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Determining the Immunity Measuring Stick: The Impact of the Health Care Quality Improvement Act and Antitrust Laws on Immunity Aspects of Granting Privileges to Physician Assistants

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DETERMINING THE IMMUNITY "MEASURING STICK": THE IMPACT OF THE HEALTH CARE QUALITY IMPROVEMENT ACT AND ANTITRUST LAWS ON IMMUNITY ASPECTS OF GRANTING PRIVILEGES TO PHYSICIAN ASSISTANTS

I. INTRODUCTION 115
II. GENERAL OVERVIEW OF ANTITRUST ISSUES CONCERNING NON-PHYSICIAN PROVIDERS 117
  A. *Health Care and Antitrust* 117
  B. *The Health Care Quality Improvement Act of 1986* 118
  C. *Antitrust* 122
  D. *Antitrust Implications for Non-Physician Providers* ... 124
    1. Peer Review and Staff Privileges 125
    2. Non-Physician Providers Case Analysis 126
      a. *Nurse Midwife Case Analysis*........................ 127
        i. *Nurse Midwifery Associates v. Hibbett* 127
        ii. *Sweeney v. Athens Regional Medical Center*....................................... 129
      b. *Nurse Anesthetists Case Analysis: Oltz v. St. Peter's Community Hospital* 132
III. PHYSICIAN ASSISTANTS AND ANTITRUST: IMPLICATIONS OF CASE COMPARISONS AND RELEVANT HEALTH CARE LEGISLATION 134
IV. CONCLUSIONS 139

I. INTRODUCTION

Antitrust is an ominous field of study. Many legislative enactments, such as the Sherman Act[1] and the Clayton Act,[2] have shaped the scope and purpose of antitrust law, setting boundaries for the various businesses that affect the public. The health care industry is constantly evolving in patient treatment and assessment, genetic research, and management and interaction of existing and emerging health care disciplines within health care facilities. As a result of the evolution of health care, so too must the laws evolve to meet these changing needs.

Many antitrust laws have been enacted since the Sherman Act of 1890.[3] As a response to societal requirements, each antitrust statute either broadly encompasses business transactions or narrowly focuses on a particular industry. This note

[1] 15 U.S.C. §§ 1-7 (1997).

[2] 15 U.S.C. §§ 12-27, 44 (1997).

[3] II ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS 1256 (4th ed. 1997).

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examines the antitrust developments that affect the health care industry; the Health Care Quality Improvement Act of 1986[4] (hereinafter "HCQIA"); the treatment of peer review process immunity for physicians as it now exists; how non-physician providers are dealt with in the peer review process; and where physician assistants fit into the whole scheme.

Part I of this note lays a foundation of antitrust principles, briefly explaining the applicable portions of the Sherman Act. Next, the note sets forth the approaches, rule of reason versus per se rule,[5] that courts utilize when dealing with antitrust situations. After explaining these governing principles[6] and citing examples, the note provides a brief history regarding health care, and antitrust strategies and approaches utilized by legal professionals in the health care area.

Part I continues by setting forth the Health Care Quality Improvement Act of 1986, its purposes and goals, and practical applications to alleged antitrust violations. It also explores the limitations of the HCQIA, especially with respect to non-physician providers. Once the HCQIA foundation is in place, the note specifically speaks to typical contexts in which antitrust violations arise regarding non-physician providers, such as staff privileges granted through the peer review process.

This note then reviews several cases to allow the reader a view into how non-physician antitrust suits are handled in the court system, and to provide insight as to how physician assistants may be handled once that profession reaches for the protection of the antitrust statutes. In part II of this note, a profile is constructed on physician assistants as a group, in order to lay a foundation regarding the impact they have on health care services. Implications of case comparisons and relevant health care legislation are also examined.

Part III concludes that physician assistants should be addressed separately from other non-physician providers by including physician assistants in the HCQIA, as a "measuring stick" from which courts can take their cues.

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[4]42 U.S.C. §§ 11101-11152 (1997).

[5]Gayle Reindl, Note, *Denying Hospital Privileges to Non-Physicians: Does the Quality of Care Justify Potential Restraint of Trade?*, 19 IND. L. REV. 1219, 1220-21 (1986). Using the rule of reason approach, a court analyzes the challenged conduct in great detail, looks to the specific market, and weighs the procompetitive effects against the anticompetitive effects. As a result of applying this rule of reason analysis to numerous antitrust actions, courts recognized certain practices that were repeatedly found to be anticompetitive in various contexts; therefore, these certain trade restrictions are considered per se illegal. *See* Northern Pac. Ry. Co v. United States, 356 U.S. 1, 5 (1958) (explaining that division of markets, group boycotts, tying arrangements, and price fixing are per se offenses).

[6]Governing principles as set forth in case precedent focus on a results-oriented approach of handling these difficult types of antitrust violations. With respect to the end result regarding antitrust injury, the Court in *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc*., 429 U.S. 477, 489 (1977), stated:

> Plaintiffs must prove antitrust injury, which is to say injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful. The injury should reflect the anticompetitive effect . . . of the violation or of anticompetitive acts made possible by the violation. It should, in short, be 'the type of loss that the claimed violations . . . would be likely to cause.'
> (quoting Zenith Radio Corp. v. Hazeltine Research, Inc., 395 U.S. 100, 125 (1969)).

II. General Overview of Antitrust Issues Concerning Non-Physician Providers

During the past two decades non-physician providers have brought the various antitrust ramifications of practicing in the medical community to the minds of the public. Nurse practitioners, podiatrists, chiropractors, nurse midwives, nurse anesthetists, and other non-physician providers have alleged Sherman Act violations, with specific emphasis on restraint of trade, concerted refusals to deal, and group boycotts. For example, a group boycott occurs when physicians who sit on hospital peer review boards deny hospital staff privileges to a group of physician assistants in a particular geographical area as a means to eliminate competition. As a result of anticompetitive conduct, the occurrence of these antitrust suits will continue to increase as the services provided by these non-physicians also increase.

Physician assistants are a group of non-physicians that have emerged as a likely candidate for antitrust issues due to their tandem work with physicians and because physician assistants have grown as a non-physician provider group and because these providers work in tandem with physicians.[7] While no judicial precedent has been set for these providers and their future in the health care arena, the probability of antitrust claims regarding violations will increase as their numbers rise.

A. Health Care and Antitrust

Beginning with *Goldfarb v. Virginia State Bar*,[8] which held that "learned professions" were not exempt from antitrust laws, the Supreme Court has held that antitrust liability laws apply to the health care industry.[9] After the decision in *Goldfarb*, physicians who had been excluded from hospital medical staffs have used antitrust laws as "their weapon of choice."[10] On many occasions the Court has opined that health care providers' activities do, in fact, affect interstate commerce, and are reachable by antitrust laws.[11]

Both individuals and organizational health care providers have engaged in joint ventures, mergers, and other collaborative activities to adapt to the rapidly changing face of the healthcare marketplace.[12] An example of a joint venture is a cancer research center funded and operated by a cancer research hospital and a medical university, which are independent entities, but that join forces to form a separate

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[7]Lou Falligant, *Physician Assistants (PAs) Provide Quality Care*, WIS. MED. J. June 1997, at 13.

[8]421 U.S. 773 (1975).

[9]II ABA SECTION OF ANTITRUST LAW, *supra* note 3

[10]Kurt Erskine, Comment, *Square Pegs and Round Holes: Antitrust Law and Privileging Decision*, 44 U. KAN. L. REV. 399, 403 (1996). Note that during the five-year period after the *Goldfarb* decision, almost five times as many health care antitrust actions were brought than were brought in the eighty-five years since the Sherman Act was enacted. *Id.* at 403-404.

[11]ABA SECTION OF ANTITRUST LAW, *supra* note 3, at 1256. *See*, *e.g.*, Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 348-49 (1982)(explaining that rules are set forth through the enactment of the Sherman Act regarding price-fixing agreements as they pertain to all industries).

[12]ABA SECTION OF ANTITRUST LAW, *supra* note 3, at 1256.

company for a specific purpose, in this example, cancer research. An example of a merger is the situation in which two groups of physicians merge the assets of both independent entities to form one entity—the former independent entities cease to exist.

Another example of a collaborative activity is when an insurance company, which contracts with hospitals regarding medical insurance coverage, purchases a hospital. Although these alliances provide efficient and cost effective services, they are also exposed to antitrust allegations of group boycotts, market division, restraint of trade and other traditional antitrust concerns.[13]

From the defendant's perspective, the type of defense available sets the "measuring stick" for handling future antitrust actions. Typically, as in *Crosby v. Hospital Authority of Valdosta and Lowndes County*,[14] the centerpiece of the antitrust analysis regarding physicians denied privileges or having privileges terminated is the defense of immunity. The immunity defense can take three different forms: [1] state action immunity under *Parker v. Brown*;[15] [2] immunity under the Local Government Antitrust Act;[16] and [3] immunity under the Health Care Quality Improvement Act.[17] As discussed later, immunity defenses impact the outcome of the antitrust allegations by either defending challenged conduct or by failing to provide a reasonable explanation for the challenged conduct.

B. The Health Care Quality Improvement Act of 1986

In 1986, in response to the "medical malpractice crisis" that allegedly dealt a severe blow to the medical community,[18] Congress enacted the Health Care Quality

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[13]ABA SECTION OF ANTITRUST LAW, *supra* note 3. In 1996, the Federal Trade Commission and the Department of Justice issued the *1996 Health Care Statements*. These nine statements are guidelines for the various activities that are prevalent in the health care industry: [1] hospital mergers; [2] joint ventures involving high-tech health care equipment and hospitals; [3] joint ventures between expensive specialized health care services and hospitals; [4] "providers collective provision of fee-related information to purchasers of health care services"; [5] "providers collective provision of non-fee related information to purchasers of health care services"; [6] health care provider participation in information exchanges on price and cost; [7] collaborative purchasing arrangements among health care providers; [8] joint ventures involving physician networks; and [9] networks involving multiproviders. *Id.*

[14]873 F. Supp. 1568 (M.D. Ga. 1995).

[15]317 U.S. 341 (1943). *See Crosby*, 873 F. Supp. at 1573. "The Parker doctrine exempts only anticompetitive conduct engaged in as an act of government by the State as sovereign, or, by its subdivisions, pursuant to state policy to displace competition with regulation or monopoly public service." *Id.* at 1574 (citing City of Lafayette v. Louisiana Power and Light Co., 435 U.S. 389, 409 (1978)).

[16]15 U.S.C. § 34(1)-(2)(1994). *See Crosby*, 873 F. Supp. at 1581. With the Local Government Antitrust Act (LGAA), a defendant, first, must be a "local government" or a "person" as those term are defined in the statute. Then, second, the defendant, either a "person" or "local government," must cross claim on the basis that the action was taken in an official capacity. *Id.*

[17]The Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1997).

[18]Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J.L. & MED. 453, 457 (1990).

Improvement Act (hereinafter "HCQIA"). The HCQIA was derived from various bills that addressed several factors, including unrealistic public expectations of health care services, high medical malpractice insurance rates, expanded tort liability, and physicians' overestimation of expected results in patient assessment and treatment.[19]

The underpinning of the HCQIA is to provide a greater incentive for professional review bodies[20] to engage in effective professional peer review of the quality of service provided by a physician, thus preventing incompetent physicians from locating to different geographical areas without disclosing their previous acts of damaging or incompetent performance.[21] Additionally, another main objective set forth in the HCQIA is providing a limited form of immunity to these physicians on peer review boards to objectively evaluate physician qualifications without fear of antitrust allegations resulted in the implementation of a plan for reporting and collecting information regarding the actions taken against physicians.[22]

The HCQIA has been hailed by some healthcare providers as providing shelter to hospitals where there previously was little protection.[23] The immunity aspect included in the HCQIA, however, has left peer review boards[24] with more exposure

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[19]*Id.* at 457-58.

[20]42 U.S.C. § 11151(11) (1997). HCQIA defines "professional review body" to mean a health care entity and the body or committee which governs the health care entity, which conducts the professional review process, including any committee of the medical staff of the health care entity. *Id.*

[21]Scott M. Smith, Annotation, *Construction and Application of Health Care Quality Improvement Act of 1986 (42 U.S.C.A. §§ 11101-11152)*, 121 A.L.R. FED. 255, 264 (1994). Hospitals are required to obtain information from the Secretary of Health and Human Services whenever a physician submits for privileges, and every two years for those physicians who have privileges at that hospital. *Id.*

[22]*Id.* at 263-64.

[23]Erskine, *supra* note 10, at 415. *See, e.g.*, Austin v. McNamara, 731 F. Supp. 934 (C.D. Cal. 1990).

[24]The HCQIA defines the various terms used in the statute in the following manner.

> In this title: (1) The term "adversely affecting" includes reducing restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity. (2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body. (3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity. (4)(A) The term "health care entity" means—(i) a hospital that is licensed to provide health care services by the State in which it is located, (ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and (iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follow a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary). (4)(B) The term "health care entity" does not include a professional society (or committee thereof) if, within the previous 5 years, the society

than originally intended. Section 11101 of the HCQIA, which sets forth the findings of Congress, has a narrow scope that only includes "a national need to restrict the ability of incompetent physicians . . . ."[25]

From this section it can be construed that Congress determined that the responsibility for the medical malpractice crisis lay only at the feet of incompetent physicians.[26] Because Congress intended to encourage physician participation in effective professional peer review processes,[27] it granted immunity from antitrust

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> has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

42 U.S.C. § 11151 (1997).

[25]42 U.S.C. § 11101(1)-(2). Section 11101 contains the following congressional findings: (1) The increasing occurrence of medical 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. (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. *Id. See also*, Susan O. Scheutzow and Sylvia Lynn Gillis, *Confidentiality and Privilege of Peer Review Information: More Imagined Than Real*, 7 J.L. & HEALTH 169, 175-79 (1992-1993).

[26]The HCQIA defines various terms used in the statute in the following manner:

> (5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act. (6) The term "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services . . . (8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or an individual who, without authority holds himself or herself out to be so authorized). (9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to professional review action . . . . (11) the term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assessing the governing body in a professional review activity.

42 U.S.C. § 11151 (1997).

[27]§ 11101(3)-(5).

> (3) This nationwide problem can be remedied through effective professional peer review. (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. (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

actions for physicians who participate on peer review boards. But Congress did not formally address the question of why non-physician providers were excluded from the HCQIA. The granting of immunity requires that standards for professional review actions are complied with by review boards; otherwise, immunity will not shield physicians from liability.[28]

Section 11112 of the HCQIA outlines the standards for professional review actions[29] and specifies the responsibilities of the professional review board.[30] The HCQIA speaks of physicians, as members of a peer review board, being immune from antitrust actions brought by physicians denied hospital staffing privileges. Thus, this immunity appears not to apply when a non-physician provider brings allegations of antitrust violations against physicians on professional review boards.

Section 11115(c), states that nothing in the statute "shall be construed as affecting or modifying any Federal or State law, with respect to activities of professional review bodies regarding nurses, other licensed health care practitioners, or other health professionals who are not physicians."[31] Commentators have remarked that the exclusion of the non-physician providers was a major political compromise in enacting the HCQIA.[32] Further, it is arguable that incompetence among non-physician providers may well be higher in incidence because of the limited educational and professional training as compared to physicians.[33]

Prior to the HCQIA and the immunity provision, physicians participating on professional peer review boards had the threat of private money damage liability, and although this act grants immunity, it is limited. *Id.*

[28]Smith, *supra* note 21, at 265. *See, e.g.*, Decker v. IHC Hosp., Inc., 982 F.2d 433 (10th Cir. 1992)(HCQIA establishes immunity only from liability, not from suit); Hancock v. Blue Cross-Blue Shield, 21 F.3d 373 (10th Cir. 1994).

[29]Smith, *supra* note 21, at 264.

> [A] professional review action must be taken (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the manner, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) [42 U.S.C. § 11111(a)] unless the presumption is rebutted by a preponderance of the evidence.

§ 11112(a)(1)-(4).

[30]*Id.*

[31]42 U.S.C. § 11115(c) (1997). The full text of this subsection reads: "(c) Treatment of nurses and other practitioners. Nothing in this title [42 U.S.C. §§ 11111 et seq.] shall be construed as affecting, or modifying any provision of Federal or State law, with respect to activities of professional review bodies regarding nurses, or other licensed health care practitioners, or other health professionals who are not physicians." *Id.*

[32]Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 738 (1991).

[33]*Id.* The Health Care Quality Improvement Act allows permissive reporting of actions taken against non-physician providers, but this is not a mandatory requirement.

It is also arguable that the limited medical training corresponds to the more limited duties and discretion that non-physician providers have in providing services. Yet, physician assistants receive their training in accredited programs that matriculate anywhere from twelve months to forty-two months, depending on the state.[34] This type of training program leads many physician assistants to have a limited autonomy with their physician "counterparts," and in certain cases the physician assistants' duties are not limited but enhanced. The reasoning behind the exclusion of non-physician providers from the HCQIA is open to debate. Given the fact that their inclusion was specifically considered and rejected, however, it is fair to presume that their exclusion was intentional and not due to oversight on the part of Congress.

C. Antitrust

The Sherman Act of 1890[35] sets forth the basis for determining when an action constitutes an antitrust violation. Specifically, Section One of the Sherman Act has been the basis for many antitrust suits brought regarding the health care industry. In the most pertinent part of the Act, Section 1 provides:

> Every contract, combination in the form of a trust, or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony and, on conviction, thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments in the discretion of the court.[36]

In the health care industry section one covers restraint of trade situations, such as a non-physician provider being denied access to hospital privileges due to a combination, contract or conspiracy of another group (e.g., a peer review board).[37]

Courts use two approaches in determining Sherman Act violations: one, the "rule of reason"[38] and two, the "per se" rule.[39] Under the rule of reason, courts examine the challenged conduct to determine whether the restraint merely regulates and thus promotes competition, or whether it suppresses or destroys competition.[40] Under the

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[34]TERENCE J. SACKS, OPPORTUNITIES IN PHYSICIAN ASSISTANT CAREERS, 122-37 (1995).

[35]26 Stat. 209 (1890)(codified at 15 U.S.C. §§ 1-7).

[36]The Sherman Act of 1890, 15 U.S.C. §§ 1-7 (1997).

[37]*See* Nurse Midwifery Associates v. Hibbett, 918 F.2d 605 (6th Cir. 1990).

[38]Although the statute reads "every contract . . .," the Supreme Court held *in Standard Oil Co. v. United States*, 221 U.S. 1 (1911), that section one should be interpreted to prohibit only those contracts, combinations, and conspiracies that unreasonably restrain trade. ANTITRUST ADVISOR 7 (Carla Anderson Hills ed., 3rd ed. 1985).

[39]*Id.*

[40]I ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS 52 (4th ed. 1997). In *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918), the framework of the rule of reason was articulated by Justice Brandeis :

rule of reason, the plaintiff has the burden to prove that the conduct is likely to have an adverse effect on competition, while the defendant must show the procompetitive objectives.[41] Finally, the trier of fact must determine whether the procompetitive aspects outweigh the anticompetitive effects of the restraint.[42] Thus many courts now have eliminated their in-depth analyses of the challenged conduct that has already been decided in court, and instead have limited the application of the per se rule to categories that require no further in-depth analysis in determining that the nature and effect of the conduct are obviously anticompetitive.[43]

The second analytical approach under section one of the Sherman Act, the "per se" rule,[44] addresses violations that are so obviously anticompetitive that they are considered illegal without further examination into the reasons for their existence.[45] Because of the emphasis placed on economics as a viable part of the analysis for per se violations, the per se doctrine has lost much of the momentum it gained early in its history.[46]

The determination of labeling an activity per se illegal depends upon the nature of the restraint.[47] Due to the diverse business practices and the new business developments that constantly emerge onto the business scene, courts are having a harder time designating an activity as illegal per se. Courts have determined that lengthy explorations into the questionable activity along with market factors and practices that surround the activity are not a viable approach.[48] As a result of the movement away from the per se rule, many lower courts have been uncertain as to which rule to use in their analysis of cases.

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting that particular remedy, the purpose or end sought to be attained, are all relevant facts.

[41]ABA SECTION OF ANTITRUST LAW, *supra* note 40, at 53. *See, e.g.*, Higgins v. Med. College, 849 F. Supp. 1113, 1121-1122 (E.D. Va. 1994); Hassan v. Indep. Practice Assoc., 689 F. Supp. 679, 690 (E.D. Mich. 1988).

[42]ABA SECTION OF ANTITRUST LAW, *supra* note 40, at 53.

[43]ABA SECTION OF ANTITRUST LAW, *supra* note 40, at 45. *See, e.g*., Arizona v. Maricopa County Med Soc'y, 457 U.S. 332, 344 (1982).

[44]ANTITRUST ADVISOR 7 (3rd ed. 1985).

[45]*Id. See also*, National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 692 (1978); Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

[46]ANTITRUST ADVISOR 1-2 (3rd ed. 1985 and Supp. 1993). *See* Business Electronics Corp. v. Sharp Electronics Corp., 485 U.S. 717 (1988).

[47]ABA SECTION OF ANTITRUST LAW, *supra* note 40, at 44.

[48]*Id.* at 44-45. *See also*, FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 458-59 (1986) ("[W]e have been slow . . . to extend per se analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious.").

In 1984, the Supreme Court modified the rule of reason's interpretation to a "quick look" approach.[49] Under this "quick look" rule of reason approach, the plaintiff does not bear the initial burden of the restraint's anticompetitive effects because the challenged behavior is presumed to be anticompetitive.[50] Instead, the defendant has the burden to prove that there existed procompetitive defenses for the restraining conduct.[51] If the defendant is unsuccessful in proving such justification, then the restraint is judged to be illegal without further examination.[52]

For example in 1985, a United States District Court noted that the distinction between the rule of reason and the per se rule has never been completely clear.[53] Further, the court indicated that factors such as market power and the probable effects of the alleged restraint on competition must be considered as part of a truncated rule of reason analysis before deciding to apply the per se rule.[54] In summary, courts are still trying to maintain two categories of approaches to use, otherwise, all cases would require in-depth analysis.[55] The movement towards the rule of reason is obvious. This approach is workable in more situations at the center of antitrust violations, whereas per se analysis requires the restraint to be conclusively presumed unreasonable.[56]

D. Antitrust Implications for Non-Physician Providers

Antitrust problems are nowhere more prevalent than in the area of granting staff privileges at hospitals or clinics. The crux of this type of antitrust case is the hospital's or clinic staff's decision to deny privileges to the non-physician provider.[57] The contexts in which staff privilege antitrust suits arise include, (1) the denial of initial privileges to the clinic or hospital, (2) the refusal to renew the provider's

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[49] *Id. See* NCAA v. Board of Regents of Univ. of Okla., 468 U.S. 85, 104 (1984) ("But whether the ultimate finding is the product of presumption or actual market analysis, the essential inquiry remains the same—whether or not the challenged restraint enhances competition.").

[50] ABA SECTION OF ANTITRUST LAW, *supra* note 40, at 53.

[51] *Id.*

[52] *Id. See, e.g.,* United States Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 596 (1st Cir. 1993) (explaining that absent a showing of anticompetitive effect, it is unnecessary to analyze motives or procompetitive benefits of allegedly anticompetitive conduct).

[53] Quinn v. Kent Gen. Hosp., 617 F. Supp. 1226, 1244 (D. Del. 1985) (explaining that physician sued the hospital which had denied him staff privileges, alleging that the denial constituted a group boycott in violation of section 1 of the Sherman Act). *See* Note, *Fixing the Price Fixing Confusion: A Rule of Reason Approach*, 92 YALE L.J. 706 (1983) (arguing the problematic nature of distinction between rule of reason and per se rule analysis).

[54] *Quinn*, 617 F. Supp. at 1244. *See* NCAA v. Board of Regents of Univ. of Okla., 468 U.S. 85 (1984) ("Per se rules may require considerable inquiry into market conditions before evidence justifies a presumption of anticompetitive conduct.").

[55] ABA SECTION OF ANTITRUST LAW, *supra* note 40, at 43.

[56] *Id. See also* Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

[57] John J. Miles, *Antitrust, Hospital Staff Privilege Decisions and Hospital Joint Ventures*, 17 U. TOL. L. REV. 873, 875 (1986).

privileges, (3) the suspension of privileges, (4) the reduction of privileges, (5) the granting of limited privileges, (6) the termination of privileges, (7) the denial of status upgrade in privileges, and (8) the denial of privileges because of an exclusive contract with another provider who provides the same services as that of the denied applicant.[58] Categories one through seven form the basis of a claim that the hospital or clinic and/or certain staff members acted in concert to exclude the non-physician provider from gaining access to the hospital or clinic, and, therefore, engaged in a group boycott.[59] Category eight deals with exclusive contract claims, which result in tying arrangements[60] between the hospital or clinic and its patients in need of the particular service provided.[61] For example, a patient requires a surgical procedure and goes to hospital A to have it performed, hospital A also provides the anesthesia services necessary for the surgery. This additional service for anesthesia is only performed by hospital A, whereby the patient does not have a choice of anesthesia providers. Thus, this service is tied to the main surgical service provided.

1. Peer Review and Staff Privileges

The peer review process has given rise to many antitrust claims. Courts have recognized that the peer review process has the potential of enhancing competition by promoting efficient and effective health care services provided only by qualified and competent health care practitioners.[62] There is also, however, the risk of anticompetitive abuse through the peer review process and the granting of privileges.[63] In other words, the physicians that sit on the peer review board can eliminate their prospective competitors through this process. The granting of staff privileges to independent non-physician providers is essential if these non-physicians

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[58]*Id.* at 876.

[59]*Id.* at 876-77.

[60]"A tying arrangement is defined as one in which one party conditions the sale or license of a product [or service] (the tying product) upon the sale or license of another product [or service] (the tied product) or agrees not to obtain the tied product from another supplier." ANTITRUST ADVISOR 5-39 (Irving Scher ed., 4th ed. 1995).

[61]Miles, *supra* note 57, at 877.

[62]ABA SECTION OF ANTITRUST LAW, *supra* note 3, at 1257. *See also*, Quinn v. Kent Gen. Hosp. Inc., 617 F. Supp. 1226, 1239 (D. Del. 1985)("[A] peer review process is arguably procompetitive, for by monitoring the qualifications and performances of physicians it may compensate for the relative lack of information about these matters by consumers."); Willman v. Heartland Hosp. E., 34 F.3d 605, 610 (8th Cir. 1994) (arguing that public interest to monitor physician quality of care and competence through the peer review process, and to revoke privileges because of legitimate concerns of competency issues are lawful objectives).

[63]ABA SECTION OF ANTITRUST LAW, *supra* note 3, at 1257. *See also* Johnson v. Nyack Hosp., 891 F. Supp. 155, 157 (S.D.N.Y. 1995) (explaining that the power that professional review boards wield may be abused for many reasons, including personal animus and anticompetitive motives), *aff'd*, 86 F.3d 8 (2d Cir. 1996); Patrick v. Burget, 800 F.2d 1498, 1506 (9th Cir. 1986) ("The peer review process allows doctors to agree to eliminate a competitor from the market because they believe his or her product is substandard."), *rev'd on other grounds*, 486 U.S. 94 (1988).

desire to provide services at a hospital or clinic.[64] But this desire may be thwarted during the peer review process.

Although specific procedures may vary from hospital to hospital, there exist some general similarities in the peer review process.[65] The credentialling committee of the hospital or clinic undertakes an investigation into the applicant's background to determine the extent of his/her board certification and licensing, medical malpractice insurance (current policy), and medical training and experience.[66] This committee reports the findings of its investigation to the whole medical staff, or to the board of directors, which makes the final decision based on the committee's recommendation.[67]

If a non-physician provider is denied privileges, the hospital or clinic usually will provide an opportunity for review and appeal of the decision.[68] If the appeal process proves to be unsuccessful for the non-physician provider, the provider may make antitrust allegations against the hospital and/or medical staff.[69] To be successful in an antitrust action, the claimant must satisfy all the requirements of Section One of the Sherman Act. These requirements are: [1] combination, conspiracy or contract among two or more independent actors; [2] unreasonable restraint of trade; and [3] substantially affects interstate markets.[70]

2. Non-Physician Providers Case Analysis

Judicial precedent has yet to be established regarding physician assistant antitrust treatment. A comparative analysis using nurse midwives and nurse anesthetists and the outcomes of their antitrust challenges provide a view into the future. The focal point of this analysis is the approach that the courts have used in the types of antitrust actions in which the peer review processes at health care entities are under attack by non-physician providers who have lost or been denied staff privileges. In the first case discussed,[71] the outcome hinges on the conspiracy aspect of restraint of trade cases and on sorting out its applicability to the various involved parties.

The second case analysis discusses, in-depth, jurisdictional issues, conspiracy evidence and proof, defenses asserted, and proof of treble damages.[72] The third case analysis focuses on the rule of reason approach in determining if the restraint of trade was unreasonable.[73] The courts imply through their opinions that the non-physician provider is denied staff privileges whereby the opportunity for providing his/her

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[64]Erskine, *supra* note 10, at 399.

[65]John Neff, Note, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 613 (1988).

[66]*Id.* at 614.

[67]*Id.*

[68]*Id.*

[69]*Id.* at 614-15.

[70]ANTITRUST ADVISOR, *supra* note 60, at 1-7.

[71]Nurse Midwifery Assoc. v. Hibbett, 918 F.2d 605 (6th Cir. 1990).

[72]Sweeney v. Athens Reg'l Med. Ctr, 709 F. Supp. 1563 (M.D. Ga. 1989).

[73]Oltz v. St. Peter's Community Hosp., 861 F.2d 1440 (9th Cir. 1988).

services is either eliminated in the relevant market or substantially diminished.[74] This leads to the conclusion that recovery in an antitrust action of this nature is most likely when the non-physician provider's ability to compete in his/her relevant market has been eliminated or substantially diminished. The cases analyzed below discuss this possibility.

a. Nurse Midwife Case Analysis

i. *Nurse Midwifery Associates v. Hibbett*

In *Nurse Midwifery Associates v. Hibbett*,[75] nurse midwives[76] and other named plaintiffs, brought an action alleging that the defendants[77] had engaged in conspiracies to restrain trade in violation of the Sherman Act, § 1.[78] The District Court held that (1) the plaintiffs failed to support their claim of an illegal conspiracy between the university hospital and the obstetrician/gynecologist (OB/GYN);[79] (2) the insurance company and the insureds, the physicians, were capable of conspiring;[80] (3) the doctrine of intracorporate conspiracy[81] did not apply to the claim that OB/GYNs conspired with other OB/GYNs and with the medical staff, and (4) the doctrine of intracorporate conspiracy barred claims that the hospitals conspired with pediatricians on their medical staffs.[82] Plaintiffs' case focused on the physicians' attempt to eliminate the competition of the nurse midwives by conspiring to prevent them from operating a maternity practice and to prevent them from

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[74]*See, e.g.*, Sweeney v. Athens Reg'l Med. Ctr, 705 F. Supp. 1556 (M.D. Ga. 1989).

[75]Nurse Midwifery Assoc. v. Hibbett, 918 F.2d 605 (6th Cir. 1990).

[76]"[A]n individual educated in the two disciplines of nursing and midwifery [independent management of newborns and women], who possesses evidence of certification according to the requirements of the American College of Nurse-Midwifes." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1163 (28th ed. 1994).

[77]*Nurse Midwifery Assoc.*, 918 F.2d at 605. Hibbett, M.D.; Shackleford, M.D.; Andrews, M.D.; Melkin, M.D.; Baer, M.D.; State Volunteer Mutual Insurance Company; Vanderbilt University Hospital; Southern Hills Hospital; and Hendersonville Community Hospital. All defendants are located in the Nashville, Tennessee area.

[78]*Id.* at 607.

[79]*Id.* at 616. *See* Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 588 (1986).

[80]*Nurse Midwifery Assoc.*, 918 F.2d at 616. *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 356-357 (1982).

[81]In 1984, the Court considered the intracorporate conspiracy doctrine when it decided *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984) (holding that "allowing plaintiffs to bring antitrust claims against single firms, claiming an "intra-enterprise" conspiracy would erode the distinction Congress had intended between sections 1 and 2 of the Sherman Act.") (quoting Kurt Erskine, Comment, *Square Pegs and Round Holes: Antitrust Law and Privileging Decision*, 44 KAN. L. REV. 399, 407 (1996)).

[82]*Nurse Midwifery Assoc.*, 918 F.2d at 613. *See e.g.*, Smith v. Northern Michigan Hosp. Inc., 703 F.2d 942, 950 (6th Cir. 1983); Bolt v. Halifax Hosp. Med. Ctr, 851 F.2d 1273, 1280 (11th Cir. 1988).

receiving hospital staff privileges so that they could provide maternity services.[83] The plaintiffs claimed that competition was eliminated when the defendants put pressure on the supervising physicians,[84] who collaborate with the nurse midwives in practice, and also put pressure on the hospital boards, who grant staff privileges to the nurse midwives through the peer review board process.[85] As a result of this conspiracy, the plaintiffs were unable to continue their midwifery practice, and filed suit alleging antitrust violations.[86]

In order to establish antitrust violations under section one of the Sherman Act, the plaintiffs "must establish that the defendants combined or conspired with an intent to unreasonably restrain trade."[87] The plaintiff must prove that the allegedly violative conduct transpired between two independent entities, because section one does not reach "unilateral conduct" even if it unreasonably restrains trade.[88] The *Nurse Midwifery Assoc.* court explained that conspiracies occur when independent entities have joined to act in the mutual benefit of all entities.[89] This combination may benefit consumers as well, but the anticompetitive potential warrants antitrust scrutiny.[90] Additionally, the court also examined the intracorporate conspiracy doctrine and its application to the instant case.[91]

The intracorporate conspiracy doctrine[92] is a collection of rules that govern the conduct between corporations and their agents or employees, or between parent corporations and wholly owned subsidiaries.[93] For example, an agreement between officers and employees of a corporation usually does not constitute a section one conspiracy because each group is neither independent of the other, nor does it have separate economic interests.[94] The same is true of the parent company and its wholly owned subsidiary, when both agree to a specific course of action, then section one scrutiny is not justified because there is "no sudden joining of economic resources that had previously served different interests."[95] Courts have come down on both

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[83]*Id.* at 608.

[84]*Id.* In order for nurse-midwives to provide patient care, they must have a supervising physician qualified in obstetrics who takes responsibility for the medical care provided.

[85]*Nurse Midwifery Assoc.*, 918 F.2d at 608.

[86]*Id.* at 611.

[87]*Nurse Midwifery Assoc.*, 918 F.2d at 611 (quoting, Smith v. N. Mich. Hosp., 703 F.2d 942, 949 (6th Cir. 1983)).

[88]*Id.* at 611-12. Unilateral conduct is governed by Section 2 of the Sherman Act, which states in its relevant part: "unlawful only when it threatens actual monopolization." *Id.*

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[90]*Id.* at 612.

[91]*Id.*

[92]*See e.g.*, Milton Handler and Thomas A. Smart, *The Present Status of the Intracorporate Conspiracy Doctrine*, 3 CARDOZO L. REV. 23 (1981).

[93]*Nurse Midwifery Assoc.*, 918 F.2d at 612.

[94]*Id.* at 612.

[95]*Id.*

sides of the intracorporate conspiracy doctrine when applying the various facets of that doctrine to antitrust statutes.[96] Some courts have found that the doctrine of intracorporate conspiracy does not preclude a finding that collaborative activities rising to the level of conspiracy have occurred between a hospital and its medical staff.[97]

After a court has found the challenged conduct to be a conspiracy, then it will determine if the conduct is unreasonable.[98] Along this line of analysis, the court, in *Nurse Midwifery Assoc.*, found that some of the plaintiffs' antitrust claims had merit and remanded the case to the district court for further proceedings not inconsistent with the Court of Appeals' decision.[99]

ii. *Sweeney v. Athens Regional Medical Center*

In *Sweeney v. Athens Regional Medical Center*,[100] the plaintiff, a certified nurse midwife, brought antitrust claims under the Sherman Act and the Clayton Act,[101] as well as state law claims against a public hospital and doctor partners in a professional group alleging restraint of trade violations.[102] The district court held, in relevant part to this note: (1) the interstate commerce requirement was satisfied to establish jurisdiction under the Sherman Act;[103] (2) the evidence of conspiracy raised factual questions and; therefore, summary judgment was denied for the "no evidence

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[96] *Id.*

[97] *Id. See, e.g.*, Bolt v. Halifax Hosp. Med. Ctr, 851 F.2d 1273, 1280 (11th Cir. 1988)(reasoning that members of a hospital's medical staff are capable of conspiring, because each member of the staff "is a separate economic entity potentially in competition with other physicians"); Weiss v. York Hosp., 745 F.2d 786, 813-17 (3d Cir. 1984)(explaining that members of a medical staff could conspire among themselves because they were not only practicing medicine they were competing with each other). The *Weiss* court stated:

> [A] conspiracy involving a corporation and one of its agents would occur every time an agent performed some act in the course of his agency, for such an act would be deemed an act of the corporation . . . [a] hospital and the members of its medical staff, in contrast, are legally separate entities, and consequently no similar danger exists that what is in fact unilateral activity will be bootstrapped into a conspiracy.

Id. at 819 (citing Kurt Erskine, Comment, *Square Pegs and Round Holes: Antitrust Law and Privileging Decisions*, 44 KAN. L. REV. 399, 409 (1996)). These courts opined that for the purposes of antitrust liability, member of a hospital's medical staff are more than just agents of the hospital.

[98] *Nurse Midwifery Assoc.*, 918 F.2d at 612.

[99] *Id.* at 617.

[100] Sweeney v. Athens Reg'l Med. Ctr., 709 F. Supp. 1563 (M.D. Ga. 1989).

[101] 38 Stat. 730 (1914) (codified at 15 U.S.C. §§ 12-27, 44).

[102] *Sweeney*, 709 F. Supp. at 1567.

[103] *Id.* at 1571. The court stated that Sweeney's relationship to interstate commerce in combination with the business activities of the physicians adequately shows that those activities have a substantial effect on interstate commerce. *Id.*

of conspiracy" defense;[104] (3) the plaintiff sufficiently established causation under Section IV of the Clayton Act for treble damages;[105] and (4) the physicians' defenses failed against plaintiff.[106]

Sweeney mainly focused on the independent physician groups' collaborative activities to eliminate competition by denying plaintiff staff privileges and the effects on plaintiff's occupation. In 1982, plaintiff Sweeney had held staff privileges at defendant hospitals as a labor and delivery nurse and midwife, had received a masters degree in nurse midwifery,[107] and had taught obstetrics nursing at the medical school.[108] In 1985, Sweeney established a private business which provided alternative childbearing options for women in the relevant market.[109]

In fall of 1985, after Sweeney advertised her alternative childbearing methods, one of the physicians who provided back-up obstetrical care terminated his services with Sweeney's patients.[110] At the same time, the physicians that comprised the obstetrics departments at the two defendant hospitals met jointly to discuss Sweeney's business.[111] The obstetricians at the two hospitals wrote a joint letter to the hospitals' administrators expressing the position that Sweeney's medical practice must be eliminated.[112] In early 1986, the physicians of one of the hospitals agreed to deny Sweeney patient access, and formalized this agreement in a letter to the nursing director of that hospital.[113] As a result of the restrictive nature of these actions, Sweeney's private childbirth business and teaching opportunities were greatly diminished.[114]

The court thoroughly analyzed the plaintiff's claims and, starting with the Sherman Act, noted that, in order "[t]o invoke the jurisdiction of the Sherman Act, . . . a plaintiff [must] show (1) that the local activity has a (2) substantial affect

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[104]*Id.* at 1572-73. The factual evidence "tends to exclude the possibility that the [defendants] were acting independently." Monsanto v. Spray-Rite Serv. Corp., 465 U.S. 752, 764 (1984).

[105]*Sweeney*, 709 F. Supp. at 1574. The established causation precluded the court from ruling as a matter of law that Sweeney can prove no actual damages; therefore, Sweeney had the obligation of proving damages at trial. *Id.*

[106]*Id.* at 1574-76. The quality of care defense, illegal business defense, burden of proof defense, and the incapable of conspiring defense all failed for the defendant physicians. *Id.*

[107]*See supra* note 75 and accompanying text.

[108]Sweeney v. Athens Reg'l Med. Ctr, 705 F. Supp. 1556 (M.D. Ga. 1989).

[109]*Id.* at 1558. The business was called "Family Birth." The business' purpose was to have midwives, not physicians, provide the prenatal care as well as complete delivery services, as an alternative to traditional prenatal care. *Id.*

[110]*Id.* at 1559.

[111]*Id.* at 1563, 1567.

[112]*Id.* at 1568.

[113]*Sweeney*, 709 F. Supp. at 1569. The Hospital officials honored this request in denying Sweeney patient access, as a nurse midwife.

[114]*Id.*

on (3) interstate commerce."[115] The court explained that to satisfy the jurisdiction requirement, the defendants' activities in aggregate must have a substantial effect on interstate commerce or markets.[116]

Further, the court explained that under the Sherman Act, in order to prove conspiracy, the plaintiff must produce evidence that reasonably tends to prove that defendants "had a conscious commitment to a common scheme designed to achieve an unlawful objective."[117] In addition, the evidence must show that the defendants were acting in accord with one another—mutually assenting.[118]

Next the court noted that in order for the plaintiff to recover treble damages under the Clayton Act,[119] the plaintiff must initially show that standing exists, and then that any injury suffered bears a close relationship to the alleged antitrust violation.[120] To determine the relevant market in question the court used the "target area test," which states that to establish the requisite "close relationship" between the harm and the violative conduct, the plaintiff must show that both the harm and the conduct are within the market zone threatened by the alleged anticompetitive activity.[121] The court then determines whether the injury actually occurred within the target area.[122]

Finally, the court analyzed the various defenses asserted by the defendant physicians. The "patient care" defense, as asserted by these defendants, built its legal basis on *Wilk v. American Medical Association*,[123] in which the court had held that doctors were allowed to share a common view, i.e. agreeing to not associate with a chiropractor in their health care team approach in treating a patient because the

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[115] *Id.* at 1570 (citing Shahawy v. Harrison, 778 F.2d 636, 639 (11th Cir. 1985)).

[116] *Id. See Shahawy*, 778 F.2d at 640-641.

[117] *Sweeney*, 709 F. Supp. at 1572. *See also* Monsanto v. Spray-Rite Serv. Corp., 465 U.S. 752, 764 (1984) (quoting Edward J. Sweeney & Sons, Inc. v. Texaco, Inc., 637 F.2d 105 (3d Cir. 1980)).

[118] *Id.* at 1572.

[119] The Act reads in relevant part:

> Whenever the United States is hereafter injured in its business or property by reason of anything forbidden in the antitrust laws it may sue therefore in the United States district court for the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold [treble] the damages by it sustained and the cost of suit. The court may award . . . threefold the damages.

15 U.S.C. § 15(a)(1997).

[120] *Sweeney*, 709 F. Supp. at 1574. *See* Amey, Inc. v. Gulf Abstract and Title, Inc., 758 F.2d 1486, 1492-93 (11th Cir. 1985).

[121] *Id.* at 1574. The court identifies the area of the economy threatened by the alleged antitrust activity and then determines if the plaintiff's injury occurred within the target market. *Id. See Amey*, 758 F.2d at 1500.

[122] *Sweeney*, 709 F. Supp. at 1574. Sweeney's private business was in competition as a childbirth alternative in the area; plaintiff was within the target area—the market threatened by the alleged violation. *Id.*

[123] 719 F.2d 207 (7th Cir. 1983).

quality of care they provide outweighs that of the chiropractor.[124] But the *Sweeney* court further noted that Supreme Court precedent does not support the application of the patient care defense.[125] While the *Sweeney* defendants argued that they were incapable of conspiring because they were partners in a partnership,[126] the court opined that the two independent partnerships conspired, and this action brought them within the scope of the Sherman Act. The court also analyzed other issues that are not applicable for the purposes of this note. The court ultimately allowed the plaintiff's claims under the antitrust laws.

b. Nurse Anesthetists Case Analysis: Oltz v. St. Peter's Community Hospital

In *Oltz v. St. Peter's Community Hospital*,[127] the plaintiff, a nurse anesthetist, brought an antitrust action against the hospital and the anesthesiologists after he was terminated because of an exclusive staff arrangement between the hospital and the anesthesiologists, which implied that all other anesthesia providers would not be granted privileges at the hospital.[128] After applying the rule of reason approach to determine whether plaintiff should prevail,[129] the appellate court held that the plaintiff's antitrust claims had merit.[130]

The court set forth the three elements that must be proven by the plaintiff for success under a section one claim: (1) a conspiracy or mutual assent among two or more individuals or entities; (2) the individuals or entities intended to injure or restrain competition; and (3) competition is injured.[131] Once it has been proven that

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[124]*Id.* at 226.

[125]*Sweeney*, 709 F. Supp. at 1575. *See* National Soc'y of Prof'l Eng'r v. United States, 435 U.S. 679, 695-96 (1978) ("Exceptions to the Sherman Act for potentially dangerous goods and services would be tantamount to the repeal of the statute . . . . The judiciary cannot indirectly protect the public against this harm by conferring monopoly privileges on the [defendants].").

[126]*Sweeney*, 709 F. Supp. at 1576 (citing Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 356 (1982)).

[127]Oltz v. St. Peter's Community Hosp., 861 F.2d 1440 (9th Cir. Nov. 28, 1988). St. Peter's is only one of two hospitals in the Greater Helena, Montana area and because it is the only hospital open to the public for general surgery, it boasts a market share of 84% for general surgical service in the relevant local market. *Id.*

[128]*Id.* Mr. Oltz was employed as a free lance nurse anesthetist, who administered the anesthesia under the supervision of a physician. When he started at the defendant/hospital, there were three anesthesiologists on the medical staff. Eventually the number of anesthesiologists increased to four. The evidence at the trial showed that Oltz was in direct competition with the anesthesiologists for the anesthesia services. (The anesthesiologists settled out of the suit before trial.) *Id.*

[129]*Id.* at 1445. This court concluded that [1] the defendant (St. Peter's) did not prove the grounds for reversal nor did they lack capacity to conspire with the anesthesiologists; [2] the trial court properly defined the relevant market; [3] the evidence of conspiracy, intent, and injury to competition presented at the trial supports the jury findings; and [4] the plaintiff failed to establish ground for reversing the order granting a new trial on damages. *Id.* at 1452-53.

[130]*Oltz*, 861 F.2d at 1452-53.

[131]*Id.* at 1445.

the conspiracy has injured competition, the trier of fact must balance the restraint against any procompetitive justifications to determine whether the restraint is unreasonable.[132] A closer look at the court's analysis of the rule of reason elements is appropriate.

In this case, in order to satisfactorily prove conspiracy under section one of the Sherman Act, it required a showing that St. Peter's Hospital had conspired with the anesthesiologists. Courts have split on whether a hospital is legally capable of conspiring with its medical staff under section one of the Sherman Act.[133] The *Oltz* court relied on an Eleventh Circuit decision[134] to determine that the interests of the anesthesiologists were that of independent contractors pursuing their economic interests when they pressured St. Peter's into eliminating plaintiff as a direct competitor.[135]

In effect, the anesthesiologists and St. Peter's coalesced their economic power.[136] In other words, because the hospital held the power to terminate the plaintiff and to award an exclusive contract to the anesthesiologists, the hospital was not acting under the guise of an employer relationship and, therefore, could conspire with the anesthesiologists.[137] This concerted action by the hospitals and the anesthesiologists to eliminate the direct competition of Oltz evidenced the co-conspirators' intent to restrain competition.[138]

The second element in section one analysis is that the individuals or entities intended to injure or to restrain competition.[139] The rule of reason approach requires that each challenged activity be evaluated in light of the special circumstances involved.[140] Evidence supported the claim that St. Peter's and the anesthesiologists conspired to terminate the plaintiff's billing contract as well as to enter into an exclusive contract.[141]

The third element of a section one claim, proof of injury or harm to competition, requires that the plaintiff prove the relevant market's effects upon competition.[142] The relevant market encompasses the geographical aspects of the product or service

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[132]*Id. See also* Los Angeles Mem'l Coliseum Comm'n v. NFL, 726 F.2d 1381, 1391 (9th Cir. 1984).

[133]*Oltz*, 861 F.2d 1440, 1450 (9th Cir. 1988).

[134]Bolt v. Halifax Hosp. Med. Ctr., 851 F.2d 1273, 1276-77, 1280 (11th Cir. 1988).

[135]*Oltz*, 861 F.2d 1440, 1450 (9th Cir. 1988).

[136]*Id.*

[137]*Id.* at 1450.

[138]The *Oltz* court opined that the decision made cannot be read to set forth a rule applicable to other situations involving rural hospitals engaged in exclusive agreements regarding staff privileges. *Id.* at 1449.

[139]*Id.* at 1445.

[140]*Id.* at 1449. *See also*, Business Electronics Corp. v. Sharp Electronics Corp., 485 U.S. 717 (1988).

[141]*Oltz*, 861 F.2d at 1449.

[142]*Id.* at 1445-46. *See also* Kaplan v. Burroughs Corp., 611 F.2d 286, 291 (9th Cir. 1980).

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as well as the use, description, and quality.[143] That market encompasses the "area of effective competition . . . where buyers can turn for alternate sources of supply."[144] The *Oltz* court determined that the relevant market was Helena because St. Peter's would be the sole market server where an anesthesia specialist could provide services.[145] The evidence showed that patients had no reasonable substitute for anesthesia services and that patients could not effectively go outside the relevant market for alternate sources.[146] Although defining the relevant market is not the aim of antitrust law, it does offer a "measuring stick" to determine reasonable and unreasonable restraints.[147] Thus, the evidence supported the element of intent to harm competition.

The overall anticompetitive effect was that St. Peter's and the anesthesiologists obtained power through the exclusive agreement to raise prices and to exclude competition, thereby, increasing their incomes and eliminating all other competitors in the market.[148] Through this rule of reason analysis, the *Oltz* court found that the conspiracy, intent, and injury to competition aspects had been proven, and, thus, affirmed the district court's decision.[149]

III. PHYSICIAN ASSISTANTS AND ANTITRUST: IMPLICATIONS OF CASE COMPARISONS AND RELEVANT HEALTH CARE LEGISLATION

Physician assistants are trained health care professionals who provide medical care under a physician's supervision, however limited, these services are substitutable with physician services.[150] Statistics from the American Academy of Physician Assistants indicate that, as of 1993, there were approximately 23,500 practicing physician assistants in the United States.[151]

The statistical profile of these 23,500 physician assistants was as follows:[152]

Gender:	58% male, 42% female
Age:	40 years average
Education:	85% have a 4 year college degree
Specialty:	25% surgery
	56% primary care

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[143]*Oltz*, 861 F.2d at 1446.

[144]*Id*. *See* Moore v. Matthews and Co., 550 F.2d 1207, 1218 (9th Cir. 1977) (citing Otter Tail Power v. United States, 410 U.S. 366, 369 (1973) and Standard Oil Co v. United States, 337 U.S. 293, 299-300 (1949)).

[145]*Oltz*, 861 F.2d at 1447.

[146]*Id.*

[147]*Id.* at 1448. St. Peter's and the anesthesiologists had no competition in providing their services in the relevant market when they eliminated Oltz through their exclusive contract. *Id.*

[148]*Id.*

[149]*Id.* at 1452-53.

[150]Falligant, *supra* note 7, at 13.

[151]TERENCE J. SACKS, OPPORTUNITIES IN PHYSICIAN ASSISTANT CAREERS, 19 (1995).

[152]*Id.* at 19-21.

- 33% family practice
- 9% general internal medicine
- 9% emergency medicine
- 3% obstetrics/gynecology
- 2% pediatrics

Setting: 75% outpatient
25% inpatient
Patient visits/day: 22 outpatient, 14 inpatient
Average annual salary: $53,000

In a time when people are living longer, the unmet demands of medical care have caused the medical community to expand its ranks to include many diversified and efficient providers, such as physician assistants.[153] As a result of this need, physician assistants have become an integral part of the health care industry. Physician assistants provide services traditionally provided by physicians that are now being provided effectively and efficiently by these non-physician providers, such as writing prescriptions, which is permitted in more than thirty states.[154] Physician assistants exercise a degree of autonomy in the diagnosis and treatment of illness and injury.[155] While some members of the medical community may embrace these physician assistants and their invaluable service to patients, others try to deal with them using a different approach.

This author's research has not yielded a case that deals with antitrust issues involving physician assistants.[156] But as this specialty field expands, through the various accreditation programs throughout the United States, so too will the many antitrust problems that have already affected other non-physician providers.[157]

From the analysis of cases involving nurse midwives and nurse anesthetists, and the relevant health care legislation, many general applications can be made to non-physician providers as a group, especially physician assistants. The case analysis

[153]Falligant, *supra* note 7, at 13. "[L]iterature indicates that PAs can substitute for physicians anywhere from 75% to 90% of the physician's primary care functions." *Id.*

[154]Prerna Mona Khanna, *Medicine: While Physician Extenders Proliferate, Doctors Worry About Competition, Care*, WALL ST. J., Aug. 5, 1992, at B1.

[155]Falligant, *supra* note 7, at 13.

[156]*But see* Gilliam v. National Comm'n for Certification of Physician Assistants, Inc., 727 F. Supp. 1512 (E.D. Pa. 1989). The case is unrelated to this note and therefore it carries no weight in the analysis of this note. The substance of the physician assistant's claim is based on being denied recertification of his license. Although plaintiff brought a claim under antitrust laws, the court ruled that the claim had no merits, because plaintiff was not injured.

[157]*See generally* TERENCE J. SACKS, OPPORTUNITIES IN PHYSICIAN ASSISTANT CAREERS, 19 (1995); Lou Falligant, *Physician Assistants (PAs) Provide Quality Care*, WIS. MED. J. June 1997, at 13; Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683 (1991); Gayle Reindl, Note, *Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?*, 19 IND. L. REV. 1219 (1986); John J. Miles, *Antitrust, Hospital Staff Privilege Decisions and Hospital Joint Ventures*, 17 U. TOL. L. REV. 873 (1986); Scott M. Smith, J.D., Annotation, *Construction and Application of Health Care Quality Improvement Act of 1986 (42 U.S.C.A. §§ 11101-11152)*, 121 A.L.R. FED. 255 (1994); Kurt Erskine, Comment, *Square Pegs and Round Holes: Antitrust Law and Privileging Decision*, 44 U. KAN. L. REV. 399(1996).

and the examination of relevant legislation, such as the Health Care Quality Improvement Act, points to the conclusion that legislation seems to be lacking in a very important common aspect.[158] This aspect will continue to draw the line between how courts will handle non-physician antitrust suits in comparison with physician antitrust suits.[159] The aspect is immunity.

The peer review process does not offer physicians or other peer review board members immunity in the process of reviewing non-physician providers for staff privileging situations; ultimately the central issue of the antitrust action is that a physician or a non-physician provider was denied privileges or had privileges that were terminated.[160] For example, a physician assistant applies for privileges at a hospital and is denied these privileges and seeks relief under the antitrust laws; the peer review board (consisting of two physicians, an administrator, a nurse and a physician assistant) is not granted immunity for its decision in denying the physician assistant privileges.[161] Conversely, if a physician seeks privileges and is denied, although that physician may seek redress under antitrust laws, the same peer review board is immune from the action.[162] This distinction has major ramifications for the health care industry. Because Congress eliminated the proposed provision of the HCQIA which would have granted immunity to peer review boards regarding reviews of non-physician providers, it has, in effect, left it to the courts to determine whether the peer review process is an effective means to evaluate non-physician providers for staff privileges through the use of physicians.[163]

Unfortunately, the "measuring stick" for these two groups—physicians and non-physicians—will not be identical; thus, different standards must be applied to the groups respectively.[164] There are procompetitive and anticompetitive reasons for denying staff privileges to non-physicians.[165]

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[158]*Id.*

[159]*Id.*

[160]*Id.*

[161]*See generally* TERENCE J. SACKS, OPPORTUNITIES IN PHYSICIAN ASSISTANT CAREERS, 19 (1995); Lou Falligant, *Physician Assistants (PAs) Provide Quality Care*, WIS. MED. J. June 1997, at 13; Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683 (1991); Gayle Reindl, Note, *Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?*, 19 IND. L. REV. 1219 (1986); John J. Miles, *Antitrust, Hospital Staff Privilege Decisions and Hospital Joint Ventures*, 17 U. TOL. L. REV. 873 (1986); Scott M. Smith, J.D., Annotation, *Construction and Application of Health Care Quality Improvement Act of 1986 (42 U.S.C.A. §§ 11101-11152)*, 121 A.L.R. FED. 255 (1994); Kurt Erskine, Comment, *Square Pegs and Round Holes: Antitrust Law and Privileging Decision*, 44 U. KAN. L. REV. 399(1996).

[162]*Id.*

[163]Adler, *supra* note 32, at 738. The political decision to eliminate the provision of HCQIA that dealt with non-physician providers, was a means for Congress to shift the burden to the judicial branch. *Id.*

[164]*See generally* TERENCE J. SACKS, OPPORTUNITIES IN PHYSICIAN ASSISTANT CAREERS, 19 (1995); Lou Falligant, *Physician Assistants (PAs) Provide Quality Care*, WIS. MED. J. June 1997, at 13; Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683 (1991); Gayle Reindl, Note, *Denying Hospital Privileges to Non-Physicians: Does Quality of Care Justify a Potential Restraint of Trade?*, 19

First, non-physician groups that must be supervised by physicians add costs to the hospital's ability to provide its patients with quality care at an effective cost.[166] For example, a physician assistant may cause the hospital to incur an expense for his/her supervision by a physician because of the physician assistant's ability to provide services "above" that of a nurse but "below" the level of a physician—the physician assistant has limited autonomy in relation to that of the supervising physician. When physicians consult on other physicians' patients, the costs of this "supervision consultation"[167] are not unduly burdensome to the health care facility because it is viewed as a normal course of action.[168] Yet, physician assistants have the ability to act independently in the health care facility, while providing services generally performed by physicians, such as writing prescriptions for medication.[169] The expenses associated with supervising physician assistants, however, may contain additional costing aspects, such as increased insurance rates, because of the increased level of patient treatment.[170] Additionally, the training and types of services provided by physician assistants tend to make similar physicians and physician assistants with respect to costs.

Second, physicians provide consumers with the ability to choose the type of care through the quality of care issues attached to physicians' services.[171] The ability for a consumer to choose physician services provides a basis for the quality of care defense, such that if consumers want changes in the choices of medical services available, then the consumers will influence market forces to make the necessary changes.[172]

Finally, an antitrust action involving a physician usually involves only one physician as plaintiff, but non-physician provider groups are bringing antitrust claims

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IND. L. REV. 1219 (1986); John J. Miles, *Antitrust, Hospital Staff Privilege Decisions and Hospital Joint Ventures*, 17 U. TOL. L. REV. 873 (1986); Scott M. Smith, J.D., Annotation, *Construction and Application of Health Care Quality Improvement Act of 1986 (42 U.S.C.A. §§ 11101-11152)*, 121 A.L.R. FED. 255 (1994);Kurt Erskine, Comment, *Square Pegs and Round Holes: Antitrust Law and Privileging Decision*, 44 U. KAN. L. REV. 399(1996).

[165]*Id.*

[166]Gayle Reindl, Note, *Denying Hospital Privileges to Non-Physician Providers: Does Quality of Care Justify a Potential Restraint of Trade?*, 19 IND. L. REV. 1219, 1244 (1986). *See* Philip C. Kissam et al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CAL. L. REV. 595, 655 (May 1982).

[167]By the term "supervision consultation" the author means that the physician is lacking a certain expertise that another physician possesses. Therefore when the original physician calls in the consulting physician for an opinion on a course of treatment for a patient, the consulting physician is, in essence, supervising the original physician for that particular treatment.

[168]Reindl, *supra* note 5, at 1244.

[169]Falligant, *supra* note 7, at 13.

[170]*Id.*

[171]Reindl, *supra* note 5, at 1245-46.

[172]*See* Marrese v. American Academy of Orthopaedic Surgeons, 706 F.2d 1488, 1497 (7th Cir. 1983) ("A consumer has no interest in the preservation of a fixed number of competitors greater than the number required to assure his being able to buy at the competitive price."), *rev'd on other grounds*, 470 U.S. 373.

for having the whole group of non-physician providers eliminated from competition.[173] Therefore, depending on the circumstances, excluding an individual physician from the hospital staff is much less likely to have anticompetitive results in the physician-patient market,[174] but excluding an entire group of non-physician providers protects the physicians from all competition that is provided by non-physicians, such as substitutable services at lower costs.[175]

The foregoing analyses illustrate that there is a chance that physicians reviewing non-physician providers will be acting for anticompetitive reasons. This information justifies the distinction in the Health Care Quality Improvement Act as to when physicians receive immunity and when immunity is not applicable. The application of immunity generally applies to non-physician providers; however, physician assistants are different from other non-physician providers, which justifies a different treatment for physician assistants under the HCQIA. Physician assistants are different from other non-physician providers because they have the authority to act independently from their supervising physician.

This independence provides greater risk to consumers; therefore, it is important to make sure that physician assistants are reviewed under close scrutiny to ensure high qualifications in order to protect consumers. This type of review is similar to that which physicians are subjected to within the scope of the peer review process. Further, the process is similar to what Congress intended when it granted physicians immunity in the peer review of other physicians.

Looking at immunity from the reviewing physicians' point of view, immunity exists for peer review boards when reviewing physicians, as provided under the Health Care Quality Improvement Act. The type of immunity granted under the HCQIA, although not absolute, supports the objective of encouraging effective peer review. The shortcoming of this immunity is that non-physician providers can abuse the process due to the lack of immunity for peer reviews of these health care practitioners.

For example, a nurse midwife can threaten antitrust allegations against the review board for being denied staff privileges. This may occur as a means to strong arm the board into granting privileges, even when the review board determined that the nurse midwife was not qualified to join the staff. On the other hand, physicians being reviewed by these boards do not have this leverage because, under the HCQIA, review boards are provided immunity in these types of decisions. The legislature allowed this imbalance when it eliminated the section of the statute that also granted immunity with respect to the review of non-physician providers.

Physicians are not immune from antitrust liability with respect to the reviewing of non-physician providers. Physician assistants should be treated differently from other non-physician providers and subject to peer review by physicians without the risk of the review board being subject to antitrust liability because this group has the

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[173]Reindl, *supra* note 5, at 1246-47. *See* Bhan v. NME Hosp. Inc., 772 F.2d 1467, 1471 (9th Cir. 1985).

[174]The author wishes to point out that this example may have an opposite effect. For example, if the individual physician who is being denied staff privileges through the review process is part of a market that only contains a small number of physicians (rural areas), then the impact of that decision to deny privileges has significant ramifications on that market.

[175]Reindl, *supra* note 5, at 1247.

training to perform "physician similar" services. If this is to happen, physician assistants should be included in the definition of "physician" under the applicable provision of the HCQIA.

IV. CONCLUSIONS

This note has attempted to familiarize the reader with the impact of the antitrust laws on the health care industry. The overall purpose of this note is to lead the reader to the conclusion that although the Health Care Quality Improvement Act has provided a framework regarding the peer review process, the HCQIA must be amended to address the issue of immunity in the peer review process regarding physician assistants.

The author focused on the immunity aspect of the HCQIA with respect to when immunity is provided to review boards and when it does not apply, as in the case of a non-physician provider being reviewed by the peer review board. This note addresses the changes that have occurred in health care, with an eye toward the impact of the antitrust decisions regarding staff privileges and non-physician providers. Further, with the increasing numbers of physician assistants joining the ranks of hospital staffs, the note explores the impact that the peer review process will have on this unique group. Finally, this author concludes that because physician assistants are different from other non-physician providers and that physician assistants should be included in the definition of "physician" under section 11151 of the Health Care Quality Improvement Act.

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