PHYSICIANS AS PROFESSIONAL PEER REVIEWERS: EFFECTS OF ANTITRUST LAW

I. INTRODUCTION

There was once a time when a person could visit the family doctor and rely upon the physician to treat all of his ailments. It would not have been unusual for the same physician to treat a heart attack victim in the morning, and deliver a baby in the afternoon. Those days are long gone, since the advent of the ever-increasing number of medical specialties.\(^1\) Today, a person may find it necessary to visit a variety of specialists in order to make certain that his health is well-monitored. This expansion of medical specialties has gone hand in hand with the growing competition that is now evident among physicians.\(^2\) Recent forecasts predict that by 1990 the American health care system will see a glut, with the supply of physicians increasing by forty percent.\(^3\) In addition, it is predicted that by 1990, eleven and one half percent of the gross national product will be applied toward health care expenditures.\(^4\) A direct consequence of these in-

\(^1\) See Foster, Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?, 26 St. Louis U.L.J. 535, 536-37 (1982) [hereinafter Foster]. The various number of medical specialties that are now offered for physicians include radiology, nuclear medicine, renal dialysis, pathology, anesthesiology, cardiac catheterization, cardiac surgery, emergency medicine, and general surgery. Id.

\(^2\) Id. at 538. Over the last decade, there has been an oversupply of physicians due to the placement of federal funds into medical education loan programs. Id. It is evident that this has fueled the competition among and between physicians who are vying for desirable hospital privileges. Id. See also Yarbrough, Exclusive Contracts and Hospital-Based Physicians, 5 Pace L. Rev. 57, 58 (1984) [hereinafter Yarbrough]. The hospital marketplace has shown a steady rise in the development of competition. Id.

\(^3\) See Nagin, Antitrust and the Physician-Institution Relationship: How to Defend the Hospital, 59 Fla. B.J. 39 (May 1985) [hereinafter Nagin]. This increase will be measured over a 12 year time frame, between 1978-1990. Id. See also Yarbrough, supra note 2, at 57. Over the past twenty years, hospitals have by necessity been viewed in a more pragmatic light. Id. This change was based on the theory of supply and demand. Id. There has been a steady increase in the number of physicians in this country, along with forecasts for an over-abundance in the future. Id.

\(^4\) See Marinelli, The Role of Antitrust Laws in the Health Care Fields, 3 Det. C.L. Rev. 687 (1984) [hereinafter Marinelli]. Compare this to 1929, when health care expenditures made up only 3.6% of the gross national product. Id. at n.1. In 1965, this figure had risen to 6.2%, and by 1978 it represented 9.1%. Id.
creases is that competition among physicians will also be on the upward trends.\textsuperscript{6}

Whenever the notion of competition is present, the possibility of antitrust liability follows closely behind.\textsuperscript{6} It is somewhat surprising that until recently, physicians have enjoyed virtual exemption from the antitrust laws.\textsuperscript{7} Recent court decisions, however, have reversed this trend.\textsuperscript{8} Physicians are now being subjected to the same rules that some believe should apply only to commerce.\textsuperscript{9}

5. See Nagin, supra note 3, at 39. As the number of physicians increases, there will be a subsequent rise in competition for patients as well as for access to hospital privileges and facilities. \textit{Id.}

6. See Havighurst, \textit{Professional Peer Review and the Antitrust Laws}, 36 CASE W RES. 1117, 1119 (1986) [hereinafter Havighurst, \textit{Professional Peer Review}]. Any time there is collective action within a group which otherwise operates independently, antitrust liability may be triggered. \textit{Id.} at 1118. Any such collaboration may adversely affect competition among the collaborators or others with whom they compete. \textit{Id.} Whenever there is a collaboration among competitors, section 1 of the Sherman Act is invoked. \textit{Id.} at 1119. Section 1 prohibits "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade." 15 U.S.C. § 1 (1982). \textit{See also} Black's Law Dictionary 241 (5th ed. 1985) (defines combination in restraint of trade as "[a]n agreement or understanding between two or more persons for the purpose of unduly restricting competition. Such combinations are prohibited by the Sherman Antitrust Act").

7. See Yarbrough, supra note 2, at 58. Health care professionals have only recently been challenged by antitrust laws. \textit{Id.} Prior to this, competition within the hospital marketplace was allowed to develop steadily, without risk of antitrust liability. \textit{Id. See also} Marinelli, supra note 4, at 688. In the past, infrequent antitrust complaints were made against health care providers for a number of reasons: (1) it was thought that certain legal theories provided defenses to all health care providers; (2) health care services were considered intrastate commerce, meaning that federal antitrust statutes were not applicable; (3) because it is a regulated industry, the health care industry was exempt; (4) antitrust exemptions were in existence for the insurance business; and (5) as guided by the "rule of reason" analysis, health care industry activities were exempt from antitrust liability. \textit{Id.} at 688-89.


9. See Yarbrough, supra note 2, at 59. It is believed that physicians were excluded from antitrust liability because they are involved in a profession rather than in commerce. \textit{Id.} \textit{See also} Black's Law Dictionary 244 (5th ed. 1985) (defines commerce as "the exchange of goods, products, or property by way of trade, traffic, transportation, or communication among the states"). \textit{See also} J. Van Cise, W Lifland, & T Sorkin, \textit{Understanding The Antitrust Laws}, 20, 40 (2d ed. 1976) [hereinafter J. Van Cise, W Lifland, & T. Sorkin].

On its face, section 1 of the Sherman Act is applicable in the event of interstate or foreign commerce. \textit{Id.} However, the term commerce as used in the Sherman Act has been
The fact that physicians are no longer immune from antitrust liability will have a major impact on critical aspects of health care regulation such as professional peer review. This Note will focus on the current barriers to antitrust immunity for physician peer reviewers. In addition, this Note will reinforce the need for professional peer review committees and proposes means by which peer reviewers can and should be exempt from antitrust laws.

II. ANTITRUST LAW

The first and most important of the American antitrust laws is the Sherman Act. The significance of the passage of this Act is best understood if one recognizes the fact that it occurred amidst much discussion about laissez faire, socialism, commi-

interpreted to apply to a variety of activities including: “transportation of goods and passengers, the purchase and sale of commodities, dealings in intangibles, commercial services, other business activity for gain, and even the practice of law.” Id. at 40-41. See also Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U. 219, 236 (1948). The Court, in reference to the Sherman Act, held that “[t]he Act is comprehensive in its terms and coverage, protecting all who are made victims of the forbidden practices by whomever they may be perpetrated.” Id. See also Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), reh'g denied, 423 U.S. 886 (1975). Goldfarb involved a dispute over a minimum fee schedule for title insurance. Id. Petitioners brought action against a member of the Virginia State Bar, alleging section 1 violations of the Sherman Act. Id. The Court stated that Congress did not intend any general “learned profession” exclusion from the Sherman Act. Id. at 774. Furthermore, a title examination is a service, and the exchange of this service for money, constitutes commerce. Id. See also Patrick v. Burget, 486 U.S. 94 (1988) (Court applied Sherman Act requirements to physician peer review group).

10. See Taylor, DOCTORS CAN SUE IN PEER REVIEWS, JUSTICES DECLARE, N.Y. Times, May 17, 1988, at A1, col. 4 [hereinafter Taylor]. Those who oppose physicians being subjected to antitrust laws argue that doctors would no longer perform effective competence review of their peers. Id. Consequently, “the threat of giant Federal lawsuits will have a ‘chilling effect’ on efforts to discipline incompetent doctors.” Id. at D24, col. 6.

11. See J. Van Cise, W Lifland, & T. Sorkin, supra note 9, at 20. Following the Civil War, businessmen formed large organizations called ‘trusts.’ Id. The continued growth of these trusts encouraged Congress to enact legislation which gave federal control over the restraint of trade. Id. Senator Sherman is credited with introducing the bill that declared unlawful any activities which prevented full and free competition. Id. at 21. Senator Sherman believed that placing a concentration of power in the hands of only a few was inconsistent with the goals of the American government. Id. at 22. Other senators echoed Senator Sherman’s intention to adopt, as federal legislation, existing common law principles which proscribed trade restraints. Id. at 23. It is apparent from the 1974 amendments to the Sherman Act, that Congress continues to support and demand rigorous application of the Act. Id. at 24.
nism, and anarchism. By enacting the Sherman Act, its authors merely reaffirmed their ancestors’ support of private enterprise. Legislative debates surrounding the Act’s enactment made clear that its authors were sincere proponents of private initiative.

For many years after the first federal antitrust statutes were adopted, those who enforced the laws and those who provided health care services seemed to ignore one another. However, as the health care industry evolved and grew more sophisticated, antitrust enforcers became aware of the fact that even the health care industry could pose antitrust issues. Peer review has been one of the significant health care areas that has been focused on by antitrust enforcers.

In the context of antitrust law, the most important aspect of medical peer review is that a collaborative effort by otherwise independent competing physicians takes place. Whenever competition among collaborators exists, physician or otherwise, section 1 of the Sherman Act is invoked. Basically, section 1 asks whether the concerted efforts by competitors are compatible

12. *Id.* at 23. Prior to the passage of the Sherman Act in 1890, “The Communist Manifesto” and “Das Kapital” had been authored by Karl Marx. *Id.* However, the American people chose reform rather than revolution, when trade abuses became prevalent. *Id.*

13. *Id.*

14. *Id.* The authors of the Sherman Act emphasized that only those business combinations which interfered with competition should be prohibited. *Id.* In addition, they would not discourage monopolization by skill. *Id.*

15. See M. Thompson, Antitrust and the Health Care Provider 1 (1979) [hereinafter Thompson]. If not for disputes which arose from the introduction of alternatives to the fee-for-service method of providing care, the health care industry would have escaped antitrust enforcement for 75 years after antitrust law enactment. *Id.*

16. *Id.* This awakening took place with the evolution of the health care industry from its so-called “cottage industry” status to a more sophisticated industry. *Id.*

17. See Borsody and Tiano, Peer Review and the Antitrust Laws: An Analysis and a Proposal, 26 St. Louis U.L.J. 511, 512 (1982) [hereinafter Borsody & Tiano]. Peer review can significantly affect prices in the health care industry. *Id.* There is a risk that an antitrust challenge will be invoked whenever there is the existence of cooperative effort between health care workers, which will have an effect on prices. *Id.* Usually, it is a peer reviewer who will determine the presence of unreasonable or uncustomary prices. *Id.* Such action may lead to the lowering of prices indirectly through insurance intermediaries. *Id.*

18. See Havighurst, Professional Peer Review, supra note 6, at 1118. Any type of collaboration such as this may have a negative effect on competition among either the collaborators or their competitors. *Id.*

19. *Id.* at 1119.
with the maintenance of a competitive market, the goal of which is to promote consumer welfare.\textsuperscript{20} Collaboration among competitors is procompetitive whenever it achieves efficiency in production or provides a new product or service, unless the impulse to compete is not preserved.\textsuperscript{21}

There are times when the goals of collaborators may be procompetitive, but the collective power of the collaborators is sufficient to generate concern that competition will be adversely affected.\textsuperscript{22} When this occurs, a court must examine the restraints imposed by the collaborators to make certain they are reasonable.\textsuperscript{23} A court may scrutinize these restraints prior to making its determination by employing a number of traditional antitrust law concepts.\textsuperscript{24}

\begin{itemize}
\item \textsuperscript{20} 15 U.S.C. § 1 (1982).
\item \textsuperscript{21} See Havighurst, Professional Peer Review, supra note 6, at 1119. In certain cases, competitors are permitted to cooperate in an attempt to make competition more effective by providing a remedy for a market's defective operation. \textit{Id.}
\item \textsuperscript{22} \textit{Id.} at 1119. Although the goals of the collaborators are procompetitive, there are times when it becomes evident that their restraints are either: (1) not truly necessary to achieve the alleged procompetitive objective, or (2) not designed to minimize the risk of anticompetitive risks. \textit{Id.}
\item \textsuperscript{23} See United States v. Addyston Pipe & Steel Co., 85 F 271, 280-84 (6th Cir. 1898), aff'd. 175 U.S. 211 (1899). In \textit{Addyston}, the court established two tests for determining the reasonableness of imposed restraints. \textit{Id.} The first test is to ask whether the restraints are ancillary to the alleged procompetitive objective. \textit{Id.} at 282. The second test is to ask whether the restraints are crafted to minimize the risk of anticompetitive effects. \textit{Id.} at 287-91. Even if a restraint is determined to be ancillary and reasonable under these tests, there remains the danger that competition will be jeopardized because of the collective power among the collaborators. See Havighurst, Professional Peer Review, supra note 6, at 1119. The court must then weigh the danger against any potential benefits to consumers and to competition. \textit{Id.} at 1119-20.
\item \textsuperscript{24} See Foster, supra note 1, at 539. See also Ace Beer Distributors, Inc. v. Kohn, Inc., 318 F.2d 283, (6th Dir. 1963), \textit{cert. denied}, 375 U.S. 922 (1963). The rule of reason analysis examines challenges which fall under section 1 of the Sherman Act, to determine whether "the challenged agreement involved normal commercial activity." \textit{Id.} This analysis focuses on two encompassing questions: (1) whether the challenged agreement adversely affects competition; and (2) whether it arises from a purpose that is anticompetitive. \textit{Id.} The first question is based on the premise that antitrust laws protect competition and not competitors. See also United States v. United States Gypsum Co., 438 U.S. 422, 436 n. 13 (1978). The second question focuses on the notion that a civil violation of the antitrust laws "can be established by proof of either an unlawful purpose or an anticompetitive effect." \textit{Id.}
\end{itemize}

The per se analysis is imposed when either one of two situations is present: (1) where there is an intent to decrease competition, or (2) where members of a group comprise a majority of the market. See Greaney and Sindelar, Physician-Sponsored Joint Ventures: An Antitrust Analysis of Preferred Provider Organizations, 18 Rutgers L.J. 513, 581-82 (1987). Under the per se approach, an analysis of the particular facts of the
There are two antitrust observations which are pertinent to the discussion of professional peer review. First, physicians may not defend a restriction on competition by merely claiming that their action was generated by public-spirited motives. They must bear in mind that competitive power may never be restricted, even for seemingly worthwhile causes. Second, it is imperative to note that antitrust law is not primarily concerned with the fate of individual competitors. The Sherman Act was devised to protect the process of competition. The extent to which this purpose will be carried out in the area of peer review is currently unfolding.

III. PROFESSIONAL PEER REVIEW

Professional peer review is a means by which physicians can examine the quality of the health care provided by other physicians. There are two types of peer review—voluntary and mandatory. Physicians are generally involved in voluntary peer

business or profession, the history of the restraint or action, and the purposes for the action are performed. See generally L. Sullivan, Part B. Development Of The Rule Of Reason And The Per Se Doctrine 165-71 (1977). The per se rule accomplishes three goals. It (1) guides the business community; (2) decreases the burden on litigants, and (3) considerably minimizes court time and expense. See Marinelli, supra note 4, at 698.

25. See Havighurst, Professional Peer Review, supra note 6, at 1120.  
26. Id. at 1120. Physicians who are sued for participating in peer review cannot assert that their purpose for doing so was a worthy one. Id. Rather, they must prove that their actions were compatible with maintaining effective competition. Id. See also National Soc'y of Professional Engineers v. United States, 435 U.S. 679, 692-93 (1978) (restriction of competitive bidding for professional services to ensure public safety rejected by Court).

27. See Havighurst, Professional Peer Review, supra note 6, at 1121.  
28. Id. at 1122. While it is true that litigation against a peer review committee is very often instituted by a physician who has been injured, the real concern is how competition rather than competitors have been affected. Id. In addition, harm to an individual does not constitute harm to competition. Id.

29. Id. at 1122.  
30. See Borsody & Tiano, supra note 17, at 511. Peer review is also a procedure whereby insurance companies seek advice from health care professionals regarding whether health care charges are realistic and appropriate. Id. In addition, these peer reviewers assess whether the performance of certain health care services are necessary. Id. See also Kopit, Commentary: Professional Peer Review and the Antitrust Laws, 36 Case W Res. 1170, 1172 (1986). "Peer review is the process whereby standards for medical practice relating to appropriate utilization and quality of care are established and individual practitioners are judged for compliance with those standards." Id.

31. See Borsody & Tiano, supra note 17, at 511. Voluntary peer review is usually performed by professionals such as a medical society committee. Id. Mandatory peer
Voluntary peer review may be conducted for several purposes, such as: (1) self-regulation; (2) examination of quality or necessity of provided services; or (3) evaluation of reasonableness of the charge for the services.\textsuperscript{33}

To some physicians, peer review is a means of exemplifying their professionalism and promoting their dedication to quality care of the patient.\textsuperscript{34} To other health care workers, the ultimate goal of peer review is to improve professional practice by physicians.\textsuperscript{35} Whatever the goal, it would be unrealistic to expect peer review to produce perfect information about health care quality.\textsuperscript{36} However, the public does expect peer review to yield basic

---

\textsuperscript{32}See Borsody & Tiano, supra not 17, at 511. Voluntary peer review usually involves a group of professionals. \textit{Id.} Compare this with mandatory peer review which usually involves a professional health care organization such as the federal Medicare program. \textit{Id.}

\textsuperscript{33}\textit{Id.} Compare this with mandatory peer review. Peer review is mandatory whenever professional health services are paid for with federal funds under the Professional Standards Review Organization (PSRO) Law. \textit{Id.} In addition, peer review is required for any health service subsidized by state funds under state laws (for example worker's compensation laws and insurance laws). \textit{Id.} See also \textit{J. BLUM, P GERTMAN, \\& J. RABINOW.} There are two basic methodologies that are employed in mandatory peer review programs; (1) utilization review, and (2) medical audit. \textit{Id.} Utilization review is usually carried out by a hospital-formed committee. \textit{Id.} Its function is to minimize patient care costs by assessing the way in which the hospital utilizes its resources. \textit{Id.} The goal of the Utilization Review Committee is to assure that excess utilization of resources is prevented. \textit{Id.} The second methodology employed, medical audit, attempts to evaluate the quality of care provided. \textit{Id.} at 8. This is accomplished through a retrospective review of crucial elements in specific diagnostic categories. \textit{Id.} An audit committee is usually selected to carry out this evaluation. \textit{Id.} at 9.

\textsuperscript{34}See Havighurst, \textit{Professional Peer Review, supra} note 6, at 1117 (peer review allows professionals to perform an overview of a fellow doctor's performance). See also Dolin, \textit{Antitrust Law versus Peer Review}, 313 \textit{NEW ENG. J. MED.} 1156 (1985) (peer review symbolizes a physician's "selflessness and devotion to patient care").

\textsuperscript{35}See Lohr, \textit{Commentary: Professional Peer Review in a "Competitive" Medical Market}, 36 \textit{CASE W RES.} 1175, 1177 (1986) [hereinafter Lohr]. Professional peer review is a form of quality assurance. \textit{Id.} See also \textit{K. LOHR \\& R. BROOK, QUALITY ASSURANCE IN MEDICINE: EXPERIENCE IN THE PUBLIC SECTOR} 2 (1984). Quality assurance is defined as "a formal and systematic exercise in identifying problems in medical care delivery, designing activities to overcome the problems, and carrying out follow-up monitoring to ensure that no new problems have been introduced and that corrective steps have been effective." \textit{Id.}

\textsuperscript{36}See Lohr, \textit{supra} note 35, at 1176. Despite the growth and refinement of quality assurance, the field is not sufficiently developed to yield perfect results. \textit{Id.} See also \textit{L. REYNOLDS, ECONOMICS: A GENERAL INTRODUCTION} 24-25 (4th ed. 1973) [hereinafter Reynolds]. The aspect of perfect information is not attainable in the medical field. \textit{Id.} Pa-
information which will assist the health care consumer in competently choosing his medical provider.37

Peer review, whether by physicians or other health care professionals, can be viewed as a cooperative effort.38 Cooperation among groups who share similar interests can naturally be linked to the notion of competition.39 In turn, the inhibition of competition invokes the threat of antitrust liability.40 Physicians have been especially offended by antitrust suits based on their belief that they have a collective responsibility to maintain the quality of health care.41 To them, antitrust suits are equated with self-interested economic motives.42 Therefore, they have attempted to avoid antitrust lawsuits at all cost, including not participating in peer reviews.
IV Antitrust Laws And Physicians

Historically, antitrust claims were rarely brought against health care providers including physicians. For many years, physicians had free reign to provide patient care without fear that their activities would be scrutinized. Physicians were shielded from antitrust liability for several reasons: (1) the shortage of physicians; (2) the modest health care costs; and (3) the public service nature of the health care profession, which protected it from review. When a complaint was filed, the medical profession was usually found to be exempt from liability. Public and private health care providers utilized certain legal theories as defense. For example, earlier courts read the antitrust laws and construed the words “trade or commerce” to be inapplicable to the rendering of professional services. Based on

43. See Marinelli, supra note 4, at 688. There are several reasons why there were so few antitrust complaints. First, there was a general belief that certain legal theories acted as defenses to health care providers in both the public and private sectors. These defenses were based on Supreme Court dictum which expressed that the learned professions were exempt from the usual interpretation of trade or commerce. Second, factual antitrust statutes were not applicable to industries that conducted only intrastate commerce such as the health care industries. Third, regulated industries such as health care, were automatically exempt from antitrust laws. Id. at 688-89.

44. See Yarbrough, supra note 2, at 57. Hospitals and their internal organizations, including physicians, were free to establish relations and operate as they saw fit. Id.

45. Id.

46. See Marinelli, supra note 4, at 691 (older decisions exempted medical professionals from trade regulation). But see, e.g., Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), reh'g denied, 423 U.S. 886 (1975). In this more recent decision, the Court could find no basis for an exemption from antitrust law. Id. at 787. It stated that “[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act (cite omitted) nor is the public-service aspect of professional practice controlling in determining whether section 1 includes professions.” Id. (quoting Associated Press v. United States, 326 U.S. 1, 7 (1945) and United States v. National Ass'n of Real Estate Bds., 339 U.S. 385, 489 (1950)).

47. See Marinelli, supra note 4, at 688. These legal theories were based on dictum expressed by the Supreme Court that the learned professions did not constitute “trade or commerce.” Id. See, e.g., Atlantic Cleaners & Dyers, Inc. v. United States, 286 U.S. 427, 436-37 (1932); Federal Baseball Club of Baltimore, Inc. v. National League of Professional Baseball Clubs, 259 U. 200, 209 (1922). See also THOMPSON, supra note 15, at 25. It has only been recently that the health care industry has been subjected to antitrust laws and government economic regulation. Id. Price competition in the industry was limited by a consolidation of factors including: (1) combined effects of state licensing laws; (2) professional associations; and (3) the economic distinction that “health care” is a commodity. Id.

48. Id. See also Yarbrough, supra note 2, at 58-59. The medical profession was excluded from antitrust liability because the practice of a profession was not considered
such interpretations, the medical profession enjoyed virtual exemption from the antitrust laws from the enactment of Sherman Act in 1890,\(^49\) until the mid 1970's.\(^50\)

In 1975, \textit{Goldfarb v. Virginia State Bar}\(^51\) suggested that important changes in public attitude were taking place. In \textit{Goldfarb}, the Supreme Court examined an advisory fee schedule in relation to antitrust violations.\(^52\) The Court found that antitrust laws do apply to professionals, and laid to rest the "learned profession" exemption even though the Court expressed some reluctance at applying the per se rule.\(^53\) The Court satisfied itself in finding that professionals are engaged in "trade or commerce."\(^54\)

Following \textit{Goldfarb}, other courts considered the professional

\begin{itemize}
\item \textit{commerce} for antitrust law purposes. \textit{Id. See also} United States v. Oregon State Medical Soc'y, 343 U. 326, 338 (1952) (rendering of medical services not trade or commerce within meaning of section 1 of Sherman Antitrust Law); Atlantic Cleaners and Dyers v. United States, 286 U.S. 427, 436-37 (1932) ("learned professions" do not constitute "trade"); Federal Baseball Club of Baltimore, Inc. v. National League of Professional Baseball Clubs, 259 U.S. 200, 209 (1922) ("learned professions" are not equated with commerce).
\item 49. 15 U.S.C. §§ 1-7 (1982). The Sherman Antitrust Act makes every contract, combination, or conspiracy in restraint of trade or commerce among state illegal. \textit{Id.}
\item 50. \textit{See Havighurst, A Comment: The Antitrust Challenge to Professionalism, 41 Md. L. Rev.} 30 (1981) [hereinafter Antitrust Challenge]. Although this exemption was more de facto than de jure, judicial dicta would occasionally bolster the idea that professional organizations should be free from rules which were devised to shield free enterprise. \textit{Id.}
\item 51. 421 U.S. 773 (1975), \textit{reh g denied}, 423 U.S. 886 (1975) ("learned professions" are subject to antitrust laws).
\item 52. \textit{Id. at} 781-83. The issue in \textit{Goldfarb} surrounded a minimum fee schedule for lawyers. \textit{Id. at} 780. The schedule had been published by the county bar association and enforced by the State Bar of Virginia. \textit{Id. at} 776. The question was whether this fee schedule violated section 1 of the Sherman Act. \textit{Id. at} 790.
\item 53. \textit{Id. at} 788-89 n.17. The Court warned that:
\begin{itemize}
\item [t]he fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.
\end{itemize}
\textit{Id. See also} Marinelli, \textit{supra} note 4, at 691. The Court made an important qualification in \textit{Goldfarb}, "by recognizing that professions are not interchangeable with other business activities and that public service might require particular practices which would otherwise be violations of the Sherman Act." \textit{Id.}
\item 54. \textit{See Goldfarb, supra} note 8, at 787-88. The Court held that the "learned professionals" are not exempt from antitrust laws. \textit{Id. at} 792-93. The Court also stated that Congress intended section 1 of the Sherman Act to cover a broad spectrum of practices. \textit{Id. at} 787-88.
\end{itemize}
exemption defense and found: (1) that no exemption exists and (2) that a violation will result where professional groups are seeking to gain economic advantage by anticompetitive devices.\footnote{See, e.g., Ballard v. Blue Shield for Southern West Va., Inc., 543 F.2d 1075, 1079 (4th Cir. 1976); Feminist Women's Health Center, Inc. v. Mohammad, 415 F. Supp. 1258, 1263 (N.D. Fla. 1976). In each of these cases, the court was not convinced that professionals, such as physicians, should be treated differently from non-professionals. See also Marinelli, supra note 4, at 692 (legislative intent of Sherman Act is to promote competition via improved production of goods and services, and lower prices).}

They concluded that while it is true that professionals are liable where per se antitrust violations are present,\footnote{See, e.g., Arizona v. Maricopa County Med. Soc'y., 457 U.S. 332, 347-48 (1982) (Court rejected arguments that medical field was different from other economic fields and found no exception to per se rule against price-fixing).} they may offer their professional status and the purpose of the restraint for court consideration.\footnote{Id. at 788-89 n.17. It is therefore unrealistic to interchange professions and other business activities, and to apply antitrust concepts which were created in other contexts. Id.} Therefore, although physicians may bring up the fact that they hold a professional status, this fact will not automatically be enough to warrant exemption from antitrust liability.

The Supreme Court reaffirmed its abolition of the "learned professional" defense in Arizona v. Maricopa Med. Soc'y.\footnote{457 U.S. 332 (1982).} In Maricopa the Court found two per se violations of the Sherman Act when defendant instructed its members to charge agreed-upon prices only\footnote{Id. at 336-37. The Court concluded (in a four-to-three decision) that the medical field was not so different from other economic fields and found no exception to the per se rule against price-fixing. Id. at 356-57. The fact that physicians were involved in the price-fixing agreement rather than nonprofessionals, failed to justify any different treatment. Id. at 348.} Although the defendant claimed this was done as cost containment, the Court charged it with price-fixing.
Maricopa made clear that antitrust laws specifically apply to the activities of the medical profession. Based on the Maricopa Court's holding, the medical profession must assess its conduct for evidence of competition based entirely upon the competitive model outlined by the hospital services marketplace.

In each of its decisions involving professionals, the Court has narrowed the grounds for possible exceptions to antitrust principles. Clearly, the traditional antitrust defenses in health care suits have been substantially reduced. Recently the Supreme Court decided a case of great importance to the medical profession. In Patrick v. Burget the Court reinstated an anti-

60. Id. at 342, 357. See also Thompson, supra note 15, at 6. Price-fixing usually refers to an arrangement between competitors to establish a common price for their product. Id. See also Arizona v. Maricopa County Med. Soc'y., 457 U.S. 332 (1982). In Maricopa, the Court found that these price-fixing agreements were horizontal agreements to fix maximum prices. Id., at 357. See also State of Connecticut, Antitrust Law in Connecticut 1 (1981). Agreements are called horizontal when they are made among competitive businesses. Id. Price-fixing interferes with each business' ability to independently set prices for goods or services. Id. This ability to determine prices is a fundamental right of the free market system in this country. Id. The consequence of price-fixing is that it leads to higher consumer prices. Id. The reason for these higher consumer prices is that businesses lose their incentive to lower prices whenever they do not have to be concerned about being underpriced by competitors. Id. Such horizontal agreements are on the same legal and economic footing as agreements to fix minimum or uniform prices. Id. See Thompson, supra note 15, at 6. The per se rule is violated when a price restraint provides the same economic rewards to all practitioners despite their skill, training, and experience. Id. This type of restraint discourages entry into the market, and deters experimentation and new development. Id.

61. See Maricopa, 457 U.S. at 349.

62. See Yarbrough, supra note 2, at 59. See also supra note 28 (discussion on competitive practices).

63. See, e.g., Goldfarb v. Va. State Bar, 421 U.S. 773 (1975), reh'g denied, 423 U.S. 886 (1975) ("learned professions" not interchangeable with other business activities); United States v. Oregon State Medical Soc'y., 343 U.S. 326 (1952) (medical services not considered trade or services under section 1 of Sherman Act). See also Havighurst, Antitrust Challenge, supra note 50, at 33. The Court has also left open, however, the chance that professionalism may possibly make a difference. Id.

64. See National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378, 383 (1981). A clear repugnancy must exist between antitrust laws and subsequent legislation in order to have implied repeal of antitrust laws. Id. See also United States v. National Ass'n. of Sec. Dealers, Inc., 442 U.S. 694, 715 (1975) (Congressional intent to repeal antitrust laws must be clear); National Soc'y. of Professional Engineers v. United States, 435 U. 679, at 695-96 (1978) (professionals violated Sherman Act via trade restraint's impact on competitive conditions). See also Marinelli, supra note 4, at 692. However, "[t]he full extent to which anticompetitive practices in the highly regulated health care field are immune from antitrust liability is not clear at this time." Id.

65. See Taylor, supra note 10, at A1, col. 4 (discussing Patrick v. Burget with re-
trust award of $2.2 million won by a surgeon who claimed other physicians had acted against him because he was a competitor.66 In the 8-to-0 ruling, the Court determined that Oregon's state action doctrine did not protect physicians from federal antitrust liability.67 Although the Court expressed awareness that any such threat of antitrust liability would prevent physicians from openly and actively practicing peer review,68 it did not yield to this fear by physicians that has long led them to believe that they should and must be immune from antitrust laws.69 The Court concluded that physicians who initiated and participated in peer review would not be exempt from antitrust laws if their alleged purpose was to reduce competition.70 However, an increase in antitrust cases against health care professionals warrants a closer examination of the issue.71


67. Id. In Patrick, an Oregon physician brought an antitrust suit against a group of doctors who were partners in a medical clinic. Id. at 97. The plaintiff, a surgeon, turned down an offer from defendants to join them as a partner in the clinic. Id. at 96. Plaintiff established an independent practice which competed with the clinic. Id. Soon after, plaintiff suffered professional difficulties in dealing with the clinic physicians. Id. These difficulties culminated in defendants' involvement in peer review proceedings which sought to terminate plaintiff's privileges at the city's only hospital. Id. at 97. Defendants claimed that plaintiff's patient care fell below the hospital's standards. Id. at 96. Plaintiff claimed that this group of physicians violated sections 1 and 2 of the Sherman Act when it initiated and participated in hospital peer review proceedings with the intent of reducing competition rather than improving patient care. Id. at 97. See also 42 U.S.C. § 2 (1976) (discussion of section 2 of the Sherman Act). This section focuses on monopolizing trade. Id. The statute states that every person who monopolizes any part of the trade or commerce among the states shall be deemed guilty of a felony. Id.

68. Id. at 105.

69. Id. The Court stated: "[i]n so holding, we are not unmindful of the policy argument that respondents and their amici have advanced for reaching the opposite conclusion." Id. The Court went on to assert that the defendant's argument challenged the wisdom of subjecting medical care to antitrust laws. Id. The Court recommended that such arguments be directed to the legislature. Id.

70. Id.

71. See Patrick 486 U.S. 94 (1988). See also Havighurst, Professional Peer Review, supra note 6, at 1117. Physicians believe that they have a collective responsibility as a profession to maintain quality medical care at a reasonable cost. Id. They become understandably resentful when their efforts to do so are met with antitrust actions. Id. Physi-
V Traditional Defenses To Antitrust Law

The legal status of professional peer review depends upon whether its effect is to control medical practice or merely to circulate information which will influence decision making in a competitive market. If its effect is the latter, certain antitrust defenses have been used to exempt physicians from liability Peer review bodies typically defend their actions by employing the same means used by public regulatory agencies in defending themselves: by promoting their actions as having been taken in the public interest. However, antitrust defenses based on this reasoning are conceptually mistaken. Moreover, had the peer reviewer used a proper antitrust defense, the risk of exposure to greater antitrust liability and high litigation costs would have been lessened.

The stronger defenses for peer review actions is that peer review is consistent with the maintenance of competition rather than the restraint of trade. Incidentally, this type of defense is best asserted by peer review bodies through immunities which have been implicitly created by judicial interpretations of antitrust laws.

cians view any antitrust threat to peer review as a serious battle between professionalism and the notion of procompetitive activity in the industry of health care. Id. at 1117-18.

72. See Marinelli, supra note 4, at 697. There has been a rise in the number of antitrust actions against health care providers due to an unwillingness to continue to accept procedural defenses. Id.

73. See Havighurst, Professional Peer Review, supra note 6, at 1119.

74. Id. at 1130.

75. Id. at 1130. Peer review bodies usually defend their actions in policy debates and in the courts. Id. They promote their public interest defense by basing it upon such actions as due process and substantial evidence support. Id. This is similar to the way in which public regulatory agencies defend their actions. Id.

76. Id. at 1130. This is true even though it may be natural to uphold peer review to the public, as a regulatory service. Id. The best antitrust defense for peer review efforts is the fact that rather than restraining trade, peer review promotes and maintains competition. Id. The argument in favor of this is that peer review merely provides decisionmakers with information and authoritative advice that is often difficult to obtain. Id. In the absence of coercion and regulation, peer reviewers can reasonably assert that they have not fostered trade restraint. Id.

77. See Havighurst, Professional Peer Review, supra note 6, at 1130.

78. Id. at 1130. If peer reviewers have performed their functions properly, they can contend that they merely provide decisionmakers with information and advice that is difficult to obtain. Id. This is a persuasive defense especially when the peer reviewers are employed by a certain client whose intent it is to obtain this information and advice. Id. However, it can also be valid when the peer review body acts on its own initiative. Id.
There are three basic antitrust exemptions asserted by peer review bodies. The first type is the "implied repeal doctrine" which refers to mandatory conduct as specified by federal legislation.\textsuperscript{79} This doctrine states that when repugnancy is evident between the regulatory scheme and the antitrust law, courts are allowed to impliedly repeal the antitrust laws.\textsuperscript{80} The antitrust law may be repealed, however, only to the minimum extent necessary to allow proper functioning of the health care regulatory scheme.\textsuperscript{81} The basis of the implied repeal doctrine is that Congress, upon passage of subsequent conflicting antitrust legislation, intends an implied repeal of the antitrust law in order to

There is no doubt that peer reviewers must not engage in coercive activities. \textit{Id.} As long as peer reviewers do not take on regulatory or coercive functions, they may present a strong defense to challenge of trade restraints. \textit{Id.}

\textsuperscript{79} \textit{See} THOMPSON, \textit{supra} note 15, at 19. Regulated industries are able to avoid the standard application of the antitrust laws if their activities fall within an express or implied statutory exemption. \textit{Id.} at 18. \textit{See also} L. SULLIVAN, \textit{ANTITRUST} 743-44 § 239 Regulated Industries. (1977) (certain regulated industries exempt from antitrust laws including utilities, rail, banking, and communication industries); United States v. Marine Bancorporation, Inc., 418 U.S. 602, 606 (1974) (antitrust restraints on banking); Utility Users League v. Federal Power Comm'n., 394 F.2d 16, 20-21 (7th Cir. 1968) (electric and gas company merger does not violate antitrust laws since State Commissioner considered public interest). \textit{See infra} note 87 (discussion of policy reasons behind exempting regulated industries from antitrust actions). \textit{See also} 42 U.S.C. § 3001-1(b)(4) (1976 & Supp. V 1981) (Congressional attempt at legislating health care planning). The National Health Planning and Resources Development Act of 1974 created antitrust exemptions which provide limited immunity for members and employees of specific public agencies. \textit{Id.} In addition, the Act provided a limited immunity for members and employees of health service agencies. \textit{Id.} The policy reasons for these exemptions were based on congressional concern over the continued increases in health care cost and misallocation of health services. S. Rep. No. 1285, 93d Cong., 2d Sess. 36, \textit{reprinted in} 1974 U.S. Code Cong. & Admin. News 7842, 7878-79. The rationale behind the anticompetitive policies and provisions of the Act is that the health care market is different from the competitive market since health care consumers lack sufficient knowledge to make informed judgments about health care services. Blumstein & Sloan, \textit{Health Planning and Regulation Through Certificate of Need: An Overview}, 1978 \textit{UTAH L. REV.} 3, 3-4. In addition, non-profit institutions play a major role in the health care field, and these agencies lack the profit motive necessary to restrain competition. \textit{Id.} at 4.

\textsuperscript{80} \textit{See} Borsody & Tiano, \textit{supra} note 17, at 515. This exemption does not apply to voluntary activities or those activities performed under state law. \textit{Id.} at n.27. Rather it refers only to activities performed under federal law. \textit{Id.}

\textsuperscript{81} \textit{See Note, Antitrust Law and Health Planning Under the National Planning and Resources Development Act of 1974, 40 WASH. & LEE L. REV. 1505, 1518 (1983) [hereinafter Note]} (antitrust law can be repealed only to minimum extent necessary to allow operation of regulatory scheme). \textit{See also} Gordon v. New York Stock Exchange, Inc., 422 U.S. 659, 682 (1975) (showing of clear repugnancy between antitrust laws and regulatory system justified implied antitrust immunity).
make the subsequent legislation effective. This doctrine is not favored, however, and is justified only when there is evidence of clear repugnancy between antitrust laws and the regulatory system. The implied repeal doctrine has been overshadowed by the Supreme Court's ruling in United States v. Philadelphia National Bank. The Court held that it did not favor immunity from antitrust laws, and therefore courts should not imply antitrust immunity lightly.

A second exemption to antitrust laws is the Noerr-Pennington doctrine. The Supreme Court has recognized this exemption as one which involves anticompetitive effects of government activity. The doctrine allows for the influence of

82. See Silver v. New York Stock Exchange, 373 U.S. 341, 357 (1963) (implied repeal permitted only if necessary to make regulatory scheme operate, then only to minimum extent necessary).

83. See Borsody & Tiano, supra note 17, at 515.

84. Id. See also United States v. Nat'l. Ass'n. of Sec. Dealers, Inc., 422 U.S. 694, 695 (1975) (convincing evidence of repugnancy between regulatory system and antitrust law necessary for implied repeal).


87. See Eastern R.R. President's Conf. v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961) and United Mine Workers v. Pennington, 381 U.S. 657 (1965) (no violation of Sherman Act can be based upon attempts to influence passage or enforcement of laws). See also Marinelli, supra note 4, at 696. The basic premise of the doctrine is that private parties are allowed to collaborate before governmental bodies in order to oppose their competitors, despite the presence of anticompetitive intent. Id. at 696-97.

88. See Noerr, 365 U.S. at 127. Noerr was the first case which exempted joint activities aimed at achieving anticompetitive governmental decisions from the Sherman Act. Id. at 128-29. In Noerr, several railroads lobbied state legislators and the governor in an attempt to influence legislation that would eliminate trucking companies as competitors. Id. at 142-43. The trucking companies brought an antitrust suit against the railroads, after they succeeded in obtaining the desired legislation. Id. at 129-30. The suit was based on the railroad's anticompetitive purposes and on a fraudulent publicity campaign it had organized. Id. The Supreme Court held that the railroad's activities did not violate the Sherman Act because (1) the Sherman Act regulated monopolistic businesses and not political behavior; and (2) the case would raise important first amendment issues concerning the right to petition the government if the Court allowed the Sherman Act to cover lobbying activities. Id. at 137-38. The Court declared that courts may refuse to grant antitrust immunity if the challenged activities were a cover-up for an attempt to directly interfere with a competitor's business relationships. Id. at 144.

See also Pennington, 381 U.S. at 657. In Pennington, the Court again faced the question of antitrust immunity against government officials. Id. Pennington involved mine owners and workers who lobbied to persuade a government official to set higher
government officials by private parties in an effort to obtain legislation or favorable action, even if the parties’ underlying intent is to discourage competition. The exemption fails, however, if the parties attempt to influence a public official who is actually a co-conspirator. The Noerr-Pennington doctrine has been the focus of several cases challenging the anticompetitive consequences of health planning. It permits health professional to lobby for enactment of new legislation and allows them to identify and attack perceived illegal practices.

The third exemption available to physician peer reviewers is the state action defense. State action exempts from antitrust liability those practices which are compelled by the state through direct action of the state’s executive, legislative, or judicial branches. Although the state action exemption is not stat-

wages for employees. Id. at 660. The Supreme Court held that these activities were immune from antitrust laws. Id. at 670. It also expanded the Noerr doctrine to imply that joint efforts to influence public officials do not violate antitrust laws even though intended to eliminate competition. Id.

89. See Note, supra note 81, at 1520. The Supreme Court takes the stand that efforts to persuade fall under the protection offered by the first amendment right to free speech and to petition the government. Id. See, e.g., California Motor Transp. Co. v. Trucking Unlimited, 404 U.S. 508, 511-11 (1972) (Court recognized constitutional right to petition government as exemption from certain concerted efforts to influence government action). See also supra note 87 (discussion of Noerr-Pennington doctrine).

90. See Duke and Co., Inc., v. Foerster, 521 F.2d 1277 (3d Cir. 1975). In Duke, a manufacturer claimed that three municipal corporations, three private corporations, and a county commissioner conspired to boycott the plaintiff’s product. Id. at 1278. The court sustained the allegations based on the fact that both Noerr and Pennington involved suits against private parties rather than against a conspiracy involving the government. Id. at 1282.


93. See Borsody & Tiano, supra note 17, at 513. “Action that is ‘state action’ is exempt from scrutiny under the antitrust laws.” Id. The exemption is only applicable to activities performed under state law. Id. at n.11. It does not apply to either voluntary activities, or activities which are performed under federal law. Id.

94. See THOMPSON, supra note 15, at 58 (certain conduct compelled by state is
utory, it is a clearly defined exemption as noted from case law.\textsuperscript{95} \textit{Parker v. Brown}\textsuperscript{96} was the first Supreme Court case which enunciated this exemption. \textit{Parker} held that the Sherman Act did not intend "to restrain state action or official action directed by a state."\textsuperscript{97} Under the \textit{Parker v. Brown} doctrine, anticompetitive acts that are mandated by state governments are not subject to federal antitrust laws.\textsuperscript{98}

Over the years, the scope of the state action exemption has significantly narrowed.\textsuperscript{99} It has become increasingly clear that there is no state action defense for most health care antitrust suits.\textsuperscript{100} Despite this narrowed scope, several recent cases with

\begin{footnotesize}
\begin{enumerate}
\item See \textit{Parker v. Brown}, 317 U.S. 3431, 352 (1943) (state action exemption first announced by Supreme Court). \textit{See also} \textit{Borsody & Tiano}, supra note 17, at 513 (well-defined state action exemption has evolved in case law).
\item 317 U.S. 3412 (1943). In \textit{Parker}, the Court considered whether the Sherman Act prohibited anticompetitive actions of the State. \textit{Id.} at 350. The Court relied on principles of federalism and state sovereignty to conclude that the Sherman Act did not nullify a state's control over its officers. \textit{Id.} at 352.
\item Id. at 351.
\item See, e.g., California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980). The Supreme Court held that any restraint of trade that is challenged must be clearly articulated and affirmatively expressed as state policy. \textit{Id.} at 105. The Court held that any restraint of trade that is challenged must be clearly articulated and affirmatively expressed as state policy. \textit{Id.} at 105. The policy must also be actively supervised by the state itself, via enforcement proceedings. \textit{Id. See also} Community Communications Co., Inc. v. City of Boulder, 455 U.S. 40 (1982) (home rule statute provided insufficient authorization to city to regulate activities in anticompetitive manner to avoid antitrust action under state action exemption); Cantor v. Detroit Edison Co., 428 U.S. 579, 591-92 (1976) (Court refused to apply state action exemption to utility company's practice). The Court held that a state's implicit approval of certain programs did not implement any state policy. \textit{Id.} at 596-97. \textit{See also} City of Lafayette v. Louissiana Power & Light Co., 435 U.S. 389, 408 (1978) (lesser governmental entities are not automatically entitled to antitrust immunity). In addition, these entities cannot claim a state action exemption unless the challenged conduct is executed according to a state regulation policy. \textit{Id.} at 413.
\item See, e.g., Cantor v. Detroit Edison Co., 428 U.S. 579, 592 (1976) (legality of an act of the state must be examined before state action exemption applied); City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 413 (1978) (only government acts to displace competition with regulation or monopoly are exempt). \textit{See also} \textit{Borsody & Tiano}, supra note 17, at 513 (apparent breadth of exemption has recently been narrowed).
\item See, e.g., California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980) (state action exemption limited); Community Communications Co., Inc. v. City of Boulder, 455 U.S. 40 (1982) (municipality regulations generally subjected
\end{enumerate}
\end{footnotesize}
facts more analogous to peer review gave hope that certain peer review activities might fall under this exemption. In *Huron Valley Hosp. Inc. v. City of Pontiac*, a hospital that was denied application for a Certificate of Need (CON) and Capital Expenditure Review brought an antitrust suit. The case was dismissed on various grounds including the state action exemption. The court held that the defendants were not subject to antitrust laws because their activities were explicitly mandated by the state law and not because they held the status of public bodies.

101. See also Marnelli, *supra* note 4, at 696 (federal antitrust laws not applicable to anticompetitive acts mandated by state governments).


103. *Id.* at 1304-05. The plaintiff (Huron) was a nonprofit organization whose purpose was to construct a new hospital. *Id.* at 1304. Huron applied for a Certificate of Need (CON) in 1976, requesting building approval. *Id.* The Michigan state health agency refused to issue plaintiff a CON, and instead issued a CON to Huron's competitor to rebuild its existing hospital. *Id.* at 1305-06. Huron charged that the state CON process constituted a basic antitrust violation by failing to allow new entrants into the hospital industry for the benefit of existing hospitals. *Id.* at 1306-07. The court disagreed, and asserted:

Congress established a "Capital Expenditure Review" program to assure that federal funds appropriated for medicare, medicaid and other federal programs are not used to support unnecessary capital expenditures for health care facilities. Only states complying with these requirements may receive federal funding for a wide variety of purposes relating to health care. *Id.* at 1304-05.

This program is usually seen in conjunction with a state Certificate of Need program, which mandates that persons who wish to engage in certain health care facility construction must first obtain a Certificate of Need. *See, e.g.,* N.Y. Pub. Health Law §§ 2901-07 (McKinney & Supp. 1981-82).

104. *Huron*, 466 F Supp. at 1311. The district court held, on the merits, that defendants were allowed a blanket exemption from antitrust liability based on the National Health Planning and Resources Development Act of 1974. *Id.* at 1312. See *supra* notes 78 and 80 for a discussion of the Planning Act of 1974. In an alternative holding, the district court concluded that defendants were also shielded from antitrust liability by virtue of the state action exemption and the *Noerr-Pennington* doctrine. *Huron*, 466 F Supp. at 1312-15. See *supra* notes 86 and 87 for a discussion of the *Noerr-Pennington* doctrine.

105. *Huron*, 466 F Supp. at 1312. See *supra* note 103 for a discussion of state law outlining the Certificate of Need program. *See also* Cantor v. Detroit Edison Co., 428 U.S. 579, 597-98 (1976) (when regulated party causes state to adopt anticompetitive rule, it is not sufficient to confer state action exemption). The Supreme Court has expressly noted that it could foresee cases where state participation in a decision would be sufficiently dominant so that it would be unfair to hold a private party responsible for implementing it. *Id.* at 594-95. See also Borsody & Tiano, *supra* note 17, at 514-15 (safe to conclude that antitrust law exemptions apply to state-mandated peer review
Despite the favorable results in *Huron* and other antitrust suits,\(^{106}\) it soon became evident that health care institutions would generally be subjected to antitrust scrutiny\(^ {107}\) They would no longer be able to use the *Parker v Brown* doctrine to protect themselves from antitrust violations.\(^ {108}\) This has become apparent in more recent health care cases. In *Patrick v. Burget*,\(^ {109}\) The Court held that even though the state of Oregon required hospitals to have a process of reviewing medical competence, the practice was not so closely supervised by state officials that it qualified for state action exemption.\(^ {110}\) *Patrick* may have helped to diminish an era of state action as a defense by health care providers against antitrust liability

The defendants in *Patrick* raised several compelling arguments that physicians who participate in peer review should continued to be exempt from antitrust laws under the state action defense.\(^ {111}\) They balked at what they viewed as the Court's unwillingness to protect the integrity of the physician peer review system.\(^ {112}\) The defendants and their supporters, including

---


110. Id. at 102-105. The *Patrick* Court held that under the state-action doctrine, Oregon physicians were not protected from federal antitrust liability when they initiated and participated in hospital peer-review committee proceedings when their purpose was to: (1) terminate the surgeon's privileges at a city's only hospital; or (2) to reduce competition between surgeons. Id.

111. See Taylor, supra note 10, at D25, col. 2.

112. Id. at A1, col. 1. The defendants' main contention was that the threat of antitrust suits inhibited peer reviewers from effectively reviewing other physicians. Id. The defendants also argued that physicians who seek to discipline other physicians they feel are incompetent, should not be subjected to large money damages (which insurance does not cover) whenever a jury finds their behavior was not acceptable and their motives unpure. Id. at D25 col. 2-3.
the American Medical Association, argued that even if they had used the peer review process to disadvantage a competitor rather than to improve patient care, their conduct as peer reviewers was immune from antitrust scrutiny. The intent of peer review is to promote the review of a physician's competence and this review should not be inhibited because of antitrust threats.

The Patrick Court relied on earlier cases to explain its unwillingness to accept the antitrust state action defense. In Parker, the Supreme Court considered whether the Sherman Act prohibits anticompetitive actions of the state. It relied on principles of federalism and state sovereignty when it refused to identify in the Sherman Act "an unexpressed purpose to nullify a state's control over its officers and agents." The Court concluded that the Sherman Act was not "intended to restrain state action or official action directed by a state."

Following Parker, the Court realized that the state action exemption also applied in certain cases to private parties. In Southern Motor Carriers Rate conferences, Inc. v. United States, the Court addressed the following issue: whether a

113. Id. at D25, col. 3. Kirk B. Johnson, general counsel of the American Medical Association, described the Court's decision as "the atom bomb of the antitrust laws." Id. He believed the Patrick decision would be used against peer review panels in the future and claimed that the threat of antitrust lawsuits would have a "chilling effect" on efforts on disciplinary actions of incompetent physicians. Id.

114. See Patrick v. Burget, 486 U.S. 94, 98(1988). The court of appeals agreed. Id. It believed that the peer review activities of Oregon physicians came under the state action exemption from antitrust liability because Oregon had developed a policy which supported and actively supervised the peer review process. Id. The court therefore reversed the district court's holding in favor of the plaintiff. Id. The court of appeals described the defendants' conduct as "shabby, unprincipled and unprofessional" Id. at 98 n.3. However, such bad faith behavior was not sufficient to subject them to antitrust scrutiny. Id. at 98.

115. See supra note 114 and infra notes 116-118 and accompanying test for a discussion of cases relied upon by the Court in Patrick.


117. Id. at 351.

118. Id.

119. See, e.g., Patrick v. Burget, 486 U.S. 94, 99-100(1988). The Court believed that the federalism rationale derived from Parker should be made applicable against private parties demanding state action exemption. Id. See also Southern Motor Carriers Rate Cong., Inc. v. United States, 471 U.S. 48 (1985) (private parties could claim state action immunity from Sherman Act liability only when their actions were purely the product of state regulation).

state would be ineffective in implementing a program restraining competition among either a private litigant or the federal government, both of whom were entitled to enforce the Sherman Act against private parties. In addition, the Court attempted to assure the ability of private parties to claim antitrust immunity by state action whenever their anticompetitive acts were undoubtedly the product of state regulation. Achieving success in meeting this delicate balance was not easy. The Court sought to establish a standardized manner by which state action would be applied.

V STATE ACTION AND THE TWO-PRONGED TEST

In its attempt to come to some conclusion regarding state action, the Court established a rigorous two-pronged test to determine whether anticompetitive behavior by private parties should be considered state action and thereby receive protection from antitrust laws. The first prong maintains that "the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy' " The second prong asserts that the anticompetitive conduct "must be 'actively supervised' by the State itself."

An anticompetitive act will be fairly attributable to the state only if a private party meets both of these requirements. In Patrick, the Court found it clear that the "active supervi-

121. Id. (administrative agency concerned with state supervision over private doctrine).
122. Id. at 55-57.
123. See Patrick v. Burget, 486 U.S. 94, 100 (1988). On one hand, a state would not be able to implement an effective competition restraining program against either the federal government or a private litigant if they were allowed to enforce the Sherman Act against private parties. Id. On the other hand, the Court had to ensure that private parties could claim exemption from Sherman Act liability based on state action, only in situations where their anticompetitive acts actually stemmed from state regulation. Id. The Court established the two-pronged test accordingly. Id.
124. Id. See also California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 103-04 (1980) (challenged restraint of trade must be clearly articulated as state policy).
125. Midcal, 445 U.S. at 105.
126. Id.
127. See Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978). The Court emphasized that only government acts carried out by the state as sovereign are exempt under state action. Id. at 413. In addition, private parties must meet both prongs of the required test in order to receive state action immunity. Id. at 415.
sion” requirement of the two-pronged test was not satisfied. The Court noted that there was no showing that the State Health Division, the State Board of Medical Examiners, or the State Judiciary Review, were entitled to review private decisions regarding hospital privileges. These agencies were therefore unable to determine whether such decisions complied with state regulatory policy, and were unable to correct abuses. This active supervision requirement derives from the understanding that “[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State.” The purpose of the requirement is to make certain that the state action doctrine will protect only those anticompetitive acts of private parties which actually promote state regulatory policies. In order to meet this goal, the active supervision requirement directs the state to “exercise ultimate control over the challenged anticompetitive conduct.”

128. Patrick v. Burget, 486 U.S. 94, 101(1988). The active supervision prong requires state officials to assert their power to review and evaluate certain anticompetitive acts performed by private parties, and to disallow any acts which do not conform with state policy. Id. When an active supervision program is not present, there is no assurance that a private party’s anticompetitive actions will promote state policy rather than the individual’s own interests. Id. In Patrick, the Court did not even need to consider “clear articulation”, the second prong of the test, since the first requirement had not been met. Id. at 100.

129. Id. at 101. Both the Court of Appeals and the defendants were unsuccessful in showing that any of these agencies either reviewed or could review, private decisions concerning hospital privileges. Id. Therefore, no determination could be made regarding whether such decisions complied with state regulatory policy. Id.

130. Id.


132. Id. at 46-47. “A private party may be presumed to be acting primarily on his or its own behalf.” Id. at 45. See e.g., Parker v. Brown, 317 U.S. 341 (Court stressed that marketing plan by raisin growers could not take effect unless approved by state board as promoting state regulatory policies).

133. Patrick, 486 U.S. at 101. The active supervision prong set forth in Midcal mandates state officials to review anticompetitive acts by private parties and to disallow those which do not comply with state policy. Id. See also Southern Motor Carriers Rate Conf., Inc. v. United States, 471 U.S. 48, 51 (1985) (state public service commissions “have and exercise ultimate authority and control over all intrastate rates”); Parker v. Brown, 317 U.S. 341 (1943) (marketing plan cannot take effect unless approved by state board). In addition, the Patrick Court reiterated that it is not sufficient to have the mere presence of some state involvement or monitoring. Patrick, 486 U.S. at 101. See also Liquor Corp. v. Duffy, 479 U.S. 335, 345 n.7 (1987). The Court held that not all forms of state scrutiny of a restraint established by a private party constitute active supervision. Id. The reason is that they do not exert any significant control over the terms of the
sion program is not available, there is no means of assuring that the anticompetitive acts of a private party enhance state policy, rather than merely promote the party's self-interests.\textsuperscript{134}

It is evident, following \textit{Patrick}, that the Court took a limited view of antitrust immunity in peer review cases. However, during the time that \textit{Patrick} was before the Supreme Court, Congress enacted legislation which again broadened the application of antitrust immunity. The Health Care Quality Improvement Act of 1986 served to offer peer review committees hope that their actions would not be automatically deemed anticompetitive.\textsuperscript{135}

\textbf{VII. The Health Care Quality Improvement Act of 1986}

The medical profession has had a long-standing fear of antitrust lawsuits brought by health care workers harmed by professional peer review.\textsuperscript{136} This fear was recently addressed.\textsuperscript{137} Congress has developed a series of new legislative proposals to protect peer reviewers from litigation.\textsuperscript{138} These measures were established primarily to combat a disruption that arose in the area of medical malpractice insurance.\textsuperscript{139} The hope was that by strengthening professional peer review, there would be forced restraint.\textsuperscript{Id.}

\begin{itemize}
\item \textsuperscript{134} \textit{Patrick}, 486 U.S. 94, 101(1988).
\item \textsuperscript{135} 42 U.S.C. §§ 11101-52 (Supp. V 1987). The main focus of the HCQIA is on self-review by physicians that takes place in such settings as hospitals, medical group practices, and medical societies. \textit{See} Havighurst, \textit{Professional Peer Review}, supra note 6, at 1162. However, by its definition of a health care entity, the Act allows free-standing peer review bodies to qualify for antitrust exemption. \textit{See} 42 U.S.C. § 11151 (Supp. V 1987). The HCQIA takes an unusual approach to antitrust immunity. \textit{See} Havighurst, \textit{Professional Peer Review}, supra note 6, at 1161. Under the Act, a plaintiff who challenges professional peer review action, is faced with "a statutory presumption of reasonableness and procedural regularity." \textit{Id.} All participants in the action qualify for antitrust immunity unless the presumption is rebutted by a "preponderance of the evidence." \textit{Id.} This approach may serve to deter prospective plaintiffs because of the additional burdens of proof required, while increasing the plaintiff's stakes in the outcome by providing a fee-shifting provision. \textit{Id.} The plaintiff will be liable for the defendant's legal costs under this provision if the court finds the claim frivolous or unreasonable. \textit{Id.} The Act may therefore prevent certain lawsuits from being initiated. \textit{Id.}
\item \textsuperscript{136} \textit{See} Havighurst, \textit{Professional Peer Review}, supra note 6, at 1160.
\item \textsuperscript{137} \textit{Id.} at 1160.
\item \textsuperscript{138} \textit{Id.} at 1160. Congress enacted the HCQIA in order to insulate certain peer review activities from antitrust liability. \textit{See} 42 U.S.C. § 11101 (Supp. V 1987).
\item \textsuperscript{139} \textit{See generally} 42 U.S.C. §§ 11101-52 (Supp. V 1987).
\end{itemize}
improvement in the quality of care offered by physicians.\textsuperscript{140} Unfortunately, these measures were not implemented until after the events at issue in Patrick were well underway.\textsuperscript{141} The measures were not retroactive.\textsuperscript{142}

The most significant of these measures to promote the quality of medical care is the Health Care Quality Improvement Act of 1986 (HCQIA).\textsuperscript{143} Essentially, the Act exempts from liability peer review action which occurred "in the reasonable belief that the action was in the furtherance of quality health care."\textsuperscript{144} The basic purpose of the Act was to combat the threat of private money damage liability under federal laws which serve to discourage physicians from actively participating in professional peer review.\textsuperscript{145}

Legal analysis of the HCQIA spans a broad spectrum. The Patrick Court viewed the act in a positive light.\textsuperscript{146} In its opinion, Congress had observed and responded to the concern expressed by the health care field, that the possibility of antitrust liability

\begin{itemize}
\item \textsuperscript{140} See Havighurst, Professional Peer Review, supra note 6, at 1160. See also 42 U.S.C. §§ 11101-52 (Supp. V 1987). Section 402 of the HCQIA sets forth the following as findings of Congress:
\item malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.
\item (2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.
\item (3) This nationwide problem can be remedied through effective professional peer review.
\item (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
\item (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.
\item Id.
\item \textsuperscript{141} See Patrick v. Burget, 486 U.S. 94, 105-106 n. 8 (1988). The Act was enacted long after the Patrick case was instituted. Id.
\item \textsuperscript{142} Id.
\item \textsuperscript{143} 42 U.S.C. § 11112(a)(1) (Supp. V 1987).
\item \textsuperscript{144} Id. See also Patrick, 486 U.S. at 105-106 n. 8 (1988).
\item \textsuperscript{145} See U.S.C. §§ 11101 (Supp. V 1987). This also includes treble damage liability under Federal antitrust law. Id. In addition, the Act makes the provision for a central office to receive and make available to designated person reports of actions: (1) which negatively affect individual physician's hospital privileges, (2) of payments made in setting malpractice claims; and (3) of disciplinary actions taken by state licensing boards. Id. at §§ 11131-37.
\item \textsuperscript{146} See generally Patrick, 486 U.S. 94 (1988).
would “discourage effective peer review.” The Act expressly provides that it does not alter other immunities under law, including the state action immunity, and thereby allows states to immunize peer review activity that does not meet the federal standard. The Patrick Court does suggest that if physician peer reviewers are not satisfied with the Act in terms of the sufficiency of immunity provided, they are encouraged to take the matter up with Congress.

On the other end of the spectrum, there were those who viewed the Act as flawed. They questioned whether the HCQIA’s attempt to protect peer reviewers against antitrust and other lawsuits was necessary. Statutes were already in place which offered some immunity for peer reviewers. For example, state statutes often protect those who participate in peer review despite the fact that they are not interpreted as dispelling federal antitrust regulations.

\[\text{\textsuperscript{147}}\text{Id. at 105-106 n. 8 (1988).}\]
\[\text{\textsuperscript{149}}\text{See Patrick, 486 U.S. at 105-106 n. 8 (1988). If physicians think the act is inadequate, they should take the matter up with Congress. Id. See also 42 U.S.C. §§ 11101-52 (Supp. V 1987). Congress’s intent in enacting the HCQIA of 1986 was to address the concern that the possibility of antitrust liability would discourage effective peer review. 42 U.S.C. § 11101 (Supp. V 1987).}\]
\[\text{\textsuperscript{150}}\text{See, e.g., Havighurst, Professional Peer Review, supra note 6, at 1162. According to Professor Havighurst, one of the greatest flaws in the HCQIA is its inability to note and maintain the delineation between peer review that is advisory, and peer review that is attached to sanctions. Id. A hospital medical staff that has authority over clinical privileges can qualify for immunity from antitrust law as guided by the statute. Id. In an attempt to prevent the occurrence of abuse, however, the Act makes certain that immunity only applies to specific actions such as those that are “based on the competence and professional conduct of an individual physician.” Id. In addition, it goes on to stipulate that immunity does not apply: (1) to disciplinary actions toward a physician for maintaining certain affiliations or associations; (2) to advertising; (3) to price cutting or similar competitive acts; or (4) to relationship with other health care professionals. Id. Such provisions promote the opportunity to extensively litigate the true motives of the peer reviewers. Id. at 1163. The threat of lawsuits may not show as significant a decrease as the sponsors of the bill hoped, since numerous potential plaintiffs believe that the suits against them come under these exceptions. Id.}\]
\[\text{\textsuperscript{151}}\text{Id. at 1163.}\]
\[\text{\textsuperscript{152}}\text{Id. For example, legislation which established Peer Review Organizations (PRO’s), granted criminal and civil liability immunity to those individuals who proceeded with PRO activities, and to those who provided information to PRO’s. Id.}\]
\[\text{\textsuperscript{153}}\text{Id. See, e.g., CAL. CIV. CODE § 43.7, 160 (West 1982) (individuals but not professional societies or hospitals, immunized from monetary liability); FLA. STAT. ANN. § 768.40(3)(a) (West 1986) (members of medical review committees immunized); ILL. ANN. STAT. ch. 111 § 151.2 (Smith-Hurd Supp. 1986) (hospitals and their staffs immunized).}\]
PHYSICIAN PEER REVIEW

though a state may find sufficient evidence in a peer review issue to support a state action exemption from antitrust laws, the decisions do not automatically extend to other states.

Because of the Act’s numerous limitations, the threat of antitrust actions against peer reviewers remains uncontrolled. The HCQIA, an attempt by Congress to decrease the risk of antitrust actions against peer reviewers, has not lived up to its claim. Physicians have only one option if they are to proceed, unchallenged, with peer review activities. They must heed the Supreme Court’s suggestion in Patrick, and further pursue the matter with Congress. Only through further legislation will the issue of antitrust immunity for peer reviewers be settled once and for all.

VIII. PROPOSAL

Professional peer review is an essential feature of the health care industry. Unless appropriate peer review activities are promoted by the courts, physicians will hesitate, if not outright re-

But see Memorial Hosp. For McHenry county v. Shadur, 664 F.2d 1058, 1063 (7th Cir. 1981). The court construed a state law, which restricted the discoverability of peer-review records, to read: “the public interest in private enforcement of federal antitrust law in this context is simply too strong to permit the exclusion of relevant and possibly crucial evidence by application of the Hospital’s privilege.” Id. See also Havighurst, Professional Peer Review, supra note 6, at 1163 (statutes construed not to displace oversight of federal antitrust). In an instance where state laws impede a plaintiff who wishes to bring tort actions for defamation, unfair competition, or contractual relations interference, but there is no impact upon federal antitrust actions, this latter type of claim increases, and the argument for federal action to relieve peer reviewer pressure, strengthens. Id. at n.134.


155. See Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986) (court read state law as expressing a state policy which was inconsistent with federal law). See also Havighurst, Professional Peer Review, supra note 6, at 1163-64 n.136 (state had merely urged hospitals to exercise scrutiny over medical staff access). It was unrealistic to believe that state policy differed or offered consumer protection against anticompetitive discretions. Id.

156. See Havighurst, Professional Peer Review, supra note 6, at 1161. The HCQIA does not touch the antitrust statutes or any other legal doctrine under which an aggrieved physician may sue. Id. Instead it provides barriers to the institution of private suits for money damages under both federal and state law. Id. In addition, there is a question as to the validity of the HCQIA’s “premise that antitrust law itself supplies inadequate deterrence to these suits.” Id. at 1164. The act itself may complicate litigation and add to the sky-rocketing costs, while performing a disservice to antitrust laws through the implication that courts are unable to reach sound results on their own if they comply with traditional notions. Id. at 1165.
fuse, to examine and evaluate the actions of their peers. Three steps must be taken to prevent this prediction from becoming a reality.

First, federal legislation must be passed that will assure the immunization of peer review activities for other than anticompetitive purposes. Establishing a national peer review committee for health care providers will best achieve this goal. Those belonging to the committee would be guaranteed automatic immunity from antitrust liability. The committee would be broken down into divisions. For example, there would be a division to specifically preside over physician peer reviewers, and additionally Medicare, worker’s compensation, and insurance law.

The purpose of enacting a national peer review committee (NPRC) would be to assure that individual peer reviewers focus on the right activities for the right reasons. The NPRC would be responsible for establishing guidelines and protocol outlining the steps that individual peer reviewer committees must take. For example, peer reviewers would be mandated to examine the activities of a peer based on specific criteria such as appropriate medical treatment, patient safety, and medical follow-up.

Based upon these criteria, the NPRC would provide a random screening of peer review committees in order to make certain that guidelines and protocol for proper peer review are realistic and are being followed. In addition, individuals who have been evaluated by a peer review committee and who believe that antitrust laws have been violated may submit the committee’s findings to the NPRC. The NPRC would perform a cursory review of the findings and then make one of two determinations. Either the findings and decision of the peer review committee would be allowed to stand, or the case would be subjected to an extensive investigation in order to determine whether antitrust violations exist. Because of the great expense that such an investigation would generate, in light of the federal government’s push to lower health care costs, the NPRC would be required to select only those cases which posed a prevalent risk of antitrust violation.

The NPRC would work in conjunction with the Antitrust Division of the United States Department of Justice. If the NPRC found that individual peer reviewers were evaluating peers for the purpose of promoting the quality of care, the re-
viewers would be immune from antitrust action. If, on the other hand, the NPRC found that the actions of peer reviewers were strictly anticompetitive or intended to violate antitrust laws, the case would be turned over to the Antitrust Division.

Under this system, only peer reviewers working toward promoting their own self-interests would hesitate to participate for fear of being threatened with an antitrust violation. Reviewers working to promote quality care would have no reason to refuse to get involved. Their activities would be well-guided and closely monitored with recommendations made according to their findings. This legislation would in fact take the worry of antitrust liability out of the hands of individual reviewers and place it in those of the NPRC.

Secondly, state legislation is required to assure that the state hospital licensing laws provide for “sufficient formal review within the state system” to qualify for antitrust immunity \(157\). In *Patrick*, the Supreme Court overturned the appellate court’s decision that peer reviewers were exempt because of actions by state regulatory authorities and by private parties who enforce state policies through “closely supervised” activities by state officials.\(^8\) The Court ruled that state action under the active supervision requirement, forces the state to exercise the ultimate control over the challenged conduct.\(^9\) Unless it is clear that the state controls the conduct, the peer reviewers’ actions will not be immune from antitrust laws. It is essential, therefore, that hospital licensing laws be changed to incorporate a means by which the state will have ultimate control. The most effective means of doing this would be for states to establish a statutory obligation requiring hospitals to outline peer review procedures. The state’s health division would then regularly review these procedures and the hospital’s compliance with them.

Thirdly, the courts must begin focusing on the existing state statutes that provide immunity to individual peer reviewers.\(^\)160

---

157. See Taylor, *supra* note 10, at D24 col. 6. Kirk B. Johnson, general counsel of the American Medical Association, expressed the need to take this step in decreasing antitrust liability. *Id.* The *Patrick* decision must be closely examined, and state hospital licensing laws amended, in order to comply with the decision. *Id.*


159. *Id.* at 101.

160. See *supra* note 117 and accompanying text for a discussion on state antitrust exemptions.
State courts must shape their doctrine so that they begin to rely on the provisions of their own state statutes rather than turning to legislation such as the HCQIA, which may serve only to confuse the issue. \textsuperscript{161} "It would be ironic indeed if the solution to the problem of vexations and burdensome litigation against professional peer review were ultimately to be found in antitrust principles themselves, and not in the legislation." \textsuperscript{162}

IX. THE FUTURE OF PEER REVIEW

Peer review is more than a source of useful, procompetitive information.\textsuperscript{163} In terms of physicians, peer review is intended to provide answers as to whether the quality of care is acceptable.\textsuperscript{164} Peer review is strongly encouraged by public health policy.\textsuperscript{165} The numerous statutes requiring peer review of health care make this evident.\textsuperscript{166} However, antitrust law has proven to be a direct source of conflict for physician peer review. This conflict will continue to grow, and the quality of health care will continue to decrease, if a resolution is not reached.

A serious discrepancy exists between enforcing antitrust

\textsuperscript{161} See Havighurst, \textit{Professional Peer Review}, supra note 6, at 1165.

\textsuperscript{162} Id. at 1165.

\textsuperscript{163} Id. at 1134. Both professional and non-professional observers are of the belief that peer review is more than just basic opinion. Id.

\textsuperscript{164} Id. at 1134. Originally, peer review was based on the premise that the medical profession was the only official authority on the acceptable level of care. Id. Formal peer review first developed in the early twentieth century. Id. See also Blum, supra note 33, at 1. At that time, medicine was developing into an increasingly scientific profession. Id. Two studies were conducted at that time. Id. One study found that most institutions surveyed were not able to meet a defined standard of care. Id. The other study concluded that medical education was inadequate. Id. As peer review evolved, there was a push to improve the standards of medical practice. Id. at 2. The Peer Standards Review Organization Act of 1970 (PSRO) was developed to "promote the effective, efficient, and economical delivery of health care services of proper quality." 42 U.S.C. § 11151 (Supp. V 1987). Senator Wallace Bennett viewed the Professional Standards Review Organization Act of 1970 as providing physicians "with an imaginative and exciting opportunity to assume basic responsibility for reviewing health care as a whole." 116 Cong. Rec. 22, 475 (1970).

\textsuperscript{165} See Borsody & Tiano, supra note 17, at 531. This is evident by the many statutes which require peer review of health care for which the government pays. Id. See also 48 \textit{NATIONAL ADVISORY COMM’N ON HEALTH MANPOWER REP.} (1967) (professional societies, health insurance organizations, and government should extend development and effective use of peer review procedures in maintaining high quality health and medical care).

\textsuperscript{166} See Borsody & Tiano, supra note 17, at 531.
laws against physicians in order to reduce organized medicine's political power and enforcing them to prevent anticompetitive activities.\textsuperscript{167} The aim of both the legislature and the judicial system must be to promote a health care field that is primarily concerned with the well-being of its consumers. If this goal is to be achieved, peer reviewers must be assisted to evaluate unhesitatingly and without fear of antitrust liability, the actions of other health care professionals.

Melinda Simeon Monson

\textsuperscript{167} See Antitrust Challenge, supra note 50, at 34. The author noted that "the current antitrust attack on professional power" provides most of the necessary tools to combat excessive deference to the medical profession by both the public and private sectors. Id. As courts realize, penalize, and publicize abuses by the medical profession, the public will experience a change in attitude. Id. This change should help reduce the political power of the profession. Id. Exposure of the shallowness of the profession's claims to special virtue via antitrust activity, should help the public to realize that medicine is just another typical interest group trying to survive. Id. As time passes, the legislature's habit of playing favorites to professional groups will no longer be distinguishable from problems which are inherent to special-interest politics. Id.