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THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS: PRIVATE REGULATION OF HEALTH CARE AND THE PUBLIC INTEREST

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Recent months have seen a flurry of books and articles examining the relative merits of government regulation or market competition as means of addressing perceived problems in the health care industry.¹ The primary focus of

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¹ For a sampling of the large and growing literature of the health care regulation-competition debate see, generally criticizing regulation and favoring competition or market reform: A. ENTHOVEN, *HEALTH PLAN* (1980) (hereinafter cited as ENTHOVEN, *HEALTH PLAN*); M. FELDSTEIN, *HOSPITAL COSTS AND HEALTH INSURANCE* (1981); C. HAVIGHURST, *DEREGULATING THE HEALTH CARE INDUSTRY* (1982) (hereinafter cited as HAVIGHURST, *DEREGULATION*); F. SLOAN & B. STEINWALD, *INSURANCE, REGULATION, AND HOSPITAL COSTS* (1980); Blumstein & Sloan, "Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?," 34 VAND. L. REV. 849 (1981); Blumstein & Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL., POL'Y & L. 382 (1979); Bovbjerg, *Competition versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965 (1981); Enthoven, *A Competitive Strategy*, 304 NEW ENG. J. MED. 109 (1980); Enthoven, *Consumer Choice Health Plan*, 298 NEW ENG. J. MED. 709 (1978); Havighurst, *Competition in Health Services: Overview, Issues, and Answers*, 34 VAND. L. REV. 1117 (1981) (hereinafter cited as Havighurst, *Competition*); Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSRO's*, 70 NW. U. L. REV. 6 (1975); McClure, *Implementing a Competitive Medical Care System Through Public Policy*, 7 J. HEALTH POL., POL'Y & L. 2 (1982) (hereinafter cited as McClure, *Implementing*); McClure, *Structure and Incentive Problems in Economic Regulation of Medical Care*, 59 MILLBANK MEM. FUND Q. 107 (1981) (hereinafter cited as McClure, *Structure*); Noll, *The Consequences of Public Utility Regulation of Hospitals* in CONTROLS ON HEALTH CARE 25 (Institute of Med. ed., 1975); Pollard, *The Essential Role of Anti-Trust in a Competitive Market for Health Services*, 59 MILLBANK MEM. FUND Q. 256 (1981); generally favoring regulation or counselling caution as to procompetitive reform: Brown, *Competition and Health Cost Containment: Cautions and Conjecture*, 59 MILLBANK MEM. FUND Q. 145 (1981); Dunham, Morone & White, *Restoring Medical Markets: Implications for the Poor*, 7 J. HEALTH POL., POL'Y & L. 488 (1982); Ginzberg, *Procompetition in Health Care: Policy or Fable*, 60 MILLBANK MEM. FUND Q. 386 (1982); Marmor, Boyer & Greenberg, *Medical Care and Pro-Competitive Reform*, 34 VAND. L. REV. 1003 (1981); Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067 (1981); Sigelman, *Palm Reading the Invisible Hand: A Critical Examination of Pro-Competitive Reform Proposals*, 6 J. HEALTH POL., POL'Y & L. 578 (1982);

this debate has been the problem of the high and rapidly rising cost of health care.²

Market reform advocates argue that the excessive cost of health care is largely attributable to structural problems in the health care delivery system and health insurance industry, as well as to government policies that perversely impede competition.³ They contend that health care costs can best be controlled by reintroducing competition into the health care sector through anti-trust enforcement,⁴ reform of health care delivery and health insurance,⁵ and alteration or elimination of anticompetitive government policies and programs.⁶ They reject direct command and control regulation as a means of regulating cost,⁷ arguing that it has not worked when tried,⁸ and indeed cannot work because of basic failures in the regulatory model.⁹

Vladeck, *The Market and Regulation: The Case for Regulation*, 59 MILLBANK MEM. FUND Q. 209 (1981); Weiner, *Reflections on Cost Containment Strategies*, 59 MILLBANK MEM. FUND Q. 269 (1981) (hereinafter cited as Weiner, *Reflections*); Weiner, *Governmental Regulation of Health Care: A Response to Some Criticisms Voiced by Proponents of a "Free Market,"* 4 AM. J. L. & MED. 15 (1978) (hereinafter cited as Weiner, *Governmental*); and collections of essays: AMERICAN MEDICAL ASSOCIATION, NATIONAL COMMISSION ON THE COSTS OF MEDICAL CARE (1978); HOSPITAL COST CONTAINMENT (M. Zubkoff, I. Raskin & R. Hanft eds. 1978); NATIONAL HEALTH INSURANCE (M. Pauly ed. 1980); and A NEW APPROACH TO ECONOMICS OF HEALTH CARE, M. Olson ed. 1981 (hereinafter cited as NEW APPROACH).

² See, e.g., ENTHOVEN, HEALTH PLAN, *supra* note 1, at xv-xvii; HAVIGHURST, DEREGULATING, *supra* note 1, at 25; Blumstein & Sloan, *supra* note 1, at 853; Bovbjerg, *supra* note 1, at 965; Marmor, *supra* note 1, at 1003; Sigelman, *supra* note 1, at 578. Throughout this article "health care" will refer to care or treatment that promotes or restores human health; "medical care" will refer more narrowly to care provided by physicians in accord with traditional medical models.

³ See, e.g., ENTHOVEN, HEALTH PLAN, *supra* note 1, at 16-32; Blumstein & Sloan, *supra* note 1, at 856-58; Bovbjerg, *supra* note 1, at 967-73, 980-93; Havighurst, *Competition*, *supra* note 1, at 1120-25; Cohodes, *Where You Stand Depends on Where You Sit: Musings on the Regulation/Competition Dialogue*, 7 J. HEALTH POL., POL'Y & L. 54, 55-61 (1982); Havighurst & Blumstein, *supra* note 1, at 9-30; McClure, *Structure*, *supra* note 1, at 139-41.

⁴ See, e.g., Blumstein & Sloan, *supra* note 1, at 908-24; Havighurst, *A Comment: The Anti-Trust Challenge to Professionalism*, 41 MD. L. REV. 30 (1981); Havighurst, *Competition*, *supra* note 1, at 1148-49; Pollard, *supra* note 1, at 260-66.

⁵ See, e.g., ENTHOVEN, HEALTH PLAN, *supra* note 1; HAVIGHURST, DEREGULATING, *supra* note 1, at 381-434; Bovbjerg, *supra* note 1, at 976-80; Cohodes, *supra* note 3, at 65-67; Marmor, Boyer & Greenberg, *supra* note 1, at 1016-21.

⁶ See, e.g., HAVIGHURST, DEREGULATING, *supra* note 1, at 92-96; Blumstein & Sloan, *supra* note 1, at 867-86; McClure, *Structure*, *supra* note 1, at 139-41.

⁷ See, e.g., ENTHOVEN, HEALTH PLAN, *supra* note 1, at 93-114; HAVIGHURST, DEREGULATING, *supra* note 1, at 25-50; Blumstein & Zubkoff, *supra* note 1, at 387-93; McClure, *Implementing*, *supra* note 1, at 17-20; McClure, *Structure*, *supra* note 1, at 139-42. As used in this article command/control regulation is government regulation that relies on direct enforcement of regulatory commands, as opposed to, e.g., use of incentives to encourage compliance.

⁸ See, e.g., Blumstein & Sloan, *supra* note 1, at 870-80; SLOAN & STEINWALD, *supra* note 1, at 167-75, 193-96; Steinwald & Sloan, *Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence* in NEW APPROACH, *supra* note 1, at 274.

⁹ See, e.g., ENTHOVEN, HEALTH PLAN, *supra* note 1, at 110-13; P. FELDSTEIN, HEALTH CARE ECONOMICS, 235-42 (1979); McClure, *supra* note 1, at 117-41; Noll, *supra* note 1, at 28-47.

On the other hand, defenders of regulation (some of whom would rather be identified as skeptics of competitive reform)¹⁰ point to the modest successes of some forms of health care regulation¹¹ or argue for new forms of public intervention more responsive to public values.¹² They reject competitive alternatives as inappropriate to and inconsistent with the basic nature of the health care industry,¹³ as conceptually flawed,¹⁴ and, as unresponsive to basic political values which regulation protects, such as public accountability and promotion of distributional equity.¹⁵

It is not surprising that this debate has focused on the issue of health care costs. Recent increases in health care expenditures have been substantial, not only in absolute terms,¹⁶ but also relative to the general inflation rate¹⁷ and to expenditures for other goods and services.¹⁸ Increases in government expenditures on health care have also been dramatic and highly visible.¹⁹

This focus on costs, however, has overshadowed a more traditional concern of health care policy: the quality of health care. To the extent that advocates of procompetitive market reform address the issue of quality, they do so in disparate fashion. Some argue that increased competition would improve quality by making health care delivery more efficient and eliminating excessive and iatrogenic care.²⁰ Others see a continuing minimalist role for regulation to assure that basic standards of quality are maintained.²¹ Some theorize that as the health care market becomes competitive a variety of levels of quality of care

¹⁰ See, e.g., Rosenblatt, *supra* note 1, at 1069.

¹¹ Weiner, *Reflections*, *supra* note 1, at 274-75.

¹² See generally Rosenblatt, *supra* note 1, at 1069, 1108-14.

¹³ See, e.g., Luft, *On the Potential Failure of Good Ideas: An Interview with the Originator of Murphy's Law*, 7 J. HEALTH POL., POL'Y & L. 45 (1982); Marmor, Boyer & Greenberg, *supra* note 1, at 1011-26; Rosenblatt, *supra* note 1, at 1078-88; Sigelman, *supra* note 1, at 583-87; Vladeck, *supra* note 1, at 210-12.

¹⁴ See, e.g., Brown, *supra* note 1, at 174-87; Weiner, *Reflections*, *supra* note 1, at 287-93.

¹⁵ See, e.g., Dunham, Morone & White, *supra* note 1; Rosenblatt, *supra* note 1, at 1108-14; Sigelman, *supra* note 1, at 587-600; Vladeck, *supra* note 1, at 212-14; Vladeck, *The Limits of Regulation: Implications of Alternative Models for the Health Sector* in TOWARD A NATIONAL HEALTH CARE POLICY, 107, 137-40, 144-45 (K. Friedman & S. Rakov eds. 1977).

¹⁶ National Health expenditures have increased from \$26.9 billion in 1960 to \$74.7 billion in 1970 to \$286.8 billion in 1981. 4 HEALTH CARE FINANCING REV., Sept. 1982, at 19-20.

¹⁷ For the 12 month period ending March, 1982, medical care prices increased at a rate of 11.4%. The consumer price index, all items, increased at a rate of 9.5%. *Health Care Financing Trends*, June 1982, at 21.

¹⁸ Health care expenditures consumed 5.3% of the gross national product in 1960; 7.5% in 1970; 9.8% in 1981, 4 HEALTH CARE FINANCING REV., Sept. 1982, at 19-21.

¹⁹ Government expenditures for health programs have increased from \$10.8 billion in 1965 to 122.53 billion in 1981. *Id.* at 31-32. In 1981 they constituted 42.75% of all health care expenditures. *Id.* at 27. Health care expenditures currently consume more than 10% of the federal budget, Executive Office of the President, Office of Management & Budget, *Budget of the United States Government, Fiscal Year 1983*, 3-34 (1972).

²⁰ See, e.g., Enthoven, *Shattuck Lecture: Cutting Costs Without Cutting the Quality of Care*, 298 NEW ENG. J. MED. 1229 (1978).

²¹ See, e.g., Havighurst, *Competition*, *supra* note 1, at 1140; Noll, *supra* note 1, at 46.

could emerge, offering consumers a greater range of choices.²² Finally, a few assert that high health care costs may be the direct result of reliance on excessively high quality medical care (or perhaps on excessively intensive medical care, inappropriately identified as of high quality).²³ Defenders of regulation have even less to say on the issue of quality, though some fault advocates of competition for an excessively narrow and economic reductionist view of quality.²⁴

There are a number of reasons why health care quality and methods of quality control ought to be at the center of the competition/regulation debate. For market reform advocates the following issues of health care quality ought seriously to be considered. First, the ultimate success of a competitive reform strategy may turn largely on whether the public perceives competition as maintaining or threatening the quality of health care.²⁵ Second, quality issues have long been a focus of command and control regulation;²⁶ if market reform advocates depend on a critique of regulatory failures, analysis of regulation of quality should be a fruitful ground for inquiry. Finally, self-regulation has been a pervasive form of quality control in the health care sector;²⁷ and some have

²² See, e.g., HAVIGHURST, DEREGULATING, *supra* note 1, at 305-08.

²³ See, e.g., Blumstein and Havighurst, *supra* note 1, at 20-38; Zubkoff and Blumstein, *The Medical Market Place: Health Policy Formulation in Consideration of Economic Structure* in II AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 88-89.

²⁴ Rosenblatt, *supra* note 1, at 1091-1108.

²⁵ A frequent comment of observers of the health care market is that consumers are more concerned about the quality (or at least the effectiveness) of care they receive than about cost. Blumstein & Sloan, *supra* note 1, at 857; Bovbjerg, *supra* note 1, at 972; Mechanic, *Some Dilemmas in Health Care Policy*, 59 MILLBANK MEM. FUND Q. 1, 3 (1981). Some attribute this to the prevalence of third party payments that anesthetizes patients to the cost implications of health care decisions. Blumstein & Sloan, *supra* note 1, at 856-57; HAVIGHURST, DEREGULATING, *supra* note 1, at 83-84. While there is undoubtedly a great deal of truth in this, it is likely that consumers would remain vitally concerned about the quality of health care even if procompetitive reforms were to be fully implemented.

²⁶ Physician licensing laws, to maintain the quality of practitioners, have existed in the United States since the colonial period and were enacted in all states by 1895. DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 3-8 (1969). The licensure of health care institutions to assure quality came later, but was common by the middle of this century. Lander, *Licensing of Health Care Facilities*, in LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS, 130-33 (R. Roemer & G. McKray eds. 1980). Regulation aimed at cost control, in contrast, is much more recent. The first state certificate of need law was enacted by New York in 1964. The federal government enacted the 1122 Health Planning Program (P.L. 92-603, Title II § 221(a)) 86 Stat. 1386 (codified at 42 U.S.C. § 1320a-1 (1976)) in 1972, and P.L. 93-641 (86 Stat. 2225 (codified at 42 U.S.C. § 300k-300t (1976))), making certificate of need and health planning programs ubiquitous, in 1974. D. SALKEVER & T. BICE, HOSPITAL CERTIFICATE OF NEED CONTROLS: IMPACT ON INVESTMENT, COSTS, AND USE 3, 4 (1979). Professional Standards Review Organizations were established in 1972. 42 U.S.C. § 1320c-1320c-19 (1976 & Supp. IV, 1980). Prospective rate review programs date from around 1970 (most existing programs having been established in the mid 1970's). Coelen & Sullivan, *An Analysis of the Effects of Perspective Reimbursement Programs on Hospital Expenditures*, 2 HEALTH CARE FIN. REV., Winter 1981, 1, 2.

²⁷ Medical associations play a prominent role in licensing and disciplining physicians in a number of states. F. GRAD & N. MARTI, PHYSICIANS' LICENSURE AND DISCIPLINE, 191-200

argued that self-regulation may be anti-competitive.²⁸ Self-regulation based quality control should, therefore, be subjected to close scrutiny by those who favor the promotion of competition.

Defenders of regulation also ought to be concerned about quality control. Just as critics of regulation may look to the effects of quality regulation to establish their theories of regulatory failure, so defenders of regulation may there find evidence of regulatory successes. Further, they legitimately may challenge advocates of market reform to state how adequate quality of health care will be guaranteed if current regulatory structures are swept aside. Finally, the values of public accountability and distributional equity to which defenders of regulation express allegiance, are, if anything, more relevant to concerns of health care quality than to cost control.

This article examines the Joint Commission on Accreditation of Hospitals (JCAH or Commission), the organization which has primary responsibility for regulating the quality of care provided in American hospitals, and to a lesser extent, that provided in nursing homes and other health care facilities. This institution is of particular relevance to the competition-regulation debate for several reasons. First, the institutional medical (hospital and nursing home) sector consumes a majority of health care expenditures and has been a major offender in the dramatic health care cost inflation of recent years.²⁹ It is also the sector that consumes the vast majority of governmental funds expended on health care.³⁰ Second, the JCAH is a private institution governed by representatives of hospitals and physicians, the participants in the health care industry who have the most to lose from competition, and thus should be of particular interest to those who seek to identify and eliminate impediments to competition in the health care industry. Third, the JCAH is a private, non-governmental entity, which wields considerable governmental authority. Those who defend public regulation principally because of its responsiveness to public values

(1979). Certification of medical specialists is a totally private, intraprofessional function. *Id.* at 81; Grad, *The Antitrust Laws and Professional Discipline in Medicine*, 1978 DUKE L.J. 443, 472-77. Medical schools are accredited by the Liaison Committee on Medical Education and hospitals and nursing homes by the Joint Commission on Accreditation of Hospitals, both of which are private, intraprofessional regulatory bodies. Professional Standards Review Organizations, authorized by federal law to review utilization and quality of services delivered recipients of federal medical benefits, are private peer review organizations composed of medical professionals. Control over staff privileges in hospitals, another form of professional self-regulation, is significantly controlled by physicians. *Id.* at 468-72.

²⁸ See Pollard, *supra* note 1, at 265-66; HAVIGHURST, DEREGULATING, *supra* note 1, at 89-91.

²⁹ Hospital and nursing home care consumed \$132.2 of the \$255 billion spent on personal health care in 1981. 4 HEALTH CARE FIN. REV., Sept. 1982, at 20. In the twelve month period ending March 1981, the cost of hospital care increased at a rate of 14.1%, compared to a 10.7% increase for medical care generally. 4 HEALTH CARE FINANCING TRENDS, June 1982 at 13.

³⁰ Federal and state expenditure for hospital and nursing home care in 1981 constituted \$77.7 billion of the \$102.9 billion government spent on personal health care. 4 HEALTH CARE FIN. REV., Sept. 1982 at 27.

must examine seriously whether this particular private regulator is defensible at all.

An examination of JCAH may also be of interest beyond its relevance to health policy. The Reagan Administration, in a dramatic departure from the policies of its predecessors, has proposed a regulatory reform policy that relies on private voluntary standards for government regulation without any requirement for procedural safeguards to assure due process within the standard setting organizations, or any review mechanism to protect the public or competitors.³¹ In that JCAH is a source of voluntary standards, scrutiny of its effects on consumers, competitors and the public may shed light on the wisdom of this policy.

After describing the organization and history of JCAH in section I, this article in sections II and III analyzes JCAH standards and accreditation programs in light of economic analysis of standardization and information. Section IV evaluates the efficacy of governmental standardization and accreditation of the medical care industry as compared to JCAH standardization and accreditation, and also considers whether JCAH should be made to function like a public entity. The final section, section V, discusses legal tools that could be used to reform or supplement JCAH in response to public quality and cost concerns. In particular, section V considers the application of the Sherman Antitrust Act to JCAH standards and accreditation, and also touches upon tort law, federal Medicare law, and the non-delegation doctrine as means of controlling JCAH.

I. THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

A. *Description*

The JCAH is an Illinois Not For Profit Corporation headquartered in Chicago. It is governed by a board composed of twenty-two commissioners³² appointed by the members of JCAH:³³ three by the American College of Physicians (ACP); three by the American College of Surgeons (ACS); one by the American Dental Association (ADA); seven by the American Hospital Association (AHA); and seven by the American Medical Association (AMA).³⁴ An additional Commissioner is appointed by the Commission to serve as a public member.³⁵ The Commissioners meet at least three times a year,³⁶ and designated representatives of the constituent members meet at least once a year.³⁷

³¹ See Proposed Revision to OMB circular A-119, 47 Fed. Reg. 16, 919 (1982).

³² BYLAWS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, art. VI, § 1 (1982).

³³ *Id.* at art. IV, § 1.

³⁴ *Id.* at art. VI, § 1.

³⁵ *Id.*

³⁶ *Id.* at VI, § 7.

³⁷ *Id.* at art. V, § 1.

The purposes of the Commission, as stated in Article One of its by-laws are:

- (a) to establish standards for the operation of hospitals and other health-related facilities and services;
- (b) to conduct survey and accreditation programs that will encourage members of the health professions, hospitals, and other health-related facilities and services voluntarily to:
 - (1) promote high quality of care in all aspects in order to give patients the optimum benefits that medical science has to offer,
 - (2) apply certain basic principles of physical plant safety and maintenance, and of organization and administration of functions for efficient care of the patient,
 - (3) maintain the essential services in the facilities through coordinated effort of the organized staffs and the governing body of the facilities;
- (c) to recognize compliance with standards by issuance of certificates of accreditation;
- (d) to conduct programs of education and research and publish the results thereof which will further the other purposes of the corporation. . . .³⁸

The accreditation of hospitals is the most publicly visible, and probably the most important, function of the JCAH.³⁹ JCAH also, however, accredits child, adolescent, and adult psychiatric facilities; alcoholism and drug abuse facilities;⁴⁰ community mental health service programs;⁴¹ long-term care facilities;⁴² and ambulatory health care services.⁴³

Accreditation decisions are based on standards developed by members of the Commission's four Professional Technical Advisory Committees (PTAC's)⁴⁴ and JCAH staff, and approved by the Board of Commissioners.⁴⁵

³⁸ *Id.* at art. I.

³⁹ See JCAH, ACCREDITATION MANUAL FOR HOSPITALS (hereinafter cited as AMH) (1982).

⁴⁰ See JCAH, CONSOLIDATED STANDARDS MANUAL FOR CHILD, ADOLESCENT, AND ADULT PSYCHIATRIC, ALCOHOLISM, AND DRUG ABUSE FACILITIES (1981).

⁴¹ See JCAH, PRINCIPLES FOR ACCREDITATION OF COMMUNITY MENTAL HEALTH SERVICES PROGRAMS (1979).

⁴² See JCAH, ACCREDITATION MANUAL FOR LONG-TERM CARE FACILITIES (1980).

⁴³ See JCAH, ACCREDITATION MANUAL FOR AMBULATORY HEALTH CARE (1982). JCAH is also currently considering the development of accreditation programs for hospices and for facilities for the developmentally disabled. See *Pilot Test of Proposed Hospice Standards Conducted*, JCAH PERSPECTIVES, July-Aug 1982, at 5 cited as *Director Appointed to Develop Hospice Standards and Guide*, JCAH PERSPECTIVES, Nov-Dec 1981, at 4.

⁴⁴ The PTAC's are responsible for the hospital, ambulatory health care, long-term care and psychiatric facilities accreditation programs. JCAH, MILESTONES OF PROGRESS, A CORPORATE REPORT 22, 23 (1962) (hereinafter cited as MILESTONES).

⁴⁵ AMH, *supra* note 39, at xi; See Affeldt, *JCAH and Voluntary Accreditation*, 39 J. ORAL SURG. Feb. 1981, at 94, 95.

These standards undergo a process of continual review and revision based on input from the PTAC's, accredited institutions, and health care professionals.⁴⁶ The PTAC's include representatives of health care organizations in addition to the members of the JCAH.⁴⁷ The Board is also advised by a Policy Advisory Committee (PAC) composed of representatives of the PTAC's, representatives of organizations involved in the provision of health related services, representatives of other national organizations with interests similar to those of JCAH, and selected individuals.⁴⁸

Accreditation by the JCAH is voluntary. Facilities must request a survey by JCAH staff⁴⁹ who, based on the survey results, recommend to a Committee of the Commissioners for or against accreditation.⁵⁰ To be JCAH accredited a facility must substantially comply with the JCAH standards as a whole, but need not comply, nor even substantially comply, with every JCAH standard.⁵¹ Facilities denied accreditation by the committee may request review by an appeals hearing panel appointed by the president of JCAH, and, ultimately if necessary, review by the Board of Commissioners or by a committee of the Board.⁵² Most facilities that are surveyed receive accreditation: in a recent survey only one percent were denied full or provisional accreditation.⁵³

JCAH does not view accreditation as a public regulatory program, rather JCAH identifies itself as a consultant, paid by and responsible to the medical care industry.⁵⁴ It acts as a quality control consultant to the hospitals that it in-

⁴⁶ AMH, *supra* note 39, at x; Affeldt, *supra* note 45, at 95; McCleary, *Joint Commission on Accreditation of Hospitals: Twenty-Five Years of Promoting Improved Health Care Services*, 34 AM. J. OF HOSP. PHARM. 951, 953 (1977).

⁴⁷ MILESTONES, *supra* note 44, at 22, 23. For example, the hospital accreditation program PTAC includes representatives of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Hospital Administrators, the American College of Obstetricians and Gynecologists, the American Nurses Association, the American Psychiatric Association, the American Society of Anesthesiologists, the Association of American Medical Colleges, the Association of Operating Room Nurses, and the College of American Pathologists, and representatives of the five member programs.

⁴⁸ *Id.* at 22; *Reorganization Sets Future for Voluntary Accreditation*, PERSPECTIVES ON ACCREDITATION, Mar.-Apr. 1979, 1, at 6 (hereinafter "Reorganization").

⁴⁹ AMH, *supra* note 39, at xix.

⁵⁰ *Id.* at xxi, xxii, 199-200.

⁵¹ *Id.* at xvii. Schlicke, *Does the Joint Commission Have a Future*, 63 AM. C. OF SURG., Apr. 1978, at 7, 11.

⁵² AMH, *supra* note 39, at xxii, 200-04.

⁵³ Affeldt, *Voluntary Accreditation in Regulating Health Care: The Struggle for Control* (ed. A. Levin), 33 PROC. ACAD. POL. SCI. 182, 189 (1980). See also *Nursing Home Survey and Certification: Assuring Quality Care, Hearings, Senate Special Comm. on Aging 97th Cong. 2d Sess.* (1982) (hereinafter cited as *Senate Hearings*) (20 hospitals denied JCAH accreditation in 1981). Hospitals can either receive full three year accreditation or accreditation with contingencies requiring follow-up by progress-reports or on-site visits. Affeldt, *What to Expect from New Contingency System*, 56 HOSP. Oct. 16, 1982, at 60.

⁵⁴ *Senate Hearings, supra* note 53, at 103 (testimony of John Affeldt, JCAH President). *Physician Training Facilities and Health Maintenance Organization: Hearings before the Subcomm. on Health of the Senate Committee on Labor & Public Welfare*, 92nd Cong., 2d Sess. 1990 (1972); (Statement of John Porterfield, JCAH director); Crosby, *Accreditation and Associated Quality Assurance Efforts*, 13

spects and provides with confidential reports of deficiencies.⁵⁵ In addition, it provides essential information to physicians and other private certification entities, who rely on JCAH accreditation.⁵⁶ Despite the fact that JCAH considers itself a private consultant, it plays a major role in government regulatory programs. Indeed, although accreditation is in theory voluntary, hospital accreditation is either explicitly or implicitly a requirement for participation in many private or public licensing, certification and financing programs. For example, the federal government relies heavily upon JCAH accreditation for certifying health care facilities for participation in the Medicare program. Section 1864 of the Social Security Act⁵⁷ permits the Secretary of Health and Human Services (HHS) to enter into agreements with state health departments to survey hospitals to determine their compliance with Medicare regulations. But Section 1864 provides,⁵⁸ as an alternative, that if an institution is accredited as a hospital by the JCAH and the hospital authorizes JCAH to release to the Secretary (on a confidential basis) a copy of the most recent accreditation survey of the hospital, then such hospital shall, subject to minor exceptions,⁵⁹ be deemed to comply with Medicare certification requirements for hospitals. These hospitals are said to have "deemed" certification status. JCAH is responsible for monitoring quality in deemed status facilities for the Medicare program, subject only to verification inspections done by state agencies randomly and on the basis of substantial complaints.⁶⁰

PROF. PSYCHOLOGY 132, 133, (1982); Ellis, *Critical Challenges Lie Ahead for New JCAH President*, HOSP. MED. STAFF, Oct. 1977, at 34, 41; Porterfield, *The JCAH: An Assessment of Strengths, Needs, Intentions*, 5 HOSP. MED. STAFF, Feb. 1976, 19, 20; Punch, *JCAH Says it's as Tough as Government Surveyors*, 12 MOD. HEALTH CARE, Sept. 1982, at 38, 40; Schlicke, *supra* note 51, at 12, *but cf.* JCAH's mission and scope statement, MILESTONES, *supra* note 44, at 25 (asserting JCAH's mission to be to "secure for the public an excellence of health care consistent with social and economic considerations.")

⁵⁵ AMH, *supra* note 39, at xxi, xxii, xxiv.

⁵⁶ JCAH also operates educational programs to acquaint medical professionals with JCAH accreditation standards, MILESTONES, *supra* note 44, at 11, *JCAH Education Programs, 1982 Fall/Winter Calendar*, and conducts research, *see* MILESTONES, *supra* note 44, at 9.

⁵⁷ 42 U.S.C. § 1395aa(a) (1976 and Supp. IV, 1980).

⁵⁸ 42 U.S.C. § 1395bb (1976). *See also* 42 C.F.R. 405.1902(a)(2) (1981). Under the regulation a hospital need only authorize the release of the JCAH survey if the hospital is the subject of a validation survey.

⁵⁹ Independent state inspection of accredited facilities is necessary for compliance with utilization review requirements and with any additional requirements promulgated by the Secretary of HHS higher or more specific than JCAH accreditation requirements. 42 U.S.C. § 1395bb (1976).

⁶⁰ The Secretary contracts with state survey agencies to inspect, on a random basis and in response to substantial complaints, JCAH accredited facilities to validate the JCAH accreditation, 42 C.F.R. 405.1901(e) (1981). If facilities are determined, upon state inspection, to be out of compliance with one or more conditions of Medicare participation and a significant deficiency is determined to exist, the hospital will no longer be deemed to meet the conditions of participation and will be subject to full review by the state agency survey. 42 C.F.R. § 405.1901(e)(4)(i) (1981). A significant deficiency will not be determined to exist, however, if (1) JCAH accepts the state survey agency findings of deficiencies and agrees to monitor their correction; (2) the state agency does not justify to HHS the need for continued full review by the state agency; and (3)

While general hospitals are given the option of obtaining Medicare certification either through deemed status based on JCAH accreditation or independent state agency survey, a psychiatric hospital generally must be accredited by the JCAH to participate in the Medicare or Medicaid program.⁶¹ Moreover, Section 1865 also provides that HHS may grant deemed status to skilled nursing facilities and home health agencies to the extent that the Secretary of HHS finds that JCAH accreditation provides "reasonable assurances" that the provisions of the Medicare Act will be met by such institutions.⁶² The Secretary has, under this power, published proposed regulations to grant deemed status to JCAH accredited skilled nursing homes,⁶³ though Congress has passed two moratoria delaying the implementation of these proposed regulations.⁶⁴

To varying degrees, thirty-eight states have also incorporated JCAH standards or accreditation decisions into their licensing programs for health care institutions.⁶⁵ A few states, by statute, regulation, or administrative fiat, deem hospitals to meet state licensure requirements by virtue of their JCAH accreditation.⁶⁶ Other states, by statute or regulation, permit, but do not require the licensure agency to license on the strength of JCAH accreditation.⁶⁷

JCAH in fact provides HHS with periodic reports of progress towards correction. 42 C.F.R. § 405.1901(e)(4)(ii) (1981). Moreover, if the deficiencies, individually or in combination, jeopardize the health and safety of patients or seriously limit the provider's capacity to render adequate care, or if the non-complying facility does not come into compliance within a reasonable period of time, it may be terminated from Medicare participation. 42 C.F.R. § 405.1905, 1907 (1981).

⁶¹ 42 U.S.C. §§ 1395x(f), 1396d(h) (1976). A "distinct part" of a nonaccredited psychiatrist facility may be certified for medicare without JCAH accreditation if HHS determines that it meets requirements equivalent to those of JCAH. 42 U.S.C. § 1395x(f) (1976), 42 C.F.R. 405.1036 (1982). "Distinct part" certification can also be used to establish medicaid eligibility for institutions for mental diseases for persons aged 65 and older, 42 C.F.R. § 440.140(2) (1982), but not for institutions for mental diseases for persons aged 21 and younger.

⁶² 42 U.S.C. § 1395bb (1976).

⁶³ 47 Fed. Reg. 23404, (May 27, 1982) (to be codified at 42 C.F.R. 405, 431, 442, 489, 490).

⁶⁴ Pub. L. No. 97-248 § 135, 96 Stat. 324, 375, places a six month moratorium on the final promulgation of the rule to "provide opportunity for further review, revision or withdrawal" of the proposed regulations, H.R. Rep. 97-760 97th Cong. 2d Sess. 441 (1982). This moratorium has been extended 120 days by Pub. L. No. 276 § 146, 96 Stat. 1186, 1199 (1981). See Robinson, *Congress Stalls HHS Survey Proposal*, 12 MOD. HEALTH CARE, Sept. 1982, at 38. Several Congressional hearings have reviewed the HHS proposal: *Department of Health and Human Services Oversight, Hearings before the Subcomm. on Oversight and Investigations on the House Comm. on Energy and Commerce*, 97th Cong. 2d Sess. (1982); *Nursing Home Inspections; New Jersey, Hearing before House Select Comm. on Aging*, 97th Cong. 2d Sess. (1982) (hereinafter cited as House hearings); *Senate hearings*, *supra* note 53.

⁶⁵ Telephone interview with Eleanor Wagner and Daniel Schuyler, attorneys for JCAH (December 9, 1982). See also MILESTONES, *supra* note 44, at 7 (an earlier source stating 34 states rely on JCAH); *Senate hearings*, *supra* note 53, at 76 (36 states).

⁶⁶ See, e.g., ALA. CODE § 22-21-24 (Supp. 1982); ARIZ. REV. STAT. ANN. § 36-401, 424 (West. Supp. 1982); N.M. STAT. ANN. § 24-1-5 (1978); TEX. STAT. ANN. art. 4437h § 4(a) (Vernon Supp. 1982); NEV. ADMIN. CODE Part II, Chapt. II § 9B.

⁶⁷ CAL. HEALTH & SAFETY CODE § 1282 (1979); OR. REV. STAT. § 441.055(2) (1981). California is reportedly abandoning cooperation with JCAH because of dissatisfaction with JCAH performance. See Plaintiff's and Plaintiff-Intervenor's Trial Brief, 8-10 submitted Oct. 26,

Still others rely on accreditation supplemented with some form of validation program.⁶⁸ Several states require licensed hospitals to meet certain specific JCAH standards, the most common requirement being that hospitals comply with JCAH medical staff privilege standards.⁶⁹ A few states require that state mental hospitals or state university hospitals be JCAH accredited.⁷⁰ Finally, at least two states have insurance laws permitting private health insurance companies to pay for specific forms of care only if the care was provided in a JCAH accredited facility.⁷¹

JCAH hospital accreditation is also relied on by the private health care sector. JCAH accreditation is required for institutions to participate in some Blue Cross plans.⁷² Some professional organizations limit membership to professionals associated with JCAH accredited hospitals.⁷³ Finally, JCAH accreditation is effectively required for hospitals to be approved for residency programs.⁷⁴ As a result of these factors, eighty percent of all acute care hospitals in the United States are JCAH accredited,⁷⁵ including virtually all hospitals with more than twenty-five beds.⁷⁶ This is true despite the expense of "voluntary" accreditation: hospitals must pay \$250 plus \$1,000 per surveyor per day for a survey, a minimum of \$4,250 and often much more.⁷⁷

B. *The Development of the JCAH*

1. The American College of Surgeons Hospital Standardization Program, 1912 Through 1951.

1982 in *Wyatt v. Ireland*, No. 3195-N (M.D. Ala.) (hereinafter cited as *Wyatt Brief*). (*Wyatt v. Ireland*, is part of the ongoing Alabama mental hospital litigation, see *Wyatt v. Strickney*, 344 F. Supp. 373 (M.D. Ala. 1972) *aff'd in part sub. nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). The JCAH has become involved because of a proposal of the defendants to permit JCAH accreditation to substitute, in part, for the earlier system of monitoring imposed by the courts); *Senate hearings, supra* note 53, at 40 (testimony of Mildred Simmons, Deputy Director Cal. Dept. of Health Services).

⁶⁸ VA. CODE § 32.1.125.1(B) (1979); KAN. ADMIN. REGS. Art. 34 § 28-34-2, 28-34-3; La. Admin. Reg. (Hosp.) § 41.

⁶⁹ FLA. STAT. ANN. § 395.065 (West Supp. 1982). R.I. GEN LAWS § 23-17-23 (1979); VT. STAT. ANN. tit. 18 § 1905(9) (1968); N.H. ADMIN. CODE (Hosp) § 2130.

⁷⁰ OHIO REV. CODE ANN. § 5119.10 (Page 1981) represents one such statute.

⁷¹ OHIO REV. CODE ANN. § 1739.061 (Page 1981) 3923.27 (Page 1970); OR. REV. STAT. § 743.412(4)(b), 743.557(2)(b) (1981).

⁷² See F. Hair, *Hospital Accreditation: A Developmental Study of the Social Control of Institutions*, 204-09 (Ph.D. dissertation Vand. U. 1972); I COMPETITION AMONG HEALTH PRACTITIONERS IV-11 (W. Lazarus ed., 1981) (hereinafter cited as W. Lazarus). Schlicke, *American Surgery's Noblest Experiment*, 106 ARCH. SURG. 379, 381 (1973). In 1972, 20 of the 75 Blue Cross plans in the United States required or encouraged JCAH accreditation. F. Hair, *supra*, at 208.

⁷³ Schlicke, *supra* note 72, at 381.

⁷⁴ ESSENTIALS OF ACCREDITED RESIDENCIES IN GRADUATE MEDICAL EDUCATION § 1.4 in 1981-1982 DIRECTORY OF RESIDENCY TRAINING PROGRAMS.

⁷⁵ Affeldt, *supra* note 45, at 95; Affeldt, *supra* note 53, at 189, *Senate hearings, supra* note 53, at 78.

⁷⁶ Affeldt, *supra* note 45, at 95; Affeldt, *supra* note 53, at 189.

⁷⁷ Affeldt, *The Three Year Cycle*, 55 HOSP., Dec. 16, 1981, at 69. Nursing homes pay

To understand fully the origins and development of JCAH, the history of organized American health care delivery must be considered. The extensive, indeed almost exclusive, reliance on large medical institutions which characterizes the current health care delivery system is a quite recent development. Though hospitals existed in the nineteenth century, they bore little resemblance to the modern institution of the same name.⁷⁸ Until late in the nineteenth century a hospital was primarily a charitable institution that provided housing, moral nurture, and health care for the worthy poor,⁷⁹ usually for free.⁸⁰ Middle and upper class patients received medical care, including surgery, in their own homes and seldom entered hospitals.⁸¹

During the late nineteenth and early twentieth centuries, however, the organization of medical care changed rapidly and radically. Scientific and technical developments, especially the development of antisepsis and asepsis, made hospitals much safer and more attractive to the middle class,⁸² at the same time that social changes were making home treatment less feasible.⁸³ With new technology came increases in hospital costs.⁸⁴ In response, hospitals began to charge for their care, and to permit physicians who practiced within the hospital to charge for their services.⁸⁵ All of this led to rapid growth. The number of hospitals increased from 178 in 1873 to 4359 in 1909.⁸⁶

As the nature of the hospital was changing, so was the nature of the practice of medicine. In the nineteenth century most physicians were generalists.⁸⁷ Specialization for physicians, uncommon in the nineteenth century, developed rapidly in the twentieth.⁸⁸ Especially remarkable was the emergence of surgery as a specialty practice. The discovery of antisepsis, following upon the earlier discovery of anesthesia, made surgery safer and more common;⁸⁹ the demand

\$625 per surveyor per day. *Id.*

⁷⁸ G. ROSEN, FROM MEDICAL POLICE TO SOCIAL MEDICINE: ESSAYS IN THE HISTORY OF HEALTH CARE 293-95 (1974); REVERBY, THE SEARCH FOR THE HOSPITAL YARDSTICK: NURSING AND THE RATIONALIZATION OF HOSPITAL WORK IN HEALTH CARE IN AMERICA: ESSAYS IN SOCIAL HISTORY 206, 207-09 (S. Reverby & D. Rosner eds. 1979) (hereinafter cited as HEALTH CARE IN AMERICA); Rosner, *Health Care for the "Truly Needy": Nineteenth Century Origins of the Concept*, 60 MILLBANK MEM. FUND. Q. 355, 372, 375 (1982); Vogel, *The Transformation of the American Hospital 1850-1920* in HEALTH CARE IN AMERICA, *supra*, at 105-10.

⁷⁹ Vogel, *supra* note 78, at 105-10.

⁸⁰ *Id.* at 109.

⁸¹ *Id.* at 105.

⁸² *Id.* at 111-13.

⁸³ *Id.* at 110-11.

⁸⁴ *Id.* at 112.

⁸⁵ Rosner, *supra* note 78, at 378-79; Rosner, *Business at the Bedside: Health Care in Brooklyn, 1890-1915*, in HEALTH CARE IN AMERICA, *supra* note 78, at 122-28.

⁸⁶ R. STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 52 (1972).

⁸⁷ *Id.* at 43-49.

⁸⁸ *Id.* at 49, 50, 77-80.

⁸⁹ The death rate for abdominal and pelvic surgery was 40% in the decade 1880-1890, by 1900 it was below 5%. *Id.* at 49, 78-80.

for surgery increased greatly and surgeons' incomes grew rapidly.⁹⁰ Though surgeons increasingly relied on hospitals, the hospitals of the early twentieth century continued to be organized poorly for the practice of surgery. Hospitals lacked clinical laboratories, radiology, pathology, and other equipment and services necessary for proper pre-operative and post-operative care.⁹¹ Inadequate medical records made it difficult to analyze the results of surgery.⁹²

Though surgical specialization and sub-specialization were becoming increasingly common in the early twentieth century, it was hard for the public to identify doctors qualified to perform surgery. General practitioners continued to perform surgeries, as did many incompetent doctors who called themselves surgeons.⁹³ General practitioners could identify qualified surgeons, and refer patients to them, but this arrangement often resulted in fee splitting, which was costly and increasingly viewed as unprofessional conduct.⁹⁴ Hospitals generally made staff privileges — the privilege of admitting patients to and being primarily responsible for patients within the hospital — available to any and all physicians.⁹⁵ A closed staff system developed at this time in Britain, limiting the practice of surgery to experienced specialists, but a similar system did not develop in the United States.⁹⁶

The American College of Surgeons was organized in November 1912 in an attempt to standardize and organize the practice of surgery.⁹⁷ One of the first tasks undertaken by the ACS was the standardization of hospital care. The 1912 Clinical Congress, at which the ACS was founded, adopted a resolution calling for "some system of standardization of hospital work."⁹⁸ A committee, established to study the improvement of hospital standards,⁹⁹ issued a report recommending investigations, reports, and administrative procedures to improve and standardize hospital care.¹⁰⁰ In January of 1916, the ACS received a \$30,000 grant from the Carnegie Foundation to develop hospital standards,¹⁰¹ and in October of the following year the first conference on hospital standardization was held.¹⁰² In December of 1917, a questionnaire was circulated to

⁹⁰ L. DAVIS, *FELLOWSHIP OF SURGEONS: A HISTORY OF THE AMERICAN COLLEGE OF SURGEONS* 139 (1960).

⁹¹ Affeldt, *supra* note 53, at 182; *Reorganization Sets Future of Voluntary Accreditation*, JCAH PERSPECTIVES ON ACCREDITATION, Mar.-Apr. 1979, at 2.

⁹² Affeldt, *Voluntary Accreditation*, *supra* note 53, at 182; L. DAVIS, *supra* note 90, at 117, 204-05.

⁹³ L. DAVIS, *supra* note 90, at 69-70; R. STEVENS, *supra* note 86, at 81.

⁹⁴ L. DAVIS, *supra* note 90, at 87-88, 97-98, 137-42; R. STEVENS, *supra* note 86, at 83-84.

⁹⁵ R. STEVENS, *supra* note 86, at 83.

⁹⁶ *Id.* at 82.

⁹⁷ L. DAVIS, *supra* note 90, at 61-62, 69-70; R. STEVENS, *supra* note 86, at 86-87.

⁹⁸ Affeldt, *supra* note 53, at 183; L. DAVIS, *supra* note 90, at 63, 475-76; F. Hair, *supra* note 72, at 36; Schlicke, *supra* note 72, at 379.

⁹⁹ The committee was directed by Dr. Ernest A. Codman. F. Hair, *supra* note 72, at 36.

¹⁰⁰ L. DAVIS, *supra* note 90, at 116, 117; F. Hair, *supra* note 72, at 37.

¹⁰¹ L. DAVIS, *supra* note 90, at 176; R. STEVENS, *supra* note 86, at 91.

¹⁰² L. DAVIS, *supra* note 90, at 207; F. Hair, *supra* note 72, at 45.

2711 hospitals in the United States and Canada,¹⁰³ followed by a survey of 692 hospitals in 1918 and the same number in 1919.¹⁰⁴ The standards on which the survey was based concentrated on the surgeon's needs in the physician-hospital relationship. The standards required medical staff organization; limitation of staff privileges to qualified physicians and surgeons; regular meetings of the medical staff; accurate, complete and accessible medical records; and provision of diagnostic and therapeutic facilities (including clinical laboratory and x-ray facilities).¹⁰⁵ Of the 671 facilities of over 100 beds surveyed by the ACS, only 89 could comply with the requirements.¹⁰⁶ To avoid embarrassment to the prominent hospitals that had failed the standard examination, the list of approved hospitals was burned the night before its scheduled presentation in October 1919.¹⁰⁷

The shocking results of the 1919 survey added impetus to the interest of the ACS in hospital standardization.¹⁰⁸ On December 20, 1919, the Board of Regents of the ACS established the Hospital Standardization Program (HSP) the predecessor of the JCAH.¹⁰⁹ The HSP attempted to identify and recognize efficiently organized hospitals with well-run diagnostic and therapeutic services, and accurate and complete case records. In addition the HSP sought regularly to analyze and audit hospital progress toward compliance with the minimum HSP standards.¹¹⁰ Like the earlier ACS standards, HSP standards focused on the organization and suitability of the hospitals for physicians. The HSP standards stressed self-regulation of the medical staff, but left ultimate responsibility for granting staff privileges with the hospital administration and governing board.¹¹¹

Between 1926 and 1941 the Manual for Hospital Standardization was revised seven times and grew from an eighteen-page pamphlet to a 118 page book.¹¹² By 1941, the minimum standard had been supplemented by sixteen additional standards addressing not only the organization of physician care, but also the physical plant, equipment, and administrative organization of the hospital.¹¹³ The HSP effort to bring about medical staff organization had some fairly dramatic immediate results: between 1918 and 1935 the percentage of hospitals with organized medical staffs increased from twenty percent to ninety

¹⁰³ L. DAVIS, *supra* note 90, at 207; F. Hair, *supra* note 72, at 45.

¹⁰⁴ L. DAVIS, *supra* note 90, at 222; F. Hair, *supra* note 72, at 45, 46.

¹⁰⁵ The standards are reproduced at Affeldt, *supra* note 53, at 184.

¹⁰⁶ L. DAVIS, *supra* note 90, at 221; F. Hair, *supra* note 72, at 46.

¹⁰⁷ L. DAVIS, *supra* note 90, at 221; A. GERBER, THE GERBER REPORT 101-03 (1971); F. Hair, *supra* note 72, at 46.

¹⁰⁸ Affeldt, *supra* note 53, at 184.

¹⁰⁹ L. DAVIS, *supra* note 90, at 221; F. Hair, *supra* note 72, at 47; Affeldt, *supra* note 53, at 184.

¹¹⁰ L. DAVIS, *supra* note 90, at 172-74, 489-90; F. Hair, *supra* note 72, at 47.

¹¹¹ L. DAVIS, *supra* note 90, at 221; F. Hair, *supra* note 72, at 49; M. ROEMER & J. FRIEDMAN, DOCTORS IN HOSPITALS 36-37 (1971).

¹¹² F. Hair, *supra* note 72, at 66.

¹¹³ *Id.* at 66-67, 76-77.

percent of hospitals surveyed.¹¹⁴ Nevertheless, many hospitals continued to rely on unqualified staff, and shortages of physicians brought about by World War II further aggravated problems in upgrading the quality of hospital physicians.¹¹⁵

The ACS and its HSP were from the first opposed by many physicians.¹¹⁶ The American Medical Association (AMA) which represented the broader spectrum of physicians, had previously passed a resolution opposing distinguishing marks for specialists.¹¹⁷ Many physicians opposed the HSP as a threat to their freedom of medical practice and resisted mandatory medical record charting and routine use of diagnostic laboratory tests.¹¹⁸ The AMA declined an invitation from the 1914 ACS Congress to take over HSP,¹¹⁹ in 1918 threatened to establish its own hospital standardization program, and even organized a rival hospital conference. Tension continued to exist between the AMA and ACS throughout the first half of the twentieth century,¹²⁰ reflecting the differences between the elite and well paid hospital-based surgeons, and the predominantly poorer community-based general practitioners.¹²¹ The American Hospital Association (AHA), and Catholic Hospital Association on the other hand supported the HSP.¹²²

2. The Founding and Early Years of the Joint Commission on Accreditation of Hospitals 1951-1965

The 1940's saw further changes in the organization of the delivery of medical care in the United States. Well-defined classifications for medical specialists developed in the armed forces during World War II,¹²³ and public subsidies for graduate medical education under the GI Bill led to a rapid rise in specialization during the 1940's and 1950's.¹²⁴ Hospital expansion was stimulated by the Hospital Survey and Construction Act of 1946¹²⁵ (the Hill-Burton Act) which made generous federal assistance available for hospital construction. The Hill-Burton program also changed the nature of hospital regulation. It imposed a cut-off on Hill-Burton funds to any state that did not, by July 1, 1948, enact "legislation providing that compliance with minimum standards of maintenance and operation shall be required" of hospitals assisted through the

¹¹⁴ *Id.* at 78.

¹¹⁵ *Id.* at 80-84.

¹¹⁶ L. DAVIS, *supra* note 90, at 79, 89-93, 113-15 and 130-32.

¹¹⁷ R. STEVENS, *supra* note 86, at 89. *See also* L. DAVIS, *supra* note 90, at 131; F. Hair, *supra* note 72, at 34 (discussing the opposition of the AMA to the ACS).

¹¹⁸ L. DAVIS, *supra* note 90, at 205-06; F. Hair, *supra* note 72, at 42-43.

¹¹⁹ L. DAVIS, *supra* note 90, at 158, 175; F. Hair, *supra* note 72, at 91.

¹²⁰ L. DAVIS, *supra* note 90, at 230; R. STEVENS, *supra* note 86, at 128-29.

¹²¹ *See* L. DAVIS, *supra* note 90, at 133, 139; R. STEVENS, *supra* note 86, at 176-77 and 198.

¹²² L. DAVIS, *supra* note 90, at 185, 206-07; F. Hair, *supra* note 72, at 43-44.

¹²³ R. STEVENS, *supra* note 86, at 298-99.

¹²⁴ *Id.* at 297, 299.

¹²⁵ Pub. L. No. 79-725, 60 Stat. 958 (Codified at 42 U.S.C. §§ 291-291n (1946)).

Hill-Burton Act.¹²⁶ In response to the Hill-Burton minimum standards requirement, the AHA, with the assistance of the American Public Welfare Association, developed a model licensing law.¹²⁷ This bill, as modified by a larger group convened by the Council of State Governments, became the model hospital licensing act upon which most current state hospital licensing laws are based.¹²⁸ The Hill-Burton Act, therefore, led to a radical increase in state interest in hospital licensure: whereas only twelve states licensed general hospitals prior to 1945, twenty-six additional states enacted licensure laws between 1945 and 1950.¹²⁹

The growing complexity of hospital care and increasing number of hospitals gradually overwhelmed the HSP. Until 1950, ACS had single-handedly financed the HSP, principally from the dues of its members, spending two million dollars on the HSP, during the thirty-one years of the HSP, including \$68,577.27 for the fiscal year 1949.¹³⁰ In 1950, the new director of the ACS, Paul R. Hawley, began to seek out alternatives for the management of the program.¹³¹ Because of past AMA coolness toward the HSP, Hawley turned first to the AHA,¹³² which had considered initiating its own hospital standardization program as early as 1943 but had not proceeded because of the existence of the ACS program.¹³³ The AHA offered to take over the standardization program,¹³⁴ and on July 21, 1950 a committee of the ACS and AHA drafted an agreement for transfer of the HSP.¹³⁵ The proposal for transfer was rejected by the ACS Board of Regents on August 4, 1950, but on August 5, the AHA Board of Trustees adopted a resolution to create its own standardization program.¹³⁶ At this point, the AMA entered the fray, attacking AHA control over hospital standardization as an attempt to "superimpose lay judgment on professional knowledge and ability,"¹³⁷ other medical association journals called for a boycott of hospitals accredited by the AHA,¹³⁸ and attacks on the ACS standardization program within the AMA and the newly formed American Academy of General Practice (AAGP) were revived.¹³⁹

¹²⁶ 42 U.S.C. § 291f(d) (1946).

¹²⁷ Lander, *supra* note 26, at 131, A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 107 (1969).

¹²⁸ Lander, *supra* note 26, at 131, A. Somers, *supra* note 127, at 107.

¹²⁹ F. Hair, *supra* note 72, at 245.

¹³⁰ L. DAVIS, *supra* note 90, at 379, 380; F. Hair, *supra* note 72, at 99; Schlicke, *supra* note 72, at 380.

¹³¹ F. Hair, *supra* note 72, at 100.

¹³² L. DAVIS, *supra* note 90, at 381.

¹³³ F. Hair, *supra* note 72, at 100.

¹³⁴ *Id.* at 101.

¹³⁵ *Id.* The transfer as proposed would have created a 25 member commission: 13 members (including the chairman) appointed from hospital trustees; 6 hospital administrators, 3 surgeons appointed by the ACS, and 3 physicians appointed by the ACP. L. DAVIS, *supra* note 90, at 382; F. Hair, *supra* note 72, at 101-02.

¹³⁶ L. DAVIS, *supra* note 90, at 382, 383; F. Hair, *supra* note 72, at 102.

¹³⁷ Editorial, *Inspection of Hospitals by Hospitals*, 144 J. AM. MED. A. 394, 395 (1950).

¹³⁸ F. Hair, *supra* note 72, at 105-06.

¹³⁹ L. DAVIS, *supra* note 90, at 383; F. Hair, *supra* note 72, at 108.

In this context of strife and suspicion, efforts at cooperation nevertheless were begun. On November 19, 1950, the AHA, AMA, ACS, and ACP agreed tentatively to coordinate their efforts and attempt to establish a joint hospital standardization program.¹⁴⁰ Characteristically, the meetings that followed were "highlighted by tangential discussion, misstatement of facts, misunderstandings of purposes, and evasive answers to pointed questions."¹⁴¹ The AMA continued to take a dim view of the involvement of non-physicians in hospital standardization. Continued discussions, however, finally resulted in the proposal of a joint commission, with representation of six members each for the AMA and AHA, three members each for the ACS and ACP and one member to represent the Canadian Medical Association.¹⁴² The Commission was to be funded by each of the member groups in proportion to its representation, with field inspection staff provided by the ACS and the AMA.¹⁴³

The proposed commission was quickly approved by the AHA, ACS and ACP, but opposition continued within the AMA.¹⁴⁴ The AAGP led the opposition, insisting upon either a standardization program conducted solely by the AMA, or independent representation for itself on any joint commission.¹⁴⁵ The AMA house of delegates finally approved the formation of the Joint Commission on September 16, 1951, with a proviso admonishing the AMA to continue to press for strengthened representation on the Commission for the AMA, and for less representation for the AHA.¹⁴⁶ The JCAH held its organizational meeting on December 15, 1951.¹⁴⁷

Although JCAH adopted the ACS standards without alteration, it paid more attention to specific aspects of the hospital medical program: medical records, staff appointments, clinical pathological conferences, and tissue review.¹⁴⁸ This was seen as interference in medical practice and provoked some opposition from physicians.¹⁴⁹ Continued opposition from the General Practice section of the AMA necessitated AMA committees which in 1956 and again in 1961 and 1963 investigated the JCAH, each time recommending continued AMA participation.¹⁵⁰

¹⁴⁰ L. DAVIS, *supra* note 90, at 343, 500; F. Hair, *supra* note 72, at 109.

¹⁴¹ L. DAVIS, *supra* note 90, at 384.

¹⁴² L. DAVIS, *supra* note 90, at 386. The Canadians withdrew in 1959 when they founded their own accrediting commission, Schlicke, *supra* note 72, at 380.

¹⁴³ F. Hair, *supra* note 72, at 112.

¹⁴⁴ L. DAVIS, *supra* note 90, at 386, 387.

¹⁴⁵ F. Hair, *supra* note 72, at 113; *Joint Commission is Proposed*, 76 MOD. HOSP., June 1951, at 70; *Looking Forward*, 76 MOD. HOSP., May 1951, at 49.

¹⁴⁶ F. Hair, *supra* note 72, at 116. (The AHA and AMA have continued to have an equal number of representatives on the Commission and AMA efforts to change this appear to have been abandoned).

¹⁴⁷ *Id.* at 117.

¹⁴⁸ *Id.* at 119. The hospitals accredited by the ACS were also automatically accorded accreditation by the JCAH, L. DAVIS, *supra* note 90, at 387.

¹⁴⁹ F. Hair, *supra* note 72, at 119-22.

¹⁵⁰ *Id.* at 122-32.

The early 1960's saw changes in the JCAH. In 1961, JCAH developed its own paid survey staff permitting an end to reliance on the field staff of the ACS and AMA.¹⁵¹ In 1964, the JCAH began to charge fees for its inspection program, reducing the financial burden of its members.¹⁵² Then, in 1965, the JCAH expanded its scope, assuming responsibility for nursing home accreditation, and adding commissioners to represent the American Nursing Home Association and American Association of Homes for the Aging.¹⁵³ JCAH also expanded by adding a program to accredit psychiatric facilities in 1960 and a program for accreditation of rehabilitation facilities in 1967.¹⁵⁴

3. The Joint Commission and the Medicare Program: 1965-1975

With the advent of Medicare in 1965, JCAH was radically changed from a private, voluntary accreditation program to an agency with a major role in public health care regulation and financing. Though national health insurance had been a popular issue for much of this century, legislation which directly spawned the current Medicare and Medicaid programs was introduced only in the late 1950's.¹⁵⁵ Early drafts of this legislation paid minimal attention to controlling the quality of health care services which the new government funds would purchase.¹⁵⁶ Subsequent bills, however, began to contemplate quality control through the use of existing accrediting agencies. A bill introduced in 1961 would have required the Secretary of Health, Education and Welfare (HEW) to consult with "recognized national listing or accrediting bodies" in setting standards for hospitals, nursing homes, and home health agencies.¹⁵⁷ This bill also permitted the Secretary to grant deemed status to these health care providers: to the extent that the Secretary found national accreditation bodies to provide reasonable assurances that conditions of participation would be met, accredited hospitals, nursing homes, and home health agencies would be deemed to meet quality conditions of Medicare participation.¹⁵⁸ Both

¹⁵¹ Schlicke, *supra* note 72, at 380.

¹⁵² *Id.*

¹⁵³ F. Hair, *supra* note 72, at 148-50. The ANHA (now the American Health Care Association) and AAHA lost their seats on the Commission when the Accreditation Council for Long Term care was established in 1971, *Reorganization*, *supra* note 91, at 5.

¹⁵⁴ F. Hair, *supra* note 72, at 150-51.

¹⁵⁵ P. CORNING, *THE EVOLUTION OF MEDICARE FROM IDEA TO LAW 74-76* (1969); Cohen & Ball, *Social Security Amendments of 1965: Summary and Legislative History*, SOC. SEC. BULL., Sept. 1965, at 3, 3-4.

¹⁵⁶ H.R. 4700, introduced in 1959 would have permitted any licensed hospital to receive Medicare funds. H.R. 4700, 86th Cong., 1st Sess. § (d)(1) (1959), *reprinted in Hospital, Nursing Home, and Surgical Benefits for OASI Beneficiaries*, Hearings on H.R. 4700 before the House Comm. on Ways and Means, 86th Cong., 1st Sess. 3 (1959).

¹⁵⁷ H.R. 4222, 87th Cong., 1st Sess. § 1607 (1961) *reprinted in Health Services for the Aged Under the Social Security Insurance System Hearings before the House Comm. on Ways and Means*, 86th Cong., 1st Sess. 7 (1961).

¹⁵⁸ *Id.*, § 1608(b) at 7.8.

HEW¹⁵⁹ and AHA¹⁶⁰ supported reliance on JCAH accreditation to assure quality.

Proposed Medicare legislation introduced in subsequent years steadily strengthened the position of the Joint Commission.¹⁶¹ These changes were warmly supported by the AHA. Kenneth Williamson, an Associate Director of the AHA, testified in 1965:

We also believe that it is particularly important that the references to the Joint Commission on the Accreditation of Hospitals . . . be retained in the bill as it provides that the Secretary cannot establish standards whose requirements are in excess of those which the health field itself prescribes. This understandably gives a great feeling of comfort to the health field.¹⁶²

The Medicare statute, as finally enacted, not only required HEW to accept JCAH accreditation as a conclusive determination of hospital quality for participation in the Medicare program, but forbid HEW to promulgate standards of quality higher than those adopted by JCAH.¹⁶³

The reasons for heavy reliance by Medicare on JCAH were twofold. First, there was substantial political pressure to get the Medicare program fully operational rapidly.¹⁶⁴ President Johnson, with a large political stake in Medicare,

¹⁵⁹ *Id.* at 223 (statement of Abraham Ribicoff, Secretary of HEW July 24, 1961). During 1961 hearings, Secretary Ribicoff of HEW testified that if required to immediately implement Medicare, he would "... hand down an order that any hospital that was accredited by the Joint Commission on Accreditation would be prima facie eligible." *Id.* at 223. He further stated "I would give the greatest respect, as I do now, to the Joint Commission on Hospital Accreditation. I think they are doing a fine job in America to raise the standards of our hospitals, and I would not look behind their accreditation." *Id.* at 224.

¹⁶⁰ In his testimony during the 1961 hearings, AMA president Frank Groner supported the notion of permitting JCAH accredited hospitals to participate in Medicare. *Id.* at 250 (statement of Dr. Frank S. Groner, President, AMA, July 26, 1961).

¹⁶¹ § 1806(a) of H.R. 11865, defined hospital as an institution which "meets such other of the requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals as the Secretary finds necessary in the interest of health and safety of individuals who are furnished services by or in the institution." H.R. 11865, § 1806(a) 88th Cong., 2d Sess., (1964), reprinted in *Social Security, Medical Care for the Aged Amendments: Hearings before the Senate Comm. on Finance*, 80th Cong., 2d Sess. 21 (1964). The bill further provided that "an institution shall be deemed to meet the conditions of participation under § 1806(a) ... if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals." *Id.* § 1808(b)(1) at 25. H.R. 6675 provided that hospital certification requirements promulgated by the Secretary could not "be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals." H.R. 6675, § 1861(c)(8), 89th Cong., 1st Sess. (1965), reprinted in *Social Security: Hearings before the Senate Comm. on Finance*, 89th Cong., 1st Sess., 21 (1965).

¹⁶² *Medical Care for the Aged*, Executive Hearings before the House Committee on Ways and Means, 89th Cong., 1st Sess., 2236 (1965) (Statement of Kenneth Williamson, Associate Director AHA, Feb. 2, 1965).

¹⁶³ See Pub. L. No. 89-97, § 1861(e)(8) (codified at 42 U.S.C. 1395x(e)(g) (Supp. II 1966)); § 1865 (codified at 42 U.S.C. 1395bb (Supp. II 1966)) 79 Stat. 290, 315, 326, 327, 89th Cong., 1st Sess. (1965). Insofar as § 1861(e)(7) required hospitals to be licensed in states that had licensing laws as an additional prerequisite to certification, it was possible that an accredited hospital could be refused Medicare certification if a state denied it licensure.

¹⁶⁴ J. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* 11

believed that its success depended on maximum access from the beginning of the program, and thus on immediate near universal hospital participation.¹⁶⁵ Those who had to administer the program were greatly relieved to have a fully developed quality certification system,¹⁶⁶ that, by the mid-1960's, accredited sixty percent of the hospitals, and eighty-seven percent of the hospital beds in the country.¹⁶⁷ Second, reliance on the JCAH was strongly supported by the AHA. Though the AMA had consistently and vigorously opposed Medicare,¹⁶⁸ the AHA had cautiously supported parts of the Medicare program¹⁶⁹ and the use of JCAH for hospital regulation strengthened this support.

Following the passage of the Medicare law in 1965, JCAH entered a period of rapid growth and elaboration. In 1966 it had about a dozen staff, a dozen surveyors and a budget of about \$500,000 annually; by the late 1970's it had about 350 employees, 100 surveyors and an annual budget of \$14 million.¹⁷⁰ The JCAH also further diversified its efforts, entering into agreements with twenty-four national organizations representing health constituencies to establish four accreditation councils to accredit different kinds of medical care.¹⁷¹ While the councils were subject to the ultimate authority of the Board of Commissioners, they functioned with substantial independence in setting standards and in recommending accreditation decisions.¹⁷² Finally, between 1966 and 1971 the JCAH completely rewrote its hospital accreditation standards. The effect of this rewrite is disputed: JCAH claims it created a higher national minimum hospital quality care standard;¹⁷³ others claim that the new standards were more vague and less demanding than the earlier standards.¹⁷⁴

(1977).

¹⁶⁵ *Id.*; J. FEDER, *THE SOCIAL SECURITY ADMINISTRATION AND MEDICARE: A STRATEGY FOR IMPLEMENTATION IN TOWARD A NATIONAL HEALTH POLICY* 19, 22-23 (K. Friedman & S. Rakoff eds. 1977).

¹⁶⁶ See *supra* note 159, telephone interview with Wilbur Cohen, Aug. 30, 1982.

¹⁶⁷ J. FEDER, *supra* note 164, at 9; Cashman and Myers, *Medicare: Standards of Service in a New Program — Licensure, Certification, and Accreditation*, 57 AM. J. OF PUB. HEALTH 1107, 1114 (1967).

¹⁶⁸ See generally R. HARRIS, *A SACRED TRUST* (1966) (describing the AMA lobbying campaign against Medicare).

¹⁶⁹ See P. CORNING, *supra* note 155, at 79, 80; Telephone interview with Wilbur Cohen, (Aug. 30, 1982). See also H. SOMERS & A. SOMERS, *MEDICARE AND THE HOSPITALS* 83 n.10 (1967).

¹⁷⁰ Schlicke, *supra* note 51, at 8.

¹⁷¹ Affeldt, *supra* note 53, at 186.

¹⁷² See *JCAH Plans Reorganization*, PERSPECTIVES ON ACCREDITATION, Sept.-Oct. 1978 at 6. The Accreditation Council for Services for the Mentally Retarded and Other Developmentally Disabled Persons was established in 1969; the Accreditation Council for Psychiatric Facilities in 1970, the Accreditation Council for Long-Term Care Facilities in 1971, and the Accreditation Council for Ambulatory Health Care in 1975, *Reorganization*, *supra* note 93, at 5.

¹⁷³ Schlicke, *supra* note 51, at 8; Schlicke, *supra* note 72, at 381.

¹⁷⁴ S. LAW & S. POLAN, *PAIN AND PROFIT*, 65-67 (1978); A. SOMERS, *supra* note 127, at 130, 131. The revised standards included a standard for review of hospital utilization by patients parallel to that found in the Medicare law. H. SOMERS & A. SOMERS, *supra* note 169, at 83.

This period of growth and elaboration was not without its trials. In the early 1970's, growing consumer awareness led to controversy about the JCAH role in the Medicare program. In mid-1970, the National Welfare Rights Organization and a number of other consumer groups met with the JCAH,¹⁷⁵ presenting JCAH with twenty-five demands for opening up the accreditation process and for altered standards to require of hospitals more consumer participation and greater responsibility toward the poor.¹⁷⁶ Almost simultaneously several consumer groups sued HEW, challenging the delegation of authority for Medicare certification to the JCAH as a delegation of public authority to a private body in violation of the United States Constitution.¹⁷⁷ The case was precipitated by JCAH accreditation of the San Francisco General Hospital and the District of Columbia General Hospital despite serious problems and consumer complaints.¹⁷⁸ Also in 1970 and 1971 a number of legislative proposals, including a bill introduced by Senator Edward Kennedy to establish an independent federal commission for accreditation, further challenged the role of the JCAH.¹⁷⁹

JCAH responded to this consumer pressure by adding a preamble to its standards recognizing patient's rights, and incorporating public information interviews into the accreditation process.¹⁸⁰ It briefly had a consumer advisory committee. The leadership of JCAH, however, continued to identify JCAH as a consultant accountable to the medical care industry and to reject the role of a regulator accountable to the public.¹⁸¹

JCAH standards and enforcement also had become a source of concern to those administering the Medicare program. The annual report on Medicare of the Health Insurance Benefits Advisory Council (HIBAC), issued July 1969 and covering July 1, 1966 through December 31, 1967, stated that the Council "found reason for concern that JCAH standards are not applied with the frequency of inspection and range of inspector skills necessary to assure a high degree of effectiveness" and that "the JCAH standards in some cases impose an undesirably low ceiling" on Medicare health and safety standards.¹⁸²

¹⁷⁵ Schlicke, *supra* note 72, at 382, 383.

¹⁷⁶ Other demands are set forth in Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROBS., 305, 328-31 (1970).

¹⁷⁷ *Self-Help for the Elderly v. Richardson*, No. 2016-71 (D.D.C. 1972). See *infra* text accompanying notes 571-616 discussing the delegation doctrine.

¹⁷⁸ *Hearings*, *supra* note 54, at 1944-71 (testimony of Fred Hiestand, attorney for plaintiffs), 1976-89 (testimony of Kenneth Barres and Bruce Terris); J. FEDER, *supra* note 164, at 23, *Suit Challenges Delegation of Medical Standards to JCAH*, 7 HOSP. PRAC., Feb. 1972, at 186, 187, 195, 196, 199 (1972) (hereinafter cited as *Suit Challenges*); *Suit Calls JCAH Role in Medicare Unconstitutional*, 12 MED. WORLD NEWS, Nov. 5, 1971, at 18 (hereinafter cited as *Suit Calls*).

¹⁷⁹ S. 3327, 92d Cong., 2d Sess., (1972) reprinted in 118 Cong. Rec. 31551, 31557-31561; Schlicke, *supra* note 72, at 382.

¹⁸⁰ Porterfield, *The JCAH: A Look at What Has Changed, What Has Endured*, 5 HOSP. MED. STAFF, Sept. 1976 at 23, 25; Schlicke, *JCAH and the Federal Government*, 64 BULL. AM. COLL. SURG., March 1979, 23, 24, 25; Schlicke, *supra* note 72, at 382.

¹⁸¹ Schlicke, *supra* note 51, at 8-9, 11, 12; *Suit Calls*, *supra* note 178, at 19.

¹⁸² HEALTH INSURANCE BENEFITS ADVISORY COUNCIL (HIBAC) REPORT COVERING

HIBAC recommended that HEW be given authority to set standards for hospitals and that states be given authority to inspect accredited facilities.¹⁸³ Similarly, several state agencies also began to criticize JCAH standards and inspections.¹⁸⁴

Congress responded to consumer and HIBAC concerns through the Social Security Amendments of 1972, which permitted HEW to promulgate hospital standards exceeding JCAH accreditation standards;¹⁸⁵ to validate JCAH accreditation by state inspections performed randomly and in response to substantial complaints;¹⁸⁶ and to decertify accredited hospitals that failed to comply with the federal regulations.¹⁸⁷ The amendments relieved consumer pressure on JCAH but increased tension between JCAH and HEW. The first HEW report to Congress concerning the results of the validation surveys submitted in 1976 identified wide discrepancies between JCAH and state surveys, with JCAH finding fewer deficiencies.¹⁸⁸ JCAH responded publicly to this report, pointing out that most of the additional deficiencies were in the physical plant or fire safety areas, which it regarded as less directly related to the quality of care.¹⁸⁹ JCAH also improved its fire safety standards and inspection.¹⁹⁰

HEW and the JCAH also clashed over the confidentiality of hospital accreditation reports. The 1972 amendments required hospitals, as a condition of Medicare participation, to release JCAH accreditation survey reports to HEW for validation of accreditation.¹⁹¹ Although the statute specified that the reports were to be kept confidential, HEW in 1975 released a number of JCAH deficiency letters to a consumer organization pursuant to a Freedom of Information Act request.¹⁹² JCAH immediately ceased providing validation reports to

THE PERIOD JULY 1, 1966 - DECEMBER 31, 1967, 11 (1969).

¹⁸³ *Id.* at 11, 12.

¹⁸⁴ HIBAC, *Task Force on Extended Care Services*, SELECTED STATE REPORTS, staff report, at 5, Ark. Report at 5, 6. Fla. Report at 9, 10 (Sept. 4, 1968).

¹⁸⁵ Pub. L. No. 92-603 § 244(b)(1), 86 Stat. 1329, 1423 (1972) (codified at 42 U.S.C. § 1395bb(a)(4) (1976)). See SEN. REP. NO. 92-1230 92d Cong., 2d Sess. 290 (1972) for the legislative history.

¹⁸⁶ Pub. Law No. 92-603 § 244(a), 86 Stat. 1329, 1422, 1423 (1972) (codified at 42 U.S.C. § 1395aa(c) (1976)).

¹⁸⁷ Pub. Law No. 92-603 § 244(b)(2), 86 Stat. 1329, 1423 (1972) (codified at 42 U.S.C. § 1395bb(b) (1976)).

¹⁸⁸ HEW, REPORT OF MEDICARE VALIDATION SURVEYS OF HOSPITALS ACCREDITED BY THE JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS 5-7 (1975). Annual reports on the results of validation surveys were required by Pub. Law No. 92-603, § 244d, 86 Stat. 1329, 1423 (1972) (codified at 42 U.S.C. § 1395bb (1976)).

¹⁸⁹ JCAH REPORT TO CONGRESS ¶ IIIB (1975).

¹⁹⁰ Lewis, *The Uncertain Future of JCAH*, 4 MOD. HEALTH CARE, August 1975, 21-22; Schlicke, *supra* note 51, at 9, 10; Schlicke, *supra* note 185, at 26. See also Affeldt, *JCAH the Best Game in Town*, 59 HOSP. PROG. September 1978, 51, 53 (explaining differences in HEW and JCAH survey procedures that resulted in discrepancies in survey results).

¹⁹¹ Pub. Law No. 92-603, § 244(b)(1) 86 Stat. 1329, 1423 (1972) (codified at 42 U.S.C. § 1395bb(a)(2) (1976)).

¹⁹² Schlicke, *supra* note 51, at 9; Van Amringe, *Putting Hospital Standards on the Examining Table*, HCFA FORUM, December 1980, at 23; *Hospital Accreditation — Where Do We Go From Here*, 2 HEALTH PERSPECTIVES Mar.-Apr. 1975, at 4, (hereinafter cited as *Hospital Accreditation*).

HEW and sued to enjoin any further releases.¹⁹³ In October of 1975, JCAH and HEW reached a settlement barring release by HEW of accreditation letters or accompanying recommendations or comments.¹⁹⁴

Finally, the emergence of Professional Standards Review Organizations (PSRO's)¹⁹⁵ in 1972 challenged JCAH dominance of hospital regulation.¹⁹⁶ The PSRO legislation established a quality and utilization peer review program for Medicare and Medicaid financed hospital care wholly independent of JCAH. The program even duplicated some of JCAH's quality audit procedures.¹⁹⁷

A final notable development in the early 1970's was the increased emphasis of JCAH on evaluation of quality of patient care. JCAH had long been accused of emphasizing physical and administrative structures — the capacity to deliver care, rather than the actual quality of patient care.¹⁹⁸ In response to this criticism (and perhaps to other factors)¹⁹⁹ JCAH began to require outcome oriented hospital quality review programs. It also developed a specific system, the Performance Evaluation Procedure for Auditing and Improving Patient Care (PEP),²⁰⁰ that hospitals could use to meet this standard.

4. Recent Developments — 1975 to the Present

During 1977 and 1978, JCAH was extensively reorganized. The accreditation councils, set up in the mid-1960's, had functioned with increasing autonomy, creating administrative and managerial problems and, some claim, threatening the control of JCAH's member groups over the accreditation program.²⁰¹ Accreditation staff functioned under a dual authority, responding both to the accreditation councils and to JCAH management.²⁰² To eliminate these accountability problems, JCAH abolished the accreditation councils and established the current PTAC system described earlier.²⁰³ Two of the four ac-

¹⁹³ *Joint Commission on Accreditation of Hospitals v. Weinberger*, No. 75 C175 (N.D. Ill. Oct. 8, 1975) (dismissed by stipulation).

¹⁹⁴ *Id.*

¹⁹⁵ Pub. Law No. 92-603, § 249F, 86 Stat. 1329, 1429-1445, (1972) (codified at 42 U.S.C. § 1320c-1320c19 (1976)).

¹⁹⁶ Ellis, *supra* note 54, at 36; Porterfield, *supra* note 180, at 23, 24; Schlicke, *supra* note 180, at 26, 27.

¹⁹⁷ Schlicke, *supra* note 51, at 10, 11; see Crosby, *supra* note 54, at 133, 134.

¹⁹⁸ Crosby, *supra* note 54, at 133.

¹⁹⁹ For an analysis which attributes the development of JCAH quality review to the malpractice crisis, see S. LAW & S. POLAN, *supra* note 174, at 65-67 (1976).

²⁰⁰ *Id.* See C. JACOBS, T. CHRISTOFFEL & N. DIXON, *MEASURING THE QUALITY OF PATIENT CARE: THE RATIONALE FOR OUTCOME AUDIT*, ix-x (1976). See also Crosby, *supra* note 54, at 134; Porterfield, *A Farewell Look at JCAH Standard Audit Requirements*, 6 HOSP. MED. STAFF, July 1977, at 29, 31; Porterfield, *JCAH Board Adopts Schedule for Implementation of Quality Review*, 3 HOSP. MED. STAFF, Sept. 1974, at 33 (discussing the PEP).

²⁰¹ Crosby, *supra* note 54, at 136, 137; *JCAH Moves to Change its Policy Structures*, 7 AHCA WEEKLY NOTES, Oct. 6, 1978, at 3 (hereinafter *JCAH Moves*); *Reorganization*, *supra* note 91, at 5; *JCAH Plans Reorganization*, *supra* note 172, at 6.

²⁰² *JCAH Moves*, *supra* note 201, at 3.

²⁰³ See *supra* notes 44-47 and accompanying text.

creditation councils refused to go along with the reorganization proposal: three of the five members of the Ambulatory Health Care Council broke off to establish an independent Accreditation Association for Ambulatory Health Care;²⁰⁴ eight of the eleven members of the Mental Retardation and Developmental Disabilities Council also rejected the arrangement and set up an independent accreditation body.²⁰⁵ JCAH continued its own ambulatory facility accreditation program under a PTAC, but has largely abandoned the mental retardation/developmental disabilities facility program.²⁰⁶

The late 1970's and early 1980's also marked a rapprochement between JCAH and HEW. A 1979 GAO Report essentially supported a continued JCAH role in Medicare certification.²⁰⁷ Increasingly, HEW sought to cooperate with rather than to police JCAH:²⁰⁸ new HEW validation regulations issued in 1980 emphasized reconciling discrepancies between JCAH and state inspection reports more than monitoring JCAH performance.²⁰⁹ JCAH overtures included attempts to coordinate activities with the PSRO's.²¹⁰ In May of 1981, the Reagan Administration, as part of its regulatory reform efforts, proposed permitting JCAH to certify nursing homes for participation in Medicare and Medicaid.²¹¹ The late seventies also saw an increase in state reliance on JCAH for licensure. 1979 and 1980 GAO Reports recommended that HEW encourage coordination between the JCAH accreditation and state licensure programs.²¹² As of 1982, thirty-eight states relied on JCAH standardization or accreditation in some way in their medical regulation programs.²¹³

At the same time as the government increasingly has been relying on JCAH as part of a program of deregulation, JCAH, ironically, has undertaken deregulation efforts of its own. The 1970 standards are currently being substantially revised to make them simpler and more flexible.²¹⁴ In particular, the

²⁰⁴ Crosby, *supra* note 54, at 137.

²⁰⁵ *Id.*

²⁰⁶ *Id.*, *AP-MRDD Discontinued in Present Form*, JCAH PERSPECTIVES ON ACCREDITATION, July-Aug. 1979, at 2.

²⁰⁷ GAO REPORT B-164031(4), THE MEDICARE HOSPITAL CERTIFICATION SYSTEM NEEDS REFORM, ii, 14, 16, 19, 31 (1979); Schlicke, *supra* note 185, at 27-28; *GAO Report Favors JCAH*, PERSPECTIVES ON ACCREDITATION, July-Aug. 1979, at 1.

²⁰⁸ See, e.g., Derzon, *Needed: A Durable JCAH-HCFA Partnership*, 59 HOSP. PROGRESS, Sept. 1978, at 54; Schlicke, *supra* note 180, at 25-27; Van Amrige, *supra* note 192, at 23-25.

²⁰⁹ 45 Fed. Reg. 74826 (1980) (codified at 42 C.F.R. §§ 405.1901, 405.1902 (1981)).

²¹⁰ S. BLUM, P. GERTMAN & J. RABINOW, PSRO's AND THE LAW, 78-79 (1977); Schlicke, *supra* note 51, at 10-11; Van Amrige, *supra* note 192, at 24.

²¹¹ See *supra* text accompanying and authority cited in notes 63, 64.

²¹² GAO Report B-199186, INFORMATION ON HOSPITAL INSPECTIONS, REPORTING REQUIREMENTS AND LIFE SAFETY CODE ENFORCEMENT 3-5 (1980) (hereinafter cited as 1980 GAO REPORT); GAO Report, *supra* note 207, at 34; Schlicke, *supra* note 51, at 11.

²¹³ See *supra* text accompanying and authority cited in notes 65-71.

²¹⁴ Affeldt, *New Directions in Standards and Survey Process*, 10 HOSP. MED. STAFF, Aug. 1981, at 24; Laviolette, *JCAH Board Mulls Radical Survey Change*, 11 MED. HEALTH CARE, June 1981, at 18-19; Laviolette, *Simpler JCAH Standards on Drawing Board*, 11 MED. HEALTH CARE, Feb. 1981, at 33, 34; Laviolette, *JCAH Will Go Easy on QA Standards Surveys*, 10 MED. HEALTH

quality assurance standard has been revised to eliminate specific numerical audit requirements and give hospitals substantial flexibility in achieving compliance.²¹⁵ JCAH has also moved from a two to three year accreditation cycle and toward more reliance on self-conducted surveys by hospitals.²¹⁶

Finally, JCAH, which has spent relatively little time in court during its 31 year history, has recently become the defendant in an increasing number of law suits that reflect varying aspects of JCAH's significant role as a private and public regulator. Several antitrust cases have been brought, pressing claims that JCAH and its constituent members and hospitals have conspired to exclude chiropractors, psychologists and other non-physician health care practitioners from access to hospitals.²¹⁷ Psychiatric hospital patients who lost their eligibility for Supplemental Social Security payments when the hospital lost its Medicaid certification because of JCAH disaccreditation, have challenged the delegation of authority to JCAH to certify health care facilities for federal programs.²¹⁸ The suit claims alternatively that JCAH decertification decisions are acts of the federal government, requiring due process. Moreover, a number of malpractice cases brought against hospitals have included the JCAH as a defendant, claiming that JCAH accreditation should serve as a guarantee of quality.²¹⁹

In summary, JCAH is a private entity governed by representatives of hospitals and physicians. Its most important function is the accreditation of hospitals, but JCAH also accredits a variety of other health care providers. In theory, JCAH accreditation is voluntary. In practice, most acute care hospitals are JCAH accredited because of the important role of accreditation in private or public licensing, certification, and financing programs. Despite JCAH's

CARE, Nov. 1980, at 11-12; *Board Considers Major Changes*, JCAH PERSPECTIVES, July-Aug. 1981, at 1; *JCAH Treads Lightly on Survey of QA Standard*, 11 MED. HEALTH CARE, June 1981, at 46. One particular move towards deregulation is a weakening of requirements for informed consent documentation, Affeldt, *Patients Rights*, 11 HOSP. MED. STAFF, Feb. 1982 at 9, 10-11.

²¹⁵ *New QA Standard Approved*, PERSPECTIVES ON ACCREDITATION, May-June 1979, at 1.

²¹⁶ *Board Sets Guidelines for Three Year Accreditation*, JCAH PERSPECTIVES, Jan.-Feb. 1982, at 1; *JCAH Board Approves Three-Year Accreditation*, JCAH PERSPECTIVES, Sept.-Oct. 1981, at 1.

²¹⁷ *Levin v. JCAH*, 354 F.2d 515 (D.C. Cir. 1965); *Wilk v. AMA*, 635 F.2d 1295 (7th Cir. 1980) (appeal pending No. 81-1331 7th Cir. argued 1981); *Garland v. Soc'y of Anesthesiologists* No. 81-4278 (N.D. Cal. Second amended complaint filed May 10, 1982); *Health Care Equalization Comm. of the Iowa Chiropractic Society v. Iowa Medical Soc'y*, 501 F. Supp. 970 (S.D. Iowa 1980) pending No. 79-381-A; *New York v. AMA*, No. 79C 1732 (E.D.N.Y. dismissed July 9, 1981); *Ohio v. JCAH*, Civ. No. C-2-79-1158 (filed Dec. 14, 1979); *Slavek v. AMA*, 1982-1 Trade Cas. (CCH) ¶ 64,509 (E.D. Pa. Jan. 27, 1982). See also *In re Chiropractic Antitrust Litigation*, 483 F. Supp. 811 (J.P.M.D.L. 1980) (deciding issues in same litigation not directly related to those considered here).

²¹⁸ *Cospito v. Califano*, No. 77-869 (D.N.J. 1983) (granting and denying several cross-motions for partial summary judgment); 80 F.R.D. 374 (1981).

²¹⁹ *Green v. Carlson*, 581 F.2d 669 (7th Cir. 1978) *aff'd*, 446 U.S. 14 (1980); *Ruggirello v. Memorial Hospital*, No. 79-314-C7 (Cir. Ct. Macomb County Mich.); *Kele v. United States*, No. C79-1093A (N.D. Ga.); *Blanchard v. Our Lady of the Lake Medical Center*, No. 231,311 (19th Judicial Dist. East Baton Rouge, La.); *State of La. v. JCAH*, No. 82-938 (4th Dist. Quachita, La. filed March 18, 1982).

continued identification as a private consultant to the medical industry, JCAH plays a major and sometimes controversial role in government regulatory programs. The Medicare program, in particular, relies heavily on JCAH accreditation for certifying facilities for participation in Medicare. Through its standards and its accreditation program, JCAH has the primary responsibility for the quality of care provided in American hospitals.

II. A MODEL FOR UNDERSTANDING THE JOINT COMMISSION

A. Standardization

Standardization and certification are not, of course, unique to hospital care.²²⁰ During the first three decades of the twentieth century the idea of achieving efficiency through voluntary standardization swept the country, bringing about the standardization of characteristics of many industrial products,²²¹ including the viscosity of oil, sizes of lumber, and composition of steel alloys.²²² While the role of, and reasons for, standardization in medical care have received little study, the phenomenon of industrial standardization, particularly the economics of standardization, has been the subject of extensive inquiry.²²³ This literature contributes much to an understanding of the hospital standardization effort. This article will, therefore, discuss at some length the economics of standardization, as it has generally come to be understood, and apply this learning to understanding the JCAH.

Industrial standards fall into two basic categories: standards for uniformity and standards for quality.²²⁴ Uniformity standards can further be broken down into standards primarily adopted to promote interchangeability of products (usually of parts such as nuts and bolts) or standards primarily adopted to promote economies of scale either by making possible large scale production or by simplifying market exchanges (such as standard bond paper or lumber sizes).²²⁵

Although this is not their primary purpose, JCAH hospital standards can be understood as uniformity standards. They help to make the product, "hospital care," or component parts of this product, such as radiology and

²²⁰ Standardization of medical care itself was not limited to hospitals. The AMA assumed the task of standardizing medical education by founding its Council on Medical Education in 1904 and went on to achieve rapid and dramatic results following the release of the Flexner Report in 1910. The ACS undertook not only to standardize hospital care but also the practice of surgery. See L. DAVIS, *supra* note 90, at 33, 61; R. STEVENS, *supra* note 86, at 58-73, 87.

²²¹ D. HEMENWAY, *INDUSTRY-WIDE VOLUNTARY PRODUCT STANDARDS*, 13-16, 22-24 (1975); NATIONAL BUREAU OF STANDARDS, *REPORT OF THE VOLUNTARY STANDARDIZATION POLICY STUDY GROUP 2-3* (1970); Hamilton, *The Role of Non-Governmental Standards in the Development of Mandatory Federal Standards Affecting Safety or Health*, 56 TEX. L. REV. 1329, 1368-70 (1978).

²²² D. HEMENWAY, *supra* note 221, at 15, 16, 24.

²²³ See FEDERAL TRADE COMMISSION, *STANDARDS AND CERTIFICATION* (1978); P. HARTER, *REGULATORY USE OF STANDARDS* (1979) and authorities cited *supra*, at note 221.

²²⁴ D. HEMENWAY, *supra* note 221, at 8, 9, 19, 45.

²²⁵ *Id.* at 19.

pathology, more uniform, and thus promote interchangeability of radiologists and pathologists between hospitals and, perhaps, simplify comparisons of hospitals by those who consume their services. JCAH standards are, however, more commonly and accurately understood as quality standards. To understand quality standards it is necessary to consider the economics of information.

B. Economics of Information

Quality standards are a form of information. A major function they serve is to facilitate the smooth operation of markets for goods and services. For a competitive market to exist, participants in the market must have the means of acquiring information regarding exchange opportunities and the prices of available goods and services in the market.²²⁶ Traditional price theory assumes that this information is costless and universally available.²²⁷ Price and quality information is, of course, seldom universally available and is often costly. Consumers, however, have economic incentives to try to seek out or create information, as informed choices are more efficient and can lead to an increase, potentially significant, in the real utility of income.²²⁸ Consumers may obtain information about goods and services in a variety of ways: from their own efforts, from sellers, or from independent sources.

First, consumers may produce information themselves through inspection (search) or experience.²²⁹ Consumers may themselves inspect simple goods, or search advertisements or literature concerning products to make informed decisions.²³⁰ Consumers also get information through experience by purchasing a product and evaluating the utility obtained from it²³¹ or relying upon the experience of others with the product.²³² Experience is most useful for evaluating frequently purchased goods, as to which extensive experience can be rapidly acquired.²³³

Consumer inspection and experience are, however, of limited value for purchasing hospital services.²³⁴ First, the complex, technological nature of

²²⁶ *Id.* at 47; J. GELMAN, COMPETITION AND HEALTH PLANNING: AN ISSUES PAPER, 38 (1982).

²²⁷ D. HEMENWAY, *supra* note 221, at 47.

²²⁸ J. GELMAN, *supra* note 226, at 40-42; Beales, Craswell & Salop, *The Efficient Regulation of Consumer Information*, 24 J. LAW AND ECON., 491, 501-02 (1981).

²²⁹ D. HEMENWAY, *supra* note 221, at 51; Nelson, *Information and Consumer Behavior*, 78 J. OF POL. ECON., 311, 311-12 (1970).

²³⁰ J. GELMAN, *supra* note 226, at 40.

²³¹ D. HEMENWAY, *supra* note 221, at 51-52; Hirschliefer, *Where Are We in the Theory of Information*, 85 PROC. AM. ECON. ACAD. 31, 37-38 (1972); Nelson, *supra* note 229, at 312.

²³² Nelson, *supra* note 229, at 321-23.

²³³ Hirschliefer, *supra* note 231, at 37-38; Nelson, *supra* note 229, at 314.

²³⁴ *Cf.* J. GELMAN, *supra* note 226, at 39, 40 (discussing consumer use of search and experience in medical care purchases). For a more sanguine view of the ability of consumers to make medical care purchases, see Frech, *The Long Lost Market in Health Care* in NEW APPROACH, *supra* note 1, at 44, 47-50. Frech argues that consumers are more knowledgeable concerning their

hospital care makes direct inspection by consumers impractical. Second, the emergent nature of many hospitalization decisions limits the time available for evaluating alternative hospitals. Moreover, inpatient hospitalization is a sufficiently infrequent experience that consumers will find experience of limited use in evaluating quality. While the experience of others may occasionally be of some use, the wide variety of medical conditions makes this experience unreliable. Finally, consumers are handicapped in assessing the product of hospital care, as it is distinguished from most other products by "credence" qualities:²³⁵ not only is the consumer ill-equipped to evaluate hospital care by search before purchase, but also to understand and evaluate experience afterwards. The consumer must trust professionals not only as to diagnosis and treatment, but also for interpretation of treatment results.

Sellers are a second source of quality information for consumers. A seller may have particular incentives to produce information if it tends to differentiate advantageously the seller's product from other products on the market, and thus allows the seller to recover the cost of information production and dissemination through increased sales.²³⁶ Individual sellers disseminate information through a variety of means, including advertising, brand name promotion, or guarantees. Advertising assists consumer investigation by providing accessible product information; brand names facilitate consumer use of experience by allowing easy identification of products with which the consumer has previously had a good (or bad) experience; guarantees permit the seller to appear to alter his pay-off matrix so that superior product quality appears to be a rational goal for the seller to pursue.²³⁷ These means may also serve as signals of other quality characteristics not otherwise readily discernable.²³⁸ While consumers may find seller produced information useful, there are risks in consumers relying exclusively on such information. Information produced by discrete sellers may be unreliable and one-sided. In particular, sellers may tend to emphasize marginally important attributes which differentiate their products from others in a particular market.²³⁹

Again, this traditional source of consumer information is not well-suited to the medical care context. Dissemination of medical care quality information to ultimate consumers by sellers has been relatively rare.²⁴⁰ Advertising aimed

own value schedules than are providers, and thus are better equipped to make certain health care choices.

²³⁵ For a discussion of "credence goods," see Darby & Karni, *Free Competition and the Optimal Amount of Fraud*, 16 J. LAW & ECON., 67, 68-72 (1973); Wolfson, Tribilcock & Tuohy, *Regulating The Professions: A Theoretical Framework* in S. ROTTERBERG, OCCUPATIONAL LICENSURE AND REGULATION 180, 190-92 (1980).

²³⁶ Beales, Craswell & Salop, *supra* note 228, at 502.

²³⁷ D. HEMENWAY, *supra* note 221, at 52-53; Hirschliefer, *supra* note 231, at 37; Nelson, *Advertising as Information*, 82 J. POL ECON., 729 (1974).

²³⁸ Beales, Craswell & Salop, *supra* note 228, at 506-07.

²³⁹ *Id.* at 506.

²⁴⁰ Advertising aimed at intermediate producers of health care, on the other hand, is extensive and highly sophisticated, as a cursory examination of pharmaceutical advertisements in

directly at consumers by professionals has until recently been regarded as unethical, and guarantees may increase malpractice exposure.²⁴¹ Moreover, the complexity of a product such as hospital care renders advertising of limited value.²⁴² Similarly, brand name identification may play a role in the competition of health care institutions — consider the Mayo or Menninger Clinics — but the role is minor.

Third, information about products may be produced neither by consumers nor sellers but independently as a separate commodity. Information is a quite peculiar commodity. First, on the supply side, the economies of scale in the production of information are significant: once information is produced it can be disseminated at very low marginal cost.²⁴³ These economies of scale should in theory lead to a natural production monopoly and discourage entry of additional information sellers into the market.²⁴⁴ Such a monopoly may not be profitable, however. Information is not subject to the same imperatives of scarcity as are most other goods: its possession by one person does not exclude its possession by others. Indeed, sharing of information may improve its quantity and quality.²⁴⁵ As buyers of information have no incentives not to resell it, or even pass it on for free, sellers of information face substantial free rider problems. Finally, the initial cost of production of information about a complex product (such as hospital care) may be very substantial, further discouraging sellers from entering the market. These factors are serious impediments to the production of information about products.

There are also significant problems with marketing information on the demand side. A purchaser will often be unable to judge the value of information until it is purchased, for if the seller of information allows the buyer to inspect the information, it is effectively transferred before purchase.²⁴⁶ Moreover, even after a buyer has purchased information, he can never be sure of its value, because this value can only be evaluated by the use of additional information which can only be obtained at additional cost.²⁴⁷ These factors may discourage demand for information and further impede its production.

any major medical journal will show.

²⁴¹ It is possible, however, that otherwise uninformative advertising could serve as a signal of high quality care, see Hirschliefer, *supra* note 231, at 38; Nelson, *supra* note 237, at 745.

²⁴² See Comment, *A Prescription for Doctors: Avoid Warranties*, 28 LOY. L.J. 307 (1982), Sullivan v. O'Connor, 363 Mass. 579, 296 N.E.2d 183 (1973).

²⁴³ D. HEMENWAY, *supra* note 221, at 47; Beales, Craswell & Salop, *supra* note 228, at 503-05.

²⁴⁴ Beales, Craswell & Salop, *supra* note 228, at 503-05.

²⁴⁵ D. HEMENWAY, *supra* note 221, at 47; Beales, Craswell & Salop, *supra* note 228, at 503-04.

²⁴⁶ D. HEMENWAY, *supra* note 221, at 48. The seller may, however, convey some information about information through signaling: one piece of information can be divulged that serves as an adequate signal of the quality of undisclosed information.

²⁴⁷ *Id.* at 48-49.

C. *Standardization and Certification: Contributions to Efficiency*

Standardization and certification programs are common means of producing information as an independent commodity. By identifying for buyers relevant aspects of product quality,²⁴⁸ standards enable consumers to compare rapidly and accurately the quality of a range of products, thus lowering search costs and increasing efficiency.²⁴⁹ Standards identify more accurately than advertising those product characteristics that are genuine signals of overall product quality.²⁵⁰ By focusing buyer-seller negotiations on a limited number of relevant quality characteristics, standards lower exchange transaction costs, focus competition on price, and lessen costly misunderstandings or disputes.²⁵¹

On the supply side, standards narrow product variation, permitting economies of scale and accumulation of standardized inventory for rapid or repeated delivery.²⁵² This in turn enhances buyer opportunities to evaluate quality by experience. Standardization also facilitates producer entry into markets by lowering research and development costs, decreasing brand allegiance and increasing buyer acceptance.²⁵³

Certification or grading programs further enhance the benefits of standardization, especially where complex products are involved.²⁵⁴ While standards identify important quality attributes, they do not inform the consumer which products possess those attributes to what extent. If standards are complex or application of standards requires technical expertise, standardization itself does the consumer little good. An impartial certification program, however, can apply standards to evaluate products for the consumer, thus simplifying consumer choices and assuring greater utility.²⁵⁵ Certification programs also facilitate entry of products into a market by reducing the need for consumer reliance on brand names or advertising.²⁵⁶

D. *Efficiency Enhancing Motivations for Standardization and Certification Programs*

Because of the problems in marketing information discussed earlier, it is by no means certain that standardization or certification programs will emerge

²⁴⁸ *Id.* at 55.

²⁴⁹ FEDERAL TRADE COMMISSION, *supra* note 223, at 42, 43. *See also* Nelson, *supra* note 229, at 312-18 (discussing determinants affecting the optimal amount of consumer search).

²⁵⁰ *See* Beales, Craswell & Salop, *supra* note 228, at 506-07 on the limitations of advertising as a signal of product quality.

²⁵¹ FEDERAL TRADE COMMISSION, *supra* note 223, at 47-48; D. HEMENWAY, *supra* note 221, at 55.

²⁵² D. HEMENWAY, *supra* note 221, at 55, *see* Stigler, *The Economics of Information*, 69 J. POL. ECON. 213 (1961).

²⁵³ FEDERAL TRADE COMMISSION, *supra* note 223, at 45-46. Howe & Badger, *An Anti-trust Challenge to Non-Profit Certifying Organizations: Conflicts of Interest and a Practical Rule of Reason Approach to Certification Programs as Industry-wide Builders of Competition and Efficiency*, 60 WASH. U.L.Q. 357, 376-78 (1982).

²⁵⁴ FEDERAL TRADE COMMISSION, *supra* note 223, at 86, 87.

²⁵⁵ *Id.*

²⁵⁶ D. HEMENWAY, *supra* note 221, at 60.

in any particular market. Though consumers have much to gain from standardization and certification, it is unlikely that consumers will create standards if the demand side of a market is large and diffuse.²⁵⁷ The production of standards and the evaluation of sellers for a certification program is too costly a job for any one consumer to undertake. Individual consumers, or groups of consumers, theoretically could go into the business of creating standards for resale, but the marketing problems discussed earlier, particularly the problem of free riders, makes this a difficult undertaking. If consumers of a product are unorganized and atomistic and the product itself is technical and complex, consumer standardization and certification is particularly unlikely. Medical care is such a product; not surprisingly, consumer standardization and certification of medical care has been rare.²⁵⁸ Nor is it surprising that JCAH, the major agent of standardization and certification for institutional health care, is not sponsored by consumers.

Though sellers have some economic incentives to initiate standardization or certification programs as discussed above, such programs will seldom be advantageous to any particular seller. Sellers of poor quality products will prefer competition in a market characterized by minimal quality information, as they have more to gain from purchase decisions based on random choice or strictly on price. Sellers of high quality goods may well prefer product differentiation based on brand name identification or advertising which may lift their goods out of the competitive market.²⁵⁹ Sellers may also oppose standardization because it facilitates entry of new producers into the market. Standardization by sellers is, therefore, not common,²⁶⁰ and it is understandable that the initial push for hospital standardization did not come from the hospital industry; that the ACS hospital standardization program existed for thirty-two years without significant hospital input; and that even now the representatives of hospitals make up less than a third of the JCAH Board.²⁶¹

Under special conditions, however, either buyers or sellers may have economic incentives to set up standardization and certification programs. Buyers may do so if the demand side of a market is oligopsonistic or monopsonistic.²⁶² If any one buyer, or small group of easily organized buyers, con-

²⁵⁷ See D. HEMENWAY, *supra* note 221, at 63-68.

²⁵⁸ It might be possible for consumers to accumulate the resources to carry on evaluation of some health care services provided in highly concentrated urban markets or of health related goods and services sold in a national market. See CONSUMER HEALTH PERSPECTIVES published by the Consumer Commission on the Accreditation of Health Services, Inc., a New York-based non-profit organization with union and consumer support, or publications of the Public Citizen Health Research Groups, a Ralph Nader affiliate, which focus largely on pharmaceutical and medical devices.

²⁵⁹ D. HEMENWAY, *supra* note 221, at 68.

²⁶⁰ *Id.*

²⁶¹ See *supra* text accompanying notes 34, 97-122, 130-47.

²⁶² D. HEMENWAY, *supra* note 221, at 63-68. (If a market is controlled by one buyer it is monopsonistic; if controlled by a few buyers, it is oligopsonistic).

trols such a large share of a market that it can internalize enough of the benefits of standardization and certification to outweigh the costs of the program, standardization or certification is likely.²⁶³

This form of concentration is likely if products are produced in vertical chains of production, with highly concentrated intermediate producers, or if products produced in one industry (complementary products) are necessary complements to products produced in a coordinated, highly concentrated industry (primary products). Certification and standardization are common wherever vertical or complementary production is found.²⁶⁴ For example, the Society of Automotive Engineers (SAE), composed of employees and representatives of the auto companies, standardized component parts of autos such as steel tubing or lock washers, and complementary products such as oil.²⁶⁵

Standardization and certification of complementary products by producers of a primary product increases demand for the primary and complementary product, considered as a unit, by reducing the cost and, perhaps, improving the quality of the complementary product.²⁶⁶ The cost of the complementary product is lowered because of reduced information costs and economies of scale induced by coordinated demand.²⁶⁷ Improved quality of the complement may improve the utility of the primary product and protect it from malfunctioning, thus preserving the reputation of and demand for the primary product.²⁶⁸ Intermediate producers in vertical production chains standardize products higher up the chain (initial products) to lower their costs and improve the quality of inputs into their product (final products), thus increasing the ultimate quality and utility of and demand for the final products.²⁶⁹

The initial push for hospital standardization and certification came from a group of surgeons, the ACS.²⁷⁰ Surgeons are, in effect, intermediate producers in the hospital production chain. Laboratory tests, medical records, and x-rays, for example, are consumed not by patients but by physicians and surgeons, who in turn deliver the products of diagnosis and treatment to the patient.²⁷¹ Other aspects of hospital care, such as the hospital rooms, hospital

²⁶³ *Id.* A classic example of standardization involving a single buyer is the prominent role General Motors played in the standardization of steel alloys. *Id.* at 15.

²⁶⁴ *Id.* at 74-75.

²⁶⁵ *Id.* at 13-18. In addition the National Petroleum Institute has written standards not for petroleum products, but for products purchased by petroleum companies such as steel plug valves. *Id.* at 66. Similarly, the American Gas Association writes standards for gas appliances and accessories which are complementary to their product. *Id.* at 75, 82.

²⁶⁶ *Id.* at 75.

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ *Id.* at 75-76.

²⁷⁰ See *supra* text accompanying notes 97-111.

²⁷¹ M. FELDSTEIN, HEALTH CARE ECONOMICS 392 (1979); M. FELDSTEIN, HEALTH ASSOCIATIONS AND THE DEMAND FOR LEGISLATION: THE POLITICAL ECONOMY OF HEALTH 44-46 (1977) (hereinafter FELDSTEIN, ASSOCIATIONS); J. Harris, *The Internal Organization of Hospitals: Some Economic Implications*, 8 BELL J. ECON., at 467-470 (1977); See, Redisch, *Physician Involvement in Hospital Decision Making* in Zubkoff, Raskin & Hanft, *supra* note 1, 217 at 222-223.

social work, and some nursing services complement the services of surgical care, making the entire product of hospitalization of more or less utility to the patient. Though the supply side of the market for surgeons is not as highly concentrated or organized as is the auto industry, the small size of the market in the early twentieth century and the unity created by professional identity made organization of the market relatively easy. Moreover, the market for surgery is highly concentrated in any particular geographic and specialty market.²⁷²

Surgeons had much to gain from hospital standardization. Standardization and certification helped to make surgery in the hospital a safe and attractive alternative to home surgery, thus making the work of surgeons more efficient and effective, and permitting radical increases in demand for surgery and the productivity of surgeons.²⁷³ Control over hospital standardization also, incidentally, assured physicians a central, indeed controlling, position in hospitals.²⁷⁴

To the extent that JCAH standardization and certification programs are attributable to physicians and surgeons acting as intermediate producers, JCAH may increase the utility of hospital services for ultimate consumers. A primary economic goal of physicians and surgeons, as producers in a vertical line of production and as sellers of services complementary to hospital care, should be to increase patient satisfaction and thus to increase demand for their services.²⁷⁵ Though the relative inelasticity of demand for the services of physicians and surgeons attributable to the necessity of those services may weaken the influence of this goal, it still remains a significant determinant of physician behavior. This goal of patient satisfaction is, moreover, also consistent with the professional self-image of surgeons and physicians. It is to be expected, therefore, that physicians within JCAH would push for standards and accreditation decisions that would assure production by hospitals of high quality inputs and complements to their services, to the benefit of patients.

Physician and surgeon dominance of hospital standardization, which no doubt results from the relationship between physician and hospital services, has a second, incidental, efficiency enhancing effect. Because JCAH is currently responsive to a broad constituency of physicians, a major effect of JCAH at the

²⁷² See discussions of market for surgery in *Marrese v. American Academy of Orthopaedic Surgeons*, 692 F.2d 1083, 1095 (7th Cir. 1982) and in *Robinson v. Magovern*, 521 F. Supp. 842, 877-86 (W.D. Pa. 1981).

²⁷³ H. SOMERS & A. SOMERS, *DOCTORS, PATIENTS, AND HEALTH INSURANCE* 41-42, 56, 57 (1962); Redisch, *supra* note 271, at 223.

²⁷⁴ See generally, Saltman & Young, *The Hospital Power Equilibrium*, 6 J. HEALTH POL. POLY & L. 391 (1982).

²⁷⁵ See D. HEMENWAY, *supra* note 221, at 75, 76. The pervasive effects of third party payments on the medical care delivery system has been discussed exhaustively elsewhere and is beyond the scope of this paper. It should be noted, however, that one effect of third party payment is undoubtedly to diminish consumer consciousness of the price of medical care, and thus to increase the need for physicians to attend to consumer satisfaction and utility as arenas for competition.

local hospital level is probably to increase the access of physicians to hospitals through JCAH requirements of reasonable and fair procedures for determining physician eligibility for staff privileges.²⁷⁶

Just as producers of complementary or intermediate goods and services — here physicians and surgeons — may have economic incentives for standardization and certification of product quality, so too may sellers — here hospitals. The economic incentives of sellers will likely outweigh the disincentives discussed above when the external costs placed on sellers of high quality products by sellers of low quality products exceed the costs of standardization. This phenomenon was described by Akerlof in his classic article on the market for lemons.²⁷⁷ If buyers are cognizant of the average quality of a product, but not the quality of any particular individual product, buyers will be unwilling to pay premium prices for allegedly superior products the quality of which they are unable to assess. Thus sellers of above average products will be forced to sell their products at a loss, and will either be driven out of the market or reduce product quality. As sellers of high quality products leave the market, the average quality in the market will continually decline. This will in turn decrease demand and harm all sellers. In this situation, product standardization and certification will increase consumer confidence in the average product by increasing the quality of that product.²⁷⁸ This will increase demand, willingness to pay higher prices, and product quality.²⁷⁹

While standardization under these circumstances should improve the quality of products in the market,²⁸⁰ the degree to which quality will improve is uncertain. If demand for a product is relatively inelastic because the product is a necessity for which there are few substitutes, sellers may not be able to cause any substantial increase in demand by raising the quality of the average product above a very minimal level.²⁸¹ Further, if a product is sufficiently impermeable to consumer evaluation, standards emphasizing symbolic aspects of

²⁷⁶ A. SOUTHWICK, *THE LAW OF HOSPITAL & HEALTH CARE ADMINISTRATION* 456 (1978); Kissam, Webber, Bigns, & Holtzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595, 648 (1982).

²⁷⁷ See Akerlof, *The Market for Lemons: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970); D. HEMENWAY, *supra* note 221, at 70-71; Weingast, *Physicians, DNA Research Scientists, and the Market for Lemons*, in *REGULATING THE PROFESSIONS: A PUBLIC POLICY SYMPOSIUM* 81 (R. Blair & S. Rubin eds. 1980). This phenomenon is even more likely to occur in a market in which sellers are unable to differentiate their product from other products through advertising, brand market identification, or guarantees, see Beales, Craswell & Salop, *supra* note 228, at 502.

²⁷⁸ D. HEMENWAY, *supra* note 221, at 70-71.

²⁷⁹ One of the most dramatic examples of this effect of standards is the effect of Japanese standards and inspection laws, enacted in 1949, which revolutionized the overall quality of products exported from Japan. *Id.*

²⁸⁰ See Gelman, *supra* note 226, at 134.

²⁸¹ For example, an inner city public hospital can allow the quality of its care to fall to very low levels before its clientele, dependent on its service by necessity, will cease to come to it for help. It has little economic incentive to raise the quality of its care above that low level.

quality may, in the short run at least, be as effective in increasing consumer demand as standards emphasizing real quality.²⁸² As compliance with such symbolic standards may be much less expensive than compliance with standards that accurately reflect quality, sellers may find misleading symbolic standardization profitable.

The Akerlof phenomena probably played a role in the initial acceptance of standards by hospitals in the early twentieth century. It also undoubtedly has contributed to the increasing interest of nursing homes in standardization. The nursing home industry has suffered extensive negative publicity in the last decade²⁸³ and is increasingly experiencing competition from the home health care industry.²⁸⁴ If consumers of nursing home care accepted JCAH accreditation with the same respect it has received in the hospital field, accreditation could have a significant positive effect on the image of the industry and thus on demand for its product.

In sum, seller standardization probably provides only minimal assurances of quality to consumers of the services of medical care institutions. As institutional medical care is usually urgently necessary, difficult for consumers to evaluate, and without readily available substitutes, sellers will, for the reasons just discussed, seldom have substantial incentives for creating or enforcing standards that will increase the quality of their product above a fairly minimal level.

E. *Causes of Inefficient or Efficiency Neutral Standardization and Certification*

To this point we have focused on the contributions of standardization and certification programs to efficiency, and discussed conditions under which certification and standardization programs may emerge that will enhance the utility of standardized goods and services to the ultimate consumer. Unfortunately, standardization and certification programs may also emerge that make little contribution to efficiency, or even that are seriously inefficient.

First, sellers may establish standardization or certification programs to avoid or co-opt government regulation.²⁸⁵ If public concern about the quality deficiencies of a particular product — especially deficiencies that threaten health or safety — reaches the level where government action seems inevitable,

²⁸² See Weingast, *supra* note 277, at 92, 93.

²⁸³ See, e.g., M. MENDELSON, *TENDER LOVING GREED* (1974); F. MOSS & V. HAL-AMANDRIS, *TOO OLD, TOO SICK, TOO BAD* (1977).

²⁸⁴ Many current nursing home residents could be cared for in their own homes or in other non-medical settings given adequate home health care. See B. VLADECK, *UNLOVING CARE*, 221-23 (1980); Butler, *Financing Noninstitutional Long-Term Care Services for the Elderly and Chronically Ill: Alternatives to Nursing Homes*, 13 *CLEARINGHOUSE REV.* 335, 335-40 (1979). Recent amendments to the Medicare statute greatly expand the availability of home health care services to elderly persons currently in nursing homes. See Pub. Law No. 96-499 §§ 930b, 930g, 94 Stat. 2599, 2631-2633 (codified at 42 U.S.C. § 1395d(a)(3), 1395(K)(a)(2)(A) (Supp. IV, 1980)).

²⁸⁵ D. HEMENWAY, *supra* note 221, at 68-70.

a threatened industry may act first to develop a standardization program, either out of fear of adverse effects of bureaucratic government administration²⁸⁶ or of uncomfortably rigorous government definitions of quality, or both. While such a program may in fact make a market function more efficiently and enhance product quality, its main goal is political rather than economic. If, therefore, political pressure can be relieved by symbolic rather than real quality control, the program may contribute less to consumer utility than would government regulation.

This preemptive form of standardization may be illustrated in the history of the JCAH. The AHA became a member of the JCAH in 1950, immediately following the great expansion of hospital licensing programs in the late 1940's.²⁸⁷ There are some who believe that the program implemented thereafter was less demanding of health care institutions than was the ACS program that preceded it.²⁸⁸ Similarly, JCAH began accrediting nursing homes in the late 1960's, just as the government began to discuss the need for increased regulation of nursing homes under the Medicaid program.²⁸⁹ JCAH has consistently held itself out to the industry as an attractive alternative to government regulation.²⁹⁰ It has also been put forward as a single alternative to the host of public and private programs that regulate various aspects of hospital care,²⁹¹ and its accreditation program has been widely relied on by federal and state government regulators.²⁹²

Standardization and certification programs that are efficiency neutral or inefficient from a consumer perspective may emerge for a second reason. Sellers may establish standardization and certification programs to avoid disputes and limit liability.²⁹³ To the extent that sellers can create consumer acceptance of standards or certification, sellers will be less likely to incur disputes with or liability to consumers regarding certified standard products. If sellers can convince courts to judge their products by industry created quality standards,

²⁸⁶ See Katz, *Industry Self-regulation: A Viable Alternative to Government Regulation* in KATZ, PROTECTING THE CONSUMER INTEREST 167, 168 (1976) (claiming that industries may prefer self regulation, even if its substantive effects are more rigorous than government regulation, because of a psychological preference for dealing with peers).

²⁸⁷ See *supra* text accompanying notes 125-29. That the AHA played a major role in drafting the model licensing act may cast doubt on this explanation of the AHA's behavior, but may, alternatively, demonstrate that the AHA adopted several strategies to coopt regulation.

²⁸⁸ See GERBER, *supra* note 107, at 130-31.

²⁸⁹ See B. VLADECK, *supra* note 284, at 59-69. For an alternative explanation of JCAH involvement in nursing home accreditation, see FELDSTEIN, ASSOCIATION, *supra* note 271, at 158-59. Feldstein argues that hospitals attempted to use JCAH accreditation of nursing homes as a means of controlling competition from nursing homes.

²⁹⁰ See Affeldt, *supra* note 45, at 95 (1981); Affeldt, *supra* note 53, at 189-91; Affeldt, *supra* note 190, at 52; Porterfield, *supra* note 54, at 20; Schlicke, *supra* note 51, at 9, 10; Schlicke, *supra* note 72, at 384-85; Schlicke, *supra* note 180, at 28.

²⁹¹ See 1980 GAO REPORT, *supra* note 212, at 2.

²⁹² See *supra* text accompanying and authorities cited at notes 57-71.

²⁹³ D. HEMENWAY, *supra* note 221, at 73-74.

sellers may lessen their adjudicated liability.²⁹⁴ It is, therefore, possibly not coincidental that the JCAH push for hospital output quality control followed closely on the heels of the revolutionary changes that resulted in the mid-1960's when *Darling v. Charleston Hospital Association*²⁹⁵ found a hospital liable for physician malpractice.

Standards created under these conditions will undoubtedly have some tendency to enhance consumer utility, for if they did not they would stand little chance of being accepted by the courts. But, because of the substantial costs of establishing the meaning of negligence through independent expert testimony or economic analysis, judges may generally find it expedient to rely on industry standards to define reasonable care rather than independently to create new standards on a case by case basis.²⁹⁶ Accordingly, industry standards may find judicial acceptance despite the fact that they ultimately may bring about lower quality products than would independent adjudications, if such adjudications were costless.²⁹⁷

Finally, standardization and certification programs may be used, or perhaps even created, to facilitate efforts to suppress competition.²⁹⁸ If standards are widely publicized and accepted, the sponsors of the standards may be able to exclude from the market potential competitors who produce non-standard goods.²⁹⁹ Moreover, if standardization and certification are enforced by ancillary means of policing, exclusion can become quite coercive and effective. For example, in *Radiant Burners v. People Gas & Electric*,³⁰⁰ the plaintiff's non-standard burner was not only denied certification, but also persons using the burners were refused gas by natural gas producers.³⁰¹ The plaintiff's product was thus eliminated from the market.

The target of an anticompetitive standardization or certification program will depend on the sponsor of the program. First, if the program is originated, as most are, by a group of intermediate producers, it may limit access to the in-

²⁹⁴ Cf. Jackson, *The Subject was Standards*, 10 AKRON L. REV. 185, 187-89, 216-18 (1976) (arguing that industries lobby for federal standards legislation to limit their products liability exposure).

²⁹⁵ 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966). See Schlicke, *supra* note 180, at 24.

²⁹⁶ The difficulties of proving medical negligence no doubt are a major contributor to the substantial administrative costs of the malpractice litigation system. It has been estimated that lawyers consume over half of the malpractice insurance premium dollar. See S. LAW & S. POLAN, *supra* note 174, at 88.

²⁹⁷ Definite standards for medical practice may also put some limits on the practice of defensive medicine, a major factor in the high cost of medical care.

²⁹⁸ D. HEMENWAY, *supra* note 221, at 76-78. See G. LAMB & C. SHIELDS, *TRADE ASSOCIATION LAW AND PRACTICE*, 78-84 (1971); FEDERAL TRADE COMMISSION, *supra* note 223, at 113-88.

²⁹⁹ FEDERAL TRADE COMMISSION, *supra* note 223, at 55, 161; D. HEMENWAY, *supra* note 221, at 77.

³⁰⁰ 364 U.S. 656 (1961).

³⁰¹ *Id.* at 658.

initial product by other competing intermediate producers or standardize the initial product in such a way that it is useless to competitors.³⁰² Second, if the program is originated by sellers, they may use it so as to eliminate products that compete with their products.³⁰³ Third, because the production of information is a natural monopoly, a standardization program may itself either intentionally or unintentionally exclude competing standardization programs. The elimination of alternative sources of certification may, in turn, assist the sponsors of the program by discouraging the production of competing uncertified products.

As JCAH is responsive to both intermediate producer and seller constituencies, it could potentially suppress competition in all three of these respects. First, insofar as JCAH limits competition on behalf of its intermediate producer constituency, the physicians, it does so through its standardization of hospital medical staff organization. An early and continuing concern of first the HSP and then JCAH has been the organization of medical staff.³⁰⁴ The original constituents of the HSP were surgeons. Their economic interest lay in requiring hospital organization along a closed staff model that would exclude competition from general practitioners. This would have maximized the demand for and income of surgeons. The fear of this possibility no doubt explains much of the opposition of the AMA to the HSP during the first half of this century, when the AMA's constituency was still largely general practitioners.³⁰⁵ The lingering fear of exclusion of general practitioners from hospital practice by surgeons and other specialists also may explain the continuing opposition of the general practitioner section of the AMA to the JCAH until the late 1960's.³⁰⁶

In fact, despite early efforts by specialists to limit staff privileges, most hospitals were open to almost all physicians at least until the late 1930's.³⁰⁷ This very likely reflects the political power of general practitioners within the health care professions until that point — the general practitioners were no

³⁰² See D. HEMENWAY, *supra* note 221, at 67, 68.

³⁰³ *Id.* at 77.

³⁰⁴ See *supra* text accompanying notes 105, 111, 114. On the literature concerning anti-competitive effects of hospital staff organization, see: W. Lazarus, *supra* note 72, at IV-1-IV-76; Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707 (1981); Kissam, et al., *supra* note 276; Comment, *Denial of Open Staff Hospital Privileges: An Anti-Trust Scrutiny*, 26 ST. LOUIS U. L.J. 751 (1982). Cf. on staff privileges generally M. ROEMER & D. FRIEDMAN, *supra* note 111; Southwick, *supra* note 276, at 427-65 (1978); Groseclose, *Hospital Privilege Cases: Braving the Dismal Swamp*, 26 S.D.L. REV. 1 (1981).

³⁰⁵ See *supra* text accompanying notes 116-22; see DAVIS, *supra* note 90, at 133, E. RAYACK, *PROFESSIONAL POWER AND AMERICAN MEDICINE: THE ECONOMICS OF THE AMERICAN MEDICAL ASSOCIATION*, 41-43 (1967); M. ROEMER & D. FRIEDMAN, *supra* note 111, at 38.

³⁰⁶ See *supra* text accompanying notes 137-39, 149-50; F. Hair, *supra* note 72, at 123-32, see also E. RAYACK, *supra* note 305, at 230-32; R. STEVENS, *supra* note 86, at 252 (general practitioner opposition to restricted staff privileges).

³⁰⁷ STEVENS, *supra* note 86, at 163, 253; Dolan & Ralston, *supra* note 304, at 724, 725.

doubt politically able to stop the surgeons who controlled the HSP from using it to exclude competition from the general practitioners. That hospitals have become increasingly selective in granting staff privileges to physicians is surely attributable in part to the increasing power of specialists within the medical professions.³⁰⁸ Because JCAH has had to respond to a broad constituency of both generalist and specialist physicians, its impact on staff privileges has not been consistently to the advantage of either group. It has played a major role in the growing articulation and rigor of staff privilege requirements, but has also opened up hospitals to physicians through its standards requiring fair consideration of staff privilege applications.³⁰⁹

JCAH has also responded to its physician constituency by playing a major role in limiting the role of non-physician health care practitioners in hospitals. The Accreditation Manual for Hospitals (AMH) recognizes several categories of staff privileges. Under the AMH, members of the medical staff may admit patients to the hospital and supervise their care within it.³¹⁰ Moreover, active medical staff also play a major role in hospital governance.³¹¹ Unless provided otherwise by state law, only physicians (medical doctors or osteopaths) or dentists may be members of the medical staff.³¹² Podiatrists may be granted clinical privileges, permitting them to provide medical care in a hospital, but podiatrist admissions and discharges must be supervised by a physician.³¹³ Only "licensed practitioners," that is, physicians, dentists or podiatrists, may have direct responsibility for diagnosis and treatment of patients; other health professionals may not admit patients and may provide medical care only if supervised by a licensed physician.³¹⁴

JCAH standards assure, therefore, that accredited hospitals will primarily rely on physicians to be responsible for patient care and to provide governance through the medical staff structure. JCAH standards limit to a subordinate role psychologists, chiropractors, midwives, nurse practitioners and other non-physician practitioners who compete with physicians. Yet many of these practitioners may need access to hospitals for certain aspects of their practice if they are to compete with physicians: the psychologist to provide a controlled environment for observing or stabilizing a difficult patient; the midwife for a delivery that threatens to become complicated.³¹⁵

³⁰⁸ See W. Lazarus, *supra* note 72, at IV-31-IV-39 for a discussion of the effects of staff privilege controls on limiting the practices of generalists and of certain specialists.

³⁰⁹ See authorities cited *supra* note 276.

³¹⁰ AMH, *supra* note 39, at xviii, 93.

³¹¹ *Id.* at 100-09.

³¹² *Id.* at 93.

³¹³ *Id.* at xviii, 97.

³¹⁴ *Id.* at xviii, 209; see also W. Lazarus, *supra* note 72, at IV-15-IV-16; Affeldt, *Accreditation Clinic: JCAH Requirements for Delineation of Clinical Privileges and Duties*, 9 HOSP. MED. STAFF, Feb. 1980, at 7 (discussing effect of JCAH staff privilege standards on non-physicians). If state law requires admission of non-physician practitioners to medical staff privileges, the standard would also permit them admitting privileges, see AMH, *supra* note 39, at xviii, 93.

³¹⁵ See Lavine, *Memorandum Supporting Investigation of Joint Commissions on Accreditation of*

Because of the practical necessity of accreditation for a hospital to function, JCAH accreditation is a powerful tool for limiting competition against physicians in the hospital setting and thus for limiting competition against physicians generally.³¹⁶ JCAH may, by thus restraining competition, increase the cost of health care.³¹⁷ It is not surprising that JCAH is currently involved in litigation on several fronts concerning its role in controlling staff privileges in hospitals.³¹⁸

JCAH not only limits the role of non-physician practitioners in hospitals but also does so in a variety of other institutional settings. The "all or none" policy of JCAH requires that all facilities operated by a JCAH accredited institution be JCAH accredited as a condition for any part of the institutions to retain JCAH accreditation.³¹⁹ Under this policy, a hospital that includes a distinct part facility for the developmentally disabled or a substance abuse program also would have to limit staff privileges in its auxiliary programs to comply with JCAH standards for those programs³²⁰ to retain accreditation for its hospital program.

JCAH may not only limit competition against physicians, but also limit competition against its seller constituent members: the hospitals. If hospitals can get state legislatures or private insurance companies to license or pay for only those health care services delivered by JCAH accredited facilities, where those services delivered could also be provided in a non-institutional or non-medical program, the hospitals can exclude competition from the non-accredited programs. For example, a recent legislative proposal in Ohio permitted insurance companies to use JCAH standards as an alternative to state certification for determining reimburseability of substance abuse programs. Opponents contended that use of JCAH standards might require delivery of these services in institutions using a medical model and exclude social service-oriented substance abuse programs.³²¹

Hospitals and American Medical Associations, submitted to the FTC, July 12, 1976, at 29-34; W. Lazarus, *supra* note 72, at IV-40-IV-42, IV-50; Grad, *Allied Health Professionals and Hospital Privileges*, 10 L. MED. & HEALTH CARE 165, 165 (1982). Cf. *Blue Shield of Va. v. McCready*, 102 S. Ct. 2540 (1982) acknowledging competition between psychologists and psychiatrists.

³¹⁶ W. Lazarus, *supra* note 72, at IV-5, IV-7.

³¹⁷ *Id.* at IV-19-IV-20, IV-50-IV-52, IV-54-IV-55.

³¹⁸ See cases cited *supra* note 217.

³¹⁹ See AMH, *supra* note 39, at xx.

³²⁰ Staff privilege standards for mental health facilities are set forth in the CONSOLIDATED STANDARDS, *supra* note 40.

These standards are, on the whole, considerably more open than those of the AMH, and permit staff privileges for not only physicians, but also for clinical psychologists, social workers, psychiatric workers and substance abuse workers. § 9.2.1. They do, however, maintain a central role for physicians in diagnosis, §§ 3.1, 1.10.3.11, and professional staff governance, § 3.7.2.1. Moreover, the JCAH is currently considering evaluating all hospital based mental health facilities under the AMH, a move that could strengthen the hand of physicians in those facilities.

³²¹ Telephone interview with David Shover, Director of Operations, Council on Accreditation (September 8, 1982), regarding Subst. Sen. Bill 336 § 3923.28 (1982) (codified at Ohio Rev. Code § 3923.28 (Baldwin)).

Finally, through its all or none policy JCAH can limit competition against itself from rival accrediting programs. If a hospital operating a substance abuse program must have the program accredited by JCAH to maintain its hospital accreditation, the hospital is unlikely to seek additional accreditation for the program from the Council on Accreditation, a social service oriented accreditation agency which also accredits substance abuse programs.³²²

F. Reasons Why Standardization and Certification Programs Beneficial to Intermediate Producers and Sellers May Not Optimize Consumer Utility

Standardization programs originated to enhance the utility of initial products to intermediate producers may fail to optimize the utility of those products for ultimate consumers. First, a standardization or certification program necessarily requires identification of some products as standard, others as non-standard. If consumers must rely on standards or certificates for consumption decisions, either because of the complexity of a product or because enforcement methods — such as licensing requirements — eliminate the possibility of consumer choice, consumers will not buy non-standard products even though they may better suit some consumers. Any standardization or certification program will thus narrow consumer choices and cause some consumers to buy products that are not suited to their needs.³²³ Some consumers may have preferred to have lower cost, lower quality products available, others just different products. If JCAH requires all hospitals to provide certain services, a consumer must go to a hospital with such services, even though they are useless to that consumer and may increase the costs of hospitalization.

Second, if a standardized or certified product is complex, and the quality standardization program relies on many criteria, it is likely that the program will err in providing products of too high or too low quality in some respect.³²⁴ If standards permit some aspects of the product to be of low quality, consumers will derive less utility from that aspect of the product. If standards require excessive quality as to some product characteristics, consumers may have to pay for quality of no use to them.

If a standardization and certification program is initiated by intermediate producers, both the problem of non-availability of non-standard goods and the problem of error as experienced by the ultimate consumer may be exacerbated. If the market power of the intermediate producer is sufficiently strong, or if the program is enforced independently, the initial producer may eliminate non-standard initial products that may independently be of use to the ultimate consumer but do not enhance the utility of the intermediate producer's product. Moreover, the program may discourage the initial producer from producing

³²² COUNCIL ON ACCREDITATION, PROVISIONS FOR ACCREDITATION, 80-84 (1982).

³²³ FEDERAL TRADE COMMISSION, *supra* note 223, at 55, 56; J. GELMAN, *supra* note 226, at 135.

³²⁴ FEDERAL TRADE COMMISSION, *supra* note 223, at 567-69.

products that could be useful to competitors of the intermediate producer. If intermediate producers use standardization as a means to deny the initial product to competing producers of substitute final products, the consumer may be denied access to a final product he prefers. Finally, a standardization and certification program initiated by an intermediate producer will not necessarily increase the utility of the product of the intermediate producer to the ultimate consumer. In relation to the ultimate consumer, intermediate producers are sellers; intermediate producers will assure the quality of their own product through standardization only to the extent that it is independently in their interest to do so as sellers.³²⁵ Similar effects may result from the standardization of complementary products.

This analysis may provide insight into the effect of JCAH standards on quality of institutional health care as experienced by the ultimate consumer: the patient. JCAH was initiated by surgeons and a majority of the commissioners are still physicians and surgeons. The analysis above would suggest that JCAH standards, and the hospitals developed to comply with them, would be structured to assure high quality initial inputs to be used by or to complement the services of physicians and surgeons. Accordingly, it is not surprising that JCAH standards have been criticized frequently for excessive emphasis on the quality of medical care inputs as opposed to the quality of actual medical outcomes in accredited hospitals.³²⁶ The hospital, the major product of JCAH standardization, has also been criticized for relying excessively on costly, complex, and technological forms of medical care³²⁷ that increase the demand for and the price of physician or surgeon services. The hospital appears to have been organized largely for the convenience and welfare of the physician rather than the patient.³²⁸

This analysis also explains deficiencies critics have identified in the JCAH survey and accreditation program. First, JCAH accreditation inspections are arranged beforehand with ample warning to the institutions, assuring that JCAH only sees the institution at its best behavior and not in its normal condi-

³²⁵ See *supra* text accompanying notes 277-78, 285-86, 293-94, 298-303, discussing circumstances in which sellers may standardize or certify their products.

³²⁶ Wyatt Brief, *supra* note 67, at 10-14; J. Feder, *supra* note 164, at 8; Gelman, *supra* note 226, at 128; A. GERBER, *supra* note 107, at 130-136; S. LAW & S. POLAN, *supra* note 174, at 58, 64; A. Somers, *supra* note 127, at 106; Crosby, *supra* note 54, at 133-35; Gerber, *Surgical Pros and Cons*, 135 SURG. GYNOL. OBSTE. 431, 432 (1972); Worthington & Silver, *supra* note 176, at 312; *Suit Challenges*, *supra* note 101, at 186.

³²⁷ This criticism has been voiced both from the perspectives of concerns about the cost of care, see Havighurst & Blumstein, *supra* note 1, at 25-30; Cohodes, *supra* note 3, at 65-66; Rosenblatt, *supra* note 1, at 1094-1106, and concerns about quality, see V. SIDEL & R. SIDEL, A HEALTHY STATE, 69-78 (1977); ILLICH, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH 18-25 (1975).

³²⁸ See Pauly & Redisch, *The Not-For-Profit Hospital as a Physician Cooperative*, 63 AM. ECON. REV. 63, 87-99 (1973); Redisch, *supra* note 271, at 218-31; Saltman & Young, *supra* note 274, at 406-10.

tion.³²⁹ Second, a two hour public information interview provides the only opportunity for hospital staff and consumer representatives to participate in the JCAH survey process. Moreover, hospital administrators are normally present at this interview, a factor that may intimidate hospital staff members.³³⁰ JCAH further limits hospital staff and consumer input into accreditation decisions by permitting hospital employees and staff and consumer representatives no further opportunity to participate in the accreditation process, rebut administration claims, or review a decision to grant accreditation.³³¹ JCAH provides a lengthy appeal process during which a hospital denied accreditation may continue to operate as though accredited.³³² Dissatisfaction with these procedures and their results is evidenced by the charges of inadequacy leveled at the JCAH surveys.³³³ The inspection process itself takes place only once every three years and, under new JCAH survey procedures, may even rely on self-survey to assure the correction of violations identified by the inspection process.³³⁴ Finally, JCAH does not require facilities to meet all, or indeed any, of its requirements or standards, but only to "substantially comply" with the standards as a whole.³³⁵

JCAH has responded to these criticisms principally by asserting that they are based on a misunderstanding of JCAH's role. JCAH perceives itself not as an enforcer, but rather as a consultant or educator whose role is to encourage and inspire hospitals voluntarily to deliver high quality care.³³⁶ JCAH asserts that its primary role is to assure that hospitals have the capacity to deliver care rather than to guarantee that such care is in fact delivered.³³⁷

Both the criticisms of JCAH and its response are not surprising, given that JCAH is a standardization and certification program enacted by sellers and by

³²⁹ *House hearings*, *supra* note 64, at 6; *Senate hearings*, *supra* note 53, at 38, 44, 103-05; *Hearings*, *supra* note 54, at 1904; Wyatt Brief, *supra* note 67, at 15; Rubin, *The Accreditation of Hospitals, What Does it Promise?*, HEALTH L. PROJ. LIB. BULL. 90, 93 (1980).

³³⁰ See AMH, *supra* note 39, at xx; xxi; Rubin, *supra* note 320, at 94. See also *Misericordia Hospital Medical Center v. NLRB*, 623 F.2d 808 (2d Cir. 1980) (sustaining an NLRB order reinstating a nurse fired for testifying at a JCAH public information interview).

³³¹ See *Hearings*, *supra* note 54, at 1905; Wyatt Brief, *supra* note 67, at 15-17; Rubin, *supra* note 329, at 94.

³³² See Rubin, *supra* note 329, at 96.

³³³ See Wyatt Brief, *supra* note 67, at 8-19; *Senate hearings*, *supra* note 64, at 38, 66, 68; *House hearings*, *supra* note 64, at 56-60.

³³⁴ See Wyatt Brief, *supra* note 67, at 16, and authorities cited *supra* at note 216. JCAH does accept complaints regarding hospitals from patients or staff and, on occasion, makes unannounced inspections based on such complaints. Telephone interview with Eleanor Wagner and Daniel Schuyler, attorneys for JCAH, Dec. 9, 1982. However, recent hearings brought out that JCAH only received 24 complaints in 2 years (*Senate hearings*, *supra* note 64, at 104) (compare the 3400 complaints received by the California Health Department over a one year period (*id.* at 45)). Moreover, though JCAH has made some unannounced surveys in response to complaints (*id.* at 104), it handles many complaints by asking the facility to investigate itself (*id.* at 39, 116; *House hearings*, *supra* note 64, at 81).

³³⁵ See authorities cited *supra* note 51.

³³⁶ See authorities cited *supra* note 54.

³³⁷ *Hearings*, *supra* note 54, at 1901.

complementary and intermediate producers. Physicians and surgeons who practice in the hospital setting are not as interested in the final product the hospital delivers as they are in the capacity of the hospital to support their own production of services.³³⁸ While infrequent announced inspections may not guarantee continued high quality care, they are adequate to insure that the hospital will be organized along the lines set out in the JCAH standards, and that physician goals can be met within the hospital. It is not in the interests of physicians or surgeons to have an accreditation program that would monitor their own performance or be a constant intrusive presence in the hospital, interfering with their practice.³³⁹ The institutions also have no interest in a more intrusive inspection program or higher standards. As long as the JCAH program is adequate to avoid political pressure for more intensive government regulation, and, perhaps, to keep the worst violators of consensus standards out of operation, institutions ought to be satisfied.³⁴⁰

This is not to say, however, that the JCAH accreditation program has not had or cannot have a positive affect on the quality of care patients receive from hospitals. Weaknesses in the inspection system need not mean that hospitals do not in fact comply with the standards. Insofar as the standards address major administrative systems or physical plant characteristics, it is unlikely that compliance will fluctuate markedly over the three year accreditation period, or that a hospital seriously out of compliance will be able to achieve compliance solely for the purposes of an accreditation inspection.³⁴¹

Empirical and anecdotal evidence concerning the effect of JCAH standards on the quality of hospital care is inconclusive. JCAH accreditation of hospitals with serious quality deficiencies played a prominent role in consumer criticisms of JCAH in the early 1970's.³⁴² Implementation of the JCAH quality audit, the centerpiece of its quality control system, has been criticized as inadequate.³⁴³ Research has found low correlations between JCAH accreditation and other measures of hospital quality³⁴⁴ and wide variations in quality be-

³³⁸ See *supra* text accompanying notes 270-74.

³³⁹ *Id.*

³⁴⁰ See *supra* text accompanying notes 277-97.

³⁴¹ It is instructive that in 1970, 74% of all hospitals inspected received full accreditation but that only 45% of the hospitals inspected for the first time did so. Schlicke, *supra* note 72, at 381. Hospitals apparently find it easier to maintain compliance with accreditation standards than to initially meet them.

³⁴² BRESLOW, QUALITY AND COST CONTROL: MEDICARE AND BEYOND IN THE ADMINISTRATION OF MEDICARE: A SHARED RESPONSIBILITY, 17, 30, 31 (B. Smith & N. Hollander eds. 1973); Worthington & Silver, *supra* note 176, at 312-13; see *Hospital Accreditation*, *supra* note 192, at 3; *Suit Challenges*, *supra* note 178, at 187.

³⁴³ See Escovitz, Burkeitt, Kuhn, Zeleznick & Gonnella, *The Effects of Mandatory Quality Assurance*, 16 MED. CARE, Nov. 1978, at 941.

³⁴⁴ J. NEUHAUSER, THE RELATIONSHIP BETWEEN ADMINISTRATIVE ACTIVITIES AND HOSPITAL PERFORMANCE 60-69, 100 (1971); see also Roemer, Mostafa & Hopkins, *A Proposed Hospital Quality Index: Hospital Death Rate Adjusted for Case Severity*, 3 HEALTH SERV. RESEARCH 96, 115 (1968) (finding little difference in quality between accredited and unaccredited hospitals).

tween JCAH accredited hospitals.³⁴⁵ Nevertheless, overall consumer satisfaction with medical care remains high³⁴⁶ and JCAH itself continues to enjoy general respect.³⁴⁷

G. Non-Accountability of Self-Regulation

A final basis for criticizing self-regulatory standardization and certification programs is their lack of accountability to the public, a factor not directly related to efficiency. Inefficient regulation may to some extent be excused if a regulatory program advances public policy goals other than efficiency, such as distributional equity or public participation. Industry self-regulation lacks, however, a commitment to these goals. JCAH claims that it is responsible primarily to its members and the institutions that it accredits, not to the public.³⁴⁸ JCAH asserts this even though it has accepted a major role in federal and state programs regulating health care, a role responsible for much of its growth over the last two decades.³⁴⁹

Few opportunities for public participation in either its standardization or its accreditation programs are provided by JCAH. Its consumer advisory council was short-lived. Its one "public" member was added only recently and cannot seriously be considered a representative of health care consumers.³⁵⁰ It has been claimed that representation and participation of consumers in the accreditation councils may have been a significant factor in JCAH's disbanding the councils and establishing the PTAC system.³⁵¹ Since the early 1970's, JCAH has allowed some consumer participation in its accreditation inspections through its public information interviews, but this participation is strictly limited, and JCAH still makes no provision for consumer appeals of accreditation decisions.³⁵²

³⁴⁵ See Longest, *Administrative Coordination in General Hospitals*, Georgia State University, School of Business Administration, Research Monograph No. 55 (1973) cited in P. O'DONOGHUE, EVIDENCE ABOUT THE EFFECTS OF HEALTH CARE REGULATION 86 (1974).

³⁴⁶ See Anderson, Fleming & Champney, *Exploring a Paradox: Belief in a Crisis and General Satisfaction with Medical Care*, 59 MILLBANK MEMORIAL FUND Q. 329 (1982).

³⁴⁷ See, e.g., 1979 and 1980 GAO Reports urging substitution of JCAH accreditation for state licensure; *People v. Barksdale*, 8 Cal.3d 320, 336-37, 503 P.2d 257, 269-70, 105 Cal. Rptr. 1, 13-14 (1972); *Senate hearings*, *supra* note 53, at 16 (testimony of Carolyn Davis, Administrator, Health Care Financing Administration).

³⁴⁸ See authorities cited *supra* note 54.

³⁴⁹ About 30-32% of the survey fees paid JCAH are reimbursed by the federal government. GAO REPORT, *supra* note 207, at 5. More important, the prominent role of JCAH in federal and state regulation undoubtedly explains much of its growth since 1965. See *supra* text accompanying note 170.

³⁵⁰ JCAH's first public member, appointed in 1981, is a governor of a hospital, president of a telephone company and director of several corporations including a major Chicago bank. See *BOC Selects First Public Member*, JCAH PERSPECTIVES, Nov.-Dec. 1981, at 4.

³⁵¹ Crosby, *supra* note 54, at 137 n.4.

³⁵² See AMH, *supra* note 39, at xx-xxi describing JCAH's public information interview procedure. Persons wishing to testify at the public information interview must request the right to do so in writing. The request must be received by JCAH at least two working days before the

The most serious failure of JCAH with respect to public accountability is its refusal to provide public access to information. As related earlier, JCAH maintains strict confidentiality regarding its survey records, and has gone so far as to sue the federal government to maintain the confidentiality of these records.³⁵³ The question of availability of survey information if deemed Medicaid certification status is to be accorded to accredited nursing homes continues to be a major issue in that policy decision.³⁵⁴ The JCAH policy of confidentiality not only decreases the accountability of JCAH and of the hospitals it regulates to the public, but also diminishes the possibilities for competition between health care providers by not disclosing information to consumers that might permit consumers to make more informed decisions among competing providers.

Considering the earlier analysis,³⁵⁵ none of this is surprising. If JCAH has been created to serve the needs of a constituency of physicians and surgeons and a constituency of institutions, there is no reason for it to become accountable to the public, encourage public participation, or make its operations and records public. Not having been formed to serve the public, JCAH is not accountable to the public.

III. JCAH: BENEFITS AND PROBLEMS

At this point it is appropriate to stop and draw up a balance sheet based on what the economics of the information model reveals about JCAH. Having done this, it will be possible to evaluate JCAH as compared to alternative means of quality control.

survey begins. JCAH notifies the hospital of all requests for public information interviews and hospital representatives are expected to attend. The public information interview takes place on the first survey day and normally does not exceed two hours in length. Any further participation in the survey by outside sources of information must be authorized by the hospital. *See Hearings*, *supra* note 54, at 1990, at which then director Porterfield testified that turning the accreditation process into an adversary procedure by allowing consumer appeals would destroy the "internal quality promotion mechanism" of the JCAH. *See also* Rubin, *supra* note 329, at 94 (criticizing the JCAH inspection process).

³⁵³ *See supra* text accompanying note 193; Affeldt, *Maintaining Confidentiality of Survey Data*, 56 HOSP., Sept. 16, 1982, at 70; Affeldt, *Accreditation Problems: Confidentiality of Survey Reports*, 53 HOSP. Mar. 16, 1979, at 44 (hereinafter cited as *Confidentiality*). JCAH defends its confidentiality policy in part by claiming that the public is incapable of understanding survey information. Lewis, *supra* note 190, at 20, 21.

³⁵⁴ *See* 47 Fed. Reg. at 23406 (1982), Letters, from John E. Affeldt, president of JCAH to Edward L. Kelley, acting director Health Standards and Quality Bureau (Dec. 2, 1980) insisting on confidentiality of accreditation survey reports and reply from Kelley to Affeldt (Jan. 30, 1981) affirming the critical need for disclosure of survey records before HHS could grant JCAH accredited nursing homes deemed status for Medicare and Medicaid certification. *See also Senate hearings*, *supra* note 53, at 16, 64-65, 102, 241, *House hearings*, *supra* note 64, at 76 (discussing JCAH confidentiality policy).

³⁵⁵ *See supra*, §§ IIA-IIF.

First, on the positive side of the ledger:

1) JCAH standards assure the organization of hospitals so as to maximize the utility of hospitals to physicians and surgeons. Derivatively, the standards in some instances increase the utility of hospitals to patients. They do so first by identifying and describing factors that assure the quality of inputs necessary for physician care in hospitals. For the reasons discussed earlier,³⁵⁶ it is much more efficient for a single entity to do this than for each physician, acting as an atomistic consumer, to identify these attributes through his own search and experience. Second, JCAH, through its accreditation program, assisted by ancillary enforcement tools both public and private — such as licensure requirements — assures that institutions are organized to enhance the quality of these inputs. Third, and perhaps most important, JCAH standards give physicians a controlling role in many aspects of hospital organization. In particular, the standards require self-governing, organized hospital medical staffs, with initial responsibility for staff appointments and quality control.³⁵⁷ Through these JCAH requirements physicians have created a structure perhaps unparalleled elsewhere in industrial organization. JCAH standards assure physicians a prominent role in administering aspects of the hospital relevant to their practice without requiring them to assume economic or general administrative responsibility for the hospital. Hospitals must accept this arrangement because of ancillary private and public enforcement devices, including government licensure and Medicare certification. Thus to the extent that physicians' services are useful to hospital patients, JCAH assures that those services will be delivered in a context that provides optimal inputs for those services.

2) Hospital participation in JCAH further assures patients an adequate level of care in accredited hospitals. Hospitals are motivated to use standards to maintain a sufficiently high average level of quality to assure confidence in and demand for their services, to minimize political pressure for increased regulation and to minimize tort liability. They will therefore generally be motivated to exercise their power within JCAH to maintain at least a minimally adequate level of quality in hospitals.

3) JCAH operates efficiently. JCAH can get by with a minimal inspection program because the bulk of standards enforcement is achieved through physicians and administrators within the hospital. As JCAH standards promote the self-interest of physicians and hospitals, they are largely self-enforcing. JCAH is a consultant, not an enforcer. Moreover, because JCAH is responsive to the industry, it can draw heavily on industry expertise at a minimal cost and efficiently create and review standards. There is some empirical evidence of such

³⁵⁶ See discussion of problems faced by consumer standardization efforts, *supra* text accompanying notes 229-35, much of which would apply to physicians acting as individual consumers.

³⁵⁷ See AMH, *supra* note 39, at xviii, 103-05, 151-54, 209.

efficiency. The 1979 GAO Report relates that state validation inspections cost on the average \$150 more than JCAH accreditation surveys.³⁵⁸

4) Finally, the standards would appear to minimize regulatory inefficiencies. A frequent complaint about regulation is that it creates inefficiencies in the regulated industry.³⁵⁹ As JCAH is accountable to the institutional medical care industry, such inefficiencies ought to be minimal. JCAH analyzes its regulations for cost effectiveness, and attempts to allow hospitals maximum flexibility in applying standards.³⁶⁰

The negative side of the balance, however, also is weighty:

1) JCAH provides little useful information to ultimate consumers about accredited institutions. Consumer preferences in health care vary, but JCAH provides consumers with almost no information to assist their choices.

2) JCAH provides ultimate consumers with little protection as to the quality of the medical care they receive. JCAH focuses on the quality of the initial products physicians use in delivery of care, less on the quality of the final product: physician/hospital services provided to patients.

3) JCAH does not address the quality of services of non-institutional health care services, as they are generally not accredited by JCAH. It addresses poorly the issue of quality of care delivered by non-physician practitioners. Its standards have the effect of excluding non-physician practitioners or subjecting them to the supervision of physicians rather than of optimizing the use of their skills.

4) Moreover, the effects of JCAH standards on alternative health care providers are anticompetitive. JCAH standards restrict significantly the role of non-physician practitioners in hospital settings. JCAH accreditation also limits health care delivery to institutional settings by excluding competing non-institutional alternatives, insofar as accreditation is used as a requirement for licensing or insurance payments.

5) JCAH is less useful for identifying the quality of services of institutions in which physicians are not involved. In institutions such as hospitals, where physicians are heavily involved, the intermediate producer "cross-regulation" aspects of JCAH counterbalance its self-regulatory aspects. For facilities like nursing homes, however, where physician involvement is minimal,³⁶¹ JCAH represents pure self-regulation, and provides less protection for consumer interests.

³⁵⁸ See GAO REPORT, *supra* note 207, at iii, 24-25, but see Senate hearings, *supra* note 53, at 46 (testimony of Mildred Simmons, deputy director of California Department of Health Service, claiming that state inspections are less expensive).

³⁵⁹ See, e.g., McClure, *Structure*, *supra* note 1, at 136-39; Noll, *supra* note 1, at 38, 39.

³⁶⁰ See Affeldt, *Cost Effective Health Care, How JCAH Will Help*, 9 HOSP. MED. STAFF, Apr. 1979, at 7-9.

³⁶¹ See Mechanic & Arkin, *A Cooperative Agenda for Medicine and Nursing*, 307 NEW ENG. J. MED. 747, 749 (1982).

6) JCAH lacks the saving grace of availability for achieving public policy goals other than efficiency. It is not open to public scrutiny, participation or responsibility.

IV. ALTERNATIVES

The picture of JCAH that emerges at this point is mixed. Significant contributions to efficiency and consumer welfare are counterbalanced by inefficiencies and an absence of accountability. With this assessment before us, we can consider how JCAH compares to alternative means of quality regulation.

Some of these alternatives can be disposed of summarily. First, suppression of JCAH in favor of leaving hospital quality to be determined by a completely unregulated market does not seem warranted. The positive contribution of JCAH to maintaining health care quality is significant. The negative aspects of JCAH, such as its anticompetitive effects, may perhaps be controlled without suppressing JCAH itself. The major problem with JCAH's quality standards is not that they are wrong, just incomplete.

Second, consumer accreditation does not seem an adequate alternative. Though this alternative has much to commend it in theory, it is impractical. For the reasons set out earlier,³⁶² the cost of standardization and certification of medical care facilities would be high, the difficulties with consumers recapturing this cost by reselling information insurmountable. It is also unlikely that consumers could assemble the expertise necessary to evaluate technically complex health care, or even that they would be allowed admission to private health care facilities for accreditation inspections. This is not to say that consumers cannot play a significant role in assuring health care quality. It is, however, unlikely that they could ever replace the JCAH.

There are, however, other, more viable options. A comprehensive federal regulatory program could be established. Alternatively, JCAH could be made a public body. Finally, JCAH as it stands could be supplemented and controlled.

A. Government Standardization and Accreditation

A first possibility is comprehensive federal government regulation of institutional medical care in addition to the JCAH program. Government regulation of medical care institutions, of course, has already existed at the state and local level for at least thirty to forty years. Almost all states now require hospitals and nursing homes to be licensed.³⁶³ Nevertheless, state standards and inspections often are more superficial than those of JCAH.³⁶⁴ And

³⁶² See *supra* text accompanying notes 229-35.

³⁶³ A. SOMERS, *supra* note 127, at 107 n.4. See also Lander, *supra* note 26, at 132, 133 (discussing hospital licensure).

³⁶⁴ GAO REPORT, *supra* note 207, at 16-21; Schlicke, *supra* note 72, at 381; J. GELMAN,

many states, encouraged by the federal government, have moved towards relying on JCAH accreditation for state licensure.³⁶⁵

There is currently no comprehensive federal government program for standardizing and certifying medical care facilities. The Senate passed a bill in 1973 to establish a federal Commission of Quality of Health Care Assurance which could have replaced the JCAH for the purpose of certifying facilities to participate in federal programs.³⁶⁶ The idea of such a commission has much to commend it. It would presumably be more directly accountable and responsive to the public interest than JCAH. It could easily be made subject to the Freedom of Information Act³⁶⁷ and to Administrative Procedure Act rule-making requirements,³⁶⁸ thus assuring public access to information and public participation in standard setting. It might also have less anticompetitive effects than JCAH.

There are, however, reasons why the creation of such a program might be unwise. As to a federal hospital regulatory program these arguments are quite strong. First, it is probable that if a federal program were created the constituency of JCAH would retain JCAH as a separate parallel private program. Certainly physicians would support a continued JCAH program to protect their interests. A federal program would therefore constitute an expensive duplication of the JCAH program. Because JCAH represents professional organizations of substantial size and experience, and can consult with additional professional groups through its PTAC's, it has access at minimal cost to extensive and widely varied expertise. For a health care regulatory commission to operate independently it would need to develop its own duplicate system of experts at considerable cost.³⁶⁹ Though the program could avoid this cost initially by adopting JCAH standards, it would still need to develop its own expertise to update and enforce the standards. This duplication would of necessity be inefficient to the patient/taxpayer unless the benefits of the federal pro-

supra note 226, at 126; Lewis, *supra* note 190, at 23; Worthington & Silver, *supra* note 176, at 308-310.

³⁶⁵ See authorities cited *supra* notes 66-71, 212.

³⁶⁶ Health Maintenance Organization and Resources Act of 1973, S. 14 § 403, 93rd Cong., 1st Sess. S. REP. NO. 129, 81-88 (1973), reprinted in Boggs, "A Context for Quality Control," in *THE MENTALLY RETARDED CITIZEN AND THE LAW*, 357, at 370-371 (M. Kindred ed. 1976) (the proposal passed the Senate but was dropped from the bill in the House, see Boggs, *supra* at 370). Cf. Clark, *Why Does Health Care Regulation Fail?*, 41 MD. L. REV. 1, 26-28 (1981) (suggesting the establishment of a Commission on Medical Technologies to provide some non-physician control over medical decision making). The federal government has not always shown interest in health care standardization. In 1913 the ACS petitioned the Public Health Service to take over the hospital standardization effort. The government declined the offer, stating that standardization was a task for the public sector. M. ROEMER & D. FRIEDMAN, *supra* note 111, at 36.

³⁶⁷ See 5 U.S.C. § 552(a)(2) (1976, Supp. IV 1980).

³⁶⁸ See 5 U.S.C. § 553 (1976).

³⁶⁹ Henderson & Pearson, *Implementing Federal Environmental Policies, the Limits of Aspirational Commands*, 78 COL. L. REV. 1419, 1438 (1978); McClure, *Structure*, *supra* note 1, at 136; Wolfson, Trebilcock & Thohy, *supra* note 235, at 211.

gram were so significant as to justify the costs of establishing and operating a duplicate program. It is generally believed, both at the federal and the state level, that JCAH does a sufficiently adequate job of regulation of hospitals so that such additional costs would not be justified.³⁷⁰

A second problem is the potential lack of flexibility in a federal hospital standardization effort. JCAH has responded to the constantly changing nature of the technology of health care delivery by continually revising and updating its standards. By contrast, the federal government basically adopted JCAH standards for its small independent Medicare hospital certification program for non-accredited hospitals in 1966³⁷¹ and has made only minor changes since.³⁷² While public rulemaking procedures facilitate public participation and accountability, they are cumbersome and time-consuming and impose upon a standardization program an inflexibility that would hinder regulation of a rapidly evolving industry like institutional medical care.³⁷³

Third and most significant, it has frequently been noted that regulatory agencies have a tendency to favor the interests of organized regulated industries over those of diffuse and unorganized consumers.³⁷⁴ This tendency is particularly strong in the medical care industry, which has shown itself remarkably adept at co-opting any programs designed to regulate it.³⁷⁵ Hospital patients are singularly atomistic and unorganized; they have no common characteristics to facilitate organization other than their idiosyncratic medical problems. Accordingly, there is little ground for optimism that a federal government regulatory agency would be any more responsive to consumer interests or less responsive to hospitals than JCAH.

All of these arguments, however, carry much less force when applied to regulation of nursing homes and perhaps of other non-hospital institutions. First, JCAH nursing home accreditation is much less pervasive than is hospital accreditation. Whereas the vast majority of hospitals are now subject to JCAH accreditation, only 1,300 of the nation's 23,000 nursing homes are currently JCAH accredited.³⁷⁶ Six hundred of these are hospital based facilities.³⁷⁷ JCAH nursing home accreditation has never been accepted by state licensing

³⁷⁰ See authorities cited *supra* note 347.

³⁷¹ J. FEDER, *supra* note 164, at 11; A. SOMERS, *supra* note 127, at 117.

³⁷² Recent proposed changes in the federal program appear to aim at bringing it in line with proposed JCAH changes. See 48 Fed. Reg. 299 (1983).

³⁷³ P. HARTER, *supra* note 223, at 203-07 (1979); McClure, *Structure*, *supra* note 1, at 129-131; Noll, *supra* note 1, at 35-38; Schlicke, *supra* note 51, at 384. Cf. FELDSTEIN, *HEALTH CARE ECONOMICS*, 241-242 (1979) (Feldstein argues that regulatory agencies resist change both to limit their risks of failure and to protect regulated industries from competition and diminished profitability).

³⁷⁴ McClure, *Structure*, *supra* note 1, at 122-26; Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1671, 1684-87 (1975).

³⁷⁵ See generally Clark, *supra* note 366 (addressing the problem of physician co-option of medical regulation).

³⁷⁶ House hearings, *supra* note 64, at 83; Punch, *supra* note 54, at 40.

³⁷⁷ Downey, *Nursing Homes vs. JCAH*, MODERN HEALTH CARE, April 1975, at 35.

agencies or for federal Medicare and Medicaid program certification purposes as a "deemed" equivalent of state or federal inspection and approval. Virtually all states license nursing homes³⁷⁸ and most nursing homes are certified to participate in some federal program,³⁷⁹ so government regulation is much more pervasive than is JCAH accreditation. As to nursing homes, therefore, it is clearly JCAH accreditation and not government regulation which is the duplicative program. Second, the arguments based on lack of expertise and flexibility carry much less weight here. Nursing home care is much less technologically complex than hospital care and is subject to less frequent and substantial changes in technology. Further, the federal and state governments have regulated nursing home care for some time and have had an opportunity to accumulate significant expertise.³⁸⁰ In addition, the highly organized nature of the senior citizen and nursing home consumer lobby makes it less likely that regulatory agencies will become subservient to provider interests.³⁸¹ Finally, and most important, the internal guarantees that make JCAH a more acceptable instrument for regulating hospitals are not applicable to nursing homes. As the model developed earlier shows, the independent interests of physicians and surgeons in hospital regulation, combined with their heavy representation on the JCAH, assures that the hospital regulatory program at least guarantees patients high quality theatres for the performance of physicians and surgeons.³⁸² The presence and interest of physicians in nursing homes is minimal,³⁸³ however, and thus physicians are much less likely to operate as a balancing force against the nursing home constituency within JCAH. JCAH nursing home regulation may well be an undesirable form of self-regulation.

In summary, JCAH accreditation may be superior to government regulation for some purposes such as hospital accreditation, but not for other purposes, such as nursing home regulation.

B. Make JCAH a Public Body

A second option is to make JCAH function essentially like a government entity. This could be done by making JCAH accountable to the public: opening its board to public participation and its records and reports to the public.

³⁷⁸ See T. JOST, MODEL RECOMMENDATIONS: INTERMEDIATE SANCTIONS FOR ENFORCEMENT OF QUALITY OF CARE IN NURSING HOMES, at 57-71 (1981).

³⁷⁹ 17,000 nursing homes participate in Medicaid, *House hearings*, *supra* note 64, at 79.

³⁸⁰ Most states adopted nursing home licensing statutes in the 1940's or earlier. F. Hair, *supra* note 72, at 246. The JCAH nursing home accreditation program did not begin until 1965. *Id.* at 148-50.

³⁸¹ The strength and effectiveness of this lobby is demonstrated by the response to regulations proposed to permit deemed status for JCAH accredited nursing homes. A position statement opposing use of JCAH accreditation for Medicare and Medicaid certification of the National Citizens Coalition for Nursing Home Reform was endorsed by 43 national organizations (July 12, 1982). A letter to Secretary Schweicker expressing opposition to the bill was signed by 49 Congressmen. A six month moratorium on the issuance of the regulations was passed by Congress. The moratorium was subsequently extended 120 days. See *supra* note 64.

³⁸² See *supra* text accompanying notes 270-276.

³⁸³ Mechanic & Arkin, *supra* note 361, at 749.

In the recent past the federal government has explored this option with regard to private standard-setting bodies generally. JCAH is, of course, not the only private standard-setting and certifying body with considerable authority over public decisions.³⁸⁴ The implications of such power being held by private bodies have not been lost on the federal government, which, during the Carter Administration, showed real concern about the accountability of private standard-setting bodies. A policy statement of the Office of Management and Budget (OMB)³⁸⁵ and proposed rules of the Federal Trade Commission (FTC)³⁸⁶ issued in the late 1970's would have required considerable expansion of opportunities for public participation and public access to the standard making process.³⁸⁷ Similar proposals were made by the National Standard Policy Advisory Committee³⁸⁸ and raised in Congress.³⁸⁹ The Reagan Administration has, however, distanced itself from these proposals, and given free reign to private standard setting.³⁹⁰

There are legal arguments under existing law for making JCAH function like a public entity. First, there is the Administrative Procedures Act (APA).³⁹¹ The APA generally requires "agencies" of the federal government generally to conduct public rule-making procedures,³⁹² provide procedural protections to subjects of formal adjudicatory decisions³⁹³ and, with certain exceptions, hold their records and determinations available for public inspection and copying.³⁹⁴ If JCAH were deemed a federal agency, it essentially would have to function like a public body and, in all likelihood, would be less efficient.

While the question is not wholly free from doubt, it seems unlikely that the JCAH is an agency under the APA. In *Forsham v. Harris*,³⁹⁵ the Supreme Court considered the definition of agency under the Freedom of Information Act (FOIA) (which incorporates the definition of agency from the APA). Drawing on an earlier case defining agency for tort claims act purposes,³⁹⁶ and on

³⁸⁴ See FEDERAL TRADE COMMISSION, *supra* note 223, at 31-38.

³⁸⁵ OMB Circular A-119, Federal Participation in the Development and Use of Voluntary Standards, 45 Fed. Reg. 4325 (1980); *but see* Proposed Revision of OMB Circular A-119, 47 Fed. Reg. 16,919 (1982).

³⁸⁶ See Proposed Trade Regulation Rule — Standards and Certification, 43 Fed. Reg. 57,269 (1978) (*see* 46 Fed. Reg. 39845 (1981), setting new schedule for submission of final staff report) (to be codified at 16 C.F.R. 457).

³⁸⁷ These proposals generally excluded from their coverage professional standardization and certification, *see* 47 Fed. Reg. 16920 (1982), 43 Fed. Reg. 57269 (1978), 45 Fed. Reg. 4326.

³⁸⁸ 43 Fed. Reg. 6298 (1978).

³⁸⁹ See Voluntary Standards Accreditation Act, S.825, 95th Cong., 1st Sess. (1977).

³⁹⁰ *See* 47 Fed. Reg. 16,919 (1982).

³⁹¹ 5 U.S.C. § 551-559 (1976 and Supp. IV, 1980).

³⁹² 5 U.S.C. § 553 (1976). The rulemaking provisions do not apply to matters involving loans, grants, benefits, or contracts and therefore might not cover much of the Medicare program, JCAH's principal federal responsibility.

³⁹³ 5 U.S.C. §§ 554, 556, 557 (1976 and Supp. IV 1980).

³⁹⁴ 5 U.S.C. § 552 (1976 and Supp. IV 1980).

³⁹⁵ 445 U.S. 169 (1980).

³⁹⁶ *Id.* at 180 and note 11 citing *United States v. Orleans*, 425 U.S. 807 (1976).

legislative history of the FOIA showing that Congress did not intend to include within the FOIA corporations that merely received grants from the federal government,³⁹⁷ the Court held that absent "extensive, detailed, and virtually day-to-day supervision,"³⁹⁸ grantees of the federal government do not become agencies.

Although the JCAH receives large sums of money from the federal government through reimburseable survey fees and is actively cooperating with the federal government by providing information as to hospital accreditation, a recent case — *Cospito v. Califano*³⁹⁹ — has held that JCAH is not sufficiently subject to day-to-day control by the federal government to make it an agency under this test. The Court rejected the argument of the plaintiffs in *Cospito* (patients in a mental hospital who had lost federal assistance because JCAH had discredited their facility) that JCAH was a federal agency subject to the APA.⁴⁰⁰

A stronger argument can be made for JCAH agency status under another test that also appears in earlier cases and has not explicitly been rejected by the Supreme Court. Under this test the question is whether an entity has independent "authority by law" to take "final and binding action affecting the rights and obligations of individuals."⁴⁰¹ Even under the independent authority test, however, JCAH would probably not be subject to the APA and FOIA, as decisions of the JCAH are in most instances not final independent government decisions. Only in two instances does JCAH exercise authority that might subject it to the federal APA and FOIA under the independent authority test. The first involves JCAH certification decisions concerning Medicaid payments to psychiatric hospitals for minors; the second, certification decisions for Medicare or Medicaid payments to psychiatric hospitals not eligible for distinct part certification. In both situations JCAH accreditation is required for program participation.⁴⁰² It should be noted, however, that the extensive authority

³⁹⁷ *Forsham v. Harris*, 445 U.S. at 179-80.

³⁹⁸ *Id.* See also *Public Citizen Health Research Group v. Department of Health Education and Welfare*, 668 F.2d 537 (D.C. Cir. 1981); *St. Michael's Convalescence Hosp. v. California*, 643 F.2d 1369 (9th Cir. 1981); *Irwin Memorial Blood Bank of the San Francisco Medical Soc'y v. American Nat'l Red Cross*, 640 F.2d 1051 (9th Cir. 1981) (applying a similar test).

³⁹⁹ No. 77-859, at 23-25 (D.C. N.J. 1983) (granting JCAH motion for summary judgment as Agency issue).

⁴⁰⁰ *Id.* at 23.

⁴⁰¹ *Lumbardo v. Handler*, 397 F. Supp. 792, 795 (D.D.C. 1975), *aff'd* 546 F.2d 1043 (D.C. Cir. 1976), *cert. denied*, 431 U.S. 932 (1977) (quoting *Freedman, Administrative Procedure and the Control of Foreign Direct Investments*, 119 U. PA. L. REV. 1, 9 (1970)). See also *Washington Research Project Inc. v. DHEW*, 504 F.2d 238, 248 (D.C. Cir. 1974) *cert. denied*, 421 U.S. 963 (1975); *Gruman Aircraft Eng'g Corp. v. Renegotiation Bd.*, 482 F.2d 710, 714, 715 (D.C. Cir. 1974) *rev'd on other grounds*, 421 U.S. 168 (1975); *Soucie v. David*, 448 F.2d 1067, 1073 (D.C. Cir. 1971); *Wolfe v. Weinberger*, 403 F. Supp. 238, 241 (D.D.C. 1975); Note, *The Definition of "Agency" Under the Freedom of Information Act as Applied to Federal Consultants and Grantees*, 69 GEO. L.J. 1223 (1981) (applying a similar test).

⁴⁰² 42 U.S.C. § 1395x(f)(5) (1970). See *supra* note 61.

given JCAH by law or regulation in some states may subject JCAH to some state APA's or FOIA's.⁴⁰³

A second potential legal tool for increasing public control over JCAH is the Federal Advisory Committees Act (ACA).⁴⁰⁴ If JCAH were an advisory committee under the ACA it would have to hold open meetings, publish notice of its meetings in the Federal Register, make its records available to the public, keep detailed minutes, and generally function subject to public oversight.⁴⁰⁵ Section three of the Advisory Committees Act defines advisory committee to mean:

any committee, board, commission, council, conference, panel, task force, or other similar group, or any subcommittee or subgroup thereof . . . which is . . . (C) established or utilized by one or more agencies, in the interest of obtaining advice or recommendations for the President or one or more agencies or officers of the Federal Government ⁴⁰⁶

Insofar as JCAH is a "commission" utilized by HHS in the interest of obtaining recommendations with regard to facilities that should be permitted to participate in the federal Medicare program, it is arguably covered by this definition.⁴⁰⁷

This argument, however, does not hold up to more thorough analysis. The ACA does not extend to entities that merely provide to the government consultant services under contractual relationships⁴⁰⁸ or to industry associations that voluntarily provide the government with proposals for regulatory action.⁴⁰⁹ Further, legislative history of the ACA establishes that the drafters intended to exclude from ACA coverage committees or commissions with actual responsibilities for program operations (like facility inspections).⁴¹⁰ The ACA would, therefore, not seem to apply to entities such as the JCAH that have a

⁴⁰³ See *Nassau-Suffolk Hosp. Council v. Whalen*, 89 Misc.2d 304, 390 N.Y.S. 995 (1977) (holding JCAH reports delivered to Department of Health without a promise of confidence are publicly available); *Patients of Philadelphia State Hosp. v. Commonwealth of Pa.*, 53 Pa. Commw. 126, 417 A.2d 805 (1980) (holding JCAH report on state hospital to be public record under state Right-to-Know act).

⁴⁰⁴ 5 U.S.C. App. 1 (1976 and Supp. IV, 1980).

⁴⁰⁵ See 5 U.S.C. App. 1 § 10 (1976), see *National Nutritional Food Ass'n v. Califano*, 603 F.2d 327 (2d Cir. 1979); *Food Chemical News Inc. v. Davis*, 378 F. Supp. 1048 (D.D.C. 1974).

⁴⁰⁶ 5 U.S.C. App. 1 § 3 (1976).

⁴⁰⁷ The possibility of the ACA applying to standard setting bodies has been recognized by the commentators: ADMINISTRATIVE CONFERENCE OF THE UNITED STATES, 1978 Report, p. 44 (1979); P. HARTER, *supra* note 223, at 236-41; Hamilton, *supra* note 221, at 1475-77. See also Proposed Amendment to OMB-circular A-119, 47 Fed. Reg. 16,919, at 16,921 (1982) (noting that standard setting bodies may be subject to the A.C.A. in some circumstances).

⁴⁰⁸ *Lumbardo v. Handler*, 397 F. Supp. 792, 799-800 (D.D.C. 1975); H.R. Rep. No. 1017, 92nd Cong., 2d Sess. (1972) reprinted in 1972 U.S. CODE CONG. & AD. NEWS, at 3494 (House report supporting this conclusion).

⁴⁰⁹ *Consumers Union of United States, Inc. v. HEW*, 409 F. Supp. 473, 476-77 (D.D.C. 1976).

⁴¹⁰ H.R. Rep. No. 1017, 92nd Cong., 2d Sess. (1972) reprinted in 1972 U.S. CODE CONG. & AD. NEWS, at 3494.

substantial existence independent of the federal government and that carry on their own programs in conjunction with and under contract to the federal government.

Even if JCAH is neither an agency as defined in the APA or FOIA nor an advisory committee as defined in the ACA, it may still be an instrumentality of the federal or state governments for purposes of the application of the due process provisions of the fifth and fourteenth amendments. The procedural protections of the Constitution limit only the actions of the government and not of private entities. Nevertheless, it is often hard to determine whether the acts of an entity that in some way is exercising or directing the power of the federal or state government are "state action" subject to the control of the Constitution.⁴¹¹

⁴¹¹ The Supreme Court has increasingly narrowed the scope of the state action doctrine in recent years. Two cases decided by the court in its 1981 term, *Blum v. Yaretsky*, 102 S. Ct. 2777 (1982) and *Rendell-Baker v. Kahn*, 102 S. Ct. 2764 (1982) establish that the mere facts that an entity, nominally private, receives virtually all of its funds from the government through a contractual relationship, and is extensively subject to government regulation, do not make the actions of the entity "fairly attributable to the state" for the purpose of applying the Fourteenth Amendment unless the state "has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice [motivating the private action] must in law be deemed to be that of the State," 102 S. Ct. at 2786, or the private entity has exercised powers that are "traditionally the exclusive prerogative of the state," 102 S. Ct. at 2786. Since few JCAH decisions result from government compulsion and health care standardization and accreditation are not traditional government functions, *Blum* and *Rendell-Baker* would not make JCAH actions state actions.

In *Lugar v. Edmonson Oil Co.*, 102 S. Ct. 2744 (1982), a third case decided on the same day as *Blum* and *Rendell-Baker*, a nominally private party again was involved, specifically a creditor that had seized property under a pre-judgment attachment procedure executed by the county sheriff. 102 S. Ct. at 2747, 2748. The question in *Lugar* was whether the private use of a state procedure in cooperation with a state officer was "under the color of state law" and thus subject to the civil rights law, and ultimately to the Fourteenth Amendment. 102 S. Ct. at 2747, 2748. In this situation the court set out a different test: where there is a deprivation of a federal right, this deprivation may be fairly attributable to the state if two conditions are met. First, the deprivation must be caused "by the exercise of some right or privilege created by the state or by a rule of conduct imposed by the state or by a person for whom the state is responsible." 102 S. Ct. at 2754. Second, "the party charged with the deprivation [must be] a person who may be fairly said to be a state actor . . . because he is a state official, because he has acted together with or has obtained significant aid from state officials, or because his conduct is otherwise chargeable to the state." 102 S. Ct. at 2754.

JCAH accreditation in some respects more closely resembles the private conduct in *Lugar* than that in *Rendell-Baker* and *Blum*. While the JCAH standards, pursuant to which accreditation decisions are made, are in one sense private rules of action, they have also been adopted explicitly by the federal government through the deemed status law. By deeming JCAH accredited hospitals to be eligible for Medicare participation, the federal government has effectively adopted JCAH standards as its own and then imposed them on hospitals through JCAH. In this capacity JCAH is a person for whom the federal government is responsible. Under the second branch of the *Lugar* test JCAH accreditation decisions are attributable to the federal government because they are made by JCAH in concert with HHS, which accepts them for purposes of making Medicare payments. Cf. *Fitzgerald v. Mountain Laurel Racing Inc.*, 607 F.2d 589, 598 (3rd Cir. 1979) (holding action of a race track suspending driver and approved by racing official exercising delegated state power to be state action); but cf. *Northrip v. FNMA*, 527 F.2d 23, 30-33 (6th Cir. 1975) (holding involvement of FNMA with federal government does not

Whether or not JCAH is sufficiently a surrogate for the state or federal government to subject it to the Constitution may rarely be of substantial consequence. If hospitals are denied certification by JCAH they are protected by internal JCAH procedures that are at least as extensive as those minimally required by due process.⁴¹² Fair review procedures for such denials may be required independent of the Constitution by general private organization law in many states.⁴¹³ If, on the other hand, hospitals are improperly granted accreditation and consumers or hospital employees and staff seek review, a substantial barrier to review that in all likelihood will keep courts from reaching questions of due process challenges will be raised by the lack of a casual relationship between the decision of JCAH and any injury to the employees or patients.⁴¹⁴ Thus due process as to JCAH quasi-judicial decisionmaking may seldom arise. Only if the now nascent (or aborted) trend towards imposing due process requirements on quasi-legislative rulemaking⁴¹⁵ were to be considerably expanded might due process obligations of JCAH become important. This seems unlikely.

Even if a legal theory could be found for turning JCAH into a public entity, it is not wholly clear that this would radically improve the performance of JCAH. While it might make JCAH more available for pursuing public policy goals and more sensitive to consumer preferences and utility, it might also make hospitals and physicians less cooperative with JCAH regulation. As

render its decisions not compelled by federal laws to be federal action). A similar analysis can be applied to the JCAH role in some state licensure programs. Thus the intimate involvement of the JCAH in administering federal or state government responsibilities might bring its actions within the purview of the Fifth or Fourteenth Amendments. See *Howard v. NCAA*, 510 F.2d 213 (D.C. Cir. 1975); *Intercontinental Indus. v. American Stock Exchange*, 452 F.2d 935 (5th Cir. 1971), cert. denied, 409 U.S. 842; *Stanley v. Big Eight Conference*, 463 F. Supp. 920 (W.D. Mo. 1976); *Golden Rule Life Ins. v. Mathias*, 86 Ill. App. 3d 323, 408 N.E.2d 310 (4th Dist. 1980).

The issue is, however, close and subject to debate. One case that has considered the nature of JCAH has assumed in dicta that JCAH has acquired the character of a government actor. *Sokol v. University Hosp. Inc.*, 402 F. Supp. 1029, 1031 (D. Mass. 1975). In a second case, a motion to dismiss claiming JCAH was not a state actor was denied, *Cospito v. Califano*, 89 F.R.D. 374, 381, 382 (D. N.J. 1981). Subsequently, defendant's motion for summary judgment was also denied, *Cospito v. Califano*, No. 77-869 at 22-23 (D. N.J. 1983). Finally, another case, by contrast, identified JCAH as a private entity — though the question of JCAH state action was not at issue. *Slakoff v. Harrisburg Polyclinic Hosp.*, 375 F. Supp. 999, 1001, 1004 (M.D. Pa. 1974).

⁴¹² See AMH, *supra* note 39, App. B, at 199-206.

⁴¹³ See *Duby v. American College of Surgeons*, 468 F.2d 364 (7th Cir. 1972); *Pinsker v. Pacific Coast Soc'y of Orthodontists*, 12 Cal. 3d 541, 116 Cal. Rptr. 245, 526 P.2d 253 (1974); *Falcone v. Middlesex Co. Medical Soc.*, 34 N.J. 582, 170 A.2d 791 (1961).

⁴¹⁴ See *O'Bannon v. Town Court Nursing Center*, 441 U.S. 904 (1980). Under some unusual circumstances it may, however, be possible to show causality. See *Cospito v. Califano*, 89 F.R.D. 374 (D. N.J. 1981) where JCAH disaccreditation of a psychiatric hospital led directly to loss of federal benefits by the patients of the hospital.

⁴¹⁵ See Gellhorn & Robinson, *Rulemaking "Due Process": An Inconclusive Dialogue*, 48 U. CHI. L. REV. 201 (1981); Comment, *Due Process Rights of Participation in Administrative Rulemaking*, 63 CALIF. L. REV. 886 (1975).

pointed out earlier,⁴¹⁶ JCAH can regulate efficiently because of its responsiveness to its constituency. To the extent the JCAH became a government agency, it would in all likelihood function like a government agency, with similar inefficiencies.⁴¹⁷ If the traditional constituencies of JCAH struggled to retain control, it might become even less efficient and accountable than a public agency. Salvation does not appear to lie this way.

V. SUPPLEMENTATION AND CONTROL OF JCAH

A final alternative is supplementation and control of JCAH. If JCAH is anticompetitive it ought to be reined in through the antitrust laws. Insofar as it exercises government power, it ought to be controlled and supplemented by the government.

A. *Control of Anticompetitive Conduct Through the Antitrust Law*

The public policy of the United States favors free-market competition and opposes unreasonable restraints on trade. This policy is articulated in sections one and two of the Sherman Antitrust Act.⁴¹⁸ Section one forbids "(e)very contract, combination in the form of a trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations."⁴¹⁹ Section one is aimed at concerted activity — activity by two or more persons or entities — that makes a market function less efficiently, usually by impeding competition. Section two deems it illegal for any person to "monopolize or attempt to monopolize or combine or conspire with any person or persons to monopolize any part of the trade or commerce among the several states, or with foreign nations"⁴²⁰ Section two is narrower than section one in that it focuses on one particular kind of anticompetitive conduct, monopolization, but is also of potentially broader application in that a single person or entity can violate section two. As will be developed further below, insofar as JCAH in concert with other persons or organizations impedes competition in the markets for physician, hospital or other medical services, it may violate section one. Insofar as it monopolizes the market for accreditation services, it may violate section two.

1. Antitrust: Preliminary Considerations

Before applying substantive antitrust law to JCAH it is first necessary to consider antitrust jurisdictional requirements and antitrust defenses that might exempt JCAH activities from scrutiny under the Sherman Act. These defenses and immunities traditionally have precluded or severely limited application of

⁴¹⁶ See *supra* text accompanying notes 358-60.

⁴¹⁷ See *supra* text accompanying and authorities cited at note 373.

⁴¹⁸ 15 U.S.C. §§ 1, 2 (1976).

⁴¹⁹ 15 U.S.C. § 1 (1976).

⁴²⁰ 15 U.S.C. § 2 (1976).

the antitrust laws in the health care context. To the extent that they retain their former vitality, they may limit the usefulness of the antitrust laws in controlling JCAH.

Establishing Sherman Act jurisdiction over JCAH should not be difficult. First, JCAH's restraints on trade must be shown to affect interstate or foreign commerce. The most frequent context in which antitrust challenges to JCAH standards are mounted is denial of hospital staff privileges. Until the mid-1970's, courts routinely dismissed antitrust challenges to denials of hospital staff privileges, holding that such denials had no effect on interstate commerce.⁴²¹ In 1976, however, the Supreme Court in *Hospital Building Company v. Trustees of Rex Hospital*⁴²² liberally construed the interstate commerce requirement as applied to hospitals, deciding that the interstate purchase of medical supplies, receipt of insurance reimbursement, payment of management fees, and arrangement of finance contracts provided sufficient interstate contacts to ground an antitrust claim concerning the blocked expansion of a hospital.⁴²³

The Court further limited the rigor of the interstate commerce requirement in *McLain v. Real Estate Board of New Orleans, Inc.*,⁴²⁴ which held that a plaintiff need only show that a defendant's total activities have a substantial effect on interstate commerce, and need not show that a particular alleged violation will itself affect interstate commerce.⁴²⁵ Recent antitrust cases concerning hospital staff privileges have readily found interstate commerce jurisdiction.⁴²⁶

If an antitrust action is brought directly challenging the anticompetitive effects of a JCAH decision to refuse accreditation to a facility or class of facilities — as opposed to a challenge to a JCAH standard — interstate commerce jurisdiction may be found even more easily. Denial of JCAH accreditation to the facility is likely to have, in itself, a significant effect on interstate commerce.⁴²⁷

⁴²¹ See, e.g., *Wolf v. Jane Phillips Episcopal-Memorial Medical Center*, 513 F.2d 684, 687, (10th Cir. 1975); *Spears Free Clinic and Hosp. for Poor Children v. Cleere*, 197 F.2d 125, 128 (10th Cir. 1952).

⁴²² 425 U.S.C. 738 (1976).

⁴²³ *Id.* at 744.

⁴²⁴ 444 U.S.C. 232 (1980).

⁴²⁵ *Id.* at 242, 243.

⁴²⁶ See, e.g., *Mischler v. St. Anthony's Hosp. Sys.*, 1981-2 Trade Cas. (CCH) ¶ 64,342 (10th Cir. Nov. 2, 1981); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715, 721-27 (10th Cir. 1981); *Feminist Women's Health Center Inc. v. Mohammed*, 586 F.2d 530, 539-41 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979); *McDonald v. St. Joseph's Hosp. of Atlanta*, 524 F. Supp. 122, 127-30 (N.D. Ga. 1981); *Robinson v. McGovern*, 521 F. Supp. 842, 876-77 (W.D. Pa. 1981); *Malini v. Singleton & Assoc's.*, 516 F. Supp. 440, 441-45 (S.D. Tex. 1981); *Feldman v. Jackson Memorial Hosp.*, 509 F. Supp. 815, 820, 821 (S.D. Fla. 1981); *Denver v. Santa Barbara Community Dialysis Center*, 1981-1 Trade Cas. (CCH) ¶ 63,946 (C.D. Cal. Feb. 26, 1981); *Zamiri v. William Beaumont Hosp.*, 430 F. Supp. 875, 877 (E.D. Mich. 1977). *Contra Capili v. Shott*, 620 F.2d 438, 439 (4th Cir. 1980).

⁴²⁷ See also *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626, 629 (9th Cir. 1977) (holding denial of membership in a national association may itself affect interstate commerce);

Until less than a decade ago JCAH might have raised a second jurisdictional barrier, arguing that professional, non-commercial activities were excluded from the coverage of the antitrust laws. Dicta in earlier Supreme Court cases had left open the distinct possibility that professional self-regulatory activities, even activities that intentionally restrained competition, were not subject to scrutiny under the antitrust laws, which, after all, applied only to trade and commerce.⁴²⁸ An antitrust exemption for professional services was rejected by the Supreme Court, however, in a series of cases beginning with *Goldfarb v. The Virginia State Bar*⁴²⁹ in 1975. Following *Goldfarb*, a court has recently rejected the professional exemption defense in a case challenging JCAH standards limiting access of chiropractors to hospitals when the defense was raised by the AMA and other codefendants.⁴³⁰ Other defenses, however, are more troublesome.

a. Antitrust Law and Freedom of Communication

Activity which would otherwise be proscribed by the Sherman Act may be protected from antitrust sanctions by two doctrines developed in response to first amendment concerns. The first doctrine protects certain concerted activities intended to influence governmental action. The second protects commercial speech.

In opposing antitrust challenges to its program, JCAH has argued that the procompetitive policy of the antitrust law must be subordinated to the constitutional policy protecting freedom of petition and expression.⁴³¹ Reconciliation of the antitrust laws with the first amendment has been accomplished traditionally through the *Noerr-Pennington* doctrine, developed by the Supreme Court in a series of cases in the early 1960's.⁴³² *Noerr-Pennington* protects from antitrust sanctions concerted attempts to influence public political opinion or legislative,

but see *Nara v. American Dental Ass'n*, 526 F. Supp. 452, 455-57 (W.D. Wis. 1981) (finding no effect on interstate commerce where dentist denied membership in A.D.A.).

⁴²⁸ See *United States v. Oregon State Medical Soc.*, 343 U.S. 326, 336 (1952); *American Medical Ass'n v. United States*, 317 U.S. 519, 528 (1943). See also *Marjorie Webster Junior College Inc. v. Middle States Ass'n of Colleges and Secondary Schools, Inc.*, 432 F.2d 650, 653-655 (D.C. Cir. 1970) cert. denied, 400 U.S. 965 (1970) (holding an educational accrediting association exempt from the antitrust laws).

⁴²⁹ 421 U.S. 773, 786-88 (1975). See also *Arizona v. Maricopa County Medical Soc'y*, 102 S. Ct. 2466, 2465-2478 (1982); *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679, 696 (1978). State antitrust laws, on the other hand, frequently do not apply to professional activities: see *Mohammed*, 586 F.2d at 552, 553; *Moles v. White*, 336 So.2d 427, 429-30 (Fla. Dist. Ct. App. 1976), cert. dismissed, 355 So.2d 516 (Fla. 1978); *People v. Roth*, 52 N.Y.2d 440, 447-48, 420 N.E.2d 929, 930 (1981).

⁴³⁰ *Health Care Equalization Comm. of the Iowa Chiropractic Soc'y v. Iowa Medical Soc'y*, No. 79-381-A943-6 (order Feb. 12, 1982) (earlier order at 501 F. Supp. 970).

⁴³¹ See *id.* at 12-13 (refusing to strike first amendment defense at pleading stage).

⁴³² See *United Mine Workers of Am. v. Pennington*, 381 U.S. 657, 669-71 (1965); *Eastern R.R. Presidents Conf. v. Noerr Motor Freight Inc.*, 365 U.S. 127, 137-38 (1961); see also *Cal. Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 513-15 (1972) (applying the *Noerr-Pennington* doctrine to a case where plaintiffs challenged defendant's allegedly anticompetitive use of administrative agencies and the courts).

executive, or judicial decision-makers, even if the efforts are meant to achieve an anticompetitive result.⁴³³ The *Noerr-Pennington* doctrine is based not only on the first amendment but also on congressional intent that the antitrust laws not constrain political advocacy.⁴³⁴

The *Noerr-Pennington* doctrine is subject to an important exception, the "sham" exception: "there may be situations in which a publicity campaign, ostensibly directed towards influencing government action, is a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationship of the competitor and the application of the Sherman Act would be justified."⁴³⁵ In many cases extended consideration of the true nature of concerted anticompetitive activities that resemble political advocacy is necessary to determine whether they are protected by *Noerr-Pennington* or fall within the sham exception.

The second defense stemming from the first amendment and limiting antitrust sanctions arises from recent Supreme Court cases limiting application of the antitrust laws to commercial speech. *Virginia State Board of Pharmacy v. Virginia Consumers Council Inc.*,⁴³⁶ a case considering statutory limitations on drug advertising, held that the first amendment protects commercial speech, defined as speech that does "no more than propose a commercial transaction."⁴³⁷ A series of subsequent cases have further clarified the perimeters of "commercial speech" and the extent to which it is subject to government regulation.⁴³⁸ *Metro-Media Inc. v. City of San Diego*,⁴³⁹ a 1981 Supreme Court case, set out a four point test for determining the permissibility of government restrictions on commercial speech:

- (1) The First Amendment protects commercial speech only if that speech concerns lawful activity and is not misleading. A restriction on otherwise protected commercial speech is valid only if it (2) seeks to implement a substantial governmental interest, (3) directly advances that interest, and (4) reaches no further than necessary to accomplish the given objective.⁴⁴⁰

Although the first amendment protections of commercial speech have not yet been applied in the antitrust area, commentators have argued that commercial speech doctrine should be applied broadly to protect medical accreditation and standardization programs from antitrust scrutiny.⁴⁴¹ This is an un-

⁴³³ See *Noerr*, 365 U.S. 135-38.

⁴³⁴ *Id.* at 137, 138.

⁴³⁵ *Id.* at 144. See also *California Motor Transp.*, 404 U.S. at 511-16 (further elaborating on the "sham" exception).

⁴³⁶ 425 U.S. 748 (1976).

⁴³⁷ *Id.* at 762 (citing *Pittsburgh Press Co. v. Human Relations Comm'n.*, 413 U.S. 376, 385 (1973)).

⁴³⁸ *Metromedia Inc. v. City of San Diego*, 453 U.S. 490, 498-521 (1981); *Central Hudson Gas & Elec. v. Public Serv. Comm'n.*, 447 U.S. 557, 563-66 (1980) (setting out four-part test).

⁴³⁹ 453 U.S. 490 (1981).

⁴⁴⁰ *Id.* at 507, citing *Central Hudson*, 447 U.S. at 563-66.

⁴⁴¹ See Kissam, *supra* note 284, at 677-80; Kissam, *Applying Antitrust Law to Medical*

warranted extension of the commercial speech doctrine. *Virginia Pharmacy* and its progeny explicitly protect only advertising, one of the many forms of non-political speech "of an entirely private and economic character."⁴⁴² Communication intended to facilitate anticompetitive coordination among producers occupying parallel positions in a production chain differs in significant respects from advertising, i.e., communication between ultimate buyers and sellers.⁴⁴³

The Court based its decision in *Virginia Pharmacy* in part on the postulate that society has a strong interest in free exchanges of information regarding products and prices to preserve the free enterprise system and to assure proper allocation of resources.⁴⁴⁴ Exchanges of information between coordinate sellers could, in contrast to advertising directed at consumers, hamper the efficient allocation of resources and threaten the free enterprise system.⁴⁴⁵ Even speech ostensibly directed at consumers might do more harm than good to the market if its real purpose and effect were to coordinate anticompetitive activities.⁴⁴⁶ Accordingly, antitrust law has long limited certain kinds of information exchanges, recognizing that the free exchange of information must bow to enforcement of the antitrust law where communication has been used to hamper competition.⁴⁴⁷

This is not to say that communication between competitors is not entitled to some protection. Indeed, antitrust law has traditionally recognized the beneficial aspects of dissemination and exchange of information.⁴⁴⁸ But just as first amendment doctrine concerning advertising has developed independently of the law of political speech, with its own exceptions and subject to its own unique balancing test,⁴⁴⁹ so the law of communication between competitors has

Credentiaing, 7 AM. J. OF L. & MED. 1, 18-25 (1981); Kissam, *Antitrust Law, the First Amendment, and Professional Self-Regulation of Technical Quality*, in REGULATING THE PROFESSIONS, *supra* note 277, at 143 (hereinafter cited as Kissam, *First Amendment*). See also W. Lazarus, *supra* note 72, at III 94-III 97 (discussing Kissam's commercial speech argument).

⁴⁴² See 425 U.S. 763, n.17. For a comparison of the commercial speech doctrine with first amendment doctrine as it has developed in regard to another kind of economic speech, see Note, *Labor Picketing and Commercial Speech*, 91 YALE L.J. 938 (1982).

⁴⁴³ W. Lazarus, *supra* note 72, at III 95-III 96.

⁴⁴⁴ 425 U.S. at 762-65.

⁴⁴⁵ W. Lazarus, *supra* note 72, at III 95-III 96.

⁴⁴⁶ *Id.*

⁴⁴⁷ *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 697 (1978); *United States v. Container Corp. of Am.*, 393 U.S. 333, 337 (1969); *American Column and Lumber Co. v. United States*, 257 U.S. 377, 392, 412 (1921); *American Medical Ass'n v. F.T.C.*, 638 F.2d 443, 451, 452 (2d Cir. 1980).

⁴⁴⁸ This is especially true as to information exchanges through standardization programs, see FEDERAL TRADE COMMISSION, *supra* note 223, at 39-54, 86-87; G. LAMB & C. SHIELDS, *supra* note 298, at 78-80, 90, 95. Cf. M. POLLARD & R. LIEBENLUFT, *ANTITRUST AND THE HEALTH PROFESSIONS* 34-37 (1981); Liebenluft & Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927, 947-949 (1981) (discussing procompetitive effects of health care standardization).

⁴⁴⁹ See *supra* text accompanying note 440.

developed and ought to continue to develop independent of the law of commercial speech, subject to its own exceptions and its own balancing test. Specifically, if communication between competitors is intended to exclude coercively other competitors from a market, it ought not to be protected speech.⁴⁵⁰

The effect of the first amendment limitations on antitrust controls over certification and standardization programs must, to a large extent, depend on the nature of those programs. If standardization or certification programs are accurately characterized as petitions for political action, as might be the case if a trade association developed standards explicitly for government regulation or advocated government adoption of its certification or accreditation program, such programs may be protected by the *Noerr-Pennington* rule. If, on the other hand, a standardization or certification program is aimed primarily at facilitating purchasing decisions by consumers, as may be true of the Good Housekeeping Seal of Approval, the program may be protected by the commercial speech exception.

The analysis presented earlier in this article,⁴⁵¹ however, shows that the JCAH standardization and accreditation programs are not aimed at ultimate consumers of health care. Though JCAH does not conceal its standards from the public, it has made few attempts to disseminate its standards to the public or to educate the public as to the content of these standards.⁴⁵² Indeed, JCAH officials have opined that the public has little ability to comprehend JCAH standards.⁴⁵³

Neither are JCAH standards aimed at government. Although the federal government and some state governments have in effect incorporated JCAH standards into their regulations by granting deemed status for licensure or certification to JCAH accredited facilities, JCAH has not advocated government adoption of its standards,⁴⁵⁴ and indeed has self-consciously developed standards independent of government regulatory purposes.⁴⁵⁵ JCAH standards are only in the most attenuated sense advertising and are not significantly political speech.

This is also true to a somewhat lesser extent of the JCAH accreditation program. Although a list of accredited facilities is publicly available, JCAH makes no effort to publicize this information.⁴⁵⁶ Moreover, it is militantly pro-

⁴⁵⁰ Although I am unaware of cases in which courts have squarely addressed this question, there is no reason why the approach that courts have taken to communications between competitors in other antitrust contexts (*see supra* at note 447) ought not to apply here.

⁴⁵¹ *See supra* Section II.

⁴⁵² The ACCREDITATION MANUAL FOR HOSPITALS, for example, is only available from the JCAH Chicago office at a cost of \$20.00.

⁴⁵³ *See* Lewis, *The Uncertain Future of JCAH*, 4 MODERN HEALTH CARE, Aug. 1975 at 20, 21.

⁴⁵⁴ Schlicke, *supra* note 51, at 8; Schlicke, *supra* note 72, at 385.

⁴⁵⁵ *See* authorities cited *supra* note 54.

⁴⁵⁶ *See Hearings, supra* note 54, at 1900 (testimony of J. Porterfield, Director of JCAH); Affeldt, *Confidentiality, supra* note 353, at 44.

tective of the information on which its accreditation decisions are based.⁴⁵⁷ Thus, JCAH accreditation programs should not be characterized as commercial speech. Neither is it appropriate to characterize JCAH accreditation programs as petitions to government. JCAH does not affirmatively petition the government to pay or to license accredited facilities; instead, when required by statute, it merely informs the government of its decisions.

The main functions of the JCAH standardization and accreditation programs, according to the economic analysis developed earlier⁴⁵⁸ are, first, to enhance the acceptability of sellers of medical care services — hospitals and other institutional medical care providers — and, second, to produce information for the benefit of other medical care providers who are intermediate or complementary producers of services — physicians — or for other private entities with independent interests in the suitability of health care facilities — professional associations.⁴⁵⁹ This information may serve a useful societal function, but it is no more political petitioning or commercial speech than was the data dissemination held to be illegal in earlier trade association cases⁴⁶⁰ (or the price information at issue in *Goldfarb*). If JCAH programs otherwise violate the anti-trust laws, they ought not to be protected because they incidentally involve communication.

b. *Antitrust Law and Federal Preemption*

JCAH has also argued that its standardization and accreditation program is impliedly immune from federal antitrust scrutiny because of the role of JCAH in the administration of the federal Medicare program.⁴⁶¹ Immunity problems arise when antitrust laws come into conflict with other federal statutes promoting other policies. The courts must then reconcile the conflict or explicitly choose one set of statutes and policies over the other.

Based on its Medicare role, JCAH can argue that: (1) the federal Medicare law explicitly adopts JCAH standardization and accreditation, thereby making JCAH a federal regulator, and immunizing JCAH from antitrust scrutiny; or (2) even if the Medicare law does not make JCAH a federal regulator as such, it does compel JCAH to adopt and enforce anticompetitive policies, again conferring immunity. If JCAH is merely carrying out federal policy, it would be unfair to punish JCAH for its anticompetitive effects.

National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City,⁴⁶² is the most recent Supreme Court case considering antitrust immunity

⁴⁵⁷ See *supra* text accompanying notes 353-54.

⁴⁵⁸ See *supra* text accompanying notes 257-322.

⁴⁵⁹ See authorities cited *supra* at notes 73-74.

⁴⁶⁰ See cases cited *supra* note 447.

⁴⁶¹ Memorandum of Defendant JCAH for Summary Judgment, at 10-37 (April 27, 1981); Reply Memorandum of Defendant JCAH in Support of Motion for Summary Judgment (July 2, 1981) (hereinafter cited as Reply Memorandum); *Ohio v. JCAH*, No. C-2-79-1158 (S.D. Ohio filed Dec. 14, 1979).

⁴⁶² 452 U.S. 378 (1981).

based on implied exemption. The defendant Blue Cross, ostensibly to promote the policies established by the National Health Planning and Resources Development Act of 1974,⁴⁶³ had refused to allow a hospital to participate in its health insurance plan because the hospital had failed to obtain approval for facility construction from the local Health Systems Agency (which was responsible under the federal Health Planning Act for approving capital investment by hospitals).⁴⁶⁴ When the hospital sued under the antitrust law, Blue Cross claimed that its decision was immune from antitrust scrutiny because the Health Planning Act had impliedly repealed the antitrust laws as to its conduct.⁴⁶⁵ In rejecting this contention, the Court stated that the antitrust law sets out a fundamental national policy.⁴⁶⁶ Under settled law on implied immunity from the antitrust law, a party claiming exemption must show by convincing evidence a clear repugnancy between the antitrust laws and a specific regulatory program.⁴⁶⁷ According to the court, repeal will be implied only to the minimum extent necessary to make the subsequent regulatory law work and when clear congressional intent to repeal the antitrust laws is shown.⁴⁶⁸ The Supreme Court rejected the argument that extensive government regulation of the health care industry in itself repealed the antitrust laws and held that the National Health Planning Law was not so incompatible with the antitrust laws as to repeal pervasively the Sherman Act.⁴⁶⁹ The Court further held that as Blue Cross' actions were not specifically compelled by the health planning law, the mere fact that they were consistent with the policy of that Act did not protect them.⁴⁷⁰

National Gerimedical is relevant to both of JCAH's exemption arguments. First, JCAH should not be able to claim that the incorporation of its standards into federal law through the deeming process immunizes its standardization and accreditation program from antitrust scrutiny. *National Gerimedical* noted, "antitrust repeals are especially disfavored when the antitrust implications of business decisions have not been considered by a governmental entity."⁴⁷¹ Like the Blue Cross decision in *National Gerimedical*, JCAH standards are not themselves specifically compelled by federal "regulatory coercion" but are instead "governed in the first instance by business [or professional] judgment."⁴⁷²

⁴⁶³ 42 U.S.C. § 300L (1976 and Supp. III).

⁴⁶⁴ *National Gerimedical*, 452 U.S. at 381.

⁴⁶⁵ *Id.* at 382.

⁴⁶⁶ *Id.* at 388.

⁴⁶⁷ *Id.* at 388. *United States v. National Ass'n of Securities Dealers*, 422 U.S. 694, 719-20 (1975); *Gordon v. New York Stock Exchange*, 422 U.S. 659, 682 (1975).

⁴⁶⁸ *National Gerimedical*, 452 U.S. at 389.

⁴⁶⁹ *Id.* at 391-93.

⁴⁷⁰ *Id.* at 389-91. *See also* *Otter Tail Power Co. v. United States*, 410 U.S. 366, 374 (1973) (holding that Federal Power Commission regulation of power company did not immunize the power company's actions from antitrust scrutiny if those actions were not coerced by the FPC).

⁴⁷¹ *National Gerimedical*, 452 U.S. at 390.

⁴⁷² *Id.* at 390, quoting *Otter Tail*, 410 U.S. at 374.

Moreover, it is difficult to argue that Congress considered and adopted specific JCAH standards by merely permitting hospitals "deemed status" for Medicare participation based on JCAH accreditation.⁴⁷³

Second, *National Gerimedical* may weaken JCAH's argument that insofar as its standards are consistent with federal requirements, those standards are immune from antitrust sanctions. This argument is currently being litigated in *Ohio v. The Joint Commission on Accreditation of Hospitals*, a case brought by the State of Ohio claiming that JCAH has conspired with its member organizations in violation of the Sherman Act to keep psychologists from competing with doctors.⁴⁷⁴ Ohio has claimed that JCAH has excluded psychologists from hospital practice through its standards.⁴⁷⁵ JCAH in defense has argued that its restrictions on the hospital staff privileges of psychologists in psychiatric and general hospitals are immune from antitrust scrutiny because they are consistent with and authorized by the Medicare law's definitions of hospital and psychiatric hospital and with federal regulations that require hospital care to be supervised by a physician and define physician to include doctors but to exclude psychologists.⁴⁷⁶

Ohio has raised two responses to this argument. First, it has argued that JCAH's hospital staffing standards are more restrictive than those of the Medicare statute and regulations.⁴⁷⁷ This argument seems weak: while the Medicare definition of physician is for some purposes broader than that of JCAH,⁴⁷⁸ the federal and JCAH standards as to psychologists are in fact very similar.⁴⁷⁹

The state's second argument is that the Medicare program is an insurance program rather than a regulatory program and, therefore, neither the JCAH

⁴⁷³ Another parallel to the authority accorded the medical industry by the federal government to regulate itself in the context of federal financing programs through JCAH is the extensive self-regulatory authority granted the stock exchanges. In both instances the federal government has abstained from exerting the full potential force of its regulatory power, deferring instead to self-regulation. Yet, the courts have held that statutes permitting self-regulation of the stock exchanges do not immunize anticompetitive conduct of the stock exchanges from the antitrust laws. *Silver v. New York Stock Exchange*, 373 U.S. 341, 357-61 (1963); *Otter Tail*, 410 U.S. 366, 372-375 (1973); *California v. FPC*, 369 U.S. 482, 485-90 (1962); *United States v. Radio Corp. of Am.*, 358 U.S. 334, 346-53 (1959).

⁴⁷⁴ No. C-2-79-1158 (S.D. Ohio filed Dec. 14, 1979).

⁴⁷⁵ See Plaintiff's Memorandum in Opposition to Defendant's Motion for Summary Judgment (June 5, 1981), at 1-5 in *Ohio v. JCAH*, civ. No. 3-2-79-1158 (S.D. Ohio filed) (hereinafter cited as Plaintiff's Memorandum).

⁴⁷⁶ See authorities cited *supra* note 461.

⁴⁷⁷ See Plaintiff's Memorandum, *supra* note 475, at 9-13.

⁴⁷⁸ Compare the definition of physician in 42 U.S.C. § 1395x(r) (1976) and 42 C.F.R. § 405.232a (1982) (including chiropractors, optometrists, podiatrists, dentists, physicians, and osteopaths for some purposes) with the JCAH definition of physician, AMH, *supra* note 39, at 209 (including only medical doctors and osteopaths). 42 U.S.C. § 1395x(e)(1) & (4) (1976) requires that all patients in Medicare certified hospitals be under the supervision of a physician.

⁴⁷⁹ Psychologists are not defined as physicians under the federal Medicare law; see *id.*

nor the hospitals are required to comply with Medicare conditions of participation.⁴⁸⁰ The state draws support for its second argument from *National Society of Professional Engineers v. United States*.⁴⁸¹ The Court held in *Professional Engineers* that just because the federal government as a purchaser may choose not to pursue a competitive purchasing policy, a combination of sellers of services is not thereby justified in pursuing an identical policy against competitive bidding.⁴⁸² The state has argued, similarly, that just because the Medicare program has chosen to purchase services from certain kinds of providers, JCAH standards favoring those same providers by suppressing competition from others are not thereby permissible. JCAH has attached private consequences to governmental policies, the potential effects of which go beyond the immediate consequences of governmental actions, just as Blue Cross did in *National Gerimedical*.

JCAH has stressed in response that as a practical matter virtually all hospitals participate in the Medicare program, and most hospitals are forced to do so economically, if not legally.⁴⁸³ JCAH's argument here makes sense. Even though neither JCAH nor the hospitals are legally compelled to comply with anticompetitive Medicare standards, it is difficult to argue that anticompetitive results of compliance with both JCAH and federal standards are proximately caused by JCAH anticompetitive policies. Hence, JCAH may be able to defend itself from antitrust claims where its standards parallel federal law — as they seem to with regard to psychologists. Where JCAH standards are more restrictive of competition than is federal law, on the other hand, the status of accreditation in the Medicare program ought not alone to be enough to protect JCAH from antitrust scrutiny.

c. *Antitrust Law and State Regulation*

A final defense to antitrust complaints relevant to JCAH is the state action exemption first articulated in and thus identified with, *Parker v. Brown*.⁴⁸⁴ Under this exception, the courts have, in reliance on considerations of federalism, statutory construction⁴⁸⁵ and fairness to persons caught between the Scylla of federal antitrust law and the Charybdis of state regulation, excused state required concerted anticompetitive actions from antitrust sanctions. JCAH could argue that the *Parker Brown* exception immunized JCAH policies from antitrust scrutiny in those states where JCAH accreditation plays a major role in licensure decisions.

The state action exception, however, has been interpreted very narrowly.⁴⁸⁶ For private action to be immune from antitrust scrutiny, it must

⁴⁸⁰ Plaintiff's Memorandum, *supra* note 475, at 6-9.

⁴⁸¹ 435 U.S. 679, at 694 n.21 (1978). See Plaintiff's Memorandum, *supra* note 475, at 7-8.

⁴⁸² *Id.*

⁴⁸³ Reply Memorandum, *supra* note 461, at 13.

⁴⁸⁴ 317 U.S. 341, 351-52 (1943).

⁴⁸⁵ Congress did not intend the antitrust laws to preempt state regulatory policies. *Id.*

⁴⁸⁶ See *Community Communications Co. v. City of Boulder*, 102 S. Ct. 835, 841-44

not only be compelled by state law but also be actively supervised by state regulation.⁴⁸⁷ Mere state reliance on JCAH standards and accreditation decisions for licensing of health care institutions falls short of the state compulsion and supervision standard, and thus would not exempt JCAH from antitrust scrutiny.⁴⁸⁸ Indeed, absent state regulatory oversight JCAH may not be protected even in pursuing legislatively articulated state policies.⁴⁸⁹ Questions of JCAH causation of anticompetitive effects, however, may arise in specific cases when JCAH standards parallel state regulations. For example, if a state licensing law forbids psychologists hospital admitting privileges, a psychologist can hardly blame JCAH for a hospital's refusal of such privilege. But the state action exemption itself is unlikely to prove an effective shield for anticompetitive JCAH accreditation and standardization activities.

In summary, the defenses discussed above — the *Noerr-Pennington* doctrine, the commercial speech doctrine, federal preemption, and the state action exemption — seem unlikely to protect JCAH activities from scrutiny under antitrust law to any significant extent. Thus, if JCAH activities violate antitrust law, that law can be used to control the anticompetitive aspects of JCAH programs.

2. JCAH Restraints of Trade

Two elements are necessary to establish a violation of section one of the Sherman Act. First, concerted activity must be shown. Second, it must be established that such activity unreasonably restrains trade.

a. *Proof of Concerted Activities*

To establish a violation of section one of the Sherman Act the plaintiff must first show the existence of an agreement between two or more persons.⁴⁹⁰ It is not enough to show that the actions of one, or even several entities, acting individually pursuing their independent interests are in fact anticompetitive. An initial issue, therefore, is whether any anticompetitive effects of the JCAH standardization or accreditation programs are the result of concerted activity.

The first and surest means of establishing the requisite concerted activity is to show that the JCAH has in fact explicitly agreed with other persons or entities to engage in anticompetitive conduct. It is not necessary, however, to

(1982); *California Retail Liquor Dealers Ass'n v. Mid Cal Aluminum, Inc.*, 445 U.S. 97, 102-06 (1980); *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 394-97 (1978).

⁴⁸⁷ *Mid Cal*, 445 U.S. at 105.

⁴⁸⁸ Just as in *Mid Cal*, the state enforced private wine-pricing scheme was held invalid because the prices were privately established and not reviewed by the state.

⁴⁸⁹ *Id.*, but see *Kartell v. Blue Shield*, 542 F. Supp. 782, 790 (D. Mass. 1982) (holding legislation compelling a practice may make state supervision unnecessary).

⁴⁹⁰ See 15 U.S.C. § 1 (1976); L. SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* § 108 (1977).

prove the terms of an explicit written or oral agreement,⁴⁹¹ an agreement can be implied from the conduct of the parties. If the existence of an explicit or implicit agreement must be established by circumstantial evidence, there are several factors the courts generally find persuasive: the uniformity of the parties' conduct; whether the parties had meetings or other opportunities to form an agreement; whether the conduct is in the interests of the the parties if they act together but against their individual interests acting independently; whether any party has sacrificed its individual interests in reliance on a similar sacrifice by other parties, and whether any party has sufficient coercive power to compel another to give up its independent decision making.⁴⁹² Proof only of uniformity of conduct is generally insufficient to establish an agreement.⁴⁹³ Thus, the mere fact that several organizations have similar standards limiting the economic competitiveness of non-physicians might not be enough to establish an unlawful restraint of trade. Where uniformity is accompanied by other conduct, however, an agreement may be inferred from all the circumstances. Thus, in *Wilk v. American Medical Association*, the plaintiffs set out to prove to a jury by circumstantial evidence the existence of an agreement between the JCAH, AMA, Illinois Medical Society, ACS, American Academy of Orthopedic Surgeons, American College of Radiology, and ACP to boycott chiropractors through, *inter alia*, the imposition of JCAH standards.⁴⁹⁴

A second method for meeting the concerted action requirement would be to allege and prove that the JCAH is in itself an unlawful combination. In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*,⁴⁹⁵ the court held that the defendant, the Blue Shield Association of Virginia, in appearance a discrete and independent corporation, was in fact a combination of participating physicians who had conspired together through the Blue Shield to boycott psychologists: "It is not sufficient to assert, as defendants do, that a corporation cannot conspire with itself. We must look at substance rather than form."⁴⁹⁶ In support of its analysis, the court cited *United States v. Sealy Inc.*⁴⁹⁷ in which the Supreme Court held that where a manufacturer was substantially owned and controlled by its licensees, its action in allocating territories be-

⁴⁹¹ See L. SULLIVAN, *supra* note 490, at § 109.

⁴⁹² See *Interstate Circuit Inc. v. United States*, 306 U.S. 208, 227 (1939); *C-O Two Fire Equip. Co. v. United States*, 197 F.2d 489, 491-94 (9th Cir.) *cert. denied*, 344 U.S. 892 (1952); L. SULLIVAN, *supra* note 490, at § 110.

⁴⁹³ See *Theatre Enterprises v. Paramount Film Distributing Co.*, 346 U.S. 537, 541 (1954).

⁴⁹⁴ See Preliminary Brief for Plaintiffs-Appellants at 11-52 (May 13, 1981); *Wilk v. AMA*, No. 81-1331 (pending 7th Cir.) (hereinafter cited as Preliminary Brief).

⁴⁹⁵ 624 F.2d 476 (4th Cir. 1980).

⁴⁹⁶ *Id.* at 481.

⁴⁹⁷ 388 U.S. 350 (1967). See also *Marrese v. American Academy of Orthopedic Surgeons*, 496 F. Supp. 236, 240 (N.D. Ill. 1980) (enforcement of alleged anticompetitive by-law through internal sanctions by an association of competitors sufficient to ground antitrust complaint).

tween them was in fact a horizontal agreement between the licensee stockholders. Applying this analysis, a court could hold that the JCAH was in fact an ongoing conspiracy between the AMA, AHA, ACS, ACP, and ADA, and find any of its standards or accreditation decisions arrived at by a common vote of the members to be concerted action in restraint of trade. Evidence that JCAH commissioners voted as directed by member organizations would support this theory.⁴⁹⁸

Finally, the agreement between a hospital and JCAH for a hospital to submit to JCAH standards, and for JCAH to accredit the hospital could be a sufficient basis for finding an illegal combination if it resulted in the hospital taking anticompetitive actions that it might not have taken independently.

Because so many independent entities act together in the JCAH standardization and accreditation process, it will probably be possible in many instances to show concerted action. It is therefore necessary to decide whether any aspects of the JCAH program are unreasonable restraints on trade.

b. *Introduction to Substantive Analysis of Trade Restraints*

Section one of the Sherman Act forbids all combinations in "restraint of trade."⁴⁹⁹ The courts recognized very early, however, that all contractual relationships to some extent restrain trade, and thus that the law cannot mean what it seems to say.⁵⁰⁰ The Supreme Court, in the early case of *Chicago Board of Trade v. United States*, set forth a distinction between reasonable and unreasonable or undue restraints of trade which the courts continue to apply:

Every agreement concerning trade, every regulation of trade, restrains. To bind, to restrain is of their very essence. The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.⁵⁰¹

Under "rule of reason" analysis the courts applying section one of the Sherman Act examine concerted conduct to see if its purpose and effect is to promote or restrain competition, that is, to increase or decrease allocative efficiency.⁵⁰² Thus, agreements that on their face restrain trade may be permissible because they expand a market, improve market functioning or achieve integrated efficiencies, thus ultimately making the market more efficient.⁵⁰³ For

⁴⁹⁸ Cf. W. Lazarus, *supra* note 54, at IV-11, IV-12. This argument has been raised on appeal in *Wilk*. See Preliminary Brief, *supra* note 494, at 78-81.

⁴⁹⁹ 15 U.S.C. § 1 (1976).

⁵⁰⁰ *Standard Oil Co. v. United States*, 221 U.S. 1, 59, 60 (1911).

⁵⁰¹ *Board of Trade v. United States*, 246 U.S. 231, 238 (1918).

⁵⁰² *Professional Eng'rs*, 435 U.S. at 688-92 (1979); *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49, 50 n.16 (1977); *Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1183 (D.C. Cir. 1979). See R. BORK, *THE ANTITRUST PARADOX*, 107-60 (1978); Gerhart, *The Supreme Court and Antitrust Analysis: The Near Triumph of the Chicago School*, 1982 SUP. CT. REV. 319 at 321, 330-32 (1982).

⁵⁰³ See M. POLLARD & R. LIEBENLUFT, *supra* note 448, at 31-39, Gerhart, *supra* note

example, commodities exchanges have been permitted to limit trading to day-time hours to focus the market and make it more competitive.⁵⁰⁴

This mode of analysis, however, creates high administrative costs for the courts that must apply it and high costs in accomodating uncertainty for industries that must anticipate its application.⁵⁰⁵ To avoid or limit these costs the Supreme Court has identified certain practices, that it considers to be manifestly and per se anticompetitive. These practices include price fixing,⁵⁰⁶ market divisions,⁵⁰⁷ tying arrangements,⁵⁰⁸ and concerted refusals to deal — boycotts.⁵⁰⁹ Once such activities are detected in a particular case, liability follows and further analysis is unnecessary. Moreover, in a per se case, the plaintiff need not establish evidence of actual public injury,⁵¹⁰ and the defendant may not rely on the reasonableness, or even the procompetitiveness of its conduct for justification.⁵¹¹

Unfortunately, however, the Supreme Court's attempts at simplified per se analysis have not been wholly successful. In many instances per se rules as applied by the Supreme Court merely transfer the problem from one of analysis to one of characterization.⁵¹² This is particularly true for elusive categories like group boycotts which can often be identified only after analysis that rivals in complexity the analysis required to apply the rule of reason.

c. *Rule of Reason Analysis*

Lower court cases generally have held that rule of reason rather than per se analysis is the appropriate form of antitrust analysis for certification or standardization activities.⁵¹³ Moreover, dicta in recent Supreme Court opin-

502, at 334-44, *Liebenluft & Pollard*, *supra* note 448, at 947-50.

⁵⁰⁴ *Board of Trade of Chicago v. United States*, 246 U.S. 231 (1918).

⁵⁰⁵ See *Arizona v. Maricopa County Medical Soc'y*, 102 S. Ct. 2466, 2472, 2473 (1982).

⁵⁰⁶ See *id.*; *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940); *Dr. Miles Medical Co. v. John D. Park & Sons Co.*, 220 U.S. 373 (1911).

⁵⁰⁷ Market division entails competitors dividing up a market with each taking an exclusive share, thus creating local monopolies. *Timken Roller Bearing Co. v. United States*, 341 U.S. 593 (1951).

⁵⁰⁸ Tying arrangements are discussed *infra* at text accompanying note 539. *Northern Pac. Ry. v. United States*, 356 U.S. 1 (1958).

⁵⁰⁹ *Klors, Inc. v. Broadway-Hale Stores*, 359 U.S. 207 (1959); *Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457 (1941).

⁵¹⁰ *Klors*, 359 U.S. at 213.

⁵¹¹ *Maricopa Co.*, 102 S. Ct. at 2473.

⁵¹² See Gerhart, *supra* note 502, at 323-25; Ponsoldt, *The Application of Sherman Act Anti-boycott Law to Industry Self-Regulation: An Analysis Integrating Nonboycott Sherman Act Principles*, 55 S. CAL. L. REV. 1, 17, 18 (1981).

⁵¹³ *Gunter Harz Sports v. United States Tennis Ass'n*, 1981-82 Trade Cases (CCH) ¶ 64,243 (D. Neb. March 4, 1981), *aff'd* 1981-82 Trade Cas. 64,381 (8th Cir. Dec. 2, 1981); Note, *Trade Association Exclusionary Practices: An Affirmative Role for the Rule of Reason*, 66 COLUM. L. REV. 1486, 1487 (1966); Kissam, *First Amendment*, *supra* note 441 at 164; see *Structural Laminates Inc. v. Douglas Fir Plywood Ass'n*, 399 F. Supp. 155, 155 (9th Cir. 1968).

ions indicates that per se rules may not be appropriate for analyzing professional self-regulation of the quality of professional services.⁵¹⁴ Thus, the JCAH standardization and accreditation programs, considered alone, should be analyzed under the rule of reason.

Under the rule of reason, anticompetitive effects of JCAH standards — for example standards limiting hospital staff privileges of non-physician practitioners — must be justified by the demonstrable procompetitive effects of those policies.⁵¹⁵ Only procompetitive justifications may be considered: JCAH policies could not be justified by health and safety benefits that do not in themselves promote competition.⁵¹⁶ A court reviewing JCAH standards would need to balance the likelihood and magnitude of injury to competition by those standards, against the likelihood and magnitude of procompetitive effects of the JCAH standards at issue. The court would need to consider the effects of JCAH policies in the specific professional context in which they operate, recognizing that different and perhaps more substantial procompetitive effects may result from standardization or certification in professional settings than would be true in commerce or industry.⁵¹⁷

Certification and standardization programs have been justified as procompetitive for reasons discussed earlier — they lower search and transaction costs, permit economies of scale, and facilitate market entry.⁵¹⁸ These justifications only apply, however, to the extent that certification standards are actually related to quality and a certification program is fairly and objectively conducted.⁵¹⁹

⁵¹⁴ *Arizona v. Maricopa County*, 102 S. Ct. 2466, 2475 (1982); *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 696 (1978); *Goldfarb v. The Virginia State Bar*, 421 U.S. 773, 787 n.17 (1975). See also Rigler, *Professional Codes of Conduct After Goldfarb: A Proposed Method of Analysis*, 29 ARK. L. REV. 185, 189-91 (1975) (distinguishing between professional restraints that are commercial in nature, which should be subject to antitrust scrutiny, and those that are not, which should not be).

⁵¹⁵ See *National Soc'y Professional Eng'rs v. United States*, 435 U.S. 679, 687-91 (1978); *Eliason Corp. v. National Sanitation Found.*, 614 F.2d 126, 130 (6th Cir. 1980); *Hatley v. American Quarterhorse Ass'n*, 552 F.2d 646, 652 (5th Cir. 1977); *Bridge Corp. of Am. v. American Contract Bridge League, Inc.*, 428 F.2d 1365, 1370 (9th Cir. 1970); *Deesen v. Professional Golfers Ass'n of Am.*, 358 F.2d 165, 170 (9th Cir. 1966).

⁵¹⁶ See *National Soc'y Professional Eng'rs*, 435 U.S. at 690, 695, 696; cf. *Health Care Equalization Comm. of the Iowa Chiropractic Soc'y v. Iowa Med. Soc'y* (S.D. Iowa, Ruling & order Feb. 12, 1982), striking defendant's public welfare defense in Sherman Act claim. The admission of evidence concerning non-economic justifications of exclusionary actions aimed at chiropractors is also on appeal in *Wilk v. American Medical Ass'n*, see *infra* note 522.

⁵¹⁷ *National Soc'y Professional Eng'rs*, 435 U.S. at 696; *Goldfarb*, 421 U.S. at 787 n.17.

⁵¹⁸ See *supra* text accompanying notes 248-56.

⁵¹⁹ See *Eliason*, 614 F.2d at 130; *Bridge Corp.*, 428 F.2d at 1370; *Deesen*, 358 F.2d at 170; *POLLARD & LIEBENLUFT*, *supra* note 448, at 34-37; *Liebenluft & Pollard*, *supra* note 448, at 947-49.

It is arguable that even a standardization or certification program using unreasonable standards and unfair certification procedures, such as rules that forbid marketing of non-standard products, does not violate the Sherman Act. Absent ancillary enforcement mechanisms, standardization and certification programs directed at consumers only operate to exclude products to the extent that independent consumers rely on the standards or certificates for making

To assure a real relationship between certification and quality, antitrust cases applying rule of reason analysis have required that certification programs use clear, objective and reasonable standards directly related to quality characteristics, and that the entity administering the program have fair procedures to assure that standards are evenly applied.⁵²⁰ Under rule of reason analysis the specific anticompetitive and procompetitive effects of JCAH policies would be addressed on a case by case basis.

Insofar as JCAH standards apply to non-physician practitioners they have been criticized as being irrational — as totally ignoring the contributions of non-physician practitioners to health care — and as denying procedural fairness — excluding non-physician practitioners as a class from hospital practice and providing no procedure to consider staff privileges for such practitioners on an individual basis.⁵²¹ JCAH has defended the standards, claiming they contribute to hospital quality and are thus procompetitive. In the one case on this question that has gone to trial, a jury applying rule of reason analysis has concluded that JCAH standards excluding one group of non-physicians — chiropractors — from hospitals are not violative of the Sherman Act.⁵²²

d. *Per Se Analysis*

To this point we have considered standardization and accreditation programs as they function independently. JCAH, however, does not exist in a vacuum, but is the trigger mechanism for a reticulate structure of private and public programs for rewarding institutions that comply and sanctioning in-

their own purchasing decisions. If the standard or certification decisions are unreasonable, this will in all likelihood eventually dawn on the consumers, who will find other means of choosing products. Thus in the long run, such programs will not restrain trade. However, where a complex product is involved, not readily subject to evaluation by independent consumer search or experience, an unreasonable or unfair standardization or certification program may substantially damage competition over a prolonged period of time. Moreover, if a standardization or certification program is not directed at ultimate consumers, but rather at controlling the production of initial or complementary products for the benefit of intermediate or complementary producers, it may control the production of initial procedures to the detriment of the competitors of those persons directing the standardization or certification program or of consumers. See discussion *supra* at text accompanying notes 323-47. Thus antitrust controls should apply.

⁵²⁰ *Hydrolevel Corp. v. American Soc'y Mech. Eng'rs*, 635 F.2d 118, 126 (2d Cir. 1980), *aff'd*, 102 S. Ct. 1935 (1982); see *Silver v. United States Stock Exchange*, 373 U.S. 341, 357-67 (1963); *Blalock v. Ladies Professional Golf Ass'n*, 359 F. Supp. 1210, 1267 (N.D. Ga. 1973); *W. Lazarus*, *supra* note 72, at III 90-III 93; *Howe & Badger*, *supra* note 253, at 381-84; *Ponsoldt*, *supra* note 512, at 47-50.

⁵²¹ See generally cases cited *supra* note 217; *Lavine*, *supra* note 315, at 20, 21; but see *Kissam, et al.*, *supra* note 276, at 680.

⁵²² *Wilk v. American Medical Ass'n*, No. 76-C-3777 (N.D. Ill. Jan. 30, 1981), *app. pending*, No. 81-1331 (7th Cir.). This case is on appeal, however, with the plaintiffs contesting, *inter alia*, the court's permitting the jury to consider non-economic justifications of the JCAH policy — specifically the legitimacy of chiropractic health care. Preliminary Brief, *supra* note 494, at 59-70. See Comment, *Professional Association Permitted to Raise Public Welfare Justification in Defense of Group Boycott*, 60 WASH. U.L.Q. 249 (1982).

stitutions that fail to comply with the JCAH standards.⁵²³ Moreover, JCAH standards require a form of hospital medical staff organization that is itself exclusionary. Taking into account these coercive elements, *per se* analysis might be appropriate both for analyzing the effects of JCAH on the competitors of its physician constituency and the competitors of its hospital constituency.

i. Practices Suppressing Competition Against Physicians

An issue in most antitrust litigation brought against JCAH has been the effects of the JCAH accreditation program on competition between physicians and non-physician health care practitioners, specifically chiropractors, podiatrists, nurse anesthetists and psychologists.⁵²⁴ There are two possible theories under which such practitioners, excluded from or limited in hospital practice by JCAH hospital standards, could allege a *per se* illegal boycott by JCAH.

First, they could try to prove that physicians, perhaps acting through representative organizations like the AMA, have conspired together with hospitals, through the link of the JCAH and perhaps other entities (like the AMA Liaison Committee on Medical Education or Blue Cross Associations) to boycott non-physician practitioners and their patients. The hospitals boycott the non-physician practitioners by refusing to permit them admitting privileges and boycott the patients of non-physician practitioners by refusing to allow them admission, except under the supervision of doctors.⁵²⁵

Characterized in this way, the accreditation program resembles the facts in cases where retailers have conspired with wholesalers to deny other competing retailers needed goods,⁵²⁶ or where suppliers of goods and services have conspired together to deny their competitors access to necessary facilities under their control.⁵²⁷ Insofar as the boycott is directed at patients, this characterization of the JCAH accreditation program also resembles the facts in *per se* cases in which suppliers have boycotted buyers to coerce the buyers to cease dealing with competitors of the suppliers.⁵²⁸ Under this characterization, the JCAH accreditation program can be classified as a boycott or a refusal to deal, a *per se* violation of the antitrust laws.⁵²⁹

⁵²³ See *supra* notes 58-74 and accompanying text.

⁵²⁴ See cases cited *supra* note 217.

⁵²⁵ Cf. *Blue Shield of Va. v. McCready*, 102 S. Ct. 3540 (1982) as to consumers' standing to sue for injuries resulting from such a boycott.

⁵²⁶ *United States v. General Motors*, 384 U.S. 127 (1966); *Klor's Inc. v. Broadway-Hale Stores*, 359 U.S. 207 (1959); *Dolan & Ralston*, *supra* note 304, at 752-59.

⁵²⁷ See *Associated Press v. United States*, 326 U.S. 1 (1945); *United States v. Terminal R. Ass'n of St. Louis*, 224 U.S. 383 (1912); *U.S. Dental Inst. v. American Ass'n of Orthodontists*, 396 F. Supp. 565, 580-81 (N.D. Ill. 1975); but see *Kissam et al.*, *supra* note 276, at 657, 659.

⁵²⁸ See *Radiant Burners, Inc. v. Peoples Gas Light & Coke Co.*, 364 U.S. 656 (1981); *Fashion Originators Guild of Am. v. FTC*, 312 U.S. 457 (1941). Cf. *Feminist Women's Health Union v. Mohammad*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (claiming that doctors were refusing to treat patients of plaintiff's abortion clinic in effort to eliminate competition from plaintiff).

⁵²⁹ This type of arrangement has also been criticized as a "private economic govern-

Second, the JCAH accreditation program could be characterized as a concerted effort by physicians, the JCAH, and other professional organizations to compel hospitals to refuse to deal with non-physician practitioners and their patients. Here the hospitals would be co-victims of the conspiracy rather than co-conspirators. Under this characterization the JCAH accreditation program would somewhat resemble boycotts in which retailers have boycotted wholesalers to eliminate competition.⁵³⁰ This characterization fits less comfortably under the conventional definition of boycott as a concerted coerced refusal to deal that directly excludes a competitor from a market.⁵³¹ Under the earlier characterization the elements and direction of coercion and exclusion were clear: non-physician practitioners and their patients were explicitly barred from the market of hospital practice through the denial of staff privileges by cooperating hospitals. Under the second characterization the element of coercion is the denial of certification directed in the first instance against the hospital. In general, whether denial of certification by a certification program is coercive is a question of fact, and depends upon the actual power of a certification program to bring to bear economic pressure to exclude from a market an entity refused certification.⁵³² The coercive power of JCAH against hospitals is open to question. There is no explicit professional requirement forbidding doctors from cooperating with or practicing in hospitals not accredited by JCAH; in fact, non-accredited hospitals do exist, are staffed by physicians and even participate in Medicare.⁵³³ Moreover, because the coercion in the second characterization is aimed at hospitals in the first instance rather than at competitors of the boycotting physicians, the courts may have difficulty characterizing the activity as a per se illegal group boycott.⁵³⁴ On the other hand, the ancillary economic (and regulatory) consequences of a JCAH non-accreditation decision exert substantial coercive force against non-accredited hospitals.⁵³⁵ And the ultimate targets of this boycott are the non-physician practitioner com-

ment." W. Lazarus, *supra* note 72, at III-83.

⁵³⁰ See *Eastern States Retail Lumber Dealers Ass'n v. United States*, 234 U.S. 600 (1914).

⁵³¹ See Note, *Restrictive Practices in Accreditation of Medical Schools: An Antitrust Analysis*, 51 S. CAL. L. REV. 657, 684, 685 (1978); Comment, *Boycott: A Specific Definition Limits the Applicability of the Per Se Rule*, 71 NW. U.L. REV. 818, 823 (1977).

⁵³² See *Paralegal Inst. v. American Bar Assoc.*, 475 F. Supp. 1123, 1130 (E.D.N.Y. 1979); W. Lazarus, *supra* note 72, at III-91, III-96.

⁵³³ Twenty percent of all the nation's hospitals are non-accredited. Affeldt, *supra* note 45, at 95.

⁵³⁴ *Smith v. Pro Football*, 593 F.2d 1173, 1179 (D.C. Cir. 1979); cf. *St. Paul Fire and Marine Ins. Co. v. Barry*, 438 U.S. 531, 542 and n.14 (1973) (in dicta leaving open the question of whether a boycott must be intended to suppress competition to be a per se antitrust violation). See also Ponsoldt, *supra* note 500, at 59 (identifying a horizontal [competitive] relationship between plaintiff and defendants as a necessary element of a per se group boycott) and *Marrese v. American Academy of Orthopedic Surgeons*, 692 F.2d 1083, 1093-94 (7th Cir. 1982) (stating boycotts are not illegal per se unless they further other per se illegal anticompetitive agreements).

⁵³⁵ See *supra* text accompanying notes 64-74.

petitors of the perpetrators of the boycott. Thus even under this characterization a court could find a *per se* illegal boycott.

ii. Practices Suppressing Competition Against Hospitals

JCAH may also be engaged in anticompetitive conduct favoring its other constituency, the institutional providers of health care. JCAH accredits not only hospitals but also institutional health care programs such as long-term care facilities, psychiatric hospitals, drug and alcohol treatment programs, and facilities for the mentally retarded.⁵³⁶ Though JCAH accredits principally medical institutions, many of the programs carried on in these institutions could be delivered equally well in a non-medical institution. For example, some facilities for the mentally ill or developmentally disabled rely heavily on psychology or social work, and utilize only minimally the medical services of physicians or psychiatrists. Substance abuse could be addressed by community-based social services providers rather than by hospital-based medical programs. Yet, where JCAH accreditation is required for government licensure or participation in private insurance programs such as Blue Cross, substance abuse programs that do not rely on a medical treatment model may be excluded. This exclusion will limit competition against hospitals and hospital-based programs. This in turn may raise consumer costs.⁵³⁷ The JCAH policies supporting this exclusion might be found to violate the antitrust laws under rule of reason analysis similar to that discussed earlier.

Two *per se* violation theories could be used to challenge exclusion of non-medical programs from JCAH accreditation. First, these exclusions could again be characterized as a concerted refusal to deal, a boycott, this time directed by hospitals against their competitors. The coercive effects of JCAH denial of accreditation when combined with the requirements of private insurance programs or state licensing laws for accreditation may constitute sufficient coercion to ground a *per se* challenge.

Second, JCAH's all-or-none policy⁵³⁸ could in some instances be characterized as a tying arrangement, a *per se* violation of the antitrust law.⁵³⁹ Through its all-or-none policy JCAH may be able to discourage some hospitals from expanding and diversifying into more efficient and competitive non-medical health care delivery programs, and thus protect other hospitals from

⁵³⁶ See *supra* notes 40-43.

⁵³⁷ See *M.D. Surplus Could Incite Opposition to Nurse Midwife Market Intrusion*, 12 MOD. HEALTH CARE, Nov. 1982 at 102, 103 (reporting that a midwife supervised delivery in a birthing center costs only 40% of a normal inpatient delivery).

⁵³⁸ See *supra* text accompanying note 319.

⁵³⁹ See *Northern Pac. Ry. v. United States*, 356 U.S. 1, 5-6 (1958); *Bogus v. American Speech and Hearing Ass'n*, 582 F.2d 277, 285-88 (3rd Cir. 1978); *Dolan & Ralston*, *supra* note 304 at 756-63.

A tying arrangement exists where a seller enjoying competitive advantages in the market for a tying product requires buyers of that product also to buy an economically severable tied product, thus restraining competition in the market for the tied product. *Northern Pac. Ry. v. United States*, 356 U.S. at 5-6 (1958); L. SULLIVAN, *supra* note 490 at § 150. If JCAH carries out

competition. Certification of hospitals and of other health care delivery programs are clearly economically severable services. JCAH obviously controls the market for the tying product, hospital accreditation. Indeed, in some markets JCAH has been granted a monopoly over this product by law.⁵⁴⁰ Therefore, the all-or-none policy which ties the purchase of the tied product — accreditation of the non-hospital (e.g., substance abuse or developmental disabilities) program — to the purchase of the tying product — hospital accreditation — meets all the requirements of the classic definition of a tying arrangement, a per se antitrust violation.⁵⁴¹

3. JCAH Monopolization

The JCAH standardization and accreditation programs may also violate Section two of the Sherman Act, forbidding monopolization.⁵⁴² To establish a violation of Section two, a plaintiff would have to show that JCAH has unlawfully monopolized the market in health care certification in the United States to the exclusion of other certification agencies.

The first step in determining whether a monopoly in fact exists is to identify the arena for the defendant's market power in terms of both the geographic and product market in which the seller competes.⁵⁴³ The Supreme Court in *United States v. E.I. DuPont de Nemours & Co.*⁵⁴⁴ defined a product market as including all goods and services that are reasonably interchangeable, i.e. goods and services that may be substituted for those of the seller if the seller raises his price. The courts have defined geographic market as the territory from which competitors of the alleged monopolist's product are excluded by high transaction costs.⁵⁴⁵ To find that a monopoly exists a court need not find that the defendant has taken over an entire product market within an entire geographic market, but the court must find that the defendant controls a substantial proportion of both markets.⁵⁴⁶

JCAH accredits eighty percent of the nation's hospitals and has no competition for the accreditation of non-osteopathic hospitals.⁵⁴⁷ Its share of the total health institution accreditation market in the United States is smaller, but within this market JCAH has no substantial competition and arguable monopoly power.

its present plan to regulate evaluation of hospital based mental health facilities under the AMH, the presence of an illegal tying arrangement would be even clearer. See *supra* note 320.

⁵⁴⁰ Cf. Blumstein & Calvani, *State Action as a Shield and Sword in a Medical Services Antitrust Context*, 1978 DUKE L.J. 389, 435-36 (1978) (discussing the reliance on state created monopolies to establish market power to ground tying arrangements).

⁵⁴¹ See *supra* note 539.

⁵⁴² See 15 U.S.C. § 2 (1976).

⁵⁴³ See L. SULLIVAN, *supra* note 490, at §§ 12, 19.

⁵⁴⁴ 351 U.S. 377, 393-95 (1956).

⁵⁴⁵ See *Robinson v. McGovern*, 521 F. Supp. 842, 879 (W.D. Pa. 1981); *Dolan & Ralston*, *supra* note 304, at 765, 766.

⁵⁴⁶ See *Dolan & Ralston*, *supra* note 304, at 766 and n.278.

⁵⁴⁷ See *Affeldt*, *supra* note 53, at 189.

To establish Section two liability, it is not enough for a plaintiff to show merely the existence of monopoly power. The plaintiff must also show that the defendant willfully acquired the monopoly power, that it is not merely the result of a "superior product, business acumen, or historical accident."⁵⁴⁸ JCAH could well argue that its dominance in the health care accreditation field results from the quality of its work, from government recognition, or perhaps from the fact that the service of information production through standardization and certification is a natural monopoly. Even if it could be demonstrated that JCAH sought and obtained government sanction for its monopoly position, such conduct would probably be protected by *Noerr-Pennington*⁵⁴⁹ and not be vulnerable to a Section two charge. On the other hand, if it could be shown that JCAH excluded competition from other accreditation bodies through organizing or cooperating in concerted refusals to deal — as by obtaining cooperation from Blue Cross to refuse to reimburse facilities accredited by competitors — or through tying arrangements, a violation of Section two could be established.⁵⁵⁰

If Section two litigation served no purpose other than to further illuminate and sanction conduct already illegal under Section one, it would probably not be worth the effort. Section two, however, might also serve as the basis for government litigation to compel JCAH to divest itself of its non-hospital accreditation programs. This could result in the development of new accreditation programs which in turn might encourage greater diversity and competition in the health care industry.

4. Effects of Antitrust Litigation on JCAH

JCAH has not been blind to the ramifications of antitrust law for its programs, nor has it failed to take note of the litigation against it. It appears that JCAH in its most recent AMH rewrite, may be retreating from standards excluding non-physician health care providers from hospitals.⁵⁵¹ This move seems to be largely attributable to antitrust litigation against JCAH, and testifies to the potential of antitrust litigation to control the anticompetitive ef-

⁵⁴⁸ *United States v. Grinnell Corp.*, 384 U.S. 563, 570-571 (1966); *Eliason v. National Sanitation Foundation*, 614 F.2d 126, 130, 131 (6th Cir. 1980); see also *Roof Fire Alarm Co. v. Royal Indemnity Co.*, 202 F. Supp. 166, 168, 169 (E.D. Tenn. 1963), *aff'd*, 313 F.2d 635 (6th Cir. 1963), *cert. denied*, 373 U.S. 949 (1963) (widespread acceptance of standard setting organization because of its competence, not monopolization); *Veizaga v. National Bd. for Respiration Therapy*, 1977-1 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill., Jan. 27, 1977) (case dismissed against health practitioner certifying organization as plaintiff failed to allege willful acquisition or maintaining of monopoly power).

⁵⁴⁹ See *supra* text accompanying notes 432-35.

⁵⁵⁰ See Sullivan, *supra* note 490, at §§ 33-48.

⁵⁵¹ See Harrington, *JCAH Board Drops Medical Staff Requirement*, PSYCHIATRIC NEWS, Jan. 7, 1983 at 1, 8, 9; Robinson, *Medical Staff Standards May Be Eased*, MOD. HEALTH CARE, March, 1983 at 23; *AMA Acts on Doctors' Plight at Hospitals*, MED. WORLD NEWS, Jan. 10, 1982 at 35; *Revised Hospital Standards Threaten Roosts Long Ruled by Doctors and Denitsts*, MED. WORLD NEWS, July 19, 1982 at 33-34.

fects of private standardization and certification efforts. JCAH earlier settled a case brought against it by podiatrists by substantially expanding the recognition of the role of podiatrists in hospitals under JCAH standards.⁵⁵² It may well be that if JCAH is closely monitored by interested parties and by the Justice Department, the anticompetitive effects of its programs may be reduced to an acceptable level and the procompetitive effects strengthened.⁵⁵³

B. Control of Inadequate Standards and Inspections Through Tort Law

An evaluation of JCAH must also take into account the fact that the JCAH inspection and accreditation program is not the only, and indeed may not be the most effective, means of assuring hospital compliance with JCAH standards.

Following the Illinois Supreme Court's lead in *Darling v. Charleston Community Hospital*,⁵⁵⁴ courts increasingly have relied on JCAH standards for evaluating whether or not hospital practices are negligent,⁵⁵⁵ or for rejecting the "locality rule," under which negligence is evaluated in terms of practice in the community in which medical care is given, in favor of national standards like those of JCAH.⁵⁵⁶ Though hospitals may be able to deceive JCAH inspectors as to compliance with JCAH standards, hospitals that attempt to do so may eventually face substantial negligence judgments. Prudent hospitals will pursue risk management programs structured around compliance with JCAH standards to limit tort exposure.⁵⁵⁷

Reliance on JCAH standards to define reasonable hospital behavior could, of course, lower the quality of care rather than raise it. Some critics have claimed that JCAH has purposely weakened its standards to protect hospitals

⁵⁵² *Levin v. JCAH*, 354 F.2d 515 (D.C. Cir. 1965); see *Shaw v. Hospital Authority of Cobb County*, 614 F.2d 646 (5th Cir. 1980); Hollowell, *The Growing Legal Contest — Hospital Privileges for Podiatrists*, 23 ST. LOUIS U.L.J. 491, 501 n.55 (1979).

⁵⁵³ An additional source of potential control over JCAH anticompetitive activities is the Federal Trade Commission Act, 15 U.S.C. §§ 41-58 (1976). After an extensive preliminary investigation, see Schlicke, *supra* note 180, at 27, the FTC decided that it did not have jurisdiction over JCAH. Telephone interview with Joan Moreland, FTC (July 27, 1982); see 15 U.S.C. § 44 (1976).

⁵⁵⁴ 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

⁵⁵⁵ *Steves v. United States*, 294 F. Supp. 446, 454, 455 (D.S.C. 1968); *Fox v. Cohen*, 84 Ill. App. 3d 744, 750, 406 N.E.2d 178, 182 (1980); *Silkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 349 A.2d 245, 254 (1975); cf. *Hunsaker v. Bozeman Deaconess Found.*, 588 P.2d 493, 502 (Mont. 1976) (JCAH standards accepted into evidence by trial court as part of plaintiff's cases).

⁵⁵⁶ *Kapuschinsky v. United States*, 248 F. Supp. 732, 744 (D.S.C. 1966); *Rucker v. High Point Mem. Hosp.*, 285 N.C. 519, 524, 206 S.E.2d 196, 201, 202 (1974); *Durling v. Bluefield Sanatorium, Inc.*, 149 W. Va. 567, 142 S.E.2d 754, 765 (1965); Lundlam, *The Impact of the Darling Decision Upon the Practice of Medicine & Hospitals*, 11 THE FORUM 756, 757, 758 (1976).

⁵⁵⁷ See R. Dalton, *Reducing Risks Through Compliance with Accreditation Standards*, 6 QUALITY REV. BULL. 3-4 (1980); Passett, *The "Systems Approach" to Patient Safety: An Update*, 9 LEGAL ASPECTS MED. PRAC. Apr. 1981 1, 1-3.

from tort liability.⁵⁵⁸ Moreover, some hospitals are now relying on compliance with JCAH standards to defend the reasonableness of their practices against claims that the hospital's care was inadequate.⁵⁵⁹ Nevertheless, the role of JCAH standards in tort litigation probably encourages better quality care and treatment.

Tort actions are also a potential means of getting directly at the problem of inadequate JCAH standards and inspections. In a number of recent hospital negligence cases, plaintiffs have added the JCAH as an additional defendant, claiming that JCAH is a guarantor of the quality of care in and responsible for the negligence of accredited hospitals.⁵⁶⁰ The barriers facing a plaintiff in such a lawsuit are readily apparent. As the major function of JCAH is to serve as a consultant to the hospital, it may be hard to show a duty owed by JCAH to individual patients. It may also be difficult to establish that JCAH proximately caused any particular negligence by a hospital or physician. The general ignorance of JCAH accreditation would make it difficult for any plaintiff to claim that JCAH could foresee actual reliance on its accreditation as a guarantor of quality. Finally, establishing that JCAH standards or inspections were negligent will not be easy.

The use of tort litigation against JCAH is also questionable from a policy standpoint. If the purpose of tort litigation is to spread risks,⁵⁶¹ JCAH is a poor candidate. JCAH is not only not a "deep pocket," but it is also a poor insurer. If the purpose is to encourage expenditure of resources to prevent an injury commensurate with the likely extent of the injury,⁵⁶² JCAH is again an inappropriate defendant. Medical injuries normally are caused by the failure of a hospital or physician to take adequate precautions by the expenditure of adequate resources rather than by a failure of JCAH. But, in other contexts some courts have held independent certifying or testing agencies liable under a negligent misrepresentation theory to ultimate consumers for injuries caused by approved products,⁵⁶³ and such litigation may be on the increase against JCAH.

Ultimately, such cases may do more harm than good to the quality of care hospital patients as a group receive. If JCAH became a routine defendant in

⁵⁵⁸ See *Hearings*, *supra* note 54, at 1954, 1972 (testimony of Fred Hiestand).

⁵⁵⁹ See *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332 (1982); *Moreaux v. Argonaut Ins. Co.*, 350 So.2d 240, 246 (La. Ct. App. 1977), *cert. denied*, 351 So.2d 776 (La. 1977). See also *Pelphrey v. United States*, 674 F.2d 243 (4th Cir. 1982) (JCAH accreditation of hospital cited as fact supporting granting of summary judgment to defendant in malpractice action).

⁵⁶⁰ See cases cited *supra* note 219.

⁵⁶¹ See C. Morris & C. R. Morris, Jr., *Morris on Torts*, 232-37 (2d Ed. 1980).

⁵⁶² Posner, *Economic Analysis of Law*, 122-25 (1977).

⁵⁶³ See *Hempstead v. General Fire Extinguisher Corp.*, 269 F. Supp. 109 (D. Del. 1967) (Underwriters Laboratories may be liable, if negligent, for injuries caused by explosion of approved fire extinguishers); *Hanberry v. Hearst Corp.*, 276 Cal. App. 2d 820, 81 Cal. Rptr. 519 (1969) (plaintiff states cause of action under negligent misrepresentation theory against Hearst Corp. for injury caused by shoes covered by Good Housekeeping Seal of Approval).

hospital negligence actions, its exposure for legal fees alone, even if it consistently won the lawsuits, would for a time be staggering.⁵⁶⁴ The result might well be to eliminate JCAH, and its beneficial effects.

C. Federal Supplementation

The 1972 amendments to the Social Security Act provide another means for improving the quality of care in JCAH accredited facilities. These amendments, described earlier,⁵⁶⁵ permit the Secretary of HEW (now HHS) to promulgate standards in excess of those required by JCAH standards; to validate JCAH accreditation with inspections by state agencies on a random and substantial complaint basis; and to decertify accredited facilities if they are found not to be in substantial compliance with HEW certification standards. Implementation of these amendments has been largely inadequate: the state validation program has been characterized by a GAO report as inconsistent and ineffective.⁵⁶⁶ Furthermore, recent validation regulations issued by the Department of Health and Human Services⁵⁶⁷ require state survey agency monitoring of accredited facilities with substantial deficiencies only if JCAH refuses itself to monitor deficiencies or HHS otherwise determines state review necessary. As of the 1978 GAO report, HHS had never decertified an accredited hospital.⁵⁶⁸ Finally, HHS has never in fact promulgated any standards higher than JCAH standards, and has committed itself not to promulgate higher standards without first consulting JCAH.⁵⁶⁹

Nevertheless, the 1972 amendments permit HHS to take a more active role in the standardization and certification process. While the arguments made earlier⁵⁷⁰ demonstrate that it is unwise for HHS to duplicate JCAH regulatory efforts, an HHS role is particularly appropriate for filling the gaps left by JCAH regulation of hospital quality and for encouraging competition. In particular, HHS should focus its standard setting authority on quality of

⁵⁶⁴ Of course, if JCAH consistently won, plaintiffs would cease suing it. If the idea of suing JCAH became popular, however, it might take some time for the law to become clear, and JCAH could encounter substantial expenses in the interim.

⁵⁶⁵ See *supra* text accompanying notes 185-87.

⁵⁶⁶ GAO REPORT, *supra* note 207, at 16-21.

⁵⁶⁷ 45 Fed. Reg. 74, 826 (1980) (codified at 42 C.F.R. §§ 405.1901, 405.1902 (1981)).

⁵⁶⁸ GAO REPORT, *supra* note 207, at 14.

⁵⁶⁹ Telephone interview with Spencer Colburn, Hospital Services Branch, Health Standards and Quality Bureau, Health Care Finance and Administration, Department of Health and Human Services (Sept. 17, 1982). In 1978, HEW issued regulations concerning quality control and proficiency testing standards for laboratories in Medicare hospitals that would have exceeded JCAH standards, but delayed full implementation for nine months. See 43 Fed. Reg. 7984 (1978). By the time the rule was to be fully operational JCAH standards were upgraded to equivalency; thus, independent surveys were never begun. See 44 Fed. Reg. 3288 (1979). A general revision of hospital certification standards proposed by HHS on January 4, 1983 does not propose standards exceeding those of JCAH. In fact, it is an attempt to comply with a proposed JCAH revision of its standards. 48 Fed. Reg. 299, 300 (1983).

⁵⁷⁰ See *supra* text accompanying notes 369-75.

hospital care output and on health care inputs not directly of interest to physicians. It should also encourage the availability of alternatives for patient care where appropriate. Finally, HHS should use the validation process to assure enforcement where JCAH has been clearly remiss in its efforts.

D. Government Review of JCAH Accreditation

Finally, JCAH ought to be subject to government review in its exercise of delegated authority. This is not only good policy, but is required by the constitutionally based nondelegation doctrine which restricts the delegation of authority from the government to private entities. Early nondelegation cases primarily addressed the issue of delegation of policy-making authority from the legislative to executive or judicial branches.⁵⁷¹ This application of the nondelegation doctrine rests on the principle that in a representative democracy the responsibility to make policy ultimately resides with the legislature — there is an irreducible minimum of responsibility that it cannot delegate.⁵⁷² The appropriate function of the executive branch as articulated in early nondelegation cases is to make subordinate rules, attend to details, and determine facts.⁵⁷³ Subordination of the executive to the legislature is not only necessary to preserve representative government, but also to provide criteria for judicial review of executive decisions and actions.⁵⁷⁴

Despite doctrinal limits on delegation of power from Congress to the executive branch, actual attempts to limit such delegation have largely failed. The complex and highly technical nature of problems faced by government, as well as its need to act rapidly and flexibly in changing situations, requires concentration of considerable policy-making authority in the executive branch.⁵⁷⁵ Moreover, the legislative branch is subject to political pressures from which administrators are more insulated by anonymity and the civil service laws. These pressures render it more difficult for the legislature to make controversial programmatic decisions and encourage abandonment of such decisions to the executive.⁵⁷⁶

⁵⁷¹ See, e.g., *Hampton & Co. v. United States*, 276 U.S. 394 (1928); *Buttfield v. Stranahan*, 192 U.S. 470 (1904); *Field v. Clark*, 143 U.S. 649 (1892); *Wayman v. Southard*, 23 U.S. 1 (1825).

⁵⁷² S. BARBER, *THE CONSTITUTION AND THE DELEGATION OF CONGRESSIONAL POWER* 18 (1975); Note, *Rethinking the Nondelegation Doctrine*, 62 B.U.L. REV. 257, 260-64, 314-23 (1982).

⁵⁷³ See, e.g., *Buttfield v. Stranahan*, 192 U.S. 470 (1904) (Congress can delegate power to administer law to bring about result Congress sets out); *Field v. Clark*, 143 U.S. 649, 691-94 (1892) (Congress can delegate authority to determine facts); cf. *Wayman v. Southard*, 23 U.S. 1 at 42, 43 (1825) (Congress can delegate to courts power to fill up the details of legislation to regulate practice).

⁵⁷⁴ See Note, B.U.L. REV., *supra* note 572, at 295, 296.

⁵⁷⁵ See *Amalgamated Meat Cutters & Butcher Workers v. Connelly*, 337 F. Supp. 737, 746, 747 (D.D.C. 1971). But see Aranson, Gellhorn & Robinson, *A Theory of Legislative Delegation*, 68 CORNELL L. REV. 1, 21-24 (1982) (arguing that managerial explanations are not fully adequate to explain the phenomenon of delegation).

⁵⁷⁶ See Barber, *supra* note 572, at 3-4.

Delegation is particularly likely if sharp conflict between groups with varying interests makes it politically attractive for the legislature to maintain an ambiguous position on an issue and delegate responsibility to act to the executive.⁵⁷⁷ The legislative branch is also likely to delegate authority to the executive if it can thereby confer benefits on politically focused groups, thus gaining their approbation, while at the same time shifting responsibility — and the risk of public disapproval — to the executive.⁵⁷⁸ Though the principle of limiting delegation from the legislature to the executive continues to show signs of lingering vitality,⁵⁷⁹ courts have long recognized the practical need for allowing delegation of extensive discretionary power to the executive⁵⁸⁰ and having bow to pressure from the legislature permitted a steady weakening of this branch of the non delegation doctrine.⁵⁸¹

Delegation of legislative authority to a private entity rather than to a coordinate branch of government threatens more directly the ideal of representative democracy that grounds the non delegation doctrine. Even though the executive may be less directly answerable to the people than the legislature, it is still accountable through election of major officials, legislative approval of significant appointed officials, and laws requiring fair and open executive rule-making and adjudicatory procedures. Substantial dangers arise when legislative or executive power is transferred to private bodies neither accountable nor responsible to the people.⁵⁸² These problems are most acute when the private policymaker is responsible to private groups whose interests potentially are in conflict with those of the public. It is particularly offensive for the government to transfer authority to a private body to not only make policy but also quasi-judicial decisions affecting the rights of specific persons. Such private application of policy raises serious fairness and due process problems.⁵⁸³ Again, this is

⁵⁷⁷ Aranson, Gellhorn & Robinson, *supra* note 575, at 59-62.

⁵⁷⁸ *Id.* at 556-59.

⁵⁷⁹ See *Industrial Union Dept. v. American Petroleum Inst.*, 448 U.S. 607, 672-76 (1980) (Rehnquist, J., concurring).

⁵⁸⁰ *United States v. Grimaud*, 220 U.S. 506, 516 (1911); *Buttfield v. Stranahan*, 192 U.S. 470, 496 (1904).

⁵⁸¹ See *FPC v. New England Power Co.*, 415 U.S. 345, 352, 353 n.1 (1976) (Marshall, J. concurring); *Quincy College v. Burlington N. R.R.*, 328 F. Supp. 808, 811 (N.D. Ill. 1971), *aff'd.*, 405 U.S. 906 (1972).

⁵⁸² See *Carter v. Carter Coal Co.*, 298 U.S. 238 (1936); see generally, discussing delegation to private groups: Jaffe, *Law Making By Private Groups*, 51 HARV. L. REV. 201 (1937); Liebman, *Delegation to Private Parties in American Constitutional Law*, 50 IND. L.J. 650 (1975); Wirtz, *Government by Private Groups*, 13 LA. L. REV. 440 (1953); Note, *The State Courts and Delegation of Public Authority to Private Groups*, 67 HARV. L. REV. 1398 (1954) (hereinafter cited as Note, *The State Courts and Delegation*).

⁵⁸³ See, e.g., *Carter v. Carter Coal Co.*, 298 U.S. 238, 311-12 (1936); *Group Health Ins. of N.J. v. Howell*, 40 N.J. 436, 193 A.2d 103 (1963); *Fink v. Cole*, 302 N.Y. 216, 97 N.E.2d 873 (1951); *Farias v. City of New York*, 101 Misc. 2d 598, 421 N.Y.S.2d 753 (1979); *United Chiropractors of Washington, Inc. v. Washington*, 90 Wash. 2d 1, 578 P.2d 38 (1978); Liebman, *supra* note 582, at 659-61; Note, *The State Courts and Delegation*, *supra* note 582, at 1401-04.

particularly true if the interests of the private decision-maker conflict with the interests of those subject to it or of the public.⁵⁸⁴

Government may, however, delegate its power to private parties under certain conditions. In fact, such delegation is common: through private civil law the government extensively delegates its authority by affording private parties its power to enforce private agreements, remedy private injuries, or reconcile conflicting private property claims, often on the basis of the public interest. It even creates enforceable private rights as a means of effectuating public policy.⁵⁸⁵ Moreover, whether or not they are explicitly granted power to make public policy, private entities exert significant influence over governmental decisions at both the policy determination and implementation level.⁵⁸⁶ Where private groups possess specific expertise or unique administrative resources, or where public problems affect primarily a small cohesive group, it may be reasonable for the government to delegate some power to private bodies to make, or even enforce, policy.⁵⁸⁷

Delegation of public authority to a private entity is a particularly rational legislative strategy if the legislature confronts simultaneously a focused private interest group — the constituency of the private entity — and an apathetic or ignorant public, that may be harmed by the delegation but is unlikely immediately to respond. By delegating authority to the private entity, the legislature can gain the private group's support while risking little public blame.⁵⁸⁸ If the public subsequently becomes aware of the private entity acting contrary to its interests, there is nothing to stop the legislature turning on

⁵⁸⁴ See, e.g., *State Bd. of Dry Cleaners v. Thrift-D-Lux Cleaners*, 40 Cal. 2d 436, 254 P.2d 29 (1953); *People v. Pollution Control Bd.*, 83 Ill. App. 3d 802, 404 N.E.2d 352 (1980); *Johnson v. Michigan Milk Marketing Board*, 295 Mich. 644, 295 N.W. 346 (1940); *Group Health Ins. of N.J. v. Howell*, 40 N.J. 439, 193 A.2d 103 (1963); *United Trust Co. v. Simmons*, 116 Utah 422, 211 P.2d 190 (1949).

⁵⁸⁵ Hanslowe, *Regulation by Visible Public and Invisible Private Government*, 40 TEX. L. REV. 88, 92-113 (1961); Jaffe, *supra* note 582, at 212-21; Note, *The State Courts and Delegation*, *supra* note 582, at 1399.

⁵⁸⁶ Wirtz, *supra* note 582, at 457-60.

⁵⁸⁷ See, e.g., *Packer v. Bd. of Behavioral Science Examiners*, 52 Cal. App. 3d 190, 125 Cal. Rptr. 96 (1975) (licensing requirement of degree from accredited college upheld); *Natural Milk Producers Ass'n v. City and County of San Francisco*, 20 Cal. 2d 101, 124 P.2d 25 (1942) (municipal reliance on milk standard established by medical experts approved); *Colorado Polytechnic College v. State Bd. of Community Colleges and Occupational Educ.*, 173 Colo. 39, 476 P.2d 38 (1970) (professional training and experience of educational accounting body justifies legislative reliance); *Florida Welding and Erection Service v. American Mut. Ins. Co. of Boston*, 285 So. 2d 386 (Fla. 1973) (permissible to rely on private insurance rating service where guidelines and standards established by legislation); *Cities Serv. v. Koenke*, 137 Kan. 7, 20 P.2d 460 (1933) (statute exempting from regulation securities listed with New York, Boston and Chicago stock exchanges approved because of standing and responsibility of those bodies); *Humane Soc'y of United States N.J. Branch v. New Jersey State Fish & Game Council*, 70 N.J. 565, 362 A.2d 20 (1976) (no conflict of interest); *Morgan v. N.Y. Racing Ass'n*, 72 A.D.2d 740, 421 N.Y.S.2d 249 (1979) (state reliance on preexisting register of thoroughbred pedigrees approved).

⁵⁸⁸ See Aranson, Gellhorn & Robinson, *supra* note 575, at 56-59.

and criticizing the entity, thereby gaining public approval.⁵⁸⁹ Delegation to private entities, like delegation to the executive, has frequently been upheld by the courts. Indeed, federal courts have increasingly accepted delegation to private parties subject to certain safeguards and rarely hold such delegations improper.⁵⁹⁰ Courts are particularly likely to find delegation unobjectionable where the circumstances of the delegation provide some assurances of accountability and fairness.

First, courts consider it more appropriate for the legislature to adopt existing articulations of private policy than to delegate prospectively to a private body continuing power to make policy for the government. A number of cases have approved government adoption of preexisting private product or professional service certification standards.⁵⁹¹ Here accountability is assured by independent government review of the standards before adoption. Adoption of a body of private standards, however, including all future changes to those standards has been held improper, since this effectively delegates unreviewable discretion to private entities to modify government policy thereafter at their own initiative.⁵⁹²

Second, a number of courts have upheld legislation permitting private entities the option of participating in a government regulation program once that program has been established. For example, the Supreme Court has on several occasions upheld legislation permitting industries to accept or reject legislative industry codes, holding that the legislature's actions were proper both in making the policy articulated in the code and in providing for optional implementation.⁵⁹³

Third, courts have been more hospitable towards delegation of power where articulated legislative standards canalize the scope of the private discretion.⁵⁹⁴ Here the standards assure that the legislature has made basic policy

⁵⁸⁹ *Id.* at 58.

⁵⁹⁰ *See* *Corum v. Beth Israel Medical Center*, 373 F. Supp. 550, 553 (S.D.N.Y. 1974); *Quincy College and Seminary Corp. v. Burlington N. R. R.*, 328 F. Supp. 808, 811 (N.D. Ill. 1971), *aff'd*, 405 U.S. 906 (1972).

⁵⁹¹ *See, e.g.*, *Noblecraft Indus. Inc. v. Secretary of Labor*, 614 F.2d 199, 203 (9th Cir. 1980); *Attwood v. State ex rel Newman*, 53 So. 2d 825 (Fla. 1951); *Spencer v. Hunt*, 109 Fla. 248, 147 So. 282 (1933); *City of Warren v. State Construction Code Comm'n.*, 66 Mich. App. 493, 239 N.W.2d 640 (1976); *Allen v. State Bd. of Veterinarians*, 72 R.I. 372, 52 A.2d 131 (1947).

⁵⁹² *See, e.g.*, *City of Tucson v. Stewart*, 45 Ariz. 36, 40 P.2d 72 (1935); *State v. Crawford*, 104 Kan. 141, 177 P. 360 (1919); *State ex rel Kirschner v. Urquhart*, 50 Wash. 2d 131, 310 P.2d 261 (1957).

⁵⁹³ *United States v. Rock Royal Coop.*, 307 U.S. 533, 577-78 (1939); *Currin v. Wallace*, 306 U.S. 1, 15 (1939). *See also* *Brock v. Superior Court*, 9 Cal. 2d 291, 71 P.2d 209 (1937); *Palmer Oil Corp. v. Phillips Petroleum*, 204 Okla. 543, 231 P.2d 997 (Okla. 1951) (state court cases similarly upholding industry codes).

⁵⁹⁴ *See, e.g.*, *Mount Vernon Mem. Park v. Board of Funeral Directors and Embalmers*, 79 Cal. App. 3d 874, 145 Cal. Rptr. 275 (1978); *Florida Welding and Erection Service, Inc. v. American Mut. Ins. Co. of Boston*, 285 So. 2d 386 (Fla. 1973); *Superintending School Comm'n v. Bangor Educ. Ass'n*, 433 A.2d 383 (Me. 1981); *In re Garrison*, 44 N.C. App. 158, 260 S.E.2d

decisions. Similarly, courts have been more willing to permit delegation where there are external safeguards to assure the proper exercise of authority.⁵⁹⁵ This may be true where standards have a scientific basis or were developed for purposes independent of the governmental program at issue by experts unlikely to be affected by improper influences such as conflicts of interests.⁵⁹⁶

Finally, courts are more willing to approve delegation of authority to private entities, even authority to make quasi-judicial determinations, where the private entity is subject to procedural safeguards imposed by the government, or to direct government agency review of its decisions.⁵⁹⁷ Private quasi-judicial decision-making is less objectionable if there is an articulated formal and fair procedure for decision-making within the entity and access to a government body that can fully review the private decision. In all of these cases a common theme is discernible: delegation to private entities is permissible only if there are assurances of fair private decision-making and ultimate control by accountable government entities.

Judged by these standards the current extent of delegation of federal authority to JCAH under the Medicare program is highly questionable. The law does not merely adopt pre-existing JCAH accreditation standards, but rather permits hospital accreditation to serve as a basis for Medicare certification of general hospitals,⁵⁹⁸ and further, requires accreditation for psychiatric hospitals under some circumstances,⁵⁹⁹ regardless of future changes by JCAH in its standards. The Medicare legislation not only allows the hospital industry the choice of accepting or rejecting HHS certification standards but also permits the industry, as an alternative, to comply with standards established by itself through JCAH. The Medicare statute provides no standards to guide JCAH in creating its standards and imposes on JCAH no internal procedural safeguards to protect persons applying for or contesting the grant of accreditation.

445 (1979), *appeal dismissed*, 299 N.C. 545, 265 S.E.2d 404 (1980). *See also*, finding insufficient standards, *Bayside Timber Company v. Board of Supervisors*, 20 Cal. App. 3d 1, 97 Cal. Rptr. 431 (1971); *Jennings v. Exeter-West Greenwich Regional School Dist. Committee*, 116 R.I. 190, 352 A.2d 634 (1976).

⁵⁹⁵ *Potter v. New Jersey Supreme Court*, 403 F. Supp. 1036 (D.N.J. 1975); *Natural Milk Producers Ass'n v. City and County of San Francisco*, 20 Cal. 2d 101, 124 P.2d 25 (1942); *Colorado Polytechnic College v. State Bd. of Community Colleges and Occupational Education*, 173 Colo. 39, 476 P.2d 38 (1970). Other courts, however, have held that special expertise of a private association does not in itself qualify it to assume government responsibility. *See, e.g.*, *Hetherington v. McHale*, 458 Pa. 479, 329 A.2d 250 (1974); *Hillman v. Northern Wasco County Peoples Utility Dist.*, 213 Or. 264, 323 P.2d 664 (1957).

⁵⁹⁶ *State v. Wakeen*, 263 Wis. 401, 57 N.W.2d 364 (1953).

⁵⁹⁷ *See, e.g.*, *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 399 (1940); *Todd & Co., Inc. v. SEC*, 557 F.2d 1008 (3d Cir. 1977); *R. J. Johnson and Co. v. FCC*, 198 F.2d 690 (2d Cir. 1952), *cert. denied*, 344 U.S. 855 (1952); *Hogan v. State Bar*, 36 Cal. 2d 807, 228 P.2d 554 (1951); *People v. Chicago R.R. Terminal Auth.*, 14 Ill. 2d 230, 151 N.E.2d 311 (1958); *Podiatry Soc'y of N.Y. v. Regents*, 78 Misc. 2d 731, 358 N.Y.S.2d 276 (1974).

⁵⁹⁸ 42 U.S.C. § 1395bb (1978).

⁵⁹⁹ 42 U.S.C. § 1395x(f), 42 U.S.C. § 1396(h) (1976).

Even more important, there is no direct federal review of JCAH decisions. The decision to grant accreditation is only reviewable by HHS through its retained power to deny certification if a subsequent verification investigation is made and shows substantial non-compliance with the Medicare Act and standards,⁶⁰⁰ a power HHS has never exercised.⁶⁰¹ A JCAH decision to deny a general hospital accreditation is only reviewable to the extent that HHS may independently certify a non-accredited facility for participation in the Medicare program. JCAH psychiatric facility accreditation decisions have a final and unreviewable effect on Medicaid certification — except insofar as distinct part certification may provide relief.⁶⁰²

A review of the history of the delegation of federal authority to JCAH reveals an obvious attempt by the legislature to confer benefits on the member groups of JCAH to secure their support.⁶⁰³ As the delegation resulted in the creation of private goods at the public expense, it is a suspect delegation.⁶⁰⁴ The delegation of Medicare certification power to JCAH was even more suspect prior to the 1972 Medicare amendments and was the major issue raised in *Self-help v. Richardson*, the case brought against JCAH by consumers that precipitated the 1972 Social Security amendments.⁶⁰⁵ *Leone v. Mathews* has subsequently held there to be no unconstitutional delegation to JCAH of responsibility to certify psychiatric facilities for Medicare and Medicaid funding where recourse to the federal government through independent distinct part certification was available.⁶⁰⁶ The federal district court in *Cospito v. Califano*⁶⁰⁷ has also upheld delegation to JCAH in the same context. The court relied on cases upholding delegation of government authority where technical questions were decided by private scientific bodies and pointed to reliance on private educational accreditation by Congress and private drug formulas by the Food and Drug Administration.⁶⁰⁸ The most difficult current federal delegation problem, the absolute power of JCAH to decide whether or not a psychiatric facility for patients under the age of twenty-one may participate in the Medicaid program (where distinct part certification is not available), remains to be decided.⁶⁰⁹

While the extensive federal delegation to JCAH is questionable, even more substantial problems of delegation are raised in those states in which licensing statutes grant JCAH absolute discretion in licensing decisions.⁶¹⁰

⁶⁰⁰ See 42 U.S.C. § 1396bb(b) (1976).

⁶⁰¹ See GAO REPORT, *supra* note 207, at 14.

⁶⁰² See *supra* note 61.

⁶⁰³ See *supra*, text accompanying notes 155-169, 588.

⁶⁰⁴ See Aranson, Gellhorn & Robinson, *supra* note 575, at 63-67.

⁶⁰⁵ *Self-Help for the Elderly v. Richardson*, No. 2016-71 (D.D.C. 1970); see *supra* text accompanying notes 177, 178, 185.

⁶⁰⁶ No. 76-1059 (D.N.J. Aug. 2, 1977).

⁶⁰⁷ No. 77-869 (D.N.J. 1983); see also earlier decision at 89 F.R.D. 374 (1981).

⁶⁰⁸ See *Cospito v. Califano*, No. 77-869 at 18-22 (D.N.J. 1983).

⁶⁰⁹ See *supra* note 61.

⁶¹⁰ See *supra* note 66.

Challenges to delegation may also be more successful at the state level because the delegation doctrine has retained more vitality there than it has in the federal courts.⁶¹¹

Though the delegation question has not yet arisen at the state level in regard to licensing, it has been raised in another context. In the late 1960's and early 1970's many state statutes outlawing abortion were amended to permit abortions but only in JCAH accredited facilities. This legislation was challenged in a number of cases raising the question of the legality of state governments delegating to JCAH the authority to determine whether or not a facility was appropriate to perform abortions. In *Poe v. Menghini*⁶¹² the Kansas abortion statute was held to delegate legislative policy-making authority to JCAH unconstitutionally. *People v. Barksdale*,⁶¹³ on the other hand, found the same delegation in the California statute to be unobjectionable. *Doe v. Bolton*⁶¹⁴ held the JCAH accreditation requirement unconstitutional on equal protection grounds rather than on delegation grounds: the court decided states could not limit abortions to JCAH accredited facilities if they imposed no such limitations on other similar medical procedures.⁶¹⁵

Though the 1972 amendments to the Medicare law brought about the dismissal of the *Self-help* case and rendered the delegation of federal certification authority to JCAH less suspect, certain specific changes could be made within the Medicare program that would address the concerns of accountability and fairness that support the non-delegation doctrine, and thus render the delegation of authority to JCAH less subject to constitutional attack. These changes would also clarify JCAH's status under the APA and assure due process for those affected by the JCAH. First, HHS ought to take seriously its authority to create standards in excess of those promulgated by JCAH. Second, the validation process ought to be restructured to focus on monitoring closely, and where necessary decertifying, substandard accredited hospitals. This would largely remedy the problem of the absence of any direct review mechanism for questionable accreditation decisions. Finally, the Social Security legislation ought to be amended to permit direct administrative and judicial review of accreditation decisions affecting psychiatric hospitals to eliminate JCAH's unreviewable discretion in this area.⁶¹⁶ Direct review of accreditation decisions affecting the Medicare or Medicaid status of general hospitals, which could be initiated by affected hospital staff or employees or patients ought also to be considered.

⁶¹¹ Note, *The State Courts and Delegation*, *supra* note 582, at 1398.

⁶¹² 339 F. Supp. 986 (D. Kan. 1972).

⁶¹³ 8 Cal. 3d 320, 503 P.2d 257, 105 Cal. Rptr. 1 (1972).

⁶¹⁴ 410 U.S. 179 (1973).

⁶¹⁵ *Id.* at 193-95.

⁶¹⁶ This is a change JCAH has itself advocated, telephone interview with Eleanor Wagner, Daniel Schuyler and Paul Mullen of JCAH (December 10, 1982).

CONCLUSION

We began by considering the two models currently being debated as means for protecting the public's interest in health care: market reform to promote competition and command and control government regulation. It may come as a surprise that JCAH, the entity that has actually developed for protecting the public's interest in institutional medical care quality, is a private non-government regulator and fits neither of these models. Yet, considering the economic interests of its constituencies, it is quite easy to understand why JCAH exists, and why it functions as well (and as poorly) as it does in protecting the public interest.

The JCAH, as a private regulator, has had a significant impact on the development of institutional medical care in America, and continues to play a major role in determining the nature of that care. Private standardization and certification as means of regulation have received strong support from the current administration. The potential, and problems, of private standardization and certification are illuminated by the JCAH experience. This article's analysis of that experience suggests that private entities be used as regulators only with the utmost care, with consideration of the nature and interests of the private regulator and of the adequacy of legal remedies for the problems that private regulation may cause.