

January 1982

## Vicarious Antitrust Liability in the Health Care Field

Dean M. Harris

Follow this and additional works at: <http://scholarship.law.campbell.edu/clr>

 Part of the [Antitrust and Trade Regulation Commons](#), and the [Health Law and Policy Commons](#)

---

### Recommended Citation

Dean M. Harris, *Vicarious Antitrust Liability in the Health Care Field*, 5 CAMPBELL L. REV. 61 (1982).

This Article is brought to you for free and open access by Scholarly Repository @ Campbell University School of Law. It has been accepted for inclusion in Campbell Law Review by an authorized administrator of Scholarly Repository @ Campbell University School of Law.

# VICARIOUS ANTITRUST LIABILITY IN THE HEALTH CARE FIELD

DEAN M. HARRIS\*

I.	INTRODUCTION .....	62
II.	THE CHANGING VIEW OF THE HOSPITAL AND ITS RELATIONSHIP TO PHYSICIANS .....	66
	A. <i>Hospital Liability Where the Negligent Party Was Actually an Agent of the Hospital</i> .....	69
	B. <i>Hospital Liability Where the Negligent Party Was the Apparent or Ostensible Agent of the Hospital</i> .....	75
	C. <i>Hospital Liability for Its Own Negligence</i> .....	78
III.	THE EFFECT OF THE NEW NEGLIGENCE RULES ON THE STRUCTURE OF THE RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN .....	81
IV.	THE APPLICATION OF ANTITRUST LAW TO THE HEALTH CARE FIELD .....	86
	A. <i>The Health Care Marketplace</i> .....	86
	B. <i>Major Areas of Antitrust Concern for Health Care Providers</i> .....	94
	1. <i>Planning and Certificate of Need</i> .....	94
	2. <i>Price fixing</i> .....	99
	3. <i>Medical Staff Privileges and Exclusive Contracts</i> .....	102
V.	THE APPLICATION OF AGENCY THEORIES TO IMPOSE VICARIOUS ANTITRUST LIABILITY ON HEALTH CARE PROVIDERS .....	105
	A. <i>The Theory of Vicarious Antitrust Liability</i> ...	105
	B. <i>Practical Applications of Vicarious Antitrust Liability in the Health Care Field: Claims, Defenses and Preventive Measures</i> .....	112

---

\* Associate, Moore, Van Allen and Allen, Raleigh, North Carolina; B.A., 1973, Cornell University; J.D. with High Honors, 1981, University of North Carolina at Chapel Hill. A portion of this article first appeared in the Newsletter of the North Carolina Society of Health Care Attorneys and is reprinted by permission.

## VI. Conclusion ..... 117

## I. INTRODUCTION

The application of antitrust law to the health care field is a relatively recent phenomenon, because, until recently, the provision of health services was not even considered to involve interstate commerce.<sup>1</sup> Antitrust litigation in the health care field is ex-

---

1. See *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738 (1976). In *Hospital Bldg. Co.*, plaintiff alleged a conspiracy by defendants to prevent the construction of plaintiff's hospital. The United States Court of Appeals for the Fourth Circuit, *en banc*, held that such a conspiracy, even if proved, would not have a sufficient effect on interstate commerce to invoke the federal anti-trust laws. 511 F.2d 678, 684 (4th Cir. 1975), *en banc*, *rev'd.*, 425 U.S. 738 (1976). However, the United States Supreme Court reversed, and held that such an alleged restraint would substantially affect interstate commerce. 425 U.S. at 739-40. As the Supreme Court explained,

[t]he complaint, fairly read, alleges that if respondents and their co-conspirators were to succeed in blocking petitioner's plan of expansion, petitioner's purchases of out-of-state medicines and supplies as well as its revenues from out-of-state insurance companies would be thousands and perhaps hundreds of thousands of dollars less than they would otherwise be. Similarly, the management fees that petitioner pays to its out-of-state parent corporation would be less if the expansion were blocked. Moreover, the multi-million dollar financing for the expansion, a large portion of which would be from out-of-state, would simply not take place if the respondents succeeded in their alleged scheme. This combination of factors is certainly sufficient to establish a "substantial effect" on interstate commerce under the Act.

*Id.* at 744. See also *infra* notes 206-11, 219-21 and accompanying text.

Although the United States Supreme Court had dealt with restraints on medical and hospital services in 1943, that early case was based on Section 3 of the Sherman Act, 15 U.S.C. § 3 (1976), which prohibits restraints of trade in the District of Columbia, and, therefore, it was unnecessary to establish a sufficient nexus with interstate commerce. See *American Medical Ass'n. v. United States*, 317 U.S. 519, 526 (1943) (affirming convictions of medical societies conspiring to restrain prepaid medical care by salaried physicians). See generally M.J. THOMPSON, *ANTI-TRUST AND THE HEALTH CARE PROVIDER*, 1, 15-17 & 21 n.1 (1979). As Thompson explains, "[t]he dispute addressed by the Supreme Court in *American Medical Assn. v. United States*, . . . is the first major instance of applying anti-trust principles to health providers. Even after this early case, little activity occurred within the area for close to 30 years." *Id.* at 21 n.1.

Today, the dispute over the nexus with interstate commerce most often arises in cases involving a hospital's denial of medical staff membership and admitting privileges to an individual physician. Compare *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981) (upholding federal jurisdiction), *aff'd.*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 103 S. Ct. 302 (1982) with *Cardio-Medical Assocs.*,

pected to increase in the future, as competition intensifies and alternative types of providers enter the field. Moreover, the United States Supreme Court has recently held that the health care field is subject to *per se* rules of antitrust liability, rather than the rule of reason applied by the United States Court of Appeals for the Ninth Circuit.<sup>2</sup>

In applying antitrust law to the health care field, two developments can be combined to impose vicarious antitrust liability. The first of these developments is the imposition of antitrust liability on the basis of apparent authority, and the second is the application of agency theories to the health care field in cases of professional malpractice. Briefly stated, the agency theories developed in the negligence area to impose liability on health care institutions can be applied outside the negligence field to impose vicarious antitrust liability on health care institutions.

The United States Supreme Court has recently held that a nonprofit organization can be held liable for treble damages on a theory of apparent authority for the acts of its agents, even though the organization never ratified the activities of its agents and the agents did not act with an intent to benefit the organization.<sup>3</sup> In *American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp.*,<sup>4</sup> employees of one manufacturer used their positions and contacts with the nonprofit, standard-setting organization to injure a competitor, by causing the organization to publish a letter stating that their competitors' product failed to comply with the organization's standards. The nonprofit organization was held vicariously liable for treble damages and attorneys' fees on the theory of apparent authority.<sup>5</sup> Similarly, vicarious antitrust liability on the basis of apparent authority can be readily applied to the health care field because of the numerous agency relationships in the health care marketplace.

Over the past ten years, a great deal of attention has been given by courts and commentators to hospital liability in negli-

---

Ltd. v. Crozer-Chester Medical Center, 536 F. Supp. 1065 (E.D. Pa. 1982) (denying federal jurisdiction).

2. *Arizona v. Maricopa County Medical Soc'y*, 102 S. Ct. 2466 (1982). See *infra* notes 228-34 and accompanying text.

3. See *American Soc'y. of Mechanical Eng'rs, Inc. v. Hydrolevel Corp.*, 102 S. Ct. 1935 (1982).

4. *Id.*

5. *Id.* at 1942-48.

gence for the acts of non-employed physicians.<sup>6</sup> Modern theories of corporate liability and agency have been used to impose greater liability on the hospital entity.<sup>7</sup> As both hospitals and personal injury plaintiffs learned in the area of negligence, severe liability can now be imposed in spite of the traditional independent contractor relationship between the hospital and its physicians. However, very little attention has been paid to the hospital's potential liability in areas other than negligence for actions taken by non-employed physicians.

Hospital liability for actions of non-employed physicians is a function of the agency relationships in the health care field. In his article on the relationship between the hospital and its medical staff,<sup>8</sup> Professor Southwick explained that "the organized medical staff is an 'agent' of the hospital corporation with a mandate to effectuate corporate purposes."<sup>9</sup> Similarly, courts have held that "the members of such [medical] staff act as agents for the [hospital authority]. . . ."<sup>10</sup> This agency relationship between hospitals and staff physicians invites the application of the Supreme Court's antitrust analysis in *American Society of Mechanical Engineers*, and raises the possibility of vicarious antitrust liability for the acts of non-employed physicians.

In the area of negligence, hospitals traditionally avoided liability for injuries to patients, because physicians were considered to be independent contractors rather than agents of the hospital,<sup>11</sup> and the hospital's own duty to patients in the area of patient care was narrowly construed.<sup>12</sup> However, during the past twenty or thirty years, the protective wall around the hospital has been breached by developments in the law of agency,<sup>13</sup> and by the imposition of a duty on hospitals to act affirmatively in monitoring and supervising patient care.<sup>14</sup> As two commentators<sup>15</sup> recently stated,

6. See *infra* notes 40 and 100.

7. See *infra* notes 20-119 and accompanying text.

8. Southwick, *The Hospital as an Institution—Expanding Responsibilities Change its Relationship With the Staff Physician*, 9 CAL. W.L. REV. 429 (1973).

9. *Id.* at 437-38.

10. See, e.g., *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 142, 189 S.E.2d 412, 414 (1972).

11. See *infra* notes 29-33 and accompanying text.

12. See *infra* notes 20-28 and accompanying text.

13. See *infra* notes 41-48 and accompanying text.

14. See *infra* notes 100-12 and accompanying text.

15. Zaremski & Spitz, *Liability of a Hospital as an Institution: Are the Walls of Jericho Tumbling?*, 16 F. 225 (1981).

"a hospital as an entity may no longer be able to hide under the ambit of independent contractor status of its physicians. Query, then, whether the Walls of Jericho are still standing."<sup>16</sup>

The decline of the independent contractor defense in negligence cases will not go unnoticed by plaintiffs' attorneys in cases outside the negligence field. Plaintiffs will borrow modern theories of hospital liability from the law of negligence, and use those theories as powerful weapons in actions based on statutory and regulatory violations, including the antitrust laws. Hospitals, in turn, will take concrete steps to protect themselves, just as they did in response to increased liability for negligence. For example, the imposition of greater negligence liability on hospitals has caused hospitals to protect themselves by exercising greater control over the activities of their staff physicians.<sup>17</sup> Therefore, hospitals need not be afraid of losing the independent contractor defense in areas other than negligence. Rather, just as in the past, the imposition of greater liability will enable the hospital to assert greater control over its staff physicians, in order to comply with its responsibilities and protect itself against liabilities.

In order to understand the interface between vicarious antitrust liability and the decline of the independent contractor defense in the health care field, it is necessary to understand the complex relationship between the hospital and the physician, as well as the recent changes that have taken place in that relationship. Therefore, this article will briefly trace the changes that have occurred in the traditional rules of the hospital's relationship with its physicians.<sup>18</sup> Then, the current relationship between hospital and staff physician will be examined in light of legal requirements, accreditation standards and practical considerations.<sup>19</sup> After a brief introduction to the health care marketplace as a context for antitrust law, the new theories of liability will be applied to the health care field, in order to give examples of claims likely to be asserted by plaintiffs and defenses that can be raised by health care institutions.

---

16. *Id.* at 229.

17. F. GRAD & N. MARTI, *PHYSICIANS' LICENSURE AND DISCIPLINE: THE LEGAL AND PROFESSIONAL REGULATION OF MEDICAL PRACTICE*, 202, 210 (1979). *See generally*, Southwick, *supra* note 8, at 465-67.

18. *See infra* notes 20-119 and accompanying text.

19. *See infra* notes 120-50 and accompanying text.

## II. THE CHANGING VIEW OF THE HOSPITAL AND ITS RELATIONSHIP TO PHYSICIANS

The traditional view of the hospital was that it was merely a "workshop"<sup>20</sup> for physicians. As one commentator<sup>21</sup> explained, "[t]he hospital was simply a physical place consisting of bricks and mortar, beds and equipment, where the private practicing physician found facilities to support his art."<sup>22</sup> The nature and function of the hospital were limited, and, therefore, the hospital's legal duties were limited.<sup>23</sup> Under this traditional view, the hospital did not have a duty to provide or supervise patient care.<sup>24</sup> The lack of any duty to provide care may be traceable to the historic inability of a corporation, including a hospital, to practice medicine.<sup>25</sup> Because the hospital entity could not provide care, it could not control the provision of care by physicians.<sup>26</sup> Moreover, the lack of a hospital duty to supervise patient care is also based on the traditional deference paid to the powerful medical profession by both hospital governing boards and the courts.<sup>27</sup> Whether based on the

20. Southwick, *supra* note 8 at 434.

21. *Id.*

22. *Id.*

23. *Id.*

It was formerly accepted that the hospital as an institution played little or no role with respect to patient care . . . Accordingly, the legal duties of the corporation to the patient, even after the removal of charitable immunity for tort, were limited to an obligation to exercise reasonable care with respect to the maintenance of buildings and grounds, the equipment, and in the selection for employment of lay and paramedical personnel.

*Id. Accord*, Smith v. Duke Univ., 219 N.C. 628, 634, 14 S.E.2d 643, 647 (1941) ("Ordinarily, the hospital undertakes only to furnish room, food, facilities for operation, and attendance . . .").

24. See Southwick, *supra* note 8, at 434. See also *supra* note 23.

25. See Southwick, *supra* note 8, at 430-31; Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 392 & n.49 (1975). "Many, therefore, viewed the hospital as two organizations—administrative and medical—each limited by custom, and perhaps even by a literal application of the corporate practice rule, to their respective roles and responsibilities." Southwick, *supra* note 8, at 431.

26. See Southwick, *supra* note 8, at 431.

27. See, e.g., Smith v. Duke Univ., 219 N.C. 628, 635, 14 S.E.2d 643, 647 (1941) ("[P]hysicians are not the servants of their employers but are professional men who 'exercise their profession to the best of their abilities according to their own discretion . . .'). See also Wing & Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 N.C.L. REV. 1165, 1168

corporate practice rule, professional prestige, or the practical inability of lay administrators to supervise professional performance, the physician's treatment of his patient was clearly beyond the control of the hospital. Even employed physicians were often considered to be beyond the control of the hospital which employed them.<sup>28</sup>

This lack of control over physicians, in turn, insulated the hospital from vicarious liability for the physicians' negligence. Under the tort law doctrine of *respondeat superior*, an employer or principal will only be held vicariously liable for the acts of its employees or agents, but not for the acts of its independent contractors.<sup>29</sup> In determining whether a party is an employee or agent, as opposed to an independent contractor, courts look at the degree of control over the manner of performing the work.<sup>30</sup> Therefore, the conclusion that physicians are beyond the control of the hospital meant that the hospital would not be held liable on grounds of *respondeat superior* for the negligence of those physicians.<sup>31</sup> As one court explained,

[t]he doctrine of *respondeat superior* does not apply to a physician who acts upon his own initiative, and in the exercise of his own judgment and skill, without direction or control of an employer, . . . and on the part of a physician who is not the servant or employee of the hospital, and who is pursuing an independent calling, the responsibility is not that of the hospital. . . .<sup>32</sup>

This legal rule appears to be grounded in fairness as well as tradition, because it would be inequitable to hold a party liable for the acts of someone beyond his control, and such vicarious liability would be ineffective as a deterrent. Therefore, under the traditional rules, the hospital as an entity was insulated from vicarious

(1979) ("Political considerations account for the relative immunity enjoyed by individual providers.").

A further example of the traditional deference given to professionals is that, until recently, members of the "learned professions" were thought to be exempt from the federal antitrust laws. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787-88 (1975).

28. See, e.g., *Smith v. Duke Univ.*, 219 N.C. 628, 635, 14 S.E.2d 643, 647 (1941).

29. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* §§ 69-71 (4th ed. 1971).

30. See *infra* notes 49-67 and accompanying text.

31. See generally F. GRAD & N. MARTI, *supra* note 17, at 201.

32. *Smith v. Duke Univ.*, 219 N.C. 628, 634, 14 S.E.2d 643, 647 (1941).



liability for the acts of its physicians by the shield of their independent contractor status.<sup>33</sup>

The changes in these rules which have taken place since the 1950's have been attributed to various social needs and phenomena. One commentator<sup>34</sup> noted the role of the hospital entity as a potential "deep pocket" to compensate the injured patient where his damages exceeded the individual physician's liability insurance.<sup>35</sup> In contrast, others have concluded that the changes in legal rules resulted from the recognition that the hospital was more than a mere workshop.<sup>36</sup> For example, in *Bing v. Thunig*,<sup>37</sup> the Court of Appeals of New York concluded that the old conception of the hospital was no longer realistic:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.<sup>38</sup>

---

33. In addition, hospitals often had a charitable immunity. See *Bost v. Riley*, 44 N.C. App. 638, 645, 262 S.E.2d 391, 395, cert. denied, 300 N.C. 194, 269 S.E.2d 621 (1980). See also Southwick, *supra* note 8, at 434.

34. Payne, *Recent Developments Affecting a Hospital's Liability for Negligence of Physicians*, 18 S. TEX. L.J. 389, 389 (1977).

35. *Id.*

36. F. GRAD & N. MARTI, *supra* note 17, at 202-03. See also Southwick, *supra* note 8, at 434 ("In actual fact the practice of medicine has been institutionalized.") According to Southwick, the physician and the hospital are mutually dependent. *Id.* at 466.

37. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

38. *Id.* at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

Similarly, "[i]n abolishing the doctrine of charitable immunity, formerly available to charitable hospitals as a defense to negligence actions in North Carolina, Justice (later Chief Justice) Sharp acknowledged the changed structure of the modern hospital . . ." *Bost v. Riley*, 44 N.C. App. 638, 645, 262 S.E.2d 391, 395, cert. denied, 300 N.C. 194, 269 S.E.2d 621 (1980) (citing *Rabon v. Hospital*, 269 N.C. 1, 11, 152 S.E.2d 485, 492 (1967)).

Therefore, in recognition of new circumstances—or perhaps preexisting circumstances that had been conveniently ignored—the old rules of the hospital's limited role and the physicians' independent contractor status began to change.

The old rules obviously did not change all at once, but rather in a series of stages. In analyzing the changes as well as the limitations on those changes, a fundamental distinction must be made. On one hand, a hospital may be held vicariously liable on grounds of *respondeat superior* for the acts of its physicians. On the other hand, a hospital may be held liable for its own failure to exercise reasonable care in fulfilling its own duties. This distinction is analogous to the situation of a trucking company which can be held vicariously liable for the negligence of its employee driver, as well as for its own negligence in failing to exercise reasonable care in hiring, training or supervising its employee. In addition, there is an important distinction between vicarious liability for the acts of an actual agent and vicarious liability, on principles akin to estoppel, for the acts of an apparent or ostensible agent.<sup>39</sup>

#### A. Hospital Liability Where the Negligent Party Was Actually an Agent of the Hospital<sup>40</sup>

Among the first steps in changing the traditional rules in agency cases were the holdings in *Bing*<sup>41</sup> and similar cases<sup>42</sup> that a hospital would be vicariously liable for the negligent acts of its employee physicians and nurses, even if the physician's or nurse's act was characterized as "medical" or "professional" rather than merely "administrative."<sup>43</sup> This development made the field of hospital liability more consistent with the general tort concepts of

39. See Southwick, *supra* note 8, at 452.

40. See generally, Southwick, *supra* note 8, at 452; Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452, 455 (1978); Annot., 69 A.L.R. 2d 305 (1960 & Supp. 1980).

41. See *supra* notes 37-38 and accompanying text.

42. See *e.g.* Waynick v. Reardon, 236 N.C. 116, 120, 72 S.E.2d 4, 7 (1952) (Duke University Hospital would be vicariously liable for the negligence of a salaried resident).

43. Southwick, *supra* note 8, at 452; Stromberg, *Corporate Hospital Liability and Responsibility for Health Care*, in CRITICAL ISSUES IN HEALTH LAW, 16 (1978). But see Comment, *supra* note 25, at 392 n.50 (*Beeck v. Tucson Gen. Hosp.*, 18 Ariz. App. 165, 500 P.2d 1153 (1972) applied the rejected doctrine of distinguishing administrative acts from medical acts, because of the court's confusion in attempting to apply the control test).

vicarious liability for the acts of employees. However, in accordance with general rules of tort liability, a hospital would not be liable for the acts of physicians who were independent contractors rather than employees.

After courts began to hold that a hospital could be vicariously liable for the negligent "medical" acts of its employees, including physicians and nurses, the borrowed servant doctrine took on added significance. Under the borrowed servant doctrine, an independent contractor physician temporarily makes the hospital's nurse or employed physician<sup>44</sup> his own agent rather than the hospital's agent. Under those circumstances, the negligence of the "borrowed" nurse or employed physician will be imputed only to the "borrowing" physician as his or her temporary master.<sup>45</sup> When a hospital was not held liable for the professional acts of its employee physicians and nurses, it made little difference whether the hospital's employees were borrowed by an independent contractor, or, alternatively, remained the servants of the hospital. However, once a hospital could be held liable for its employees' professional acts, it was crucial to determine whether the doctor or the hospital was the master for purposes of vicarious liability. Eventually, however, courts began to reject the borrowed servant doctrine.<sup>46</sup>

Since the rejection of the borrowed servant doctrine and the distinction between "professional" acts and "administrative" acts,<sup>47</sup> the rules in health care agency cases have been consistent with cases outside the health care field. Thus, a hospital will be held vicariously liable on grounds of *respondeat superior* if the

44. It is not clear whether the borrowed servant doctrine applied to employed physicians as well as employed nurses. However, the rationale of the doctrine apparently applies to residents assisting in surgery and possibly to an anesthesiologist as well.

45. Southwick, *supra* note 8, at 442.

Sometimes a private physician (an independent contractor) will temporarily "borrow" a hospital employee to direct with respect to a given task. If the doctor's ability to control the doing of the task is readily visible, a court may apply the Borrowed Servant Doctrine, thereby rendering the physician vicariously liable for any negligence of *his* temporary employee, and perhaps insulating the hospital from liability.

*Id.* (footnote omitted).

46. *Id.* at 442, 452. "Recent cases, especially litigation involving erroneous sponge counts by surgical nurses, indicate a demise of or a judicial reluctance to apply the Borrowed Servant Doctrine. Hence, the liability (vicarious) is the hospital's and not the doctor's . . ." *Id.* at 442 (footnote omitted).

47. See *supra* notes 41-43 and accompanying text.

negligent physician is an employee or agent, but not if the physician is an independent contractor.<sup>48</sup> However, although the formal rule structure comports with negligence cases in other industries, there are unique problems in applying the doctrine of *respondeat superior* in the health care field. Specifically, the attempt to apply the control test as the determinant of independent contractor status leads to confusion when applied to the right of lay hospital administrators and trustees to control a physician's treatment of his patient in the hospital.<sup>49</sup>

According to one court,<sup>50</sup> the legal standard for independent contractor status is whether the alleged employer "assumes the right to control the time, manner and method of executing the work, as distinguished from the right merely to require certain definite results in conformity to the contract."<sup>51</sup> Does this mean that a physician is always an independent contractor, because the lay hospital administrator cannot direct the physician in the performance of an operation or require him to prescribe a particular medication? Or is a physician always sufficiently controlled to be an agent or employee of the hospital, because he is required to comply with the rules and regulations of the hospital as to privileges, consultations and committee reviews?<sup>52</sup> Courts appear to have taken both of these extreme positions. For example, in *Mduba v. Benedictine Hospital*,<sup>53</sup> the court held that because the emergency room physician was required to comply with the rules of the hospital board, he "was controlled by the defendant hospital as to the means or manner of achieving this result."<sup>54</sup> Similarly, in *Beeck v.*

48. See, e.g., *Johnson v. St. Bernard Hosp.*, 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979); *Waynick v. Reardon*, 236 N.C. 116, 120, 72 S.E.2d 4, 7 (1952). See also Harty & Mullholland, *The Legal Status of the Hospital Medical Staff*, 22 St. Louis U.L.J. 485, 491 n.28 (1978) ("Generally, courts readily have imposed liability on hospitals under the doctrine of *respondeat superior* for the negligent medical acts of employee physicians.").

There is a separate requirement that the employee or agent must be operating within the scope of his employment or agency. See *James v. Holder*, 34 A.D.2d 632, 309 N.Y.S.2d 385 (1970); *Waynick v. Reardon*, 236 N.C. 116, 72 S.E.2d 4 (1952); *Smith v. Duke Univ.*, 219 N.C. 628, 14 S.E.2d 643 (1941).

49. Comment, *supra* note 25, at 392-94 (control test does not work because control by laymen is impractical and illegal.)

50. *Hodges v. Doctors' Hosp.*, 141 Ga. App. 649, 234 S.E.2d 116 (1977).

51. *Id.* at 651, 234 S.E.2d at 117.

52. See *infra* notes 141-43 and accompanying text.

53. 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976).

54. *Id.* at 452, 384 N.Y.S.2d at 529.

*Tucson General Hospital*,<sup>55</sup> the court looked at many factors including the fact that "the hospital could regulate operation of its x-ray department to the extent of requiring that the descent-arresting stop be in place before undertaking the type of procedure in question here."<sup>56</sup> However, a contrary interpretation of the control test was taken in *Beck v. Lovell*,<sup>57</sup> which held that the hospital would not be liable for a surgeon's acts on the basis of *respondet superior*, because there was no showing that the hospital had any control of the surgeon or the manner of performing surgery.<sup>58</sup> Moreover, in *Overstreet v. Doctors' Hospital*,<sup>59</sup> the court held that where the hospital had no right to control the specific techniques used by the emergency room physicians, but could merely monitor the quality of the work, the physicians were independent contractors, notwithstanding the hospital's control of matters other than the method of treatment.<sup>60</sup> As indicated by these conflicting decisions, the control test yields neither reasoned nor consistent solutions when applied to physicians in hospitals.<sup>61</sup> As one court<sup>62</sup> concluded, "hornbook rules of agency" do not apply, and the relationship is *sui generis*.<sup>63</sup> Commentators have reached the same conclusion.<sup>64</sup> As one commentator<sup>65</sup> explained, because the control test does not work in this context, courts speak of control, but actually ignore the issue of control in favor of a tacit analysis of the

55. 18 Ariz. App. 165, 500 P.2d 1153 (1972).

56. *Id.* at 170, 500 P.2d at 1158.

57. 361 So. 2d 245 (La. Ct. App. 1978).

58. *Id.* at 252.

59. 142 Ga. App. 895, 237 S.E.2d 213 (1977).

60. *Id.* at 897, 237 S.E.2d at 215.

61. *See supra* note 49.

62. *Adamski v. Tacoma Gen. Hosp.*, 20 Wash. App. 98, 579 P.2d 970 (1978).

63. *Id.* at 105, 579 P.2d at 974.

64. Southwick, *supra* note 8, at 465; Comment, *supra* note 25, at 392-94. Placing the doctor in the legal status as an "employee" or as a "servant" is not necessarily inconsistent with a professional's clinical freedom to possess and exercise independent skill and judgment. To be sure, the traditional legal definition of an employee is that he or she is an individual subject to the master's right to control the means and methods of the performance of the employee's work. *But in both English and American decisions the courts have departed from traditional definition: in hospital liability cases.* In short, professional individuals are deemed to be employees even though the practice of their professional work is not in fact subject to detailed control by lay hospital administrators.

Southwick, *supra* note 8, at 465 (emphasis added).

65. Comment, *supra* note 25, at 392-94.

relations between hospital and patient and between hospital and physician, such as whether the physician was on salary at the hospital.<sup>66</sup> If the physician receives a salary from the hospital, then he will be deemed to be an employee, and the hospital will be held vicariously liable.<sup>67</sup>

Determining whether a negligent physician is the agent of a hospital for purposes of *respondeat superior* is much more difficult if the physician does not receive a salary from the hospital.<sup>68</sup> In general, a physician in private practice who merely has staff privileges at the hospital will not be considered an agent or employee of the hospital.<sup>69</sup> "Courts consider it irrelevant that a physician has 'staff privileges' at a hospital, since such privileges merely permit the physician to use the hospital for his or her private patients."<sup>70</sup> However, a court may look at the facts of a particular case to determine whether a physician is an independent contractor,<sup>71</sup> and the evidence may be sufficient to raise a jury question as to the physician's status in some cases.<sup>72</sup>

66. *Id.* According to that commentator, salary is the only significant factor of the hospital/physician relation. *Id.*

67. *See, e.g.,* Johnson v. St. Bernard Hosp., 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979); Waynick v. Reardon, 236 N.C. 116, 72 S.E.2d 4 (1952) (salaried assistant resident was an agent, servant and employee).

68. *See* Horty and Mulholland, *supra* note 48, at 491 n.28 ("Whether the physician's status is that of an independent contractor with staff privileges at a hospital or of an actual employee of the hospital often may be unclear, however, due to the various methods of paying physicians and the various levels of staff privileges commonly granted in hospitals.").

69. Evans v. Bernhard, 23 Ariz. App. 413, 417, 533 P.2d 721, 725 (1975) (staff privileges do not necessarily make the doctor an employee); Cooper v. Curry, 92 N.M. 417, 419, 589 P.2d 201, 203 (1978); Jeffcoat v. Phillips, 534 S.W.2d 168, 173 (Tex. Civ. App. 1976) ("[A] doctor of the choice of a patient is still considered by a majority of states to be an 'independent contractor' with regard to hospitals at which he has staff privileges.").

70. Cooper v. Curry, 92 N.M. 417, 419, 589 P.2d 201, 203 (1978). *See also*, Zaremski & Spitz, *supra* note 15, at 228-29. "Even if the physician is a member of a hospital's medical staff, he is generally held to be an independent contractor if he does not receive a regular salary from the hospital, maintains a private practice, and if he is directly chosen by the patient . . ." *Id.* (footnote omitted).

71. Evans v. Bernhard, 23 Ariz. App. 413, —, 533 P.2d 721, 725 (1975).

72. *See e.g.,* Hodges v. Doctors' Hosp., 141 Ga. App. 649, 653, 234 S.E.2d 116, 118 (1977).

Procedurally, when the defendant hospital files a motion for summary judgment on the ground that the allegedly negligent physician is an independent contractor, supported by the hospital administrator's affidavit disclaiming control, it is perilous for the plaintiff patient to fail to respond with evidence sufficient to

In contrast to physicians in private practice with admitting privileges, specialists such as radiologists, anesthesiologists and emergency room physicians may be held to be employees or agents of the hospital even without receiving a salary from the hospital. For example, in *Beeck*<sup>73</sup> the court held that the radiologist was an employee of the hospital, notwithstanding contractual provisions to the contrary, where he and his associates operated the hospital's radiology department under an exclusive contract, with payment based on a percentage of income from the x-ray department rather than a salary.<sup>74</sup> Similarly, the court in *Kober v. Stewart*<sup>75</sup> held that the radiologist might be an agent of the hospital because the contract might have been a means of hiring a supervisor for the hospital's x-ray department.<sup>76</sup> There are analogous cases involving anesthesiologists.<sup>77</sup> Finally, emergency room physicians may also be held to be agents or employees of the hospital.<sup>78</sup>

In conclusion, the nonsalaried physician with staff privileges will probably not be held to be an agent or employee of the hospital, although specialists under contract to perform certain hospital

make out a genuine issue of material fact. See, e.g., *Badeaux v. East Jefferson Gen. Hosp.*, 364 So.2d 1348 (La. Ct. App. 1978).

73. *Beeck v. Tucson Gen. Hosp.*, 18 Ariz. App. 165, 500 P.2d 1153 (1972).

74. *Id.* at 169-71, 500 P.2d at 1158. See Southwick, *supra* note 8, at 442-43. "Of major significance in *Beeck* was that recitals in the contract between the hospital and the medical specialists that the latter are to be considered independent contractors did not prevent the court from finding otherwise." *Id.* at 443 (footnote omitted).

75. 148 Mont. 117, 417 P.2d 476 (1966).

76. *Id.* at 123, 417 P.2d at 479.

77. *Compare Garcia v. Tarrio*, 380 So. 2d 1068 (Fla. Dist. Ct. App. 1980) (*per curiam*) (sufficient evidence of agency) with *Holzberg v. Flower and Fifth Ave. Hosp.*, 39 A.D.2d 526, 330 N.Y.S.2d 682, *aff'd without op.*, 32 N.Y.2d 716, 344 N.Y.S.2d 3 (1973) (anesthetist was independent contractor).

78. See, e.g., *Mduba v. Benedictine Hosp.*, 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976); *Rucker v. High Point Memorial Hosp., Inc.*, 20 N.C. App. 650, 202 S.E.2d 610 (1974), *aff'd*, 285 N.C. 519, 206 S.E.2d 196 (1974) (contract for emergency room doctors established an employer-employee relation where they lacked admitting privileges, worked full-time and had no private practice); *Adamski v. Tacoma Gen. Hosp.*, 20 Wash. App. 98, 579 P.2d 970 (1978) (nonsalaried emergency room physicians might have really been agents of the hospital because plaintiff went to the emergency room and had no choice of doctor, and because the physicians performed "an inherent function of the hospital") (quoting *Beeck v. Tucson Gen. Hosp.*, 18 Ariz. App. 165, 500 P.2d 1153 (1972)). *But see Overstreet v. Doctors' Hosp.*, 142 Ga. App. 895, 237 S.E.2d 213 (1977) (emergency room physicians were not employees); *Johnson v. St. Bernard Hosp.*, 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979) (no vicarious liability for acts of emergency room physician).

functions will often be held to be agents or employees. It can be argued that a physician with staff privileges should be deemed to be the agent of the hospital in light of the current organizational and administrative structure of the hospital and its medical staff.<sup>79</sup> However, courts seldom analyze the nature and organization of the modern hospital or its medical staff in making decisions on agency status. Moreover, courts may avoid holding that all staff physicians are agents in order to avoid imposing liability on the hospital for every negligent act of every member of its medical staff.<sup>80</sup>

*B. Hospital Liability Where the Negligent Party Was the Apparent or Ostensible Agent of the Hospital*

Even if a physician is not the agent of the hospital, as between the physician and the hospital, courts may treat the physician as the hospital's agent on the ground that the hospital deceived the patient into believing that he was being treated by an agent of the hospital.<sup>81</sup> The doctrine of apparent agency as a basis for imposing vicarious liability in tort is not a new or controversial concept.<sup>82</sup> Moreover, courts have recognized its application in the health care field for at least forty years.<sup>83</sup> As explained in *Seneris v. Haas*,<sup>84</sup> there are three elements required to establish ostensible agency:

An agency is ostensible when the principal intentionally, or by want of ordinary care, causes a third person to believe another to be his agent who is not really employed by him . . . . Before a

79. See *infra* notes 120-51 and accompanying text.

80. See Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 *RUTGERS L. REV.* 342, 359 (1979). "It appears unlikely, therefore, that courts would expand the theory of respondeat superior to provide a basis on which hospitals are found liable for the malpractice of the independent private physician members of its medical staff." *Id.* at 359 (footnote omitted).

81. See, e.g., *Grewe v. Mt. Clemens Gen. Hosp.*, 404 Mich. 240, 250-52, 273 N.W.2d 429, 433-34 (1978) (degree of control exercised by hospital is irrelevant); *Mduba v. Benedictine Hosp.*, 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976); *Shagrin v. Wilmington Medical Center, Inc.*, 304 A.2d 61 (Del. Super. Ct. 1973). See also *Horty & Mulholland, supra* note 48, at 491 n.28; *Southwick, supra* note 8, at 452.

82. See *W. PROSSER, supra* note 29, § 70, at 467.

83. See, e.g., *Stanhope v. Los Angeles College of Chiropractic*, 54 Cal. App. 2d 141, 128 P.2d 705 (1942); *Smith v. Duke Univ.*, 219 N.C. 628, 635, 14 S.E.2d 643, 648 (1941) (hospital not liable on ground of apparent authority in absence of evidence, *inter alia*, that doctor was "held out by the [hospital] as having been employed by it to treat pay patients").

84. 45 Cal. 2d 811, 291 P.2d 915 (1955).



recovery can be had against a principal for the alleged acts of an ostensible agent, three things must be proved, to-wit . . . (First) The person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one; (second) such belief must be generated by some act or neglect of the principal sought to be charged; (third) and the third person in relying on the agent's apparent authority must not be guilty of negligence.<sup>85</sup>

Although the courts look at various factors in determining whether there is an ostensible agency, the fundamental inquiry is whether the hospital "held out" the physician as its agent,<sup>86</sup> thereby estopping the hospital from denying an agency relationship.<sup>87</sup> For example, in *Shagrin v. Wilmington Medical Center, Inc.*,<sup>88</sup> the court held that there were issues of fact as to both the actual relationship of the hospital to the emergency room physicians and the hospital's representation to the public that the emergency room was part of the hospital.<sup>89</sup> The court in *Shagrin* held that, especially where there is a holding-out, the hospital can be liable for the acts of "independent contractors performing medical services ordinarily performed by the hospital."<sup>90</sup> The significance of "performing medical services ordinarily performed by the hospital"<sup>91</sup> is not entirely clear, because courts appear to consider it as having a significance even beyond its effect in misleading the patient. Rather, courts in ostensible agency cases appear to analyze the relationships between patient and physician and between patient and hospital in order to determine whose treatment the patient sought.<sup>92</sup> For example, in *Grewe v. Mt. Clemens General Hospital*,<sup>93</sup> the court held that a physician with staff privileges

85. *Id.* at 831, 291 P.2d at 927 (quoting *Stanhope v. Los Angeles College of Chiropractic*, 54 Cal. App. 2d 141, 146, 128 P.2d 705, 708 (1942) and *Hill v. Citizens Nat. Trust & Sav. Bank*, 9 Cal. 2d 172, 176, 69 P.2d 853, 855 (1937)).

86. *Mduba v. Benedictine Hosp.*, 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976).

87. *See, e.g., Grewe v. Mt. Clemens Gen. Hosp.*, 404 Mich. 240, 250-52, 273 N.W.2d 429, 433-34 (1978). *See also* *Horty & Mulholland, supra* note 48, at 491 n.28 ("[T]he hospital may be held to be estopped from claiming that the physician is not an employee where a plaintiff patient applied directly to the hospital for treatment and the hospital provided the services of a physician.").

88. 304 A.2d 61 (Del. Super. Ct. 1973).

89. *Id.* at 64.

90. *Id.*

91. *Id.*

92. *See supra* notes 65-66 and accompanying text.

93. 404 Mich. 240, 273 N.W.2d 429 (1978).

would be the agent of the hospital if the patient sought treatment from the hospital and the hospital provided a physician for the patient.<sup>94</sup> Under those circumstances, there would be no independent doctor-patient relation, and, therefore, the patient would not view the hospital as the place where his own doctor treats him.<sup>95</sup> Although the patient in *Grewe* had no reason to know that the physician was an independent contractor rather than an employee,<sup>96</sup> the court stated in dictum that the hospital might be liable despite that knowledge on the part of the patient.<sup>97</sup> Therefore, ostensible agency may encompass a functional analysis of the patient's relationships as well as the more traditional analysis of a "holding-out" by the hospital. The traditional "holding-out" theory of ostensible agency is based on the obvious unfairness of subjecting an injured party to secret limitations on the authority of an apparent agent,<sup>98</sup> and on the desire to place the loss on the party

94. *Id.* at 251, 273 N.W.2d at 433.

95. *Id.* at 250-51, 273 N.W.2d at 433.

96. *Id.* at 253, 273 N.W.2d at 434.

97. *Id.* at 255, 273 N.W.2d at 435. In addition, the court in *Grewe* cited *Shagrin v. Wilmington Medical Center, Inc.*, 304 A.2d 61 (Del. Super. Ct. 1973) and stated that vicarious liability should be applied where independent contractors perform "medical services ordinarily performed by the hospital." 404 Mich. at 251-52, 273 N.W.2d at 433.

98. *See, e.g.,* *Beeck v. Tucson Gen. Hosp.*, 18 Ariz. App. 165, 500 P.2d 1153 (1972) (radiologist was really the hospital's agent, notwithstanding a contract to the contrary). *See supra* note 74. Although *Beeck* was not based on ostensible agency, the concept of fairness is the same. Southwick, *supra* note 8, at 452. Moreover, the *Beeck* court refused to give effect to the patient's acceptance of the independent contractor relationship in a hospital consent form. As Southwick explains,

[t]he court further held that a "Conditions of Admissions" form signed by the patient whereby she purportedly agreed to such an independent contractor relationship, and acknowledged that the radiologist was not an employee of the hospital, was of no legal effect. To be sure, in *Beeck*, the patient was a native of Germany who was handicapped in her understanding of the English language, this being one reason the court disregarded the contractual language. However, it is believed that the result would be the same were there no language barrier chiefly because the bargaining power of the parties in the hospital setting is so grossly unequal.

*Id.* at 443 (footnotes omitted).

Arguably, recitations in a consent form would have greater significance in cases of ostensible agency than in cases of actual agency, because ostensible agency doctrine often relies on the patient's knowledge rather than the reality of the hospital-physician relationship. Nevertheless, such clauses in consent forms

whose "holding-out" made the loss possible. However, a "holding-out" analysis is often somewhat superficial, in that the patient probably did not change his position or consent to treatment in reliance on the hospital's representation to him that a physician was its agent. Therefore, it is awkward to attempt to apply a classic estoppel theory. For this reason, the functional analysis of the patient's relationships with the hospital and the physician is a valuable addition to ostensible agency theory. Moreover, although courts use the language of reliance and estoppel, they might be using the doctrine of ostensible agency in order to force the hospital to bear and distribute the loss.<sup>99</sup>

### C. Hospital Liability for Its Own Negligence

Aside from vicarious liability on grounds of *respondeat superior* for the negligence of its actual or ostensible agents, a hospital can also be held liable for its own negligence, which is often referred to as "corporate liability."<sup>100</sup> "In contrast to the vicarious nature of *respondeat superior*, the doctrine of 'corporate negligence' involves the violation of a duty owed *directly* by the hospital to the patient."<sup>101</sup> A hospital always had a duty to its patients.<sup>102</sup> However, as explained above,<sup>103</sup> in accordance with the traditional nature of the hospital as a mere "workshop," the hospital's duty was limited to such areas as providing safe facilities, and the hospital did not have a duty to provide or supervise patient care.<sup>104</sup> Therefore, as the court explained in the landmark case of

---

should be ignored by the courts, because they do not indicate knowledge or understanding on the part of the patient. It is interesting to note that the Patient's Bill of Rights of the Joint Commission on Accreditation of Hospitals provides that the patient has the right to know the professional relationships of those who treat him. Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals: 1982 Edition*, xiv (1981) [hereinafter JCAH]. See *infra* notes 128-39 and accompanying text.

99. See also *infra* note 112.

100. See generally Stromberg, *supra* note 43; Zaremski and Spitz, *supra* note 15; Note, *supra* note 80; Southwick, *supra* note 8; Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383 (1980); Annot., 13 A.L.R. 3d 873 (1967 & Supp. 1980).

101. *Bost v. Riley*, 44 N.C. App. 638, 645, 262 S.E.2d 391, 395, *cert. denied*, 300 N.C. 194, 269 S.E.2d 621 (1980).

102. See *supra* notes 23-24 and accompanying text.

103. See *supra* notes 20-24 and accompanying text.

104. See *supra* note 24 and accompanying text.

*Darling v. Charleston Community Memorial Hospital*,<sup>105</sup> the relatively recent recognition of a hospital's duty in regard to patient care is really an issue of "the standard of conduct required to satisfy the duty," because "the duty is always the same . . ."<sup>106</sup> As with changes in the application of agency doctrines,<sup>107</sup> the corporate liability doctrine resulted, at least in part, from a recognition of the changed nature of the modern hospital.<sup>108</sup>

Although the precise facts and holding of *Darling* are unclear,<sup>109</sup> *Darling* is generally identified with the corporate liability doctrine, under which the hospital's duty to its patient requires the hospital to supervise the provision of all patient care within the hospital, including the care provided by physicians acknowledged to be independent contractors. In *Darling*, the court held that a hospital could be liable for failing to provide enough trained employees or for failing to require a physician to consult with a specialist or to review the physician's treatment of the patient.<sup>110</sup> Other courts have held that a hospital will be liable on the ground of corporate liability for negligently admitting an incompetent physician to staff membership,<sup>111</sup> and negligently permitting a

105. 33 Ill. 2d 326, 211 N.E.2d 253, cert. denied, 383 U.S. 946 (1966).

106. *Id.* at 331, 211 N.E.2d at 256-57 (quoting W. PROSSER, HANDBOOK OF THE LAW OF TORTS 331 (3d ed. 1964)).

107. See *supra* notes 34-48 and accompanying text.

108. See *Darling*, 33 Ill. 2d at 332, 211 N.E.2d at 257 (citing *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957)); *Bost v. Riley*, 44 N.C. App. 638, 645, 262 S.E.2d 391, 395 cert. denied, 300 N.C. 194, 269 S.E.2d 621 (1980) ("In contrast, today's hospitals regulate their medical staffs to a much greater degree and play a much more active role in furnishing patients medical treatment.").

109. Although *Darling* is almost always cited as a case of corporate liability, the court in *Collins v. Westlake Community Hosp.*, 12 Ill. App. 3d 847, 299 N.E.2d 326 (1973), *rev'd on other grounds*, 57 Ill. 2d 388, 312 N.E.2d 614 (1974), stated that *Darling* dealt with a physician employed by the hospital. *Id.* at 851, 299 N.E.2d at 328.

110. *Darling*, 33 Ill. 2d at 333, 211 N.E.2d at 258. *Accord*, *Bost v. Riley*, 44 N.C. App. 638, 647, 262 S.E.2d 391, 396, cert. denied, 300 N.C. 194, 269 S.E.2d 621 (1980) ("[I]t seems axiomatic that the hospital have the duty assigned by the *Darling* Court to make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the facility.").

*Darling* arguably involves an element of vicarious liability in that the hospital is held liable for the failure of its nurses and administrators to provide and supervise care. However, the significance of *Darling* appears to be the recognition that the hospital entity will violate its corporate duty by failing to meet its own standard of conduct.

111. *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307

known incompetent to practice medicine in the hospital.<sup>112</sup>

How can the hospital fulfill its duties under *Darling* to review a physician's treatment of a patient and keep incompetent physicians off its medical staff? For both practical and legal reasons, these supervisory duties must be delegated to licensed medical professionals.<sup>113</sup> In practice, a hospital delegates these duties to its medical staff,<sup>114</sup> and the medical staff acts as an agent of the hospital in carrying out those duties.<sup>115</sup> This delegation of authority from the hospital to the medical staff is significant for several reasons. First, the possibility of delegation eliminates any excuse by the hospital that it is legally unable to perform its duty to supervise treatment.<sup>116</sup> The hospital cannot avoid its duty by the excuse

(1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972).

112. 229 Ga. at 142-43, 189 S.E.2d at 414. *Accord*, *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super, 302, 307, 350 A.2d 534, 537 (1975) ("placing an incompetent in a position to do harm.").

However, some courts have held that the corporate negligence doctrine should not be extended to cases based on a lack of informed consent. *See, e.g.*, *Cooper v. Curry*, 92 N.M. 417, 589 P.2d 201 (1978); *Cox v. Haworth*, 54 N.C. App. 328, 283 S.E.2d 392 (1981).

Questions have been raised as to whether the doctrine of corporate liability should be retained as a separate theory in addition to the doctrine of vicarious liability. For example, one commentator has concluded that the two doctrines of *respondeat superior* and corporate negligence have merged as a result of the desire to impose liability on the institutional provider of health care. Southwick, *supra* note 8, at 452. Moreover, there is often an overlapping area of liability involving both doctrines. For example, a failure of the hospital's medical staff, as agent of the hospital, to properly supervise patient care is both the negligence of the hospital's agent for purposes of *respondeat superior* and the hospital's own negligence in failing to carry out its own duty of oversight.

113. *See supra* notes 25-28 and accompanying text.

114. *See JCAH, supra* note 98, at 55. "The governing body shall delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants for clinical privileges. Such delegation, however, does not relieve the governing body of its responsibility for appointing members of the medical staff." *Id.* *See also infra* text accompanying notes 138-39.

115. According to the RESTATEMENT (SECOND) OF AGENCY § 1 (1958), "[a]gency is the fiduciary relation which results from the manifestation of consent by one person to another that the other shall act on his behalf and subject to his control, and consent by the other so to act." *See also* BLACK'S LAW DICTIONARY 59 (5th ed. 1979) (an agent is "[a] person authorized by another to act for him . . ."). *See also infra* note 118.

116. For example, in *Darling*, the hospital argued on appeal that the trial court should have instructed the jury that only a doctor can practice medicine. The appellate court, however, upheld the trial court's instruction. 33 Ill. 2d at 338-39, 211 N.E.2d at 261.

that it is legally unable to perform a task itself, but rather the hospital must meet its duty by delegating the performance of the required task. A second significant aspect of delegation is that the hospital entity remains liable, notwithstanding its delegation of performance to the medical staff.<sup>117</sup> Thus, the hospital is still responsible for both the quality of care and the conduct of its professional agents in supervising that care.<sup>118</sup> Finally, the delegation of supervisory authority to the medical staff, as agent for the hospital's governing board, has caused fundamental changes in the structure of the modern hospital, as explained in detail below.<sup>119</sup>

### III. THE EFFECT OF THE NEW NEGLIGENCE RULES ON THE STRUCTURE OF THE RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN

As stated above, the changes in tort law resulted, at least in part, from changes in the nature and operation of the hospital, or perhaps from a belated recognition of its preexisting nature and operation.<sup>120</sup> These changes in the law of negligence, in turn, caused profound changes in the structure of the modern hospital and its relations with physicians.<sup>121</sup> The threat of financial liability for failure to properly supervise physicians' treatment in the hospital caused hospitals to exercise greater supervision and control over physicians.<sup>122</sup> As two commentators explained,

[t]he consequence of *Darling* and the many cases that followed it has been to require hospitals to protect themselves against medical malpractice claims by exercising far greater care and control not only over staff physicians hired by the hospital

117. See *supra* note 114. See also *infra* note 118 and text accompanying note 139.

118. See *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972). "[T]he delegation of the authority to screen applicants for staff membership on the medical staff does not relieve the [Hospital Authority] of its responsibility, since the members of such staff act as agent for the [Hospital Authority] . . ." 229 Ga. at 142, 189 S.E.2d at 414.

119. See *infra* notes 120-51 and accompanying text.

120. See *supra* notes 34-38 and accompanying text.

121. See *Southwick*, *supra* note 8, at 434 ("[T]he author's contention is that expanding rights of the patient vis-a-vis the hospital dictate a new relationship between the hospital and the private physician, which in turn will affect the patient-physician relationship in ways yet to be clarified.") (footnote omitted).

122. F. GRAD & N. MARTI, *supra* note 17, at 202, 210.

but also over those who are granted the privilege of treating patients in the hospital and using its facilities.<sup>123</sup>

The hospital's exercise of greater control over physicians required changes in the roles played by the hospital's governing body, administrators and medical staff.<sup>124</sup> Moreover, as might be expected, the changes in traditional roles have led to anxiety and insecurity.<sup>125</sup> Commentators have also concluded that the traditional view of the hospital, which distinguished between lay hospital functions and professional medical functions, has given way to a newer view of the hospital as a single institution under the control of the governing board.<sup>126</sup> As one commentator explained the effect of *Darling* on hospital organization,

[i]t will have a very significant effect upon the management of many community hospitals because it demands that fragmentation within the walls of the institution be minimized. In other words, the historical separation between lay hospital administration, on one hand, and the clinical practice of medicine, on the

123. *Id.* at 202 (footnote omitted).

124. See JCAH, *supra* note 98, at xii.

It is a fact that hospital governing bodies are responsible for the overall conduct of the hospital in a manner consonant with the hospital's objective to delivering a high-quality of patient care. A clear statement to this effect should serve to dispel any confusion and to establish a sound basis for a realistic and workable set of relationships among the governing body, the hospital administration, and the medical staff. While these internal relationships are in the process of development and adjustment, it is essential that the responsibility of the hospital's governing body be stated, that the essential role of the chief executive officer acting on behalf of the governing body be recognized, that the role of the medical staff be stated, and that conflicting lines of authority and communication be avoided.

*Id.*

125. Rourke, *Medical Staff Organization*, in *THE MEDICAL STAFF IN THE MODERN HOSPITAL*, 9 (C. Eisele, ed. 1967). "The administrator, often caught between the board and the staff, keeps his antacid bottle filled and handy and hopes that some day he may understand it all." *Id.*

126. Horthy & Mulholland, *supra* note 48, at 487-88; Southwick, *supra* note 8, at 430, 443, 453, 466-67; Southwick, *Legal Aspects of Medical Staff Function*, in *THE MEDICAL STAFF IN THE MODERN HOSPITAL*, 82 (C. Eisele, ed. 1967). Although the hospital administration, rather than the governing board, controls the daily operations of the hospital, the administration is accountable to the governing board, just as the medical staff is accountable to the governing board. See JCAH, *supra* note 98 at 55, 93.

other, is clearly deemphasized, if not abolished.<sup>127</sup>

However, courts may not adopt the concept of the hospital as a unified entity, because of their reluctance to infringe on the freedom of staff physicians in their practices outside the hospital, as well as their reluctance to impose liability on the hospital for all torts and statutory violations by medical staff members.

The current relationship between hospital and physician, as a matter of organizational dynamics, results from the interaction of various legal requirements, professional standards and practical considerations. The interaction of these legal and practical factors is illustrated by the accreditation standards of the Joint Commission on Accreditation of Hospitals (JCAH).<sup>128</sup> These accreditation standards play an important role in federal law as a method of compliance with the conditions of participation in the Medicare and Medicaid programs.<sup>129</sup> Although the JCAH standards set forth in the Accreditation Manual for Hospital (AMH) are technically voluntary, hospitals must comply with these standards as a practical matter.<sup>130</sup> The JCAH standards, therefore, can be viewed as a blueprint of hospital organization.<sup>131</sup>

The accreditation standards of the JCAH require the hospital to have an organized governing body with "overall responsibility

127. Southwick, *supra* note 126, at 82.

128. See F. GRAD & N. MARTI, *supra* note 17, at 203-04; JCAH, *supra* note 98, at x.

129. See F. GRAD & N. MARTI, *supra* note 17, at 203-04; JCAH, *supra* note 98, at x. As Grad and Marti explain, Congress gave JCAH standards "the practical force of law" by the enactment of the Medicare and Medicaid programs, because the requirements for a provider to participate in those programs can be satisfied by state agency certification or by JCAH accreditation. F. GRAD & N. MARTI, *supra* note 17, at 203-04. See 42 U.S.C. § 1395bb (1976); 42 C.F.R. § 405.1901 (1981). However, there have been various formulations of the degree of federal review of this method of deemed compliance. See, e.g., 45 Fed. Reg. 74,826, 74,826-33 (1980). See generally, Jonas, *Measurement and Control of the Quality of Health Care*, in HEALTH CARE DELIVERY IN THE UNITED STATES, 387-88 (S. Jonas, ed. 1977).

In addition, many state hospital licensure laws are based on the standards issued by the precursor to the JCAH. M. ROEMER & J. FRIEDMAN, *DOCTORS IN HOSPITALS: MEDICAL STAFF ORGANIZATION AND HOSPITAL PERFORMANCE*, 36-40 (1971).

130. See *supra* note 129.

131. In addition, the JCAH standards require the governing board to enact certain policies, see, e.g., *id.* at 56, and adopt certain bylaws, see, e.g., JCAH, *supra* note 98, at 51, 56.



for the conduct of the hospital . . . ."<sup>132</sup> In addition, the hospital must have an "organized medical staff that has the overall responsibility for the quality of all medical care . . . as well as for accounting therefor to the governing body."<sup>133</sup> Under JCAH requirements, "only a member of the medical staff with admitting privileges shall admit patients to the hospital . . . ."<sup>134</sup> Moreover, the organized medical staff operates under bylaws which must conform to hospital policy and legal requirements,<sup>135</sup> and which have the dual function of providing for self-government of the medical staff and regulating the staff's relationship with the hospital.<sup>136</sup> The staff's relationship with the hospital is *not* limited to matters of patient care. Rather, medical staff bylaws must include "a formal means for medical staff participation in the development of hospital policy relative to both hospital management and patient care."<sup>137</sup> Finally, the JCAH standards clarify that, although the governing body must delegate the authority to judge physicians' performance to the medical staff,<sup>138</sup> the governing body retains responsibility for staff appointments.<sup>139</sup>

As a matter of organizational dynamics, the control of physicians' performance, which is delegated to the medical staff,<sup>140</sup> is accomplished by several mechanisms. First, admission to staff membership is strictly controlled, as is advancement to higher levels of privileges.<sup>141</sup> Second, even for physicians with full privileges, there are conditions, rules and regulations on such matters

132. *Id.* at 51. Although the governing body has "overall responsibility," the implementation of board policy is delegated to the chief executive officer. *See id.* at 55. *See also supra* note 126.

133. JCAH, *supra* note 98, at 93.

134. *Id.* at 56.

135. *Id.* at 55. *See generally* 9 AM. JUR. LEGAL FORMS 2d §§ 136:25-136:28 (1972 & Supp. 1980).

136. JCAH, *supra* note 98, at 55, 103. *See also* JCAH MONOGRAPH: MEDICAL STAFF BYLAWS 5 (1978) [hereinafter cited as MONOGRAPH].

137. JCAH, *supra* note 98, at 55. *See* MONOGRAPH, *supra* note 136, at 27 ("Both the hospital and medical staff bylaws should include a formal means for the medical staff or its representatives to participate in the development of hospital policy, particularly as it relates to the discharge of medical staff responsibility and the quality of patient care.").

138. *See supra* notes 113-15 and accompanying text.

139. *See supra* notes 113-18 and accompanying text.

140. *See supra* notes 113-15 and accompanying text.

141. *See* JCAH, *supra* note 98, at 93-101. *See generally*, F. GRAD & N. MARTI, *supra* note 17, at 204-05; McCall, *A Hospital's Liability for Denying, Suspending and Granting Staff Privileges*, 32 BAYLOR L. REV. 175 (1980).

as consultation and supervision.<sup>142</sup> Finally, there is an organized committee system to monitor physicians' performance.<sup>143</sup>

What is the legal relationship between the hospital and its medical staff in light of the accreditation standards and the organizational mechanism for quality control? Unfortunately, there is no clear answer to this question. On one hand, there is persuasive evidence that the medical staff is simply one part of the hospital, rather than an independent body. For example, one monograph published by the JCAH states, "in general, the medical staff is not considered a distinct legal entity, but rather an element of the hospital corporation. This symbiotic relationship needs to be reflected in the medical staff bylaws."<sup>144</sup> Several commentators agree that the hospital and its medical staff are unified.<sup>145</sup> Under this unity theory, "the organized medical staff is an 'agent' of the hospital corporation with a mandate to effectuate corporate purposes."<sup>146</sup> On the other hand, a few courts have treated the medical staff as an entity, by allowing an injured patient to sue the medical staff as an unincorporated association,<sup>147</sup> by holding that the medical staff can bring an action for a declaratory judgment as an unincorpo-

142. F. GRAD & N. MARTI, *supra* note 17, at 204-05. See Southwick, *supra* note 8, at 437.

143. F. GRAD & N. MARTI, *supra* note 17, at 204-05. See Southwick, *supra* note 8, at 437. As a result of these mechanisms, commentators have concluded that the hospital now plays a larger role in medical quality assurance. See M. ROEMER & J. FRIEDMAN, *supra* note 129, at 33. According to Roemer and Friedman, the hospital's increased role even applies to medical quality assurance outside of the hospital. *Id.* See also F. GRAD & N. MARTI, *supra* note 17, at 210.

144. MONOGRAPH, *supra* note 136, at 6.

145. See, e.g., Horthy & Mulholland, *supra* note 48, at 487-88, 499. "In fact, the hospital medical staff is not a legal entity at all. The medical staff has no legal life of its own and is merely one component of the hospital corporation." *Id.* at 499. See also Southwick, *supra* note 126, at 65, 82. ("A hospital, therefore, does not consist of two organizations or institutions—business and medical. Rather, it is a single organization."); Stromberg, *supra* note 43, at 32 ("a non-independent part of the hospital's corporate form").

146. Southwick, *supra* note 8, at 437-38. Accord, Stromberg, *supra* note 43, at 32.

147. Corleto v. Shore Mem. Hosp., 138 N.J. Super. 302, 311-12, 350 A.2d 534, 539 (1975) ("Plaintiffs could have named all 141 doctors individually as defendants, but to do so would serve no useful purpose.").

As to the tort liability of individual members of an unincorporated association for the torts of the association, "mere membership in a voluntary association does not make all members liable for acts of their associates done without their knowledge or approval." 6 AM. JUR. 2d *Associations and Clubs* § 48 (1963).

rated association,<sup>148</sup> and by holding that medical staff bylaws are a contract between the staff and the hospital.<sup>149</sup> However, those cases have been persuasively criticized by the commentators.<sup>150</sup> In light of the hospital's delegation of its supervisory authority to the medical staff, it is clear that the medical staff often acts as the agent of the hospital, regardless of whether the medical staff is also an independent entity. Therefore, it is unnecessary to determine whether the medical staff has an independent existence. Rather, for purposes of hospital liability on grounds of *respondet superior*, in antitrust as well as in negligence, the relevant questions with regard to a particular action or decision of the medical staff are (1) whether the physicians were acting as the hospital's medical staff rather than as individual physicians; and (2) if so, whether the staff was acting within the scope of its authority as agent of the hospital. Only if those two requirements are met can the hospital be held liable for acts of the medical staff as its actual agent. However, even if the physicians were not acting as the organized agent of the hospital, or even if they acted beyond the scope of their authority as agents, the hospital can be held liable on a corporate liability theory for failure to meet its own legal obligations, and can also be held liable on a theory of apparent authority for the acts of those it has held out as its agents.

#### IV. THE APPLICATION OF ANTITRUST LAW TO THE HEALTH CARE FIELD

##### A. *The Health Care Marketplace*

The health care marketplace has several characteristics which create a unique context for the application of antitrust law. As expressed in a 1974 Senate Report, "the health care industry does not respond to classic marketplace forces."<sup>151</sup> Because of this unique market behavior and the regulatory structure enacted to control that behavior, the United States Supreme Court has indicated that some cooperative activities in the health care field may

148. *St. John's Hosp. Medical Staff v. St. John's Regional Medical Center*, 90 S.D. 674, 245 N.W.2d 472 (1976).

149. *Id.* at 679, 245 N.W.2d at 474-75.

150. Harty & Mulholland, *supra* note 48, at 496-500; Stromberg, *supra* note 43, at 32.

151. S. Rep. No. 1285, 93rd Cong., 2d Sess. 39, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842, 7878.

be immune from federal antitrust laws.<sup>152</sup> Moreover, even in the absence of antitrust immunity, a trial court in a health care antitrust case "should give attention to the particular economic context in which the alleged conspiracy . . . took place."<sup>153</sup> Therefore, it is crucial to have at least a basic understanding of the "particular economic context" of the health care marketplace.

Under traditional forces of supply and demand, the entry of new suppliers into the marketplace will reduce prices for the goods or services, by increasing supply and intensifying competition among suppliers. This increased competition, in turn, will ordinarily drive inefficient suppliers from the market, and will discourage potential suppliers from entering the market. However, in the case of institutional health care, an increase in the number of providers in a geographic market does not ordinarily decrease price.<sup>154</sup> Therefore, competition does not weed out the inefficient or prevent the entry of new providers. Moreover, as Congress has explicitly determined, "competition does not or will not appropriately allocate supply . . ." of "institutional health services."<sup>155</sup> The failure of competition to properly allocate supply, geographically or by product, results from—and perpetuates—the phenomenon that an excess supply of institutional health care does not decrease the prices charged. Thus, new providers are still willing to enter an overcrowded market, and consumers do not derive lower prices

152. *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 101 S. Ct. 2415, 2423 n.18 (1981). See *infra* notes 176-99 and accompanying text.

153. *Id.* at 2424 n.19.

154. One exception to this phenomenon may be the entry of an alternative type of institutional provider. For example, the opening of an ambulatory surgical center may provide a less expensive alternative, and may even stimulate local hospitals to increase their outpatient surgery. Similar examples include abortion clinics, emergency medical centers and alternative financing systems such as health maintenance organizations.

155. 42 U.S.C. § 300k-2(b)(2) (Supp. IV 1980). In addition, Congress has found that "the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished," which results in "duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services." 42 U.S.C. § 300k-2(b)(1) (Supp. IV 1980). See also S. REP. NO. 1285, 93rd Cong., 2d Sess. 39, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842, 7878 ("investment in costly health care resources . . . is frequently made without regard to the existence of similar facilities or equipment already operating in an area."). The North Carolina General Assembly has similarly found that "the forces of free market competition are largely absent . . ." N.C. GEN. STAT. § 131-175(1) (Supp. 1981).

from increased competition among providers.

The reasons for the failure of competition to properly allocate supply or reduce prices for health care are complex. On the demand side, the presence of widespread health insurance severely limits the need for consumer price consciousness and creates an insensitivity to price.<sup>156</sup> In addition, faced with potentially life-threatening illness, consumers feel that money is no object, especially when it is largely their insurer's money. Thus, individual demand is inelastic, in that an individual's demand for necessary health services will remain constant despite increases in price. Finally, health care providers need not compete with the suppliers of non-health goods and services, because there are no substitutes for health care, and, therefore, there is no cross-elasticity of demand.

Turning to the supply side, the health care marketplace "does not respond to classic marketplace forces"<sup>157</sup> because the market is a natural monopoly or natural oligopoly.<sup>158</sup> Institutional health care requires a high level of capital investment, and, therefore, each provider has high fixed costs, both in absolute terms and in relation to variable costs. A hospital's capital investment in land, buildings and equipment cannot be diverted to other product lines during times of excess capacity, nor can it be moved to another location to reach patients beyond the hospital's limited service area. The combination of high fixed costs with the inability to divert to other product or geographic markets indicates a natural monopoly or natural oligopoly. Under these circumstances, each

156. See generally Marmor, Boyer, and Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003, 1008 (1981) ("[B]ecause of the coverage afforded by health insurance, the decision to consume medical care is not made with limited financial resources.").

157. See *supra* note 151 and accompanying text.

158. See generally Gellhorn, *An Introduction to Antitrust Economics*, 1975 DUKE L.J. 1, 35 n.32. "When it is necessary to allow a firm a market monopoly in order to realize economies of scale, a 'natural monopoly' is said to exist. In such markets, government price regulation is frequently imposed to prevent the 'natural monopolist' from pushing price above competitive levels." *Id.*

Significantly, almost every state regulates market entry for institutional health care, but few states regulate health care prices. The anomaly of entry barriers without rate regulation was one of the factors cited by the North Carolina Supreme Court in invalidating the prior North Carolina certificate of need law. *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 550, 193 S.E.2d 729, 734 (1973). The presence of governmental barriers to market entry, combined with the absence of widespread price regulation, creates a unique marketplace for the application of antitrust law.

provider must have a large market share in order to provide enough services to cover its high fixed costs. A new provider's entry into the marketplace will decrease the market shares of existing providers, and cause the high fixed costs to be spread over a smaller volume of services. This increases the cost for each unit of services, and forces each provider to raise the price it charges to consumers.

Normally, when there is excess supply and high price in an overcrowded market, at least one provider would be expected to lower its price in order to obtain a larger share of the total market demand and to drive less efficient providers from the marketplace. However, there is little, if any, price competition among health care institutions, even in an overcrowded market. One reason is that a price-cutter would not necessarily obtain a larger share of the health care market, because consumers do not make choices among competing hospitals on the basis of price. Rather, consumers are treated at a hospital where their own physician has admitting privileges. Therefore, the choice of provider is delegated to the admitting physician, rather than being made by the consumer or third-party payor. In addition, as discussed above, the market is insensitive to price. Hospitals do not advertise their prices, nor do they encourage physicians to choose a hospital for their patients on the basis of price. Although hospitals may compete for each physician's patients on matters other than price, such as new equipment and convenience for physicians, a hospital would not necessarily obtain a larger market share by cutting its prices.

Another reason for the lack of price competition is that society does not want the adverse effects of price competition in the health care field, and, therefore, has not encouraged price competition. Despite the recent clamor for competition as the supposed panacea for all problems of cost and bureaucracy, society cannot tolerate the effects of cutthroat price competition in health care. First, price competition would reduce the quality of care, by forcing providers to use the cheapest methods and supplies, regardless of the provider's judgment as to quality. This situation is analogous to the milk industry, for which society has rejected price competition in favor of price supports, in order to prevent producers from having to cut corners on cleanliness.<sup>159</sup> Moreover, price competi-

---

159. See, e.g., *State of North Carolina ex rel North Carolina Milk Comm'n v. National Food Stores, Inc.*, 270 N.C. 323, 332, 154 S.E.2d 548, 555 (1967) ("[T]he purpose of the act creating the Milk Commission was to protect the public inter-

tion in the health care field would have one of two alternative consequences, neither of which is socially desirable. If price competition significantly reduces prices, then one or more hospitals in each area will be driven out of business because of their inability to meet their high fixed costs. One aspect of a competitive market is that some existing providers will be driven out of the market, but this is socially unacceptable in the case of local hospitals. The other possible result of price competition is that prices will not be reduced, but rather will stabilize at a high level in a mature oligopoly. Each provider in a mature oligopoly follows the others' changes in price, and all providers charge high prices. No provider could obtain a long-term advantage by cutting its price, because the other providers would follow suit by cutting their prices, thereby restoring the original market shares at lower prices for all providers.<sup>160</sup> Therefore, prices will remain at a high level, and even more providers will be willing to enter the overcrowded market. Despite the political rhetoric of competition and deregulation, the consequences of cutthroat competition in health care are socially intolerable.<sup>161</sup>

Because competition does not properly allocate supply or reduce price, the federal and state governments have developed a complex regulatory scheme, which, in turn, has furthered the distortion from traditional market behavior. The most significant element in this regulatory scheme is the system of state certificate of need laws, which create a governmental barrier to market entry.<sup>162</sup>

---

est in a sufficient, regularly flowing supply of wholesome milk and, to that end, to provide a fair price to the milk producer for his product.”).

160. See Turner, *The Definition of Agreement Under the Sherman Act: Conscious Parallelism and Refusals to Deal*, 75 HARV. L. REV. 655, 666 (1962) (“We could say that each seller has simply decided individually, perhaps after bitter experience, that it is more profitable not to indulge in price competition under any but the most pressing circumstances, appealing as price cutting might appear to be from a less experienced viewpoint.”).

161. Even Professor Havighurst, a longtime advocate of competition in health care, recognizes the dangers of competition.

If we are not careful, the victims of competition may include not only those who lose monopoly power but also some innocent citizens whose losses, and some activities whose loss, we are not prepared to tolerate . . . . Political leaders and market advocates now have a duty to address the danger that competition-induced stringencies may widen the cracks into which some citizens and some useful activities can fall.

Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117, 1158 (1981).

162. See, e.g., N.C. GEN. STAT. §§ 131-175 to -188 (1981 & Supp. 1981).

Under the National Health Planning and Resources Development Act of 1974 [NHPDA],<sup>163</sup> each state is encouraged to enact a certificate of need law which meets federal standards, as a condition of receiving a substantial amount of federal funds.<sup>164</sup> In order to meet federal standards, a state certificate of need law must require a showing of need for constructing new facilities or offering new services.<sup>165</sup> As one court explained, "[t]he state system of awarding certificates of need represents a statutory division of markets, pursuant to a Congressional mandate."<sup>166</sup> Thus, the regulatory structure replaces the free market economy in the health care field, thereby perpetuating the lack of competition which made regulation necessary.<sup>167</sup>

163. 42 U.S.C. §§ 300k to 300n-5 (1976 & Supp. IV 1980). See generally, Schonbrun, *Making Certificate of Need Work*, 57 N.C.L. Rev. 1259 (1979).

164. See 42 U.S.C. § 300m(d) (Supp. IV 1980). "The Act provides for reductions in various federal grants to States that do not participate in the planning process." National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City, 101 S. Ct. 2415, 2420 n.9 (1981).

In 1972, the prior North Carolina Certificate of Need Law was held to violate the North Carolina Constitution. *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973). A new certificate of need statute was enacted in 1978, together with extensive legislative findings. See N.C. GEN. STAT. §§ 131-175 to -188 (1981 & Supp. 1981). Although the North Carolina Supreme Court has not yet had the opportunity to consider the constitutionality of the new law, that law is currently being challenged. *In re Denial of Request by Humana Hosp. Corp. for Reconsideration Hearing for Project No. J-1561-81-Proposed Construction of Parkway Medical Center, No. 82 CVS 1081* (Super. Court of Wake County, N.C. filed Feb. 17, 1982).

Although Congress could not require the State of North Carolina to enact a certificate of need law which violates its state constitution, the United States Supreme Court has held that Congress has the power to condition federal grants on North Carolina's passage of such a law, even if it would violate its state constitution. *North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532 (E.D.N.C. 1977), *aff'd mem.*, 435 U.S. 962 (1978). This federal decision did not deal with the issue of whether the new North Carolina Certificate of Need Law is valid under the North Carolina Constitution. See generally, *Survey of Developments in North Carolina Law, 1978*, 57 N.C.L. Rev. 827, 852-55 (1979).

165. See generally, *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 101 S. Ct. 2415, 2418-21 (1981).

Certificate of need laws arguably give preference to existing providers, in that the laws do not require existing providers to demonstrate need for the continuation of their existing facilities and services.

166. *Phoenix Baptist Hosp. and Medical Center v. Samaritan Health Servs., No. 81-5848*, slip op. at 5 (9th Cir. August 25, 1982).

167. In 1979, Congress enacted the Health Planning and Resources Development Amendments of 1979, Pub. L. 96-79, 93 Stat. 592, which amended the 1974



The regulatory structure established by the certificate of need laws is based on planned development of new facilities and services, in order to assure that they are needed and prevent unnecessary duplication.<sup>168</sup> This planning, in turn, contemplates cooperation among the competing providers.<sup>169</sup> In a planned economy, as opposed to a free market economy, it would be considered inefficient for two hospitals in close proximity to provide obstetrical services at 50 percent capacity in each hospital. Similarly, it is wasteful for each of two hospitals in an area to purchase expensive equipment, such as a CAT scanner, if each hospital would only use its new machine on a part-time basis. Therefore, the theory of the planning laws is that one hospital would be designated to perform all obstetrical services for the area, and the other hospital might be designated to provide all CAT scanning services for the area. Although this allocation is consistent with the theory of a planned economy, it could run afoul of the antitrust laws as an allocation of markets if arranged by providers acting entirely on their own without any involvement by planning agencies.<sup>170</sup> Even if the state makes the final decision on which provider may offer a particular service, the process requires a substantial amount of cooperation and joint planning by the competing providers, as well as involvement by competing providers with their local planning agencies.<sup>171</sup>

---

planning legislation. *See generally* S. REP. NO. 96, 96th Cong., 1st Sess., reprinted in 1979 U.S. CODE CONG. & AD. NEWS 1306; H. Conf. Rep. No. 420, 96th Cong., 1st Sess., reprinted in 1979 U.S. CODE CONG. & AD. NEWS 1422. Although one purpose of the 1979 amendments was to emphasize the importance of competition in the health care field, "Congress recognized a distinction between areas where competition could serve a useful purpose and those where some other allocation of resources remained necessary." *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 101 S. Ct. 2415, 2421 (1981) (footnote omitted). Even in the 1979 amendments, Congress determined that "competition does not or will not appropriately allocate supply. . ." for "inpatient health services and other institutional health services," and, therefore, the planning agencies should continue to regulate their supply. 42 U.S.C. § 300k-2(b)(2) (Supp. IV 1980).

168. *See, e.g.*, 42 U.S.C. § 300l-2(a) (1976 & Supp. IV 1980).

169. *See National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 101 S. Ct. 2415, 2423 (1981) ("Congress expected HSA planning to be implemented mainly through persuasion and cooperation.").

170. *See United States v. Topco Assocs., Inc.*, 405 U.S. 596 (1972) (agreement between competitors to allocate markets is a *per se* violation of Section 1 of the Sherman Act).

171. For example, under federal law, at least 40 percent of the board members of the local Health Systems Agencies must be "providers." 42 U.S.C. § 300l-

Therefore, health care providers are subject to competing federal policies of the planning laws and antitrust laws.

In predicting the future of the health care marketplace, the recent political rhetoric of competition must be kept in perspective. For example, in May, 1982, the Congressional Budget Office concluded that the short-run effect of competition on hospital costs may seem inadequate to some people.<sup>172</sup> Moreover, even proponents of competition do not advocate the elimination of all regulation and the substitution of pure competition.<sup>173</sup> There will always be some mixture of competition and regulation in health care, with the issue being the amount of each in the mixture. For example, the regulatory approach of prospective payment has been suggested as a complement to competition, rather than as a substitute for competition.<sup>174</sup> Thus, at any one time, a mixture of competition and regulation will make up the "particular economic context" of the health care marketplace.

1(b)(3)(C) (Supp. IV 1980).

172. Congressional Budget Office, *Containing Medical Care Costs Through Market Forces* xvi (May, 1982).

Some may not regard the magnitude of the effects of market-oriented options to be large enough in the short run, however, especially with regard to hospital costs. Prospective payment of hospitals—a regulatory approach in which third parties set rates for hospital payment in advance—might be considered as a complement to market-oriented options.

*Id.* (footnote omitted).

173. See, e.g., Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117 (1981). "Informed advocates of a market-oriented strategy do not all view issues in precisely the same way. Significant differences exist, for example, regarding the need for regulation to structure and limit the range of consumer choice in order to improve the intelligibility of choices and to prevent improvident ones." *Id.* at 1118.

See generally, Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965, (1981). "The possibilities usually are posed as a choice between increased government regulation to control medical costs or increased competition. This dichotomy, however, is overly simplistic." *Id.* at 966.

174. See *supra* note 172.

## B. Major Areas of Antitrust Concern for Health Care Providers<sup>175</sup>

### 1. Planning and Certificate of Need

Although there is no blanket antitrust immunity for all health planning activities, the United States Supreme Court has recognized that there may be antitrust immunity for some cooperative health planning.<sup>176</sup> In *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, Blue Cross refused to contract with plaintiff's new hospital on the ground that the local Health Systems Agency (HSA) had not made a finding of need for plaintiff's hospital.<sup>177</sup> Plaintiff brought an antitrust action under Sections 1 and 2 of the Sherman Act,<sup>178</sup> claiming that the refusal by Blue Cross to enter into a participating hospital agreement constituted a wrongful refusal to deal and a conspiracy with the HSA.<sup>179</sup> The United States District Court for the Western District of Missouri granted summary judgment for defendants on the ground that the antitrust laws were impliedly repealed by the NHRDA.<sup>180</sup> The summary judgment for defendants was affirmed on the same ground by the United States Court of Appeals for the Eighth Circuit,<sup>181</sup> but the United States Supreme Court granted *certiorari*<sup>182</sup> and reversed.<sup>183</sup>

175. See generally M. THOMPSON, ANTITRUST AND THE HEALTH CARE PROVIDER (1979); Thompson & Scott, *Antitrust Considerations and Defenses in Reorganizing for Multi-Institutional Activities*, 26 ST. LOUIS U.L.J. 465 (1982).

176. *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 101 S. Ct. 2415, 2423 n.18 (1981).

177. *Id.* at 2417-18.

178. 15 U.S.C. §§ 1, 2 (1976).

179. 101 S. Ct. at 2418. The Supreme Court noted that Blue Cross had entered into participating hospital agreements with plaintiff's competitors, which may have put plaintiff at a competitive disadvantage. 101 S. Ct. at 2417 n.2. As the Court explained:

participating hospitals receive direct reimbursement of the full costs of covered services rendered to individual Blue Cross subscribers. When subscribers receive care in hospitals that are not participating members, Blue Cross pays only 80% of the cost, and these payments are made to the subscriber, rather than directly to the hospital.

*Id.* at 2417 (footnote omitted).

180. 479 F. Supp. 1012 (W.D. Mo. 1979).

181. 628 F.2d 1050, 1055-56 (8th Cir. 1980) ("the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim.").

182. 101 S. Ct. 938 (1981).

183. 101 S. Ct. 2415 (1981).

As the Supreme Court explained, implied antitrust immunity is a matter of congressional intent.<sup>184</sup> Moreover, implied repeal of the antitrust laws requires a "clear repugnancy" between the antitrust laws and the subsequent legislation.<sup>185</sup> For example, there may be an implied repeal of the antitrust laws where the subsequent legislation *requires* a party to do something forbidden by the antitrust laws, or where applying the antitrust laws would conflict with the orders of a regulatory agency.<sup>186</sup> However, there was no implied antitrust immunity on the facts of that particular case, because there was no congressional intent to repeal and no "clear repugnancy."<sup>187</sup> Because there had been no state certificate of need law in effect in Missouri, there was no state regulation of hospital construction and the HSA merely acted in a private advisory capacity.<sup>188</sup> Moreover, the NHPRDA does not *require* Blue Cross to enforce HSA advice by refusing to deal with plaintiff, nor is there any indication that Congress intended HSA advice to be enforced by private insurers.<sup>189</sup> Finally, there was no regulatory compulsion or approval of Blue Cross' actions by an administrative agency.<sup>190</sup> Therefore, there was no congressional intent to repeal the antitrust laws, and no "clear repugnancy."<sup>191</sup>

After holding that there was no implied immunity on the facts of that particular case, the Court also held that there is no blanket antitrust immunity for all private planning activities.<sup>192</sup> "In other industrial contexts, we have refused such a blanket exemption, de-

184. 101 S. Ct. at 2421 ("To be sure, where Congress did intend to repeal the antitrust laws, that intent governs . . . , but this intent must be clear.").

185. *Id.*

186. *See* 101 S. Ct. at 2421-22. "Intent to repeal the antitrust laws is much clearer when a regulatory agency has been empowered to authorize or require the type of conduct under antitrust challenge." *Id.* Moreover, as the Court noted, "antitrust repeals are especially disfavored where the antitrust implications of a business decision have not been considered by a governmental entity." 101 S. Ct. at 2422.

187. *Id.* at 2422-23.

188. *Id.* at 2422 & n.15. Moreover, according to the HSA's health systems plan, new hospital construction would be regulated "by an appropriate review agency." *Id.* at 2422 n.14. The HSA's advisory status was unaffected by its federal creation and funding. *Id.* at 2422.

189. *Id.* at 2422-23. The Court also noted that HSAs are only required to seek the assistance of private parties "to the extent practicable." *Id.* at 2423 (citing 42 U.S.C. § 300l-2(c)(1)).

190. 101 S. Ct. at 2422.

191. *Id.* at 2422-23.

192. *Id.* at 2423-24.

spite a clear congressional finding that some substitution of regulation for competition was necessary."<sup>193</sup> The rejection of blanket immunity in other industries has been based on the goal of reconciling the antitrust laws and the subsequent legislation, rather than simply rejecting the antitrust laws.<sup>194</sup> Because there was no evidence of a contrary congressional intent in the health care field, the court rejected a blanket immunity for all health planning activities.<sup>195</sup>

*National Gerimedical* involved a unique factual situation which will be easily distinguished in future cases. First, there was no state certificate of need law in effect at the time.<sup>196</sup> Moreover, the Court took pains to clarify that its holding referred only to the facts of that particular case.<sup>197</sup> Finally, the Court gave an example of a possible case for antitrust immunity. "Where, for example, an HSA has expressly advocated a form of cost-saving cooperation among providers, it may be that antitrust immunity is 'necessary to make the [NHPRDA] work.'"<sup>198</sup> Thus, there may be implied antitrust immunity where an HSA expressly advocates a course of action rather than merely advises. Similarly, there would be a stronger case for immunity in cases of cooperation as opposed to a refusal to deal, especially if the cooperation involved providers rather than a third party insurer.<sup>199</sup>

Even in the absence of antitrust immunity for health planning activities, there is a narrow area for the application of the rule of reason under the doctrine enunciated in *Silver v. New York Stock*

193. *Id.* at 2423.

194. *Id.*

195. *Id.*

196. *Id.* at 2422-23. See *supra* note 188 and accompanying text. See also Note, *Health Law—The Conflict With Antitrust Law—National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 18 WAKE FOREST L. REV. 591, 609 (1982) ("the court has not decided how it will apply antitrust immunity to a health planning scheme when state mechanisms are in effect").

197. 101 S. Ct. at 2422-23, 2423 n.18. "[W]e emphasize that our holding does not foreclose future claims of antitrust immunity in other factual contexts." *Id.* at 2423 n.18.

198. 101 S. Ct. at 2423 n.18 (quoting *Silver v. New York Stock Exch.*, 373 U.S. 341, 357 (1963)).

199. As the Court noted in *National Gerimedical*, "[s]uch a case would differ substantially from the present one, where the conduct at issue was not cooperation among providers, but an insurer's refusal to deal with a provider that failed to heed the advice of an HSA." 101 S. Ct. at 2424 n.18.

*Exchange*.<sup>200</sup> In *Silver*, the Exchange and its members boycotted a nonmember by ordering members to eliminate telephone connections with the nonmember.<sup>201</sup> Thus, the Supreme Court was required to address the interface between the Securities Exchange Act of 1934 and the federal antitrust laws. As the Court noted, "[i]t is plain, to begin with, that removal of the wires by collective action of the Exchange and its members would, had it occurred in a context free from other federal regulation, constitute a *per se* violation of § 1 of the Sherman Act."<sup>202</sup> Although the Court rejected the defense of implied immunity from the antitrust laws,<sup>203</sup> it held that it was necessary to apply the rule of reason, rather than the *per se* rule, in order "to permit the Exchange sufficient breathing space within which to carry out the mandate of the Securities Exchange Act."<sup>204</sup> As the Court explained, "particular instances of exchange self-regulation which fall within the scope and purposes of the Securities Exchange Act may be regarded as justified in answer to the assertion of an antitrust claim."<sup>205</sup>

In a recent decision, the United States Court of Appeals for the Fourth Circuit applied the *Silver* analysis to health planning activities.<sup>206</sup> In *Hospital Building Company v. Trustees of Rex Hospital*,<sup>207</sup> the Fourth Circuit held that the trial court should use a rule of reason analysis to determine whether defendants' health planning activities were an unreasonable restraint of trade, rather than simply condemning their activities as unlawful *per se*.<sup>208</sup> As the court explained, "planning activities of private health services providers are not 'unreasonable' restraints under § 1 if undertaken in good faith and if their actual and intended effects lay within those envisioned by specific federal legislation in place at the time of the challenged activities as desirable consequences of such planning activities."<sup>209</sup> Thus, just as in *Silver*, the competing demands

200. 373 U.S. 341, 360-61 (1963).

201. *Id.* at 343, 347-48.

202. *Id.* at 347.

203. *Id.* at 360-61.

204. *Id.* at 360.

205. *Id.* at 361.

206. *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 691 F.2d 678 (4th Cir. 1982).

207. *Id.*

208. *Id.* at 685-86.

209. *Id.* at 685 (citing *Silver v. New York Stock Exch.*, 373 U.S. 341, 360-61 (1963)). "Specifically we hold that 'planning' under this special rule of reason is not 'reasonable' if its purpose or effect is *only* to protect existing health care prov-

of the antitrust laws and another federal statute require the application of the rule of reason.<sup>210</sup> In the language of *Silver*, "particular instances . . . which fall within the scope and purposes of the [other federal statute] may be regarded as justified in answer to the assertion of an antitrust claim."<sup>211</sup>

Another crucial concept in applying antitrust law to health planning is the first amendment protection for joint petitioning activity. Under the doctrine of *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*<sup>212</sup> and *United Mine Workers v. Pennington*,<sup>213</sup> private parties are entitled to take concerted action before governmental bodies to oppose their competitors, regardless of anti-competitive intent.<sup>214</sup> Nevertheless, the first amendment protection for joint petitioning activity may be lost if the joint opposition is a mere "sham."<sup>215</sup> As the court explained in *Noerr*, "[t]here may be situations in which a publicity campaign, ostensibly directed toward influencing governmental action, is a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationships of a competitor and the application of the Sherman Act would be justified."<sup>216</sup> For example, in the administrative or judicial arenas, abuses such as perjury, misrepresentations, and conspiracy with a licensing authority would constitute a "sham," and, therefore, would be subject to antitrust scrutiny.<sup>217</sup> The first amendment immunity will be lost if the purpose of the joint petitioning activity is solely to prevent a competitor from having access to governmental agencies.<sup>218</sup>

---

iders from the competitive threat of potential entrants into or expanders within the same 'market.'" *Hospital Bldg. Co.*, at 686 (emphasis added).

210. *Hospital Bldg. Co.*, at 685-86.

211. *Silver*, 373 U.S. at 361.

212. 365 U.S. 127 (1961).

213. 381 U.S. 657, 669-71 (1965).

214. *Noerr*, 365 U.S. at 139-40; *Pennington*, 381 U.S. at 670. "[A]t least insofar as the railroads' campaign was directed toward obtaining governmental action, its legality was not at all affected by any anticompetitive purpose it may have had." *Noerr*, 365 U.S. at 139-40. Cf. *Parker v. Brown*, 317 U.S. 341 (1942) (antitrust immunity for acts of a state).

215. *Noerr*, 365 U.S. at 144.

216. *Id.*

217. *California Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 512-13 (1972).

218. See *id.* at 515; *id.* at 518 (Stewart, J., concurring). "[T]he respondents are entitled to prove that the real intent of the conspirators was not to invoke the processes of the administrative agencies and courts, but to discourage and ultimately to prevent the respondents from invoking those processes." *Id.* at 518

In the health care field, the United States Court of Appeals for the Fourth Circuit has recently emphasized that the sham exception to *Noerr-Pennington* immunity depends upon the defendants' intent.<sup>219</sup> As examples of a possible "sham," the Fourth Circuit cited a baseless appeal with intent to delay plaintiff's entry into the market and a conspiracy with intent to prevent plaintiff from having "meaningful access" to the planning agency and certificate of need agency.<sup>220</sup> Finally, in the context of judicial proceedings, the sham exception to *Noerr-Pennington* immunity would apply "if such proceedings are baseless, repetitive and brought with the intent to abuse the judicial process."<sup>221</sup>

## 2. Price Fixing

Price fixing is a term of art which includes any means to control or stabilize price, even if the price to consumers is lowered or maintained at a "fair market price."<sup>222</sup> Thus, it is even unlawful to fix a maximum price.<sup>223</sup> Price fixing agreements are unlawful *per se*, in that they can never be justified as reasonable or necessary in a particular case.<sup>224</sup> Moreover, the United States Supreme Court

(Stewart, J., concurring). Fair access to governmental agencies is also protected by statutes and regulations concerning conflicts of interest and *ex parte* contacts. See, e.g., 42 U.S.C. § 300n-1(b)(12)(F) (Supp. IV 1980) (*ex parte* contacts); 42 C.F.R. § 122.308(a)(11) (1981) (conflicts of interest within health systems agency).

219. *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 691 F.2d 678, 687-88 (4th Cir. 1982).

220. *Id.* at 687-88. Similarly, "misrepresentations made with intent to abuse the administrative processes so as to deny [plaintiff] meaningful access to the [state certificate of need agency] would fall within the sham exception." *Id.* at 687.

221. *Id.* at 688.

222. See *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940) ("a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce . . ."). Even an agreement on credit terms is illegal price fixing. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980).

223. *Kiefer-Stewart Co. v. Seagram & Sons, Inc.*, 340 U.S. 211 (1951). As the Court explained, "[f]or such agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment." *Id.* at 213.

224. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940). It is not only illegal *per se* for competitors to horizontally agree on price, but it is also illegal *per se* for a wholesaler to vertically agree with a retailer on the price at which the retailer will resell the goods. *Dr. Miles Medical Co. v. John D. Park & Sons Co.*, 220 U.S. 373 (1911) (vertical agreement fixing minimum resale prices).



has recently held that price fixing in the health care field is subject to the same rules of *per se* illegality as in any other industry, notwithstanding the unique characteristics of the health care marketplace.<sup>225</sup> Therefore, avoiding price fixing is just as important to health care providers as to any other business or individual.<sup>226</sup> Moreover, the reimbursement system and the public policy of cost containment create additional price fixing problems in the health care field.

Many health care providers do not realize that cost containment schemes, although otherwise laudable, may involve illegal price fixing.<sup>227</sup> For example, the United States Supreme Court recently condemned a mechanism for medical cost containment as

Such vertical minimum price fixing is also known as resale price maintenance. A vertical agreement to fix maximum resale prices is also *per se* unlawful. *Albrecht v. Herald Co.*, 390 U.S. 145 (1968).

Nevertheless, in at least one alleged price fixing case, the United States Supreme Court avoided the *per se* rule by holding that the arrangement only constituted price fixing in a "literal sense." *Broadcast Music, Inc. v. Columbia Broadcasting Sys. Inc.*, 441 U.S. 1, 8 (1979). In *Broadcast Music*, the Court concluded that the blanket license was a different product from the license that any individual member could have offered, and, therefore, the blanket licensor was not merely a joint sales agency fixing prices for all its members. 441 U.S. at 22-24. One author has suggested that the holding in *Broadcast Music* was based on the traditional doctrine permitting reasonable restraints which are ancillary to licensing agreements and joint ventures. *Louis, Restraints Ancillary to Joint Ventures and Licensing Agreements: Do Sealy and Topco Logically Survive Sylvania and Broadcast Music?* 66 VA. L. REV. 879, 880, 898 (1980).

225. *Arizona v. Maricopa County Medical Soc'y*, 102 S. Ct. 2466 (1982). "We are equally unpersuaded by the argument that we should not apply the *per se* rule in this case because the judiciary has little antitrust experience in the health care industry." *Id.* at 2476 (footnote omitted).

226. Just as any other sellers of services, health care providers must independently determine their rates. Similarly, as large-scale purchasers of labor, providers must act independently in determining their employees' salaries. *See also White and White, Inc. v. American Hosp. Supply Corp.*, 540 F. Supp. 951 (W.D. Mich. 1982) (awarding treble damages and enjoining joint purchasing arrangement).

227. One cost containment scheme that is now subject to antitrust scrutiny is peer review in which an insurer contracts with a provider's professional society to determine the reasonableness of the provider's claim for insurance reimbursement. In *Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982), the United States Supreme Court held that such peer review is not included within the "business of insurance," and, therefore, is subject to antitrust scrutiny. *Id.* at 3011. *See generally, Borsody and Tiano, Peer Review and the Antitrust Laws: An Analysis and a Proposal*, 26 ST. LOUIS U.L.J. 511 (1982).

horizontal price fixing.<sup>228</sup> In *Arizona v. Maricopa County Medical Society*,<sup>229</sup> two county medical societies established "foundations for medical care," which are nonprofit corporations composed of physicians.<sup>230</sup> Under the foundation membership agreements, physicians agreed among themselves to adhere to a schedule of maximum fees set by majority vote.<sup>231</sup> These maximum fees applied to all patients insured by plans which had agreed to pay up to the maximum amount.<sup>232</sup> In those cases, the member physicians agreed to accept the maximum fee from the insurer as payment in full, and could not charge the patient for any excess amount.<sup>233</sup> The Supreme Court held that the foundation membership agreements constituted horizontal price fixing, and, therefore, were illegal *per se*.<sup>234</sup>

*Maricopa* raises serious questions about other cooperative activities for cost containment, including activities of provider associations and coalitions. Health care providers often forget that a society of providers, by definition, is a combination of competitors and that anything a society does in restraint of trade is a *combination* in restraint of trade. This is especially important in the area of data dissemination.<sup>235</sup> Under established case law, the exchange of price information among competitors may constitute illegal price fixing, even without an agreement to adhere to a fixed price, if the effect is to stabilize prices by permitting each seller to match its competitors' prices.<sup>236</sup> In the health care field, the Antitrust Di-

228. *Arizona v. Maricopa County Medical Soc'y*, 102 S. Ct. 2466, 2472, 2480 (1982). Although there was a dispute as to whether the challenged mechanism raised or lowered health care costs, the Court was obligated for purposes of summary judgment to accept defendants' position that costs were lowered. *Id.* at 2470-71.

229. *Id.*

230. *Id.* at 2470-71.

231. *Id.* at 2471.

232. *Id.*

233. *Id.*

234. *Id.* at 2475. The holding is based on a four-to-three decision, with two justices not participating. *Id.* at 2480.

235. See generally Comment, *Anticompetitive Data Dissemination in the Medical Profession: The Conflict Between the Sherman Act and the First Amendment*, 1980 DUKE L.J. 1142; Comment, *Relative Value Guides and the Sherman Antitrust Act*, 33 VAND. L. REV. 233 (1980).

236. See *United States v. Container Corp. of Am.*, 393 U.S. 333, 336-37 (1969) ("Stablizing prices as well as raising them is within the ban of § 1 of the Sherman Act."). As Justice Fortas explained in his concurring opinion,

Thus the exchange of prices made it possible for individual defendants

vision of the United States Department of Justice has recently released a business review letter indicating that it will not challenge the collection of hospital data by a Health Systems Agency (HSA).<sup>237</sup> Under that proposal, providers would not communicate among themselves, but rather would voluntarily supply the information to the HSA.<sup>238</sup> Moreover, providers would retain the right to alter their prices at will.<sup>239</sup> Similarly, the Antitrust Division recently issued a business review letter approving the activities of a "business coalition" in reviewing information already collected by the Maryland Health Services Cost Review Commission.<sup>240</sup> However, this proposal involved data which had already been collected and did not involve the direct exchange of data among competing providers.<sup>241</sup> Moreover, the Antitrust Division warned that participants must avoid "procedures that could facilitate anticompetitive arrangements among competing members . . . ." <sup>242</sup> Therefore, the apparent safe harbors established by these business review letters are quite narrow, and providers must still be cautious of any "interference with the setting of price by free market forces . . . ." <sup>243</sup>

### 3. *Medical Staff Privileges and Exclusive Contracts*

The denial or revocation of staff privileges is an area of increasing antitrust concern, and there are additional complications

---

confidently to name a price equal to that which their competitors were asking. The obvious effect was to "stabilize" prices by joint arrangement—at least to limit any price cuts to the minimum necessary to meet competition. In addition, there was evidence that, in some instances, during periods when various defendants ceased exchanging prices exceptionally sharp and vigorous price reductions resulted.

*Id.* at 339-40 (Fortas, J., concurring). *But see* United States v. American Soc'y of Anesthesiologists, Inc., 473 F. Supp. 147, 159 (S.D.N.Y. 1979) (society's publication of "relative value guide" not unlawful *per se*).

237. Letter from William P. Baxter, Assistant Attorney General, to Robert Azar, Executive Director of Southwest Michigan Health Systems Agency (March 2, 1982).

238. *Id.*

239. *Id.*

240. Letter from William P. Baxter, Assistant Attorney General, to Patrick N. Renaud, Bethlehem Steel Corporation, and John P. Hanna, Esq., Senior Vice President and General Counsel of Health Insurance Association of America (February 22, 1982).

241. *Id.*

242. *Id.*

243. United States v. Container Corp. of Am., 393 U.S. 333, 337 (1969) (citing United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 224 n.59 (1940)).

if the denial is based on the hospital's exclusive contract with the aggrieved physician's competitor.<sup>244</sup> Although there is still dispute as to the nexus with interstate commerce in staff privilege cases, courts often find a sufficient effect on interstate commerce to invoke the federal antitrust laws.<sup>245</sup> Therefore, health care providers must consider the anticompetitive effects of their staff privilege decisions and exclusive contracts, and not merely the patient care aspects or procedural requirements of their medical staff bylaws.<sup>246</sup>

As discussed above, a health care institution will be held liable on grounds of corporate liability for negligently admitting an incompetent physician to staff membership or negligently permitting a known incompetent to practice medicine in the institution.<sup>247</sup> This potential liability forces institutions to screen and supervise staff physicians.<sup>248</sup> The institution's supervisory duties are delegated to the licensed professionals on its medical staff, who act as agents for the institution in reviewing applications for staff privileges.<sup>249</sup> Nevertheless, the institution's governing body remains responsible for medical staff appointments.<sup>250</sup> Therefore, the institution is the legally responsible party; but it is forced to use a procedure which delegates screening and supervision to a physician's competitors, which involves serious anticompetitive potential.<sup>251</sup>

244. See generally Liebenluft and Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927, 932 (1981) ("Increasingly, boycott tactics are being employed in the denial of hospital privileges . . ."). See generally Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 ST. LOUIS U.L.J. 535 (1982); Comment, *Denial of Open Staff Hospital Privileges: An Antitrust Scrutiny*, 26 ST. LOUIS U.L.J. 751 (1982); Annot., 74 A.L.R.3d 1268 (1976) (exclusive contracts).

245. See *supra* note 1. A sufficient nexus with interstate commerce was also found in the following cases: *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715 (10th Cir. 1981) (rehearing en banc); *McDonald v. St. Joseph's Hosp. of Atlanta, Inc.*, 524 F. Supp. 122 (N.D. Ga. 1981); *Malini v. Singleton & Assocs.*, 516 F. Supp. 440 (S.D. Tex. 1981); *Feldman v. Jackson Memorial Hosp.*, 509 F. Supp. 815 (S.D. Fla. 1981); *Robinson v. Magovern*, 521 F. Supp. 842, 876 (W.D. Pa. 1981), *aff'd*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 103 S. Ct. 302 (1982).

246. Cf. Annot., 37 A.L.R.2d 645 (1971) (discussing non-antitrust aspects of medical staff privilege disputes).

247. See *supra* notes 111-12 and accompanying text.

248. See *supra* notes 121-23 and accompanying text.

249. See *supra* notes 113-15 and accompanying text.

250. See *supra* notes 114, 117-18 and accompanying text.

251. In a recent business review letter, the Antitrust Division of the Office of

In addition to the anticompetitive potential in the staff privilege procedure, special problems are presented by exclusive contracts between the hospital and an aggrieved physician's competitor. Traditionally, exclusive contracts to provide services in specialized departments were upheld as reasonable and necessary for quality medical care.<sup>252</sup> Under more recent antitrust challenge, courts have differed in analysis and result. For example, in *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*,<sup>253</sup> the United States Court of Appeals for the Seventh Circuit refused to enjoin an exclusive anesthesiology contract.<sup>254</sup> In contrast, in *Hyde v. Jefferson Parish Hospital District No. 2*,<sup>255</sup> the United States Court

---

the Maryland Attorney General succinctly explained the anticompetitive potential in the staff privilege procedure:

The principal danger, in antitrust terms, inherent in the procedure for awarding hospital staff privileges is that doctors with privileges may combine to use their decision-making authority to exclude their competitors from access to essential hospital facilities. The members of the Medical Staff are independent practitioners, competing with each other for patients and profit. In almost all medical specialties, the ability to admit and treat patients at a hospital is essential to a physician's practice. Without hospital privileges, a physician must refer to other physicians those patients who require hospitalization. For these reasons, it inures to the competitive and financial advantage of doctors who have staff privileges to preclude their competitors from obtaining them. Where doctors with privileges are empowered to, and do in fact, deny privileges to applicants for their personal competitive advantage, a group boycott exists, in violation of the Maryland Antitrust Act, Md. Com. Law Code Ann. §§ 11-201 - 11-213 (1975). Restraints of trade are contrary to our most basic national policy in favor of free competition and cannot be tolerated. In the final analysis, the question presented here, like so many antitrust issues relating to the professions, is *who* controls professional access to the marketplace. In this respect, the medical profession is no different than any other business or industry — it is vulnerable to the danger that concentrated economic power will be used to choke off competition.

Letter from Stephen H. Sachs, Maryland Attorney General, to Benson E. Legg, Esq. (Feb. 10, 1982). See also Note, *Physician Influence: Applying Noerr-Pennington to the Medical Profession*, 1978 DUKE L.J. 701. "When physicians as independent professionals act in concert with other doctors to influence the hospital staff committees to deny potentially competing, qualified applicants hospital staff privileges, these physicians may be violating the antitrust laws." *Id.* at 715-16.

252. See, e.g., *Centeno v. Rolesville Community Hosp.*, 107 Cal. App. 3d 62, 167 Cal. Rptr. 183 (1979); *Lewin v. St. Joseph Hosp. of Orange*, 82 Cal. App. 3d 368, 146 Cal. Rptr. 892 (1978).

253. 684 F.2d 1346 (7th Cir. 1982) (dissolving preliminary injunction).

254. *Id.* at 1348 and 1355.

255. 686 F.2d 286 (5th Cir. 1982), *rev'g*. 513 F. Supp. 532 (E.D. La. 1981).

of Appeals for the Fifth Circuit condemned an exclusive anesthesiology contract as a *per se* unlawful tying arrangement.<sup>256</sup> Therefore, exclusive contracts are an area of increasing antitrust concern for health care institutions.

## V. THE APPLICATION OF AGENCY THEORIES TO IMPOSE VICARIOUS ANTITRUST LIABILITY ON HEALTH CARE PROVIDERS

### A. *The Theory of Vicarious Antitrust Liability*

Vicarious liability is liability for the fault of another.<sup>257</sup> For example, hospitals are often held liable in tort for the malpractice of an agent, without any evidence of negligent selection or supervision by the hospital.<sup>258</sup> Rather than being based on a concept of fault, vicarious liability is based on policy grounds of allocating risk, providing adequate compensation to injured parties, and providing an incentive to practice caution on the part of employers.<sup>259</sup>

256. *Id.* at 294. The Fifth Circuit reasoned that defendant hospital forced users of its operating rooms to also use its anesthesiology service. *Id.* at 289. As the court explained:

A tying arrangement is "an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product . . . ." *Northern Pacific Ry. v. United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed. 2d 545 (1958). The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that users of the hospital's operating rooms (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain separately.

*Id.* at 289. Under the court's analysis, defendant hospital had sufficient market power in operating rooms to constitute an illegal tying arrangement. *Id.* at 291.

257. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 69 (4th ed. 1971). As the United States Supreme Court explained in *Gleason v. Seaboard Air Line R. Co.*, 278 U.S. 349 (1929), "few doctrines of the law are more firmly established or more in harmony with accepted notions of social policy than that of the liability of the principal without fault of his own." *Id.* at 356. See generally, *supra* notes 29-33 and accompanying text.

258. See *supra* notes 29-39 and accompanying text.

259. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 69 (4th ed. 1971).

What has emerged as the modern justification for vicarious liability is a rule of policy, a deliberate allocation of a risk. The losses caused by the torts of employees, which as a practical matter are sure to occur in the conduct of the employer's enterprise, are placed upon that enterprise itself, as a required cost of doing business. They are placed upon the employer because, having engaged in an enterprise which will, on the basis of all past experience, involve harm to others through the torts of

Because vicarious liability is liability without fault, the party held liable will consider it unfair and perhaps frightening. Even more frightening is the prospect of vicarious liability without fault for treble damages and attorneys' fees in a civil antitrust suit. Under established case law, businesses and nonprofit corporations can be held vicariously liable for antitrust violations, with consequent liability for treble damages and attorneys' fees.<sup>260</sup>

Vicarious antitrust liability is not a new concept. In 1973, a corporation was held criminally liable under federal antitrust law for the conduct of its agent, without the need for any evidence that the corporate entity joined in the illegal activities.<sup>261</sup> In *United States v. Hilton Hotels Corp.*,<sup>262</sup> the corporate defendant's purchasing agent participated in a boycott of certain suppliers, in violation of direct instructions from the corporate defendant's manager.<sup>263</sup> The corporation was convicted under Section 1 of the Sherman Act, and the conviction was affirmed by the United States Court of Appeals for the Ninth Circuit.<sup>264</sup> As the Ninth Circuit explained, "as a general rule a corporation is liable under the Sherman Act for the acts of its agents in the scope of their employ-

---

employees, and sought to profit by it, it is just that he, rather than the innocent injured plaintiff, should bear them; and because he is better able to absorb them, and to distribute them, through prices, rates or liability insurance, to the public, and so to shift them to society, to the community at large. Added to this is the makeweight argument that an employer who is held strictly liable is under the greatest incentive to be careful in the selection, instruction and supervision of his servants and to take every precaution to see that the enterprise is conducted safely.

*Id.*

260. See *infra* notes 261-75 and accompanying text.

261. *United States v. Hilton Hotels Corp.*, 467 F.2d 1000, 1007 (9th Cir. 1972), *cert. denied sub nom.* *Western Int'l Hotels Co. v. United States*, 409 U.S. 1125 (1973).

A corporate entity can violate a statute through the acts of its agents. *United States v. A & P Trucking*, 358 U.S. 121, 125-26 (1958) ("it is elementary that such impersonal entities can be guilty of 'knowing' or 'willful' violations of regulatory statutes through the doctrine of *respondet superior*."). Moreover, a corporation can be held criminally liable for the acts of its agents. *United States v. Dotterweich*, 320 U.S. 177, 281 (1943).

262. 467 F.2d 1000 (9th Cir. 1972), *cert. denied sub nom.* *Western Int'l Hotels Co. v. United States*, 409 U.S. 1125 (1973).

263. *Id.* at 1007.

264. *Id.* at 1002, 1008. Moreover, even though the corporation's manager was acquitted, evidence connecting the manager with the conspiracy was properly considered in connecting the corporation with the conspiracy. *Id.* at 1008.

ment, even though contrary to general corporate policy and express instructions to the agent."<sup>265</sup>

The impact of the holding in *Hilton Hotels Corp.* was limited somewhat by the court's further holding that a corporation will only be held vicariously liable if the agent was acting to benefit the corporation.<sup>266</sup> As the Ninth Circuit explained, vicarious antitrust liability would only be imposed where the agent was acting within the scope of his employment, which was defined to require that the agent acted to benefit the corporation.<sup>267</sup> However, this limitation has recently been rejected by the United States Supreme Court in *American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp.*<sup>268</sup> In *American Society of Mechanical Engineers*,<sup>269</sup> the Supreme Court held that a nonprofit organization was properly held liable under Section 1 of the Sherman Act for the acts of its agents, even though the agents did not act with an intent to benefit the organization.<sup>270</sup> Moreover, the nonprofit organization was held liable without having ratified the acts of its agents who were only acting with apparent authority.<sup>271</sup> In that case, employees of one manufacturer used their positions and contacts with a nonprofit, standard-setting organization to injure a competitor of their employer.<sup>272</sup> Specifically, they caused the nonprofit organization to publish a letter stating that the competitor's product failed to comply with the organization's standards.<sup>273</sup> These activities put the competitor at a severe disadvantage in the marketplace, even though the organization's agents were only acting with apparent authority.<sup>274</sup> Therefore, the nonprofit organization was held vicariously liable for treble damages on a theory of apparent authority.<sup>275</sup>

The application of vicarious antitrust liability in *Hilton Hotels Corp.* and *American Society of Mechanical Engineers* is analogous

265. *Id.* at 1007.

266. *Id.* at 1006 n.4 & 1007.

267. *Id.*

268. 102 S. Ct. 1935 (1982).

269. *Id.*

270. *Id.* at 1946-48.

271. *Id.*

272. *Id.* at 1939-41.

273. *Id.*

274. *See id.* at 1941.

275. *Id.* at 1948 ("We have no difficulty in finding that this set of facts falls well within the scope of ASME's liability on an apparent authority theory.")



to the vicarious tort liability of a hospital for the negligence of its agent, even though the hospital was not negligent in its selection or supervision of the agent.<sup>276</sup> In contrast, if the corporate entities had made corporate decisions to join in an illegal boycott or restrain competition, it would have been analogous to a hospital's corporate liability in tort for violation of the hospital's own duty of care.<sup>277</sup> In one sense, it is redundant to speak of a corporation's vicarious liability for the acts of its agents, because a corporation can only act through its agents, including its officers, directors and employees. Thus, every act of a corporation is arguably nothing more than the act of its agent which is imputed to the corporation. Nevertheless, in dealing with the legal fiction of the corporation, a distinction can be made between the corporation's "own" action through its board of directors or management, on one hand, and the corporation's vicarious liability for the act of a mere agent, on the other hand. This distinction, in turn, is analogous to the distinction between a hospital's vicarious liability and corporate liability in the negligence field.<sup>278</sup> The significance of this distinction is that additional defenses may be available in cases of vicarious liability.<sup>279</sup>

The reasons for imposing vicarious antitrust liability, as well as the contours of that liability, are based on the procompetitive policies of the antitrust laws.<sup>280</sup> These policies, in turn, will control the application of vicarious antitrust liability to the health care field. As a policy matter, the principal basis for imposing vicarious antitrust liability is to deter future restraints against competition.<sup>281</sup> For example, in *Hilton Hotels Corp.*, the Ninth Circuit concluded that it would be ineffective to attempt to punish individual agents,<sup>282</sup> whereas "exposure of the corporate entity to po-

276. See *supra* notes 40-99 and accompanying text.

277. See *supra* notes 100-19 and accompanying text.

278. See *supra* text at notes 38-39. However, vicarious liability and corporate liability often overlap. See *supra* note 112.

279. See *infra* note 319 and accompanying text.

280. See, e.g., *Hilton Hotels Corp.*, 467 F.2d at 1005. "The breadth and critical character of the public interests protected by the Sherman Act, and the gravity of the threat to those interests that led to the enactment of the statute, support a construction holding business organizations accountable, as a general rule, for violations of the Act by their employees in the course of their businesses." *Id.*

281. See *id.* at 1006; *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. at 1945.

282. *Hilton Hotels Corp.*, 467 F.2d at 1006. The Ninth Circuit identified at least two separate reasons for the ineffectiveness of attempting to punish individual agents. First, it may be impossible to identify the responsible individual

tential conviction may provide a substantial spur to corporate action to prevent violations by employees."<sup>283</sup> A second reason for imposing vicarious antitrust liability is the fairness of imposing liability on the corporate entity which reaps the illegal profit from its agent's restraint of trade.<sup>284</sup> Finally, the court in *Hilton Hotels Corp.* concluded that there is a probability that high corporate officers were involved in—or had knowledge of—the policy decisions which formed the basis for the illegal acts.<sup>285</sup>

The Supreme Court also used a policy analysis to define the contours of vicarious antitrust liability in *American Society of Mechanical Engineers*.<sup>286</sup> In holding that vicarious liability would be imposed even in the absence of actual authority, the Court noted that the threat to competition arose from the mere appearance of authority.<sup>287</sup> As the Court explained, "[w]hen [the organization] cloaks its subcommittee officials with the authority of its reputation, [it] permits those agents to affect the destinies of businesses and thus gives them the power to frustrate competition in the marketplace."<sup>288</sup> Therefore, the acts of agents with apparent authority pose just as serious a threat to competition as acts of agents with actual authority. Similarly, the Court held that it was irrelevant that the agents did not intend to benefit the organization, because the threat to competition did not depend on which party the agents intended to benefit.<sup>289</sup> In fact, the greatest threat

within a complex business organization. *Id.* Second, punishment of individuals will not necessarily deter future violations by their employer. *Id.*

283. *Id.* at 1006. See also *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. at 1945 ("But if, in addition, ASME is civilly liable for the antitrust violations of its agents acting with apparent authority, it is much more likely that similar antitrust violations will not occur in the future."). Moreover, the Supreme Court concluded that the defendant organization is in the best position to prevent future violations by its agents. *Id.* at 1945-46, 1948 n.15.

284. *Hilton Hotels Corp.*, 467 F.2d at 1006.

285. *Id.*

286. 102 S. Ct. at 1944-48. As a matter of antitrust policy, the imposition of vicarious antitrust liability was justified by the facts of that case, in which the dominant manufacturer in the industry used the nonprofit organization to destroy an aggressive competitor which had developed an innovative product. *Id.* at 1939-41.

287. *Id.* at 1944. See also *id.* at 1946 ("ASME's agents exercise economic power because they act with the force of the Society's reputation behind them."). The Court also noted that such standard-setting organizations possess great economic power and involve a serious danger of restraining trade. *Id.* at 1944-45.

288. *Id.* at 1944.

289. *Id.* at 1946.

is posed by agents with apparent authority who have ulterior motives.<sup>290</sup> Finally, the Court reasoned that liability could be imposed even without ratification by the principal, because a requirement of ratification would encourage ignorance by the principal, and, thereby, make violations more likely.<sup>291</sup>

The procompetitive policies of the antitrust laws will also determine the ways in which vicarious antitrust liability will be applied to the health care field. For example, courts will be more willing to impose vicarious antitrust liability in the health care field in those situations where deterrence appears to be most necessary and effective.<sup>292</sup> Vicarious antitrust liability is also likely to be imposed in the health care field where the hospital entity reaped the profits of the violation,<sup>293</sup> or where there is a strong suspicion of administration or governing board knowledge of the agent's violation.<sup>294</sup> Finally, vicarious liability will be imposed in the health care field where the threat to competition from the agent's violation is just as serious as if the violation had been committed by the hospital itself.<sup>295</sup>

The United States Supreme Court has also indicated that a private antitrust action for vicarious liability should be evaluated under the standards used for analogous tort actions.<sup>296</sup> In tort actions in the health care field, there is widespread liability for the acts of agents and a frequent expansion of agency relationships to permit an injured person to recover. In addition, there has been a great increase in the number and variety of non-employed physicians who are held to be agents of the hospital. Therefore, if courts considering vicarious antitrust liability in the health care field analogize to health care negligence actions, then health care providers will often be held vicariously liable under the antitrust laws for the acts of their agents, because courts have been expansive in

290. *Id.*

291. *Id.*

292. *See supra* notes 281-83 and accompanying text.

293. *See supra* note 284 and accompanying text.

294. *See supra* note 285 and accompanying text.

295. *See supra* notes 287-90 and accompanying text.

296. *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. at 1944. "In this case, we can honor the statutory purpose best by interpreting the antitrust private cause of action to be at least as broad as a plaintiff's right to sue for analogous torts, absent indications that the antitrust laws are not intended to reach so far." *Id.* *See also id.* at 1942 (discussing torts analogous to antitrust violations, including fraud, misrepresentation, defamation and tortious interference with business relations).

finding agency relationships in the health care field and because health care institutions have so many agents.

In addition to the policy reasons for imposing vicarious antitrust liability in the health care field, a prediction of vicarious antitrust liability can be made on the basis of certain fact patterns. Specifically, the scope of vicarious antitrust liability in the health care field can be defined to encompass those anticompetitive situations in which there is no independent basis for hospital liability. If the hospital is the responsible decision-maker or a conspirator in its own right, then it will be unnecessary for antitrust plaintiffs to rely on a theory of vicarious liability. For example, in matters involving a hospital's denial of staff privileges, there will be no need for a plaintiff to rely on vicarious liability, because the hospital entity is already the responsible decision-maker in its own right.<sup>297</sup> Similarly, it will be unnecessary to apply vicarious liability where the hospital entity is alleged to have conspired with other hospitals, planning agencies or third party payors.<sup>298</sup> Finally, vicarious liability will be inapplicable where a hospital conspires with members of its own medical staff. Although a hospital and its medical staff are merely parts of a unified entity,<sup>299</sup> with the staff acting as agent of the hospital,<sup>300</sup> at least one court has explicitly held that a hospital can conspire with a member of its own medical staff, thereby creating a conspiracy between two separate entities for antitrust purposes.<sup>301</sup> In that case, the director of the hospital's surgery department was acting as agent of the hospital in considering his competitor's application for staff privileges, but he also had "an independent, personal stake in achieving the object of the conspiracy."<sup>302</sup> Where the hospital conspires with one or more members of

---

297. See *supra* notes 113-18, 139 and accompanying text.

298. See, e.g., *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738, 740 (1976) (allegations that defendant hospital, its administrator, and one of its trustees conspired with unrelated parties, including the head of the local planning agency).

299. See *supra* notes 126-27, 144-45 and accompanying text.

300. See *supra* note 146 and accompanying text.

301. *Robinson v. Magovern*, 521 F. Supp. 842, 907 (W.D. Pa. 981), *aff'd*, 688 F.2d. 824, (3d Cir. 1982), *cert. denied*, 103 S. Ct. 302 (1982). See *supra* note 245.

The district court also held that a hospital or its agents is legally capable of conspiring with a professional association of physicians which provides services at the hospital. 521 F. Supp. at 906. *But see Sokol v. University Hosp., Inc.*, 402 F. Supp. 1029, 1030 (D. Mass. 1975) (joint action by personnel of a hospital is not an antitrust conspiracy).

302. *Robinson*, 521 F. Supp. at 907. As the court explained,

its medical staff, it is unnecessary to attempt to impose vicarious antitrust liability. However, where the hospital is neither the responsible decision-maker nor a conspirator in its own right, an antitrust plaintiff will seek to rely on vicarious antitrust liability, just as a malpractice plaintiff will seek to rely on vicarious negligence liability when there is no violation of duty by the hospital itself. In addition, plaintiffs may begin to plead vicarious antitrust liability as an alternative basis of liability in their antitrust complaints in the health care field.

### *B. Practical Application of Vicarious Antitrust Liability in the Health Care Field: Claims, Defenses and Preventive Measures*

The Supreme Court's analysis in *American Society of Mechanical Engineers*<sup>303</sup> is directly applicable to standard-setting organizations in the health care field, such as the Joint Commission on Accreditation of Hospitals.<sup>304</sup> More importantly, the Court's analysis may be applied to impose vicarious antitrust liability on a hospital for the acts of non-employed physicians. In *American Society of Mechanical Engineers*, the Court held that vicarious antitrust liability could be imposed upon a nonprofit corporation for the acts of its non-employed agents acting with apparent authority, even though the agents were not acting to benefit the corporation.<sup>305</sup> Therefore, in the health care context, health

---

[c]ourts have recognized a narrow exception to the general rule that no violation occurs when a corporation conspires only with its officers, agents or employees. This exception provides that a violation can occur if the officer, agent or employee has an independent, personal stake in achieving the object of the conspiracy.

*Id.* See also Note, "Conspiring Entities" Under Section 1 of the Sherman Act, 95 HARV. L. REV. 661, 676 (1982) ("The [Supreme] Court has held that an outside contractor, such as a management consultant, may be found to have conspired with his principal firm if the contractor has an independent economic interest in the alleged restraint of trade.") (footnote omitted) (citing *Poller v. CBS*, 368 U.S. 464, 469-70 (1962)). But see *International Travel Arrangers, Inc. v. Western Airlines, Inc.*, 623 F.2d 1255 (8th Cir.), cert. denied, 449 U.S. 1063 (1980) (conspiracy existed between airline and its advertising agency, where agency materially aided airline's anticompetitive plan with knowledge of its purpose). See generally Handler & Smart, *The Present Status of the Intracorporate Conspiracy Doctrine*, 3 CARDOZO L. REV. 23 (1981).

303. See *supra* notes 268-75, 286-91 and accompanying text.

304. See *supra* notes 128-31 and accompanying text.

305. *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. 1935, 1946-48 (1982). See *supra* notes 268-75 and accompanying text.

care institutions may be subject to treble damage liability for the concerted anticompetitive activities of non-employed medical staff members, as the actual or apparent agents of the hospital.

In identifying potential applications of vicarious antitrust liability in the health care field, potential antitrust plaintiffs are not limited to the aggrieved competitors of the hospital or its medical staff members. Rather, potential plaintiffs include anyone who is injured in his business or property by a violation of the antitrust laws,<sup>306</sup> including patients<sup>307</sup> and producers of health care products.<sup>308</sup> In addition, federal and state agencies have enforcement powers in both civil and criminal arenas.<sup>309</sup>

The clearest health care analogy to *American Society of Mechanical Engineers*<sup>310</sup> is the situation in which members of a hospital's medical staff make a public statement which injures a competitor. For example, the medical staff of a hospital, in pursuit of its authority to maintain the quality of patient care and regulate the ethical practices of its members,<sup>311</sup> might make a public communication which is highly critical of a new provider in the marketplace, such as an ambulatory surgical center, emergency medical treatment center, or health maintenance organization. A similar situation arose in *Feminist Women's Health Center, Inc. v. Mohammad*.<sup>312</sup> In *Mohammad*, six of the defendants were physicians on the obstetrics and gynecology staff of a particular hospital.<sup>313</sup> In addition to individual or collective refusals by the six physicians to deal with the new health center, the obstetrics and gynecology staff adopted a resolution and voted to send out a letter concerning the new health center.<sup>314</sup> If such communications had been dissemi-

306. See 15 U.S.C. § 15 (Supp. V 1981).

307. See *McCready v. Blue Shield of Virginia*, 102 S. Ct. 2540 (1982).

308. See *infra* notes 316-17 and accompanying text.

309. See, e.g., 15 U.S.C. § 4 (1976); N.C. GEN. STAT. § 75-15 (1981).

310. See *supra* note 305.

311. See generally JCAH, *supra* note 98, at 93.

312. 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).

313. *Id.* at 535.

314. *Id.* at 536-38. As the court explained, the staff "adopted a resolution that it would not 'approve' the [plaintiff] Center if no member of the hospital staff were associated with the Center." *Id.* at 536. In addition, the staff voted to send a letter to the medical society arguing against association with providers that advertise. *Id.* at 537. Because the six physicians were acting in their role as the hospital's staff, they were probably acting as agents of the hospital. However, even if they exceeded their actual authority as agents of the hospital, the public would have perceived them to be acting with the apparent authority of the

nated to the general public, either stating or implying that the new competitor provided unsafe medical services, the new competitor could have been seriously injured in the marketplace. Moreover, because that type of statement by the medical staff would appear to carry the imprimatur of the hospital entity, the hospital might be held vicariously liable under the antitrust laws on a theory of apparent authority. Just as in *American Society of Mechanical Engineers*, "[w]hen [the hospital] cloaks its [medical staff] with the authority of its reputation, [it] permits those agents to affect the destinies of businesses and thus gives them the power to frustrate competition in the marketplace."<sup>315</sup> Similarly, if a research center or medical school published a negative report about a drug or medical device, as a result of a conspiracy between the individual researcher and a supplier of competing products, then the institution might be held vicariously liable for the act of its dishonest agent.<sup>316</sup> Even if the institution had no knowledge of its researcher's conspiracy, the institution might be held vicariously liable on a theory of apparent authority.<sup>317</sup> Finally, if medical staff members agree among themselves to furnish untruthful negative references about a former colleague or hospital employee, the hospital might be held vicariously liable for the concerted anticompetitive communications. In such a case, the plaintiff would contend that the adverse references were given by the staff members in their roles as agents of the hospital, or, at least, appeared to be backed by the prestigious reputation of the hospital. As the Supreme Court indicated in *American Society of Mechanical Engineers*, vicarious antitrust liability will be imposed where the threat

---

hospital.

315. *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. at 1944.

316. A similar prospect was suggested by the dissent in *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. at 1956 (Powell, J., dissenting). As the dissent explained,

the Court has devised what amounts to a rule of strict liability for voluntary associations in antitrust cases . . . . [I]f a private pharmaceutical school—a tax-exempt corporation like ASME—released a study condemning a particular drug, because a competing drug company had suborned the professor who wrote the report, the Court's rule would subject the school to the full brunt of treble damages.

*Id.*

317. See *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. at 1946-48 (vicarious antitrust liability can be imposed without ratification of the acts of the agents with apparent authority). See *supra* notes 271, 291 and accompanying text.

to competition arises from the mere appearance of authority.<sup>318</sup>

In response to allegations of vicarious antitrust liability, health care institutions can raise several defenses. First, the institution can answer that the members of its medical staff alleged to have conspired were not its agents, because they were acting as individual physicians rather than as the institution's medical staff. Even if the physicians were agents of the hospital, the hospital can answer that the physicians were neither acting within the scope of their employment nor acting with apparent authority.<sup>319</sup> In response to allegations of injurious anticompetitive communications, the hospital can also raise the *Noerr-Pennington* defense of first amendment protection for joint activity to influence governmental action.<sup>320</sup> For example, if the plaintiff complains about a public statement that questioned the safety of its services, defendant can answer that the statements were part of a publicity campaign to influence governmental action against the plaintiff.<sup>321</sup> A third defense to allegations of vicarious antitrust liability is that the medical staff was attempting in good faith to interpret and apply a health or safety standard.<sup>322</sup> In *American Society of Mechanical Engineers*, the Court noted that, "we do not face a challenge to a good faith interpretation of an ASME code reasonably supported by health or safety considerations."<sup>323</sup> Apparently, such a good

---

318. See *supra* note 287 and accompanying text.

319. See *supra* notes 265-71, 279 and accompanying text. In cases of apparent authority, the hospital can also respond that any injury suffered by the plaintiff as a result of an injurious publication was proximately caused by the physicians' individual reputations, rather than by the reputation of the hospital.

320. See *supra* notes 212-21 and accompanying text. Although the court in *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530, 542-44 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) restricted the *Noerr-Pennington* defense to direct communications to solicit governmental action, *Noerr* itself involved a broader publicity campaign including speeches, articles, and editorials to encourage governmental action against competitors. *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 142-43 (1961). However, the publicity campaign in *Noerr* would have violated the antitrust laws if it had been a direct attempt to dissuade customers from dealing with competitors. See *id.* at 142. Therefore, *Noerr-Pennington* immunity depends upon the goal of the communication rather than the immediate recipient of the communication. The court in *Mohammad* apparently reached the correct result in denying *Noerr-Pennington* immunity, because the communications encouraged a concerted refusal to deal rather than governmental action. See *supra* note 314.

321. See *supra* note 320.

322. See *American Soc'y of Mechanical Eng'rs*, 102 S. Ct. at 1948.

323. *Id.* (citing *Silver v. New York Stock Exch.*, 373 U.S. 341 (1963)). See



faith interpretation would have been a successful defense in that case, although the precise contours of that defense are unclear. Thus, if a hospital is alleged to be vicariously liable for the injurious statement of its agents, the hospital can raise its agents' good faith as a defense.

There are practical steps which hospitals can take to reduce the risk of vicarious antitrust liability. If the medical staff or its members publishes a statement which is injurious to a competitor or supplier,<sup>324</sup> the hospital should promptly issue a public disclaimer. In *American Society of Mechanical Engineers*,<sup>325</sup> Chief Justice Burger concurred in the judgment of the Court on the grounds that the nonprofit organization ratified the anticompetitive conduct of its agents and failed to disavow that conduct.<sup>326</sup> Even though the opinion of the Court in *American Society of Mechanical Engineers* makes ratification irrelevant for purposes of liability,<sup>327</sup> an effective disclaimer by a hospital should minimize the damages suffered by a plaintiff. Therefore, a hospital should promptly clarify that the statements of the medical staff or its members do not represent the position of the hospital. This will require vigilance in monitoring all statements which appear to be made on behalf of the hospital, as well as all other potentially anticompetitive actions of the medical staff. Although such extensive control over physicians may seem impractical, it is merely part of an historical progression toward greater hospital control of physicians.<sup>328</sup> As discussed above, the imposition of greater negligence liability on hospitals has caused hospitals to protect themselves by exercising greater control over the activities of their staff physicians.<sup>329</sup> Similarly, the threat of vicarious antitrust liability will require and enable the hospital to assert greater control over its staff physicians, in order to comply with its responsibilities and protect

---

*supra* notes 200-11 and accompanying text.

324. See *supra* notes 310-15 and accompanying text.

325. 102 S. Ct. 1935 (1982).

326. *Id.* at 1948 (Burger, C.J., concurring in the judgment). As the Chief Justice explained, "I agree with the result reached since Petitioner [ASME] permitted itself to be used to further the scheme which caused injury to respondent. At no time did petitioner disavow the challenged conduct of its members who misused their positions in the Society." *Id.*

327. See *supra* note 291 and accompanying text. In fact, the dissenting justices concluded that the majority's opinion creates a rule of strict liability. 102 S. Ct. at 1956 (Powell, J., dissenting).

328. See *supra* notes 26-28, 122-24 and accompanying text.

329. See *supra* notes 122-24 and accompanying text.

itself against liabilities.<sup>330</sup>

## VI. CONCLUSION

The formal rule structure for vicarious hospital liability, which was created to compensate negligently injured patients, now threatens to spill over into areas other than negligence. One example is vicarious antitrust liability for the acts of non-employed physicians. Another example is vicarious liability for sexual harrasment under Title VII of the Civil Rights Act of 1964.<sup>331</sup> Under the Final Interpretive Guidelines of the Equal Employment Opportunity Commission,<sup>332</sup> a hospital will be liable for sexual harrasment by its supervisors and agents, even without knowledge or negligence by the hospital.<sup>333</sup> If a non-employed member of the medical staff harrasses a hospital nurse, the nurse could seek to hold the hospital vicariously liable on the ground that the physician was an agent of the hospital. The hospital would answer that it is not responsible for the acts of an independent contractor physician; but this defense has been severely eroded in the negligence field, and it may become equally ineffective in fields other than negligence. Other examples will surely arise in the near future. Thus, in order to protect themselves, hospitals must monitor the non-medical activities of their medical staff members, which will cause further changes in the relationship between the hospital and its staff physicians.

---

330. In *American Soc'y of Mechanical Eng'rs*, the Court emphasized that the nonprofit organization has now asserted greater control over the process of interpreting its standards. 102 S. Ct. at 1947 n.15. "Apparently, ASME now gives its interpretations close scrutiny through the publication process." *Id.* at 1948 n.15.

331. 42 U.S.C. §§ 2000e to 2000e-17 (1976).

332. 29 C.F.R. § 1604.11 (1981).

333. *Id.* at § 1604.11. "The Commission will examine the circumstances of the particular employment relationship and the job junctions [sic] performed by the individual in determining whether an individual acts in either a supervisory or agency capacity." *Id.*