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On November 4, 1989, the Department of Justice announced in a New York Times article that government antitrust regulation of the health care industry is to be escalated. Keeping this in mind, consider the following scenario: A physician, Dr. Jones, joins the staff of a hospital in Pennsylvania. Although the Pennsylvania hospital received no recommendations from Dr. Jones' former hospital in California, regarding the quality of the physician's skills, Dr. Jones had attended medical school with the chief of staff of the Pennsylvania hospital. He was hired, and, a couple of years later, granted staff privileges. Following a series of unfortunate "mishaps" and after other staff members reported several confrontational discussions with the doctor, the hospital decided to reconsider Dr. Jones' staff privileges. The hospital conducted a three-day hearing, with thousands of pages of testimony and numerous exhibits. In the end, the hospital found that the "mishaps" resulted from the improper actions and misguided decisions of Dr. Jones. Further, it was discovered that Jones had left the California hospital after it had revoked his staff privileges. Several doctors also testified that Jones behaved in a disrespectful and abusive manner toward the staff. Upon the conclusion of the hearing, the hospital terminated Jones' staff privileges. Now, the hospital is compelled to expend thousands of dollars for legal fees and spend weeks in litigation in order to avoid paying thousands of dollars in treble damages arising from a private action brought by Jones, who alleges violations of the antitrust laws. All of this stands at risk because the staff of one Pennsylvania hospital sought to protect the public from harmful medical treatment.

As unreasonable as this scenario may appear, no single health care industry practice has been the target of more antitrust lawsuits than hospital denial of medical staff privileges.¹ Antitrust

claims of this nature are brought under Section One of the Sherman Act which makes “every contract, combination . . . , or conspiracy, in restraint of trade or commerce” illegal. Today, in order for a physician plaintiff to qualify for standing under the Sherman Act, he must show that the challenged activity either directly involves interstate commerce or that it bears a substantial effect on interstate commerce. Along with the obvious public policies in favor of the peer review process, and the defenses provided by the McCarran-Ferguson Act, the “learned professions” theory, and the state action exemption, the prerequisite of establishing interstate commerce was considered a substantial shield against antitrust litigation in health services until the mid-1970’s. Since then, courts have worked to tear down some of these obstacles and to offer more precise guidelines concerning the application of others.

The Supreme Court first held the interstate commerce element satisfied where the plaintiff established that a substantial relationship, direct or indirect, existed between the activities of the defendant and interstate commerce. Four years later the Supreme Court modified this standard in deciding McLain v. Real Estate Board of New Orleans Inc. McLain presented the “effects on commerce” test. Under this test, which most circuit courts follow, the plaintiff surpasses the prerequisite of the Sherman Act by showing that the particular activities of the defendant to which he objects affect interstate commerce. At least one circuit, the ninth, has adopted an even more relaxed standard in inquiring whether interstate commerce is involved in any of the defendant’s business activities. The continuing modifications of the standard contrib-

2. 15 U.S.C. § 1 (1982). In such a lawsuit, a plaintiff physician will allege that the physicians on the peer review board have conspired together to remove him from the staff of the hospital and have therefore agreed illegally to boycott the plaintiff.
5. See, Grossman Jaffe, supra, note 1 at 573.
7. Id. at 739.
9. See, Grossman Jaffe, supra, note 1 at 573, citing Cordova & Simonpictori Ins. Agency v. Chase Manhattan Bank, 649 F.2d 36, 45 (1st Cir. 1981); Furlong v. Long Island College Hospital, 710 F.2d 922, 926 (2d Cir. 1983); Stone v. William Beaumont Hosp., 782 F.2d 609, 614 (6th Cir. 1986); Seglin v. Essau, 769 F.2d 1274, 1280 (7th Cir. 1985); Hayden v. Bracy, et. al., 744 F.2d 1398, 1342-43, (8th Cir. 1984); Crane v. Intermountain Health Care, Inc., 637 F.2d 715, 719-22 (10th Cir. 1981) (en banc).
10. Western Waste Servs Sys. v. Universal Waste Control, 616 F.2d 1094, 1097 (9th
uted to the overall diminishing of defenses available in antitrust suits in the health care industry.\(^{11}\)

Only recently has the health care industry become subject to litigation founded on antitrust grounds. Before 1975, the “learned professions” defense announced in *United States v. Oregon State Medical Society*\(^{12}\) served to exempt the medical profession from such suits by construing the words “trade or commerce” in Section One of the Sherman Act to exclude areas involving professional services.\(^{13}\) In 1975, the defense was brushed away in *Goldfarb v. Virginia State Bar Ass’n*,\(^{14}\) allowing antitrust scrutiny of professionals.\(^{15}\)

Citing *Goldfarb*, the Supreme Court in *Arizona v. Maricopa City Medical Society*,\(^{16}\) firmly closed the door on the “learned professions defense” for doctors by holding that the parties to a price fixing agreement are liable under the first section of the Sherman Act, whether the parties are nonprofessionals or doctors.\(^{17}\) Interestingly, the *Maricopa* Court also rejected the argument that the per se rule in regard to price fixing should not apply to the case in view of the judiciary’s lack of experience in the health care industry.\(^{18}\)

With no professional exemption available, health care institutions began to lean on the McCarran-Ferguson Act’s exemption for the “business of insurance” as protection from antitrust lawsuits.\(^{19}\) The Supreme Court, however, has acted to limit this defense as well. In *Union Labor Life Ins. Co. v. Pireno*,\(^{20}\) advisements of a peer review committee to a health insurer concerning doctors’ treatments and charges failed to constitute part of the “business of insurance” exempted from antitrust laws by the Act.\(^{21}\) Moreover, the “business of insurance” was distinguished from “business of

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13. *Id.* at 331.
15. *Id.* at 787.
17. *Id.* at 348-49.
18. *Id.* at 349-50. In *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940), the Supreme Court established a *per se* rule to apply to all cases of price fixing: “Under the Sherman Act, a combination formed for the purpose of and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*.” *Id.* at 223.
19. See *supra* note 4.
21. *Id.*
insurers” in *Group Life and Health Ins. Co. v. Royal Drug Co.*,\textsuperscript{22} in which the Supreme Court held the exemption applicable only to the latter.\textsuperscript{23} By diminishing the defenses of hospitals, these decisions serve only to encourage antitrust litigation in the health care industry.\textsuperscript{24}

The defense which has received the most recent Supreme Court review—the “state action” antitrust exemption—originated in *Parker v. Brown*.\textsuperscript{25} *Parker v. Brown* involved a challenge to a California statute by a raisin producer who alleged the statute “tended to restrict competition among the growers and maintain prices in the distribution of their commodities to packers.”\textsuperscript{26} The Supreme Court held that the state was exempt from antitrust attack, as “nothing in the language of the Sherman Act or in its history . . . suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature.”\textsuperscript{27} In *California Retail Liquor Dealers Ass’n v. Midcal Aluminum*,\textsuperscript{28} the Supreme Court applied the state action doctrine and announced the current standard for antitrust immunity: the challenged activity must be clearly articulated and affirmatively expressed as state policy and the activity must be actively supervised by the state itself.\textsuperscript{29} The state action exemption, therefore, cannot apply to a grant of general authority that fails to give adequate direction or guidance to the enforcing agencies.\textsuperscript{30}

The Supreme Court reinforced support of this standard in *Patrick v. Burget*.\textsuperscript{31} In this case, the plaintiff physician accused the peer review committee of bad faith conduct in making their decision to deny him staff privileges. While the jury awarded the plaintiff damages, the Ninth Circuit reversed the trial court, reasoning that state-authorized medical peer review decisions are actions of one state and immune from public and private antitrust attacks.\textsuperscript{32} The Supreme Court then reversed the Ninth Circuit, although
without affirmance of the trial court’s reasoning or award of damages. Instead, the Court held that the state action doctrine did not protect Oregon physicians from federal antitrust liability for their participation in peer review committees where no showing was made that state officials had exercised their authority to review anti-competitive acts, such as the denial of staff privileges, and to disapprove of those acts which were inconsistent with state regulatory policy. In Oregon, the Supreme Court found no active supervision of peer-review decisions and no clearly articulated state policy on the matter. Therefore, the Court remanded the case for further proceedings.

With their decision in Patrick, the Supreme Court sustained the state action doctrine and its applicability as a defense for hospitals in fighting antitrust suits. Particularly, Patrick strengthened the precedential value of the Seventh Circuit’s decision in Marrese v. Intergual, Inc. In Marrese, the circuit court held that where a state designs a clearly articulated and affirmatively expressed statutory scheme requiring a hospital’s review of a physician’s privileges and where the state actively regulates the hospital’s peer review procedures, a physician is precluded from attacking any decision of the peer review committee on federal antitrust grounds.

The plaintiff in Marrese was an orthopedic surgeon whose clinical privileges at the defendant hospital were revoked in accordance with the detailed procedures followed by the hospital. Dr. Marrese opted to allege violations of sections 1 and 2 of the Sherman Act, which offered a treble damage award, rather than pursue the matter through the Indiana state court system. The trial court dismissed the plaintiff’s complaint, stating that defendants’ alleged unlawful actions did not have a substantial effect on interstate commerce. On appeal, despite finding an impact on interstate commerce, the Seventh Circuit affirmed the result of the lower court by holding that the hospital and its staff members were

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33. 108 S. Ct. at 1664.
34. Id. at 1664-65.
36. 748 F.2d at 374.
37. Id. at 374-75.
39. Id.
40. 748 F.2d at 373.
protected from antitrust liability under the state action doctrine.\textsuperscript{41}

Applying the test articulated by the Supreme Court in \textit{California Retail Liquor Dealers' Ass'n v. Midcal Aluminum},\textsuperscript{42} the \textit{Marrese} court studied Indiana's comprehensive statutory scheme which mandated that hospitals review the professional practices and procedures of their medical staffs through peer-review committees.\textsuperscript{43} Indiana also actively participated in the peer review procedures through its licensing requirements of hospitals and physicians.\textsuperscript{44} These two facts provided the court with the confidence that Dr. Marrese's clinical privileges had been revoked in accordance with "clearly articulated and affirmatively expressed "state policies of peer review which were "actively supervised" by the state. Thus, the hospital's staff privilege decision was immune from antitrust attack because of state subsidized protection.\textsuperscript{45}

The \textit{Marrese} court used the opportunity of the case to offer policy reasons supporting refusal by federal courts to review hospital staff privilege decisions under the antitrust laws. Application of the antitrust law "chill[s] the rights and obligations of the physicians to participate in peer review" and hinders the "discovery of incompetent physicians. \ldots."\textsuperscript{46} The court resolved:

> It is only logical that physicians within the State of Indiana, when presented with allegations of federal antitrust violations and the threat of treble damages, will either dilute their peer review reports and cease recommending the revocation of a hospital staff member's privileges or will discontinue their participation in the state mandated and supervised peer review process. As a result, the very lifeline of the medical peer review process will be severed.\textsuperscript{47}

It appears to be the position of the Seventh Circuit that one who suffers alleged injuries due to a peer review decision should seek remedy in the state court system. The \textit{Marrese} Court also pointed to the extensive in-house review of the peer review findings provided by the hospital itself.\textsuperscript{48} Finding the doctor's action precipitated by a motive to "circumvent[] the hospital's hearings and the

\begin{footnotes}
\footnote{41. \textit{Id}.}
\footnote{42. 445 U.S. 97 (1980), see supra note 23 and accompanying text.}
\footnote{43. 748 F.2d at 386-87.}
\footnote{44. \textit{Id.} at 387-89.}
\footnote{45. \textit{Id.} at 395.}
\footnote{46. \textit{Id.} at 391, citing Pontius v. Children's Hospital, 552 F. Supp. 1352 (N.D.Pa. 1982).}
\footnote{47. \textit{Id}.}
\footnote{48. \textit{Id.} at 393.}
\footnote{49. \textit{Id}.}
\end{footnotes}
state court review process in favor of a Federal forum,” the court concluded:

Dr. Marrese has no cause of action under the Sherman Act against the defendants as participants in the state mandated and supervised medical peer review process. Instead, Dr. Marrese must challenge the defendant’s conduct and motives through the proper forums; the hospital hearing committees and the Indiana state court systems.

To support its holding, the Marrese Court relied on a decision from the United States District Court for the Western District of Pennsylvania. In Pontius v. Children’s Hospital, the Pennsylvania District Court reviewed the applicability of traditional antitrust principles in the staff privilege context and severely limited the review which courts should undertake in such cases. The court held that judicial review of a peer review decision should not differ whether a suit is initiated in state or federal court. The threshold inquiries for any court in a staff privilege case are whether the plaintiff was afforded due process and whether there was substantial evidence to support the decision. If so, the Sherman Act is not invoked and no review of the peer review decision is necessary. Possible anti-competitive implications arise only where due process or substantial evidence or both are absent.

In accord with the Seventh Circuit, Pontius communicated that satisfactory review and remedy for staff privilege decisions are provided by state courts: “While we recognize that there is some risk that a physician might impugn the qualifications of a competitor before a credential committee or a peer review board, we have no reason to believe that the profession itself or state laws pertaining to defamation cannot adequately address this problem.” The court stated further: “We do not believe that the antitrust laws were intended to require a judicial redetermination of such decisions.”

The opinions in Patrick, Maresse and Pontius represent the majority view of courts that decisions concerning a physician’s privi-

50. Id.
53. Id. at 1353.
54. Id. at 1371.
55. Id. at 1372.
56. Id. at 1372.
57. Id. at 1372.
58. Id. at 1376.
59. Id. at 1378.
leges should remain with the hospital’s staff. If judicial review is at all necessary, courts should not review the merits of a decision but only determine whether substantial evidence existed and due process was followed. In support of this view, Congress has recently codified public policy in favor of peer review. The Health Care Quality Improvement Act, effective since November 14, 1986, shields hospitals and physicians engaged in peer review decisions from private suits under the federal antitrust laws.

Through establishment of the Health Care Quality Improvement Act ("the Act"), Congress’ first priority focused on the prevention of further harm resulting from actions of incompetent and unprofessional physicians. Congress intended the Act’s provisions to assist organizations such as state licensing boards, hospitals, and medical staffs in promptly discovering and expelling such doctors from their communities. Because of inadequate peer review procedures and a lack of communication among hospitals in various regions of the country, increasingly more physicians who have injured numerous patients were continuing their practices undetected or, once detected, transferred to distant, unsuspecting hospitals. The Act, therefore, concentrates on two principal objectives. Directed to physicians and health organizations, the Act first provides methods of encouraging and participating in extensive peer review and second, creates a system of dissemination of information through which hospitals may communicate regarding a physician’s conduct. The legislation provides a grant of immunity for peer review committees and limits their damages in any litigation initiated by a physician affected by their decisions. With this immunity and limitation of damages, Congress intended to reduce the chilling effect that antitrust suits have on peer review procedures.

As a hastily passed response to the ninth circuit’s decision in Patrick v. Burget, the Act is criticized as establishing an immunity

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60. See Otto, supra note 51, at 462.
62. Id. at 11101.
64. Id.
67. Id. at 11101(4) and (5). See Inglehardt, Congress Moves to Bolster Peer Review: The Health Care Quality Improvement Act of 1986, 316 NEW ENG. J. MED. 960 (1987).
too expansive for its purpose:

Measures already exist to discourage physicians from filing unfounded claims or claims in bad faith. One section of the Act reinforces and expands the general provision awarding attorneys' fees to defendants where the suits brought against them were frivolous or unfounded. Even without the Act's wide scope of immunity, the attorneys' fees provision will protect peer review committees more than adequately. The belief that the evaluation process may at least improve the quality of health care gives credence to the argument that reviewers need antitrust damage immunity. However, no such logic flows from giving committee members unbounded protection from damage liability. Furthermore, the Act does not condition review committees' immunity on efforts to confirm the accuracy of information they receive. Thus, by protecting reviewers from the possibility of being sued outside the antitrust context, the Act will preclude deserving plaintiffs from securing important rights and remedies without necessarily improving peer review.68

While the Act eliminates the threat of private treble damage liability, it provides less protection than the state action exemption supported by the Supreme Court in Patrick v. Burget.69 The Act is also in discord with the recently announced objectives of the Department of Justice's Antitrust Division, as it fails to encourage governmental agencies to pursue alleged antitrust violations in the health care arena.70 Instead, the Act allows physicians themselves to supervise the peer review procedures from initiation to conclusion rather than arbitrarily shifting the police power to the government on those occasions where an antitrust violation may have occurred.71 In as far as this attitude comports with Patrick, the view of the Act favors decisions by peer review committees who logically appear in the best position to make such decisions, free from threats of treble damages and the hours and costs involved in litigating an antitrust suit.72

In several cases, courts have acknowledged and respected the principle that hospitals only possess the necessary expertise to guarantee the right end in a peer review situation.73

_68. See, Grossman Jaffe, _supra_, note 1 at 589-90._
_69. _Id._ at 590._
_70. _Id._ at 592._
_71. _Id._
_72. While the Supreme Court has recognized this policy, it reserved all comment on its viability, referring the matter to Congress. "Th[e] argument [that the threat of antitrust liability chills peer review and impairs its effectiveness] essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care and as such is properly directed to the legislative branch." Patrick, 108 S. Ct. at 1665._
_73. See, Otto, _supra_, note 51 at 457, _citing_ Schulman v. Washington Hosp. Center, 222 F. Supp. 59 (D.C. Cir. 1963); Moore v. Andaluna Hosp., _Inc._, 284 Ala. 259, 244 So. 2d 617_
admittedly hold the expertise to judge competence in attorneys, for courts to profess the ability to do the same with regard to physicians raises some concern. In *Sosa v. Board of Managers of Val Verde Memorial Hospital,* the Fifth Circuit Court explains the court’s deference to review a decision of a peer review committee.

No court should substitute its evaluation of such matters for that of the Hospital Board. It is the board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their piers, subject only to limited judicial surveillance. The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered.

The fact that hospital liability arising from a physician’s conduct is a theory of judicial creation also persuades courts to exercise considerable restraint in this area. If the hospitals themselves must bear the risk of their doctors’ malpractice, it is only just that the hospitals be the judge with regard to the standard of competence for their doctors.

The hesitation of courts to review cases involving peer review decisions only contributes to the increasing number of such cases brought under federal antitrust laws. Despite the courts’ aversion


The Supreme Court recognized Congress’ action by including the following footnote in their decision of *Patrick:*

Congress in fact insulated certain medical peer review activities from antitrust liability in the Health Care Quality Improvement Act of 1986. (citation omitted). The Act, which was enacted well after the events at issue in this case and is not retroactive, essentially immunizes peer review action from liability if the action was taken in the reasonable belief that [it] was in the furtherance of quality health care.” The Act expressly provides that it does not change other ‘immunities under the law’, including the state action immunity, thus allowing states to immunize peer-review action that does not meet the federal standard.

108 S. Ct. at 1665, n.8.


75. 437 F.2d at 177.


77. *Kissam, Webber, Bigus & Holzgraefe, Antitrust and Hospital Privileges: Testing*
to awarding treble damages to the plaintiff physician, lawsuits founded on antitrust allegations thrust tremendous financial, temporal and emotional burdens on all parties involved.\textsuperscript{78} Nevertheless, in view of \textit{Patrick v. Burget} and the establishment of the Health Care Quality Improvement Act, it is apparent that neither the Supreme Court nor Congress deem the need to fully insulate medical peer review from the antitrust laws imperative at this time. Indeed, the Supreme Court in \textit{Patrick} handed all responsibility for this task to Congress and physicians.\textsuperscript{79} As for now, hospitals and peer review committees remain vulnerable targets of vengeful physicians, and, assumedly, the Department of Justice. Therefore, it must be the hope of the hospitals that the courts accept defenses such as the state action exemption and apply the immunity provided by Congress in analyzing allegations of antitrust violations in peer review cases. As precedents, the lower courts have fortunately fashioned major policy arguments favoring the hospitals as the experts in reviewing medical staff privilege decisions. Once the Supreme Court and Congress acknowledge the wisdom of such policies, medical peer review committees may resume concentration on their major objectives to provide quality medical care and to protect the public from incompetent and unprofessional medical treatment.

\textit{Jennifer L. Otto}

\textsuperscript{78} See Marrese v. Interqual, 748 F.2d at 391, which quotes Pontius v. Children's Hospital, 552 F. Supp. at 1362 concerning an antitrust lawsuit's consequence of "incurring legal fees running into six figures and a trial of a duration measured in months, on the mere allegation that they have conspired to restrain trade..." \textit{Marrese}, 748 F.2d at 391. \textit{Marrese} continued, stating that the threat of treble damages "will compel able and qualified physicians, with particular expertise in complex areas of medicine, to abdicate their participation in the medical peer review process." \textit{Id.} at 391-92.

\textsuperscript{79} In a footnote regarding the Health Care Quality Improvement Act, the \textit{Patrick} Court advised: "If physicians believe that the Act provides insufficient immunity to protect the peer review process fully, they must take that matter up with Congress." 108 S. Ct. at 1665-1667, n.8.