

HOSPITAL STAFF PRIVILEGES AND THE GROUP BOYCOTT RULE

The hospital is the focal point of modern health care.¹ Hospitals provide the technical equipment and specialized support personnel necessary for today's increasingly sophisticated medical procedures.² Modern health practitioners³ need hospital access in order to provide their patients with every available type of treatment.⁴ Moreover, practitioners without hospital access have difficulty attracting patients since they cannot offer a full range of services.⁵ Thus, hospital access is virtually indispensable for today's health practitioner.⁶

To gain hospital access, practitioners must obtain hospital staff privileges.⁷ Staff privileges represent permission from the hospital's governing body for the practitioner to admit patients to the hospital and direct the care given to them.⁸ Most hospitals administer privileges selectively.⁹ Privilege applicants are evaluated by the hospital's medical staff, an organization of all the practitioners who currently have staff privileges.¹⁰ The medical staff makes recommendations to the hospital board, which makes the final decision to grant privileges.¹¹ This decision should be based on an objective evaluation of the applicant's credentials.¹² In practice, however, qualified applicants are often denied privileges for reasons wholly unrelated to individual merit.¹³

Unsuccessful applicants always have been able to challenge privilege denials in court on procedural due process and civil rights grounds.¹⁴ Until recently, however, state and federal antitrust statutes were unavailable because most courts considered the learned professions, including medicine, to be exempt from antitrust scrutiny.¹⁵ The Supreme Court explicitly rejected this exemption in *Goldfarb v. Virginia State Bar*,¹⁶ holding that the practice of a learned profession is "trade or commerce" within the meaning of the

¹ Goldsmith & Bertolet, *The Present Status of Physician Privileges*, 1981 MED. TRIAL TECH. Q. 121, 121 (hereinafter cited as Goldsmith); Kessnick, *Physicians' Access to the Hospital: An Overview*, 14 U.S.F.L. REV. 43, 43-44 (1979); Note, *Denial of Open Staff Privileges: An Antitrust Scrutiny*, 26 ST. LOUIS U.L.J. 751, 752 (1982) (hereinafter cited as *An Antitrust Scrutiny*).

² Goldsmith, *supra* note 1, at 121.

³ As used in this note, the term "health practitioner" refers to anyone licensed by the state to perform medical procedures without supervision. This includes physicians, dentists, chiropractors, podiatrists, psychologists and nurse practitioners.

⁴ Goldsmith, *supra* note 1, at 121.

⁵ Dolan & Ralston, *Hospital Admitting Privileges and The Sherman Act*, 18 Hous. L. REV. 707, 713-14 (1981) (hereinafter cited as Dolan & Ralston).

⁶ Goldsmith, *supra* note 1, at 121.

⁷ Dolan & Ralston, *supra* note 5, at 709.

⁸ *Id.*

⁹ *An Antitrust Scrutiny*, *supra* note 1 at 752.

¹⁰ *Id.* Kissam, Webber, Bigus and Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595, 606 (1982) (hereinafter cited as Kissam); JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS, *ACCRED-MANUAL FOR HOSPITALS: 1979 Edition*, at 53 (Standard IX) (hereinafter cited as JCAH MANUAL). See *infra* text accompanying notes 64-73.

¹¹ *An Antitrust Scrutiny*, *supra* note 1, at 752.

¹² *Id.*

¹³ Kissam, *supra* note 10, at 599.

¹⁴ Dolan & Ralston, *supra* note 5, at 725-26.

¹⁵ Kissam, *supra* note 10, at 614. See *infra* text accompanying notes 409-11.

¹⁶ 421 U.S. 773 (1975).

Sherman Antitrust Act.¹⁷ Following *Goldfarb*, most state courts no longer recognize a learned profession exemption to state antitrust statutes.¹⁸ Accordingly, unsuccessful applicants now can challenge privilege denials on state and federal antitrust as well as procedural due process and civil rights grounds.¹⁹

Since *Goldfarb*, most court challenges to privilege denials have been based on the Sherman Antitrust Act rather than on state antitrust, procedural due process, or civil rights grounds.²⁰ The Sherman Act is preferable to procedural due process and civil rights theories because it provides treble damages and attorneys fees to successful plaintiffs.²¹ It is also preferable to state antitrust theories because Sherman Act challenges can be brought before federal judges²² who are more likely to be insulated from the political influence of powerful local hospitals and medical associations.

Although a large number of Sherman Act challenges to privilege denials have been filed in the lower federal courts,²³ a plaintiff practitioner has yet to prevail on the merits.²⁴ Plaintiff practitioners lose for several reasons. First, until recently,²⁵ many practitioners have been unable to demonstrate that the challenged privilege denial affects interstate commerce sufficiently to invoke Sherman Act jurisdiction.²⁶ Second, even when a sufficient effect on interstate commerce is demonstrated, Sherman Act jurisdiction is defeated where the defendant demonstrates that the privilege denial was somehow

¹⁷ *Id.* at 789. Section one of the Sherman Act provides in pertinent part: "Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is . . . illegal." 15 U.S.C. § 1 (1972).

Section two of the Act provides in pertinent part: "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of trade or commerce among the several States . . . shall be deemed guilty of a felony. . . ." 15 U.S.C. § 2 (1976).

¹⁸ See e.g., *Health Corp. of America v. New Jersey Dental Ass'n*, 424 F. Supp. 931 (D.N.J. 1977) (dental profession not exempt from New Jersey antitrust statute); *Douglas v. Hospital of San Rafael*, 33 Conn. Supp. 216, 371 A.2d 396 (Super. Ct. 1976) (anesthesiologists not exempt from Connecticut antitrust statute).

¹⁹ *Dolan & Ralston*, *supra* note 5, at 535.

²⁰ *An Antitrust Scrutiny*, *supra* note 1, at 753.

²¹ 15 U.S.C. § 15 (1976).

²² 28 U.S.C. § 1331 (1981).

²³ See, e.g., *Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982); *DeMasi v. Weiss*, 669 F.2d 114 (3d Cir. 1982); *Memorial Hosp. v. Shadur*, 664 F.2d 1058 (7th Cir. 1981); *Mishler v. St. Anthony's Hosp. Systems*, 1981-2 Trade Cas. (CCH) ¶ 64,342 (10th Cir. 1981); *Crane v. Intermountain Health Care*, 637 F.2d 715 (10th Cir. 1981); *Levinski v. Reese Hosp.*, 1982-2 Trade Cas. (CCH) ¶ 64,789 (N.D. Ill. 1982); *Cardio-Medical Associates v. Crozer-Chester Medical Center*, 536 F. Supp. 1065 (E.D. Pa. 1982); *Everhart v. Jane Stormont Hosp.*, 1982-2 Trade Cas. (CCH) ¶ 64,703 (D. Kan. 1982); *Williams v. Kleaveland*, 534 F. Supp. 912 (W.D. Mich. 1981); *Robinson v. McGovern*, 521 F. Supp. 842 (W.D. Pa. 1981); *Barr v. National Right to Life Comm.*, 1981-2 Trade Cas. (CCH) ¶ 64,315 (M.D. Fla. 1981); *Hyde v. Jefferson Parish Hosp.*, 513 F. Supp. 532 (E.D. La. 1981), *rev'd* 686 F.2d 286 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983).

²⁴ *An Antitrust Scrutiny*, *supra* note 1, at 753. *But see* *Hyde v. Jefferson Parish Hosp.*, 686 F.2d 286 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983), in which the Fifth Circuit reversed a lower court holding in favor of a hospital. The significance of this decision is unclear in light of the pending review by the Supreme Court. For a further discussion of the case, see *infra* note 335.

²⁵ See *infra* text accompanying notes 163-95.

²⁶ See, e.g., *Moles v. Morton Plant Hosp.*, 1980-1 Trade Cas. (CCH) ¶ 63,600 at 77,189. For a discussion of the interstate commerce requirement, and its role in privilege denial cases, see *infra* text accompanying notes 163-70.

mandated by state regulation.²⁷ Third, even when Sherman Act jurisdiction is established, proof of a Sherman Act violation has been extremely difficult in the privilege denial context.²⁸ Proof of a violation has been difficult in this context because, of the two alternative Sherman Act analyses, rule of reason and *per se*, most courts have uniformly used the rule of reason in privilege denial challenges.²⁹ Under the rule of reason, a plaintiff must demonstrate that the anticompetitive effects of the challenged practice outweigh its procompetitive effects.³⁰ Such a showing is extremely difficult and expensive because it requires a detailed study of the trade patterns of an entire industry.³¹ The alternative Sherman Act analysis, the *per se* approach,³² heretofore not used in privilege denial cases, is less difficult and expensive than the rule of reason approach for the antitrust plaintiff because the plaintiff is not required to demonstrate the actual anticompetitive effects of the challenged practice.³³ Under the *per se* approach, a plaintiff need only demonstrate that the challenged practice falls into one of the recognized *per se* categories,³⁴ and the court will make a conclusive presumption of illegality.³⁵ This presumption of illegality employed in the *per se* approach greatly lightens the antitrust plaintiff's burden of proof and increases his chances of success on the merits in contrast to the rule of reason, where no such presumption is employed.³⁶

The exclusive use of the rule of reason rather than the *per se* approach in privilege denial cases³⁷ has been premised on language in the Supreme Court's *Goldfarb* decision.³⁸ Although *Goldfarb* declared the professions under the ambit of the Sherman Act,³⁹ language in the case expressly left open the possibility that anticompetitive practices which would violate the Sherman Act if engaged in by other industries might be permissible for the professions.⁴⁰ Based on this language, courts have held that a full rule of reason analysis is necessary in all cases involving the professions, since activities considered *per se* illegal in non-professional contexts might be justifiable when practiced by the

²⁷ See, e.g., *Feminist Women's Health Center, Inc. v. Mohammad*, 415 F. Supp. 1258, 1268 (N.D. Fla. 1976), *rev'd*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979). For a discussion of the state action defenses, and their role in privilege denial cases, see *infra* text accompanying notes 186-92.

²⁸ Groseclose, *Hospital Privilege Cases: Braving the Dismal Swamp*, 26 S.D.L. REV. 1, 1 (1981).

²⁹ See *infra* text accompanying note 411.

³⁰ *Arizona v. Maricopa County Medical Ass'n*, 457 U.S. 332, 343 n.13 (1982).

³¹ *Id.* at 343.

³² See *infra* text accompanying notes 206-07 and note 20.

³³ *Maricopa*, 457 U.S. 332, 343-44.

³⁴ The *per se* offenses currently recognized by the court are price fixing, division of markets, group boycotts and tying arrangements. *Id.* at 344 n.15. Price fixing is the cooperative setting of price levels by competing firms. *Knuth v. Erie-Crawford Dairy Co-op Ass'n*, 326 F. Supp. 48, 53 (W.D. Pa. 1971). Division of markets is the cooperative allocation of territories by competitors. *United States v. Topco Associates, Inc.*, 405 U.S. 596, 597 (1972). Tying arrangements exist when a person agrees to sell one product, the "tying product," only on the condition that the vendee also purchase another product, the tied product. *Northern v. McGraw-Edison Co.*, 542 F.2d 1336, 1344 (8th Cir. 1976).

³⁵ *Maricopa*, 457 U.S. 332, 344-45.

³⁶ *Dolan & Ralston*, *supra* note 5, at 741.

³⁷ See *Everhart v. Jane Stormont Medical Hosp.*, 1982-1 Trade Cas. (CCH) ¶ 64, 703 at 73, 897 and cases cited therein.

³⁸ 421 U.S. 773 (1975).

³⁹ *Id.* at 785-87.

⁴⁰ *Id.* at 787 n.17.

professions.⁴¹ This reasoning recently was rejected by the Supreme Court, however, in *Arizona v. Maricopa County Medical Association*.⁴² In *Maricopa*, the Court held that the *per se* rule against price fixing applies with full force to health care professionals.⁴³ The Court reasoned that the trade practices prohibited by the *per se* rules are so clearly anticompetitive that a presumption of illegality is warranted in professional as well as non-professional contexts.⁴⁴ This reasoning supports the position that the professions, including the medical profession, are no longer exempt from the *per se* rules.⁴⁵ Accordingly, the *per se* approach should now be available to practitioners challenging staff privilege denials.⁴⁶

This article concerns the use of the *per se* approach in privilege denial challenges. Specifically, the article focuses on the group boycott rule,⁴⁷ the *per se* rule designed to deal with situations where traders collectively refuse to deal with another trader.⁴⁸ The group boycott rule is the applicable *per se* rule in the privilege denial context because, in essence, privilege denials are collective refusals by a hospital and its medical staff to deal with the applicant practitioner.⁴⁹ The availability of the group boycott rule in privilege denial challenges will depend on two factors: first, whether the challenged privilege denial can be characterized as a group boycott,⁵⁰ and, second, whether the court will adopt a *per se* approach in the privilege denial context, that is, allow the plaintiff practitioner to rely on the presumption that group boycotts are *per se* anticompetitive.⁵¹ If the group boycott *per se* rule were available in privilege denial challenges, the showing of anticompetitive effects necessary under the rule of reason would be obviated,⁵² thereby lightening the plaintiff's burden of proof and increasing his chances of success on the merits.⁵³ The increased threat of successful challenges to privilege denials will force hospitals to grant privileges to all applicants absent a legitimate, verifiable reason for denial.⁵⁴

The primary thesis of this note is that the group boycott rule should apply to staff privilege denials absent a specific exemption by Congress. Application of the rule would force hospitals to grant privileges more liberally.⁵⁵ Liberal granting of staff privileges would benefit the consumer of medical services in three ways. First, hospital patients will have greater freedom in choosing both their practitioner⁵⁶ and their hospital.⁵⁷ Second, both practitioners and hospitals will have greater incentive to lower prices and increase quality of services in order to attract patients.⁵⁸ Third, the medical profession will be

⁴¹ See, e.g., *Everhart v. Jane Stormont Medical Hosp.*, 1982-1 Trade Cas. (CCH) ¶ 64,703 at 73,897.

⁴² 457 U.S. 332 (1982).

⁴³ *Id.* at 351.

⁴⁴ *Id.*

⁴⁵ See *infra* text accompanying notes 440-57.

⁴⁶ *Id.* See, e.g., *Hyde v. Jefferson Parish Hosp.*, 686 F.2d 286 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983).

⁴⁷ For a description of the rule, see *infra* text accompanying notes 212-94.

⁴⁸ *Id.*

⁴⁹ See *infra* text accompanying notes 60-73.

⁵⁰ See *infra* text accompanying notes 212-401.

⁵¹ See *infra* text accompanying notes 402-75.

⁵² See *supra* notes 32-36 and accompanying text.

⁵³ *Id.*

⁵⁴ See *infra* text accompanying notes 458-75.

⁵⁵ See *infra* text accompanying note 475.

⁵⁶ See *infra* text accompanying notes 134-42.

⁵⁷ See *infra* text accompanying notes 131-33.

⁵⁸ See *infra* text accompanying notes 91-126.

encouraged to act against incompetent practitioners at the state licensing level, rather than merely deny them privileges and allow them to continue practicing on unsuspecting patients outside the hospital.⁵⁹

Part I will examine the administration of hospital privileges in general and the problems that arise because of the conflicting interests of the various parties involved. Part II will examine the Sherman Act, with particular emphasis on the purposes and development of the *per se* rules. Part III will analyze the group boycott precedent to ascertain whether privilege denials constitute the type of behavior courts have traditionally characterized as group boycott. Part IV will examine recent Sherman Act precedent involving the professions to determine whether the professions in general, and privilege denials in particular, are exempt from the full force of the group boycott *per se* rule. Finally, Part V will assess the potential impact of the group boycott rule on privilege administration, and examine the policy reasons for applying the group boycott rule in this context.

I. THE HOSPITAL PRIVILEGE SYSTEM

Hospital staff privileges are the embodiment of a cooperative agreement between a hospital and a practitioner to exchange services.⁶⁰ The hospital provides the practitioner with hospital facilities by allowing the practitioner to admit patients to the hospital and direct the care given to them.⁶¹ In exchange, the practitioner agrees to bring paying patients to the hospital.⁶² Thus, the hospital privilege system can be viewed as a system of "contracts" between suppliers of complementary services whereby each party provides the necessary missing element in the other's service.⁶³

A hospital's decision to enter a "contract" with a given practitioner by granting him staff privileges is not made freely by the hospital administration.⁶⁴ The hospital's decision to grant privileges is controlled primarily by the hospital's medical staff,⁶⁵ the group of practitioners with privileges at a given hospital.⁶⁶ The medical staff makes recommendations to the hospital administration concerning each applying practitioner.⁶⁷ In most hospitals, the administration routinely adopts the medical staff recommendation.⁶⁸ In the few hospitals where the administration makes an additional, independent evaluation, disagreements between the administration and the medical staff are resolved by a joint administration-staff committee.⁶⁹ Thus, while in theory the hospital administration is the final authority on all hospital related issues,⁷⁰ in practice the administration never unilat-

⁵⁹ See *infra* part V.

⁶⁰ Dolan & Ralston, *supra* note 5, at 709.

⁶¹ *Id.*

⁶² Kissam, *supra* note 10, at 606; M. ROEMER AND J. FRIEDMAN, DOCTORS IN HOSPITALS: MEDICAL STAFF ORGANIZATION AND HOSPITAL PERFORMANCE, at 44-45 (1971).

⁶³ *Id.*

⁶⁴ JCAH MANUAL, *supra* note 10, at 53 (Standard IX).

⁶⁵ *Id.*

⁶⁶ Dolan & Ralston, *supra* note 5, at 710.

⁶⁷ JCAH MANUAL, *supra* note 10, at 53 (Standard IX).

⁶⁸ Dolan & Ralston, *supra* note 5, at 712; Harty & Mullholand, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485, 487-488 (1978); Kissam, *supra* note 10, at 651.

⁶⁹ JCAH MANUAL, *supra* note 10, at 53-54.

⁷⁰ Kissam, *supra* note 10, at 606.

erally makes the final decision concerning privilege applicants.⁷¹ Privilege decisions are made either by the medical staff alone, or by agreement between the staff and the hospital administration.⁷² The medical staff, therefore, a group comprised of separate, competing business entities bound together only by their contractual relationships with a common supplier of hospital facilities, controls the access of potential competitors to the hospital facilities.

The medical staff's unfettered power to deny hospital access to competitors is abused when privileges are denied for reasons unrelated to the applicant's credentials.⁷³ It is this abuse that necessitates a strong legal response such as application of the group boycott *per se* rule. To understand how and why the abuse occurs, and the effect of the group boycott rule on the hospital privilege system, it is necessary to examine the conflicting interests and roles of the participants in privilege administration. Accordingly, the next four subsections discuss individually the interests and roles of the applicant practitioner, the medical staff, the hospital administration and the patient, in privilege administration. The final subsection describes the most common abuses of privilege denial power, abuses which could be stopped through application of the group boycott rule.⁷⁴

A. The Applicant Practitioner

Practitioners applying for privileges at a hospital either have no privileges at any hospital, or enjoy privileges at one or more other hospitals.⁷⁵ Applicants without staff privileges at other hospitals are generally young practitioners just beginning to practice or practitioners who have recently moved into the area.⁷⁶ A complete lack of access to hospital facilities is likely to make these practitioners unattractive to patients for at least two reasons. First, potential patients assume that if the hospital will not allow the practitioner on its staff, the practitioner must be incompetent.⁷⁷ Second, potential patients fear that if they ever need hospital services, they will be forced to switch to another practitioner.⁷⁸ In addition to being unattractive to patients, practitioners without privileges risk losing the patients they do attract as soon as the patients require hospital services.⁷⁹ The non-privileged practitioner must refer these patients to privileged practitioners, and thereby risk losing patients who want to "eliminate the middleman."⁸⁰ Moreover, non-privileged practitioners are denied two important sources of new patients: in-house referrals from other members of the medical staff,⁸¹ and emergency room cases.⁸² Thus, non-privileged practitioners have a distinct competitive disadvantage com-

⁷¹ *Id.*

⁷² *Id.*; Note, *Physician-Hospital Conflict: The Hospital Staff Privileges Controversy in New York*, 60 CORNELL L. REV. 1075, 1076-77 (1975).

⁷³ See *infra* text accompanying notes 145-58.

⁷⁴ See *infra* text accompanying notes 300-401.

⁷⁵ Compare *Robinson v. McGovern*, 521 F. Supp. 842, 913 (W.D. Pa. 1981), *appeal docketed*, No. 81-2726 (3d Cir. Oct. 19, 1981) (plaintiff already has privileges at three hospitals) with *Barr v. National Right to Life Comm.*, 1981-2 Trade Cas. (CCH) ¶ 64,315 at 74,408 (M.D. Fla. 1981) (plaintiff has no privileges at any hospital).

⁷⁶ See, e.g., *Barr*, 1981-2 Trade Cas. (CCH) at 74,407 (plaintiff has just relocated his practice).

⁷⁷ *Dolan & Ralston*, *supra* note 5, at 714.

⁷⁸ *Id.* at 713.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 714.

⁸² *Id.*

pared with privileged practitioners for attracting and keeping new patients.⁸³ In many cases,⁸⁴ privileges will mean the differences between success and failure for a new practitioner.⁸⁵

Not all applicant practitioners are without privileges elsewhere.⁸⁶ Often, established practitioners who already have privileges at one or more hospitals will apply for additional privileges at other hospitals.⁸⁷ Additional privileges allow the practitioner to offer patients greater freedom of choice.⁸⁸ Greater freedom of choice is likely to attract patients to practitioners with staff privileges at many hospitals.⁸⁹ Moreover, additional staff privileges allow the practitioner access to the referral and emergency room sources of patients at an additional hospital.⁹⁰ Thus, like the young practitioner seeking his first staff privileges, the established practitioner seeking additional privileges usually does so to enhance his ability to compete for new patients.

B. The Medical Staff

The enhanced ability to compete for new patients which is sought by the privilege applicant is already enjoyed by the members of the medical staff.⁹¹ Moreover, the law of supply and demand⁹² dictates that this competitive advantage will diminish as more privileges are granted.⁹³ The competitive advantage decreases because the supply of privileged practitioners rises while the demand for them, the number of patients seeking privileged practitioners, remains constant.⁹⁴ The result is fewer new patients for each

⁸³ See *supra* text accompanying notes 77-82.

⁸⁴ The need for privileges is most acute for practitioners who specialize in surgery, anesthesiology, pathology and radiology, all of which require hospital facilities. Ralston, *supra* note 5, at 713. Nevertheless, virtually all practitioners need the diagnostic, recuperative and backup facilities provided by hospitals. *Id.*

⁸⁵ Goldsmith, *supra* note 1, at 121.

⁸⁶ See *supra* note 75.

⁸⁷ See, e.g., Robinson v. McGovern, 521 F. Supp. 842, 913 (W.D. Pa. 1981), *appeal docketed*, No. 81-2726 (3d Cir. Oct. 19, 1981) (Plaintiff already had privileges at three area hospitals); Williams v. Kleaveland, 534 F. Supp. 912, 914 (W.D. Mich. 1981) (Plaintiff already had privileges at another hospital).

⁸⁸ Dolan & Ralston, *supra* note 5, at 709. Since patients can be treated only in hospitals where their practitioner has privileges, patients will have a choice of hospitals only if their practitioner has privileges at more than one hospital. *Id.*

⁸⁹ Of course, only patients who have a preference between hospitals will be attracted.

⁹⁰ See *supra* notes 81-82 and accompanying text. It must be acknowledged that additional staff privileges bring new responsibilities as well as new patients. As noted earlier, hospitals generally require members of the medical staff to perform some hospital work. See *supra* note 62 and accompanying text. Additional privileges thus entail additional hospital work. Furthermore, it is far less difficult and time-consuming for a practitioner to visit patients if they are all in one hospital than if they are spread out among many hospitals.

⁹¹ Dolan & Ralston, *supra* note 5, at 714-15.

⁹² The law of supply and demand states that the value of a commodity is determined, in part, by the relationship between the amount of the commodity available and the number of individuals who want the commodity. Other things being equal, as the demand rises, so will the value. For a discussion of the rule, see P. SAMUELSON, *ECONOMICS* 423-25 (New York: McGraw Hill Book Company, 1961).

⁹³ Dolan & Ralston, *supra* note 5, at 715.

⁹⁴ In practice, of course, the supply of patients does not remain constant. Nevertheless, the supply of patients does not fluctuate in response to the granting of staff privileges, and is therefore fixed with regard to that variable. Accordingly, increases in the number of privileged practitioners will necessarily decrease the number of patients that each practitioner has available.

privileged practitioner.⁹⁵ Consequently, there is a strong incentive for the practitioners on the medical staff to vote to deny staff privileges to all applicants in order to hold down competition.

The staff practitioner's incentive to deny privileges may be influenced by the characteristics of the particular applicant under consideration.⁹⁶ For example, the incentive to deny privileges may be strengthened when the applicant is in one's own specialty and thus represents direct competition.⁹⁷ Similarly, the incentive to deny privileges may be affected by the applicant's trade practices.⁹⁸ Applicants who offer prices and services that are more attractive than the prices and services offered by staff practitioners are likely to lure patients away from staff practitioners.⁹⁹ Accordingly, the incentive to deny privileges to these applicants is strengthened. A similar incentive to deny privileges arises when the applicant offers an alternative mode of treatment for the same illnesses handled by the staff practitioner.¹⁰⁰ Applicant osteopaths,¹⁰¹ chiropractors,¹⁰² and psychologists¹⁰³ pose this threat to staff allopaths,¹⁰⁴ orthopedists,¹⁰⁵ and psychiatrists¹⁰⁶ respectively. The incentive to deny privileges to the "alternative"¹⁰⁷ practitioners is particularly strong because the "alternative" practitioners frequently offer less expensive and more pleasant modes of treatment which are likely to lure patients away from the "traditional" staff practitioners.¹⁰⁸

⁹⁵ See *supra* note 93.

⁹⁶ Dolan & Ralston, *supra* note 5, at 714-16.

⁹⁷ *Id.* at 715. For example, a staff orthopedic surgeon is more likely to vote to deny privileges to another surgeon than to a general practitioner. From the staff orthopedic surgeon's point of view, another orthopedic surgeon inevitably will hurt business while a general practitioner will not. This follows from the fact, noted *supra* note 101, that the number of patients seeking orthopedic surgery at any given moment is fixed. The more orthopedic surgeons there are, the lower the number of patients for each surgeon. On the other hand, increases in the number of general practitioners will not lower the number of patients for each orthopedic surgeon, since general practitioners are not competing for the same patients. Moreover, the general practitioner may refer patients who need orthopedic surgery to the staff orthopedic surgeon. The applicant general practitioner represents a potential source of new patients, while the applicant orthopedic surgeon represents a potential competitor for them.

⁹⁸ Trade practice here means the practitioner's policy regarding fees, house calls, office hours and other services. For example, a staff obstetrician who refuses to perform home births has a strong incentive to deny privileges to an applicant obstetrician who performs home births. Competition from such an applicant may force the staff obstetrician to begin performing home births to avoid losing patients.

⁹⁹ Dolan & Ralston, *supra* note 5, at 715.

¹⁰⁰ *Id.*

¹⁰¹ "Osteopaths undergo training regimens quite similar to that of M.D. practitioners, except that greater emphasis is placed on family practice and on some manipulative practices." *Id.* at 728.

¹⁰² Chiropractors believe that most medical disorders are caused by misalignments of the vertebrae. These misalignments are treated by manipulation. See generally J. DENTENFASS, *CHIROPRACTIC: A MODERN WAY TO HEALTH* (1970).

¹⁰³ Psychologists receive Ph.D. degrees in psychology and are qualified to treat patients with psychological therapy. Dolan & Ralston, *supra* note 5, at 728.

¹⁰⁴ Allopaths are traditional M.D. practitioners. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 56 (1976).

¹⁰⁵ Orthopedists are M.D. practitioners who specialize in treating skeletal maladies, including those involving the spine. *Id.* at 1594.

¹⁰⁶ Psychiatrists are M.D. practitioners who specialize in the treatment of mental illness. *Id.* at 1832. Unlike psychologists, psychiatrists can prescribe drugs. *Id.*

¹⁰⁷ "Alternative" as used here denotes non-M.D. practitioners.

¹⁰⁸ Dolan & Ralston, *supra* note 5, at 708. The staff practitioner's incentive to deny privileges is

In summary, privilege administration provides the medical staff with the ability to regulate competition in their own industry.¹⁰⁹ There is no reason to assume that health practitioners, unlike other businessmen, are immune from the desire to minimize competition and maximize profits. The desire to minimize competition results in an incentive to deny privileges to all applicants, regardless of competence.¹¹⁰ The freedom of the medical staff to act on this incentive is the central problem in current privilege administration.¹¹¹

C. The Hospital Administration

The primary interest of the hospital administration is maximizing revenue.¹¹² The best way to maximize revenue is to keep all the hospital's beds full and the hospital's facilities operating at full capacity.¹¹³ At first glance, it would appear that the most effective way to accomplish this end is to maximize the number of privileged practitioners. This conclusion, however, rests on the mistaken premises that more practitioners mean more patients, and more patients mean more revenue. The reality of hospital economics is far more complicated.

Increasing the number of privileged practitioners does not necessarily increase the number of patients because not all practitioners have the same patient-drawing potential. Well-known, established practitioners attract more patients than unknown, young practitioners. It is in the hospital administration's best interest to keep as many well-known practitioners as possible on its medical staff.¹¹⁴ If these well-known practitioners become discontented with the hospital administration, they may seek additional privileges elsewhere or leave the medical staff. In either case, the hospital stands to lose patients and money. Accordingly, the hospital administration tends to give these well-known practitioners what they want.¹¹⁵ This tendency strongly affects privilege administration.¹¹⁶ Privilege decisions made by the medical staff are often approved by the hospital administration to keep the valuable, established practitioners on the staff happy.¹¹⁷ Thus, the hospital administration's interest in maximizing revenue by keeping well-known practitioners on the medical staff translates into routine approval of privilege decisions made by the medical staff.¹¹⁸ Since the medical staff generally wants to minimize competition,¹¹⁹ hospital administrations seek to minimize rather than maximize the number of privileged practitioners in order to attract the greatest number of patients.¹²⁰

also increased where the applicant has a record of incompetence. *Id.* at 715. Incompetent practitioners hurt the reputation of the medical staff as a whole and affect their ability to attract patients. *Id.* If the incompetent practitioner is sued for malpractice, the other members of the staff are called on to review the incident and testify. *Id.* This type of investigation is difficult and time-consuming. *Id.* Moreover, investigation of the competence of a member of the staff sets a dangerous precedent, for the competence of staff members is no longer beyond question. *Id.*

¹⁰⁹ See *supra* text accompanying notes 91-108.

¹¹⁰ *Id.*

¹¹¹ Dolan & Ralston, *supra* note 5, at 716.

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ Kissam, *supra* note 10, at 611.

¹¹⁵ Joskow, *The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital*, 11 BELL J. ECON. 421, 432, 445-46 (1980).

¹¹⁶ Kissam, *supra* note 10, at 611.

¹¹⁷ *Id.*

¹¹⁸ See *supra* note 68 and accompanying text.

¹¹⁹ See *supra* text accompanying notes 98-123.

¹²⁰ Kissam, *supra* note 10, at 610-11.

The scenario is further complicated by the fact that more patients do not necessarily mean more revenue.¹²¹ The revenue generated by each patient varies depending on the length of stay and the number of hospital facilities used.¹²² The best way to attract high revenue generating patients is to attract their practitioners to the hospital's medical staff. Accordingly, the hospital administration seeks to grant privileges to practitioners who: (1) treat conditions requiring many hospital services; (2) favor methods of treatment that involve many hospital services; (3) readily admit their patients to hospitals; and (4) favor long hospital stays.¹²³

The hospital board's interest in maximizing revenue thus results in selective privilege administration.¹²⁴ Primarily, the hospital board seeks to placate well-known, and high patient-producing members of the medical staff.¹²⁵ Secondarily, the hospital board seeks to attract practitioners who favor high revenue-producing modes of treatment.¹²⁶

D. The Patient

The patient, unlike the applicant practitioner, the medical staff, and the hospital board, does not actively participate in privilege administration.¹²⁷ The care the patient will receive, however, and the price he will pay for it, is profoundly influenced by privilege decisions.¹²⁸ To illustrate the effect of privilege decisions on hospital patients, it is useful to group hospital patients in two categories: (1) patients who have a chosen practitioner and are choosing a hospital;¹²⁹ and (2) patients who have a chosen hospital and are choosing a practitioner.¹³⁰

Group 1 patients can be admitted only to hospitals where their chosen practitioner has staff privileges.¹³¹ This requirement restricts their freedom of choice by preventing these

¹²¹ Dolan & Ralston, *supra* note 5, at 716.

¹²² *Id.* For example, a cancer patient would probably produce more revenue than a routine pregnancy. The cancer patient requires many hospital services, such as diagnostic testing, surgery, and radiation, not required by the pregnant patient. Since use of hospital services generates revenue for the hospital, the hospital administration is interested in attracting patients who require the greatest array of hospital services.

¹²³ *Id.* at 720.

¹²⁴ Kissam, *supra* note 10, at 610.

¹²⁵ See *supra* text accompanying notes 114-17.

¹²⁶ See *supra* text accompanying notes 122-23. In addition to maximizing revenue, the hospital board attempts to avoid malpractice liability. Dolan & Ralston, *supra* note 5, at 707-18; Kissam, *supra* note 10, at 608-09; McCall, *A Hospital's Liability for Denying, Suspending, and Granting Staff Privileges*, 32 BAYLOR L. REV. 175, 205-13 (1980). In many states, hospitals are liable for negligence in the selection and assignment of staff members, even when the staff members are not salaried hospital employees. See, e.g., *Darling v. Charlestown Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965); J. KING, *THE LAW OF MEDICAL MALPRACTICE* 304 (1977). Accordingly, the hospital board, like the medical staff, has a strong incentive to deny privileges to incompetent applicants. See *supra* text accompanying notes 98-106.

¹²⁷ See *supra* text accompanying notes 66-72.

¹²⁸ Dolan & Ralston, *supra* note 5, at 718.

¹²⁹ This group comprises the majority of patients because most have an established relationship with a particular practitioner.

¹³⁰ Patients may insist on being at a particular hospital because of the hospital location, size, religious character, or reputation for excellence. These patients will often choose a practitioner merely because he is on the medical staff of their chosen hospital.

¹³¹ This follows from the fact that practitioners may only admit patients at hospitals where the practitioner has privileges. See *supra* note 61 and accompanying text.

patients from shopping among all hospitals for the greatest array of services and the lowest prices. Since patients are not free to shop among hospitals, hospitals have no incentive to increase the services offered or lower prices.¹³² This lack of incentive translates into poor service, high prices, and high health insurance premiums for everyone.¹³³

Group 2 patients, those who have chosen a hospital and are choosing a practitioner, are also directly affected by privilege administration. The Group 2 patient's choice of practitioner is limited to those practitioners with privileges at the patient's chosen hospital.¹³⁴ Accordingly, the patient is not free to choose the practitioner who offers the combination of service, price, and reputation that best satisfies the patient's needs.¹³⁵ Most of the patient's choices have been eliminated by selective privilege administration. Among the remaining choices, the staff practitioners, the level of competition in terms of service, price, and reputation is likely to be low since the staff practitioners themselves control privilege administration.¹³⁶ By keeping the staff small and eliminating applicants that pose competitive threats, the medical staff can set prices and services at any level and still avoid losing patients.¹³⁷ The patients must accept the terms offered by the medical staff or leave the hospital. Since Group 2 patients, by definition, do not want to leave the hospital,¹³⁸ they must accept a member of the medical staff on his terms. Certain types of practitioners, such as chiropractors, osteopaths, and psychologists may be completely unavailable.¹³⁹ Among the available practitioners, it is unlikely that "extra" services such as house calls or extended office hours will be available.¹⁴⁰ Moreover, available practitioners are likely to be those that favor long hospital stays and extensive use of hospital facilities.¹⁴¹ Since only the most expensive modes of treatment are available, patient costs rise and health insurance premiums follow.¹⁴²

In summary, more liberal privilege administration, and the resulting increase in competition both between hospitals and between practitioners clearly would benefit all hospital patients. Consequently, the interests of the hospital patient in privilege administration compete directly with the interests of the medical staff and the hospital board.¹⁴³ The patient and the privilege applicant generally benefits when privileges are granted. The medical staff and the hospital board generally benefit when privileges are denied. Since the latter groups control privilege administration, the former groups must depend on the courts to protect their interests. This dependence accounts for the large volume of

¹³² Dolan & Ralston, *supra* note 5, at 721.

¹³³ *Id.* Moreover, in localities where there is a shortage of hospital beds, a patient who is restricted in his choice of hospitals will wait longer for a bed. The wait is longer because the patient cannot take the first available bed in the area, but must wait until a bed opens in the hospital where his chosen practitioner has privileges. Consequently, privilege administration directly affects the waiting period for hospital beds and the price and quality of hospital services for the Group 1 patient.

¹³⁴ See *supra* note 131.

¹³⁵ Dolan & Ralston, *supra* note 5, at 720-21.

¹³⁶ See *supra* text accompanying notes 91-108.

¹³⁷ *Id.*

¹³⁸ See *supra* text accompanying note 130.

¹³⁹ See *supra* text accompanying notes 100-08.

¹⁴⁰ See *supra* text accompanying notes 98-99.

¹⁴¹ See *supra* text accompanying notes 121-23.

¹⁴² *Id.*

¹⁴³ Compare *supra* text accompanying notes 123-37 (patient's interests) with *supra* text accompanying notes 112-26 (hospital board's interests) and *supra* text accompanying notes 91-111 (medical staff's interests).

privilege-related litigation.¹⁴⁴ In the following section, the most common types of privilege-related litigation are described.

E. *Privilege-Related Litigation*

The vast majority of privilege-related litigation involves privilege denials that are non-merit-based.¹⁴⁵ In these cases, the privilege denial is not based on the applicant's competence as a practitioner, but on some other factor such as the applicant's chosen specialty¹⁴⁶ or trade practices.¹⁴⁷ Three types of non-merit-based denials are particularly common: contract-based, class-based, and retaliatory.

Contract-based privilege denials occur where a hospital board has given a group of practitioners the exclusive right to practice their specialty at the hospital.¹⁴⁸ Under such a contract, the hospital agrees not to allow other practitioners to practice the contract group's specialty at the hospital.¹⁴⁹ In exchange, the contract group may agree to turn over a set percentage of their fees to the hospital.¹⁵⁰ Once an exclusive contract is in place, privilege applicants in the contract specialty who are not members of the contract group are denied privileges routinely, regardless of individual merit.¹⁵¹

Class-based privilege denials occur where the hospital board or medical staff has a general policy against granting privileges to a certain class of practitioners.¹⁵² Non-M.D. practitioners such as podiatrists, chiropractors, and psychologists are common targets of class-based denials.¹⁵³ Privilege applicants in these classes, notwithstanding their state licenses, are routinely denied privileges at many hospitals regardless of individual merit.¹⁵⁴

Retaliatory privilege denials occur where the hospital board or medical staff wants to discourage a particular practice such as association with Health Maintenance Organizations,¹⁵⁵ or performance of abortions or home births.¹⁵⁶ Privilege applicants who engage

¹⁴⁴ See *supra* text accompanying note 23.

¹⁴⁵ Dolan & Ralston, *supra* note 5, at 728-35.

¹⁴⁶ See *supra* note 97.

¹⁴⁷ See *supra* text accompanying notes 98-108.

¹⁴⁸ See, e.g., Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346, 1348 (7th Cir. 1982); Hyde v. Jefferson Parish Hosp., 686 F.2d 286, 288 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983).

¹⁴⁹ See, e.g., Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346, 1348 (7th Cir. 1982) (Contract provided that no anesthesiologists outside the contract group would be permitted to practice in the hospital); Hyde v. Jefferson Parish Hosp., 686 F.2d 286, 288 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983) (Contract provided that no anesthesiologists outside the contract group would be permitted to practice in the hospital).

¹⁵⁰ See, e.g., Hyde v. Jefferson Parish Hosp., 686 F.2d 286, 288 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983) (Hospital billed patient for anesthesiology services, subtracted eight percent for overhead, then split remaining receipts with contract group).

¹⁵¹ See, e.g., Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346, 1348 (7th Cir. 1982); Hyde v. Jefferson Parish Hosp., 686 F.2d 286, 287-88 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983).

¹⁵² See, e.g., Shaw v. Hospital Authority of Cobb County, 614 F.2d 946, 951 (5th Cir. 1980).

¹⁵³ Dolan & Ralston, *supra* note 5, at 727-28.

¹⁵⁴ *Id.*

¹⁵⁵ See, e.g., Williams v. Kleaveland, 534 F. Supp. 912, 915 (W.D. Mich. 1981). Health maintenance organizations (HMOs) are practitioner groups which bill their patients on a flat-rate-per-period rather than on a fee-for-service basis. Kissam, *Health Maintenance Organizations and The Role of Antitrust Law*, 1978 DUKE L. J. 487, 488.

¹⁵⁶ See, e.g., Barr v. National Right to Life Comm., 1981-2 Trade Cas. (CCH) ¶ 64,315 at 74,407 (M.D. Fla. 1981).

in these forbidden activities are routinely denied privileges at many hospitals regardless of individual merit.¹⁵⁷

Contract-based, class-based, and retaliatory privilege denials represent the most blatant abuses of regulatory power currently occurring in staff privilege administration.¹⁵⁸ The development of an efficient legal response to these abuses is the primary focus of the following sections.

II. THE SHERMAN ANTITRUST ACT AND THE *PER SE* RULES

The preceding part examined the administration of hospital privileges, and the problems that arise because of the conflicting interests of the parties involved. In preparation for discussing the Sherman Act Group Boycott Rule as a possible legal response to these problems, this part will discuss the Sherman Act in general. Emphasis will be placed on the purposes and development of the *per se* rules and particularly on the Group Boycott Rule.

The Sherman Act,¹⁵⁹ enacted in 1890, has been the preeminent federal antitrust statute for nearly 100 years.¹⁶⁰ Section One of the Act proscribes agreements which restrain free trade in interstate commerce.¹⁶¹ Section Two of the Act proscribes monopolization of an area of trade by one or more actors.¹⁶²

Under either section, a plaintiff must invoke Sherman Act jurisdiction by proving that the challenged restraint has a "substantial effect" on interstate commerce.¹⁶³ Until recently, a plaintiff could meet this requirement by showing that the particular restraint of trade challenged had a direct and purposeful effect on interstate commerce.¹⁶⁴ In two recent cases, however, the Supreme Court has substantially altered this requirement. First, in *Hospital Building Co. v. Trustees of Rex Hospital*,¹⁶⁵ the Supreme Court held that although the Sherman Act requires that the challenged restraint have a substantial effect on interstate commerce, such effect need not be either direct or purposeful.¹⁶⁶ Second, in *McLain v. Real Estate Board of New Orleans*,¹⁶⁷ the Supreme Court held that the plaintiff need only show that defendant's total activities, independent of the challenged restraint, substantially affect interstate commerce.¹⁶⁸ Under *McLain* and *Rex Hospital*, a plaintiff may successfully invoke Sherman Act jurisdiction if he can prove that the defendant's total business activities have even an indirect and unintended effect on interstate commerce. In actions challenging the denial of staff privileges, plaintiff practitioners should meet this requirement easily because most defendant hospitals either purchase some supplies from out-of-state sources or bill out-of-state insurers.¹⁶⁹ Accordingly, the Sher-

¹⁵⁷ Dolan & Ralston, *supra* note 5, at 734.

¹⁵⁸ *Id.* at 727; Kissam, *supra* note 10, at 598-99.

¹⁵⁹ 15 U.S.C. §§ 1-7 (1976).

¹⁶⁰ P. AREEDA, ANTITRUST ANALYSIS § 144 (3d ed. 1981).

¹⁶¹ 15 U.S.C. § 1 (1976). See *supra* note 17.

¹⁶² 15 U.S.C. § 2 (1976). See *supra* note 17.

¹⁶³ L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST, § 233 (1977).

¹⁶⁴ United States v. Oregon State Medical Soc'y, 343 U.S. 326, 337-39 (1952).

¹⁶⁵ 425 U.S. 738 (1976).

¹⁶⁶ *Id.* at 744.

¹⁶⁷ 444 U.S. 232 (1980).

¹⁶⁸ *Id.* at 246.

¹⁶⁹ See *Hospital Building Co. v. Trustees of Rex Hosp.*, 425 U.S. 738, 741 (1976).

man Act's interstate commerce requirement should no longer be an impediment to privilege denial cases.¹⁷⁰

Even where plaintiff establishes the requisite connection between defendant's business activities and interstate commerce, three affirmative defenses are available that will defeat Sherman Act jurisdiction. First, under *Parker v. Brown*,¹⁷¹ federal antitrust jurisdiction does not exist if the challenged restraint of trade is mandated by state regulations.¹⁷² In a recent case, however, *California Retail Liquor Dealers Association v. Midcal Aluminum*,¹⁷³ the Supreme Court greatly limited the availability of this defense. Under *Midcal*, it is not enough that the challenged restraint of trade be "necessary" for the implementation of the state regulatory scheme.¹⁷⁴ Rather, the challenged restraint must also be "clearly articulated and affirmatively expressed"¹⁷⁵ as state policy, and "actively supervised"¹⁷⁶ by the state itself. Consequently, *Midcal* precludes the use of this defense in privilege denial cases except where state regulations explicitly mandate the privilege denial and a state agency actively supervises privilege administration.

The second affirmative defense to Sherman Act jurisdiction, also derived from *Parker v. Brown*,¹⁷⁷ provides that federal antitrust jurisdiction does not exist where the challenged restraint is implemented by a state agency and can be characterized as a regulatory act.¹⁷⁸ In the Supreme Court's most recent decision involving this defense, *Community Communications Co. v. City of Boulder*,¹⁷⁹ the Court held that this defense is available only if the state has specifically "authorized or directed" a political subdivision to engage in anticompetitive conduct.¹⁸⁰ Moreover, there must be evidence that the "legislature contemplated the kind of activity complained of."¹⁸¹ Accordingly, under *Community Communications*, the "regulatory act" defense would be available in privilege denial cases only where the defendant was a public hospital, and the enabling legislation establishing the hospital specifically authorizes selective privilege administration.¹⁸² In addition, defendant hospital would need to establish that the legislature contemplated the privilege denial system used by the hospital.¹⁸³

The third affirmative defense to Sherman Act jurisdiction, the *Noerr-Pennington* doctrine,¹⁸⁴ is rooted in the first amendment's guarantee of the right to petition.¹⁸⁵ The

¹⁷⁰ See, e.g., *Mishler v. St. Anthony's Hosp. Systems*, 1981-2 Trade Cas. (CCH) ¶ 64,342 (10th Cir. 1981); *Williams v. Keaveland*, 435 F. Supp. 912, 918 (W.D. Mich. 1981); *Barr v. National Right to Life Comm.*, 1981-2 Trade Cas. (CCH) ¶ 64,315 at 74,409 (M.D. Fla. 1981). But see *Moles v. Morton F. Plant Hosp., Inc.*, 1980-1 Trade Cas. (CCH) ¶ 63,600 at 77,189 (M.D. Fla.), *aff'd* 617 F.2d 293 (5th Cir. 1980).

¹⁷¹ 317 U.S. 341 (1943).

¹⁷² *Id.* at 350-51. For the challenged restraint to be mandated by state regulation it must be necessary for the effective implementation of the state regulatory scheme. *Id.*

¹⁷³ 445 U.S. 97 (1980).

¹⁷⁴ *Id.* at 105.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ 317 U.S. 341 (1943).

¹⁷⁸ *Id.* at 350-51.

¹⁷⁹ 455 U.S. 40 (1982).

¹⁸⁰ *Id.* at 54-56 (adopting plurality approach in *City of Lafayette v. Louisiana Light and Power Co.*, 435 U.S. 389, 413-17 (1978)).

¹⁸¹ *Id.*

¹⁸² *Kissam*, *supra* note 10, at 625.

¹⁸³ *Id.*

¹⁸⁴ *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 135-36 (1961); *United Mine Workers of America, Inc. v. Pennington*, 381 U.S. 657, 669-72 (1956).

defense exempts from antitrust scrutiny genuine efforts by private parties to influence executive,¹⁸⁶ legislative,¹⁸⁷ and adjudicative¹⁸⁸ government bodies.

There are two ways the *Noerr-Pennington* doctrine might be used by defendants in a privilege denial case. First, members of the medical staff at a public hospital who allegedly conspired to deny plaintiff staff privileges might claim that their privilege denial activity was an attempt to influence a governmental agency, the public hospital board, to deny the plaintiff staff privileges. The success of this defense will depend on whether the privilege denial by the hospital board would have been exempt from antitrust scrutiny under *Parker v. Brown*.¹⁸⁹ Attempts to influence governmental action are exempt from antitrust scrutiny only if the governmental action itself is exempt.¹⁹⁰ Therefore, the privilege denial would have to be considered a "regulatory act" under *Parker v. Brown*.¹⁹¹ In order for the medical staff activity leading to the privilege denial to be exempt under *Noerr-Pennington*. Since the "regulatory act" defense would be extremely difficult to establish in this context,¹⁹² this application of the *Noerr-Pennington* doctrine is unlikely to be successful.

The second way the *Noerr-Pennington* doctrine might be used in privilege denial cases is suggested in a recent Fifth Circuit case, *Feminist Women's Health Center v. Mohammad*.¹⁹³ The *Mohammad* Court held that disciplinary action taken by a medical staff is not protected by the *Noerr-Pennington* doctrine where the state licensing board is permitted by the statute to take action against the disciplined practitioner.¹⁹⁴ The holding implies that if a statute required the state licensing board to take action against disciplined practitioners, the disciplinary action itself might be protected under *Noerr-Pennington*.¹⁹⁵ Thus, privilege denials by both public and private hospitals might be exempt from the Sherman Act when a state statute requires the state licensing board to act against all practitioners who are denied privileges.

If a defendant's *Noerr-Pennington* and *Parker v. Brown* defenses fail, and a plaintiff has established the requisite connection with interstate commerce,¹⁹⁶ Sherman Act jurisdiction is established.¹⁹⁷ Plaintiff then proceeds with proof of a Sherman Act violation.¹⁹⁸

¹⁸⁵ *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 513 (1972); Faschel, *Antitrust Liability for Attempts to Influence Governmental Action: The Bases and Limits of the Noerr-Pennington Doctrine*, 45 U. CHI. L. REV. 80, 104-10 (1977).

¹⁸⁶ *United Mine Workers of America v. Pennington*, 381 U.S. 657, 669-72 (1956).

¹⁸⁷ *Eastern R.R. Presidents Conference v. Noerr*, 365 U.S. 127, 135-36 (1961).

¹⁸⁸ *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 510-13 (1972).

¹⁸⁹ 317 U.S. 341 (1943). See *supra* text accompanying notes 171-83.

¹⁹⁰ *In re Airport Car Rental Litig.*, 474 F. Supp. 1072, 1086 (1979), *rev'd on other grounds on reassignment*, 1981-1 Trade Cas. (CCH) ¶ 63,983 (N.D. Ca. 1981).

¹⁹¹ See *supra* text accompanying notes 171-83.

¹⁹² *Id.*

¹⁹³ 586 F.2d 530 (5th Cir. 1978). *Mohammad* involved an alleged conspiracy by members of a hospital medical staff to coerce local practitioners not to associate with an outpatient abortion clinic. *Id.* at 531-32.

¹⁹⁴ *Id.* at 545.

¹⁹⁵ *Id.* No statute of this kind is currently in force in any state.

¹⁹⁶ See *supra* text accompanying notes 187-95.

¹⁹⁷ SULLIVAN, *supra* note 163, at § 233.

¹⁹⁸ The elements of the plaintiff's case differ depending on whether the case is brought under Section One or Section Two of the Act. Because this article concerns use of the Group Boycott Rule, a method of proof available only under Section One, the primary focus of the discussion will be on Section One. Before beginning this discussion, however, a brief examination of Section Two is

Section One of the Sherman Act, read literally, proscribes *every* agreement which restrains trade.¹⁹⁹ This literal reading of the statute has been rejected by the Supreme Court in favor of the "Rule of Reason."²⁰⁰ Under the "Rule of Reason," only unreasonable

worthwhile to understand the difference between the two sections and the reason Section One, and the Group Boycott Rule, provide the optimal theory in most privilege denial challenges.

Section Two of the Sherman Act proscribes "monopolization" or "attempts to monopolize." 15 U.S.C. § 2 (1926). For text see *supra* note 17. To prove "monopolization," the plaintiff must show "(1) the possession of monopoly power in the relevant market, and (2) the willful acquisition or maintenance of that power." *United States v. Grunnell Corp.*, 384 U.S. 563, 570-71 (1966). To prove an "attempt to monopolize," the plaintiff must show a specific intent to achieve (1) and (2). See Cooper, *Attempts at Monopolization: A Mildly Expansionary Answer to the Prophylactic Riddle of Section Two*, 72 MICH. L. REV. 373, 375 (1973). The Supreme Court has defined monopoly power as the near-complete lack of competing products which limit the defendant's ability to raise prices. *United States v. E.I. duPont deNemours & Co.*, 351 U.S. 377, 393 (1956); MILLHORN, *ANTITRUST LAW AND ECONOMICS* 91 (1980). Accordingly, a hospital has monopoly power if it offers a service that is unavailable at other hospitals in the area. See, e.g., *Robinson v. McGovern*, 521 F. Supp. 842, 878-79 (W.D. Pa., 1981), *appeal docketed*, No. 81-2726 (3d Cir. 1981). If the hospital with monopoly power has purposefully acquired or maintained this power, the hospital has violated Section Two of the Sherman Act. See Cooper, *supra* at 375.

The usefulness of Section Two of the Sherman Act in privilege-related cases is extremely limited by the difficulty of proving a Section Two violation. While many hospitals have monopoly power over particular services, it is difficult to prove that a particular privilege denial represents a purposeful attempt by the hospital to acquire or maintain its monopoly power. *Dolan & Ralston, supra* note 5, at 766-67. If the unsuccessful privilege applicant proceeds under Section One of the Sherman Act rather than Section Two, he need show only that the privilege denial in effect "restrains trade." See *infra* text accompanying notes 199-219. Under Section One, neither the market power nor the purpose of the hospital is at issue. *Id.* Thus the privilege applicant is far more likely to prevail under Section One of the Sherman Act than under Section Two. There are, however, instances where Section Two of the Sherman Act will provide a more promising theory of recovery. For example, consider the case where a new ambulatory surgical center opens in a community previously served by only one hospital. The hospital board, over the objection of the medical staff, denies staff privileges to all practitioners who associate with the new surgical center. (Of course, in practice, hospital boards rarely act on privilege issues without the approval of the medical staff. See *supra* text accompanying notes 68-72.) By denying these practitioners privileges, the hospital forces the practitioners to choose between association with the surgical center and staff privileges at the hospital. Because practitioners generally need staff privileges at a hospital to survive professionally, and because there is only one hospital in the area, the practitioners are forced to cease their association with the surgical center in order to maintain their practices. The surgical center, no longer able to attract practitioners, is forced out of business, and the hospital maintains its monopoly on surgical facilities. Clearly, the privilege denials in this case represent purposeful attempts by the hospital to maintain its monopoly power. In this instance, Section Two of the Sherman Act will provide a more promising theory of recovery than Section One. Section Two of the Sherman Act, unlike Section One, does not require the showing of a "contract, combination . . . or conspiracy" between severable actors. Compare 15 U.S.C. § 2 (1976) with 15 U.S.C. § 1 (1976), *supra* note 17. Because our hypothetical involved unilateral activity by the hospital board over the objection of the medical staff, proof of an agreement between the board and the staff would be impossible. Therefore, Section Two of the Sherman Act, which does not require proof of an agreement, would be a more promising theory of recovery than Section One.

In practice, virtually all privilege denials involve cooperation between the hospital board and the medical staff. See *supra* text accompanying notes 68-72. Consequently, the "agreement" requirement of Section One of the Sherman Act can virtually always be met in privilege denial cases. If the agreement requirement can be met, the privilege applicant is far more likely to prevail under Section One of the Sherman Act than under Section Two. Thus, in the vast majority of privilege litigation, the plaintiff is more likely to succeed under Section One.

¹⁹⁹ 15 U.S.C. § 1 (1976). For text, see *supra* note 17.

²⁰⁰ *Arizona v. Maricopa County Medical Ass'n*, 457 U.S. 332, 343 (1982) (citing *Standard Oil of New Jersey v. United States*, 221 U.S. 1 (1911)).

restraints of trade are prohibited.²⁰¹ Plaintiff must demonstrate that the challenged restraint of trade is unreasonable to prevail under Section One of the Sherman Act.²⁰² To prove unreasonableness, a plaintiff must demonstrate that the anticompetitive effects of the challenged agreement outweigh the procompetitive effects.²⁰³ This showing of the agreement's effects on competition in an entire industry can be extremely expensive for the plaintiff and time-consuming for the courts.²⁰⁴ The Supreme Court has responded to this problem by formulating the *per se* rules.²⁰⁵

The *per se* rules allow a plaintiff to avoid the difficult showing of anticompetitive effects that is necessary under the "Rule of Reason."²⁰⁶ Instead of demonstrating the anticompetitive effects of the challenged agreement, the plaintiff relies on a conclusive presumption by the court that certain types of agreements are always anticompetitive.²⁰⁷ If a plaintiff can demonstrate that the challenged agreement is of a type covered by the *per se* rules,²⁰⁸ the agreement is presumed violative of Section One of the Sherman Act.²⁰⁹ Once a plaintiff proves a *per se* violation, the defendant is precluded from offering evidence that the restraint of trade posed by the challenged agreement is reasonable under the circumstances.²¹⁰

III. THE GROUP BOYCOTT RULE

The group boycott rule is the *per se* rule which applies in situations where traders collectively refuse to deal with another trader.²¹¹ This section will begin by examining the Supreme Court cases in which the boycott rule was originally developed in an attempt to ascertain the policies underlying the boycott rule. Next, the section will examine several more recent Supreme Court cases which have further refined the boycott rule in order to

²⁰¹ *Id.*

²⁰² *Id.* Chicago Board of Trade v. United States, 246 U.S. 231, 238 (1918).

²⁰³ National Soc'y of Professional Engineers v. United States, 435 U.S. 679, 690-92 (1978).

²⁰⁴ Arizona v. Maricopa County Medical Ass'n, 457 U.S. 332, 343 (1982); Northern Pacific Railway Co. v. United States, 356 U.S. 1, 5 (1958).

²⁰⁵ Arizona v. Maricopa County Medical Ass'n, 457 U.S. 343-44 (1982).

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ "Among the practices courts have heretofore deemed to be unlawful in and of themselves are price fixing, division of markets, group boycotts, and tying arrangements." *Id.* at 344 n.15 (quoting Northern Pacific Railway Co. v. United States, 356 U.S. 1, 5 (1958)).

²⁰⁹ *Id.* at 344-45.

²¹⁰ *Id.*

Per se rules represent educated predictions by the court. *Id.* The court predicts, based on past experience, that particular types of agreements will unreasonably restrain trade. *Id.* As with any prediction, there is some margin of error. *Id.* Some agreements which are condemned under the *per se* rules perhaps would have survived scrutiny under the "Rule of Reason." *Id.* The Court, however, has determined as a policy matter that such cases are not sufficiently common or important to justify the time and expense necessary to identify them. *Id.* at n.16 (quoting Continental T.V. v. GTE Sylvania, 433 U.S. 36, 50 n.5 (1977)). The prediction inherent in the *per se* approach is justified because the approach promotes judicial efficiency and business certainty. *Id.* at 344. Judicial efficiency is promoted because courts avoid repeated "Rule of Reason" analyses of the most common trade restraints. *Id.* at 351 (quoting Northern Pacific Railway Co. v. United States, 356 U.S. 1, 5 (1958)). Business certainty is promoted because certain types of trade restraints are known to be beyond justification. *Id.* at 344. The judicial efficiency and business certainty promoted by the *per se* rules justify the occasional invalidation of an agreement that would have survived scrutiny under the "Rule of Reason." *Id.*

²¹¹ See *supra* text accompanying notes 212-94.

determine the way the boycott rule would be applied today. Finally, several common types of privilege denials will be discussed against the background of the boycott cases in an attempt to determine whether these types of privilege denials can be characterized as group boycotts.

A. *Development and Current Contours of the Offense*

A group boycott is an agreement²¹² between two or more industry participants, the actors,²¹³ (1) involving a refusal by two or more competitors²¹⁴ to deal with one or more other industry participants, the targets,²¹⁵ and (2) made to coerce²¹⁶ or eliminate²¹⁷ the target industry participants. This type of agreement was first recognized as a *per se* offense in *Fashion Originators Guild v. Federal Trade Commission*.²¹⁸ In *Fashion Originators*, the Court held that such an arrangement is so clearly anticompetitive that it is proper to exclude evidence of reasonableness.²¹⁹ The case involved an organization of original clothes manufacturers who combined to eliminate manufacturers of copied clothing, "style pirates," from the clothing industry.²²⁰ In order to eliminate the "pirates," the Fashion Originators Guild agreed to stop selling their clothing to retailers who also bought from the "pirates."²²¹ Since most clothing manufacturers were members of the Fashion Originators Guild,²²² most retailers were forced to stop dealing with the pirates in order to obtain merchandise and stay in business. The "pirates," unable to find retail outlets willing to deal with them, were forced out of business.²²³

The Court viewed the Fashion Originators Guild as essentially an "extra-governmental agency"²²⁴ attempting to regulate interstate commerce, precisely the type of private restraint of trade prohibited by the Sherman Act.²²⁵ Such a conspiracy could not be justified even if the Guild's goal was legitimate, since the regulation of interstate commerce is the province of the legislature and not private industry.²²⁶ Accordingly, the Court held that the conspiracy was illegal *per se*.²²⁷

The boycott agreement held illegal *per se* in *Fashion Originators* was between direct

²¹² All section one offenses require proof of an agreement. 15 U.S.C. § 1 (1976).

²¹³ *Fashion Originators' Guild of America v. Federal Trade Comm.*, 312 U.S. 457, 461 (1941). An industry participant is anyone engaged in the particular industry under consideration.

²¹⁴ Competitors are industry participants at the same level of production (e.g. retailers, manufacturers). The requirement that at least two competitors refuse to deal is basic to the concept of a group (rather than a unilateral) boycott. If only one party were refusing to deal, the agreement would be simple exclusive contract. Such a contract, although it may violate the Sherman Act, is not a group boycott. See *Fashion Originators'*, 312 U.S. at 465.

²¹⁵ *Fashion Originators'*, 312 U.S. at 465-66.

²¹⁶ See, e.g., *Kieffer-Stewart Co. v. Joseph F. Seagram & Sons, Inc.*, 340 U.S. 211, 214 (1951).

²¹⁷ See, e.g., *Fashion Originators'*, 312 U.S. 457, 461 (1941).

²¹⁸ 312 U.S. 457 (1941).

²¹⁹ *Id.* at 468.

²²⁰ *Id.* at 461.

²²¹ *Id.*

²²² *Id.* at 462.

²²³ *Id.*

²²⁴ *Id.* at 465-66 (quoting *Addyston Pipe and Steel Co. v. United States*, 175 U.S. 211, 242 (1899)).

²²⁵ *Id.*

²²⁶ *Id.* at 468.

²²⁷ *Id.*

competitors.²²⁸ In *Klor's, Inc. v. Broadway-Hale Stores*,²²⁹ however, the Supreme Court held that parties to a boycott agreement need not be in competition.²³⁰ The boycott agreement in *Klor's* was between a retailer and manufacturers.²³¹ In exchange for the loyalty of the retailer, the manufacturers agreed to boycott the retailer's competitor.²³² The Court found this boycott agreement indistinguishable in purpose and effect from the one in *Fashion Originators*.²³³ Accordingly, the Court held that the agreement was a *per se* violation of the Sherman Act.²³⁴

The boycott agreements held *per se* illegal in both *Fashion Originators* and *Klor's* were designed to force competitors out of business.²³⁵ In *Kieffer-Stewart v. Joseph E. Seagram & Sons*,²³⁶ the Court further extended the group boycott rule by holding that boycott agreements designed to coerce competitors into changing their trade practices were also *per se* violations of the Sherman Act.²³⁷ In *Kieffer-Stewart*, liquor manufacturers agreed to boycott wholesalers who sold liquor above list price.²³⁸ The boycott was not intended to force the wholesalers out of business.²³⁹ Rather, the manufacturers hoped to coerce the wholesalers into lowering their prices.²⁴⁰ The Court reasoned that such coercion of competitors is no less a restraint on free trade than the elimination of competitors.²⁴¹ Moreover, the boycott agreement in *Kieffer-Stewart* in effect eliminated competitors who refused to be coerced.²⁴² The Court held, therefore, the *Kieffer-Stewart* coercion boycott was a *per se* violation of the Sherman Act.²⁴³

Two more recent Supreme Court cases illustrate the current contours of the boycott offense. In *Silver v. New York Stock Exchange*,²⁴⁴ the Court held that a statutorily imposed duty of self-regulation will not immunize an industry from the boycott rule.²⁴⁵ In *United States v. General Motors, Inc.*,²⁴⁶ the Court held that a group boycott need not involve an explicit agreement provided there is a pattern of concerted action calculated to coerce or eliminate competitors.²⁴⁷

Silver involved a New York Stock Exchange regulation prohibiting direct phone connections between members and non-members of the Exchange.²⁴⁸ Before the regulation was adopted, the plaintiff, a non-member broker, relied on a direct phone connection with a member broker to obtain timely stock quotations.²⁴⁹ Without timely stock

²²⁸ *Id.* at 461.

²²⁹ 359 U.S. 207 (1959).

²³⁰ *Id.* at 214.

²³¹ *Id.* at 210.

²³² *Id.*

²³³ *Id.* at 214.

²³⁴ *Id.*

²³⁵ *Klor's, Inc. v. Broadway-Hale Stores*, 359 U.S. 207, 210 (1959); *Fashion Originators' Guild of America v. Federal Trade Comm.*, 312 U.S. 457, 461 (1941).

²³⁶ 340 U.S. 211 (1951).

²³⁷ *Id.* at 214.

²³⁸ *Id.* at 212.

²³⁹ *Id.*

²⁴⁰ *Id.*

²⁴¹ *Id.* at 214.

²⁴² *Id.* at 213.

²⁴³ *Id.* at 214.

²⁴⁴ 373 U.S. 341 (1963).

²⁴⁵ *Id.* at 357.

²⁴⁶ 387 U.S. 127 (1966).

²⁴⁷ *Id.* at 142.

²⁴⁸ *Silver v. New York Stock Exchange*, 373 U.S. 341, 343 (1963).

²⁴⁹ *Id.*

quotations, the plaintiff could not compete effectively as a broker.²⁵⁰ The day the Exchange regulation went into effect, the plaintiff's direct phone connection was terminated without warning,²⁵¹ eventually forcing the plaintiff out of business.²⁵²

On appeal to the Supreme Court, the plaintiff alleged that the Exchange regulation was a boycott agreement between Exchange members designed to eliminate non-member brokers from the brokerage industry.²⁵³ The Stock Exchange claimed that the regulation was intended to protect securities consumers from financially irresponsible brokers.²⁵⁴ The regulation protected consumers by effectively forcing them to buy their securities through Exchange members whose financial responsibility was assured by the rigorous requirements for Exchange membership.²⁵⁵ Moreover, the Exchange claimed, the power and duty to protect consumers from financially irresponsible brokers was statutorily imposed by the Securities Exchange Act of 1934.²⁵⁶ Since the regulation was adopted pursuant to a statutorily imposed duty of industry control, the Exchange claimed, the regulation was exempt from the boycott rule.²⁵⁷

The Court rejected the Exchange's arguments and held that the Exchange regulation clearly was a boycott agreement between Exchange members designed to eliminate non-member competitors.²⁵⁸ The Court stated that since the decision in *Fashion Originators*, such boycott agreements have been held *per se* illegal regardless of the parties' motivation.²⁵⁹ Consequently, the Court noted, even if the Exchange enacted the regulation in order to protect consumers, the fact that the regulation took the form of a group boycott made the regulation illegal *per se*.²⁶⁰ Moreover, the Court stated, the fact that the Exchange regulation was enacted pursuant to a statutorily imposed duty to police the brokerage industry did not immunize the regulation from the Boycott Rule.²⁶¹ Statutorily imposed duties cannot be accomplished by impermissible means.²⁶² To hold that the Exchange regulation was not illegal would be tantamount to repealing the Sherman Act by implication, and repeals by implication violate "a cardinal principle of (statutory) construction."²⁶³ Therefore, the Court held, the Exchange regulation violates the Sherman Act regardless of whether it was intended to fulfill a statutorily imposed duty of industry regulation.²⁶⁴ Since boycott agreements are *per se* illegal, the motivation underlying the Exchange regulation is irrelevant.²⁶⁵

The *Silver* Court repeatedly stressed the fact that the plaintiff's direct phone connection with a member broker was discontinued without notice or an opportunity to be heard.²⁶⁶ The Court indicated in dicta that if the Exchange regulation had afforded

²⁵⁰ *Id.* at 347.

²⁵¹ *Id.* at 344.

²⁵² *Id.* at 345.

²⁵³ *Id.*

²⁵⁴ *Id.* at 353-55.

²⁵⁵ *Id.* at 355.

²⁵⁶ *Id.* at 352.

²⁵⁷ *Id.* at 345.

²⁵⁸ *Id.* at 342.

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ *Id.* at 357.

²⁶² *Id.* at 364.

²⁶³ *Id.* at 357 (quoting *United States v. Borden Co.*, 308 U.S. 188, 198 (1937)).

²⁶⁴ *Id.* at 365.

²⁶⁵ *Id.*

²⁶⁶ *Id.* at 361, 365.

adequate procedural safeguards for affected brokers, then the regulation might have been considered a legitimate exercise of industry self-regulation rather than a boycott agreement.²⁶⁷ The presence of procedural safeguards in a regulatory scheme lends credence to its legitimacy and insures fairness in its administration.²⁶⁸ Moreover, the Court observed, "the affording of procedural safeguards . . . will substantively encourage the lessening of anticompetitive behavior (and) allow the antitrust court to perform its function effectively."²⁶⁹ Thus, the *Silver* Court left open the question of whether a "boycott-type" regulation would be permissible if it incorporated procedural safeguards.²⁷⁰ This question remains unanswered today.

The issue resolved in *Silver* was the significance of the motivation underlying the boycott agreement. The significance of the agreement itself was not addressed by the Court until three years later in *United States v. General Motors*.²⁷¹ In *General Motors*, the Court held that a boycott agreement could be implied by the parties' behavior even without evidence of an explicit agreement.²⁷² The case involved competition between authorized and non-authorized Chevrolet dealers in the Los Angeles area.²⁷³ The non-authorized dealers, or "discounters," purchased cars in bulk from several authorized dealers and then resold the cars to consumers.²⁷⁴ The authorized dealers who were not selling cars to the discounters complained to General Motors.²⁷⁵ The manufacturer, fearing the loss of several of its best dealers, and hoping to maintain the integrity of its authorized sales and service network, enacted a regulation forbidding its authorized dealers from selling to the discounters.²⁷⁶ The regulation was not issued pursuant to any explicit agreement between General Motors and the complaining dealers.²⁷⁷ Moreover, while it was understood by both parties that the dealers would police themselves to insure compliance with the regulation,²⁷⁸ no explicit agreement was reached between General Motors and the dealers concerning enforcement.²⁷⁹ Nevertheless, the dealers enforced the regulation and forced the discounters out of business.²⁸⁰

On appeal, plaintiff alleged that the enactment by General Motors of the regulation, and the subsequent enforcement of the regulation by the dealers, implied that General Motors and the dealers were parties to a boycott agreement.²⁸¹ Respondents, on the other hand, attempted to characterize their steps against the discounters as independent "parallel" actions rather than concerted ones.²⁸² The Court rejected respondents' argument, finding "a fabric interwoven by many strands of joint action"²⁸³ which compels the conclusion that a boycott agreement in fact existed.²⁸⁴ Lack of an explicit agreement, the

²⁶⁷ *Id.* at 360.

²⁶⁸ *Id.* at 360-63.

²⁶⁹ *Id.* at 363.

²⁷⁰ *Id.* at 366.

²⁷¹ 384 U.S. 127 (1966).

²⁷² *Id.* at 142.

²⁷³ *Id.* at 133-39.

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ *Id.*

²⁷⁷ *Id.* at 141.

²⁷⁸ *Id.* at 138.

²⁷⁹ *Id.* at 141.

²⁸⁰ *Id.* at 140.

²⁸¹ *Id.*

²⁸² *Id.* at 144.

²⁸³ *Id.*

²⁸⁴ *Id.*

Court stated, would not immunize such a conspiracy from antitrust scrutiny.²⁸⁵ Therefore, the Court held, the General Motors regulation and its enforcement by the dealers constitute an implied boycott agreement which is illegal *per se*.²⁸⁶

Fashion Originators, Klor's, Kieffer-Stewart, Silver, and General Motors, taken together, delineate the contours of the Group Boycott offense. A plaintiff must first prove an agreement between two or more industry participants.²⁸⁷ The agreement need not be explicit,²⁸⁸ and the parties need not be in competition with each other.²⁸⁹ The agreement must involve a boycott by at least two competitors against another "target" industry participant.²⁹⁰ The boycott may be designed either to eliminate the target from the industry²⁹¹ or to coerce the target into changing its trade practices.²⁹² A boycott agreement that meets the above requirements cannot be justified.²⁹³ As a result, the motivation underlying such a boycott agreement, even if it is consumer protection, becomes irrelevant.²⁹⁴

B. *Privilege Denials as Group Boycotts*

The previous section examined the leading Group Boycott precedent to ascertain the development and current contours of the group boycott offense. The purpose of this section is to determine, in light of the boycott precedent discussed in the previous section, which, if any, privilege denials constitute group boycotts.

A threshold problem in applying the boycott precedent to privilege denials is that most of the boycott cases have involved retailers and manufacturers.²⁹⁵ At first glance, the trading relationship between retailers and manufacturers seems different from the relationship between practitioners and hospitals, necessitating a different restraint-of-trade analysis. Unlike retailer and manufacturer, practitioner and hospital do not stand in the relationship of buyer and seller. Consequently, a "refusal to deal" between a practitioner and a hospital might have different purposes and effects than a "refusal to deal" between a retailer and a manufacturer. If "refusals to deal" in the retailer-manufacturer context had different purposes and effects than "refusals to deal" in the practitioner-hospital context, boycott precedent from the retailer-manufacturer context would not be useful in analyzing alleged boycotts in the practitioner-hospital context.

On closer scrutiny, however, the trading relationship between retailers and manufacturers seems essentially the same as the trading relationship between practitioners and hospitals. In each case, one party provides an essential element in the business of the

²⁸⁵ *Id.* at 142.

²⁸⁶ *Id.* at 145.

²⁸⁷ *Fashion Originators' Guild of America, Inc. v. Federal Trade Comm.*, 312 U.S. 457, 460 (1941).

²⁸⁸ *United States v. General Motors*, 384 U.S. 127, 142 (1966).

²⁸⁹ *Klor's, Inc. v. Broadway-Hale Stores*, 359, 207, 210 (1959).

²⁹⁰ See *supra* note 214.

²⁹¹ See, e.g., *Fashion Originators' Guild of America, Inc. v. Federal Trade Comm.*, 312 U.S. 457, 461 (1941).

²⁹² See, e.g., *Kieffer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 212 (1951).

²⁹³ *Fashion Originators' Guild of America, Inc. v. Federal Trade Comm.*, 312 U.S. 457, 468 (1941).

²⁹⁴ *Silver v. New York Stock Exchange*, 373 U.S. 341, 348-49 (1963).

²⁹⁵ The single exception is *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963), which involved the exchange and its member brokers. See *supra* text accompanying notes 250-76.

other. The retailer, for example, provides the manufacturer with a means of selling his goods; in exchange, the manufacturer provides the retailer with goods to sell. Similarly, the hospital provides the practitioner with hospital facilities; in exchange, the practitioner provides the hospital with paying patients. Practitioners and hospitals, like retailers and manufacturers, are indispensable elements in the delivery of certain products and services to consumers.

Boycott agreements, by restraining free competition within this delivery system, prevent consumers from receiving the best possible products and services at the lowest prices.²⁹⁶ A boycott agreement has this effect whether it involves practitioners and hospitals,²⁹⁷ or retailers and manufacturers. In either case, the industry participant who is the victim of the boycott loses his ability to compete on equal footing with other industry participants.²⁹⁸ When the ability of an industry participant to compete freely is restrained, the broad aim of the Sherman Act — to insure free competition²⁹⁹ — is frustrated regardless of the industrial context in which the competitive restraint occurs. Thus, when viewed in light of the broad aim of the Sherman Act, boycott precedent involving retailers and manufacturers should control similar cases involving practitioners and hospitals.

The following subsections discuss four common types of privilege denials in an attempt to discover which, if any, constitute group boycotts. Each subsection begins with an analysis of the privilege denial in terms of the Supreme Court group boycott precedent, and concludes with a discussion of lower court cases which might prove useful in a challenge to that type of privilege denial.

1. Class-based Privilege Denials

Many hospitals have regulations or by-laws which prohibit the granting of privileges to whole classes of practitioners such as osteopaths, podiatrists, chiropractors, and psychologists.³⁰⁰ Pursuant to these regulations, applicants in these classes are denied privileges automatically regardless of individual merit.³⁰¹ When called upon to justify this type of regulations, hospitals generally claim that true standards applied to the training of practitioners in these disciplines are not as rigorous as those applied to the training of medical doctors, and, as a result, it would be necessary for the hospital to assess the ability of these practitioners on an individual basis.³⁰² Since such an evaluation is difficult and time-consuming, hospitals argue, regulations excluding these classes of practitioners are justified.³⁰³

Cases involving class-exclusion regulations should be controlled by *Silver v. New York Stock Exchange*.³⁰⁴ In *Silver*, the Supreme Court held that consumer protection cannot be accomplished by means of a regulation which amounts to a group boycott.³⁰⁵ *Silver*

²⁹⁶ *Fashion Originators' Guild of America, Inc. v. Federal Trade Comm.*, 312 U.S. 457, 466 (1941).

²⁹⁷ See *supra* text accompanying notes 127-43.

²⁹⁸ See, e.g., *Silver v. New York Stock Exchange*, 373 U.S. 341, 344-45 (1963); *supra* text accompanying notes 75-90.

²⁹⁹ *Fashion Originators' Guild of America, Inc. v. Federal Trade Comm.*, 312 U.S. 457, 466 (1941).

³⁰⁰ See *supra* text accompanying notes 152-54.

³⁰¹ *Id.*

³⁰² *Dolan & Ralston, supra* note 5, at 729.

³⁰³ *Id.*

³⁰⁴ 373 U.S. 341 (1963). See *supra* text accompanying notes 244-70.

³⁰⁵ *Silver v. New York Stock Exchange*, 373 U.S. at 365.

involved an Exchange regulation effectively excluding non-member brokers from use of Exchange facilities.³⁰⁶ The Exchange claimed that the regulation was necessary to protect consumers from financially incompetent brokers.³⁰⁷ The duty to protect consumers, the Exchange asserted, was part of a statutorily imposed duty of self-regulation unique to the securities trading industry.³⁰⁸ In rejecting this argument, the Court reasoned that a regulation in the form of a group boycott is so clearly anticompetitive that it could not withstand scrutiny even if the regulation were actually adopted to benefit consumers.³⁰⁹

Courts should strike down class-exclusion regulations at hospitals on similar grounds. Although hospitals may have a duty to protect consumers from incompetent practitioners,³¹⁰ this duty cannot be fulfilled by adopting a regulation which amounts to a group boycott. Such regulations do not incorporate procedural safeguards to insure that only industry participants who truly present a danger to consumers are excluded.³¹¹ Moreover, the Sherman Act prohibits group boycotts regardless of their underlying motivation.³¹² Therefore, hospital regulations which in effect boycott classes of practitioners are impermissible even if the regulations are genuinely intended to protect hospital patients.

Courts may not find *Silver*, which involved stock exchange regulations, controlling in cases involving hospital regulations for two reasons. First, the hospital board, unlike the administrative board of the Stock Exchange, does not stand to benefit competitively by the challenged regulation. Members of the hospital board in no sense compete for business with the practitioners who are denied privileges. Consequently, the hospital regulation could not be designed to coerce or eliminate competition. The *Silver* regulation, on the other hand, was enacted by stock brokers who competed for business directly with the non-member brokers that the regulation eliminated.³¹³

The view that *Silver* should not apply to hospital privilege regulations because members of the hospital boards, unlike members of the administrative board of the Stock Exchange, do not compete directly with those affected by the regulations, is plausible. Courts should, however, reject this view because it rests on the false premise that the hospital board acts unilaterally when it adopts the challenged regulation. Regulations of this type are enacted on the recommendation of the hospital's medical staff.³¹⁴ Members of the medical staff, like members of the Stock Exchange, benefit directly from such a regulation.³¹⁵ Moreover, the hospital board has strong incentives to cooperate with the medical staff when the latter group insists on the enactment of a class-exclusion regulation.³¹⁶ Accordingly, such a regulation should be viewed as a boycott agreement between the hospital board and medical staff designed to eliminate a class of the medical staff's competitors. Viewed in this light, the hospital regulation falls squarely under *Silver*.

Another reason courts may not find *Silver* controlling in cases involving hospital

³⁰⁶ *Id.* at 353-55.

³⁰⁷ *Id.*

³⁰⁸ *Id.* at 352.

³⁰⁹ *Id.* at 365.

³¹⁰ See *supra* note 126.

³¹¹ *Silver v. New York Stock Exchange*, 373 U.S. 341, 364 (1963).

³¹² *Id.* at 348.

³¹³ *Id.*

³¹⁴ See *supra* text accompanying notes 66-72.

³¹⁵ See *supra* text accompanying notes 91-111.

³¹⁶ See *supra* text accompanying notes 114-26.

privilege regulation is that from a public policy standpoint, the duty to protect consumers from incompetent medical practitioners may be considered more important than the duty to protect consumers from financially insecure stock brokers. Even if this were true, however, it does not lead to the conclusion that a group boycott is permissible for the hospital even though it was impermissible for the Stock Exchange in *Silver*. The boycott is an impermissible method of industry self-regulation because it is not tailored to eliminate only the competitors who actually endanger consumers.³¹⁷ Accordingly, boycotts are impermissible regardless of the magnitude of the potential danger the boycott is designed to avoid. Under *Silver*, the only possibility that a boycott-type regulation might survive Sherman Act scrutiny is where procedural safeguards were incorporated to insure that only competitors which present a danger to consumers, such as incompetent medical practitioners, were eliminated.³¹⁸

There is a paucity of case law involving Sherman Act challenges to class-based privilege denials. In *Weiss v. York Hospital*,³¹⁹ the District Court for the Middle District of Pennsylvania denied the defendant hospital's motion for summary judgment against an osteopath alleging a class-based denial.³²⁰ Although the court did not discuss *Silver*, and reserved the question of whether the "Rule of Reason" or the *per se* rules would apply,³²¹ the court seemed to assume that the arrangement alleged by plaintiff, if proven, would amount to a group boycott.³²²

Another case, *Virginia Academy of Clinical Psychologists v. Blue Shield*,³²³ although it did not involve a staff privilege denial, is illustrative of the kind of reasoning which might be used by courts in applying the Group Boycott Rule to class-based privilege denials. In *Blue Shield*, the Fourth Circuit held that defendant insurer's refusal to reimburse policyholders for services provided by psychologists violated the Sherman Act.³²⁴ The challenged insurance plans provided reimbursement for psychologist services only when those services were administered under the supervision of a physician.³²⁵ The court found that administration of the insurance plan was controlled by physicians and psychiatrists.³²⁶ The provision in the plan which excluded psychologist services from coverage was in fact an agreement by members of the controlling group designed to eliminate competition from the psychologists.³²⁷ Accordingly, the court held that the insurance plan violated the Sherman Act.³²⁸

Although *Blue Shield* did not involve staff privileges, it provides useful precedent for cases involving class-based privilege denials. The exclusion of psychologists from the Blue Shield plan put psychologists, as a class, at a competitive disadvantage in attracting patients when compared with other classes of practitioners who were covered by the Blue

³¹⁷ *Silver v. New York Stock Exchange*, 373 U.S. 341, 358 (1963).

³¹⁸ *Id.* at 364.

³¹⁹ 524 F. Supp. 433 (M.D. Pa. 1981).

³²⁰ *Id.* at 442.

³²¹ *Id.* at 440.

³²² *Id.* at 440-41.

³²³ 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).

³²⁴ *Id.* at 486.

³²⁵ *Id.* at 484.

³²⁶ *Id.* at 481. In fact, the Court noted, Virginia law required that a majority of the board of directors be "health care providers." *Id.* at 480. In addition, the bylaws of one of the challenged plans provided that a majority of the board be physicians. *Id.* Accordingly, ultimate authority on all major policy decisions rested with physicians.

³²⁷ *Id.*

³²⁸ *Id.* at 486.

Shield plan. Similarly, the exclusion of a class of practitioners from access to hospital facilities forces the excluded practitioners into a similar competitive disadvantage.³²⁹ In addition, the administration of the Blue Shield plan, like the administration of staff privileges, is based on recommendations from an advisory board made up of practitioners. The recommendation by such an advisory board of a rule which places an entire class of the board's competitors at a disadvantage should be scrutinized carefully by antitrust courts. The *Blue Shield* court's willingness to find a violation in this situation may influence future court decisions involving class-based privilege denials.

2. Contract-based Privilege Denials

A hospital will often contractually grant a practitioner or group of practitioners the exclusive right to practice their specialty at the hospital.³³⁰ By offering exclusive contracts, the hospital is able to attract well-known practitioners to the medical staff, and insure the loyalty of practitioners on the staff who are threatening to leave the hospital.³³¹ Exclusive contracts can take many forms. The contract may be expressed in a writing signed by both parties.³³² More commonly, however, the hospital board will adopt a by-law which restricts the granting of new privileges in a given specialty to practitioners who join the existing practice group.³³³ In other instances, hospitals grant *de facto* exclusive privileges by allowing decisions concerning all privilege applicants in a given specialty to be made entirely on the recommendation of a staff practitioner group in that specialty.³³⁴ This arrangement allows the staff practitioner group to restrict the granting of privileges to applicants who join their practice group, thereby effectively maintaining an exclusive contract.

Cases involving contract-based privilege denials should be controlled by *Klor's v. Broadway-Hale Stores*.³³⁵ In *Klor's*, the Supreme Court held that parties to a boycott agreement need not be on the same level of production.³³⁶ *Klor's* involved a large appliance dealer who used his market power to force many of the local appliance distributors to refuse to supply a competing dealer.³³⁷ As a result of the boycott, the competing dealer had difficulty obtaining merchandise.³³⁸ At trial, the defendant

³²⁹ See *supra* text accompanying notes 75-90.

³³⁰ See *supra* note 148 and accompanying text.

³³¹ See *supra* text accompanying notes 112-18.

³³² See, e.g., *Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1348 (7th Cir. 1982).

³³³ Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 CUM. L. REV. 684, 700-02 (1979).

³³⁴ See, e.g., *Robinson v. McGovern*, 521 F. Supp. 842, 851-52, 860-62 (W.D. Pa. 1981), *appeal docketed*, No. 81-2726 (3d Cir. 1981).

³³⁵ 359 U.S. 207 (1959). *But see* *Hyde v. Jefferson Parish Hosp.*, 686 F.2d 286 (5th Cir. 1982), *cert. granted*, ___ U.S. ___, 51 U.S.L.W. 3649 (1983). In *Hyde*, plaintiff, an anesthesiologist, challenged a hospital's exclusive contract with an anesthesiology group as a *per se* illegal "tying arrangement" rather than a group boycott. *Id.* at 289. A tying arrangement is "an agreement by a party to sell one product, but only on the condition that the buyer purchase a different (or tied) product." *Id.* (quoting *Northern Pacific Railway v. United States*, 356 U.S. 1, 5 (1958)). The Fifth Circuit, reversing the court below, found that the effect of the exclusive contract was in fact to tie the purchase of the contract group's anesthesiology services to the purchase of the defendant hospital's services. *Id.* at 289-90, and that such an arrangement was a *per se* violation. *Id.* at 293-94.

³³⁶ *Klor's v. Broadway Hale Stores*, 359 U.S. 207, 214 (1959).

³³⁷ *Id.* at 210.

³³⁸ *Id.*

appliance dealer asserted that because there was no single agreement between the distributors, only separate agreements between each distributor and the defendant appliance dealer, there was no collective refusal to deal.³³⁹ In rejecting this argument, the Court reasoned that the challenged restraint of trade in *Klor's* was indistinguishable in purpose and effect from group boycotts involving a single agreement between industry participants on the same level of production.³⁴⁰ Accordingly, the Court held, a series of separate boycott agreements between industry participants at different levels of production, such as the arrangement in *Klor's*, constituted a group boycott.³⁴¹

Courts should strike down contract-based privilege denials on similar grounds. Contract-based privilege denials are similar in purpose and effect to the boycott held illegal in *Klor's*. In *Klor's*, a retailer used its market power to induce suppliers to boycott the retailer's competitor.³⁴² As a result of the boycott, the competitor had difficulty obtaining merchandise and was put at a competitive disadvantage.³⁴³ Similarly, in the case of a contract-based privilege denial, a practitioner or practitioner group uses its market power, its ability to attract patients to the hospital, to induce the hospital board and medical staff to boycott a competing practitioner.³⁴⁴ Since staff privileges would provide the applicant-practitioner a vital source of new patients,³⁴⁵ the practitioner, like the target competitor in *Klor's*, is put at a competitive disadvantage.³⁴⁶ Since a contract-based privilege denial is indistinguishable in purpose and effect from the boycott in *Klor's*, courts should hold these denials to be group boycotts.

Courts may not find *Klor's*, which involved a concerted refusal to deal by several appliance manufacturers, controlling in cases involving contract-based privilege denials. A contract-based privilege denial involves only a unilateral refusal to deal by a single hospital. A unilateral refusal to deal is not a *group* boycott.³⁴⁷ Since it is based on an agreement between the hospital board and a single practice group, rather than between the hospital board and the entire medical staff, the alleged boycott agreement involves only unilateral action by the hospital board, rather than joint action by competing practitioners on the medical staff. Accordingly, based on this reasoning, some courts might find that the group boycott theory which applied in *Klor's* is inapplicable here.

The view that *Klor's* should not apply to contract-based privilege denials because these denials, unlike the boycott in *Klor's*, involve only unilateral refusals to deal, is plausible. Courts should, however, reject this view because it ignores the inevitable role played by the hospital medical staff in all privilege decisions.³⁴⁸ Hospital by-laws virtually never permit the hospital board to act unilaterally on privilege matters.³⁴⁹ Conflicts between the hospital board and medical staff concerning privilege administration generally are resolved by a joint board-staff committee.³⁵⁰ Thus, all privilege related decisions, including the establishment of exclusive contracts, are approved, at least implicitly, by the

³³⁹ *Id.*

³⁴⁰ *Id.* at 214.

³⁴¹ *Id.*

³⁴² *Id.* at 210.

³⁴³ *Id.*

³⁴⁴ See *supra* text accompanying notes 330-34.

³⁴⁵ See *supra* text accompanying notes 75-90.

³⁴⁶ *Id.*

³⁴⁷ See *supra* note 214.

³⁴⁸ See *supra* text accompanying notes 66-72.

³⁴⁹ *Id.*

³⁵⁰ See *supra* note 69 and accompanying text.

medical staff. When the medical staff approves these contracts, they are in effect agreeing to boycott collectively certain privilege applicants.³⁵¹ Thus, a contract-based privilege denial entails a collective boycott by staff practitioners of a competing practitioner. Such a boycott falls squarely under *Klor's*.

The applicability of *Klor's* to contract-based privilege denials should not be limited to cases where the plaintiff produces evidence of an explicit exclusivity agreement or hospital by-law. Under *United States v. General Motors Corporation*,³⁵² proof of an explicit boycott agreement is unnecessary where a plaintiff can prove a pattern of joint action which implies a boycott agreement.³⁵³ Accordingly, a plaintiff will be able to establish the existence of a *Klor's*-type boycott merely by showing a pattern of repeated privilege denials to all applicants in a given specialty. Such a pattern would imply the existence of a *de facto* exclusive contract which is no less a group boycott than a similar explicit agreement.³⁵⁴

Until recently, plaintiffs challenging contract-based privilege denials uniformly ignored the boycott theory.³⁵⁵ This trend should change following the recent district court decision in *Robinson v. McGovern*.³⁵⁶ Although the *Robinson* court held that plaintiff failed to establish, by a preponderance of evidence, the existence of a *de facto* exclusive privilege contract,³⁵⁷ the court expressed a willingness to treat such a contract as a group boycott if the existence of the contract were established.³⁵⁸ *Robinson* involved the denial of staff privileges to a cardiothoracic surgeon.³⁵⁹ The surgeon alleged that the hospital board and medical staff granted a practice group in cardiothoracic surgery *de facto* exclusive privileges by allowing the head of the group to control privilege administration to all cardiothoracic surgeon privilege applicants.³⁶⁰ The plaintiff's case failed because he could not establish a pattern of repeated privilege denials to all cardiothoracic surgeon applicants.³⁶¹ In fact, the majority of these applicants had been granted staff privileges.³⁶² Nevertheless, the willingness of the court to entertain the plaintiff's *de facto* contract theory should be useful in future contract-based privilege denial cases.

3. Retaliatory Privilege Denials

Privilege applicants are sometimes denied staff privileges because they engage in an activity that members of the hospital medical staff wish to curtail.³⁶³ For example,

³⁵¹ The medical staff is agreeing to deny privileges to all applicants in the specialty that is subject to the exclusive contract.

³⁵² 384 U.S. 127 (1966). See *supra* text accompanying notes 271-86.

³⁵³ *United States v. General Motors Corp.*, 384 U.S. at 142.

³⁵⁴ *Id.*

³⁵⁵ See Annot., 74 A.L.R.3d 1268 (1976). The recent Fifth Circuit decision in *Hyde v. Jefferson Parish Hosp.*, 686 F.2d 286 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983) (discussed *supra* at note 335), adopting a tying arrangement *per se* theory in an exclusive contract privilege case, suggests that a tying arrangement theory is a strong alternative to a boycott theory in this factual situation. The ultimate viability of the tying theory will depend on the outcome of the Supreme Court review.

³⁵⁶ 521 F. Supp. 842 (W.D. Pa. 1981), *appeal docketed*, No 81-2726 (3d Cir. 1981).

³⁵⁷ *Id.* at 907.

³⁵⁸ *Id.* at 904-07.

³⁵⁹ *Id.* at 848.

³⁶⁰ *Id.* at 904-07.

³⁶¹ *Id.* at 912-13.

³⁶² *Id.*

³⁶³ See *supra* text accompanying notes 155-57.

practitioners who associate with a health maintenance organization³⁶⁴ or an outpatient abortion clinic³⁶⁵ are sometimes denied privileges merely because the medical staff disapproves of those organizations. By denying the applicant privileges, the medical staff hopes to coerce the applicant to discontinue his association with the disapproved organization.³⁶⁶ In addition, the medical staff hopes to deter other practitioners from becoming involved with these organizations.³⁶⁷ The ultimate goal of such a policy is to make it impossible for the disapproved organization to attract needed practitioners, and thereby force the organization to cease operations.³⁶⁸

To prove that a privilege denial is retaliatory, a plaintiff might establish a pattern of previous denials to all privilege applicants who associated with the disapproved organization. Alternatively, a plaintiff might establish that his qualifications met or exceeded the standards used to evaluate other applicants, and that all other applicants with the plaintiff's credentials who were not associated with the disapproved organization were granted privileges. In some cases, the medical staff might admit that the privilege denial was retaliatory, but claim that the action was justified to eliminate a substandard health care institution.³⁶⁹

Once a plaintiff has established that the privilege denial was retaliatory, *United States v. General Motors*³⁷⁰ should control. In *General Motors*, the Supreme Court held that a boycott agreement could be implied by the parties' behavior even absent evidence of an explicit agreement.³⁷¹ The case involved an attempt by several authorized Chevrolet dealers, in combination with General Motors, to eliminate non-authorized dealers.³⁷² On the insistence of the complaining dealers, General Motors notified all authorized dealers that they would lose their authorization if they continued to sell cars to unauthorized dealers.³⁷³ The authorized dealers policed themselves to insure compliance with the regulation.³⁷⁴ The defendants asserted that since there was no evidence of an explicit boycott agreement either between the complaining dealers and General Motors, or among the dealers themselves, there was no concerted refusal to deal.³⁷⁵ Rejecting this argument, the Court reasoned that independent, "parallel" refusals to deal were essentially similar to a concerted refusal to deal and amounted to group boycott.³⁷⁶

The boycott found illegal in *General Motors* is structurally analogous to a retaliatory privilege denial. In *General Motors*, certain authorized dealers, in combination with General Motors, threatened to revoke the authorization of all authorized dealers who participated in the disapproved practice.³⁷⁷ Similarly, in the case of retaliatory privilege denials,

³⁶⁴ See *supra* note 155.

³⁶⁵ See, e.g., *Barr v. National Right to Life Comm.*, 1981-2 Trade Cas. (CCH) ¶ 64,315 (M.D. Fla. 1981).

³⁶⁶ *Id.* at 74,407.

³⁶⁷ *Id.*

³⁶⁸ See, e.g., *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530, 535-38 (1978), *cert. denied*, 444 U.S. 924 (1979).

³⁶⁹ See, e.g., *Barr v. National Right to Life Comm.*, 1981-2 Trade Cas. (CCH) ¶ 64,315 at 74,410 (M.D. Fla. 1981).

³⁷⁰ 384 U.S. 127 (1966). See *supra* text accompanying notes 271-86.

³⁷¹ *United States v. General Motors Corp.*, 384 U.S. at 142.

³⁷² *Id.* at 133-39.

³⁷³ *Id.*

³⁷⁴ *Id.* at 138.

³⁷⁵ *Id.* at 144.

³⁷⁶ *Id.*

³⁷⁷ *Id.* at 133-39.

certain authorized hospital users, in combination with the hospital, deny authorization to practitioners who participate in the disapproved practice.³⁷⁸ Moreover, the purpose of the boycott in *General Motors* is identical to the purpose of a retaliatory privilege denial — to eliminate the disapproved practice.³⁷⁹ An essentially similar structure and purpose should make retaliatory privilege denials group boycotts under *General Motors*.

Courts may not find *General Motors* controlling in cases involving retaliatory privilege denials because the actors in *General Motors*, the authorized dealers, competed for business directly with the targets of the boycott, the unauthorized dealers.³⁸⁰ The boycott in *General Motors*, therefore, clearly was designed to eliminate competition.³⁸¹ With retaliatory privilege denials, however, the actors, members of the medical staff, do not compete for business directly with the targets of the boycott, the disapproved health care organizations. Rather, members of the medical staff compete for business with the practitioners at the disapproved organizations, not the organizations themselves. If the alleged boycott is successful, the organizations will cease to exist. The practitioners formerly associated with the organizations, however, will continue to compete for business directly with members of the medical staff. The retaliatory privilege denial, therefore, unlike the boycott in *General Motors*, is not designed to eliminate competition.

The view that *General Motors* should not apply to retaliatory privilege denials because these denials, unlike the boycott in *General Motors*, are not designed to eliminate direct competitors, is plausible. Courts should, however, reject this view because although the boycott in that case was in fact designed to eliminate competition, this element is not necessary to the boycott offense. Under *Kieffer-Stewart v. Joseph E. Seagram & Sons*,³⁸² boycotts designed to coerce competitors into changing their trade practices are no more permissible than boycotts designed to eliminate competitors.³⁸³ Retaliatory privilege denials are, in fact, efforts by members of the medical staff to coerce competing practitioners to stop offering certain disapproved services to patients.³⁸⁴ Members of the medical staff accomplish this end by eliminating the organizations through which the practitioners offer the disapproved services. Thus, for example, the medical staff may seek to eliminate a health maintenance organization in order to coerce practitioners to offer their services only on a fee-for-service basis. Similarly, the medical staff may seek to eliminate outpatient abortion clinics to coerce practitioners to offer abortion services only in the traditional hospital setting. Since "coercion boycotts" are no more permissible than "elimination boycotts,"³⁸⁵ retaliatory privilege denials fall within the contours of the boycott offense developed in *General Motors* and *Kieffer-Stewart*.

There are no cases involving retaliatory privilege denials in which the plaintiff has asserted the Group Boycott theory. Nevertheless, a recent Fifth Circuit decision, *Feminist Women's Health Center v. Mohammad*,³⁸⁶ may open the door for future application of the boycott theory to retaliatory privilege denials. In *Mohammad*, an outpatient abortion clinic asserted that members of the obstetrics-gynecology staff, or "OB-GYN" staff, at the local

³⁷⁸ See *supra* text accompanying notes 363-68.

³⁷⁹ Compare *supra* text accompanying notes 363-68 with *supra* text accompanying notes 271-86.

³⁸⁰ *United States v. General Motors Corp.*, 384 U.S. 127, 133-39 (1966).

³⁸¹ *Id.*

³⁸² 340 U.S. 211 (1951).

³⁸³ *Id.* at 214.

³⁸⁴ See *supra* text accompanying notes 363-68.

³⁸⁵ *Kieffer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 214 (1951).

³⁸⁶ 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

hospital had conspired to force the clinic to cease operations.³⁸⁷ The clinic introduced evidence that members of the OB-GYN staff harassed every physician who became involved with the clinic.³⁸⁸ The harassment was intended to coerce, and did coerce, all physicians associated with the clinic to discontinue their involvement.³⁸⁹ The district court, after concluding that plaintiff's allegations, if true, would suffice to establish a group boycott,³⁹⁰ granted summary judgment for defendants on the basis of the *Noerr-Pennington* doctrine, which exempts from antitrust scrutiny genuine efforts by private parties to influence government bodies.³⁹¹ The court of appeals reversed,³⁹² holding that the district court improperly applied the *Noerr-Pennington* doctrine.³⁹³ The case was then remanded for a full trial concerning the plaintiff's boycott claims.³⁹⁴ Significantly, the court of appeals noted that *per se* treatment of the case would be proper if the plaintiff's allegations of intimidation and coercion by the OB-GYN staff were substantiated.³⁹⁵

If a practitioner involved with the Feminist Women's Health Center had applied for staff privileges, the alleged coercion boycott in *Mohammad* might well have involved a retaliatory privilege denial. The fact that no privilege denial occurred should not detract from the applicability of the *Mohammad* court's holding to coercion boycott cases which do involve retaliatory denials.

4. Merit-based Denials

All privilege denials involve a concerted refusal to deal with the applicant practitioner by members of the medical staff.³⁹⁶ Accordingly, the assumption underlying the boycott theory, that concerted refusals to deal are rarely justifiable,³⁹⁷ supports the application of the boycott theory to all privilege denials. Nevertheless, there is no boycott case precedent which supports the application of the theory to privilege denials which are genuinely merit-based.³⁹⁸ Moreover, in *Silver v. New York Stock Exchange*,³⁹⁹ the Supreme Court indicated a willingness to except from the boycott rule legitimate instances of industry self-regulation, provided the regulation was administered fairly and incorporated procedural safeguards.⁴⁰⁰ A genuine merit-based privilege denial in which the applicant was afforded procedural due process might well pass muster under *Silver*.

³⁸⁷ *Id.* at 535-38.

³⁸⁸ *Id.*

³⁸⁹ *Id.*

³⁹⁰ 415 F. Supp. 1258, 1267 (N.D. Fla. 1976), *rev'd on other grounds*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

³⁹¹ *Id.* at 1268. See *supra* text accompanying notes 184-95.

³⁹² 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

³⁹³ *Id.* at 542.

³⁹⁴ *Id.* at 457.

³⁹⁵ *Id.*

³⁹⁶ See *supra* text accompanying notes 66-72.

³⁹⁷ *Fashion Originators' Guild of America, Inc. v. Federal Trade Comm.*, 312 U.S. 457, 468 (1941).

³⁹⁸ For examples of cases denying the boycott theory in this situation, see *Moles v. Morton F. Plant Hosp.*, 617 F.2d 293 (5th Cir. 1980), *cert. denied*, 449 U.S. 919 (1980); *Everhart v. Jane Stormont Hosp.*, 1982-1 Trade Cas. (CCH) ¶ 64,703 (D. Kan. 1982).

³⁹⁹ 373 U.S. 341 (1963).

⁴⁰⁰ *Id.* at 359-66. The Court suggested some sort of internal administrative review of regulatory decisions, if sufficiently stringent to insure fairness to those affected by the regulation, might be a sufficient procedural safeguard. *Id.*

Lower courts uniformly have upheld privilege denials when the applicant practitioner fails to demonstrate that the denial was not merit-based.⁴⁰¹ Given the weight of these decisions, and the Supreme Court's dicta in *Silver*, the boycott theory is unlikely to be useful to victims of genuine merit-based denials.

In summary, courts should find the leading boycott precedent applicable to class-based, contract-based, and retaliatory privilege denials. Accordingly, courts should apply the Group Boycott Rule to cases involving these types of privilege denials. Strictly speaking, courts should also apply the rule to merit-based denials. This application of the Rule is unlikely, however, since it contravenes the great weight of current authority.

IV. *PER SE* ILLEGALITY OF PRIVILEGE DENIALS INVOLVING GROUP BOYCOTTS

The preceding sections examined various types of privilege denials to determine which denials constituted group boycotts. This section focuses on the procedural effect of a finding that a particular privilege denial is a group boycott. The central question in this section is whether privilege denials which constitute group boycotts are *per se* violations of the Sherman Act. Clearly, boycotts which occur in non-professional industries are *per se* violations.⁴⁰² Thus, a finding that a particular activity in a non-professional industry is a group boycott raises a conclusive presumption that the activity violates the Sherman Act.⁴⁰³ Within the professions, however, there has been considerable controversy over the procedural effect of a group boycott finding.⁴⁰⁴ In particular, courts have differed over whether *per se* rules apply to the professions, or whether all professional activities should be accorded a full "Rule of Reason" analysis.⁴⁰⁵

Uncertainty over the applicability of *per se* rules to the professions has resulted in a tendency by lower courts to accord all staff privilege denials a full "Rule of Reason" analysis, even where the denials amounted to group boycotts.⁴⁰⁶ The roots of this tendency lie in two Supreme Court cases in which price fixing by the professions was not explicitly treated as a *per se* offense.⁴⁰⁷ It is the absence of *per se* language in these cases that has led most courts and commentators to conclude that the professions are exempt from the *per se* rules.⁴⁰⁸

⁴⁰¹ See *supra* note 23 and accompanying text.

⁴⁰² See *supra* text accompanying notes 219-94.

⁴⁰³ See *supra* text accompanying notes 206-207 and note 207.

⁴⁰⁴ See, e.g., *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir. 1977), *cert. denied*, 434 U.S. 825 (1977) (professions exempt from *per se* rules); *Viezaga v. National Board for Respiratory Therapy*, 1977-1 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill. 1977) (suggestion that *per se* rules apply only to commercial activity of professionals); *Bauer, Professional Activities and Antitrust Laws*, 50 NOTRE DAME LAW. 570, 584-92 (1975) (professions exempt from *per se* rules); *Liebenheft & Pollard, Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927 (1981) (*per se* violations by professions should be only presumptively illegal to allow procompetitive self-regulation if there is no less restrictive alternative); *Note, Antitrust and Non-Profit Entities*, 94 HARV. L. REV. 802 (1981) (special test for professions which would permit anticompetitive acts that are intended to correct for market failures); *Note, The Professions and Non-Commercial Purposes*, 11 U. MICH. J.L. REF. 387 (1978) (professions exempt from *per se* rules).

⁴⁰⁵ See, e.g., *Everhart v. Jane Stormont Medical Soc'y*, 1982-1 Trade Cas. (CCH) ¶ 67,703 at 73,897 (D. Kan. 1982) and cases cited therein (*per se* rules do not apply to the professions); *but see* *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530, 547 (8th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (*per se* rules apply to professions in some situations).

⁴⁰⁶ See, e.g., *Everhart*, 1982-1 Trade Cas. (CCH) at 73,897-98.

⁴⁰⁷ *National Soc'y of Professional Engineers v. United States*, 435 U.S. 679 (1978); *Goldfarb v. Virginia State Bar Ass'n*, 921 U.S. 773 (1975).

⁴⁰⁸ See *supra* notes 404-05.

Until the landmark decision of the Supreme Court in *Goldfarb v. Virginia State Bar*,⁴⁰⁹ practice of the learned professions was not considered "trade or commerce" within the meaning of the Sherman Act.⁴¹⁰ Consequently, the learned professions enjoyed complete immunity from Sherman Act scrutiny.⁴¹¹ In *Goldfarb*, the Court held that professional activity is not exempt from the Sherman Act,⁴¹² and that a mandatory fee schedule published by a state bar association violates the Act.⁴¹³ The *Goldfarb* Court reasoned that the practice of law has a "business aspect."⁴¹⁴ The language of the Sherman Act clearly manifests an attempt by Congress to bring activity under the Act.⁴¹⁵ There is no reason, therefore, to assume that Congress intended the practice of law to be exempt from the Act.⁴¹⁶ Accordingly, no such exemption for the law, or any other profession, should be read into the Sherman Act by the courts.⁴¹⁷

Although the *Goldfarb* Court clearly rejected the notion of a blanket Sherman Act exemption for the professions, the Court added the following dictum:

It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.⁴¹⁸

The Court's observation implies that certain professional activities might still enjoy a limited exemption from the Sherman Act. In addition, the dictum implies that antitrust analysis of professional activity might differ from antitrust analysis of industrial and commercial activity. In fact, the analysis applied by the Court in *Goldfarb* seemed to differ somewhat from the analysis it had applied in past cases involving price fixing by groups in other industries.⁴¹⁹

Price fixing has long been considered a *per se* offense.⁴²⁰ The *Goldfarb* opinion, however, never mentioned the *per se* rule against price fixing. Nevertheless, the Court seemed to adopt a *per se* approach, since "procompetitive" justifications for the price fixing scheme were not discussed as they would have been under the alternative "Rule of Reason" balancing approach. In essence, the *Goldfarb* Court did not clearly apply either of the traditional Sherman Act analyses. This fact, together with the Court's dictum that the professions might be "treated differently" for antitrust purposes from other industries,⁴²¹

⁴⁰⁹ 421 U.S. 773 (1975).

⁴¹⁰ See *Atlantic Cleaners & Dryers, Inc. v. United States*, 286 U.S. 427, 436 (1932); *Federal Trade Comm. v. Radam Co.*, 283 U.S. 643, 653 (1931); but see *United States v. National Ass'n of Real Estate Boards*, 339 U.S. 485, 492 (1950).

⁴¹¹ *Dolan & Ralson*, *supra* note 5, at 735.

⁴¹² *Goldfarb v. Virginia State Bar Ass'n*, 421 U.S. 773, 789 (1976).

⁴¹³ *Id.*

⁴¹⁴ *Id.* at 788.

⁴¹⁵ *Id.*

⁴¹⁶ *Id.* at 789.

⁴¹⁷ *Id.*

⁴¹⁸ *Id.* at 788 n.17.

⁴¹⁹ Compare *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940) with *Goldfarb v. Virginia State Bar Ass'n*, 421 U.S. 773, 785 (1976).

⁴²⁰ *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940).

⁴²¹ *Goldfarb v. Virginia State Bar Ass'n*, 421 U.S. 773, 788 n.17 (1976).

first spawned uncertainty among lower courts and commentators concerning the applicability of the *per se* rules to anticompetitive activity by the professions.⁴²²

The next case to come before the Court involving Sherman Act violations by the professions, *National Society of Professional Engineers v. United States*,⁴²³ added to the confusion over the proper Sherman Act analysis for professional activity.⁴²⁴ In *Engineers*, the Court affirmed a circuit court decision⁴²⁵ which held that the Society's ban of competitive bidding was *per se* illegal.⁴²⁶ Nevertheless, as in *Goldfarb*, the Court did not explicitly use either a *per se* or a "Rule of Reason" analysis.⁴²⁷

The petitioners in *Professional Engineers* admitted that their ban of competitive bidding restrained price competition among engineers.⁴²⁸ The petitioners claimed, however, that such a restraint was justified because price competition would harm the quality of engineering services, and thereby threaten public safety.⁴²⁹ The central issue addressed by the Court was whether this argument was admissible. The Court reasoned that the petitioners' argument amounted to the claim that competition itself is undesirable in this context.⁴³⁰ Since the assumption underlying the Sherman Act is that free competition is always desirable,⁴³¹ the petitioner's claim amounted to "frontal assault on the basic policy of the Sherman Act."⁴³² The Court held, therefore, that petitioner's argument failed under any Sherman Act analysis.⁴³³ This holding made it unnecessary for the Court to specify whether a *per se* or a "Rule of Reason" analysis should be applied to price fixing arrangements by the professions. As a result, uncertainty remained as to the applicability of the *per se* rules to professional activity.

Most lower courts and commentators read *Goldfarb* and *Professional Engineers* as exempting the professions from the *per se* rules.⁴³⁴ Consequently, staff privilege denial cases were analyzed under the "Rule of Reason" even where the court acknowledged that the privilege denial was a group boycott.⁴³⁵ These courts reasoned that the professions were exempt from the *per se* rules because antitrust analysis of professional activity was relatively new.⁴³⁶ A lack of knowledge concerning the inner workings of the professions made it impossible for courts to predict the effects that a particular restraint of trade would have on professional services.⁴³⁷ Since courts could not predict the effects of particular restraints, a full "Rule of Reason" analysis of these restraints was necessary to determine what effects the restraints would have.⁴³⁸ Under this line of reasoning, then, a

⁴²² See *supra* notes 404-05 and accompanying text.

⁴²³ 435 U.S. 679 (1978).

⁴²⁴ See Kissam, *supra* note 10, at 644 n.239.

⁴²⁵ *United States v. National Soc'y for Professional Engineers*, 555 F.2d 978 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679 (1978).

⁴²⁶ *United States v. National Soc'y for Professional Engineers*, 555 F.2d at 981-84.

⁴²⁷ Kissam, *supra* note 10, at 644 n.239.

⁴²⁸ *United States v. National Soc'y for Professional Engineers*, 435 U.S. 679, 684 (1978).

⁴²⁹ *Id.* at 696.

⁴³⁰ *Id.*

⁴³¹ *Id.*

⁴³² *Id.*

⁴³³ *Id.*

⁴³⁴ See *supra* notes 404-05.

⁴³⁵ See *supra* note 406 and accompanying text.

⁴³⁶ *Everhart v. Jane Stormont Hosp.*, 1982-1 Trade Cas. (CCH) ¶ 64,703 at 73,897.

⁴³⁷ *Id.*

⁴³⁸ *Id.*

"Rule of Reason" rather than a *per se* analysis must be used in all cases involving the professions, including challenges to staff privilege denials.⁴³⁹

In its most recent case involving antitrust violations by the professions, *Arizona v. Maricopa County Medical Society*,⁴⁴⁰ the Supreme Court explicitly rejected the above argument,⁴⁴¹ and held that the medical profession is not exempt from the *per se* rules.⁴⁴² *Maricopa* involved a maximum fee schedule imposed by a county medical society.⁴⁴³ The Medical Society argued that the Sherman Act's *per se* rule against price fixing should not be applied to the medical profession because the judiciary has little antitrust experience with the health care industry.⁴⁴⁴ Until the judiciary knew enough about the health care industry to predict the effect of a particular trade restraint, a *per se* rule, which inevitably incorporates such a prediction, could not be justified.⁴⁴⁵ This argument did not convince the Supreme Court.⁴⁴⁶ The Court reasoned that the necessity of rejustifying *per se* rules for each industry that has not been subject to significant antitrust litigation would undermine the purpose of the *per se* rules.⁴⁴⁷ These rules are designed to avoid complicated judicial inquiries into the nature of the industry involved to determine the competitive effects of the challenged restraint.⁴⁴⁸ If the rules had to be rejustified for each new industry, courts would constantly be making the type of complicated inquiries that the *per se* rules were designed to avoid.⁴⁴⁹ The adoption of a *per se* rule reflects a judgment by the Court, based on experience in many industries, that a particular restraint is almost certain to be unreasonable.⁴⁵⁰ Once such a judgment has been made, the *per se* rule applies uniformly to all industries, including the professions.⁴⁵¹ The Court concluded: "The respondent's arguments against the application of the *Per Se* rules in this case are better directed at the legislature. Congress may consider the exception that we are not free to read into the statute."⁴⁵² This statement seems to imply that no exemption to the *per se* rules will be granted to the professions absent a clear directive by Congress.

Although *Maricopa* involved the *per se* rule against price fixing, the Court's rationale for applying this rule to the medical profession clearly would support the application of the group boycott rule as well.⁴⁵³ The boycott rule, like the price fixing rule, is the result of the Court's judgment that a particular type of trade restraint is almost certain to be unreasonable.⁴⁵⁴ This judgment obviates the need to consider the restraint's effects in the

⁴³⁹ *Id.*

⁴⁴⁰ 457 U.S. 332, 102 S. Ct. 2466 (1982).

⁴⁴¹ *Id.* at 349-50, 102 S. Ct. at 2476.

⁴⁴² *Id.*

⁴⁴³ *Id.* at 339-41, 102 S. Ct. at 2470-71.

⁴⁴⁴ *Id.* at 349, 102 S. Ct. at 2476.

⁴⁴⁵ *Id.*

⁴⁴⁶ *Id.*

⁴⁴⁷ *Id.*

⁴⁴⁸ *Id.* at 351, 102 S. Ct. at 2476-77.

⁴⁴⁹ *Id.*

⁴⁵⁰ *Id.* at 349, 102 S. Ct. at 2476.

⁴⁵¹ *Id.*

⁴⁵² *Id.* at 354-55, 102 S. Ct. at 2478-79.

⁴⁵³ This conclusion is supported by the recent Fifth Circuit decision in *Hyde v. Jefferson Parish Hosp.*, 686 F.2d 286 (5th Cir. 1982), *cert. granted*, — U.S. —, 51 U.S.L.W. 3649 (1983), which held that, under *Maricopa*, the tying arrangement *per se* rule does apply to the medical profession. *Id.* at 293-94.

⁴⁵⁴ *Fashion Originators' Guild of America, Inc. v. Federal Trade Trade Comm.*, 312 U.S. 457, 468 (1941).

particular circumstances of each case.⁴⁵⁵ The utility of the boycott rule, like the price fixing rule, lies in the rule's promotion of judicial economy and business certainty.⁴⁵⁶ This utility would be undercut if the *per se* rules applied to some industries and not others.⁴⁵⁷ Therefore, the boycott rule, like the price fixing rule, must apply to all industries alike.

It is thus fair to conclude that under *Maricopa*, privilege denials which involve group boycotts are *per se* violations. Nevertheless, *Maricopa* did not foreclose the possibility, noted in both *Goldfarb*⁴⁵⁸ and *Professional Engineers*,⁴⁵⁹ that anticompetitive activity which would be illegal for other industries might be justifiable for the professions.⁴⁶⁰ Staff privilege denials might be one of these justifiable activities. Accordingly, an examination of these cases is warranted to determine what types of anticompetitive activities by the professions might be justifiable.

The *Maricopa* Court, citing *Goldfarb* and *Professional Engineers*, implied that anticompetitive practices which legitimately enhance "the quality of professional services" might be permissible.⁴⁶¹ This doctrine seems to open the door for a Sherman Act affirmative defense which is unique to the professions. The affirmative defense would allow the professions to escape liability for anticompetitive practices provided they could establish that the challenged practice legitimately enhanced the quality of professional services.⁴⁶² If such an affirmative defense exists, it is not without some qualifications. Clearly, under *Professional Engineers*, no justification is permitted which incorporates the assumption that competition itself is undesirable.⁴⁶³ Accordingly, justifications based on the enhancement of professional services must be grounded on claims that the challenged practice is desirable despite rather than because of its restraint of competition. In practice, this means a defendant will have to assert that the benefits of the challenged practice in terms of the quality of professional services outweigh the harm caused by the challenged practices in terms of restraints of competition.⁴⁶⁴ Although this analysis sounds like the weighing of effects under the rule of reason,⁴⁶⁵ it is significantly different in two respects. First, under the rule of reason, the negative effects on competition are weighed against the positive effects on competition.⁴⁶⁶ Under the "professional quality" defense, however, the negative effects on competition are weighed against the positive effects on the quality of professional services.⁴⁶⁷ Second, under the "professional quality" defense, it is defendant rather than plaintiff that bears the burden of proof.⁴⁶⁸ Defendant, rather than plaintiff, must demonstrate that the anticompetitive effects of the challenged practice are outweighed by the enhancement of professional services.

⁴⁵⁵ *Arizona v. Maricopa County Medical Ass'n*, 457 U.S. 332, 351 (1982).

⁴⁵⁶ *Id.* at 354.

⁴⁵⁷ *Id.* at 349-51.

⁴⁵⁸ 421 U.S. 773, 788 n.17 (1975).

⁴⁵⁹ 435 U.S. 679, 696 (1978).

⁴⁶⁰ *Arizona v. Maricopa County Medical Ass'n*, 457 U.S. 332, 348-49 (1982).

⁴⁶¹ *Id.*

⁴⁶² *Id.*

⁴⁶³ *United States v. National Soc'y for Professional Engineers*, 435 U.S. 679, 696 (1978).

⁴⁶⁴ Defendant could not assert that the quality of professional services was enhanced because of the lack of competition. This was precisely the argument rejected in *United States v. National Soc'y for Professional Engineers*, 435 U.S. at 696.

⁴⁶⁵ See *supra* text accompanying note 203.

⁴⁶⁶ *Id.*

⁴⁶⁷ *Arizona v. Maricopa County Medical Ass'n*, 457 U.S. 332, 349 (1982).

⁴⁶⁸ Compare *supra* note 202 and accompanying text with *Arizona v. Maricopa County Medical Ass'n*, 457 U.S. 332, 349 (1982).

Another qualification for the "professional quality" defense can be distilled from *Silver v. New York Stock Exchange*.⁴⁶⁹ Under *Silver* restraints which are not narrowly tailored for the particular harm sought to be prevented cannot be justified.⁴⁷⁰ Moreover, if the restraint takes the form of a regulation, it must incorporate procedural safeguards.⁴⁷¹ Restraints which do not meet these requirements could not be justified regardless of their positive effects on the quality of professional services.

The "professional quality" defense would thus allow a defendant to escape Sherman Act liability if the defendant could show:

1. That the anticompetitive effect of the challenged practice was outweighed by enhancement of the quality of professional services;⁴⁷²
2. That the challenged practice was the least anticompetitive way of enhancing professional services;⁴⁷³ and
3. If the challenged practice involved a regulation, that the regulation incorporated procedural safeguards to insure that those negatively affected by the regulation were accorded notice and an opportunity to be heard.⁴⁷⁴

A "professional quality" defense such as the one formulated above would clearly be available to defendants in some privilege denial cases. A defendant would have to demonstrate first that the privilege applicant was accorded procedural due process.⁴⁷⁵ In addition, a defendant would have to show that the challenged privilege denial was merit-based, or, in other words, that the qualifications of the privilege applicant failed to meet hospital standards. Presumably, non-merit-based denials would not meet either the first or second requirements because they in no way enhance the quality of professional services.⁴⁷⁶ An applicant who meets or exceeds all hospital standards cannot be said to detract from the quality of the medical staff. The second requirement is not met for the same reason. Denials which do not eliminate substandard applicants are not tailored to enhance the quality of the medical staff. The defendant hospital board or medical staff, therefore, will prevail under the "professional quality" defense only if it can prove that the challenged privilege denial was, or could have been based on the actual qualifications of the privilege applicant.

In summary, the recent Supreme Court holdings in *Maricopa*, that *per se* rules apply to the health care profession, dictates that privilege denials which involve group boycotts are *per se* illegal. Nevertheless, *Maricopa* implies that an affirmative defense may be available in cases involving merit-based privilege denials. If this defense exists, the procedural effect of a finding that a privilege denial amounts to a group boycott would be to shift the burden of proof to the defendant, who must then establish that the privilege denial enhanced the quality of professional services at the hospital.

⁴⁶⁹ 373 U.S. 341 (1963).

⁴⁷⁰ *Id.* at 358.

⁴⁷¹ *Id.* at 364.

⁴⁷² See *supra* text accompanying notes 461-68.

⁴⁷³ See *supra* text accompanying note 470.

⁴⁷⁴ See *supra* text accompanying note 471.

⁴⁷⁵ *Id.*

⁴⁷⁶ A possible case where non-merit based denials might support a professional quality defense is where an exclusive contract is necessary in order for the hospital to provide a certain patient service. This would be the case, for example, where a smaller rural hospital needed to offer a specialist an exclusive contract in his specialty area in order to attract him to a location which might not provide him with enough patients for a profitable practice in the event he had to compete with other physicians. Similarly, an exclusive contract for the supply of emergency room services might be necessary to insure that a group of physicians will provide services twenty-four hours a day.

V. POTENTIAL IMPACT OF THE GROUP BOYCOTT RULE

This note has demonstrated that the Sherman Act's group boycott rule applies to class-based, contract-based, and retaliatory hospital staff privilege denials. Moreover, the assumption underlying the boycott rule, that concerted refusals to deal unreasonably restrain competition, supports the application of the rule to all staff privilege denials. Under current law, group boycotts are *per se* illegal in all industries, including the professions. Accordingly, a plaintiff challenging a staff privilege denial could use the group boycott rule to avoid the difficult showing, required under the rule of reason, that the anticompetitive effects of the privilege denial outweigh the procompetitive effects. The boycott rule allows a plaintiff to rely on a presumption that concerted refusals to deal unreasonably restrain competition. A plaintiff meets his burden of proof, therefore, merely by demonstrating that the privilege denial amounts to a group boycott. If a plaintiff makes this showing, he will prevail unless the defendant hospital board or medical staff can avail themselves of a "professional quality" defense. The defense might allow the defendant to escape liability for a group boycott if the defendant can show that the boycott legitimately enhanced the quality of professional services.

Use of the boycott rule in privilege denial cases will have a profound effect on privilege administration. If challenged in court, hospital boards and medical staffs will be required to justify privilege denials by demonstrating that the qualifications of the privilege applicant did not meet hospital standards. Consequently, the hospital board and medical staff will be required, as a precautionary measure, to carefully evaluate the qualifications of each applicant practitioner to determine whether the applicant meets hospital standards. This evaluation will bring to light evidence concerning the professional competence of the practitioner. The availability of this evidence may facilitate action against incompetent practitioners at the state licensing level. Hospital boards may be encouraged to turn this evidence over to state licensing boards because an investigation by the latter, and a subsequent removal of the practitioner's license, would take the pressure off the hospital board to grant the practitioner privileges. Thus, incompetent applicant practitioners would have their licenses to practice revoked, rather than be denied staff privileges and allowed to continue practicing. Such a result would clearly benefit the consumer of medical services who generally has no way of assessing a practitioner's competence until it is too late.

In addition to facilitating the elimination of incompetent practitioners, application of the boycott rule to privilege denials would give the consumer of medical services greater freedom of choice in selecting practitioners and hospitals. Because all qualified applicants would be granted staff privileges, the hospital board and medical staff would be unable to restrain competition within the hospital by restricting the number of practitioners with access to hospital facilities. Practitioners would be able to obtain privileges at several hospitals and give their patients a choice. Moreover, patients in any given hospital would have more privileged practitioners to choose from. Competition between practitioners and between hospitals to attract patients would increase, resulting in a greater variety of services and prices available to each patient. This result is precisely what the Sherman Act is designed to achieve. Accordingly, application of the boycott rule in privilege denial cases would clearly be consistent with the aim of the Sherman Act, and in the best interests of the consumer of medical services.

CONCLUSION

This note has assessed the Sherman Act Group Boycott Rule as a potential legal response to anticompetitive practices in current hospital staff privilege administration. The central problem that has been addressed is the denial of staff privileges to licensed applicant practitioners for reasons wholly unrelated to the applicant's qualifications and abilities, reasons such as disapproval of medical organizations in which the applicant participates, discrimination against the applicant's practical discipline, and the existence of an exclusivity agreement between the hospital and a physician practice group which prohibits the hiring of the applicant because he is not a member of the contracting practice group. Courts should find that these types of privilege denials are Group Boycotts under the leading Group Boycott cases. Moreover, courts should conclude that, under a recent Supreme Court case, group boycotts in the context of the medical profession are *per se* violations of the Sherman Act, absent an affirmative showing by the defendant that the challenged restraint is necessary to maintain the quality of professional services. Accordingly, applicants who are denied staff privileges should now be able to use the Group Boycott Rule to shift the burden of proof to the defendant hospital or medical staff to justify the privilege denial. The result of this shift should be to force hospitals to grant privileges to all applicants absent a legitimate, quality-related reason for denying privileges. Consequently, practitioners will have access to the facilities of more hospitals, and hospitals will have more practitioners on their staffs. This change will ultimately benefit the hospital patient. First, since practitioners will have privileges at more hospitals, their patients will have more hospitals to choose from. Hospitals, therefore, will need to compete for these patients by lowering prices and increasing services. Similarly, since hospitals will have more practitioners on their staffs, hospital patients will have more practitioners to choose from. Competition between practitioners, therefore, will also increase. Hence, application of the Group Boycott Rule to staff privilege denials would effectuate the purpose of the Sherman Act by increasing competition and thus benefiting the consumer of medical services.

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