A COMMENT: THE ANTITRUST CHALLENGE TO PROFESSIONALISM

CLARK C. HAVIGHURST*

Professor Clark has performed a useful service in documenting ways in which the medical profession still largely controls its own environment, even after a period of regulatory incursions in the health services industry. Even though physicians claim to feel overburdened and more constrained than ever by regulation, they still are not accountable for the costs they impose on the nation. Professor Clark demonstrates the surprising extent to which American society continues to accept the costs of professional consensus and self-regulation instead of insisting that providers of medical care submit to the discipline of either public regulation or the competitive marketplace.

In reviewing manifestations of public deference to the medical profession, Professor Clark omits reference to the example that interests me most — namely, the virtual exemption from the antitrust laws that the so-called "learned professions" enjoyed from the enactment of the Sherman Act in 1890[1] until the mid-1970's. Although that exemption was more de facto than de jure, occasional judicial dicta supported the notion that the organized professions should not be subject to the usual rules designed to protect free enterprise. The most famous judicial statement of medicine's special position appeared in a 1952 antitrust case[2] in which the government alleged, but failed to prove,[3] a profession-sponsored boycott against Oregon health insurers that insisted on holding individual physicians responsible for controlling the costs of care.[4] Although such a coercive, anticompetitive boycott ordinarily would be regarded as an indefensible exercise of private regulatory power by an "extra-governmental agency" that " 'trenches upon

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* A.B. 1955, Princeton University; J.D. 1958, Northwestern University. Professor of Law, Duke University School of Law.

1. 26 Stat. 209 (1890) (current version at 15 U.S.C. §§ 1-7 (1976)).

2. United States v. Oregon State Medical Soc'y, 343 U.S. 326 (1952).

3. The trial court's findings seem to have reflected a strong professional bias. *See id.* at 331 (referring to the judge's "irrelevant soliloquies on socialized medicine, socialized law, and the like, which . . . do not add strength or persuasiveness to his opinion").

4. For a review of the record in this case, revealing the insurers' cost-containment efforts that incensed physicians, see Goldberg & Greenberg, *The Effect of Physician-Controlled Health Insurance*: U.S. v. Oregon State Medical Society, 2 J. HEALTH POL., POL'Y & L. 48 (1977).

the power of the national legislature,' "[5] the Supreme Court disclosed a tolerant disposition toward professional restraints:

> Since no concerted refusal to deal with private health associations has been proved, we need not decide whether it would violate the antitrust laws. We might observe in passing, however, that there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.[6]

The medical profession's antitrust immunity may have owed less to such judicial attitudes than to the federal law's inability to reach localized conduct not affecting interstate commerce.[7] Thus, in *American Medical Association v. United States*,[8] in which jurisdiction was not a problem, the law was brought to bear on organized physicians with surprising force, suggesting that deference to the profession was not universal and that the jurisdictional limit was the more important insulating factor.[9] In any event, the criminal indictments obtained in 1938 by the Justice Department against the American Medical Association and the Medical Society of the District of Columbia still represent the single most direct challenge ever mounted by government against professional power. As such, that litigation, which resulted in a resounding victory for the government, also represents by far the most significant breach in the long tradition of deference traced by Professor Clark. It may nevertheless be an exception that proves Professor Clark's rule, because the assistant attorney general who took on the AMA was Thurman Arnold, a man virtually unique as an iconoclast among American public officials.[10]

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5. Fashion Originators' Guild, Inc. v. FTC, 312 U.S. 457, 465 (1941) (quoting Addyston Pipe & Steel Co. v. United States, 175 U.S. 211, 242 (1899)).

6. United States v. Oregon State Medical Soc'y 343 U.S. 326, 336 (1952). For a full discussion of this language, see Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 344-53.

7. *See, e.g.*, Riggall v. Washington County Medical Soc'y, 249 F.2d 266 (8th Cir. 1957); Spears Free Clinic & Hosp. for Poor Children v. Cleere, 197 F.2d 125 (10th Cir. 1952); Polhemus v. American Medical Ass'n, 145 F.2d 357 (10th Cir. 1944).

8. 317 U.S. 519 (1943), *aff'g* 130 F.2d 233 (D.C. Cir. 1942).

9. *Id.* A strikingly similar civil case was decided against the physicians under state law, *see* Group Health Coop. v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951).

10. Footnoting this characterization of Thurman Arnold was a particular pleasure since it led me into his letters, which include two replies to newspaper editorials critical of the *AMA* case. *See* VOLTAIRE AND THE COWBOY: THE LETTERS OF THURMAN ARNOLD 274-76, 288-90 (G. Gressley ed. 1977). As an indication of Arnold's lack of illusions about the

In addition to producing criminal convictions of two prestigious medical societies, the *AMA* case yielded some judicial language relevant to Professor Clark's theme. Confronted with the argument that the doctor boycott against a health maintenance organization and its participating physicians was intended to promote the public welfare by eliminating unethical professional behavior, the court of appeals responded: "Appellants are not law enforcement agencies . . . and although persons who reason superficially concerning such matters may find justification for extra-legal action to secure what seems to them desirable ends[,] this is not the American way of life."[11] Of course, if "the American way of life" really did universally embody the principle that public responsibilities should not be assumed by, or assigned to, private groups afflicted with conflicts of interests, the problems documented by Professor Clark would never have arisen. Thus, in confronting the issues that Professor Clark has raised, it is useful to ask whether we are attempting to redefine "the American way of life" or seeking simply to enforce it — by finally giving effect to an antielitist ideal that, in this particular case, has been honored in the breach. Because I like to think that the antitrust tradition reflects the dominant norm, I would characterize the long toleration of professional dominance as an aberration, a mistaken departure from traditional values.

Just as the history of the medical profession's longstanding antitrust exemption illuminates the undue deference that Professor Clark discusses, recent history suggests that important changes in public attitudes are not only possible but already under way. Since *Goldfarb v. Virginia State Bar*[12] laid the putative "learned professions" exemption to rest in 1975, antitrust litigation has become an important feature of the health care industry.[13] In addition to satisfying themselves that professionals are engaged in "trade or commerce," the courts have

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medical profession, I particularly liked the following reference to Morris Fishbein, M.D., the dominant figure in the AMA: "John L. Lewis and Dr. Fishbein are brothers under the skin." *Id.* at 383. The editor's notes to the letters include the following illuminating anecdote:

> Hugh Cox recalls a marvelous scene between Thurman Arnold and Attorney General Cummings. Cummings commented, "Thurman, this is the Goddamnedest thing I ever heard. You propose to indict a hospital, a local medical association, and all these doctors? Well, these doctors are leading citizens of their communities, and I play golf with some of them; you know if you do this there's going to be a lot of trouble and somebody's going to catch hell. Now who is it?" Thurman replied, "Well, you will!" Cummings just laughed and waved Thurman out, "All right, go ahead."

Id. at 514 n.139.

11. American Medical Ass'n v. United States, 130 F.2d 233, 249 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943).

12. 421 U.S. 773 (1975).

13. *See* Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?* 49

made jurisdictional requirements easier to satisfy.[14] Although a few lower courts seemingly have given physicians the benefit of professional courtesy,[15] the trend seems to be running strongly toward the erosion of such deference.[16] In each of its decisions involving the professions, the Supreme Court has left open the possibility that professionalism might make a difference, but each of these successive statements has narrowed the grounds for possible exceptions to standard antitrust principles.[17] Moreover, the Court has yet to decide a case in favor of a professional group on such a basis.

The truest test yet of the Court's willingness to challenge professional dominance may come in *Arizona v. Maricopa County Medical Society*,[18] which is before the Court in its 1981-1982 term. This case challenges the legality of a dominant medical organization's setting ceilings on fees charged insured patients. Thus, it may turn on the Court's view of reforms that such professional groups might undertake in good faith to curb the propensity of some physicians to overcharge for their insured services. Unfortunately, acceptance of a professional cartel's efforts to police itself would imply acceptance of professional monopoly itself[19] and would constitute precisely the kind of delegation of public responsibilities to private interests that Professor Clark properly deplores. On the other hand, the *Maricopa County* case presents the complex question of what restraints may be justified by the presence of incentive-distorting health insurance and thus may turn solely on technical issues. If the Court is careful in its analysis, its decision

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ANTITRUST L.J. 17 (Summer 1980); Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean*? 58 MILBANK MEMORIAL FUND Q. 89 (1980).

14. *See* McLain v. Real Estate Bd., Inc., 444 U.S. 232 (1980); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975); Zamiri v. William Beaumont Hosp., 430 F. Supp. 875 (E.D. Mich. 1977).

15. *E.g.*, Arizona v. Maricopa County Medical Soc'y, 643 F.2d 553 (9th Cir. 1980), *cert. granted*, 101 S. Ct. 1512 (1981); United States v. American Soc'y of Anesthesiologists, 473 F. Supp. 147 (S.D.N.Y. 1979).

16. *E.g.*, American Medical Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980), *cert. granted*, 101 S. Ct. 3107 (1981); Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 101 S. Ct. 1360 (1981).

17. *See* National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 696 (1978); Bates v. State Bar, 433 U.S. 350, 368-70 (1977); Goldfarb v. Virginia State Bar, 421 U.S. 773, 788 n.17 (1975); United States v. Oregon State Medical Soc'y, 343 U.S. 326, 336 (1952).

18. 101 S. Ct. 1512 (1981), *granting cert. to* 643 F.2d 553 (9th Cir. 1980). Another case of interest on the current docket is American Medical Ass'n v. FTC, 101 S. Ct. 3107 (1981), *granting cert. to* 638 F.2d 443 (2d Cir. 1980). Because FTC jurisdiction over the AMA requires a finding that the latter is organized "for the profit of its members," the stage is set for a declaration by the Court concerning the AMA's purposes.

19. *See* Havighurst & Hackbarth, *Enforcing the Rules of Free Enterprise in an Imperfect Market: The Case of Individual Practice Associations*, in A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE (M. Olson ed. 1981) (forthcoming).

may finally dispel the idea that professionals can be trusted more than others to restrain trade without injuring the public. One must hope that the Court will not be led into deferring to a medical cartel as a competent decision maker because of some notion that professional services are "different."

Though belated, the current antitrust attack on professional power seems to provide most of the tools necessary to break down excessive public and private deference to the medical profession. As courts discover, punish, and publicize professional abuses, public attitudes toward the profession and its claims should begin to change, helping to reduce organized medicine's political power. By exposing the hollowness of the profession's claims to special virtue, antitrust activity will contribute to the spreading perception of medicine as just another interest group scrambling for a place at the public trough. In time — and I suspect we are nearing this point already — legislative favoritism for professional interests will no longer be characterizable in Professor Clark's terms as a problem generically distinct from the general problems of special-interest politics.

The antitrust campaign also will erode the medical profession's special status in other ways. Increased competition will give private decision makers — insurers, employers purchasing health coverage, labor unions, and individual consumers — more reasons and opportunities to question traditional arrangements and practices. Things previously taken on faith suddenly will be questioned as consumers and their agents become aware of new options with different price tags. Although consumers will always value highly anything that promises better protection, new cost-consciousness[20] could give them new reasons to doubt unsubstantiated claims and to consider the cost implications of qualitative differences. Moreover, consumers seeking to obtain the desired level of quality, appropriate utilization, and overall cost-effectiveness might come to rely heavily upon the reputations of particular procurers of professional services, such as health maintenance organizations, group practices, hospitals, selective insurance plans, and other innovative financing and delivery mechanisms. The purchasing activities of such middlemen, acting in effect as the consumer's agents, would trigger cost-oriented competition among physicians, who would

20. One element of the market strategy being contemplated in policy circles is the reduction of the tax incentives for the purchase of excess health insurance. *See* Ginsburg, *Altering the Tax Treatment of Employment-Based Health Plans*, 59 MILBANK MEMORIAL FUND Q. 224 (1981). This is expected to make consumers more cost-conscious and change their purchasing behavior. Another crucial element is the redesign of public financing programs to permit beneficiaries to make cost-conscious choices.

thus be forced to submit to the accountability that, as Professor Clark notes, is now lacking. While consumers will always have some unexamined preferences and irrational concerns, the competitive marketplace, in which unreasonable demands carry higher prices, promises to provide the best arena in which to educate consumers and others to the costs and benefits of deference to professionally developed norms and values.

The competitive process that the antitrust laws should help to unleash also will undermine organized medicine's political power, thus weakening the legislative underpinnings of professional monopoly. As employers and other organized consumer interests begin to recognize the costs currently imposed on them by the legal foreclosure of alternative providers and innovative financing and delivery mechanisms, countervailing political forces will gain strength. New political opposition to medical interests may also come from nonphysician providers, who, on seeing that antitrust law provides relief from the informal restraints that have blocked their opportunities in the past, should perceive new potential gains from fighting legislative obstacles to fair competition. Finally, competition also threatens further to erode organized medicine's already dwindling monolithic character, thereby reducing its political influence. As individual physicians in search of competitive opportunities in an increasingly crowded and cost-conscious market become more willing to participate in innovative financing and delivery arrangements, they will represent an emerging counter force to the medical establishment. Such maverick physicians will also play a part in exposing any overreaching and exaggerated claims by the dominant medical interests.

With this introduction to the possible dynamics of the future economic and political marketplaces in which decisions concerning medical services will be made, I leave it to the reader to assess the extent to which private and public deference to medical interests will continue to pose the same problems that Professor Clark correctly identifies as historical facts. Although there is a great deal that might be said about probable developments in each of the areas canvassed by Professor Clark, I see good reason to be hopeful in each of them. Indeed, I would argue that every problem he identifies is quite readily amenable to some combination of market-inspired remedies and market-oriented legislative and regulatory solutions.[21]

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21. Even the problem of malpractice law could be solved by market-inspired innovation. *See* COMMISSION ON MEDICAL PROFESSIONAL LIABILITY OF THE AMERICAN BAR ASSOCIATION, DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBIITY STUDY (1979); Havighurst, *Medical Adversity Insurance: Has Its Time Come?* 1975 DUKE L.J. 1233 (1976).

Because I regard the unleashing of competition and consumer choice as a promising strategy for changing both consumer perceptions and the political balance of power, I would strongly dispute Professor Clark's conclusion that new and better regulation is needed. His prescription would, I fear, lead us back into thickets where we have previously found ourselves dependent on medical guidance.[22] Moreover, we already have found it virtually impossible collectively to ration other people's health care and to resist medicine's expansive claims by invoking the rigorous and insensitive techniques of cost-benefit analysis.[23] Furthermore, regulation is inherently incapable of making the innumerable fine distinctions and overseeing the delicate judgments that are the grist of clinical decision making and of comparing the marginal costs and benefits at stake in the myriad of small but cumulatively significant choices that the health care system makes every day. Finally, Professor Clark's regulatory proposal seems out of step with the new political milieu, in which regulation generally is disfavored.[24] For the time being at least, the market strategy is ascendant in policy circles, and the currently interesting issue is whether the nation will be able to implement that strategy politically without compromising so fundamentally with medical interests as to perpetuate their dominance.[25]

While I agree with Professor Clark that the public is unduly deferential to the medical profession, I believe that the source of the problem lies in a deeply rooted misconception — namely the view that medical care is an exact science readily reducible to rules and thus amenable to central control. To my mind, the attitudinal reform most needed in the health care industry is a rejection of the notion that there is a single right way (or a narrow range of acceptable ways) to diagnose and treat human disease that must somehow be established and enforced on a collective basis, either by the medical profession or by the government. Instead of perpetuating that misconception, we need to establish the legitimacy of pluralistic approaches within a wide range, using public controls and professional self-regulation only to address

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22. *See* Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSRO's*, 70 NW. U.L. REV. 6 (1975).

23. *See* Havighurst, *Health Care Cost-Containment Regulation: Prospects and an Alternative*, 3 AM. J.L. & MED. 309 (1977); Havighurst, Blumstein & Bovbjerg, *Strategies in Underwriting the Cost of Catastrophic Disease*, 40 L. & CONTEMP. PROB. 122 (Autumn 1976).

24. In particular, dissatisfaction with the regulation of drug efficacy by the Food and Drug Administration would surely induce skepticism about Professor Clark's comparable regulatory format. *See generally* REGULATING NEW DRUGS (R. Landau ed. 1973); W. WARDELL & L. LASAGNA, REGULATION AND DRUG DEVELOPMENT (1975).

25. For general discussions of the market strategy and its implementation, see A. ENTHOVEN, HEALTH PLAN (1980); C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION (forthcoming).

problems bordering on misrepresenation and exploitation. As a particular example of the advantage of pluralism, I would cite the problem of technology assessment, which Professor Clark would assign to a regulatory body. In my view, the hard decisions concerning cost-benefit tradeoffs should be left primarily to the private sector and to competing providers and health plans. Government should assist only in sponsoring research, disseminating information, and policing abuse.

Regulatory prescriptions, such as Professor Clark's, for shifting control from the medical profession to the public sector embody a unitary conception of medical care and thus fall into the monopoly trap. Posing the issue as whether the profession or the government should exercise control ignores the fact that, whoever may be in charge, monopoly is apt to be wasteful, uninnovative, and unresponsive to consumer preferences. Although regulating professional monopoly might make sense if there were no feasible alternative, we are fortunate in having the antitrust laws as a vehicle for pursuing the pluralistic option. I fear, however, that Professor Clark, far from exposing the false assumption on which public deference to the medical profession is fundamentally based, may have himself fallen under its spell. In my view, the learning process that competition and consumer choice would stimulate offers the only real escape from the thralldom under which we have long been laboring.