complaint in the case were favorable recommendations of policies developed and urged by management, rather than by the dentist-members of the committee, and the third policy the committee favorably recommended was formulated by another committee apparently not under provider domination. *Id.* The court made its fundamental analysis of the claim quite explicit in its ultimate resolution of the issue:

> Distilled to its essence, the question comes to this. Blue Shield, as a purchaser of or ultimate payor for dental services, sought advice on the design and operation of its dental program from committees composed primarily of practicing dentists. To give advice when asked by the decisionmaker is not equivalent to being the decisionmaker itself.

Id. at 258-59.

[125] *See supra* part I.A.

[126] However, a hospital board could only make an independent decision if it had the power to do so—within the meaning of *Copperweld*'s "full control" test—and if it exercised that power.

ences, however, in the appropriate standards for judging the capacity of intraenterprise actors to conspire under *Copperweld* and determining whether they actually did conspire under *Pennsylvania Dental*. Specifically, the "full control" aspect of the *Copperweld* test is concerned with whether the parent firm has the full power to approve or disapprove decisions of the intraenterprise conspirators. *Pennsylvania Dental* asks whether this power was actually exercised. Thus, one can imagine a governing body, formally vested with plenary decision-making authority, that merely "rubber stamps" medical staff decisions. Under the *Copperweld* analysis, the hospital would satisfy the "full control" requirement,[127] even though the medical staff, rather than the hospital, was the substantive decision maker. In most cases, a court would properly view the resulting decision as the product of a conspiracy between the medical staff and the hospital.[128] On the other hand, if a hospital governing body treats medical staff peer review evaluations as substantive recommendations and makes the actual peer review decisions in light of hospital interests, no agreement between the hospital and its medical staff exists, and § 1 will not apply.

B. *Putting Theory into Practice: Summary Judgment*

Both hospitals and medical staff members can avoid vexatious antitrust claims if hospitals are willing to treat medical staff judgments as advisory and, perhaps more significantly, if physicians are willing to have their judgments treated as advice. Given the complexity of hospital relationships, however, the process through which governing body independence is identified is worth considering in some detail.

A physician claiming that a staff privileges decision violated § 1 will typically allege that he was wrongfully excluded from the medical staff as a result of concerted decision making of the hospital board and medical staff committees. The significance of such evidence depends, however, on whether the hospital and medical staff bylaws and state law gave the hospital board the authority to make a fully independent decision as to the contested exclusion. If the board did have such authority, the fact that both it and the medical staff voted to approve the plaintiff's exclusion will

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[127] *Copperweld* does not require that the hospital actually exercise its review power. Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 771-72 (1984) (emphasizing management's formal ability to "assert full control at any moment if the [staff] fails to act in [management's] best interests," rather than management's actual assertion of that control).

[128] Most hospitals are unlikely to meet *Copperweld*'s "complete unity of interest" requirement because staff physicians might have economic incentives to direct hospital decision making to their own competitive ends. Therefore, a finding of concerted conduct would be appropriate. *See supra* part I.A.

not, by itself, demonstrate the presence of concerted conduct.[129] The evidence would equally support two conflicting conclusions: (1) the board actually treated the staff's decision only as a recommendation; or (2) the board merely "rubber-stamped" the staff's decision without having exercised any independent judgment. Because such evidence would fail to create a factual issue regarding the existence of the conspiracy, the excluded physician's claim would be unable to survive defendants' summary judgment motion.[130]

On the other hand, if the bylaws do not empower the hospital board to act independently—even if they provide that the board makes the "final" decision[131]—it is clear that the challenged decision stems from concerted action. Because the board lacked the legal authority to impose the challenged exclusion unilaterally, the resulting decision must be subject to scrutiny on the merits under § 1.

In the case in which the hospital board in fact possessed the power to make an independent decision, the plaintiff must "introduce additional evidence sufficient to support a finding of . . . conspiracy."[132] The plaintiff might prove, for example, that the board has always followed the staff's recommendation and argue that the board's decisions are thus not meaningfully independent.[133] Assuming the plaintiff succeeds in casting genuine doubt on the board's independence, the defendants must show that the challenged decision was, in fact, unilateral in order to avoid a trial on the merits.

The test articulated in *Pennsylvania Dental* for determining the board's independence in fact for the purpose of conspiracy doctrine requires identifying the substantive decision maker.[134] The crucial inquiry is thus whether the board treated the medical staff's decision as a true recommendation and made an independent decision after due consideration of the hospital's interests. A hospital board could demonstrate that it, not

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[129] Todorov v. DCH Healthcare Auth., 921 F.2d 1438, 1459 (11th Cir. 1991) ("[T]hat the hospital board had before it recommendations from the medical staff and that the radiologists were pleased with [the board's] ultimate decision is, standing alone, insufficient to infer an antitrust conspiracy.").

[130] Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 588 (1986) ("[A]ntitrust law limits the range of permissible inferences from ambiguous evidence in a § 1 case. . . . [C]onduct as consistent with permissible competition as with illegal conspiracy does not, standing alone, support an inference of antitrust conspiracy." (citing Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 764 (1984))).

[131] *See supra* part I.B.1. (arguing that the JCAHO's accreditation requirements that hospital bylaws vest significant decision-making power in the medical staff limits the hospital board's role in credentialing decisions to a procedural check against staff misconduct).

[132] Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 764 n.8 (1984).

[133] *Cf. Todorov*, 921 F.2d at 1459 n.34 (rejecting such an argument on the basis of hospital administrator's testimony to the contrary).

[134] *See supra* part III.A.

the medical staff, was the substantive decision maker by producing affidavits and other documents, such as minutes of governing body meetings, reflecting that "privileges decisions were fully reviewed by either the full board or a committee thereof."[135] The board could also show that "the evidence supporting the medical staff's recommendation was evaluated—perhaps by outside evaluators—in light of the staff's possible conflict of interest and that the board weighed hospital interests the staff was not in a good position to consider."[136] A hospital should also produce evidence of board attempts to verify key reasons given for the decision.[137] Similarly, the court should consider the plausibility of the reasons the board gives to justify its decision in light of hospital interests.[138] If the plaintiff fails to present evidence that "tends to exclude the possibility" that the hospital board acted independently,[139] a court should grant the defend-

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[135] Havighurst, *supra* note 4, at 1120. Professor Havighurst suggests that the independence of the hospital governing board should prevent the invocation of the essential-facilities doctrine to scrutinize peer review decisions. *Id.* at 1117 (stating that "[t]he availability to the plaintiff of the essential-facilities doctrine should hinge" on a finding that the board did not act independently). Consequently, he devotes considerable discussion to the appropriate factual inquiry into the board's independence. *Id.* at 1120-22 (discussing evidence of procedural safeguards that would support a finding of independence); *id.* at 1139-42 (offering hypothetical privileges decision case and listing questions to be asked in determining the board's independence).

[136] *Id.* at 1120; *see also* McMorris v. Williamsport Hosp., 597 F. Supp. 899, 914 & n.13 (M.D. Pa. 1984) (finding that the hospital board's decision to grant defendant physician exclusive practice rights in nuclear medicine had arisen from an outside consultant's report made in light of the best interests of the hospital); Blumstein & Sloan, *supra* note 11, at 64-65 (encouraging the use of outside consultants in connection with medical staff decisions).

[137] Havighurst, *supra* note 4, at 1139 (discussing this type of evidence as relevant to the determination of whether the hospital had merely rubber-stamped the medical staff's decision).

[138] *Id.* at 1140 (focusing specifically on the hospital's financial interests). The framework for analysis suggested by Professor Kissam and his co-authors, which evaluates the relative interests of the hospital and medical staff in privileges decisions by classifying them as made by a "physician cartel," "joint venture," or "employer hospital" may be useful in evaluating the plausibility of proffered reasons. *See* Kissam et al., *supra* note 11, at 611-13 (explaining that these classifications serve as prima facie assumptions about relationships between physicians and the hospital).

Note, however, that a judge can make the suggested evaluation based solely on the pleadings and any existing record, consistent with the common practice in antitrust litigation of using judicial presumptions about conduct of market actors. *See* 2 PHILLIP AREEDA & DONALD F. TURNER, ANTITRUST LAW ¶ 316a, at 58 (1978) ("[T]he correct ultimate disposition of the case will often be adequately revealed by the pretrial record to a judge who confidently understands the substance of antitrust law, including the various relevant presumptions . . . ."). *See generally id.* ¶ 314 (discussing the utility of presumptions in the fact-finding process in antitrust law).

[139] Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 764 (1984).

ants' summary judgment motions on the procedural showing described above.[140]

Even if the plaintiff is initially unable to rebut the defendants' showing of board independence, he may request that the court deny or continue the motion for summary judgment under Rule 56(f) of the Federal Rules of Civil Procedure. Rule 56(f) permits a court to deny or continue a summary judgment motion when the nonmoving party provides adequate reasons for its inability to present facts sufficient to justify its opposition.[141] Typically, a party will invoke Rule 56(f) when the opponent is in

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[140] Professors Blumstein and Sloan acknowledge the relevance of board independence to the conspiracy inquiry. Blumstein & Sloan, *supra* note 11, at 72-73 n.509. However, they focus on the independence of the hospital board primarily in connection with whether the challenged restraint should be analyzed as a vertical or a horizontal agreement. *Id.* at 56. Blumstein and Sloan advocate a more exhaustive inquiry into the board's independence than that suggested above, arguing that unless a substantive and functional inquiry into the hospital's independence is undertaken, the independence inquiry will merely cause hospitals to leave an appropriate paper trail in connection with staff privileges decisions without assuring that the hospital actually took steps to resist undue medical hegemony. *Id.* at 60-61. Rather than accept at face value evidence that the board considered privileges decisions in light of its own competitive interests, they would require the hospital to proffer a business justification (e.g., cost containment, promotion of an image of quality services) and to substantiate the justification by demonstrating parallel efforts being made in other areas of hospital operation to achieve the articulated goal. *Id.* at 61-65.

The chief difficulty with this analysis is the significant burden it imposes. Reflecting the understandable desire to avoid an erroneous conclusion in favor of the hospital, the proposed analysis introduces another layer of difficult pretext inquiries into proceedings already overladen with them.

At present, when medical staff antitrust cases are decided on the merits, the issue is usually whether the justifications for denial of privileges—typically quality concerns based on the training or performance of a practitioner—were pretexts for anticompetitive activity. *See, e.g.*, Miller v. Indiana Hosp., 843 F.2d 139, 144 (3d Cir. 1988) (remanding the case to jury trial to decide the factual issue of whether the "hospital's revocation of [plaintiff's] privileges, although ostensibly for professional incompetence and unprofessional conduct, was motivated by the anticompetitive purpose of destroying plaintiff's competition or prospective competition"). Thus, courts and parties engage in extensive discovery and litigation examining the validity of the medical conclusions reached by the staff, the personal relationships of the actors involved, and the economic motives for anticompetitive activity on the part of staff physicians.

Professors Blumstein and Sloan propose that courts should also embark upon a purpose-based inquiry in connection with the question of hospital independence. They anticipate the criticism that their proposal is unduly burdensome by noting that a purpose-based inquiry is inevitable under the HCQIA. Blumstein & Sloan, *supra* note 11, at 84 n.606.

[141] FED. R. CIV. P. 56(f) provides:

> Should it appear from the affidavits of a party opposing the [summary judgment] motion that the party cannot for reasons stated present by affidavit facts essential to justify the party's opposition, the court may refuse the application for judg-

sole possession of the evidence needed to oppose the motion.[142] An antitrust plaintiff may not, however, simply aver that he is without access to the relevant facts. He must "show to the best of his ability what facts are within [the defendants'] exclusive knowledge or control, what steps have been taken to obtain the desired information pursuant to the discovery procedures under the Rules, and that he wishes to take advantage of these discovery procedures."[143]

A plaintiff is likely to make several arguments if he files a Rule 56(f) motion in an antitrust case. First, the plaintiff is likely to attack the finding of independence on historical grounds, arguing that the board has "always" followed the staff's recommendations.[144] The court's decision to grant the plaintiff's Rule 56(f) motion for additional discovery of evidence with respect to past hospital decisions should depend on the strength of the evidence the defendants offer in support of their contention of hospital independence. If the defendants present persuasive evidence of hospital independence, the court may conclude that even if the plaintiff correctly suggests that discovery will yield evidence that the board has always or almost always followed medical staff recommendations, such evidence would not be sufficient to prevent summary judgment.[145] For example, if the hospital employed a newly instituted policy of using an outside consultant in disputed peer review decisions, or if the hospital's interests in the decision were clearly evident, evidence of board acquiescence to medical staff decisions in prior proceedings would probably be insufficient to foreclose summary judgment. However, such evidence may suffice to create a factual issue if the hospital offers procedural evidence that is relatively unconvincing.

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ment or may order a continuance to permit affidavits to be obtained or depositions to be taken or discovery to be had or may make such other order as is just.

[142] JAMES W. MOORE & JEREMY C. WICKER, MOORE'S FEDERAL PRACTICE ¶ 56.24, at 56-809 (2d ed. 1988) ("A typical situation for the application of Rule 56(f) is where the opposing party cannot then present by affidavits facts essential to justify his opposition, because knowledge of these facts is exclusively with or largely under the control of the moving party.").

[143] *Id.* ¶ 56.24, at 56-811; *see also* Mid-South Grizzlies v. NFL, 720 F.2d 772, 777-81 (3d Cir. 1983) (upholding district court's consideration of motion for summary judgment on present record on the grounds that plaintiff failed to file Rule 56(f) affidavit, raised merely conjectural contentions that additional discovery would support its antitrust claim, and made largely irrelevant discovery requests); Contemporary Mission, Inc. v. United States Postal Serv., 648 F.2d 97, 107 (2d Cir. 1981) (similarly upholding a summary judgment motion on the ground that plaintiff "merely restat[ed] the conclusory allegations contained in his complaint, and amplif[ied] them only with speculation about what discovery might uncover").

[144] *See supra* note 133 and accompanying text.

[145] *See* Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986) (stating that evidence in summary judgment proceeding must be considered in its factual context).

Another likely means by which antitrust plaintiffs may attempt to create a factual issue about the board's independence is to produce evidence revealing the pretextual nature of the board's articulated reasons in support of the staff privileges decision.[146] A plaintiff may claim that the articulated concern is unreasonable, perhaps asserting that the defendants' allegations of incompetence are unfounded. Alternatively, the plaintiff may assert that the hospital is not seriously concerned about the interests it has articulated in support of its decision.[147]

In the case in which the plaintiff argues that the hospital's articulated concerns were unreasonable, a Rule 56(f) motion is generally not necessary. The procedural protections accorded staff physicians usually include the right to receive a written statement of the reasons for an adverse decision.[148] Moreover, the hospital's justification for its decision should appear in the defendants' evidence supporting their claim that the board acted independently in the decision-making process. In the event that the hospital has not either provided a plain statement of the concerns motivating its decision or granted the plaintiff access to the record upon which the board decision was based, a court should permit discovery with respect to these issues as a matter of course.[149] Once a plaintiff has access to this written statement, he should generally be able to demonstrate that the articulated concerns were unreasonable without further discovery from the movant.

It is not clear, however, that such evidence would always create a genuine issue of fact. Consider, for example, a case in which a hospital revokes a physician's privileges on the basis of articulated concerns about the quality of care the physician delivers. The physician may challenge the board's independence on the ground that it was medically unreasonable to conclude that he posed a threat to the quality of patient care within the hospital. The hospital board minutes might reveal that the medical staff recommendations were reviewed extensively in the first instance by

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[146] *See* Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810, 821 (11th Cir.) (holding that evidence demonstrating pretextual reason for staff privileges decision justifies an inference of conspiracy), *cert. denied*, 495 U.S. 924 (1990).

[147] *See supra* notes 138, 140 (discussing the appropriate factual inquiries into a hospital board's independence and its proffered justifications for denial of privileges).

[148] *See* HCQIA, 42 U.S.C. § 11112(b)(3)(D)(ii) (1988) (providing a physician the right "to receive a written decision of the health care entity, including a statement of the basis for the decision" as a precondition for limited immunity of the hospital and other participants in the peer review process).

[149] Antitrust law does not require procedural due process in medical staff privileges cases. Havighurst, *supra* note 4, at 1132. However, fair procedures "demonstrate . . . that the hospital and its medical staff were jointly committed to evenhanded application of objective criteria [and] aid the hospital board in exercising its independent judgment on each personnel decision; indeed, the absence of procedures facilitating effective oversight of staff actions might suggest that the hospital had abdicated its decisionmaking function in favor of the medical staff . . . ." *Id.* at 1132-33.

a committee of the board and forwarded, in light of concerns about potential conflicts of interest among medical staff members, to a well-qualified outside reviewer who confirmed the staff's recommendation. In addition, the hospital may be able to demonstrate numerous prior instances in which it acted contrary to the recommendation of its medical staff. Under such circumstances, it is doubtful that a plaintiff's proffer of an expert who will disagree with the scientific conclusions upon which the board relied will create an inference of concerted action. This may seem counterintuitive given the prominence of factual disputes among experts in modern litigation. Nevertheless, the ultimate inquiry is whether the hospital acted independently after receiving the medical staff's recommendation. Although evidence of a medical dispute over a practitioner's incompetence considered "in isolation"[150] supports an inference of concerted activity,[151] it must be "evaluated in its factual context."[152] When the hospital has introduced convincing evidence that it made an independent decision, summary judgment should not be foreclosed.[153]

Conversely, the defendants may offer much less impressive evidence of hospital independence. For example, board meeting minutes might reflect some independent consideration of the medical staff recommendation and a vague or barely plausible articulation of the hospital's interest in the decision. A strong showing that the conclusions reached were scientifically unreasonable might create an issue of fact as to whether collu-

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[150] Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986).

[151] *See* Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810, 821 (11th Cir.) (noting that factfinder could infer illegitimate purpose if hospital and peer review committees acted on the basis of unreasonable medical conclusions), *cert. denied*, 495 U.S. 924 (1990).

[152] *Matsushita*, 475 U.S. at 587.

[153] *See* Nurse Midwifery Assocs. v. Hibbett, 918 F.2d 605, 616-17 (6th Cir. 1990) (holding that hospital's explanation for denying privileges to midwives—promoting hospital as tertiary care center and high quality training and medical institution—warranted summary judgment in favor of hospital), *cert. denied sub nom.* Nurse Midwifery Assocs. v. Hendersonville Community Hosp., 112 S. Ct. 406 (1991); Kreuzer v. American Academy of Periodontology, 735 F.2d 1479, 1495-96 (D.C. Cir. 1984) (finding that summary judgment was appropriate because there was little evidence to support a conspiracy to restrain trade); Smith v. Northern Mich. Hosps., Inc., 703 F.2d 942, 947-48 (6th Cir. 1983) (upholding summary judgment because petitioner did not advance probative evidence in response to defendants' legitimate alternative explanations for their conduct). Compare Miller v. Indiana Hosp., 843 F.2d 139, 143-45 (3d Cir. 1988), in which the plaintiff, Dr. Miller, introduced sufficient evidence, that the defendants' quality concerns and Dr. Miller's dismissal for unprofessional conduct were pretextual, to survive summary judgment. Specifically, Dr. Miller showed that hospital management had long viewed him as a competitive threat, had taken actions damaging to his practice, and had failed to discipline other physicians committing offenses similar to those allegedly committed by Dr. Miller. *Id.* at 144. He also alleged that the hearing process used to discipline him was irregular. *Id.*

sion occurred. This is particularly true if the hospital's interests in the decision appear relatively weak and those of the medical staff are particularly strong, or if accompanying evidence of anticompetitive motivation or conduct exists.[154]

Professors Blumstein and Sloan have suggested an alternative formulation of the pretext argument.[155] Rather than attack the reasonableness of record findings (e.g., quality, cost) in a particular case, an antitrust plaintiff could allege that the hospital's purported justifications were pretextual in view of evidence that the hospital has, in fact, no institutional commitment to the articulated policies. It is hard to deny the relevance of such evidence. Nevertheless, in the absence of specific identification of facts that proposed discovery may reveal, courts should not continue a summary judgment motion to permit discovery on these issues. First, such evidence may not be sufficiently probative to permit inference of conspiratorial conduct.[156] Second, such an inquiry invites a focus on the overall management of the institution. This increases the potential for harassment of the hospital through exhaustive discovery of institutional inconsistencies. From a judicial perspective, the time and expense associated with such an inquiry is probably unwarranted since such evidence, even if obtained, will not necessarily demonstrate that the board was acting as the pawn of the medical staff.

In the face of significant procedural evidence of independent action by the hospital, it is unlikely that evidence showing inconsistent pursuit of articulated objectives would permit an inference of conspiracy strong enough to survive summary judgment. Therefore, if the plaintiff can avoid summary judgment only by attempting to persuade the court to permit additional discovery under Rule 56(f), the court should require a specific showing of the facts that the plaintiff expects to develop through discovery.[157] The court can then evaluate whether, in light of the board's evidence of independence, it should forestall summary judgment even if the evidence is as the plaintiff alleges. If the court permits discovery, it can be focused on the specific issues that the plaintiff identifies.[158]

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[154] Similar analyses are appropriate when the hospital's articulated interest in cost containment is alleged to be pretextual. If a physician claims that discovery will reveal that concerns about the physician's cost containment record were unjustified, but evidence of hospital independence is strong, summary judgment is appropriate.

[155] *See supra* note 140.

[156] *See supra* notes 141-53 and accompanying text.

[157] *See supra* note 141 and accompanying text.

[158] The value of "focusing" discovery when a court requires plaintiffs to be specific about the evidence they desire to discover through a Rule 56(f) motion is readily apparent. The focusing process is illustrated in Glen Eden Hosp., Inc. v. Blue Cross & Blue Shield, 740 F.2d 423, 427-28 (6th Cir. 1984). There, the plaintiff hospital sought to prove that changes to Blue Cross's reimbursement policy, which were clearly not initiated by its competitor hospitals, were nonetheless the product of the hospitals' concerted action maintained by their right to veto such changes. In its Rule

Focusing on whether the hospital board made an independent decision thus seems to hold serious promise for disposing of nonmeritorious litigation at an early stage, while simultaneously permitting scrutiny of decision making occurring under suspicious circumstances. The conspiracy issue unavoidably poses difficult questions of motivation and pretext, but courts can isolate these questions in ways that force plaintiffs to come forward with serious claims of collaboration before extensive judicial inquiry is permitted.

CONCLUSION

I have argued that in the absence of a truly independent governing board, hospital decision making on staff privileges questions should be viewed as the product of concerted action and thus subject to scrutiny under § 1 of the Sherman Act. Given the divergence of interests between hospitals and their staff physicians and the long tradition of physician dominance in hospitals, it is surprising that so many courts have been willing to overlook the potential for anticompetitive activity inherent in traditional hospital decision making concerning staff privileges.

Recognition of the potential of hospitals and their staff physicians to engage in concerted conduct invites a shift in the focus in staff privileges litigation to the hospital board's independence in the staff privileges decision-making process. However, some courts have been concerned that antitrust scrutiny would prevent hospitals and staff from achieving legitimate goals of peer review.[159] Focusing on the independence of hospital

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56(f) affidavit, the plaintiff sought information concerning the circumstances surrounding the adoption of the *initial* reimbursement arrangements, and other information related to Glen Eden's conspiracy allegations. *Id.* The Sixth Circuit reversed the trial court's grant of summary judgment as an abuse of discretion, noting that the information sought by the plaintiff was "identified with specificity," "not cumulative," and "directly related to [the plaintiff's] theory that participating hospitals either controlled or greatly influenced the reimbursement policy of Blue Cross." *Id.* The court continued: "If [the plaintiff] can show that the participating hospitals combined with Blue Cross to establish the reimbursement formula . . . , the ability of the . . . hospitals to block any change in the formula would be equally as important as the ability to initiate changes . . . ." *Id.* at 428. *But see id.* at 429 (granting more generalized discovery requests).

[159] *See, e.g.*, Oksanen v. Page Memorial Hosp., 945 F.2d 696, 704 (4th Cir. 1991) (en banc) (noting that benefit of physician expertise in peer review could be lost if potential antitrust liability accompanies participation in the peer review process), *cert. denied*, 112 S. Ct. 973 (1992).

Congress has explicitly considered whether the deterrent effect of antitrust litigation justifies exempting peer review decisions from antitrust scrutiny. In enacting the HCQIA, Congress enacted explicit statutory findings that "[t]he threat of private money damage liability . . . including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." 42 U.S.C. § 11101(4) (1988). Congress further found that "[t]here is an

board decision making preserves conspiracy doctrine's focus on scrutiny of competitive collaboration while providing a means by which hospitals and physicians can avoid liability.

Preserving judicial scrutiny of staff privileges decision making that is not reflective of independent hospital interests is also good antitrust policy. Consumers rely on hospital credentialing decisions in evaluating the quality and efficiency of the medical services they purchase. Staff privileges decisions based on the market interests of self-interested physicians may endanger the integrity of this credentialing process. Moreover, physicians may use their control over access to hospital facilities as a mechanism to facilitate other anticompetitive activity—such as blocking innovations in health care delivery and finance that might benefit consumers at the expense of the medical profession.[160]

Suppose, for example, that a hospital wished to employ a strategy of using nonphysician personnel when possible to contain costs. Because the medical staff must approve and delineate the clinical privileges of such personnel, the staff could effectively prevent the implementation of such a program. Medical staff decision making may thus prevent consumers from availing themselves of care that might be of lower quality than that rendered by physicians, though at less cost.

Nevertheless, physicians may defend medical staff interference with consumer choice on the ground that it is appropriate for the medical staff to foreclose some options because consumers lack the information required to evaluate the potential dangers the options pose. Thus, the medical staff may have acted in the consumer's interests by rejecting the proposed hospital program. There are two problems with this argument, however. First, the legitimacy of "private regulation" by a self-appointed body of professionals is open to serious question.[161] Second, even if such

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overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." *Id.* § 11101(5). Even so, the immunity Congress ultimately created was carefully limited. *See* 42 U.S.C. §§ 11111-12, 11115, 11151 (1988 & Supp. III 1991). For a discussion of statutory immunity under the HCQIA, see Austin v. McNamara, 979 F.2d 728, 733-34 (9th Cir. 1992); Smith v. Ricks, 798 F. Supp. 605, 609-12 (N.D. Cal. 1992); Fobbs v. Holy Cross Health System, 789 F. Supp. 1054, 1061-65 (E.D. Cal. 1992); Havighurst, *supra* note 2, at 1161-62 (reviewing the limits of immunity under the HCQIA).

Congress's rejection of more sweeping immunity in the face of its findings suggests that courts should be slow to look for ways to create a broader exemption. As Professors Blumstein and Sloan have pointed out, the immunity accorded by the HCQIA also reflects a congressional assumption that participants in hospital peer review are capable of concerted action under § 1. Blumstein & Sloan, *supra* note 11, at 45 n.273.

160 *See supra* text accompanying notes 34-37.

161 *See* Fashion Originators' Guild v. FTC, 312 U.S. 457, 464 (1941) (holding that rules and regulations by manufacturers of textiles and women's garments that ordered boycotting of retailers who sold copies of their garments was an unfair method of competition).

physicians do regulate themselves it is not clear whether the medical staff's evaluation of the quality issues at stake favors consumers' best interests or the competitive interests of physician decision makers. Recognition of medical staff decision making as concerted action permits courts to use antitrust law to investigate this question. Foreclosing antitrust scrutiny amounts to a conclusive presumption that professional regulation always benefits consumers.

Additionally, if physicians knew medical staff-dominated peer review decisions were subject to antitrust scrutiny, the specter of antitrust liability might create greater physician willingness to submit to hospital authority, as well as greater hospital ability to assert it. There is a strong argument that transferring credentialing and other important decisions currently in physician hands to the hospital board would better serve consumer interests in balancing cost and quality concerns. Hospitals competing for patients will rationally place appropriate emphasis on quality of care, as this will no doubt continue to be an important basis on which consumers select facilities. Presumably, hospitals will wish to continue to obtain the views of medical staff members with respect to staff privileges and other decisions important to the quality of hospital care. In addition, hospitals face direct liability for negligence in credentialing and vicarious liability for employee malpractice.[162] However, properly advised hospitals may be more likely than staff physicians to serve consumers' interests as staff privileges decision makers because of the conflict of interests that physician staff members inevitably face.[163] When staff privileges decisions threaten physician interests, physicians may tend to overemphasize differentials in the quality of services provided by physicians in comparison with less expensive nonphysician practitioners. Hospitals, on the other hand, may serve consumers' interests more faithfully by balancing quality and cost concerns.[164]

Physician control over credentialing decisions may also unduly increase hospital costs. The federal government's policy of prospective payment for Medicare services has imposed potentially severe consequences on hospitals that fail to keep costs down. Perhaps more importantly, hospitals are increasingly participating in provider networks that compete for health plan patients in significant part by offering low prices. However, it is primarily the physician, not the hospital, who determines which hospital services will be employed in the treatment of a given patient. Thus, physicians who do not practice in a cost-effective manner may threaten the economic viability of the hospital. Even so, in many hospitals, the medical staff could likely block implementation of a credentialing process

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[162] *See supra* note 40.

[163] Havighurst, *supra* note 4, at 1104.

[164] *Id.* at 1160-61.

that incorporated the economic interests of the hospital.[165] Physicians also have an incentive to encourage underutilization of hospital facilities for their greater convenience. Staff privileges decisions made on the basis of the competitive interests of hospitals, rather than physician concerns, would result in more efficient use of hospital facilities, which could benefit consumers through lower prices without appreciable sacrifices in quality of care.[166]

Similarly, antitrust scrutiny might put pressure on public and private regulators to permit greater innovation in hospital structure. The point here is not that hospital governance should be changed to mandate less physician input, but rather that hospitals should be free to innovate and experiment with alternative forms.[167] Consumers might favor hospitals with traditional governing structures. It is possible, however, that by adopting a structure bearing greater resemblance to that of traditional firms, hospitals might achieve gains in the quality or cost-effectiveness of services. Additionally, hospitals adopting an organizational structure permitting hospital management greater latitude might find it easier to compete in health care markets increasingly dominated by networks integrating health care delivery and finance.

Finally, as noted above, if courts implement a clear rule making the independence of the governing body's staff privileges decision the primary issue in determining whether concerted action is present in a given case, hospitals and medical staffs could avoid antitrust scrutiny of peer review decisions entirely by ensuring that medical staff actions on peer review decisions were, in fact, merely recommendations. Thus, the threat of antitrust liability would not be an inevitable by-product of engaging in legitimate hospital quality assurance activities. On the contrary, physicians could avoid liability entirely by consenting to a more modest, but nevertheless important, role in hospital governance.[168] Given the incentives for hospitals to maintain high standards of quality, there is little reason to think that consumers would suffer as a result of placing plenary decision-making power in the hospital board. In fact, consumers might benefit from board decisions that permitted greater economy in the delivery of hospital services.

If the governing body shares or delegates outright hospital decision making to the medical staff, resulting decisions should be subject to scrutiny under § 1 of the Sherman Act. Scrutinizing the competitive effects of medical staff decisions does not suggest that either the decisions or the

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[165] Similarly, hospitals are liable for the malpractice of physicians whose privileges are granted or continued as a result of medical staff negligence in the credentialing process. It is anomalous that hospitals frequently bear responsibility for, but lack control over, the credentialing process.

[166] Hall, *supra* note 24, at 524.

[167] *See* Havighurst, *supra* note 4, at 1082.

[168] *Id.* at 1138-39.

process through which they are reached is inherently unlawful. It merely recognizes that concerted decision making among independent market actors may, in some circumstances, pose a threat to competitive values. Moreover, a clear rule requiring scrutiny of medical staff decision making creates the potential for enhanced consumer welfare by creating an important incentive for professionals to relax controls on hospital decision making, thereby facilitating potentially beneficial innovation.

The chilling effect that antitrust scrutiny threatens to impose upon hospital peer review is an inadequate justification for refusing to apply the antitrust laws to the hospital peer review process in a straightforward manner. Hospitals and physicians can and should take reasonable steps to minimize the potential that the independent competitive interests of staff physicians will unduly influence medical staff decisions by ensuring that the hospital, and not the medical staff, is the decision maker in peer review matters. If they fail to do so, any resulting restraints on competition should be deemed the product of concerted conduct subject to antitrust scrutiny.