

held a building contractor liable for injuries sustained when a porch fell on the tenant of the grantee two years after construction of the house.²⁴ One factor present in all the cases representing the "new" or "modern" view of liability without privity is that the defect was latent and not patent. Observation of a defect upon reasonable inspection would seem to be sufficient basis for shifting the liability from the contractor to the owner of the structure.

The overwhelming majority of cases of the type under discussion have involved personal injury. However, in the instant case the injury complained of is property damage, and the court properly ruled that the principle of law should be the same as it is for personal injury. In *Central & So. Truck Lines v. Westfall GMC Truck, Inc.*,²⁵ liability for property damage was imposed for negligent repairs to plaintiff's trailer, despite lack of privity, and a New Jersey court²⁶ recently imposed liability upon a negligent repairman for both personal injuries and property damage. The sound view calls for the extension of liability to cases involving property damage as has been done in the area of manufacturer's liability.²⁷

It is submitted that this case represents the sound view of negligence liability for building contractors. There is no logical reason for applying one rule of law to building contractors and another rule with a broader liability to manufacturers, suppliers of chattels, and repairers and rebuilders. Building contractors should be subject to the duty of reasonable care for the protection of anyone who may foreseeably be endangered by their negligence, even after acceptance of the work by the owner.

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Trade Regulations—Restraint of Trade—Boycott of Doctor Excluded from County Medical Bureau.—*Hubbard v. Medical Service Corporation of Spokane County.*¹—Appellant doctor was a member of The Medical Service Bureau of Spokane County, an unincorporated association of which 275 of the 300 doctors licensed to practice in the county were members. The sole function of the bureau was to make medical and surgical services available to The Medical Service Corporation of Spokane County, a non-profit organization, by means of individual contracts executed by members of the bureau and the corporation. In turn, the corporation had agreements with various employee groups to supply these services in return for prepaid premiums. Like all other bureau members, appellant doctor entered into a contract with the corporation when he became a bureau member, whereby he agreed to treat all subscribers to the prepaid medical plan, to accept as payment in full the fees established by the bureau and approved by the

²⁴ Leigh v. Wadsworth, 361 P.2d 849 (Okla. 1961).

²⁵ 317 S.W.2d 841 (Mo. App. 1958).

²⁶ Zierer v. Daniels, 40 N.J. Super. 130, 122 A.2d 377 (1956).

²⁷ Prosser, Torts 501 (2d ed. 1955), citing *International Harvester Co. v. Sharoff*, 202 F.2d 52 (10th Cir. 1953); *Quackenbush v. Ford Motor Co.*, 167 App. Div. 433, 153 N.Y. Supp. 131 (1915).

¹ — Wash. 2d —, 367 P.2d 1003 (1962).

corporation, and to abide by the rules and regulations covering the furnishing of his services. Furthermore, the contract was made subject to cancellation at any time without cause. Among the more pertinent bureau rules to which appellant was subject are the following: a member doctor cannot associate professionally with, or refer subscribers to a non-member doctor, nor can he make a contract for his services in any competing prepaid contract medical plan; except for routine office calls, all treatment must be approved in advance by the bureau; and all charges made are subject to review. Because appellant charged subscriber patients a higher fee for certain special treatments than was fixed by the bureau, thereby violating the regulation against "double billing," his contract with the corporation was cancelled, and his membership in the bureau automatically terminated. Appellant sought both damages and injunctive relief against both the corporation and the bureau. HELD: Although the corporation was justified in cancelling the contract, the bureau's policy of preventing member doctors from referring subscriber patients to non-member doctors was in restraint of trade and an illegal boycott. An injunction was issued.

At the outset, it is important to carefully delineate the bounds of the decision in this case. Clearly, the court did not decide that the whole operation of the bureau and the corporation amounted to a monopoly.² What it did decide was that it was an illegal boycott and restraint of trade for the bureau to prohibit member physicians from referring patients to the appellant, a non-member physician.³

Although courts in England and the United States, on both the federal and the state levels, have occasionally applied anti-monopoly law to certain practices of medical organizations, the most striking feature of the cases in this area is the difficulty encountered by the courts in attempting to force a traditionally non-commercial activity within a framework of laws which historically have been applied only to conventional commercial transactions. Quite expectedly, the result is a stretching of language and a broadening of concepts.⁴ Acting as a countervailing force of considerable fortitude is the

² In a single brief paragraph the court summarily dismissed appellant's allegation that the operation of the bureau and the corporation constituted a monopoly, stating that "The evidence supports the finding of the trial court . . . to the effect that the corporation's operation is not monopolistic in nature, is not in the furtherance of any monopoly, and does not fix prices or limit protection, and that its operation is beneficial rather than injurious to the general public." *Id.* at 1006-07.

³ Two other points were decided. First, the court held that the corporation was justified in terminating appellant's contract. Second, it determined that appellant had no identifiable legal interest to challenge certain bureau regulations. These areas of the decision exceed the scope of this note and, hence, are not discussed.

⁴ In every case in which the question of whether or not a particular practice of a medical organization is in restraint of trade, the court must come to grips with the meaning of the term "trade." Mr. Justice Story, delivering the opinion of the Court in *The Nymph*, 18 Fed. Cas. 506, 507 (No. 10,388) (C.C. D. Me. 1834), defined the word thus: "... the word 'trade' is often and indeed, generally used in a broader sense, as equivalent to occupation, employment, or business, whether manual or mercantile. Wherever any occupation, employment, or business is carried on for the purpose of profit, or gain, or a livelihood, not in the liberal arts or in the learned professions, it is constantly called a trade." Although this was cited by the United States Supreme Court

impelling argument of medical organizations that, although some of their practices may amount to virtual restraints of trade, they are the essential means of enforcing the high ethical standards of the medical profession.⁵ Nevertheless, several courts have piloted their way clear of the Scylla and Charybdis of adamant legal concepts, conceived in a different age under different conditions, and of stubborn "ethical" principles, established primarily to preserve selfish interests.⁶

The federal courts seem willing to enlarge the provisions of the Sherman Anti-Trust Act to include the prohibition of certain practices of medical associations which tend to unjustly injure non-members. In a leading case,⁷ the United States Court of Appeals for the District of Columbia was confronted with the question of whether or not the practice of a local medical society of expelling members who joined or consulted with doctors employed by a cooperative group that competed with the society's prepaid medical program was a violation of Section 3 of the Sherman Act.⁸ In

in *Atlantic Cleaners & Dyers v. United States*, 286 U.S. 427, as recently as 1932, the court in *United States v. American Medical Ass'n*, 110 F.2d 703 (D.C. Cir. 1940) pointed out that the Court was using this quote as authority for the proposition that "cleaning and dyeing" are a trade within the meaning of § 3 of the Sherman Act, and not to show that the professions fall outside the meaning of "trade."

Expressing what is perhaps the more liberal view, Roscoe Steffen, in his article *Labor Activities in Restraint of Trade: The Apex Case*, avers: "The bare right to pursue one's business or calling is fundamental. . . . Trade has to do with buying and selling, yes, but its basic meaning is the pursuit of a calling. Physicians may not adopt 'rules of ethics,' for example, to prevent their more venturesome brother-physicians from charging for their services on a 'contract' basis." 50 *Yale L.J.* 787, 826 (1941).

⁵ In a comprehensive article explaining the history and function of the American Medical Association, the authors stated:

To maintain what it considers the integrity and standing of the profession, the American Medical Association has established a code of ethics to govern the behavior of practitioners. . . . Because the AMA has the consent and support of a great majority of doctors, its standards can often be enforced against an offender without formal action. The physician who is suspected of 'unethical' practice may be subjected to professional ostracism. This may involve denial by member physicians of patient referral and consultations, and the loss of advancement in hospital and other professional appointments. The American Medical Association: Power, Purpose, and Politics in Organized Medicine, 63 *Yale L.J.* 938, 949 (1954).

⁶ No imputation against the general lofty aims of organized medicine and the effectuation of them is suggested. Only those practices tagged by medical associations as "ethical," but actually motivated by desires to advance the private interests of member doctors at the expense of non-member doctors are intended. The author wholeheartedly concurs in the court's statement in *United States v. American Medical Ass'n*, *supra* note 4, at 712: ". . . we are not unmindful of the importance of rules of conduct in medical practice, rules which can best be made by the profession itself. . . . We also recognize that in personal conduct and professional skill the rules and canons, so established, have aided in raising the standards of medical practice to the advantage of the whole country."

⁷ *United States v. American Medical Ass'n*, *supra* note 4.

⁸ Every contract, combination in form of trust or otherwise, or conspiracy, in restraint of trade or commerce in any Territory of the United States or the District of Columbia, or in restraint of trade or commerce between any such Territory and another, or between any such Territory or Territories and any State or States or the District of Columbia, or with foreign nations, or between

arriving at its holding that such a violation had occurred, the court expounded:

The phrase 'restraint of trade' had its genesis in the common law, and its legal import and significance is declared again and again in the decisions of English courts, both before and after the date of our independence, as well as in American decisions in many of the states. The Supreme Court has said Congress passed the Sherman Act with this common law background in mind.⁹ . . . the common law governing restraints of trade has not been confined . . . to the field of commercial activity ordinarily defined as 'trade,' but embraces as well the field of the medical profession.¹⁰ (Footnotes added.)

Although this decision represents a landmark in the broad interpretation of the Sherman Act and is good precedent for a liberal construction of the legal concept of restraint of trade, it has very little impact upon cases of the type now under consideration in other federal courts. Here, some involvement with interstate commerce must first be established, a problem with which the courts of the District of Columbia are not concerned since, constitutionally, Congress has plenary power to legislate locally in the District. Consistently, other federal courts have found no violation of the Sherman Act, usually because interstate commerce was not involved.¹¹

England has not been totally averse to expanding the meaning of the word "trade" which has gathered the moss of legal definition. An English court has brought within the proscription of illegal restraint of trade expulsion by a medical society of a member for engaging in prepaid contract medicine and thereafter precluding member physicians from consulting with him.¹² Furthermore, the court found that the boycott effected in this and in other ways was intended to increase the area of practice and financial

the District of Columbia and any State or States or foreign nations, is declared illegal.

26 Stat. 209 (1890), 15 U.S.C. § 3 (1958).

⁹ *United States v. American Medical Ass'n*, *supra* note 4, at 707.

¹⁰ *Id.* at 711. However, the United States Supreme Court found it unnecessary to decide the question of whether or not the practice of medicine and the rendering of medical services are "trade" under §. 3 of the Sherman Act. *American Medical Ass'n v. United States*, 317 U.S. 519 (1943).

¹¹ *Elizabeth Hosp. Inc. v. Richardson*, 269 F.2d 167 (8th Cir. 1959), cert. denied, 361 U.S. 884 (1959); *Riggall v. Washington County Medical Soc'y*, 249 F.2d 266 (8th Cir. 1957); *Spears Free Clinic & Hosp. v. Cleere*, 197 F.2d 125 (10th Cir. 1952); *Robinson v. Lull*, 145 F. Supp. 134 (N.D. Ill. 1956). In *Oregon State Medical Soc'y v. United States*, 343 U.S. 326 (1952), the government charged violation of §§ 1 and 2 of the Sherman Act for conspiring to restrain and monopolize the business of providing prepaid medical care in Oregon and to restrain competition between doctor-sponsored prepaid medical plans in Oregon. Affirming the dismissal of the case by the District Court, the Supreme Court not only grounded its decision on an absence of interstate commerce activity, but also declared that the United States had failed to prove concert, pointing up another difficulty of using the remedy of the anti-trust laws—the difficulty of proving conspiracy. See *The American Medical Association: Power, Purpose, and Politics of Organized Medicine*, *supra* note 5, at 1020.

¹² *Pratt v. British Medical Ass'n*, [1919] 1 K.B. 244.

returns of members of the society. But it was on this very point of motive that a judicial tribunal in a later case with similar facts came to an opposite conclusion. In answer to the charge by a doctor who was expelled from the British Medical Society that the rule which precluded members from consulting with non-members was in restraint of trade, the Privy Council reasoned that the object of the rule was "to keep up the discipline and 'morale' of the members of the association [in order] to protect and promote its interests, though indirectly and as an entirely undesigned result some injury may incidentally be sustained by the expelled member in the practice of his profession."¹³

This illustrates the problem of the medical society's split motives giving many of its rules a Janus-faced complexion; it seeks at once to protect the public and its members.¹⁴ On the other hand, the Council also based its decision on a defense to typical restraint of trade actions, viz., one has a right to pursue his trade in any way he sees fit, even to the extent of combining with others to follow a common course of action "provided such common course of action is undertaken with a single view to the interests of the combining parties and not with a view to injure others."¹⁵ Significantly, the Council did not simply dismiss the case as not coming within the purview of the traditional concept of restraint of trade, rather it accepted the problem as one covered by anti-monopoly law, but dismissed the appeal on the ground that the society's rule was not an illegal restraint of trade.

Although some state courts have applied anti-monopoly law to certain practices of medical organizations, these decisions are noteworthy as exceptions to the general rule. The obstacles which the states face are either lack of anti-monopoly laws or an unwillingness on the part of courts to expand the application afforded by these laws to situations not traditionally labeled "trade."¹⁶ Proof of a conspiracy is just as imposing a stumbling block in

¹³ Thompson v. New South Wales Branch of British Medical Ass'n, [1924] A.C. 763 (Wales).

¹⁴ This dichotomy of motives is lucidly pointed up in 50 Yale L.J., supra note 4, at 938:

AMA successes in raising the quality of medical education, practice, and care are beyond question. However, in these endeavors it has acquired such power over both public and practitioner that it can channel the development of American medicine. Dangers inherent in such power are compounded by the layman's ignorance of medical matters and the AMA's monopoly position as spokesman for the profession. . . . The AMA is motivated both by obligations to the public and loyalties to its own members.

Generally, this statement is equally applicable to British medical societies as well as the medical organizations involved in the instant case, since these latter are intimately connected with the local affiliate of the AMA.

¹⁵ Mogul S.S. Co. v. McGregor, [1892] A.C. 25, as cited by Lord Parker in Attorney General of Australia v. Adelaide S.S. Co., [1913] A.C. 781, 797 (Austral.).

¹⁶ "While *Group Health* [infra note 19] may stand as a model solution to problems in this branch of the law, it has been correctly noted that some states do not have anti-monopoly laws, and few of those that do would be willing to construe the provisions as broadly as did the Washington court in *Group Health*." Expulsion and Exclusion from Hospital Practice and Organized Medical Societies, 15 Rutgers L. Rev. 327, 348 (1962).

state courts, as it is in federal courts.¹⁷ Additionally, the tremendous influence organized medicine exercises over legislation presents a problem of titanic proportions.¹⁸ Notwithstanding these impediments, an occasional court has given relief to doctors who are being injured by prohibitive rules of medical organizations. Notably, the leading state court decision in this area is *Group Health Coop. of Puget Sound v. King County Medical Soc'y*,¹⁹ handed down eleven years ago by the same court that decided the instant case. In that case the court held it was in restraint of trade for the local medical society, together with two medical organizations which it dominated, to conspire to exclude from membership of the society any doctor who engaged in "unauthorized" contract medicine practice. Exclusion from membership had the effect of depriving the non-member doctor of local hospital privileges and of professionally ostracizing him from his brother physicians, who were usually society members.²⁰ The only "authorized" contract medicine practice was that controlled by the society through its medical bureau and medical corporation. The prime significance of this exhaustive opinion lies in its thorough analysis of the anti-monopoly provision of its constitution,²¹ which was adopted from the common law. To constitute a monopoly, the court said three elements must be found to exist: (1) a combination, contract or other arrangement, (2) a "product" or "commodity," and (3) a purpose to fix prices, limit production, or regulate the transportation of such product or commodity. By adopting an extremely broad construction of the constitutional language, the court found a "combination" in the unwritten arrangement among the medical organization to preempt contract medicine, a "product" in the supplied medical services, and a purpose to limit production and fix prices by controlling the medical services offered on a contract basis. This decision furnishes the foundation and rationale for the holding

¹⁷ The American Medical Association: Power, Purpose and Politics in Organized Medicine, supra note 5, at 1020.

¹⁸ "The American Medical Association is considered by some observers the most powerful lobby in Washington. Measures apparently assured of passage have been voted down, buried in committee, or substantially amended upon the announcement of AMA disapproval." The American Medical Association: Power, Purpose, and Politics in Organized Medicine, supra note 5, at 955. "The medical societies also exert great influence over medical legislation on the state and local levels. The enactment of favored measures and the defeat of those opposed can usually be secured." Supra at 957. "In many states, laws authorize state and local medical societies to appoint or recommend members of regulatory bodies. AMA standards in medicine, education, training, and practice are usually adopted by law. . . . Thus the political authority of the state itself has in effect been delegated to organized medicine." Supra at 959.

Compare Mass. Gen. Laws Ann. ch. 176C (1958) in which the legislature authorizes operation by a medical organization of medical service plans, but makes termination of a physician's membership turn, inter alia, on his "failure to comply with the professional code of ethics as accepted by organized medicine."

¹⁹ 39 Wash. 2d 586, 237 P.2d 737 (1951).

²⁰ See generally, American Medical Association: Power, Purpose and Politics in Organized Medicine, supra note 5, in which the means used by the AMA to professionally ostracize a non-member physician is discussed. Some methods include prohibiting members from having consultations with him or referring patients to him and, through AMA's influence in hospitals, restricting him from using certain hospitals either entirely or for routine work.

²¹ Wash. Const. art. XII, § 22 (1889).

CASE NOTES

in the main case.²² Indeed, a court must accept the broad interpretation of anti-monopoly laws which the Washington court expressed in *Group Health Coop.* before it can arrive at a decision like the one reached in *Hubbard*.

Exemplifying the reluctance of state judicial tribunals to extend the coverage of anti-monopoly laws is the recent case of *Falcone v. Middlesex County Medical Soc'y*²³ in which the court found inapplicable the state antitrust statutes.²⁴ In that case a doctor who was licensed to practice medicine and surgery by the State Board of Medical Examiners was precluded from joining the medical society (and thereby denied the use of the county hospitals, among other essentials) because he did not meet AMA educational standards.²⁵ However, the court, in an unprecedented move, compelled the society to admit him, holding the by-law which originally excluded him to be against public policy. Although this case offers an alternative approach to the problem at hand, it, too, represents a bold new move in a direction away from traditional law, for private associations have always been allowed to freely select their membership.²⁶

The decision in the instant case is a good example of how a state court can avoid impairing the integrity of a highly useful and valuable organization by not declaring the entire operation of the medical organizations monopolistic, but, at the same time, condemn a particular practice which is injurious to non-members and not beneficial to the public. It can readily be seen that the case, though in the minority, has support in the English and the federal courts, having the advantage over the federal courts of not having to establish a connection with interstate commerce. Although there are alternative solutions to the fundamental problem of the case,²⁷ the an-

²² The court does not even discuss the problem of whether or not medical services can be the subject of a suit based on the theory of restraint of trade. It simply cites its decision in *Group Health Coop.*, supra note 19, apparently relying on its extensive analysis of the problem therein.

²³ 62 N.J. Super. 184, 162 A.2d 324 (1960), aff'd, 34 N.J. 582, 170 A.2d 791 (1961).

²⁴ "The New Jersey antitrust provisions apply solely to corporate mergers and acquisitions. N.J. Stat. Ann. § 14.3-10 (1939)." *Judicially Compelled Admission to Medical Societies: The Falcone Case*, 75 Harv. L. Rev. 1186 (1962).

²⁵ Actually, Doctor Falcone held the degrees of Doctor of Osteopathy and Doctor of Medicine, but he had not studied for four years in a medical school approved by the AMA.

²⁶ One author, writing about nonprofit associations generally, recognized this point, but also realistically appraised the iron grip some organizations have on their members: Some associations have a strangle-hold upon their members through their control of an occupation or of property which can ill be spared. In such there is operative a policy in favor of relief against wrongful treatment. . . . Medical associations refuse to take in doctors with heretical views, and greatly hamper their practice. When admission is unfairly refused to such associations, the courts might sometimes advantageously give relief if they would enjoin wrongful expulsions. Chafee, *The Internal Affairs of Associations Not for Profit*, 43 Harv. L. Rev. 993, 1022 (1930).

²⁷ Prosser suggests that a tort is committed when there is an interference with "prospective advantage," analogizing this with interference with contractual relations. However, one important element of this offense is ill will, a clear intention to cause injury to another. This would be difficult to show in the case of a practice of a medical organization which is designed to protect its members but incidentally operates to

swer suggested in *Hubbard* of broadening the anti-monopoly laws, once accepted, will provide a ready remedy for any ethical non-member doctor feeling the force of organized medicine.

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Trade Regulations—Robinson-Patman Act—Cost Justification Defense to Discriminatory Prices.—*United States v. Borden*.¹—Borden and Bowman Companies attempted to defend against a Section 2(a) Clayton Act² suit by use of the cost justification proviso which allows price differentials if they "make only due allowance for differences in the cost of manufacture, sale, or delivery resulting from the differing methods or quantities in which such commodities are to such purchasers sold or delivered." Respondents had admittedly discriminated between independently owned grocery stores and grocery chain stores by allowing the latter group a higher flat discount than the highest volume discount allowed to independents.³ The District Court allowed the defense and dismissed the injunction,⁴ but on appeal the Supreme Court reversed. HELD: The class cost justifications did not satisfy the burden of proving that the discriminatory prices reflected only a "due allowance" for cost differences.

The proviso in Section 2(a) of the Robinson-Patman Act⁵ permitting justification of price differential related to the seller's costs stems from a comparable provision in Section 2 of the original Clayton Act. The 1936 Robinson-Patman amendments to the Clayton Act attempted to strike a balance between protection of the small merchant from arbitrary and

the detriment of non-members. Furthermore, the court may still be confronted with precedent which has limited this type cause of action to traditionally commercial activities. Prosser, *The Law of Torts* 748 (2d ed. 1955).

Remedial legislation does not appear to offer a realistic solution in view of the potent political power organized medicine wields. *Supra* note 18.

Perhaps the only effective non-judicial answer to the problem is that offered by Chafee:

When an association has a strangle-hold upon an individual or occupation, internal decisions upon other questions besides expulsion and admission may be of much public concern. . . . However, the courts have usually refused to interfere in such internal questions, and perhaps public opinion is a better method for obtaining fair proceedings. Chafee, *supra* note 26, at 1023.

¹ 370 U.S. 460 (1962).

² 38 Stat. 730, as amended, 49 Stat. 1526 (1936), 15 U.S.C. § 13 (1961 Supp.), (Robinson-Patman Act). The suit is referred to as a Clayton Act suit even though the specific defense and subject of this note is the cost justification proviso introduced as the Robinson-Patman amendment.

³ Borden Company allowed percentage discounts based on volume on a sliding scale basis up to a maximum of 4%. The chain stores, however, were given flat discounts up to 8½%. Bowman Company had a similar arrangement allowing volume discounts up to 8% and flat discounts to chains of 11%.

⁴ The District Court opinion is unreported. The litigants have been involved in the controversy for nearly twelve years; for this earlier history involving the Clayton and Sherman Acts, see: *United States v. Borden*, 111 F. Supp. 562 (1953); *United States v. Borden*, 347 U.S. 514 (1954).

⁵ *Supra* note 2.