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**COMMISSION
APPROVED**

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

NO. 85-2474

Robert Lombardo, et al.,
Plaintiffs-Appellants

v.

Our Lady of Mercy Hospital, et al.,
Defendants-Appellees

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA,
HAMMOND DIVISION

BRIEF FOR THE FEDERAL TRADE COMMISSION AS AMICUS CURIAE

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TABLE OF CONTENTS

	<u>Page</u>
TABLE OF AUTHORITIES	ii
ISSUES PRESENTED	1
INTEREST OF THE FEDERAL TRADE COMMISSION	1
STATEMENT OF THE CASE	2
ARGUMENT:	
THE HOSPITAL'S DECISION TO DENY SURGICAL PRIVILEGES TO PLAINTIFFS IS NOT PROTECTED FROM ANTITRUST SCRUTINY BY THE STATE ACTION DOCTRINE	3
I. Indiana's Policy Directing Hospitals To Review The Qualifications Of Applicants For Medical Staff Membership In Order To Assure High Quality Medical Care Does Not Constitute A Clearly Articulated And Affirmatively Expressed State Policy To Displace Competition With Regulation	6
A. Indiana Law Does Not Show A State Intent To Displace Competition As Required By Supreme Court Cases	6
B. Indiana Law Does Not Evidence An Intent To Displace Competition Because Hospitals' Review Of The Qualifications Of Staff Members Can Promote Competition	12
C. Application Of The Federal Antitrust Laws To Hospital Privilege Decisions Will Not Prevent Accomplishment Of The State's Policy Favoring High Quality Medical Care	15
II. It Has Not Been Demonstrated That Indiana Actively Supervises The Challenged Conduct	16
CONCLUSION	20

TABLE OF AUTHORITIES

<u>Cases</u>	<u>Page</u>
<u>Burnham Hospital</u> , 101 F.T.C. 991 (1983).....	1, 13
<u>California Retail Liquor Dealers Ass'n v. Midcal Aluminum</u> , 445 U.S. 97 (1980).....	4, 6, 7, 16, 17
<u>Cantor v. Detroit Edison Co.</u> , 428 U.S. 579 (1976).....	8, 11
<u>City of Lafayette v. Louisiana Power & Light Co.</u> , 435 U.S. 389 (1978).....	8, 11
<u>Community Communications Co. v. City of Boulder</u> , 455 U.S. 40 (1982).....	9
<u>Forbes Health System Medical Staff</u> , 94 F.T.C. 1042 (1979).....	1, 14, 17
<u>Goldfarb v. Virginia State Bar</u> , 421 U.S. 773 (1975).....	8
<u>Hampton v. City of Chicago</u> , 484 F.2d 602 (7th Cir. 1973), <u>cert. denied</u> , 415 U.S. 917 (1974).....	4
<u>Health Care Management Corp.</u> , 50 Fed. Reg. 41,693 (1985).....	1
<u>Marrese v. Interqual, Inc.</u> , 748 F.2d 373 (7th Cir. 1984), <u>cert. denied</u> , 105 S. Ct. 3501 (1985).....	5, 6, 11, 15, 17, 18, 19
<u>North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.</u> , 740 F.2d 274 (4th Cir. 1984), <u>cert. denied</u> , 105 S. Ct. 1865 (1985).....	17
<u>Parker v. Brown</u> , 317 U.S. 341 (1943).....	7, 19
<u>Pontius v. Children's Hospital</u> , 552 F. Supp. 1352 (W.D. Pa. 1982).....	16
<u>Quinn v. Kent General Hospital, Inc.</u> , C.A. No. 84-509 (D. Del. Aug. 16, 1985).....	9, 18
<u>Ratino v. Medical Service of District of Columbia</u> , 718 F.2d 1260 (4th Cir. 1983).....	9
<u>Robinson v. Magovern</u> , 521 F. Supp. 842 (W.D. Pa. 1981), <u>aff'd mem.</u> , 688 F.2d 824 (3d Cir.), <u>cert. denied</u> , 459 U.S. 971 (1982).....	13
<u>Southern Motor Carriers Rate Conference, Inc. v.</u> <u>United States</u> , 105 S. Ct. 1721 (1985).....	4, 7, 8, 16, 17

<u>Cases</u>	<u>Page</u>
<u>Stone v. William Beaumont Hospital, 1983-2 Trade Cas.</u> <u>(CCH) ¶ 65,681 (E.D. Mich. 1983)</u>	16
<u>Town of Hallie v. City of Eau Claire, 105 S. Ct. 1713</u> <u>(1985)</u>	8, 12, 13, 17
<u>United States v. National Society of Professional</u> <u>Engineers, 435 U.S. 679 (1978)</u>	15
<u>Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984),</u> <u>cert. denied, 105 S. Ct. 1777 (1985)</u>	14
<u>Williams v. Kleaveland, 1983-2 Trade Cas. (CCH)</u> <u>¶ 65,486 (W.D. Mich. 1983)</u>	15

Statutes and Regulations

Ind. Code Ann. § 16-10-1-6.5 (Burns Supp. 1985).....	10, 11, 14
Ind. Code Ann. § 16-10-1-9 (Burns 1983).....	18
Ind. Code Ann. § 16-10-1-10 (Burns 1983).....	18
Ind. Code Ann. § 16-12.1-1-1 (Burns 1982).....	10
Ind. Code Ann. § 16-12.1-5-1 (Burns Supp. 1985).....	10
Ind. Code Ann. § 25-22.5-1-1.1 (Burns Supp. 1985).....	10
Ind. Code Ann. § 25-22.5-3-1 (Burns Supp. 1985).....	10
Ind. Code Ann. § 34-4-12.6-1 (Burns Supp. 1985).....	11
Ind. Code Ann. § 34-4-12.6-2 (Burns Supp. 1985).....	17
Ind. Code Ann. § 34-4-12.6-3 (Burns Supp. 1985).....	14
Sherman Antitrust Act, 15 U.S.C. § 1 (1982).....	3

Other

Brief for the Federal Trade Commission As Amicus Curiae, <u>Bhan v. NME Hospitals, Inc., No. 84-2256 (9th Cir.</u> <u>Oct. 2, 1985)</u>	1
Brief for the United States As Amicus Curiae, <u>Jefferson</u> <u>Parish Hospital District No. 2 v. Hyde,</u> <u>104 S. Ct. 1551 (1984)</u>	1

Other

Page

Havighurst, <u>Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships</u> , 1984 Duke L.J. 1071.....	13
Lerner, <u>Federal Trade Commission Activities in the Health Care Services Field</u> , 29 Antitrust Bull. 205 (1984).....	15

ISSUE PRESENTED

Whether denial of surgical privileges to two osteopathic physicians by a private Indiana hospital and the participation of private physicians in adopting and implementing the hospital policy excluding osteopathically-trained surgeons that led to these denials, constitute "state action" exempt from the federal antitrust laws.¹

INTEREST OF THE FEDERAL TRADE COMMISSION

As part of its responsibility for enforcing the federal antitrust laws, the Federal Trade Commission is concerned with antitrust and other competition issues involving health care, including issues relating to hospital privileges. See Health Care Management Corp., 50 Fed. Reg. 41,693 (1985) (proposed FTC consent order Oct. 10, 1985); Burnham Hospital, 101 F.T.C. 991 (1983) (advisory opinion); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order); Brief for the United States as Amicus Curiae, Jefferson Parish Hospital District No. 2 v. Hyde, 104 S. Ct. 1551 (1984); Brief for the Federal Trade Commission as Amicus Curiae, Bhan v. NME Hospitals, Inc., No. 84-2256 (9th Cir. Oct. 2, 1985).² It is the Commission's view that hospitals' selectivity in granting hospital privileges in order to achieve the effective and efficient provision of services, including the

¹ This brief, filed pursuant to Rule 29 of the Federal Rules of Appellate Procedure, focuses on the applicability of the state action doctrine to the allegations of plaintiffs' amended complaint. It will not discuss other issues that may be raised in this appeal. The Commission takes no position on whether the conduct challenged in the complaint violates the antitrust laws.

² For a general overview of the Commission's antitrust activities relating to health care, see Lerner, Federal Trade Commission Activities in the Health Care Services Field, 29 Antitrust Bull. 205 (1984).

denial of hospital privileges to unqualified practitioners, may often promote competition and consumer welfare. However, the Commission believes that the hospital privilege process has the potential for anticompetitive abuse insofar as it can be used to further private interests unrelated to the efficient provision of high quality hospital care. The Commission is interested in assuring that the state action doctrine, which limits the availability of antitrust remedies for such abuses, is properly interpreted and applied.

STATEMENT OF THE CASE

According to the amended complaint, plaintiffs are osteopathic physicians who hold unlimited licenses to practice medicine and surgery in Indiana. They are also certified by the American Osteopathic Board of Surgery ("AOBS"). (App. at 2, 6.³) Each plaintiff applied separately for membership with surgical privileges on the medical staff of Our Lady of Mercy Hospital in Dyer, Indiana ("the Hospital"). (App. at 3-4, 6.) The Hospital's Board of Trustees, acting on the recommendation of the Medical Executive Committee, denied each application. (App. at 3-4.)

The Hospital allegedly denied plaintiffs' applications solely on the basis of a Surgery Department rule requiring physicians with surgical privileges to have completed the post-graduate training required for eligibility for certification by the American Board of Surgery ("ABS"). (App. at 4.) The Department's rule disqualified plaintiffs from obtaining privileges, because plaintiffs' osteopathic post-graduate training does not meet ABS eligibility requirements. (App. at 2, 5.) Plaintiffs claim that the Department imposed the rule in order to eliminate competition from osteopathic

³ "App." refers to the appendix to plaintiffs' brief.

physicians, despite the finding of a Hospital committee that ABS training requirements are similar, and not proven to be superior, to those of the AOBBS. (App. at 5, 14.) The rule allegedly discriminates unreasonably against osteopathic surgeons, and the reliance of the Hospital on that rule in its decisions on hospital privileges allegedly prevents osteopathic surgeons from treating their patients at the Hospital. (App. at 5-7.) The complaint charges that the adoption and implementation of the rule by the Hospital and the individual defendants, who are all non-osteopathic physicians, constitute a combination and conspiracy in unreasonable restraint of trade in physician and hospital services, in violation of Section 1 of the Sherman Act, 15 U.S.C. ~~§ 1 (1982).~~ (App. at 13-14.)

The district court dismissed the complaint for failure to state a claim upon which relief can be granted. With respect to the antitrust counts, the district court ruled that the challenged conduct constituted "state action" exempt from the federal antitrust laws because Indiana law requires hospitals to establish standards for hospital privileges, and hospitals and physicians are regulated by the state.

ARGUMENT

THE HOSPITAL'S DECISION TO DENY SURGICAL PRIVILEGES TO PLAINTIFFS IS NOT PROTECTED FROM ANTITRUST SCRUTINY BY THE STATE ACTION DOCTRINE

In a series of cases applying the "state action" doctrine, the Supreme Court has carefully delineated the circumstances in which the federal policy of competition embodied in the antitrust laws will give way to conflicting state policies to displace competition with regulation. State action immunity applies to anticompetitive activity by private parties, such as the defendants in this case, only if two separate conditions are satisfied: the restraint on

competition must implement a "clearly articulated and affirmatively expressed" state policy, and the restraint must be "actively supervised by the State itself." California Retail Liquor Dealers Association v. Midcal Aluminum, 445 U.S. 97, 105 (1980) [Midcal]; Southern Motor Carriers Rate Conference, Inc. v. United States, 105 S. Ct. 1721, 1727-28 (1985) [Southern Motor Carriers]. These two requirements are designed to assure that private activity that restrains competition is immunized only when it carries out a concrete state policy rather than a private anticompetitive purpose.

Indiana laws governing the granting of hospital privileges do not require, authorize, or contemplate that hospitals establish standards for staff privileges designed to eliminate osteopathic physicians as competitors of allopathic physicians.⁴ Indeed, Indiana's policy permits quality competition among hospitals and physicians by authorizing hospitals to grant privileges only to practitioners who are highly qualified. Thus, it has not been shown that the defendants' actions were undertaken pursuant to a state policy to displace competition, as is required by Midcal. In addition, the second prong of the Midcal test is not satisfied in this case because the challenged conduct was not actively supervised by the state. Therefore, the court erred in dismissing the antitrust counts of the complaint.

⁴ The requirement for ABS-approved training may be reasonably related to the legitimate interests of the hospital. If so, the denial of privileges on this ground probably would not violate the antitrust laws. But the district court, in passing on the motion to dismiss plaintiffs' complaint, was required to assume the truth of the allegations of the complaint that the hospital's policy of denying surgical privileges to physicians with AOBs rather than ABS-approved training was adopted to eliminate competition from osteopathic surgeons and not to promote quality care or efficiency. Hampton v. City of Chicago, 484 F.2d 602, 606 (7th Cir. 1973), cert. denied, 415 U.S. 917 (1974).

The district court held that a finding of state action immunity in this case was required by Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984), cert. denied, 105 S. Ct. 3501 (1985). In Marrese, this court held that the state action doctrine applied to the review of a physician's surgical practices by a peer review committee and the subsequent termination of his hospital privileges because Indiana law requires hospitals to establish a peer review process to review the quality of care provided to patients, and because state agencies closely regulate hospitals and physicians.

As the district court recognized, the facts of this case differ from those in Marrese.⁵ However, the district court concluded that the differences were not dispositive, and adopted the Marrese court's view that state laws requiring hospitals to engage in general types of action -- such as establishment of criteria for admission to the medical staff in this case, and peer review in Marrese -- constitute a clearly articulated and affirmatively expressed state policy to supplant competition with specific anticompetitive behavior.

The Commission submits that applying Marrese's reasoning to this case, in essence granting state action immunity to all decisions to deny or revoke hospital privileges in Indiana, regardless of their purpose or effect, is unwarranted. More important, the Commission submits that Marrese should not be followed because it is inconsistent with Supreme Court decisions inter-

⁵ Marrese involved the revocation of a physician's hospital privileges after peer review of his individual medical practice, while this case involves the denial of privileges based on a rule categorically disqualifying practitioners with AOBs-approved training. The district court relied on Indiana law requiring the establishment of qualifications for membership on medical staffs, while Marrese involved different laws relating to peer review of physicians' practices. The Marrese court also found that hospital privilege terminations could be reviewed in state court, while the district court ruled that the denials of plaintiffs' applications could not be reviewed under state law.

preting the state action doctrine. Because the district court relied on Marrese without an independent analysis of the requirements of the state action doctrine, and because both cases involve a similar misinterpretation of the Midcal test, the district court's opinion and Marrese are both discussed below.

I. INDIANA'S POLICY DIRECTING HOSPITALS TO REVIEW THE QUALIFICATIONS OF APPLICANTS FOR MEDICAL STAFF MEMBERSHIP IN ORDER TO ASSURE HIGH QUALITY MEDICAL CARE DOES NOT CONSTITUTE A CLEARLY ARTICULATED AND AFFIRMATIVELY EXPRESSED STATE POLICY TO DISPLACE COMPETITION WITH REGULATION

A. Indiana Law Does Not Show A State Intent To Displace Competition As Required By Supreme Court Cases.

The first prong of the Midcal test for state action immunity requires that private conduct be undertaken pursuant to a clearly articulated and affirmatively expressed state policy displacing competition with regulation in the area subject to the challenged restraint. The district court held that the hospital's decision to deny surgical privileges to the plaintiffs because they had AOBS rather than ABS-approved surgical training was "clearly articulated and affirmatively expressed as state policy" because Indiana law requires hospitals to "establish and enforce standards for admission to the medical staff and hospital practice." (App. at 22-23.) However, nothing in Indiana law supports a finding that the state's policy is to permit hospitals and medical staffs to restrain competition among state-licensed physicians by imposing requirements for medical staff membership that are designed to serve the competitive interests of current medical staff members, as the plaintiffs have alleged that the defendants have done in the amended complaint in this case. Neither does Indiana law support a finding that these requirements were not designed to assure high quality patient care.

Cases in which the Supreme Court has found state action immunity for private anticompetitive action have involved state authorization or direction of the specific kind of activity challenged. In Southern Motor Carriers, the Supreme Court found that collective ratemaking was protected by the state action doctrine because that particular practice was "clearly sanctioned" by the legislatures of the states involved. The Court based its conclusion that the state action doctrine applied on the clearly articulated intention of the legislatures to "displace price competition among common carriers" by establishing a regulatory system under which rates were established by a state agency rather than by the market. 105 S. Ct. at 1730-31. Thus, the Court did ~~not look~~ to whether the defendants' general activities were broadly consistent with the purpose of state law, but rather to whether the specific practice challenged -- collective ratemaking -- was undertaken pursuant to state policy intended to displace the specific type of competition -- price competition -- affected by the challenged restraint.⁶

When there is no state policy to substitute regulation for competition in the specific area subject to the restraint, the state action doctrine does not apply. For example, a minimum fee schedule published by a private bar association and enforced by the Virginia State Bar was held not to be protected from antitrust scrutiny. Although many aspects of legal practice were regulated by the state, neither the state legislature nor the state

⁶ In Parker v. Brown, 317 U.S. 341 (1943), the Supreme Court found that an inherently anticompetitive agricultural prorate scheme was immune from antitrust challenge because the state "created the machinery" for it and enforced it. 317 U.S. at 352. In Midcal, although the Court found state action immunity lacking because the private activities were not actively supervised by the state, the Court found a clearly articulated state policy to displace competition because the state clearly intended to permit resale price maintenance and enforced the prices established by private parties. 445 U.S. at 105.

Supreme Court had authorized or required fee schedules, and neither had a policy designed to displace price competition among lawyers. Goldfarb v. Virginia State Bar, 421 U.S. 773, 790 (1975); see Southern Motor Carriers, 105 S. Ct. at 1729. In the absence of such a policy, the Goldfarb defendants' claim that their activities complemented the objectives of state policy, or were "prompted" by the state, was insufficient to justify state action immunity. 421 U.S. at 791.⁷

Where the legislature's policy to displace competition in an area is clear, it is not necessary for the legislature to specifically approve the particular anticompetitive practices used to implement that policy or the anticompetitive effects that naturally flow from the actions specifically authorized. Southern Motor Carriers, 105 S. Ct. at 1730-31; Town of Hallie v. City of Eau Claire, 105 S. Ct. 1713 (1985). However, where anticompetitive effects do not naturally and foreseeably result from specific conduct authorized or required by state law, the state action doctrine requires more specific legislative authorization of anticompetitive conduct. See City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 415 (1978) (conduct protected if state authorized or directed the challenged acts, or contemplated the type of action at issue). A state's general grant of power to act in an

⁷ See also Cantor v. Detroit Edison Co., 428 U.S. 579, 584-85 (1976) (light bulb exchange program embodied in tariff approved by state regulatory commission not immune because, among other reasons, the state had indicated no intention to restrict competition in the sale of light bulbs as opposed to electricity).

area, that does not contemplate anticompetitive conduct, does not confer state action immunity. Community Communications Co. v. City of Boulder, 455 U.S. 40 (1982).⁸

The district court did not identify a state policy contemplating that hospitals and their medical staffs would impose unreasonable restraints on competition among state-licensed physicians in the awarding of hospital privileges. Indiana law contemplates that hospital governing boards will establish standards for medical staff membership and clinical privileges, and will, with the advice of the medical staff, review applicants' individual training, experience, and qualifications to assure that medical staff members

⁸ See also Ratino v. Medical Service of the District of Columbia, 718 F.2d 1260 (4th Cir. 1983) (state action immunity did not apply to local medical society review of the reasonableness of physician charges, despite state law contemplating that societies would be involved in investigating complaints about physician fees and making recommendations on disciplinary action to state agency, where there was no indication of state policy to permit medical societies to engage in anticompetitive activities in carrying out their responsibilities); Quinn v. Kent General Hospital, Inc., C.A. No. 84-509 (D. Del. Aug. 16, 1985) (hospital requirement that staff members reside within reasonable distance of hospital not protected by state action immunity based on state policy favoring hospital peer review, because there was no evidence that state intended peer review to restrain competition among physicians, and peer review may be procompetitive).

meet established standards of professional competence.⁹ These requirements cannot fairly be read as authorizing anticompetitive discrimination against osteopathic physicians, who are fully licensed physicians under state law. Ind. Code Ann. §§ 25-22.5-1-1.1(g), 25-22.5-3-1 (Burns Supp. 1985) On the contrary, the Indiana statute relied on by the district court requires public and county hospitals to establish reasonable criteria for staff membership that do not discriminate against osteopathic physicians. Ind. Code Ann. § 16-12.1-5-1 (Burns Supp. 1985). Although this law apparently does not apply to the defendant hospital in this case, it reflects a state policy to

⁹ The district court relied on Ind. Code Ann. § 16-12.1-5-1 (Burns Supp. 1985) to establish a state policy to displace competition in the awarding of hospital privileges. That section of law is part of the Indiana County Hospital Law, Ind. Code Ann. § 16-12.1-1-1 et seq. (Burns 1982), and would not appear to apply to the defendant hospital, which is a private nonprofit entity. However, Ind. Code Ann. § 16-10-1-6.5(a) (Burns Supp. 1985), which applies to all licensed hospitals, imposes similar responsibilities on the hospital:

The governing board of the hospital shall be the supreme authority in the hospital, responsible for:

- (2) The appointment and reappointment of the members of the medical staff, and the assignment of privileges to members of the medical staff, with the advice and recommendations of the medical staff, consistent with their individual training, experience, and other qualifications; and
- (3) Establishing requirements for initial and subsequent appointments to and continued service on the hospital's medical staff, consistent with the appointee's individual training, experience, and other qualifications, including such requirements as:
 - (A) The submission of proof that a medical staff member has qualified as a health care provider under IC 16-9.5;
 - (B) The performance of patient care and related duties in a manner that is not disruptive to the delivery of quality medical care in the hospital setting; and
 - (C) Standards of quality medical care which recognize the efficient and effective utilization of hospital resources, as developed by the medical staff.

encourage free competition among allopathic and osteopathic physicians. Thus, the only direct evidence on the state's policy toward osteopathic physicians points away from an intention to sanction the type of categorical exclusion of surgeons with osteopathic training that allegedly occurred here.

The Marrese court identified a state policy to displace competition based on Indiana statutes contemplating that hospitals and their medical staffs would review the quality of care rendered by physicians practicing in hospitals. 748 F.2d at 387-89.¹⁰ Like the statutory provisions requiring hospital standards for medical staff membership, the statutes relating to peer review reflect an overall state policy to assure patients of high quality health care services. But the statutes do not require, authorize, or contemplate abuse of the peer review process in order to further the competitive interests of some staff physicians, and they cannot provide a basis for finding state action immunity for any action by a peer review committee, no matter how anticompetitive.

In deciding whether a state has articulated an anticompetitive policy, the Supreme Court has recognized that "all economic regulation does not necessarily suppress competition." Cantor v. Detroit Edison Co., 428 U.S. 579, 595 (1976); City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 425 (1978) (Burger, J. concurring). This is particularly true of health and safety regulations, in which states establish minimum standards of competence or performance because consumers may lack the ability to evaluate quality themselves. Physician and hospital licensure regulations, for example, establish minimum standards of performance that define the

¹⁰ According to Marrese, Indiana law requires medical staffs to review the quality of care rendered in hospitals, Ind. Code Ann. § 16-10-1-6.5 (Burns Supp. 1985), and defines the composition of peer review committees. Ind. Code Ann. § 34-4-12.6-1 (Burns Supp. 1985).

permissible boundaries of hospital and physician competition. But neither this kind of regulation nor requirements that hospitals review the qualifications or practices of staff physicians reflects a state intent to eliminate price, quality, or service competition among physicians or among hospitals. Nor do the statutes reflect a state intent to give hospitals and physicians authority to impose additional restraints on competition beyond those specifically established by state law.

B. Indiana Law Does Not Evidence An Intent To Displace Competition Because Hospitals' Review Of The Qualifications Of Staff Members Can Promote Competition.

State law does not conflict with market forces when it permits hospitals to limit privileges to high-quality or efficient practitioners. Hospital decisions to revoke or deny physician staff privileges are not necessarily anticompetitive. Withholding privileges from individual physicians excludes them from hospital facilities and may, in certain cases, make it impossible for some practitioners to practice their profession. But in most cases such decisions do not impair market competition and do not violate the antitrust laws. Competition does not require that staff membership be granted to all applicants; it requires, instead, that a hospital select the staff that best furthers its competitive objectives.¹¹

¹¹ Thus, the grant of power to deny privileges in this case does not mean that the state "contemplated" the anticompetitive effects alleged by the plaintiffs. In *Town of Hallie v. City of Eau Claire*, 105 S. Ct. 1713, 1718-19 (1985), the Supreme Court held that a state law authorizing cities to refuse to offer sewage treatment services to unannexed areas contemplated the anticompetitive actions challenged in that case because these actions were a logical and foreseeable result of the explicit statutory authorization. However, the relevant statutes in *Hallie* were found to evidence a clear "state policy to displace competition with regulation in the area of municipal provision of sewerage services." 105 S. Ct. at 1719. Furthermore, citing an opinion of the state's highest court, the Supreme Court concluded in *Hallie* that the state legislature had clearly intended the very type of action complained of by the *Hallie* plaintiff --

footnote (cont)

Quality and price are important aspects of the health care delivery market. The quality of hospitals' professional personnel and the efficiency of their operations are important factors in competition among hospitals for attending staff and for patients. Therefore, a hospital behaving competitively will respond to market forces in determining the numbers, types, and qualifications of professionals who are permitted to use the hospital's facilities. Physicians, likewise, compete with one another for appointment to hospital medical staffs and for patients. Hospitals stimulate price and quality competition by selecting certain physicians in preference to others. Moreover, hospitals' decisions concerning privileges provide consumers, who may not be able to make such judgments themselves, with information about the perceived qualifications of practitioners that might otherwise be unavailable to them. See Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir.), cert. denied, 459 U.S. 971 (1982); Burnham Hospital, 101 F.T.C. 991 (1983) (advisory opinion); Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 Duke L.J. 1971.

While most decisions concerning privileges legitimately further the business and competitive interests of the hospital, some may be designed to protect medical staff members from unwanted competition. Current medical staff members may be competitors of applicants for privileges, and there is a danger that, in some cases, physicians will attempt to use their influence in the privilege granting process to protect themselves from unwanted

the requirement that surrounding unincorporated areas accept annexation as a quid pro quo. 105 S. Ct. at 1719 n.8. In contrast, the Indiana statutory scheme manifests no intent to displace either competitive market forces or the antitrust laws with a statutory scheme in the area of hospital privileges. Instead, by permitting hospitals to use procedures and standards for denying privileges, the state has reinforced existing market forces.

competition, with resulting harm to consumers. For example, staff physicians might try to deter physicians from charging lower than prevailing fees or from joining an alternative health care delivery system, such as a health maintenance organization or preferred provider organization, by excluding them from the hospital. See, e.g., Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order). In at least one instance, allopathic physicians were found to have excluded osteopathic physicians from a hospital without reasonable justification. See Weiss v. York Hospital, 745 F.2d 786 (3d Cir. 1984), cert. denied, 105 S. Ct. 1777 (1985).

The defendants have not shown that Indiana intended to displace competition in the granting of hospital privileges or that Indiana contemplated that hospitals and medical staffs would impose requirements for staff membership designed to protect staff members from competition, as allegedly occurred here. Therefore, it has not been shown that defendant's actions implemented a clearly articulated state policy to displace competition.¹²

¹² In the absence of such a state policy, Indiana's grant of immunity from civil liability to hospitals and members of peer review committees in certain circumstances does not provide immunity from federal antitrust claims. Moreover, it is doubtful that those statutes immunize the conduct challenged in this case even against liability under state law. Immunity is limited to actions relating to disciplinary actions and investigations (Ind. Code Ann. § 16-10-1-6.5(b) (Burns Supp. 1985)), retrospective "medical review" of the quality of care provided at a hospital (§ 16-10-1-6.5(c) & (d) (Burns Supp. 1985)), and evaluation of patient care by a peer review committee (§ 34-4-12.6-3(a) & (c) (Burns Supp. 1985)). Since, according to the amended complaint, plaintiffs' applications for privileges were automatically denied for reasons unrelated to quality of care and without consideration of the quality of care they provided, the challenged conduct appears not to fall within the scope of any of these immunity provisions.

C. Application Of The Federal Antitrust Laws To Hospital Privilege Decisions Will Not Prevent Accomplishment Of The State's Policy Favoring High Quality Medical Care.

The district court held that hospitals must be granted immunity from antitrust suits arising out of their decisions on hospital privilege applications in order to protect their ability to maintain a highly qualified staff of physicians. The court asserted that subjecting hospital privilege decisions to antitrust scrutiny would "seriously jeopardize" the likelihood that a hospital would terminate a physician's privileges when that action was required to protect the public. The Marrese court, likewise, held that subjecting peer review decisions to the antitrust laws would make it impossible for hospitals to implement peer review procedures and to provide patients with a competent medical staff. 748 F.2d at 393-94.

These fears about the effects of antitrust enforcement are inconsistent with the basic premise of the antitrust laws that competition leads to better quality services as well as lower prices. United States v. National Society of Professional Engineers, 435 U.S. 679, 695 (1978). In fact, the lack of state action immunity for anticompetitive hospital privilege decisions will not prevent hospitals from conscientiously reviewing the credentials of applicants for staff privileges or from enforcing high standards of quality for medical staff members. Hospitals have compelling reasons that do not endanger competition for making careful decisions about hospital privileges, including market demands for high quality care, the threat of malpractice liability, and the requirements of state licensure and private accrediting bodies. Furthermore, in most cases challenging privileges decisions, the courts have found that the antitrust laws were not violated, and some cases have been decided on summary judgment, sparing the defendants a long trial. E.g., Williams v. Kleaveland, 1983-2 Trade Cas. (CCH) ¶ 65,486 (W.D. Mich.

1983); Stone v. William Beaumont Hospital, 1983-2 Trade Cas. (CCH) ¶ 65,681 (E.D. Mich. 1983); Pontius v. Children's Hospital, 552 F. Supp. 1352 (W.D. Pa. 1982). As the Supreme Court emphasized in the Cantor opinion, the absence of a state action exemption from the antitrust laws "does not mean that those laws have been violated." 428 U.S. at 598 n.38.

The antitrust laws are not inconsistent with Indiana's interest in assuring high quality care. It is unnecessary to bar all antitrust claims arising from hospital privilege decisions in order to protect hospitals' ability to be selective in their staff appointments. Applicability of the antitrust laws to hospital privilege decisions is, however, necessary to safeguard competition among health practitioners, because in some instances those decisions can impair competition in ways that are far beyond the purpose of state policy.

II. IT HAS NOT BEEN DEMONSTRATED THAT INDIANA ACTIVELY SUPERVISES THE CHALLENGED CONDUCT

Even if the conduct challenged in this case were shown to be undertaken pursuant to a clearly articulated and affirmatively expressed state policy to displace competition, state action immunity would not be established. It is also necessary that defendants' implementation of the state policy be "actively supervised" by the state. Midcal, 445 U.S. at 105-06. The supervision requirement for immunity with respect to private parties reflects the concern that federal policy in favor of competition not be subordinated to state policy disfavoring competition except where the "state has demonstrated its commitment to a program [to displace competition] through its exercise of regulatory oversight." Southern Motor Carriers, 105 S. Ct. at 1729 n.23,

quoting 1 P. Areeda & D. Turner, Antitrust. Law ¶ 213a (1978).¹³ Such oversight is necessary to ensure that private parties do not abuse whatever discretion they have in implementing state policy, so that competition is not displaced when it furthers only private, not public, interests. Town of Hallie v. City of Eau Claire, 105 S. Ct. 1713, 1720-21 (1985). The district court erred in holding that private hospital privilege decisions such as those challenged in this case are subject to such active state supervision in Indiana.

The district court found, with no explanation other than a reference to Marrese, that hospital privilege decisions are "closely supervised by the state." (App. at 22-23.) The Marrese court based its finding of "active state supervision" on the general regulatory powers of state agencies over hospitals and physicians, including the power to enact rules and regulations to ensure high quality patient care. Marrese, 748 F.2d at 389-91. With respect to hospital privileges decisions in particular, the court in Marrese pointed out that state agencies are informed of disciplinary actions involving a physician's hospital privileges and are authorized to examine confidential hospital records relating to, among other things, privilege decisions.¹⁴

¹³ In Southern Motor Carriers, where a state agency established the prices to be charged by common carriers, the adequacy of state supervision was conceded by the Government. In Midcal, the state's involvement in private resale price maintenance was insufficient for immunity because there was no regulatory oversight of the prices or other terms of fair trade contracts, and the state did not follow market conditions to determine whether "pointed reexamination" of its resale price maintenance program was warranted. 445 U.S. at 105-06. See also Goldfarb v. Virginia State Bar, 421 U.S. 773, 791 (1975) (state action immunity denied in part because no evidence the State Supreme Court approved the challenged activity); North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc., 740 F.2d 274 (4th Cir. 1984), cert. denied, 105 S. Ct. 1865 (1985) (state approval of merger does not immunize it when state does not oversee post-merger operation of business).

¹⁴ Ind. Code Ann. § 34-4-12.6-2(b) (Burns Supp. 1985) also permits (but does not require) peer review committees to provide otherwise confidential information about a physician or hospital to an appropriate state

footnote (cont)

The statutes and regulations cited in Marrese are inadequate to constitute "active state supervision" of the conduct challenged either in that case or this one. No state agency has established regulatory criteria determining what constitutes proper or improper grounds for a hospital's denial of an application for hospital privileges. No state agency is empowered to reverse anticompetitive denials of, or policies relating to, hospital privileges that are contrary to the public interest or state policy, or to discipline the responsible hospitals or physicians.¹⁵ It has not been shown that the state regularly reviews hospital privileges decisions; the record is silent as to whether the state was ever informed of the privilege denial at issue in this proceeding. Indeed, the district court, in its discussion of other issues, emphasized how minimal the state's supervision over privileges decisions of private hospitals is:

The State of Indiana's regulatory scheme . . . for privately owned and operated hospitals does not include state standards for judging the medical competency of individuals applying for hospital staff privileges. The statutory requirement of a medical peer review panel does not place the State of Indiana into a position of participating, regulating or reviewing a hospital's staff privilege decisions.

(App. at 26-27, emphasis supplied, citations omitted.)¹⁶

licensure agency if the committee believes the agency should take disciplinary action against the physician or hospital.

¹⁵ A hospital's license can be suspended or revoked if its actions are "detrimental to the welfare of patients" or if it fails to meet minimum health and safety standards. See Ind. Code Ann. §§ 16-10-1-9(e) & -10(c) (Burns 1983). It is highly unlikely that a hospital's anticompetitive privilege decisions would justify disciplinary action under these standards.

¹⁶ In *Quinn v. Kent General Hospital, Inc.*, C.A. No. 84-509 (D. Del. Aug. 16, 1985), the court held that a law authorizing the state Board of Health to issue rules and regulations governing hospitals, but that did not require or authorize any state agency to review decisions of peer review committees or hospitals' refusals to grant hospital privileges, fell "far short of the active state supervision required" for state action immunity for hospital privileges decisions.

Similarly, the decision of the peer review committee challenged in Marrese was not actively supervised by the state. While Indiana agencies are informed of disciplinary actions and are entitled to examine the records of peer review committees, there is no indication that the agencies have the authority to prevent anticompetitive abuse of the peer review process.

It has not been shown that Indiana exercises the kind of "regulatory oversight" of hospital privilege decisions that would provide a regulatory substitute for state-displaced competition as is required by Supreme Court decisions. A state cannot displace the federal antitrust laws merely by authorizing private parties to engage in anticompetitive conduct. Parker v. Brown, 317 U.S. 341, 351 (1943). Instead, the state must establish regulatory procedures to ensure that private conduct in fact carries out state policy. Indiana has not done so with respect to hospital privilege decisions.

CONCLUSION

For the reasons presented above, this court should reverse the district court's dismissal of the antitrust counts (Counts IV and V) of plaintiffs' amended complaint, and remand this case to the district court for further proceedings.

Respectfully submitted,

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