Private Credentialing of Health Care Personnel: An Antitrust Perspective†

Part One*

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ABSTRACT

This Article explores the antitrust and other implications of private credentialing and accrediting programs in the health care industry. Although such programs are usually sponsored by powerful competitor groups, they serve the procompetitive purpose of providing useful information and authoritative advice to independent decision makers. Part One examines the risk that credentialing will sometimes be unfair to competitors and deceive consumers. Its survey of common-law, antitrust, and regulatory interventions to correct such unfairness and deception seeks to determine the degree of oversight to which credentialing and similar activities have been and should be subjected. In recommending that judicial or regulatory scrutiny should be limited to discovering whether standards and practices have a rational relation to a procompetitive purpose, the Article argues that greater intrusion into credentialing schemes would be inconsistent with market theory and first amendment values and would discourage line-drawing efforts that stimulate competition and facilitate consumer choice. By emphasizing throughout that personnel certification and institutional accreditation embody ideology and opinion as well as factual information, Part One sets the stage for the argument in Part Two that antitrust law can and should be used to contest the dominance of a single ideology of health care and to facilitate the development of alternative sources of consumer information. The Article's overall thesis is that, whereas the quality of advice given to the

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public about health care personnel and similar matters should not be closely regulated, neither should the supply of competing information and opinion be artificially curtailed.

I. INTRODUCTION

If the market for health care services is to operate efficiently, reliable information concerning the skills and attributes of individuals employed in the industry must be available in useful forms to a variety of users. Although the mixed public-private credentialing system that now exists meets some of these information needs, its design, operation, and sponsorship provide no guarantee that it is the optimal system. Moreover, as the legal system and the public are coming to view health care more as a product purchased in a competitive market and less as a service provided by a unitary, self-regulating system,[1] old justifications for limiting the form, content, and sources of information are becoming less persuasive. Because factors influencing the quality and quantity of information in this complex and changing market are not well understood, this Article undertakes an economic, legal, and policy analysis of privately sponsored programs for certifying the attainments and skills of health care personnel.

Private credentialing includes a variety of voluntary schemes that identify certain individuals as having achieved some distinction by which they can be differentiated from their competitors. The entire private credentialing process encompasses the conferral on individuals of degrees, diplomas, or certificates by educational institutions and training programs and the accreditation of private bodies that engage in educating or certifying individuals. Although this Article's main focus is on the credentialing of personnel in the health care field, its legal analysis encompasses and applies in some measure to the accreditation of institutional providers of health care, the certification of providers of other services, the accreditation of educational and training programs of all kinds, and the certification of industrial products.

Private credentialing of personnel differs fundamentally from public credentialing. The latter is usually exclusionary, consisting not only of licensure but also of legal prohibitions against unlicensed practice.[2] On the

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[1] This conception of health care and of the health care industry has begun to take hold in recent years as a result of changes in antitrust law, disappointment with command-and-control regulation, and new policy thinking. *See generally* MARKET REFORMS IN HEALTH CARE (J. Meyer ed. 1983); C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY (1982); A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE (M. Olson ed. 1981); Symposium, *Market-Oriented Approaches to Achieving Health Policy Goals*, 34 VAND. L. REV. 849 (1981); A. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980); *The Spiraling Costs of Health Care—Rx: Competition*, BUS. WK., Feb. 8, 1982, at 58.

[2] For a classic discussion of manpower licensure, *see* M. FRIEDMAN, CAPITALISM AND FREEDOM, ch. 9 (1962).

other hand, private credentialing serves solely informational purposes; those who lack private credentials still possess a legal right to practice, though they may be disadvantaged in the marketplace because independent decision makers such as consumers, hospitals, and public or private financing plans value their services less highly. Even though this competitive disadvantage may be serious or fatal, such hardship results from numerous independent decisions about the credentials' significance and not from a collective determination to treat uncertified persons in a certain way.

Properly understood, therefore, private credentialing is nothing more than an expression of opinion. Indeed, serious legal inhibitions prevent private credentialing bodies from going beyond expressions of opinion and from seeking, as public regulators might do, to enforce their judgments through exclusionary actions. In antitrust terms, the private production and dissemination of information and opinion are presumptively procompetitive and lawful, while the collective imposition of private sanctions to enforce such opinions is anticompetitive and will usually constitute a per se violation of the Sherman Act.[3] Thus, there is a vital distinction between collective actions to produce and disseminate information, on the one hand, and unlawful private regulation, on the other.[4] This Article focuses principally on activities of the former type and the special circumstances under which their legality may be called into question.[5]

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[3] For example, the boycott, the sanction most typically employed in such private regulation, is a per se violation of the antitrust laws. *See infra* notes 137-50 and accompanying text.

[4] The distinction is easily obscured. For example, in American Soc'y of Mechanical Eng'rs v. Hydrolevel Corp., 456 U.S. 556, 570 (1982), Justice Blackmun, speaking of the appellant certifying body, stated:

> ASME wields great power in the Nation's economy. Its codes and standards influence the policies of numerous States and cities, and, as has been said about "so-called voluntary standards" generally, its interpretations of its guidelines "may result in economic prosperity or economic failure, for a number of businesses of all sizes throughout the country. . . ." H.R. Rep. No. 1981, 90th Cong., 2d Sess., 75 (1968). ASME can be said to be "in reality an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce. . . ."

The latter quotation of famous language from Fashion Originators' Guild v. FTC, 312 U.S. 457, 465 (1941), is inapposite precisely because the appellant in that case, unlike ASME, was a combination of manufacturers that had not merely stated its opinion about its competitors' products but had engaged in a boycott of retailers of unapproved merchandise. The term regulation, or self-regulation, like the legal rule against its implementation by an "extra-governmental agency," is appropriately applied only to collective activity involving the exercise of coercive power. *See infra* text accompanying notes 138-50. The analysis in this Article, and antitrust law generally, treats the provision of information, without coercive sanctions, as desirable, procompetitive activity. *See, e.g., infra* note 75. For further discussion of the *Hydrolevel* case, see *infra* text accompanying notes 164-65.

[5] A significant feature of this Article is that it deals with the less fully explored of the two features that most sharply distinguish the health care marketplace from other markets. Antitrust analysts and the courts now appear to understand fairly well how a market featuring third-party payment for services might be efficiently competitive, *see, e.g.,* P. JOSKOW, CON-

The purpose of this Article is to propose legal rules that will maximize the public benefits of private credentialing and minimize its harms. Part One, after introducing personnel credentialing and emphasizing its value as information, considers whether some private credentialing activities may violate common-law or antitrust principles because of deficiencies in the information provided or because of procedural or substantive unfairness to individual applicants. It concludes by supporting only limited judicial or regulatory scrutiny of credentialing standards and procedures. The main reason for not encouraging closer scrutiny of private credentialing activities is that market forces can do a better job than the courts in ensuring the quality of information available concerning health care personnel. Part Two of this Article examines how market forces can be made to perform this function more reliably. After describing some of the medical profession's restraints on the flow of vital information concerning health care personnel, it identifies some of those restraints as appropriate targets for antitrust action. Although some readers may regard the legal conclusions in Part One as overly conservative, the far-reaching legal theories and enforcement agenda advanced in Part Two should relieve at least some of their disappointment. By the same token, private credentialers and accreditors should wait until the discussion is complete before taking comfort from the legal arguments presented here.

II. THE NATURE AND INFORMATIONAL VALUE OF PRIVATE CREDENTIALING

An individual may be certified by a nongovernmental board or association as one who possesses certain qualifications. These qualifications, which the certifying organization itself specifies, may include completion of certain educational requirements, satisfactory performance on an examination administered by the organization, demonstration of acceptable character and fitness, and so forth. Governments may also engage in certification, as they do for certified public accountants; although only persons who have met a state's requirements may call themselves CPAs, others may compete

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TROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION 21-31 (1981); Havighurst & Hackbarth, *Private Cost Containment,* 300 NEW ENG. J. MED. 1298 (1979), and how competition in such a market might be restrained. *See, e.g.,* Arizona v. Maricopa County Medical Soc'y, 102 S. Ct. 2466, 2477-78 (1982); Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross and Blue Shield of Connecticut, 675 F.2d 502, 506-07 (2nd Cir. 1982). They have had much less opportunity, however, to appreciate the significance of consumer ignorance in markets for complex professional services and the consequent desirability of any program that supplies consumers with information and opinion regarding the relative merits of competing individuals and institutions. There has also been little recognition of the ways in which competitors can create market power by collectively controlling information or of the value of antitrust law in preserving markets as forums for testing competing ideologies and for ensuring that consumers' diverse preferences and values are well served.

in selling accounting services. It is in this respect that certification differs from licensure, which legally excludes unlicensed practitioners from the market.

Certification serves the valuable purpose of informing consumers and others that the certificate holder has been examined and approved by the particular certifying body according to its standards. Credential holders may call themselves by a particular title, refer to themselves as certified or approved by the board or association in question, or display a distinctive certificate, seal, or other evidence of recognition. By so advertising their approved status, they differentiate themselves from their uncredentialed competitors, and, to the extent that consumers and others have confidence in the certifying body, the credential holder gains a competitive advantage. The information conveyed by certification is easily accessible and saves users the time and cost of independently discovering an individual's qualifications and comparing those qualifications to the characteristics and achievements of others. Even though a particular certification scheme may not provide all the information a user needs, substantial search costs are saved, and the market works more efficiently.

Certification of an individual is closely analogous to the granting of a seal of approval to a manufactured product. In consumer markets and industrial settings, there is a wide variety of such seals and product certifications, such as those offered by the Good Housekeeping Institute and Underwriters Laboratories. The great extent to which these seals are relied upon as assurances of the product's safety and reliability suggests their value in conveying useful information to consumers and others in a complex world.[6]

There are several types of bodies engaged in standard setting, personnel and product testing, and certification.[7] Some, such as Consumers Union and Underwriters Laboratories, are independent organizations. Other certifying bodies are comprised of users of the products or employers of the individuals being certified. Particularly in the professions, certification is frequently controlled by dominant providers of services for

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[6] *See* American Soc'y of Mechanical Eng'rs v. Hydrolevel Corp., 456 U.S. at 570, *quoted in supra* note 4. *See generally* BUREAU OF CONSUMER PROTECTION, FEDERAL TRADE COMMISSION, STANDARDS AND CERTIFICATION (1983) (hereinafter cited as FTC STAFF REPORT); SCIENCE POLICY RESEARCH DIVISION OF THE CONGRESSIONAL RESEARCH SERVICE OF THE LIBRARY OF CONGRESS, REPORT TO THE SUBCOMMITTEE ON SCIENCE, RESEARCH AND DEVELOPMENT OF THE HOUSE COMMITTEE ON SCIENCE AND ASTRONAUTICS, VOLUNTARY INDUSTRIAL STANDARDS IN THE UNITED STATES (1974); Wachtel, *Product Standards and Certification Programs,* 13 ANTITRUST BULL. 1 (1968); Hummel, *Antitrust Problems of Industrial Codes of Advertising, Standardization, and Seals of Approval,* 13 ANTITRUST BULL. 607 (1968).

[7] In industrial settings it is common for certifying bodies to apply standards set by other organizations. *See* FTC STAFF REPORT, *supra* note 6, at 23-26. In health personnel credentialing, the certifiers generally set their own standards, except insofar as they require completion of educational programs accredited by others.

which the certified group can provide competitive substitutes.[8] Most certifying entities, however, are made up of representatives of the credential holders themselves or of producers of certified products. This type of certifying body seeks to gain for its sponsors the economic advantages that can result from differentiating themselves or their products from their competitors. In arrangements of this kind, the costs of the certification effort are borne by the certified individuals themselves, in the form of either fees charged to new applicants or dues paid to the organization by certified individuals.

Educational institutions also engage in a form of personnel credentialing when they issue diplomas to their graduates. These institutions set standards, administer tests, and grant credentials to students upon completion of certain requirements. The tuition paid by students reflects in large part a payment for the educational services rendered. Frequently, however, the diploma itself has a market value because prospective employers and others regard it as a sign of a certain level of ability as well as achievement. Thus, prospective students compete for admission to prestigious institutions in part because of the prestige that graduation from the institution confers, and schools set their tuition fees at levels low enough to maintain the excess demand that permits them to be selective, thus maintaining the value of the diploma as a sign of the distinction conferred by admission. Schools also grant credentials in the form of honors awarded at graduation and through election to Phi Beta Kappa.[9]

Privately conferred credentials can also be usefully compared to trademarks, which provide consumers with a type of information somewhat different from that provided by industrial seals of approval. A trademark identifies the proprietor by whom, or under whose auspices, a product or service was produced.[10] It thus conveys no direct information concerning the product's quality, which must be deduced from whatever one knows about the trademark owner or from previous experience with products bearing the mark. An educational institution's degree is similar to a trademark, identifying degree recipients as products of that institution's total educational and social experience. Although selective academic programs perform the certifying function mentioned above, they do not offer open examinations and are not willing to confer degrees (other than an

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[8] *See infra* notes 52-55 and accompanying text.

[9] Phi Beta Kappa is a private credentialing body supported by its members but administered through educational institutions.

[10] Trademarks serve to identify the origin of a product, to guarantee constancy of quality on repeat purchases, and to facilitate advertising of the product. 3 R. CALLMAN, THE LAW OF UNFAIR COMPETITION, TRADEMARKS AND MONOPOLIES § 17.01 (4th ed. 1983). The law also recognizes collective trademarks and certification marks that signify, in addition to quality standards, such characteristics as place of origin (e.g., Florida oranges) or type of producer (e.g., a trade or marketing association). *See* Note, *The Collective Trademark: Invitation to Abuse,* 68 YALE L.J. 528 (1959). *See also infra* note 204 and accompanying text.

occasional honorary one) on products of other institutions. Similarly, a trademark is not available for use by a competing product upon a demonstration of equal quality. In this respect there is an important conceptual difference between trademarks and certification schemes. Trademarks differentiate between competing goods on a *vertical* basis, signifying the origin of goods rather than their relative quality. Certification schemes, on the other hand, purport to draw *horizontal* lines—that is, to set standards—representing qualitative differences.[11] This distinction between vertical and horizontal differentiations suggests that a certification scheme might be deceptive if it drew vertical lines while purporting to measure only quality. Yet no personnel certifying body draws purely horizontal lines. Instead of offering truly open examinations, most certifiers maintain prerequisites that applicants must meet to qualify for examination. The nature and extent of such prerequisites can vary greatly, of course, and it is here that some of the potential for deception and other anticompetitive effects arises.

Because a certification scheme may not be what it seems, certification could deceive consumers as easily as it could help them. Just as the information provided by certification reduces the cost and uncertainty of independently evaluating the skills of individuals, so the risks of relying on particular certifications can be reduced by certifying the certifying bodies themselves. Programs for accrediting certifiers do indeed exist, purporting to assure the public that the credentials issued by a particular program or institution have positive information value. Not only are educational programs accredited by numerous specialized private bodies under various sponsorships,[12] but personnel and product certification and seal-of-approval schemes likewise exist under accrediting umbrellas.[13]

Because systems for accrediting credentialing schemes also possess a potential for misleading the public, a need may exist for yet another tier of accreditation. Indeed, the need for some verification of the information conveyed by accrediting bodies may suggest that there is no theoretical limit to the number of tiers of private accreditation needed and that, at

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[11] Some credentialers might deny drawing such invidious distinctions. *See infra* note 30 and text accompanying note 207.

[12] *See* COUNCIL ON POSTSECONDARY ACCREDITATION, THE BALANCE WHEEL FOR ACCREDITATION 2 (1981); W. SELDON & F. PORTER, ACCREDITATION: ITS PURPOSES AND USES (1977); CENTER FOR OCCUPATIONAL EDUCATION, N.C. STATE UNIV., PERSPECTIVES ON ACCREDITATION OF POSTSECONDARY OCCUPATIONAL EDUCATION (1970); Oulahan, *The Legal Implications of Evaluation and Accreditation,* 7 J. L. & EDUC. 193, 198 (1978); Finkin, *Federal Reliance on Voluntary Accreditation: The Power to Recognize as the Power to Regulate,* 2 J. L. & EDUC. 339, 341-42 (1973).

[13] In the area of product certification, the American National Standards Institute serves as a voluntary national clearinghouse for the approval and promulgation of standards developed and used by most of the major product testing and certification organizations. *See generally* FTC STAFF REPORTS, *supra* note 6, at 16; CONGRESSIONAL SERVICE REPORT *supra* note 6, at 28-31. The U.S. Department of Commerce also sponsors the development of and recognizes standards set by private bodies. *See* 15 C.F.R. § 10 (1983).

some point, the government or some authoritative private group should step in to provide a definitive mechanism for accrediting accreditors. In fact, the federal government does maintain an administrative structure for approving accrediting bodies in the field of education[14] and an influential private group does so as well.[15]

III. PRIVATE CREDENTIALING IN THE HEALTH CARE FIELD

The health care industry features a variety of highly developed, closely articulated systems for certifying individuals' qualifications to perform various functions. Although physician licensure supplies some assurance of general competence, it fails to identify those doctors with skills in specialized fields. Consequently, the medical profession has developed a complex system of specialty certification.[16] In nonphysician health occupations, credentialing relates differently to state licensure and is even more complex and varied. For the most part, however, nonphysician credentialing also operates under the auspices and influence of the organized medical profession. Most of these various certification schemes are linked with systems for accrediting educational programs. Finally, there are systems for accrediting the various certifying and accrediting bodies themselves. A brief overview of the various institutions and their interrelationships is provided below.

A. Physician Certification

The most extensive private personnel credentialing system anywhere is probably that maintained for certifying medical specialists. Twenty-three specialty boards, certifying physicians in carefully delineated areas of specialized practice, are recognized by the American Board of Medical Specialties (ABMS).[17] A roughly equivalent number of physician-certifying en-

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[14] The Office of Postsecondary Education in the United States Department of Education publishes a list of approved accrediting bodies; an institution must be accredited by an approved body in order for it or its students to receive federal funds. *See* 34 C.F.R. § 603 (1982); Finkin, *Reforming the Federal Relationship to Educational Accreditation,* 57 N.C.L. REV. 379 (1979). Finkin disputes the secretary's authority to do more than merely publish a list of "nationally recognized" accreditors of adequate reliability; the secretary's requirements for recognition are highly regulatory, however.

[15] The Council on Postsecondary Accreditation (COPA) is a private national accreditor which was formed in 1975 from a merger of two predecessor organizations, the National Commission on Accreditation and the Federation of Regional Accrediting Commissioners of Higher Education.

[16] On early proposals for separately licensing specialists, *see* R. STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 164-68 (1971). This book is the definitive history of specialization in the medical profession.

[17] The twenty-three boards are Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family Practice, Internal Medicine, Neurological Surgery, Nuclear Medicine, Obstetrics and Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilita-

tities exists outside the ABMS system, but these are of only limited importance. Many of the non-ABMS programs certify nonphysicians as well as physicians in specialized fields,[18] but few certify physicians in areas that compete or overlap with specialties recognized by the ABMS.[19] The ABMS system is so pervasive that health care professionals generally understand "board certification" to mean certification by an ABMS board.

Although virtually all physicians limit their practices to one or at most a few specialized areas,[20] only about half are certified specialists.[21] In the past

tion, Plastic Surgery, Preventive Medicine, Psychiatry and Neurology, Radiology, Surgery, Thoracic Surgery, and Urology. ABMS ANNUAL REPORT & REFERENCE HANDBOOK 58 (1982) (hereinafter cited as ABMS HANDBOOK).

The members of each board are selected "from nominees designated by the board's sponsoring organizations." *Id.* at 77. Each board was of course originally established by one or more prominent specialty societies in the field. *See* R. STEVENS, *supra* note 16.

The members of the ABMS are representatives of the boards and "five national organizations concerned with graduate medical education and specialty practice," plus three public members. Public members have one vote each, non-board representatives two, and the boards a number based on the number of certifications issued in the last five years (always at least two). ABMS HANDBOOK, *supra*, at 36. Since there are 23 boards, it is fair to say that the ABMS is controlled by the boards.

[18] For example, certification in maxillofacial surgery, nutrition, hypnosis, and genetics and a number of laboratory certifications are available to certain nonphysician professionals as well as to physicians. The nature, quality, and importance of non-ABMS boards appear to vary greatly. Many non-ABMS entities granting special recognition to physicians and others are not certifying boards per se but are professional groups whose admission standards may make membership a valuable distinction. *See infra* text accompanying note 45. A few are true examining boards. *See infra* note 19.

[19] The prime exception is the American Board of Abdominal Surgery (ABAS). In the 1960s, the ABAS waged a fierce and ultimately unsuccessful battle for recognition by the ABMS. The ABAS, which closely resembles the ABMS boards in its structure, functions, and objectives, currently has about 1900 diplomates. 1 ENCYCLOPEDIA OF ASSOCIATIONS § 8, p. 877 (D. Akey, ed., 17th ed. 1983). This is less than half the number of surgeons certified by the ABMS-affiliated American Board of Thoracic Surgery. At the time the ABAS was seeking recognition, it had almost 2300 surgeons in its founders' group alone and constituted a powerful challenge to the domain of the American Board of Surgery (ABS), many of whose diplomates practice primarily abdominal surgery. At that time the boards of Thoracic Surgery and Colon and Rectal Surgery, both of which certify surgeons who perform abdominal procedures, were subsidiaries of the ABS rather than independent boards, so the ABAS's attempt to achieve primary board status was especially threatening. On this history, see R. STEVENS, *supra* note 16, at 333-39.

Another non-ABMS board that models itself on the ABMS boards is the American Board of Nutrition (ABN), which certifies both Ph.D.s and M.D.s, the former in Human Nutrition and the latter in either Human or Clinical Nutrition. Most physicians obtain the clinical certification, and since one of its prerequisites is prior certification or eligibility for certification in an ABMS board primary specialty, almost all physicians with ABN certification hold an ABMS certification as well. Most are academic physicians. *See* AMERICAN BOARD OF NUTRITION, DIRECTORY OF DIPLOMATES IN HUMAN NUTRITION SCIENCES AND CLINICAL NUTRITION (1981).

[20] Physicians specialize for many reasons, many of which are distinguishable from their reasons for seeking certification. Foremost, of course, is scientific and professional interest in a particular area of specialty practice. Other reasons relate to the nature and organizational aspects of specialized practice: shorter and more regular working hours, consultant status, more interesting problems, better patient selection, and so forth. *See* R. STEVENS, *supra* note 16, at 43-49.

[21] By 1973, over 83% of all physicians were self-proclaimed specialists. H. WECHSLER,

twenty years, however, almost all new physicians have sought specialty certification,[22] and the percentage of board-certified physicians among those who hold themselves out as specialists continued to grow—from 62 percent in 1970[23] to some 70 percent in 1980.[24] The creation of the specialty of family practice in 1969 accounts for much of the growth in the percentage of physicians seeking certified specialty status, since general practitioners, who had previously provided the care that is now the province of family practice specialists, had not been viewed as specialists at all. It has been projected that, by 1990, ninety percent of all physicians will have some certification and that, by 2010, the figure will be close to one hundred percent.[25]

In order to receive ABMS recognition—a form of accreditation—a specialty board must be sponsored by existing professional groups, such as one or more specialty societies and the appropriate scientific section of the American Medical Association (AMA). The four newest boards, each of which covers an area of practice that overlaps specialties established earlier, are also sponsored by the boards representing those related specialties. All but the three newest boards are "primary" boards, which determine their own policies and select board members from nominees designated by their sponsoring organizations. Membership on the remaining three "conjoint" boards must be approved by the sponsoring primary boards, under whose auspices they were established.[26] The boards' activities are financed by

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HANDBOOK OF MEDICAL SPECIALTIES 13-14 (1976). However, by 1980, only about 53% of all physicians were *certified* specialists. AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS), DIRECTORY OF MEDICAL SPECIALTIES vii (20th ed. 1981) (hereinafter cited as ABMS DIRECTORY). Of office-based physicians responding to a 1980 survey, 75% were certified by at least one ABMS board—an increase from two-thirds in 1977. Owens, *How Much is Board Certification Worth?*, MED. ECON., Jan. 10, 1983, at 59.

[22] *See* Levit, Sabshin & Mueller, *Trends in Graduate Medical Education and Specialty Certification*, 290 NEW ENG. J. MED. 545 (1974); H. WECHSLER, *supra* note 21, at 35. Certification apparently enhances income. A 1981 survey shows that, although certified specialists have practice expenses some 35 percent higher than those of uncertified specialists, they nevertheless net a median income before taxes that is 34 percent higher than that of their uncertified counterparts (an increase in the income gap from 22 percent in 1976). Owens, *supra* note 21, at 59-60.

[23] H. LERNER, MANPOWER ISSUES AND VOLUNTARY REGULATION IN THE MEDICAL SPECIALTY SYSTEM 169 (1974).

[24] *See supra* note 21; H. SHUCHMAN, SELF REGULATION IN THE PROFESSIONS 206-09 (1981).

[25] Moore & Lang, *Board-Certified Physicians in the United States: Specialty Distribution and Policy Implications of Trends During the Past Decade*, 304 NEW ENG. J. MED. 1078, 1083 (1981).

[26] A conjoint board, such as Allergy and Immunology or Nuclear Medicine, is sponsored by at least two other approved specialties. Emergency Medicine is a "modified" conjoint board—that is, one sponsored by five or more other boards. Candidates for certification by a conjoint board must undergo some training in at least one of the sponsoring specialties, *see* ABMS HANDBOOK, *supra*, note 17, at 77, but only the conjoint board of Allergy and Immunology requires prior certification in a sponsoring specialty. Interestingly, the primary boards of Thoracic Surgery and Colon and Rectal Surgery, both formerly subsidiaries of the American Board of Surgery, require prior certification or examination by that board. In contrast, the

examination fees charged to candidates for certification and in some cases by annual dues paid by diplomates (the boards' designation for certified specialists).

Because all twenty-three specialty boards are accredited by the ABMS according to its "Essentials for Approval of Examining Boards in Medical Specialties,"[27] their certification procedures are similar. Each board requires candidates to have received specialty training in an accredited program of graduate medical education and to pass a comprehensive examination developed and administered by the board. Some variation among the boards may be found, however, in the length of required preliminary and residency training and in the range and variety of their nonmandatory continuing education and recertification guidelines.[28]

Each applicant for board certification must complete a residency program that has been approved by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME, which is comprised of representatives of the AMA, the ABMS, and other concerned organizations, develops and applies accreditation standards, called Essentials, for residency programs in each specialty. The Essentials are developed in conjunction with the appropriate specialty board, are regularly modified to correspond with changes in specialty board requirements, and must be approved by the AMA Council on Medical Education. Thus, educational accreditation processes and specialty certification processes are highly interdependent and subject to a high degree of central control.[29]

Although specialty board certification is generally considered indicative of superior technical competence, the boards and the associated specialty societies are usually careful in the claims they make, disclaiming an intent to draw invidious distinctions.[30] Yet, because such disclaimers are

American Board of Family Practice, though sponsored by five primary boards, is not considered a conjoint board.

[27] *See* ABMS HANDBOOK, *supra* note 17, at 76-79.

[28] *See generally* ABMS DIRECTORY, *supra* note 21, which lists some of the certification requirements for each specialty board.

[29] *See* ABMS HANDBOOK, *supra* note 17, at 29-30 (figures illustrating interdependent relationships); R. STEVENS *supra* note 16, at 389-92 (history).

[30] For a notable exception, *see infra* text accompanying note 196. A recent ABMS discussion group addressing the meaning of certification reported that "most boards appear to recognize that their evaluation processes are inadequate to assure that certification promises, in practice, either competence or excellence." ABMS REC. 10 (October 1982). In their official statements, the ABMS and the individual boards do not claim that a diplomate is necessarily a better practitioner than an uncertified specialist in the field but claim nevertheless that board certification indicates either competence or excellence. Typical examples of the board's disclaimers are the following:

> Certification . . . recognizes excellence in the discipline of internal medicine. . . . The Board does not intend either to interfere with or to restrict the professional activities of a licensed physician because the physician is not certified. . . .

AMERICAN BOARD OF INTERNAL MEDICINE, POLICIES AND PROCEDURES 2 (July 1982).

> Board certification in a medical specialty is evidence that a physician's qualifications

not widely heard, questions may be raised concerning the validity of the information that certification conveys. Medical practice is a complex mixture of science and art, and it is not clear that the certifying bodies are capable of measuring all of the factors that determine professional competence. Some studies question whether the ability to pass the examinations offered by the boards correlates with high-quality medical practice.[31] More seriously, there is a question whether the boards, which are controlled by incumbent members of each specialty, are wholeheartedly committed to disseminating accurate quality information. One sign of this problem is their failure to take some available quality-assurance measures. For example, few boards seriously attempt to evaluate an individual's qualifications at any time after initial certification. Although eleven boards provide for some type of periodic recertification, only four require it by issuing time-limited certificates; of those four, only one—family practice—has as yet administered a recertification exam.[32] Only the four boards that require recertification require any continuing medical education, and the continuing education requirements that do exist, whether mandatory or voluntary, are not rigorous.[33] Finally, recertification exams are not likely to be as

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> for specialty practice are recognized by his peers. It is not intended to define the requirements for membership on hospital staffs, to gain special recognition or privileges for its diplomates, to define the scope of specialty practice, or to state who may or may not engage in the practice of the specialty.

AMERICAN BOARD OF THORACIC SURGERY, BOOKLET OF INFORMATION 9 (Jan. 1982). There is no consensus among the boards as to whether certification evidences only competence or instead signifies excellence. The American Board of Dermatology, in an apparent contradiction, asserts both that it is dedicated to "the primary purpose of protecting the public by establishing and maintaining *high* standards of training, education and qualifications" of dermatologists and that its objective is "to provide assurance that a diplomate of the Board possesses the knowledge and skills *essential* for the provision of *competent* care." AMERICAN BOARD OF DERMATOLOGY, BOOKLET OF INFORMATION 4 (Jan. 1982) (emphasis added).

[31] One canvass of the few available studies suggests that the amount and nature of postgraduate professional training is more determinative of clinical competence than is the ability to pass a certification exam and that practice in a teaching hospital may be more closely related than specialty certification to satisfactory clinical performance. Williamson, *Validation by Performance Measures*, in ABMS, CONFERENCE ON EXTENDING THE VALIDITY OF CERTIFICATION 21-25 (1976).

[32] The boards that require recertification and continuing medical education (CME) are Emergency Medicine, Surgery, Thoracic Surgery, and Family Practice. Emergency Medicine will not administer mandatory recertification exams until 1990; Surgery and Thoracic Surgery will not begin until 1986. The American Board of Family Practice, established in 1969, pioneered temporary certification by issuing only 7-year certificates to its diplomates; the first mandatory Family Practice recertification exam was given in 1975. In 1976 the boards of Surgery and Thoracic Surgery, which theretofore had issued lifetime certificates, began to issue only 10-year certificates, and the new American Board of Emergency Medicine, which was approved in 1979, began by issuing only 10-year certificates. ABMS HANDBOOK, *supra* note 17, at 56.

[33] *See* H. SHUCHMAN, *supra* note 24, at 201-09; ABMS HANDBOOK, *supra* note 17, at 56. CME offerings are various and requirements are not usually rigorous. Moreover, the relevance of CME to physician competence is tenuous at best. *See* H. SHUCHMAN, *supra* note 24, at

challenging as those administered to new applicants; the passing rate on recertification exams has been upwards of ninety-five percent.[34]

The value of the information conveyed by certification is further reduced by the presence, in every recognized specialty, of practitioners who were certified under some form of grandfather clause. One type of grandfather clause permits physicians who gained practical experience in the specialty before establishment of the board to become board-certified without fulfilling the requirements for new entrants into the specialty.[35] Although this problem disappears in time as the original members of the specialty retire, another form of grandfathering continues to impair the quality of the information conveyed by certification. The boards periodically raise the requirements facing new candidates for certification without imposing corresponding new requirements on incumbent diplomates.[36] Thus, the physicians certified in a specialty have not all met the same standards. The boards' failure to adopt mandatory recertification

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239-41; Lewis & Hassanein, *Continuing Medical Education—An Epidemiologic Evaluation,* 282 NEW ENG J. MED. 254 (1970).

[34] *See* ABMS HANDBOOK, *supra* note 17, at 54 ("The ABMS recognizes that the methods and procedures employed in recertification may differ from those used in the initial certification process."). The 95-98% passing rate on recertification examinations, voluntary and mandatory, may be thought too high to ensure competence. *See* H. SHUCHMAN, *supra* note 24, at 201. Moreover, the percentage of specialists who seek voluntary recertification is quite low; for example, the American Board of Internal Medicine certifies between 3000 and 4000 new diplomates every year, *see* ABMS HANDBOOK, *supra* note 17, at 50-51, but in its three recertification exams in 1974, 1977, and 1980 it has only recertified a total of 7,245—perhaps 20% of those eligible for recertification. *See* Meskauskas & Webster, *The American Board of Internal Medicine Recertification Exam,* 82 ANN. INTERNAL MED. 577 (1975); Letter from George D. Webster, M.D., Vice President, ABIM (July 29, 1983).

[35] The founders of the early specialty boards usually grandfathered themselves in without examination. *See* R. STEVENS, *supra* note 16, at 318-19, 327. More recently, new boards have required an examination for all members but, for a limited period, have allowed established practitioners to sit for the exam without completing the formal training required of new entrants into the field. *See* ABMS DIRECTORY, *supra* note 21, at 155-56, 2086, 2412, 3976; 1 LEWIN AND ASSOCIATES, REPORT TO THE FEDERAL TRADE COMMISSION, COMPETITION AMONG HEALTH PRACTITIONERS: THE INFLUENCE OF THE MEDICAL PROFESSION ON THE HEALTH MANPOWER MARKET III—51-54, 62-64 (1981) (hereinafter cited as LEWIN REPORT).

[36] The American Board of Pediatrics now requires three years of clinical training in general pediatrics; before 1978, only two were required. ABMS DIRECTORY, *supra* note 21, at 2412. The American Board of Otolaryngology required a four-year residency until 1981, when it instituted a five-year requirement. *Id.* at 2086. The American Board of Colon and Rectal Surgery has since 1980 required candidates to first pass the American Board of Surgery qualifying exam; before 1980, the qualifying exam was not required. *Id.* at 155-56. In 1976, the American Board of Thoracic Surgery began to require that candidates attend an "approved" thoracic surgery program. *Id.* at 3976. Some boards also require documentation of precertification experience in handling a certain operative case load; the number of required cases increases periodically. In general, the first "Essentials" for approved residencies, which appeared in the 1930s, required two to three years of graduate education in each specialty. Most residencies are now at least four years in length, with some surgical residencies being six or seven years long. *AMA 82nd Annual Report on Medical Education in the U.S.*, 248 J. A.M.A. 3225, 3232 (1982). Obviously, the curriculum and examinations for each specialty have changed as well in ways less readily measurable.

requirements takes on even greater significance in light of the continual upgrading of the requirements for initial certification.[37]

The ABMS, in its capacity as accreditor of certifying boards, might be expected to act to rectify some of these problems in order to enhance the value of the information generated. However, because the ABMS consists almost entirely of representatives of the recognized boards, ABMS requirements have not offset the boards' protectiveness toward incumbent specialists. Indeed, ABMS policies generally reflect the interests of the existing boards.[38] In particular, the ABMS has adopted the policy of recognizing only one board in each specialty and of minimizing overlap between specialties.[39] In so doing, it refuses to recognize the possible informational value of competing certification schemes.

As a consequence of the division of the entire field of medicine into specialties, new boards have found it more and more difficult to achieve ABMS recognition. The three most recently approved boards—Allergy and Immunology, Nuclear Medicine, and Emergency Medicine—were made conjoint boards, thus allowing the pre-existing primary boards to retain control of their fields by requiring candidates for conjoint board certification to be certified or undergo training in one of the sponsoring primary specialties.[40] Many of the boards also offer certification in various subspecialty areas, and several offer general certification in more than one area.[41] Thus, the boards have been able to accommodate the growth of subspecialization without losing control of the originally recognized field.[42] The boards' method of handling the proliferation of subspecialties closely resembles earlier efforts by the profession to prevent specialization from fragmenting the profession as a whole.[43]

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[37] The grandfathering problem is further discussed in Part Two, Section VI.B.

[38] ABMS HANDBOOK, *supra* note 17, at 37.

[39] The Essentials for ABMS approval of new boards require that each represent "a distinct and well-defined field of medical practice," based on advances in either scientific medicine or health services delivery. *Id.* at 77. *See* R. STEVENS, *supra* note 16, at 335-37, 339-42, for application of this requirement to proposed new specialties.

[40] *See supra* note 26.

[41] For example, Internal Medicine offers ten "special certificates," Pediatrics offers six, and Obstetrics and Gynecology and Surgery both offer three; certification by the offering board is of course a prerequisite for special certification in any subspecialty. Boards issuing more than one type of general certification include Psychiatry and Neurology (five), Preventive Medicine (four), Radiology (three), and Pathology (three), which also offers special certification in eight subspecialties. ABMS HANDBOOK, *supra* note 17, at 48-49.

[42] Many of the special and general certification categories within a given specialty might easily have been treated as independent specialties were it not for accidents of history and the power of the already established boards. For example, critical care medicine, a new subspecialty offered separately by four primary boards, *see id.*, could presumably have been offered instead by a conjoint board or a new primary board similar to Family Practice. For evidence of the ABMS attempt to stem the proliferation of subspecialty certifications, *see id.* at 45-47 (policy statement on the significance of certification, discussing subspecialization).

[43] For discussion of the ongoing conflict between generalism and specialism, see generally R. STEVENS *supra* note 16, esp. at 33-55, 115-16, 124. *See also* Part Two, Section V.B.2.

The dominance of established ABMS specialty boards in physician certification is further enhanced by some hospitals' refusal to employ or grant staff privileges to non-board-certified physicians. In this respect, hospitals are influenced by the Joint Commission on Accreditation of Hospitals (JCAH), which, while not requiring hospitals to make board certification a precondition to the granting of privileges, labels it "an excellent benchmark" of physician competence.[44] Medical staffs may also exert pressure on hospitals to make certification a requirement. As a result of the dominance of the ABMS certification scheme, consumers seeking health care in a given field generally have as alternatives to board-certified specialists only uncertified but self-proclaimed specialists, a few specialists certified by non-ABMS boards, specialists certified in other fields, and the dwindling ranks of general practitioners.

Although there is little direct competition with the ABMS certification scheme, the hospital privilege system can serve as one alternative form of certification. Whether or not board certification is a factor in the granting of privileges, consumers may regard a physician's possession of admitting privileges at a particular hospital as good evidence of his or her competence. Where there is more than one hospital in a community, consumers can compare physicians on the basis of the relative prestige of the hospital or hospitals at which they have staff privileges. In addition, consumers may also rely upon a physician's membership in any of a variety of state and national specialty societies as an indication of professional distinction. Such membership is usually indicative not of specific attainments but of general professional achievement and of the approbation of one's peers. There are many specialty societies having greatly varying prestige and standards. The two most prominent are the American College of Surgeons (ACS), for certified surgical specialists, and the American College of Physicians (ACP), for specialists in internal medicine and related areas.[45] Fellows, or full

[44] JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 1983-96 (1982). The JCAH is a private accrediting body that sets and applies voluntary standards for the accreditation of hospitals and other health-related institutions. Governed by representatives of the American College of Surgeons, the American College of Physicians, the American Hospital Association, the AMA, and the American Dental Association, the JCAH is the successor to the American College of Surgeons' hospital standardization program, begun in the early part of the century. Nearly all hospitals of significant size are JCAH-accredited, and such accreditation is deemed to meet federal requirements for participation in Medicare. JCAH standards are not minimum standards; thus, it is possible for an accredited hospital to be only "in substantial compliance." *See id.* at ix-xii; R. STEVENS *supra* note 16, at 87, 91-92, 119; Affeldt, *Voluntary Accreditation*, in REGULATING HEALTH CARE: THE STRUGGLE FOR CONTROL 182 (A. Levin ed. 1980). *See also infra* note 77.

[45] The informational value of membership in a specialty society depends upon its requirements, which in turn determine the number of practitioners admitted. Because board certification is expected ultimately to encompass virtually all practitioners *see supra* notes 23-25 and accompanying text, the selectivity of ACS, ACP, and similar organizations is likely to become increasingly important as a basis for distinguishing among physicians. Board certification is a prerequisite for ACS membership, whereas ACP "Fellowship" requires membership

voting members of the Colleges, are permitted to indicate their status with the initials F.A.C.S. or F.A.C.P.

Although consumers and others have several sources to which they may turn for useful information concerning the abilities and qualifications of medical specialists, more sources of information would almost certainly serve them better. As Part Two of this Article shows, the medical profession's system for certifying specialists is not in fact intended to facilitate consumers' purchasing decisions but rather is a crucial tactic in a larger effort to standardize medical care and to limit the flow of information concerning differences among physicians and in medical practice. In general, the medical profession has prospered by maintaining—both in reality and, perhaps to an even greater degree, in appearance—an artificial homogeneity among practitioners. Specialty certification, though seeming to draw qualitative (horizontal) distinctions among physicians, is in fact a way of fostering both actual and appparent homogeneity. Now that nearly all U.S. medical graduates are achieving certified status,[46] it is clear that certification primarily draws not horizontal lines but vertical lines between specialties.[47] Thus, certification serves principally as a professional trademark indicating that the holder is the product of a controlled educational and training process rather than as an indicator of relative quality. The absence of competing trademarks is an appropriate cause for public concern.

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in other specialty societies, publications, and other evidence of substantial scholarly achievement. Both Colleges also require testimonials from other Fellows as to the applicant's personal and professional ethics and character. *See* AMERICAN COLLEGE OF PHYSICIANS, BIOGRAPHICAL DIRECTORY OF THE AMERICAN COLLEGE OF PHYSICIANS xii (1979); AMERICAN COLLEGE OF SURGEONS, 1983 YEARBOOK 1029, 1046 (listing requirements and number of fellows). Probably no more than one-third of those specializing in internal medicine and related primary care specialties are ACP Fellows, and the percentage of ACS Fellows among surgical specialists is probably no more than half. *See* AMERICAN MEDICAL ASSOCIATION, PROFILE OF MEDICAL PRACTICE 135 (1981) (Table 1, grouping Physician Masterfile 1981 data into 9 specialty categories.)

[46] Moore & Lang, *supra* note 25, at 1083, assert that "the ultimate pass rate [which includes those who pass on retakes] is close to 95% for graduates of United States medical schools," nearly all of whom now seek certification. *See supra* note 22 and accompanying text. The 95% estimate differs from the pass rates released annually by individual boards, which usually range from 60-80% but include foreign medical graduates (FMGs) as well as U.S. graduates. It also differs from the ultimate pass rate found by the American Board of Obstetrics and Gynecology, which recently determined that, by September 1981, 19% of those (including FMGs) who had first attempted certification in 1976 had failed to achieve it (though 36% of those aspirants were scheduled for a further retake). In addition to the unsuccessful 19%, 16.3% of eligible candidates had dropped out of the process, perhaps only temporarily, before or after Part I of the two-part examination. *Most Candidates Successful,* THE A.B.O.G. DIPLOMATE (Sept. 1981). Adding to the softness of these data is the fact that the boards generally require candidates, after some number of failures or the passage of some length of time, to complete further training and reapply as new candidates.

[47] *See supra* text accompanying note 11.

B. NONPHYSICIAN CERTIFICATION

The credentialing process for the large number of categories of nonphysician health care personnel is more varied and on the whole less organized and integrated than the system for certifying physician specialists. There is more conflict and controversy, more competition among certifiers, and more overlap among categories of certified personnel. In contrast to medical specialty certification, credentialing of nonphysician health care personnel is seldom used to create distinctions within a licensed class. Instead, certification of nonphysician personnel tends either to contemplate the same scope of practice permitted by state licensure laws[48] or to serve as a private alternative to exclusionary licensure.

Most nonphysician certification schemes, like the physician certification system, prescribe educational requirements and administer an examination. Although some credentialers require a candidate to receive training in programs accredited by a particular body as a prerequisite for examination, more accept completion of any of a wide range of educational programs. A few credentialers permit candidates to substitute apprentice-type training or other on-the-job experience for educational requirements.[49] Others provide for certification upon successful completion of prescribed education without requiring a separate comprehensive examination.[50] Although the system currently includes many diverse schemes, pressures toward greater standardization of requirements always exist. The paradigm of a tightly structured credentialing system, such as that maintained by the medical profession, holds great appeal for organizations certifying nonphysician health care personnel, and departures from it are usually viewed as problems to be solved by cooperative efforts.[51]

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[48] State licensing laws vary greatly and are sometimes quite narrow, with the result that educational and certification programs may teach, test, and certify competence in areas outside the lawful scope of practice of nonphysician health personnel in some jurisdictions.

[49] For example, the physician assistant (PA) examination is currently open to graduates of PA, MEDEX, and nurse practitioner training programs and to persons who have been independently ("informally") trained. *See* D. Glazer, *National Commission on Certification of Physician's Assistants: A Precedent in Collaboration,* in THE NEW HEALTH PROFESSIONALS 86, 88-89 (A. Bliss, E. Cohen eds. 1977).

[50] Some nurse practitioner specialties employ this form of certification. There is no national certification examination for nurse practitioners, and training programs vary greatly in content and length, ranging from three months to two years. *See* Sultz, Henry & Correll, *Nurse Practitioners: An Overview of Nurses in the Expanded Role,* in THE NEW HEALTH PROFESSIONALS, *supra* note 49, at 9-18.

[51] *See, e.g.,* PUBLIC HEALTH SERVICE, CREDENTIALING HEALTH MANPOWER 7-11 (1977). The trend toward limiting diversity is evident in many professions. For example, nursing educators have long worked toward standardizing and increasing nursing education requirements. *See* Dolan, *The New York State Nurses Association Proposal: Who Needs It?*, 2 J. HEALTH POL., POL'Y & L. 508 (1978); 2 PROF. REG. NEWS 9 (Nos. 4-5, Nov.-Dec. 1982). ("By 1987, a baccalaureate degree in nursing or science will become a requirement for entry into schools of nurse anesthesia. The profession's accrediting agency, the Council on Accreditation of Nurse Anes-

The role of physicians in the certification of nonphysicians varies widely and is a source of much tension and conflict. Because physicians have plenary authority over all aspects of the practice of medicine, some organizations of nonphysician health care professionals have sought the collaboration of the AMA in establishing credentialing programs. Thus, some nonphysician certifying bodies are partially composed of, or even dominated by, physicians in related specialty fields.[52] Other groups, however, including some certifying in the same personnel categories, are independent of physicians. For example, both the American Society of Clinical Pathologists, a physician specialty group, and the National Certifying Agency for Medical Laboratory Personnel, a nonphysician group, certify medical laboratory technicians, medical technologists, and nuclear medicine technologists.[53]

Educational programs for the various categories of nonphysician health care personnel are generally accredited by bodies sponsored by the national association representing workers in the particular field. Some programs, however, are accredited through systems of state or regional vocational, secondary, or postsecondary institutional accreditation.[54] Physician organizations also play an important role in accrediting nonphysician education programs, with the AMA Committee on Allied Health Education and Accreditation (CAHEA) being the most prominent accreditor in the field. CAHEA accredits educational programs offered in a wide variety of schools and health facilities for all twenty-six "allied" health occupations

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thesia Programs/Schools, announced the new requirement after surveying all 145 nurse anesthesia program directors, who concurred that the bachelor's degree was an appropriate prerequisite for entry."). Similarly, beginning in 1987, the certifying examination for physicians' assistants will no longer be open to persons with informal independent training or to graduates of some currently approved nurse practitioner programs. NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIANS' ASSISTANTS, ANNOUNCEMENT OF THE 1982 NATIONAL CERTIFYING EXAMINATION FOR PRIMARY CARE PHYSICIAN'S ASSISTANTS 5 (1982). For an interesting critique of a similar standardization movement in the accounting profession, *see* Miller & Davidson, *Accreditation: Two Views,* J. ACCT. March, 1978, at 56, 61.

The existence of alternative pathways to certification within one credentialing program may be a sign of healthy diversity if the paths are truly equivalent or if appropriate gradations are established. *Cf.* Part Two, Section VI.B. Diversity may also be reflected in the existence of more than one program for credentialing personnel in a single field. Such competition in credentialing is also generally regarded, however, as an unfortunate departure from the monolithic ideal. *See* Part Two, Sections V.A. and V.B.2.

[52] *See* LEWIN REPORT, *supra* note 35, at III-26-33; *see also AMA 82nd Annual Report, supra* note 36, at 3328 (listing medical organizations sponsoring AMA-recognized allied health professions). Medical dominance is most likely when the nonphysician professionals are dependent under licensure laws upon physician supervision or referral. Thus, the certification process for physician assistants, who are not themselves licensed but practice under the license of a supervising physician, is dominated by the affected medical specialties. *See* LEWIN REPORT, *supra* note 35, at III—33-35.

[53] *See* AMA, ALLIED HEALTH EDUCATION DIRECTORY (10th ed. 1981).

[54] For example, institutions offering nurse training programs are approved by state or regional accreditors, but the programs themselves may also seek accreditation from the National League for Nursing. *See* Finkin, *supra* note 14, at 383.

that have been recognized by the AMA's Council on Medical Education (CME), applying the "Essentials" developed by each occupation and approved by the CME.[55]

In a few instances, more than one educational accreditor exists in a given field. For example, CAHEA accredits physical therapy education programs in association with the National Assocation of Physical Therapists and the United States Physical Therapy Association, but, in addition, the American Physical Therapy Association, which has no AMA affiliation, independently accredits such programs.[56] CAHEA accreditation is nonetheless highly influential; many hospitals hire graduates of only those programs accredited by CAHEA and credentialing bodies frequently prefer graduates of such programs.[57] Thus, the close connection between accreditation and certification that exists in the medical specialty credentialing system also exists in the credentialing of "allied" health care professionals.[58]

A "second-tier" accreditor of certifiers of nonphysician health care personnel, corresponding to the ABMS in the field of physician certification, is the recently established National Commission for Health Certifying Agencies (NCHCA). This private body, which is funded through membership dues and federal grants, "sets standards for competency evaluation programs for health occupations in the United States."[59] Currently, twenty-one health professional certifying associations and other interested groups are members of NCHCA. NCHCA's extensive standards cover the development, administration, and scoring of examinations, academic and training requirements, membership and independence of certification boards, and appeals from failures to certify. NCHCA is currently the only accreditor of bodies engaged in certifying nonphysician health care personnel.

Finally, two higher-tier credentialing organizations exist to accredit accreditors of nonphysician health care professional education programs.

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[55] The AMA cooperates, through CAHEA, in the accreditation of over 3,000 educational programs, at more than 1,700 institutions, for the 26 allied health professions it recognizes. *AMA 82nd Annual Report*, *supra* note 36, at 3288.

[56] *See* LEWIN REPORT, *supra* note 35, at III—38-41. Although the standards set by the two accreditors differ, most schools seek both accreditations. *See* discussion in Part Two, Section VI.E.

[57] AMA, *supra* note 53, at 9.

[58] *See* STUDY OF ACCREDITATION OF SELECTED HEALTH EDUCATION PROGRAMS (SASHEP), COMMISSION REPORT 13 (1972) ("Both structurally and functionally, the processes of accreditation and certification are linked by strong operational and organizational ties, and are welded together by the common denominator of professional sponsorship and control."). *See also* Part Two Sections V.A. and V.B.2.

[59] *See* NATIONAL COMMISSION FOR HEALTH CERTIFYING AGENCIES, CRITERIA FOR APPROVAL OF CERTIFYING AGENCIES (mimeo 1978). The NCHCA developed as a direct result of the U.S. Health Service's manpower credentialing studies in the 1970's, which culminated in its 1977 recommendations that a national health certification system be established. *See* PUBLIC HEALTH SERVICE, *supra* note 51.

One is the Office of Postsecondary Education in the U.S. Department of Education.[60] The other is a private body, the Council on Postsecondary Accreditation (COPA). Unlike its public counterpart, however, COPA does not hesitate to accredit more than one accreditor in a given field.[61]

Among the various categories of nonphysician personnel, the independent professions such as dentistry, whose members market their services directly to consumers, frequently use self-certification in much the same way that the medical profession uses specialty certification—to control the flow of information useful in consumer choice and to standardize personnel. Occupations that are not practiced independently of physicians are also subjected to credentialing primarily to achieve standardization, which, in addition to serving the needs of would-be employers, may aid the certified practitioners themselves by minimizing competition across and within occupational boundaries. Certification may also be used to further the monopolistic objectives of a dominant profession that sponsors or otherwise controls the credentialing of a dependent personnel group. As discussion in Part Two of this Article explains, a dominant profession's control of credentialing of a subservient occupation may narrow the prospects for innovation in education and retard competitively inspired change in the delivery of services.

IV. UNFAIRNESS AND DECEPTION IN PRIVATE CREDENTIALING

The most common complaint about private credentialing is that some individuals who are as well qualified as those certified have been denied certification and thus disadvantaged in the competitive race. Such unfairness toward individuals may also be viewed as deception of those who rely on certification in making purchasing decisions. To date, nearly all of the restraint-of-trade litigation involving private credentialing and similar activities in professional and industrial fields has been initiated by individuals or firms claiming unfair treatment of themselves or their products.[62] Although a few such plaintiffs have succeeded in obtaining relief from unfair

[60] *See supra* note 14.

[61] It does so, for example, in nursing, law, physical therapy, and medical laboratory personnel training. *See* COUNCIL ON POSTSECONDARY ACCREDITATION, *supra* note 12, at 19-23. On the Department of Education's policy, see *infra* note 199 and accompanying text.

[62] Claims of unfairness or deception based on the distinctions drawn between certified and uncertified personnel are to be distinguished from those that might be made if all holders of a credential were not required to meet similar standards. Although the practice of grandfathering might be challenged on the basis that it allows practitioners with different demonstrated competences to hold identical credentials, Part Two, Section VI.B. proposes that it be challenged on a different basis. That discussion develops the view that concerted action drawing even questionable distinctions is more compatible with competition than efforts that obscure distinctions that may in fact exist.

treatment, the courts have stopped well short of imposing a general fairness requirement on private bodies engaged in credentialing or analogous activity. Even though deception in credentialing may result from the credentialers' desire for financial gain or market power, there are good legal and policy arguments for relying primarily on market forces rather than on judicial or regulatory oversight of private credentialing to ensure the quality of information available to consumers.

A. THE NATURE AND SOURCES OF THE PROBLEM

Even though credentialing can be beneficially informative, it can also be abused to generate market power in excess of that naturally flowing from the dissemination of truthful information. Concern over such abuses might trigger judicial or regulatory intervention to improve the quality of the information being disseminated. Some discussion of the function of information in the health care marketplace will help in isolating the issues that must be addressed in deciding how to deal with deceptive credentialing.

1. Imperfections in the Market for Information

In a perfectly competitive world, deceptive credentialing systems would lose their credibility and be replaced by better ones. In reality, however, the market for information concerning the skills of health care personnel is highly imperfect. Nevertheless, one should not jump to the conclusion that governmental intervention is required. Instead, the policy issue must be viewed as a choice between two imperfect mechanisms. The private market itself—however imperfect it may be—may have greater potential for curing its own problems than regulators or the courts.[63]

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[63] *See* Schwartz & Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630 (1979).

On the general question whether ignorance disables consumers, *see* S. Rottenberg, *Introduction*, in OCCUPATIONAL LICENSURE AND REGULATION 7 (S. Rottenberg ed. 1980):

> Probably market processes operate in such a way that the assumption of informational asymmetry is rarely fulfilled. Nonspecialized buyers turn out to be not so ignorant of the qualitative properties of commodities and services as they seem to be. They seek out informational surrogates that serve them well. They acquire information by repeatedly purchasing certain commodities; for infrequently purchased commodities, they are informed by the experience of kinfolk, friends, and neighbors. Sellers of complex commodities have market incentives to inform buyers of the qualities of products and services they themselves offer and of those offered by their competitors. Buyers are further informed by inference by the length of life of firms making offers, because it is reasonable to assume that firms with a long life have survived the consensual judgment of the market about the quality of the commodities they offer for sale; shops with professional staffs of buyers serve as surrogate information agents of consumers; and tort law that imposes liability on producers

In health care, as well as in other markets, information that facilitates consumer choice is chronically undersupplied. Such information is a public good that, once produced and published, can be used by anyone. Without a market in which potential users must pay for the use of valuable information, there is little incentive for independent parties to collect and disseminate it. Producers of goods and services are thus left as the main source of authoritative information concerning the quality and characteristics of their own products.

An important motive of health care providers in collectively assuming the costs of generating information about themselves and their peers is their desire to differentiate themselves from their competitors and to increase consumer confidence in and demand for the services they offer.[64] Although a few independent sources of consumer information do exist in the health care field,[65] they cannot be counted on to offset any misinformation that may come from provider groups. Moreover, although health care consumers, perceiving their choices of health care personnel to be important ones, can be expected to exert themselves in searching the market, it is difficult for them individually to make or obtain reliable comparative evaluations of providers.[66]

Obviously, the danger of unfairness and deception increases when those providing the most complete information about the quality of services have an economic interest in influencing consumers to choose in a

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and sellers to "make whole" those whom they harm gives sellers incentives to produce goods and services of a quality that does not fall below some given standard.

For a comparable analysis of consumer information problems in health care markets see C. HAVIGHURST, *supra* note 1, at 78-83. An interesting but highly inconclusive model of a professional services market has been developed by Plott & Wilde, *Professional Diagnosis vs. Self-Diagnosis: An Experimental Examination of Some Special Features of Markets with Uncertainty*, in 2 RESEARCH IN EXPERIMENTAL ECONOMICS 63 (1982). The authors conjecture that the experimental market they created failed to fail, despite buyers' reliance on sellers for all their information, because sellers were competitively motivated to provide good information to the actively searching buyers.

[64] Other motives for credentialing efforts include the lower information costs and the achievement of economies of scale in production (education) that accompany standardization. The issuance of valuable credentials may also induce individual participation in a program that has larger purposes, thus overcoming free rider problems that tend to limit the effectiveness of competitor groups as political forces or cartels. *See infra* note 174.

[65] Public interest and consumer groups sometimes compile directories of information about local physicians, and some effort has been made to disseminate morbidity and mortality statistics for different surgical procedures at different hospitals. *See* ICF, INC., SELECTED USE OF COMPETITION BY HEALTH SYSTEMS AGENCIES, ch. 5, App. D (1976). This information is difficult to gather because providers are often reluctant to cooperate. *See, e.g.*, Public Citizen Health Research Group v. DHEW, 668 F.2d 537 (D.C. Cir. 1981); Public Citizen Health Research Group v. Commission on Medical Discipline, 573 F.2d 863 (4th Cir. 1978); Health Sys. Agency v. Virginia State Bd. of Medicine, 424 F. Supp. 267 (E.D. Va. 1976).

[66] *See* Pauly & Satterthwaite, *The Pricing of Primary Care Physicians' Services: A Test of the Role of Consumer Information*, 12 BELL J. ECON. 488 (1981), arguing, contrary to simple theory, that physicians have more market power in markets where they are numerous than where they are few, because of the consumer's greater difficulty in getting comparative information.

certain way. The problem of unfair credentialing is comparable in this respect to the problem of deceptive advertising,[67] and indeed may be more serious. Consumers can readily perceive advertising's self-serving character and may consequently greet it with a healthy skepticism. They may be significantly less skeptical toward personnel credentialing as a result of its apparently objective and authoritative character, the professional auspices under which credentials are granted, and the typical absence of competing claims. On the other hand, public credulity might diminish significantly if competition among competing credentialing systems should arise. Some users of credentialing information may already be more sophisticated concerning the value of credentials than is generally recognized.[68] Recent erosion in the status of professional organizations may already be leading consumers and others to consider the source of the credentials upon which they are asked to rely.

In addition to consumer skepticism, the concern of credentialers for their own reputations for reliability can provide another source of protection aganst deceptive credentialing. Unfortunately, professional services are of such uncertain effectiveness that consumers and others may have trouble detecting deficiencies in performance even over long periods of time, thus protecting credentialing and accrediting bodies against a serious loss of public confidence.[69] Users' recognition of this reason for not de-

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[67] *See generally* R. POSNER, REGULATION OF ADVERTISING BY THE FTC 4-9 (1973); E. KITCH & H. PERLMAN, LEGAL REGULATION OF THE COMPETITIVE PROCESS 67-74 (2d ed. 1979); Nelson, *Advertising as Information,* 82 J. POL. ECON. 213 (1961). The ensuing analysis applies principles set forth in these references. For further development of the argument, *see* Part Two, Section V.B.

[68] *See generally supra* notes 63-65; Pauly, *Is Medical Care Different?,* in COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 19 (FTC 1978). Physicians act as consumer agents in making referrals and in choosing their associates in a group practice or on a hospital medical staff. Hospitals and other institutional providers such as Health Maintenance Organizations (HMOs) also have opportunities to act as sophisticated employers of personnel. The extent of the reliance on credentials by such decision makers is unknown, but undoubtedly credentials are seldom the sole criterion and often may not be a minimum prerequisite. For the argument that third parties may perform poorly as consumer agents, see *infra* text accompanying notes 77-80.

[69] The second factor that operates to discourage the making of false claims about products is the cost to the seller of developing a reputation for dishonesty. . . . Even if the seller does not depend upon repeat customers, prospective customers may hear about his fraud from his former customers and be deterred from patronizing him. False advertising in these situations will be extremely costly to the seller in the long run.

> Conversely, fraud may be attractive to two kinds of sellers. The first is one who sells a product (or service) whose effectiveness is so uncertain that consumers may not detect false claims about its performance even in the long run—as with providers of medical care.

R. POSNER, *supra* note 67, at 5. *Cf.* Darby & Karni, *Free Competition and the Optimal Amount of Fraud,* 16 J. L. & ECON. 67 (1973), discussing how the provision of difficult-to-evaluate ("credence") products and services can be privately monitored and controlled to reduce fraud.

pending upon the reputation of a competitor-sponsored certifying body should, of course, increase their skepticism toward even well-established systems. Although systems for accrediting certifiers may be helpful in identifying reliable sources of information, the auspices under which such accreditation occurs should again affect the faith consumers place in the assessments provided.

Competitors catering to the information needs of consumers offer additional protections against deceptive claims that might be made or implied on behalf of a certified group. One way in which consumers can overcome their information problems is by relying on a sophisticated middleman to act as their purchasing agent; indeed, many of the new institutional arrangements that are beginning to emerge within the health care industry are just such a response to the paucity of information helpful in making market choices.[70] Theoretically, at least, competition can also benefit consumers by generating counteradvertising and other kinds of direct criticism that might expose deception and cut dominant credentialing systems down to size. In ordinary markets, comparative advertising and counteradvertising to dispute a competitor's false claims frequently do not pay off for a single competitor, whose unilateral campaign against a single rival may benefit his other competitors more than himself.[71] Health professionals, however, are frequently organized in associations, thereby facilitating collective responses by disadvantaged groups to exaggerated claims by their competitors.[72] Part Two of this Article discusses how competition among such professional groups can be made more vigorous than it currently is. Although the many factors inhibiting the supply of reliable information about health care personnel do suggest a possible need for strict judicial or regulatory scrutiny of the information being provided through private credentialing systems, this Article finds greater wisdom in the alternative strategy of removing restraints on the free flow of information and

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For example, warranties and service contracts (which are analogous to capitation payment systems in financing health care) integrate diagnosis and repair in ways that help reduce the seller's incentives for fraud. These and other market monitoring devices, including the seller-client relationship, seller provision of service departments, and franchising, appear more effective in fraud control than government intervention.

[70] *See* Part Two, Section V.C.2.

[71] R. POSNER, *supra* note 67, at 6; Pitofsky, *Beyond Nader: Consumer Protection and the Regulation of Advertising*, 90 HARV. L. REV. 661, 666 (1977).

[72] Of course, where a self-certified group of professionals enjoys a substantial degree of monopoly power, there exists, by hypothesis, no close competitors who can be counted on to dispute its unwarranted claims of superiority. In such a case, the primary hope must be for competition to break out within the monopolistic group itself as individuals and subsets of providers within the group seek to differentiate themselves from their supposed peers. Part Two suggests some antitrust initiatives that will improve the prospects for such competition.

relying primarily on competition to solve—as well as they can be solved—the information problems that inevitably exist.[73]

2. Third-party Use of Credentials

Arguments for strictly policing credentialing systems are frequently based on the substantial de facto influence that credentials have on the market opportunities of individual professionals.[74] The simplest answer to these arguments is that, whatever its actual effects, private credentialing is still no more than the publication of information and opinion on which independent decision makers may act as they see fit.[75] Indeed, even where government makes the possession of a privately conferred credential a prerequisite for some privilege, such unilateral government action does not change the voluntary nature and private character of credentialing[76] and should not create new obligations or liabilities for the credentialers. Likewise, independent decisions of private parties to honor a particular credential are simply the market's way of rendering its verdict. The case for extensive legal intervention must rest on more than the widespread re-

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[73] Part Two, Section V.B., refutes the arguments for restricting the flow of information concerning health care personnel.

[74] *See infra* note 107 and accompanying text. *Cf.* FTC STAFF REPORT *supra* note 6, at 27-34, 247, referring to "the restraint on market forces that [industrial] standards can cause due to reliance by buyers, government regulatory agencies, and others." This statement is criticized *infra* in text accompanying note 156.

[75] *See supra* note 4 and accompanying text. A failure to maintain the crucial distinction between voluntary and mandatory standards appears in the FTC staff's recent study of industrial standards, which states that, "where reliance on a particular standard or seal is significant, noncompliance becomes so competitively disadvantageous from the point of view of producers that voluntary standards become mandatory." FTC STAFF REPORT *supra* note 6, at 34. In the absence of a privately imposed sanction, however, *see infra* text accompanying notes 138-50, it remains open to a disadvantaged competitor or competitor group to respond in kind, offering counterevidence to change the minds of those honoring the credential or standard in question. Although the seller must overcome his customers' skepticism and the goodwill possessed by his competitors, the market still operates as it is supposed to do. Under these circumstances, the presumption should be against interfering. *See also* Rickards v. Canine Eye Registration Found., 704 F.2d 1449 (9th Cir. 1983) (upholding dismissal of common-law and antitrust claims against an independent body whose recognition of credentials issued by the American College of Veterinary Ophthalmologists deprived the plaintiffs, uncertified veterinarians, of certain business); Vest v. Waring, 1983 Trade Cas. (CCH) ¶ 65,410 (N.D. Ga. 1983) (allegation of conspiracy by university- and government-affiliated ophthalmologists to monopolize the performance of a new type of surgery for severe nearsightedness by officially designating the procedure as "experimental" and declaring it unethical for ophthalmologists to perform the procedure outside the framework of a proposed clinical trial; independent decisions by insurance companies not to pay for, and by hospitals not to permit performance of, experimental procedure cited as proof of monopoly).

[76] Even though governmental decisions (building codes, for example) may sometimes be wrong, they are never irreversible. The selling effort needed to persuade a governmental body to change its mind is not fundamentally distinguishable from that needed to win a large customer having ties to a competitor.

spect accorded to the judgments of a particular certifying or accrediting body.

A somewhat more sophisticated argument for intervention in the credentialing of health care personnel can be made by questioning the wisdom or independence of third-party decision makers who control access to the ultimate consumer. In the health care field, many third parties, such as governments, insurers, hospitals, other institutional providers, professional groups, and individual physicians, make decisions to honor particular certifications and, in doing so, cut off uncertified personnel from potential customers, effectively conferring on the certified group a limited de facto monopoly similar to that fostered by exclusionary licensure.[77] Occasionally, certified personnel possess a special influence over these third-party decision makers and use it to exclude their rivals,[78] thus making the unfairness to competitors and the harm to the competitive process particularly manifest. Even where this situation does not prevail, however, the various third-party decision makers may lack economic and political

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[77] Private insurers and government financing programs sometimes refuse to reimburse consumers for services provided by uncertified personnel or reimburse for such services at a lower rate. On private insurers, see sources cited *infra* note 78. Medicare generally does not pay nonphysicians directly but reimburses their employers (physicians or institutions). When DHHS regulations address the services of nonphysicians, they frequently require certification or its effective equivalent. *E.g.*, 42 C.F.R. § 481.2(b), (d) (1982) (nurse practitioners and physician assistants employed in subsidized rural health clinics). For a federal government report expressing a positive yearning for a definitive private credentialing system on which it could rely in deciding whom to pay for services to federal beneficiaries, see PUBLIC HEALTH SERVICE, *supra* note 51 (quoted as encouraging Sherman Act violations in Part Two, Section VI.D.). The rate of reimbursement for physician services sometimes varies according to the credentials of the physician, in both private and government plans. *See, e.g.*, Michigan Academy of Family Physicians v. Blue Cross and Blue Shield, 502 F. Supp. 751 (E.D. Mich. 1980) (Medicare carrier's policy of paying certified specialists more than uncertified specialists held inconsistent with Medicare Act).

Hospitals frequently hire only certified nonphysician personnel for certain jobs. *See, e.g.*, Veizaga v. National Bd. for Respiratory Therapy, 1979-1 Trade Cas. (CCH) ¶ 62,496 (N.D. Ill. 1979). JCAH standards require hospitals to employ only personnel who are certified, eligible for examination, or graduates of accredited programs for certain positions (JCAH, *supra* note 51, at 90, 137, 155) and permit other positions to be filled by persons having specified credentials or "the documented equivalent training and experience" (*id.* at 123, 147, 156, 166, 167, 172). Where certification is not required, the difficulty of determining what constitutes equivalent training and experience and the likelihood of inviting closer JCAH scrutiny may induce a hospital to require certification. For the position of the JCAH on physician specialty certification, see *supra* text accompanying note 44.

[78] *Cf.* Virginia Academy of Clinical Psychologists v. Blue Shield, 469 F. Supp. 552 (E.D. Va. 1979), *aff'd in part and rev'd in part*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (physician-dominated Blue Shield plan discriminated against plaintiff psychologists). For other examples of such third-party discrimination, *see* LEWIN REPORT, *supra* note 35, ch. V; BUREAU OF COMPETITION, FTC, MEDICAL PARTICIPATION IN CONTROL OF BLUE SHIELD AND CERTAIN OTHER OPEN-PANEL MEDICAL PREPAYMENT PLANS 157-75 (1979). On the conflict of interest between staff physicians and applicants for hospital staff privileges, *see infra* notes 92-95 and accompanying text.

incentives that induce them to verify the value of the information conveyed by certification or to balance cost and other considerations against the evidence of quality that certification provides.[79] Under these circumstances, the credentialing process itself can perhaps be said to deprive uncertified personnel of market opportunities that in fairness they should enjoy.

Even if the health care marketplace exaggerates the importance of credentials, it does not necessarily follow that credentialing systems must be closely scrutinized by courts or regulators. It might be preferable instead to concentrate on altering the incentives or changing the views of third-party decision makers where overreliance is suspected.[80] Because many changes currently taking place in the health care industry are sharpening cost awareness and inducing greater skepticism toward claims of quality, the problems noted here may diminish over time. Moreover, competition in credentialing may open up new sources of information and reduce the pressures to accept the verdicts of a monolithic system. In general, a great deal can be said for attempting to create a health care industry in which most decisions are made on a decentralized basis by truly independent purchasing entities that are accountable, ultimately, either to consumers in the marketplace or to voters through the political process.[81] In an industry based on such principles, it would be essential to maintain a flow of information concerning the skills and attributes of health care personnel from a multiplicity of sources. Policy makers should regard this feature of the market as a high-priority concern.

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[79] Not only are competitiveness and cost-consciousness often weak in information-poor health care markets, but quality-of-care judgments are difficult as well. It thus seems probable that some decision makers err on the side of overspending and overcaution regarding credentials, preferring certified personnel for reasons not based on an independent assessment of certification's value. *Cf.* Havighurst & Blumstein, *Coping with Quality/Cost Tradeoffs in Medical Care: The Role of PSROs,* 70 Nw. U.L. Rev. 6, 9-30 (1975) (noting how distorted incentives in the health care market give rise to a "quality imperative," such as might induce the attribution of unwarranted significance to credentials). Medical-legal problems, exacerbated by the scarcity of other objective indicators by which good care can be distinguished from bad, may also induce appointment or employment of only certified individuals as a way of avoiding imputations of negligence. Indeed, even lower prices may not encourage employment of uncertified personnel because economizing choices may have negative quality implications. Such "defensive" medical practice—that is, a propensity to incur unjustified costs to reduce exposure to malpractice liability—has been widely reported, though not well documented. *See, e.g.,* Project, *The Medicare Malpractice Threat: A Study of Defensive Medicine,* 1971 Duke L.J. 939-48.

[80] Indeed, attention to such incentives is an important element in current policy moves to strengthen health sector competition. *See supra* note 1 and sources cited therein.

[81] *See generally* Havighurst, *Decentralizing Decision Making: Private Contract versus Professional Norms,* in Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions 22 (J. Meyer ed. 1983).

B. Judicial Responses

The judicial precedent relevant to the issues raised by private credentialing includes both common-law and antitrust cases involving membership in professional associations, industrial seal-of-approval programs, hospital admitting privileges, personnel certification, and educational accreditation. Although the courts have imposed some oversight on private credentialing schemes and the like, they have been hesitant to intrude very far into their inner workings. Both common-law and antitrust courts have tended to defer to the judgments of program sponsors on most points and have stopped well short of attempting to ensure that private credentialing is an entirely fair and objectively valid information source.

1. Common-Law Principles

A substantial body of common law governs membership rights in private organizations and, by extension, private personnel credentialing. Although only a minority of courts has discovered any nonstatutory basis for reviewing the membership policies and similar practices of private organizations,[82] these courts' theories may persuade other courts to supply

[82] Fifteen jurisdictions currently appear willing to scrutinize to some extent the membership or credentialing decisions of private associations, the staff privilege decisions of private hospitals, or both. Excluding those cases dealing with hospital privileges, which raise somewhat different issues, *see infra* text accompanying notes 92-95, standards or procedural practices have actually been invalidated in only three jurisdictions. California: Hackethal v. California Medical Ass'n, 138 Cal. App. 3d 435, 187 Cal. Rptr. 811 (1982); Pinsker v. Pacific Coast Soc'y of Orthodontists, 1 Cal. 3d 160, 460 P.2d 495, 81 Cal. Rptr. 623 (1969), *subsequent opinion* 12 Cal. 3d 541, 526 P.2d 253, 116 Cal. Rptr. 245, (1974) (procedures inadequate). New Jersey: Falcone v. Middlesex County Medical Soc'y, 34 N.J. 582, 170 A.2d 791 (1961); Higgins v. American Soc'y of Clinical Pathologists, 51 N.J. 191, 238 A.2d 665 (1968) (substantive standards invalid). Texas: Hatley v. American Quarterhorse Ass'n, 552 F.2d 646 (5th Cir. 1977) (procedures inadequate). Cases in the remaining twelve jurisdictions (Alaska, Arizona, Florida, Hawaii, Illinois, Michigan, New Hampshire, New York, Ohio, Oregon, Vermont, and the District of Columbia) either have not dismissed challenges out of hand or, after review, have left the challenged procedure or standards intact. *See* cases cited in Note, *Judicial Intervention in Admissions Decisions of Private Professional Associations*, 49 U. CHI. L. REV. 840, 842, 854-55 (1982); cases cited *infra* notes 83 and 86.

At one time, private health care institutions, particularly hospitals, were thought to be potential candidates for judicial scrutiny under constitutional due process and equal protection doctrine because they displayed certain indicia of "state action." Such civil rights theories lost their earlier force, however, after Jackson v. Metropolitan Edison Corp., 419 U.S. 345 (1974). *See* Modaber v. Culpeper Memorial Hosp., 674 F.2d 1023 (4th Cir. 1982). Public hospitals are, of course, subject to constitutional strictures, and these create presumptions and rights that contrast sharply with those that we find, and regard as appropriate, in cases involving only private parties. *See, e.g.*, Stern v. Tarrant County Hosp. Dist., No. CA 4-80-281-E (N.D. Tex., June 6, 1983) (public hospital's requirement of AMA-approved residency training excluded comparably qualified osteopaths and was held to deny equal protection).

The interventions discussed here are to be distinguished from judicial review of association decisions (usually expulsions from membership) where it is claimed that defendant failed

comparable oversight in similar situations. Essentially, these courts have held that membership decisions and similar practices of private associations are reviewable for procedural and substantive fairness if they have serious adverse consequences for disappointed professional applicants. It is difficult to quantify the amount of actual influence a private association must gain before it becomes subject to scrutiny by courts embracing this theory. In the words of one court, the cases range from imposing oversight when membership or certification is "a virtual prerequisite to the practice of a given profession" to requiring a showing of merely a "deprivation of substantial economic or professional advantages."[83] Courts can be expected to differ over whether denial of formal certification by an influential credentialing body would satisfy this prerequisite for judicial scrutiny.

a. The Rationale for Judicial Scrutiny

Specific attention must be given to the precise legal warrant under which a common-law court might undertake to judge the fairness of an adverse credentialing decision by a private entity.[84] If a private entity's de facto influence over professional opportunities alone supplied a sufficient basis for judicial intervention in the affairs of private organizations, then any significant association or credentialing body—indeed, any dominant employer of professionals—would become bound, like a kind of public utility, to defend its policies and practices against charges of unfairness. Not only is it unclear why professionals—an ill-defined class in any event—should enjoy such protection under the common law, but there is also no obvious reason why, if such protection is extended, nonprofessionals un-

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to follow its own bylaws, thus breaching its contract with the plaintiff; such cases do not turn on common-law due process notions but on the nature and extent of a contractual obligation.

[83] Marjorie Webster Junior College v. Middle States Ass'n of Colleges and Secondary Schools, 432 F.2d 650, 655 (D.C. Cir.), *cert. denied,* 400 U.S. 965 (1970), *citing* Falcone v. Middlesex County Medical Soc'y, 34 N.J. 582, 170 A.2d 791 (1961) (applying the former "economic necessity" test), and Pinsker v. Pacific Coast Soc'y of Orthodontists, 1 Cal. 3d at 166, 460 P.2d at 499, 81 Cal. Rptr. at 627 (applying the latter "practical necessity" test). The *Falcone* test has been applied in most of the cases, but with varying degrees of restrictiveness. *E.g.,* Treister v. American Academy of Orthopaedic Surgeons, 78 Ill. App. 3d 746, 396 N.E.2d 1225 (1979), *appeal denied,* 79 Ill. 2d 630 (1980). A number of hospital privileges cases have relied on *Falcone* to support intervention, without recognizing a possible distinction between denial of privileges at a single hospital and a membership requirement affecting access to all area institutions. *See, e.g.,* Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564, *cert. denied,* 409 U.S. 1048 (1972); Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963); Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d 246, 250 N.E.2d 892 (1969).

[84] For comprehensive discussions of the common law of associations, *see* Chafee, *The Internal Affairs of Associations Not for Profit,* 43 HARV. L. REV. 993 (1930); *Developments in the Law—Judicial Control of Actions of Private Associations,* 76 HARV. L. REV. 983 (1963). *Compare* Note, *Exclusion from Private Associations,* 74 YALE L.J. 1313 (1965) (advocating expansion of judicial involvement), *with* Note, *supra* note 82 (criticizing trend toward greater public accountability for private groups).

fairly barred from pursuing their livelihoods should not be equally entitled to it.[85]

The courts that have reviewed private decisions affecting professional opportunities without a contractual or statutory warrant have done so under common-law public utility doctrines. For example, courts in some jurisdictions have held that, because private hospitals exercise "quasi-public" responsibilities, they are subject to substantive and procedural fairness requirements in denying admitting privileges to physicians.[86] Similarly, the leading New Jersey case of *Falcone v. Middlesex County Medical Society*[87] held that a medical society's "virtual monopoly" over a physician's eligibility for hospital privileges rendered its membership policies subject to scrutiny.[88] Such uses of ancient doctrines to extend judicial oversight to new institutions is questionable on the ground that modern legislatures have long since taken over the regulatory powers formerly exercised by common-law courts and can now be presumed to define the proper extent of state intervention in private affairs. Moreover, judicial interventions premised on theories of "virtual monopoly" in the health care field fly in the face of the current movement to organize health care delivery on a more competitive basis. Although many state legislatures have in fact regulated the health care industry, particularly hospitals, along public utility lines,[89] it would seem that the legal obligations of organizations enfranchised by such regulation should be found in the regulatory legislation itself, not in judicial extensions of it.

Although a substantial following has developed for treating health care institutions as public utilities, another factor present in many of these cases provides a somewhat narrower and therefore firmer warrant for judicial intervention. When an organization dispensing valuable membership rights or credentials is controlled by competitors of the disappointed

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[85] In fact, the seminal case extending judicial scrutiny to the decisions of professional entities, Falcone v. Middlesex County Medical Soc'y, 34 N.J. 582, 170 A.2d 791 (1961), relied for its rationale on James v. Marinship Corp., 25 Cal. 2d 721, 155 P.2d 329 (1944), a case approving scrutiny of the membership standards of unions with closed-shop agreements. *Cf.* Bernstein v. Alameda-Contra Costa Medical Ass'n, 139 Cal. App. 2d 241, 293 P.2d 862, 869 (1956) ("[T]here is no fundamental difference between a medical association [and] a labor union".).

[86] The leading case is Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963). Among the cases following it are Storrs v. Lutheran Hosp. and Homes Soc'y of Am., Inc., 609 P.2d 24 (Alaska 1980); Peterson v. Tucsón Gen. Hosp., 114 Ariz. 66, 570 P.2d 186 (1976); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564, *cert. denied,* 409 U.S. 1048 (1972); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589, *cert. denied,* 404 U.S. 995 (1971); Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d 246, 250 N.E.2d 892 (1969).

[87] 34 N.J. 582, 170 A.2d 791 (1961)

[88] *Id.* at 597, 170 A.2d at 799. The notion that "virtual monopoly" supplies a warrant for regulating a private business has ancient roots. *See* Munn v. Illinois, 94 U.S. 113 (1876).

[89] On entry regulation by "certificate of need," *see e.g.,* HAVIGHURST, *supra* note 1; Symposium, *Certificate-of-Need Laws in Health Planning,* 1978 UTAH L. REV. 1.

applicant, the presence of a direct competitor bias should arouse concerns analogous to those that underlie the common law's historical opposition to restraints of trade and unfair competition.[90] Courts seeking a warrant for intervention in cases of this kind should draw on these market-oriented traditions of the common law rather than on public utility doctrines. Whereas the latter theories do violence to vital distinctions—both between public and private activities and between judicial and legislative prerogatives—the law of unfair competition and restraint of trade can protect important public values and private interests that legislatures, which tend to be responsive to dominant interest groups, may be inclined to neglect. The most obvious corollary to this market-oriented rationale for intervention in these cases would be that private credentialers could deal more freely with noncompetitors than with competitors. Nearly all of the cases subjecting private membership or credentialing decisions to fairness requirements of any kind have in fact involved decision makers who were competitors of the plaintiff.[91]

The common-law decisions responding to fairness claims by disappointed applicants for hospital admitting privileges[92] appear to treat hospitals as public utilities and fail to distinguish between collective action by competitors and the actions of a single entity having only a vertical relationship to the plaintiff in the marketplace. Although hospital privileges are frequently under the de facto control of a hospital medical staff comprised of physicians with whom the applicant seeks to compete, courts have not

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[90] The common law's historic policy against overbroad contractual covenants in restraint of trade protects both the interest of the restrained individual in plying his trade and the public's interest in obtaining his services. Nordenfelt v. Maxim Nordenfelt Guns & Ammunition Co., 1894 A.C. 535, 565; Mitchel v. Reynolds, 1 P.Wms. 181, 24 Eng. Rep. 347 (K.B. 1711). The willingness of common-law courts to interfere with private contracts in defense of such interests would seem to be a precedent for similar limited interference in the affairs of private associations, which, as horizontal combinations of competitors, present particular dangers. There are some signs that similar policies underlie common-law rules that have been applied to membership and hospital staff issues. *See* Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. 2d 806, 810, 376 P.2d 568, 570, 26 Cal. Rptr. 640, 642 (1962) ("There is an established principle at common-law that an action will lie where the right to pursue a lawful business, calling, trade, or occupation is intentionally interfered with either by unlawful means or by means otherwise lawful when there is a lack of sufficient justification."); M. HANDLER, CASES AND MATERIALS ON BUSINESS TORTS 584-674 (1972); *Developments in the Law, supra* note 84, at 1040-45 (finding close resemblance between antitrust concerns and the tort of interference with economic relations as applied to association activity affecting nonmembers).

[91] *See* cases cited *supra* note 82. The only exception appears to be Ezekial v. Winkley, 20 Cal. 3d 267, 572 P.2d 32, 142 Cal. Rptr. 418 (1977) (physician dismissed from surgical residency at private hospital held to have extensive due process rights despite clear lack of competitor bias on employer hospital's part). *See also* Blatt v. Univ. of Southern Cal., 5 Cal. App. 3d 935, 85 Cal. Rptr. 601 (1970) (court refused to review allegedly arbitrary failure to elect plaintiff to the Order of the Coif, but because of insufficient effect on plaintiff's livelihood rather than lack of competitor relationship between educational institution and its students).

[92] *See generally* Annot., 37 A.L.R.3d 645 (1971).

made this fact the explicit basis for intervention. Nevertheless, it is possible that courts have intuitively doubted whether hospital governing boards are ever truly independent of their medical staffs on certain issues of professional or economic interest.[93] Indeed, there are a number of cases in which the court wished only to be assured that the hospital was acting in its own interest before allowing it freely to take actions harmful to physicians seeking access to its facilities. Thus, even in New Jersey, a state that has led the way in overseeing hospital decisions, courts have held that a hospital board can close its medical staff altogether if it offers sound reasons that evidence its independence from staff physicians.[94] In addition, courts have usually deferred to a hospital's business judgment in awarding exclusive contracts for hospital-based physician services—a matter wherein the medical staff's only concern is the hospital's efficiency, not competition.[95]

Although courts have generally not distinguished between denials of certification or accreditation and denials of membership in professional organizations, most of the cases concern membership. Nevertheless, credentialing decisions may be somewhat better candidates for judicial scrutiny. Unlike a membership association, a credentialing or accrediting program lacks the characteristics of a private club that invite concern for associational freedoms.[96] Credentialers also differ from membership orga-

[93] Changing methods of hospital reimbursement, *see, e.g.*, Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752 (Sept. 1, 1983) (interim final DRG regulations), increasing price competition among hospitals, the increasing supply of physicians, and the continued growth of proprietary hospitals all promise to make hospital decisions on matters concerning medical staff privileges more independent in the future. *See, e.g.*, Falk, *The Challenge of Change*, 57 HOSP. 92, 98 (April 1, 1983); Feldstein & Roehrig, *Medical Staff: Closed vs. Open Staffing—What's at Stake?* 56 HOSP. 97 (July 16, 1982).

[94] *E.g.*, Guerrero v. Burlington County Memorial Hosp., 70 N.J. 344, 360 A.2d 334 (1976).; Davis v. Morristown Memorial Hosp., 106 N.J. Super. 33, 254 A.2d 125 (1969). *See also* Walsky v. Pascack Valley Hosp., 145 N.J. Super. 393, 411, 367 A.2d 1204, 1214 (1976). ("[T]he only significant effect of continuing the closure of staff appointments is to confine control of the institution's beds to its existing medical staff and to enhance their economic interests at the expense of other qualified physicians whose patients are excluded . . . . If there were any credible evidence that the continuation of the moratorium contributed or was related to the quality of patient care at PVH, this court would be both obliged and eager to sustain it.").

[95] *See, e.g.*, Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); Centeno v. Roseville Community Hosp., 107 Cal. App. 3d 62, 167 Cal. Rptr. 183 (1979); Lewin v. St. Joseph Hosp., 82 Cal. App. 3d 368, 146 Cal. Rptr. 892 (1978); Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965) and cases cited therein. *See also* Annot., 74 A.L.R.3d 1268 (1976). *But see* Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d 286 (5th Cir. 1982), *cert. granted*, 51 U.S.L.W. 3649 (U.S. Mar. 7, 1983) (No. 82-1031), where a hospital's decision to grant an exclusive contract to the plaintiff anesthesiologist's competitor was held actionable as a tying arrangement because the hospital shared in the profits of the contractor. Whatever the merit of this holding, in the absence of such a horizontal relationship with the plaintiff physician, the hospital's decision should certainly be binding.

[96] As later discussion makes clear, judicial reluctance to interfere with credentialing activities may spring in part from a desire not to encroach upon first amendment freedoms. *See infra* text accompanying notes 213-22.

nizations in holding themselves out specifically as fair dealers and as open to all qualified persons.[97] Finally, an unfair denial of certification attesting to an individual's professional competence could be construed as false disparagement of that individual, a common-law tort.[98] Indeed, because it is a person's reputation, and not a product, that is impugned by professional certification decisions, these cases may be removable from the commercial disparagement context and analyzed under the law of defamation, where the burden of proving the truthfulness of an utterance falls on the defendant.[99]

In general, denials of credentials can be better handled under the law of torts than under common-law public utility theories. Although a tort action under a theory of disparagement, defamation, or intentional interference with business relations could conceivably succeed against a credentialing entity not under competitor control, the common law's recognition of unfair competition as a conceptually separate tort should make it possible to view competitor-sponsored credentialing as presenting a distinct set of issues.[100] Thus, there would be no obstacle, such as one encounters

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[97] Thus, there is better justification for the application to certifiers and accreditors of common-law rules against discrimination by enterprises that purport to serve the general public. For a discussion of the "common calling" concept, *see* Burdick, *The Origin of the Peculiar Duties of Public Service Companies* (pt. 1), 11 COLUM. L. REV. 514 (1911). On the doubtful value of the public utility analogy, however, *see supra* text accompanying notes 84-89.

[98] Failure to certify would have to be treated as *implied* disparagement to be actionable. *See* Advance Music Corp. v. American Tobacco Co., 268 A. D. 707, 53 N.Y.S.2d 337 (1945), *rev'd*, 296 N.Y. 79, 70 N.E.2d 407 (1946). On the common-law tort of trade libel or disparagement, *see generally* E. KITCH & H. PERLMAN, *supra* note 67, at 85-116; M. HANDLER, *supra* note 90, at 584-632. A potentially important product disparagement case awaiting decision by the Supreme Court is Bose Corp. v. Consumers Union, 692 F.2d 189 (1st Cir. 1982), *cert. granted*, 51 U.S.L.W. 3774 (No. 82-1246) (Apr. 25, 1983), in which a manufacturer of a stereo speaker system sued *Consumer Reports* for a disparaging review of its product. The petition for review challenges the scope of appellate review of the trial court's finding that the defendant, not competitor-controlled, was guilty of actual malice and thus unprotected by the first amendment under the doctrine of New York Times v. Sullivan, 376 U.S. 254 (1964). For further discussion of the application of common law tort theory to credentialers, see *infra* note 100.

[99] W. PROSSER, HANDBOOK OF THE LAW OF TORTS 798 (4th ed. 1971). "[D]efamatory language is actionable without special damage when it contains an imputation upon one as an individual, or in respect of his office, profession or trade, but is not actionable when it is merely in disparagement of . . . the quality of the articles which he manufactures or sells, unless it occasions special damage. . . ." Victor Safe & Lock Co. v. Deright, 147 F. 211, 212-13 (8th Cir. 1906).

[100] The cases do not seem to differentiate sharply between actions by competitors and those by noncompeting groups, despite some suggestive language. *See generally* M. HANDLER, *supra* note 90, at chs. 6 and 7; *Developments in the Law*, *supra* note 84, at 1005, 1040-42. Noncompetitors have been treated as potentially subject to tort liability. *See, e.g.*, Mayfair Farms, Inc., v. Socony Mobil Oil Co., 68 N.J. Super. 188, 172 A.2d 26 (1961); Advance Music Corp. v. American Tobacco Co., 296 N.Y. 79, 70 N.E.2d 401 (1946). The latter decision applied the theory that all intentional infliction of damage states a cause of action, even if not falling within traditional theories of tort liability, after a lower court had refused to find unfair competition because the defendant was not plaintiff's competitor. Advance Music Corp. v. American Tobacco Co, 268 A. D. 707, 53 N.Y.S.2d 337 (1945).

under the public utility theory, to adopting a stricter standard of review for such cases—one that balances the public's interest in fair competition against the right of competitors to express their views concerning the skills and attributes of the plaintiff relative to their own.

b. The Scope of Review

Whether it is tort law or public utility theory that supplies the common-law basis for judicial review of credentialing and accrediting decisions by competitor-controlled entities, the crucial issue is the proper standard of review. The most interesting case on this subject is *Marjorie Webster Junior College, Inc. v. Middle States Association of Colleges and Secondary Schools, Inc.*,[101] in which a federal court of appeals accorded substantial deference to the policies of the defendant educational accreditors. The particular accreditation standard challenged by the plaintiff, a proprietary school, was a requirement of nonprofit status. Although this condition was arguably unrelated to educational quality, the court, in an opinion by Judge Bazelon, upheld the refusal to certify proprietary institutions as a permissible expression of "educational philosophy."[102]

Because Judge Bazelon is known as an activist and liberal judge, it may be surprising that, in the *Marjorie Webster* case, he failed to side with a small business significantly disadvantaged by actions of its powerful competitors. One may suspect, however, that in this particular instance the judge's sympathies lay with the association of nonprofit educational institutions rather than with the for-profit plaintiff and that he in fact shared the "educational philosophy" that he observed in the association's policy.[103] Whether or not this speculation explains the result in *Marjorie Webster*, the decision is felicitous in the scope that it leaves for private associations to adopt controversial policies of their own choosing without judicial interference. The opinion is particularly insightful in suggesting the possibility that

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Because a certifying body would rarely be identifiable as a horizontal combination of competitors, consumers would not be alerted to the need for skepticism regarding its certifications. For this reason, a competitor group's trade libel taking this form should probably not be granted the same leeway as is usually allowed a single competitor's "puffing" of his product in comparison to others. On "puffing," see, e.g., Smith-Victor Corp. v. Sylvania Electric Prod., Inc., 242 F. Supp. 302, 308 (N.D. Ill. 1965). *Cf.* Prosser, *Injurious Falsehood: The Basis of Liability*, 59 COLUM. L. REV. 425, 439 (1959). In addition, a threshold requirement of substantial impairment of professional opportunities would seem appropriate as an extension of the common-law requirement that special damages be proved in disparagement actions. *See supra* note 99. And in the absence of affirmative representations concerning the plaintiff, it would seem wrong to treat such a case as one of defamation rather than disparagement.

[101] 432 F.2d 650 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970).

[102] *See infra* text accompanying note 206.

[103] For Judge Bazelon's forceful expression of the closely analogous view that the profit motive undermines the integrity of broadcast journalism, see Bazelon, *FCC Regulation of the Telecommunication Press*, 1975 DUKE L.J. 213, 229-34.

proprietary schools might organize a competing accrediting body,[104] thus facilitating competition between differing philosophies of education. The conclusion that issues of this kind should be resolved in the marketplace and not in the courts is an attractive one.

It is interesting to compare the *Marjorie Webster* decision to the *Falcone* case,[105] which vindicated a licensed osteopath who had been barred from medical society membership (and thus from privileges in local hospitals) because he lacked four full years of M.D. training. In some respects, the *Falcone* case looks as though it should have been decided the same way as *Marjorie Webster.* Certainly osteopathic and allopathic medicine can be regarded as differing enough in "philosophy" to justify different treatment by a private group.[106] Moreover, osteopaths, like the proprietary schools allegedly victimized in *Marjorie Webster,* can organize their own associations; they can also operate their own hospitals or appeal directly to existing hospitals for admitting privileges. These parallels suggest that, under the standard of review employed in *Marjorie Webster,* Dr. Falcone would not have been granted the relief he obtained against his competitors.

Nevertheless, Judge Bazelon cited the *Falcone* case without disapproval and indicated in dictum why he viewed the results in the two cases as consistent. The scrutiny given to a particular credentialing or accrediting scheme, he suggested, should vary according to the plaintiff's potential injury.[107] Thus, the greater de facto exclusionary power possessed by the medical society in the *Falcone* case was thought to justify closer scrutiny of the society's membership standards than was appropriate for the accrediting standards in *Marjorie Webster.* Although other courts have not adopted this notion of a sliding scale permitting strict scrutiny in some cases but not in others, the idea has natural appeal because it offers protection against serious unfairness. It is, in fact, simply an expression of the common view that any private body whose credentialing decisions matter a great deal should somehow be legally bound to be fair toward those affected. One of

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[104] *See infra* quotation in text accompanying note 205. *Cf.* Sherman College of Straight Chiropractic v. United States Comm'r of Educ., 493 F. Supp. 976 (D.D.C. 1980), discussed *infra* notes 199 and 205.

[105] 34 N.J. 582, 170 A.2d 791 (1961).

[106] The facts in *Falcone* were not clear-cut in this regard because Dr. Falcone had earned an M.D. degree from an AMA-approved foreign institution by combining his D.O. degree with seven months of resident study. Thus, although he could not meet the society's requirement of four years at an AMA-approved medical school, he may have been philosophically indistinguishable from a typical M.D.

[107] "[T]he extent to which deference is due to the professional judgment of the association will vary both with the subject matter at issue and with the degree of harm resulting from the association's action." 432 F.2d at 655-56 (footnotes omitted). For further discussion of this sliding scale standard of scrutiny, see *infra* notes 208-10 and accompanying text.

the goals of this Article is to dispute the wisdom of making judicial scrutiny of credentialing standards vary in proportion to the respect that others accord the credentials. Not only would such a rule penalize success in establishing a reputation for sound credentialing, but it would permit intrusions into the affairs of private organizations engaged only in generating and disseminating information and opinion. Fuller appreciation of market processes and of the other values at stake will reveal the dangers of accepting Judge Bazelon's dictum.

The *Marjorie Webster* holding, as distinct from its questionable dictum, provides an excellent model for limiting judicial scrutiny of the substantive standards employed in private credentialing. The case demonstrates the benefits of confining the court's inquiry to whether the standards employed by a credentialer are rationally related to the purpose of usefully differentiating among the offerings available in the marketplace. Under this test, a dominant allopath-sponsored certification program that refused to certify osteopaths should escape sanction. On the other hand, a policy of excluding doctors who cut prices, advertise, or testify on behalf of plaintiffs in malpractice cases could be invalidated. Likewise, as in another New Jersey case,[108] a physician organization could be prevented from denying an applicant certification as a laboratory technician solely because he worked in a lab controlled by nonphysicians. Finally, evidence of a specific intent to publish a dishonest opinion of a competitor would easily support judicial relief. In general, the drawing of distinctions that consumers and other independent entities might regard as relevant in making market choices should be encouraged, whatever the consequences to individual competitors.[109] As Part Two of this Article discusses, the problem in health care markets is that there is too little such differentiation among competitors, and judicial policies contributing to greater inclusiveness by existing credentialing programs would exacerbate this problem. Sound policy suggests encouraging differentiation among practitioners, not penalizing good faith line-drawing activities.

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[108] Higgins v. American Soc'y of Clinical Pathologists, 51 N.J. 191, 238 A.2d 665 (1968).

[109] Other courts have also recognized the value of private differentiation among competing goods and services. In Roofire Alarm Co. v. Underwriters' Laboratories, Inc., 188 F. Supp. 753 (E.D. Tenn. 1959), the plaintiff sought to compel defendant to test its fire alarm, but the court, in refusing to impose any such duty at common law, stated:

> By limiting its approval of devices and by directly or implicitly indicating that unapproved devices may be less desirable to buyers of such devices, it [Underwriters' Laboratories, Inc.] has made its approval a desirable and financially rewarding goal. To require it to approve a device, and to lower, or change, its standards would, to some degree, decrease the desirability of the goal. It is not a function of the courts to interfere with the internal workings of corporations in exercising their discretion within legal limits.

In Maceluch v. Wysong, 680 F.2d 1062 (5th Cir. 1982), the court refused to invalidate on constitutional grounds a Texas medical licensing scheme that distinguished by title between

Cases involving membership in competitor-sponsored organizations can be resolved in a fashion similar to the method suggested for credentialing cases—that is, by ascertaining whether the criteria employed are rationally chosen means for advancing the association's legitimate purposes. To the extent that membership constitutes a valuable testimonial to professional standing, the tests for evaluating credentialing standards would be appropriate.[110] Where the burdens of exclusion are of a different nature, however, membership criteria could fairly exclude latecomers from free-riding on the association's past accomplishments.[111] On the other hand, selectivity that simply penalizes competitive or other unwanted behavior should be subject to challenge. Thus, in the leading California case of *Pinsker v. Pacific Coast Society of Orthodontists,*[112] the court was too tolerant of an association rule denying membership to orthodontists who delegated specialized tasks to nonmember dentists; although such a membership criterion might seem related to a professional objective of ensuring the quality of care, the implied agreement among members to foreswear one form of lawful competition and to boycott nonmembers would undoubtedly be held to violate the antitrust laws today.

In general, common-law courts have indicated a readiness to strike down substantive membership and credentialing standards only when they are "capricious,"[113] "patently arbitrary,"[114] or "contrary to established public policy."[115] These formulations are consistent with a means-ends test that prevents patently unfair treatment of competitors but leaves ample scope for private assessments and choice. Fortunately, courts have for the most part been comfortable in substituting their judgment for that of professional experts only when the substantive standard in question belied the association's ostensible purposes and thus seemed to reflect an anticompetitive animus. In many respects, the limited scrutiny thus given to membership policies and credentialing standards is equivalent to the minimal substantive scrutiny that is given in constitutional law to legislation not

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D.O. and M.D. licenseholders while applying the same licensure requirements to both and awarding identical practice privileges. Plaintiff D.O.s sought to use the M.D. designation, but the court found philosophical differences between the two schools, *id.* at 1066, and observed: "Evidently, the market cares about the distinction. Courts should not end the dissemination of information reasonably perceived by the legislature to be useful to the functioning of the market, whether the Court thinks the market is correct in any normative sense." *Id.* at 1069.

[110] *Falcone* was arguably such a case, in view of the local hospitals' policy of excluding nonmembers of the medical society.

[111] For example, a private association that, at some risk and expense, had built a program offering valuable services to its members could reasonably close its membership to those who had not contributed to its success. *See infra* note 153.

[112] 12 Cal. 3d 541, 526 P.2d 253, 116 Cal. Rptr. 245 (1974).

[113] *Id.* at 553, 526 P.2d at 262, 116 Cal. Rptr. at 254.

[114] Falcone v. Middlesex County Medical Soc'y, 34 N.J. at 598, 170 A.2d at 800.

[115] Pinsker v. Pacific Coast Soc'y of Orthodontists, 12 Cal. 3d at 558, 526 P.2d at 256, 116 Cal. Rptr. at 250.

affecting fundamental rights.[116] It seems generally proper that private groups engaged in useful conduct should enjoy a presumption of legitimacy similar to that accorded to the legislative branch of government.

Deference to professional expertise and private prerogatives has weighed less heavily in challenges to the administrative procedures used in denying membership or certification than in challenges to substantive requirements. But here, too, the common-law courts have seldom gone beyond rectifying obvious unfairness to competitors. Those courts that have been at all willing to scrutinize the procedures followed by an association in administering its rules have not insisted on full constitutional due process, but have required only that "fair," "meaningful," or "reasonable" procedures be followed.[117] Although a number of cases have found particular procedures to be unsatisfactory,[118] any procedure offering a disappointed applicant notice of the applicable standards and a meaningful opportunity to be heard should withstand scrutiny.

Because common-law courts are legitimately concerned about fairness to individual competitors, their tests for assessing substantive and procedural requirements ought to differ from the tests applied to the same conduct by antitrust courts. Even though common-law and antitrust doctrines are both rooted in market concerns, antitrust law is not concerned to the same extent with promoting fair play among competitors; instead it is primarily intended to protect consumers against the harms that flow from impairments of the competitive process.[119] Thus, common-law litigation is not likely to be entirely displaced by antitrust suits, even though antitrust law now reaches many of the same cases and offers more attractive remedies—treble damages and attorneys' fees. Common-law theories

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[116] For examples of minimal scrutiny in constitutional inquiry and the use of the familiar rational relationship test, *see, e.g.*, New Orleans v. Dukes, 427 U.S. 297 (1976); San Antonio Indep. School Dist. v. Rodriguez, 411 U.S. 1 (1973).

[117] *See* Pinsker v. Pacific Coast Soc'y of Orthodontists, 12 Cal. 3d at 544-45, 551-56, 526 P.2d at 256, 259-64, 116 Cal. Rptr. at 248, 251-56. A requirement of procedural fairness also serves the useful purpose of revealing, and facilitating scrutiny of, substantive requirements. *Cf.* Silver v. New York Stock Exch., 373 U.S. 341, 362-63 (1962).

[118] *E.g.*, Hatley v. American Quarterhorse Ass'n, 552 F.2d 646 (5th Cir. 1977); Pinsker v. Pacific Coast Soc'y of Orthodontists, 12 Cal. 3d 541, 526 P.2d 253, 116 Cal. Rptr. 245 (1974). *See also* Dietz v. American Dental Ass'n, 479 F. Supp. 554 (E.D. Mich. 1979). Procedures have also been found deficient in cases dealing with *expulsion* from professional associations. *E.g.*, Virgin v. American College of Surgeons, 42 Ill. App. 2d 352, 192 N.E.2d 414 (1963), and in numerous hospital staff privileges cases. *E.g.*, Ezekial v. Winkley, 20 Cal. 3d 267, 572 P.2d 32, 142 Cal. Rptr. 418 (1977); Ascherman v. St. Francis Memorial Hosp., 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564, *cert. denied*, 409 U.S. 1048 (1972).

[119] Antitrust law protects "competition, not competitors." Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1976); Brown Shoe Co. v. United States, 370 U.S. 294, 320 (1961). This simple formulation conceals a great deal of fundamental doctrinal disagreement, however. *See infra* note 128.

properly applied may still have independent utility in cases where a lone plaintiff cannot establish the requisite effect on the competitive process or on interstate commerce, or where a court is simply reluctant to award treble damages but would be willing to grant other, less punitive relief.[120] There appears to be ample warrant in the law of unfair competition as well as a sufficient need for a nonantitrust remedy for particular abuses for common-law courts to maintain limited—but only limited—oversight in credentialing cases.

2. Antitrust Law

A credentialing scheme is most likely to present antitrust issues cognizable under Section 1 of the Sherman Act[121] if it represents concerted action by competitors. Some certification and seal-of-approval programs are independently sponsored and, without more, present no antitrust issue. Other programs may be jointly governed by numerous interests so that no single competitor group represents a clear controlling interest on any matter of significance to themselves. In none of these cases is the necessary "contract, combination . . . , or conspiracy, in restraint of trade" inherent in the program's organization; it must be specially pleaded and proved.[122] In antitrust cases even more than under the common law, participation of

[120] This may have been the case, for example, in Hatley v. American Quarterhorse Ass'n, 552 F.2d 646 (5th Cir. 1977), where the court invoked the "breathing space" notion espoused in Silver v. New York Stock Exch., 373 U.S. 341 (1962), to approve under the antitrust laws a degree of associational discretion that it then found excessive at common law. *See infra* text accompanying note 163.

[121] 15 U.S.C. §§ 1-7 (1976).

[122] Affirming a judgment for the defendant standard-setting bodies, the court in Eliason Corp. v. National Sanitation Found., 614 F.2d 126, 130 (6th Cir.), *cert. denied*, 449 U.S. 826 (1980), stated, "NSF and NSFT [its testing subsidiary] are independent organizations and are not dominated or controlled by manufacturers of any one product. They are not in direct competition with the plaintiff and have no intent to exclude plaintiff from competition." *See also* Roofire Alarm Co. v. Royal Indemnity Co., 202 F. Supp. 166, 168 (E.D. Tenn. 1962), *aff'd*, 313 F.2d 625 (6th Cir.), *cert. denied*, 373 U.S. 949 (1963) (granting defendant's motion for summary judgment on plaintiff's claim of refusal to certify its fire alarm). The FTC staff anticipates little trouble, however, in finding concerted action where an independent body, such as the American National Standards Institute (*see supra* note 13), invites competitors to participate in industrial standard setting. FTC STAFF REPORT *supra* note 6, at 245-47, 280-1. On the strength of its view, the staff proposed a trade-regulation rule applicable, without any specific showing, to independent as well as competitor-controlled bodies. In American Soc'y of Mechanical Eng'rs v. Hydrolevel Corp., 456 U.S. 556, 571 (1982), an independent standard-setting body was held liable on agency principles for antitrust violations by its officials, whose role was described as follows: "Many of ASME's officials are associated with members of the industries regulated by ASME's codes. Although, undoubtedly, most serve ASME without concern for the interests of their corporate employers, some may well view their postions with ASME, at least in part, as an opportunity to benefit their employers. When the great influence of ASME's reputation is placed at their disposal, the less altruistic of ASME's agents have an opportunity to harm their employers' competitors through manipulation of ASME's codes."

competitors in the credentialing effort is the factor inviting judicial intervention.

Occasionally it has been argued that the existence of a noncommercial motive for collective action can preclude the imposition of antitrust standards. One case taking this approach was *Marjorie Webster,* where the court, before proceeding to apply common-law principles as discussed above, held that educational accreditation was exempt from the antitrust laws as a professional, rather than a commercial, activity.[123] This holding appears to have been invalidated by the Supreme Court's later decisons subjecting the learned professions to antitrust rules,[124] and it seems unlikely that a noncommercial purpose defense would (or should) succeed today in any case where the collaborators have an interest in stifling competition.[125] Where such a conflict of interest exists, it would seem unwise to accept claims of

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[123] 432 F.2d at 654-55.

[124] Although the putative "learned professions" exemption was laid to rest in Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), there have been occasional signs, though no Supreme Court holdings, that courts might defer to professionalism in some situations. *See* Havighurst, *The Contributions of Antitrust Law to a Procompetitive Health Policy,* in MARKET REFORMS IN HEALTH CARE, *supra* note 1, at 295, 296-306. In Arizona v. Maricopa County Medical Soc'y, 102 S. Ct. 2466 (1982), the Court suggested that "public service or ethical norms" might be regarded with equanimity. However, it had already made clear that such norms were to be evaluated only in terms of their effects on competition: "[B]y their nature, professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote this competition, and thus fall within the Rule of Reason." National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 696 (1978). Although this language may permit a professional organization to argue that its actions, by correcting a "market failure," allow the market to more nearly approximate competitive results, it leaves no room for pure public-interest defenses or a claim of noncommercial purpose.

[125] Rather than serving as a defense, noncommercial purpose has sometimes been cited as a basis for employing the rule of reason and not a per se rule. *E.g.,* Kreuzer v. American Academy of Periodontology, 558 F. Supp. 683 (D.D.C. 1983); Veizaga v. National Bd. for Respiratory Therapy, 1977-1 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill. 1977). These holdings probably amount to nothing more than a recognition of possible procompetitive justifications for concerted action and a rejection of the implications of the misplaced boycott characterization. For two cases seemingly embracing noncommercial purpose as a defense for a true restraint of trade, *see* Nara v. American Dental Ass'n, 526 F. Supp. 452 (W.D. Mich. 1981) (distinguishing *Goldfarb* and *Professional Engineers* as dealing with clearly economic issues and upholding ADA regulations precluding the advertisement of "unrecognized" dental specialties as noncommercial and in the public interest, though the conflict of interests seems clear); Selman v. Harvard Medical School, 494 F. Supp. 603, 621 (S.D.N.Y.), *aff'd,* 636 F.2d 1204 (2nd Cir. 1980) ("Academic admissions criteria may well have a purely incidental effect on the commercial aspect of the medical profession. They are, however, non-commercial in nature.") Both cases seem wrong on the point in question. On *Nara,* see Part Two, Section V.B.2. In *Selman,* the focus was on the wrong market altogether. The medical schools' agreement on admission polices was a naked restraint in the market for education but was probably exempt as a political protest against government's attempt to influence the schools' admissions criteria. *Cf.* Missouri v. NOW, 620 F.2d 1301 (8th Cir.), *cert. denied,* 449 U.S. 842 (1980) (boycott to induce legislative action not subject to Sherman Act).

Another aberrant case, Wilk v. AMA, 1983-2 Trade Cas. (CCH) ¶ 65,617 (7th Cir. 1983), though too recent for discussion here, is discussed in Part Two, Section V.C.1.

purely noneconomic motives at face value.[126] Some scrutiny under the antitrust laws should be expected.

a. The Necessity for Proving Harm to Competition

One possible obstacle to federal antitrust actions challenging denials of certification is the necessity for showing an effect on interstate commerce.[127] This jurisdictional issue is similar to the issue of whether the actions of a private organization with respect to a single competitor adversely affect not only that competitor but also competition itself, the essential concern of the Sherman Act.[128] A plaintiff in an antitrust case must establish more than injury to himself; he must allege and prove either public injury—that is, harm to the competitive process—or conduct automatically satisfying the public injury requirement—that is, a so-called per se offense.[129] Given the current size and scope of the health care industry, evidence establishing a substantive violation will probably also satisfy the jurisdictional requirement that the effects of the alleged restraint be felt in interstate markets.[130]

The substantive requirement of harm to "competition, not competitors"[131] can pose a significant barrier to antitrust relief in cases involving membership in or credentialing policies of private associations. In the recent case of *Marrese v. American Academy of Orthopaedic Surgeons,*[132] a

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[126] *See* Havighurst, *Professional Restraints on Innovation in Health Care Financing,* 1978 DUKE L.J. 303, 349-53.

[127] *See generally* P. AREEDA & D. TURNER, ANTITRUST LAW ¶¶ 231-32 (1980).

[128] *See supra* note 119. "[T]hough there is a sense in which the exclusion of any competitor reduces competition, it is not the sense of competition that is relevant to antitrust law .... The policy of competition is designed for the ultimate benefit of consumers rather than of individual competitors ...." Marrese v. American Academy of Orthopaedic Surgeons, 706 F.2d 1488, 1497 (7th Cir. 1983). Antitrust law appears to be in the midst of a transition away from an era during which, at some expense to efficiency, it softened competition and enforced fairness in business dealings between large and small firms. Though the revolution is very far from being complete, consumers' interests, as served by efficiency and vigorous competition, are an increasingly dominant focus. The watershed case, looking with a less jaundiced eye on vertical restrictions on dealers' freedom, was Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36 (1977). The intellectual struggle for the soul of antitrust doctrine has been vigorous. *See, e.g.*, R. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF (1978); R. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE (1976); Sullivan, Book Review, 75 COLUM. L. REV. 1214 (1975); Bork, Bowman, Blake & Jones, *The Goals of Antitrust: A Dialogue on Policy,* 65 COLUM. L. REV. 363 (1965). *See also infra* note 209.

[129] *See generally* Klors' Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959); P. AREEDA & D. TURNER, *supra* note 127, at ¶¶ 314, 331.

[130] On the showing required to satisfy the interstate commerce requirement, compare Crane v. Intermountain Health Care, Inc., 637 F.2d 715 (10th Cir. 1980) with Western Wastes Sys. v. Universal Waste Control, 616 F.2d 1094 (9th Cir.), *cert. denied,* 449 U.S. 869 (1980), offering opposing interpretations of the Supreme Court's articulation of the requirement in McLain v. Real Estate Bd. of New Orleans, 44 U.S. 232, 242, 246 (1980).

[131] *See supra* notes 119 and 128.

[132] 706 F.2d at 1495. An earlier opinion, 692 F.2d 1083 (7th Cir. 1982), was withdrawn

federal court of appeals invoked "the consumer-oriented view of antitrust that prevails today" in refusing to allow even limited scrutiny of a specialty association's membership policies. In denying discovery of the association's membership practices, the court reasoned that, in the absence of a per se violation, injury to competition is an essential element of the offense and is not established by injury to an individual competitor. Thus, the court, in an opinion by Judge Posner,[133] required the plaintiffs to show, prior to discovery, that the markets from which they were excluded were comprised of so few orthopedists that noncompetitive market performance was likely if the association was in fact pursuing anticompetitive purposes in excluding the plaintiffs from membership.

Judge Posner's implication that the market would still be adequately competitive if populated by enough orthopedists seems faulty on two grounds. First, the exclusion from association membership of physicians who advertise, cut prices, or serve as witnesses for malpractice-suit plaintiffs would seem to support an inference of agreement among the members to eschew the disapproved conduct; such an anticompetitive agreement, even if not alleged as a separate offense, would seem to establish the requisite threat to consumer welfare.[134] Second, Judge Posner's faith that competition will flourish wherever there is a substantial number of competitors betrays a certain obliviousness toward the risk that a professional association could parlay the tangible advantages of membership into a system for controlling the competitive behavior of a large number of physicians.[135] Professional organizations seem capable of doing significant harm in markets where interdependence among professionals is high because of their involvement in numerous common enterprises, where consumer information is imperfect, where entry is limited by licensure laws, and where passive third parties do not force physicians to engage in price competition. In the absence of better theory than Judge Posner had avail-

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and a revised opinion was issued by the same panel following the granting of a motion for rehearing *en banc*, which was then overruled. However, after the issuance of the new opinion, rehearing *en banc* was again granted (July 19, 1983).

[133] Seldom are the judicial personalities involved in a decision of as much interest as in this case. Judge Richard A. Posner, formerly of the University of Chicago Law School, has a considerable reputation for his strong antitrust views. *E.g.*, POSNER *supra* note 128; R. POSNER & F. EASTERBROOK, ANTITRUST LAW (2d ed. 1981). The dissenting judge, who believed that the trial court had exercised sound discretion, was Justice Potter Stewart, recently retired from the U.S. Supreme Court.

[134] *Cf. supra*, discussion of the *Pinsker* case in text accompanying note 112. Perhaps if the plaintiffs in *Marrese* had alleged such an agreement, they would have been allowed access to the records that might prove it.

[135] *See* M. OLSON, THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS (1967), which shows how "selective incentives" are used to facilitate collective action in markets with numerous competitors. *See infra* note 174.

able to assess the operation of professional cartels,[136] antitrust rules should be based on the probability that physicians' concerted efforts to control competitive behavior are in fact dangerous to competition.

Aside from the *Marrese* case, the analytical approach adopted and the results reached by antitrust courts in credentialing and membership cases are generally consistent with the pattern suggested above, whereby common-law courts assume somewhat wider powers to scrutinize fairness to individuals but antitrust courts are also willing to undertake limited scrutiny of credentialing activities.

b. The Antitrust Rationale for Reviewing Credentialing and Accrediting Standards

The prohibitions of Section 1 of the Sherman Act focus primarily on agreements that eliminate some form of competition among the parties thereto. Such restraints of trade are distinguishable, however, from the restraints most likely to be associated with personnel credentialing. Where competitors sponsor a joint venture for credentialing or similar purposes, the dominant antitrust concern is not with restrictions on competition among the collaborators themselves[137] but with the possibility that the collaborators will use the scheme unfairly to injure their competitors. Despite this possibility of abuse, however, competitors engaged in credentialing, accrediting, and standard setting are not, without more, involved in a restraint of trade under the standard test, which asks whether competitor collaboration "merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition."[138] Because collaboration for these purposes produces valuable information and creates desirable incentives for upgrading skills and quality, it promotes competition and is presumptively lawful.

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[136] Such theory as there is suggests that professional organizations, assisted by government regulation and other policies, have been quite successful in using social pressures, professional relationships, and professional ideology to discourage competitive behavior. *See, e.g.*, J. BERLANT, PROFESSION AND MONOPOLY (1975); E. FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE (1971); E. FREIDSON, PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE (1970); Lipscomb, *A Political Economic Theory of the Dental Care Market*, 72 AM. J. PUB. HEALTH 665 (1982). *See also* P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1983).

[137] Obviously, no important competition in standard setting and certification is eliminated, because the individual collaborators would be unlikely to engage in those activities independently. Part Two, Section VI.E., however, calls attention to situations where the formation of a joint venture for such purposes can and should be challenged. It also emphasizes, in Section VI.C., that, although standard setting itself is lawful, agreements to adhere to set standards are illegal restraints. However subtle this distinction may be in practice, its theoretical basis is clear.

[138] United States v. Chicago Bd. of Trade, 246 U.S. 231, 238 (1918), quoted in National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 691 (1978).

Unfortunately, antitrust analysis of competitor collaboration often fails to distinguish clearly between the legal tests for detecting restraints on competition among the collaborators and the tests for evaluating the conduct of a legitimate joint venture toward third parties. This analytical confusion is particularly apparent in the law relating to "boycotts" and "concerted refusals to deal." Although most lower courts and commentators address credentialing, accrediting, and standard-setting activities under these general headings, none of the Supreme Court's decisions in which these terms were used involved a joint undertaking that was objectionable only because of its impact on outsiders. Instead, the Court was concerned in each case with restraints impairing the competitive freedom of the boycotters themselves—in particular, with agreements by competing buyers or sellers to adopt a common policy toward a supplier or customer in place of the independent, self-interested decision making that is the norm in competitive markets.[139] Even though the ultimate victims of the boycotts in question were frequently competitors of the participants, the more fundamental fact, which alone justified finding a violation,[140] was the boycotters' surrender of their competitive independence. By the same token, in cases where there is a comparable type of injury but no true boycott involving several competing entities, the analysis must proceed on a different basis. Although it may be too late in the day to correct the indiscriminate use of the term "boycott" in antitrust theorizing, some discussion of the issue should help to clarify thinking about credentialing and related problems.

The confusion over what does and does not constitute a boycott or concerted refusal to deal for antitrust purposes appears to have originated in a widespread misreading of a Supreme Court decision in an industrial seal-of-approval case, *Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*[141] The plaintiff manufacturer in that case had claimed that the American Gas Association (AGA), controlled by the plaintiff's competitors, had arbitrarily denied safety certification for its product. The Supreme Court held that the plaintiff's complaint, though it failed to allege a public injury, was sufficient because it pleaded a per se violation of the Sherman Act. Instead of upholding the particular claim that the certification program was unfair,

[139] *See, e.g.*, St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 541-45 (1978).

[140] Most of the cases applying a per se rule have in fact invoved a boycott targeted at a competitor, however. *E.g.*, Klor's Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959); Fashion Originators' Guild v. FTC, 312 U.S. 457 (1941); AMA v. United States, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943). For a startling recent departure from the usual per se rule against boycotts aimed at competitors, see Wilk v. AMA, 1983-2 Trade Cas. (CCH) ¶ 65,617, discussed in Part Two, Section V.C.1. This court, like many commentators and other lower courts, fails to identify the collective nature of the decision and the coercive nature of the sanction, rather than the social desirability of the action taken, as the true issue presented by a true boycott.

[141] 364 U.S. 656 (1961).

however, the Court construed the complaint as alleging that certain utility members of the AGA had engaged in a "conspiratorial refusal to provide gas for use in the plaintiff's Radiant Burners,"[142] which, if proved, would have violated the per se rule against boycotts. Unfortunately, the author of a leading treatise misreads the case as treating the manufacturing members of the AGA as "the perpetrators of the 'boycott,' " by "concertedly inducing the agency not to supply to plaintiff the approval which is essential to successful entry."[143] Although other commentators and courts have followed this analyst into confusion,[144] the Supreme Court has been quite scrupulous in avoiding the use of the term "boycott" in connection with a refusal to deal, admit, certify, accredit, and so forth, by a single competitor-sponsored entity.[145]

Cases like *Radiant Burners,* in which a competitor-sponsored certification or similar program had allegedly been coupled with a boycott sanction, have provided courts with the opportunity to make several important distinctions, accentuating the positive aspects of the joint activity while minimizing the negative. In one case, an association of orthodontists had not only refused to accredit the plaintiff's program for training licensed dentists in orthodontics but also prevented its members from teaching in unaccredited courses; in upholding the complaint, the court appeared to observe the crucial distinction between information-generating activity and a true boycott, noting that "[d]efendants allegedly did not limit themselves . . . to exercising their First Amendment rights to criticize" the plaintiff.[146] In a case involving a challenge to the validity of a certification examination for respiratory therapists, the court correctly held that the crucial issue was whether the defendant hospitals had agreed to employ only certified personnel in higher-paying jobs;[147] the court also suggested, however, that such an agreement, because it would not affect competitors of the hospitals,

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[142] *Id.* at 659.

[143] L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST 243-44 (1977).

[144] *See, e.g.,* FTC STAFF REPORT *supra* note 6, at 248-49; E. GELLHORN, ANTITRUST LAW AND ECONOMICS 190-204 (2d ed. 1981); Bauer, *Professional Activities and the Antitrust Laws,* 50 NOTRE DAME LAW. 570 (1975); Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 484 (4th Cir. 1980), *cert. denied,* 450 U.S. 916 (1981).

[145] *Cf.* St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531 (1978), which reviews precedents in the course of defining "boycott" as used in the McCarran-Ferguson Act, 15 U.S.C. § 1013(b) (1976). For references which negotiate the terminology traps fairly successfully, see Ponsoldt, *Industry Self-Regulation: An Analysis Integrating Non-boycott Sherman Act Principles,* 55 S. CAL. L. REV. 1 (1981); Nurse Midwifery Assocs. v. Hibbett, 549 F. Supp. 1185 (D.C. Tenn. 1982).

[146] United States Dental Inst. v. American Ass'n of Orthodontists, 396 F. Supp. 565, 580-81 (N.D. Ill. 1975).

[147] Veizaga v. National Bd. for Respiratory Therapy, 1979-1 Trade Cas. (CCH) ¶ 62,496 (N.D. Ill. 1979). Proof of such a conspiracy from conscious parallelism would of course be difficult, since each hospital is likely to have sound business reasons for requiring credentials. *Cf.* Interstate Circuit v. United States, 306 U.S. 208 (1939).

might be permissible if the certification standard—that is, the examination—was not unreasonable.[148] In other cases, courts have rejected—though not always as quickly as they might have—the thoroughly spurious argument that the defendant's certification scheme caused consumers to "boycott" the plaintiff or his product.[149] Courts should always clearly maintain the distinction, so fundamental in antitrust law, between a true boycott and parallel responses to information by independent decision makers in a free market.[150] Probably the best way to maintain this distinction would be to treat the traditional antitrust rule on boycotts as inapplicable, even by analogy, to actions of a single entity.

In appraising the actions of a single competitor-controlled joint venture to see whether competition has been restrained, reference should be had not to the law of boycotts but to the body of case law that deals with the use of legitimate joint ventures to disadvantage nonparticipants unfairly. In this series of cases, the most notable of which is *Associated Press v. United States,*[151] the courts have sought to minimize anticompetitive risks without losing the procompetitive benefits of concerted action by ordering competitor groups to offer membership or access to essential facilities or resources on reasonable terms to competitors who would be seriously disadvantaged by exclusion.[152] It would seem to be a natural extension of these "essential facilities" cases to insist that credentialing, accrediting, and standard-setting bodies adopt fair procedures and rational requirements. On the other hand, the operative legal presumptions, tests, and remedies should not jeopardize efficiency-enhancing activities.[153] The crucial issue,

[148] 1979-1 Trade Cas. (CCH) at ¶ 76,904. *Cf.* Veizaga v. National Bd. for Respiratory Therapy, 1977-1 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill. 1977), an earlier opinion where the court, writing before the Supreme Court's decision in *Professional Engineers,* reached the same conclusion by establishing a rule of reason analysis for all noncommercial activities undertaken by professional organizations.

[149] *E.g.,* Eliason Corp. v. National Sanitation Found., 614 F.2d 126, 129 (6th Cir.), *cert. denied,* 449 U.S. 826 (1980); Paralegal Institute, Inc. v. American Bar Ass'n, 475 F. Supp. 1123, 1128 (E.D.N.Y. 1979), *aff'd,* 622 F.2d 575 (2nd Cir. 1980).

[150] *See supra* notes 4 and 75 and accompanying text. If competitors circulate information and opinion as a way of facilitating *their own* parallel refusals to deal, a conspiracy to boycott can be inferred. *Compare* Eastern States Retail Lumber Dealers' Ass'n v. United States, 234 U.S. 600 (1914) *with* Cement Mfrs. Protective Ass'n v. United States, 268 U.S. 588, 604 (1925). *See also* Havighurst, *supra* note 124, at 345-46.

[151] 326 U.S. 1 (1945).

[152] *See id.*; United States v. Terminal R.R. Ass'n, 224 U.S. 383 (1912); Gamco, Inc. v. Providence Fruit & Produce Bldg., Inc., 194 F.2d 484 (1st Cir.), *cert. denied,* 344 U.S. 817 (1952). See also DEPARTMENT OF JUSTICE, ANTITRUST DIVISION, ANTITRUST GUIDE CONCERNING RESEARCH JOINT VENTURES (1980), which helpfully suggests separating three questions: the legality of (1) the joint venture itself, (2) its internal arrangements affecting competition among its sponsors, and (3) its affects on competition resulting from denying "essential facilities" to competitors. Questions in the last two categories require judicious application of the less-restrictive-alternative principle discussed critically *infra* in text accompanying notes 154-59.

[153] It is not unreasonable to impose such sharing requirements in cases where the available benefits seem attainable only by organizing on a scale so large as to preclude the existence

next discussed, is simply how deeply the courts should probe in evaluating the specific standards and procedures used in credentialing or similar efforts.

c. The Scope of Judicial Scrutiny

The Bureau of Consumer Protection of the Federal Trade Commission (FTC), in a recent report on industrial product standards and certification, concluded that each collectively determined standard should be closely scrutinized under the antitrust rule of reason to determine its reasonableness.[154] Such scrutiny would apparently penalize, perhaps with treble damages, any standard that turns out, on close examination, to have a "less restrictive alternative," to lack an objective basis, or not to have a net "procompetitive" effect.[155] The FTC staff's legal conclusion rests upon its view that each standard is a "restraint of trade" to the extent that it is relied upon by independent decision makers.[156] This characterization seems improper, as does the implication from it that credentialing and similar standards should be subject to close judicial or regulatory scrutiny.

However influential a particular standard may be, it cannot be a "restraint of trade" in any technical sense. Although it may disadvantage competitors, that disadvantage occurs in the marketplace and is not a result of any short-circuiting of competition.[157] In the marketplace, independent decision makers decide for themselves what weight to give to the technical advice provided by the standard-setting body, and injured competitors can fight back by supplying contrary evidence and opinion. In short, though standard setting may be unfair and deceptive, it is not inherently restrictive of the competitive process and should not be subject to the kind of negative presumption that the FTC staff's analysis implies. Instead, a competitor-sponsored credentialing, accrediting, or standard-setting program should be viewed as a joint venture to produce a new and highly procompetitive

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of competing joint ventures. On the other hand, care should be taken not to invoke the "essential facilities" doctrine in situations where the initial enterprise involved significant risk taking or innovative skill; otherwise, a rule opening access would benefit and encourage free riders. Because credentialing and similar activities involve little risk taking and give rise to few free-rider problems, the analogy seems a sound one. *But see supra* note 111 and accompanying text. The "essential facilities" cases seem to reflect the kind of limited scrutiny that is suggested herein. *See* Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies,* 1983 WIS. L. REV. 1, 69 n.359.

[154] FTC STAFF REPORT *supra* note 6, at 242-88.

[155] *Id.* at 252-61.

[156] *Id.* at 247-48. *See supra* note 74.

[157] Case law recognizes that independent parallel conduct in response to information does not constitute a restraint of trade. *See* Cement Mfrs. Protective Ass'n v. United States, 268 U.S. 588 (1925); Maple Flooring Mfrs. Ass'n v. United States, 268 U.S. 563 (1925); McCann v. New York Stock Exch., 107 F.2d 908 (2nd Cir. 1939).

product—namely, information, opinion, and advice concerning the quality, safety characteristics, or other features of individuals, institutions, or products. Contrary to the view of the FTC staff, antitrust law provides no basis for scrutinizing the quality of the products of a procompetitive joint venture with the same strictness that is used in appraising agreements by which competitors eliminate competition among themselves.

The FTC staff, by requiring standard setters to adopt a "less restrictive alternative" to achieve their desirable purposes, would apparently make it illegal for a competitor-sponsored credentialing program to maintain any standard that could be improved upon in some way so as to reduce its unfairness to competitors or to increase the procompetitive value of the information conveyed. However, "the key difficulty in examining less restrictive alternatives lies in deciding how refined a distinction to make among the possible alternatives available to the defendants."[158] Although credentialing, accreditation, and industrial standard setting offer innumerable temptations for courts and enforcement agencies to second-guess the procedures and standards employed, basic antitrust policy favors reliance on market forces rather than regulatory oversight to guide economic activity. Fortunately, antitrust courts have generally resisted the temptation to become deeply involved in supervising administrative procedures and evaluating substantive requirements. As in the common-law cases, they have not intruded very far into these essentially private activities, confining themselves to identifying and rectifying undeniable abuses.[159]

Antitrust scrutiny of the administrative procedures followed by competitor-sponsored bodies engaged in dispensing valuable rights and privileges is usually thought to be mandated by the Supreme Court's decision in *Silver v. New York Stock Exchange.*[160] In that case, the stock exchange had ordered its members to terminate wire connections with the plaintiff, apparently because of shady dealings. Although the members' concerted refusals to deal constituted a technical boycott, the Court found a warrant in the Securities Exchange Act for the employment of this coercive and otherwise unlawful (per se) sanction. Noting the danger that these self-regulatory powers might be used to suppress competition, however, the Court insisted that the exchange employ procedures that would reveal whether good grounds existed for any actions taken. The Court then

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[158] P. AREEDA, THE RULE OF REASON IN ANTITRUST ANALYSIS: GENERAL ISSUES 9 (Federal Judicial Center 1981).

[159] "[T]hose objecting to a restraint can frequently imagine a less restrictive alternative. An alternative formula is perhaps clearer in calling only for rather gross comparisons between the course chosen by the parties and the other courses of action that might have been chosen. Some courts ask only that the challenged restraint be reasonably necessary to achieve a legitimate objective." *Id.* at 10. Such a test was applied, though perhaps too rigorously, in United States v. Realty Multi-List, Inc., 629 F.2d 1351 (5th Cir. 1981).

[160] 373 U.S. 341 (1962).

employed the least-restrictive-alternative principle to reconcile the conflicting statutory policies, and awarded the plaintiff damages based on the stock exchange's failure to give him adequate notice and a chance to contest the allegations against him.

Since the *Silver* case, it has been widely assumed, without careful analysis, that the antitrust laws require fair procedures in any case where some competitors are in a position to withhold valuable privileges from others.[161] It is not clear, however, that this assumption is sound in cases where the collective action to be justified would not normally be, as it was in *Silver,* a per se violation.[162] Indeed, procedural failings can never be an antitrust violation in themselves because they cannot alone, in the absence of substantive abuse, cause harm to competition. Nevertheless, although the antitrust laws do not directly require procedural fairness, procedures are certainly relevant in a total evaluation of a competitor-sponsored credentialing or similar program under the rule of reason to determine whether it affects competition adversely. Because poor procedures obscure the program's operation, they may signify an intent to harm competitors by improper means and may be held to increase the probability of actual harm. But in the absence of a per se violation, the mere availability of a fairer procedure should not condemn a joint venture whose overall effect is procompetitive. The law does not insist upon perfection but requires only that trade not be restrained.

In the *Silver* case, the Supreme Court warned against employing the

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[161] For suggestions of the contrary view that procedural defects alone violate the law, *see, e.g.,* McCreery Angus Farms v. American Angus Ass'n, 379 F. Supp. 1008 (S.D. Ill. 1974) (indefinite suspension of plaintiff from defendant association for alleged violation of blood typing bylaw preliminarily enjoined, apparently because of procedural inadequacies alone, although court alludes, perhaps incorrectly, to group boycott by defendant); FTC STAFF REPORT, *supra* note 6, at 262-70; Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom,* 70 CALIF. L. REV. 595, 648-50 (1982) (arguing, as do many others, that a hospital awarding staff privileges is bound under the antitrust laws to provide fair procedures).

[162] Unless conduct amounting to a per se violation appears, public injury—that is, actual harm to competition—must be proved, *see supra* text accompanying notes 120-22, and obviously cannot be established by showing only that procedures were unfair. On the other hand, where a true boycott exists but is arguably not a per se violation because ancillary to an overriding procompetitive purpose, a *Silver*-type procedure requirement would seem appropriate. *See* 373 U.S. at 348-49 (suggesting that action otherwise illegal can be justified by statute "or otherwise"); Denver Rockets v. All-Pro Management., 325 F. Supp. 1049, 1064-65 (C.D. Col. 1971). Thus, a sports league (such as was involved in *Denver Rockets*) that blacklists (boycotts) a player for gambling in order to preserve the league's appearance of integrity would be liable for failing to provide fair procedures even if it could prove that the player was a true disgrace and not just a convenient scapegoat sacrificed for the good of the game. Because denial of certification could never be a naked restraint justifying a presumption of competitive harm, however, it is unlikely (despite suggestive general language in *Silver,* 373 U.S. at 365-66 n.18) that a disappointed but clearly unqualified applicant would be allowed treble damages (as was the plaintiff in *Silver*) simply because of inadequate procedures.

less-restrictive-alternative test with undue rigor. Noting the risk that the self-regulatory zeal of the stock exchange might be diminished by the threat of antitrust liability, the Court said that "under the aegis of the rule of reason, traditional antitrust concepts are flexible enough to permit the Exchange sufficient breathing space within which to carry out . . . [its] mandate."[163] Though rejecting the dissenting justices' view that good faith alone should be an antitrust defense, the Court nevertheless indicated that the stock exchange should not be found guilty of an antitrust violation every time some minor procedural defect appeared. A fortiori, courts in credentialing cases, where the challenged conduct falls well outside the per se categories, should not risk chilling the production of procompetitive information and opinion by imposing unreasonable procedural requirements.

Procedural failings appear to have been the underlying problem in the Supreme Court's recent decision in *American Society of Mechanical Engineers v. Hydrolevel Corp.*[164] In that case, appellant ASME, a standard-setting body, was held liable for treble damages because an unofficial interpretation of its standards unfairly damaged the reputation of the plaintiff's product. Though not itself competitor-controlled, ASME had permitted employees of the plaintiff's competitor, acting as ASME's agents, to issue the offending ruling without notice to plaintiff and without a review that might have detected the deception. The dissenting justices asserted that the majority had created a rule of "strict liability" for harm done by nonprofit certifying bodies,[165] but the holding that ASME was liable under agency principles for the antitrust violations of those abusing their apparent authority says nothing at all about the legal test that the court would employ in assessing the underlying conduct. It does not follow from the imposition of vicarious liability for the egregious conduct in the *ASME* case that the Court would undertake more than limited scrutiny of the procedures employed in credentialing and accreditation, or would insist on more than reasonable precautions against anticompetitive manipulation of standards. As noted, examination of procedures must occur as part of an overall appraisal of a program's effects on competition and not be undertaken in a regulatory spirit that makes the best the enemy of the good.

The *Silver* case also touched upon the test for evaluating substantive rules (as opposed to procedures) maintained by private credentialing bodies. In noting that there was "no need for us to define further whether the interposing of a substantive justification . . . is to be governed by a

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[163] 373 U.S. at 360. This notion of "breathing space" in antitrust cases, occasioned by a reluctance to impose treble damages, suggests that room exists for granting prospective relief under common-law principles in certain cases where antitrust liability is denied. *See supra* note 120 and accompanying text.

[164] 456 U.S. 556 (1982).

[165] *Id.* at 579 (Powell, J., dissenting).

standard of arbitrariness, good faith, reasonableness, or some other measure,"[166] the Court implied that neither a hostile presumption nor the closer forms of scrutiny would be appropriate. In keeping with this suggestion, it can be argued that because competitor-sponsored credentialing programs have potential procompetitive value, they should not be discouraged by too close scrutiny under the antitrust laws. The case law indicates that the courts have in fact not been rigorous in scrutinizing such programs.

In *Structural Laminates, Inc. v. Douglas Fir Plywood Association,*[167] a certifying body, whose members were competitors of the plaintiff, failed to update its design standards to accommodate the plaintiff's equally reliable but differently made and less expensive plywood. By the time the standards were altered to recognize the plaintiff's innovation, the plaintiff had already gone out of business. Recovery under the antitrust laws was denied, however, because the plaintiff had failed to prove that the standard was unreasonable or prompted by an anticompetitive purpose. This disturbing result—condoning the use of product certification to destroy the producer of a better product—could have been prevented by insightful limited scrutiny of the standards program under the rule of reason. First of all, the defendant's procedures were seriously defective, as shown by the long delay (six years) in altering the standard.[168] In addition, because the plywood standard was based solely on design—requiring five plies and rejecting the plaintiff's three-ply variety—rather than performance, its validity was open to question on substantive grounds.[169] Situations such as this, where an industry group possesses life-and-death power over a competitor's product, certainly invite close scrutiny of procedures and standards or a shifting of the burden of proof on the reasonableness thereof.[170] The regrettable result in *Structural Laminates* could have been avoided, however, without a strict standard of review and without departing from the presumption favoring the private production and dissemination of quality-related information.[171]

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[166] 373 U.S. at 365-66.

[167] 261 F. Supp. 154 (D. Or. 1966), *aff'd per curiam,* 399 F.2d 155 (9th Cir. 1968), *cert. denied,* 393 U.S. 1024 (1969).

[168] The FTC staff has proposed a trade regulation rule intended to speed up consideration of complaints about standards. FTC STAFF REPORT, *supra* note 6, at 339-44. *See infra* text accompanying notes 192-94. For the argument that a delay in modifying a questioned design standard should not be considered probative of the standard's substantive deficiencies, lest standard-setters be deterred from making needed changes, *see infra* note 224.

[169] *See infra* text accompanying notes 201-02. *See also* CONGRESSIONAL SERVICE REPORT *supra* note 6, at 93 (quoting a Justice Department official to the effect that performance standards have less anticompetitive impact than design standards).

[170] *See* Note, *A Suggested Role for Rebuttable Presumptions in Antitrust Restraint of Trade Litigation,* 1972 DUKE L.J. 595.

[171] *See infra* note 224.

No reported antitrust case has finally invalidated a substantive membership, certification, or similar standard, although several challenges have survived motions to dismiss.[172] In one case,[173] an association of speech pathologists made membership and dues payment a prerequisite to continued certification. The court of appeals, in holding that an applicant for certification possessed standing to attack the requirement, refused to treat the linking of association membership and certification as an unlawful (per se) tying arrangement. Nevertheless, it left open the possiblity that the required dues, which exceeded the cost of the certification and were obviously unrelated to the plaintiff's competence, would be proved unlawful.[174] Judicial insistence that the prerequisites for membership or certification include only criteria rationally related to the procompetitive purposes of the joint venture would seem warranted in every case. Such a rule would permit a court to enhance the informational value of credentials without intruding into areas where technical judgment is required and opinions differ.[175]

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[172] It has been suggested that antitrust law has some role in insuring the validity of credentialing examinations, *see* Weisfeld & Falk, *Professional Credentials Required,* 57 HOSP. no. 3, 74 (Feb. 1, 1983), but no court has so held. *See* Veizaga v. National Bd. for Respiratory Therapy, 1977-1 Trade Cas. (CCH) ¶ 61,274, and 1979-1 Trade Cas. (CCH) ¶ 62,496. In Ronwin v. State Bar of Arizona, 686 F.2d 692 (9th Cir. 1981), *cert. granted,* 51 U.S.L.W. 3825 (U.S. May 16, 1983) (No. 82-1474), the court upheld the plaintiff's complaint and thus permitted him to attempt to prove his claim that the passing rate on bar examinations was determined not on the basis of merit but according to the number of new attorneys the integrated state bar chose to admit to practice each year. A credentialing standard lacking any relation to competence would fail under limited scrutiny. In this case, however, there is a serious question, which the Supreme Court will decide, whether the integrated bar, as a state agency, is subject to antitrust attack or exempt under the state action defense.

A number of cases involving athletics have considered league rules governing the integrity and behavior of players and the acceptability of athletic equipment. Such cases differ from credentialing and similar activities because the organizations involved are not concerned with publishing information but with operating a sports league (a joint venture producing a distinctive product) or setting uniform rules for athletic competition. *See* Weistart, *Player Discipline in Professional Sports: The Antitrust Issues,* 18 WM. & MARY L. REV. 703, 708-09 (1977).

[173] Bogus v. American Speech & Hearing Ass'n, 582 F.2d 277 (3d Cir. 1978).

[174] Although membership dues were modest, they were apparently more than was needed to finance the certification program. Indeed, it seems likely that the association was using the lure of certification to overcome the "free rider" problem that all professional associations face—that is, the tendency of some professionals not to contribute to the support of joint activities from which all benefit. *See* M. OLSON, *supra* note 135. Although an organization's efforts to surmount this market failure might seem justifiable, it would not necessarily be wise to foster the success of dominant professional organizations, among whose major activities is the manipulation of political processes in which the opposing consumer interests are usually badly fragmented and poorly represented. *See* M. OLSON, THE RISE AND DECLINE OF NATIONS: ECONOMIC GROWTH, STAGFLATION AND SOCIAL RIGIDITIES (1982); Stigler, *The Theory of Economic Regulation,* 2 BELL J. OF ECON. & MGT. SCI. 3 (1971).

[175] The federal enforcement agencies apparently advocate a more intrusive policy than is advocated here. The approach employed by the FTC staff in its recent study of industrial standards is criticized in detail *infra* note 224. As noted in 45 ANTITRUST & TRADE REG. REP. (BNA) 277 (Aug. 18, 1983), the Department of Justice has filed a brief as amicus curiae

Current litigation involving the Joint Commission on Accreditation of Hospitals provides an opportunity to test the legal principles emerging in this discussion. The plaintiff, the State of Ohio, claims that certain JCAH accrediting standards require hospitals to limit the admitting privileges of clinical psychologists in such a way as to preclude the psychologists from practicing their profession to the full extent of their state-conferred licenses.[176] The plaintiff further alleges that the accreditation standards in question reflect the domination of the JCAH by physicians interested in protecting their prerogatives within hospitals against incursions by nonphysician health care professionals. Under the antitrust principles appearing in credentialing and accrediting cases to date, the state's case seems weak because the requirement that physicians control the care administered to patients admitted by nonphysician practitioners is arguably related to the overall quality of care provided by a hospital. An asserted analogy to an earlier case prohibiting physician-controlled Blue Shield plans from discriminating against clinical psychologists in their reimbursement policies is unconvincing; that case involved much more than the publication by an accrediting organization of authoritative opinions on how health services are best provided.[177] Under limited scrutiny, a physician-controlled accrediting body would not be barred, without more, from adopting standards favorable to physicians as a class. Viewed strictly as an attack on an accrediting standard, Ohio's challenge to the JCAH should therefore fail.[178]

The ultimate question of antitrust policy raised in credentialing, accrediting, and similar cases is one that has frequently appeared in the administration of the antitrust laws—namely, whether courts should undertake to govern the specific conduct of powerful business entities or should instead concentrate on maintaining a competitive market structure to ensure good overall market performance. Recent trends suggest that, as

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questioning a district court's refusal to resolve what it regarded as "a philosophical difference of opinion as to what the professional practice of . . . periodontology should entail." Kreuzer v. American Academy of Periodontology, 558 F. Supp. 683, 686 (D.D.C. 1983). The court's acceptance of the Academy's membership requirement of full-time practice in the specialty would easily pass the test suggested herein but was criticized by the Department on the ground that the requirement hampers competition by specialists who choose not to limit their practice and discourages innovation in specialization. It appears, however, that the rigidities that concern the Department do not result so much from the challenged membership requirement as from ethical rules and specialty definitions of the American Dental Association (ADA). *See* the court's earlier opinion in *Kreuzer*, 516 F. Supp. 1034, 1038 (D.D.C. 1981). Practices such as the ADA's may be subject to antitrust challenge under principles developed in Part Two, SECTIONS V.B.2 and VI.D.

[176] Ohio v. Joint Comm'n on Accreditation of Hosps., Civ. Act. No. C-2-79-1158 (S.D. Ohio, filed Dec. 14, 1979).

[177] Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476 (E.D. Va. 1979).

[178] As discussion in Part Two, Sections VI.E. and VII.B. shows, however, the state could improve its prospects for relief by adopting a somewhat different legal theory.

a general proposition, antitrust law is less widely viewed as a vehicle for regulating the fairness with which individual firms conduct their business or for strictly policing the conduct of legitimate joint ventures.[179] Partly because legitimate enterprises should be freed from the threat of burdensome antitrust suits, antitrust courts should eschew close policing of credentialing, accrediting, and similar bodies and should permit them to adopt any procedure or standard that is neither dishonestly conceived nor obviously inappropriate to carrying out the procompetitive purpose of informing consumers and others about relevant matters. As Part Two of this Article shows, this counsel of judicial restraint leaves room for significant antitrust initiatives aimed at correcting structural defects in the market for information. These initiatives should materially aid the competitive cause of those in the health care field who are adversely affected by particular credentialing and accrediting standards and decisions.

C. Possible Regulatory Interventions

Many of the problems associated with private credentialing of health care personnel might be addressed by regulatory means rather than through the courts. The statutory authority of the FTC to prohibit "unfair methods of competition . . . and unfair and deceptive acts or practices"[180] provides a clear substantive basis for Commission scrutiny of credentialing activities. In recent years, the Commission has been active in the area of professional services, and it is equipped with enough staff expertise to approach health credentialing issues with confidence. It recently sponsored an independent study of issues in this area based on materials already in its files.[181] In addition to its expertise in enforcing the antitrust laws in professional fields, the FTC has long experience in policing "deceptive acts or practices," including deceptive advertising.[182] Moreover, the Bureau of Consumer Protection has extensively investigated the setting of product standards and seal-of-approval programs in industrial settings.[183] Because credentialing is potentially as deceptive as advertising and is more dangerous because it is a collective rather than an individual undertaking, a strong argument can be made for FTC action.

Still, certain barriers may preclude significant FTC involvement in the area. First, the Commission's jurisdiction extends to nonprofit entities only

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[179] *See supra* note 128 and *infra* note 209.

[180] Federal Trade Commission Act, § 5, 15 U.S.C. § 45 (1976 & Supp. V 1981).

[181] Lewin Report, *supra* note 35.

[182] 15 U.S.C. § 57a (a)(1)(B) (1976 & Supp. V 1981). *See generally* R. Posner, *supra* note 67, at 17-29.

[183] *See* FTC Staff Report *supra* note 6; FTC, Proposed Rule and Staff Report, Standards and Certification (1978).

if they are operated "for the profit of their members."[184] Although trade associations, including professional associations, fall within the FTC's powers, professional credentialing bodies might be found to be outside its purview.[185] In addition, the Commission's initiative in the area of industrial standard setting and product certification was sharply curtailed in 1980, when Congress barred the Commission from using its consumer-protection authority to issue rules, such as it had proposed in 1978, to govern such activities.[186] Finally, Congress has recently been under intense pressure from professional interests to withdraw all Commission jurisdiction over the activities of state-regulated professions. Although the FTC has retained its jurisdiction[187] and any new limitations on it are expected to affect its consumer-protection rather than its antitrust powers,[188] the Commission is likely to face further political difficulties if it challenges what are perceived to be vital quality-assurance mechanisms in markets for professional services.

Although the FTC once challenged a correspondence school that claimed to be accredited by an impressively named body of its own creation and has challenged other standardless seal-of-approval programs,[189] it has

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[184] 15 U.S.C. §§ 44, 45(a)(2) (1976 & Supp. V 1981); Community Blood Bank, Inc. v. FTC, 405 F.2d 1011, 1020-22 (8th Cir. 1969).

[185] The AMA was recently held subject to FTC jurisdiction because it offers financial and business planning services to members and lobbies for legislation it believes would profit them. AMA v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam by an equally divided court,* 455 U.S. 676 (1982). Although competitor-sponsored credentialing bodies undertake no comparable activities, the undisputable financial advantage that certification confers on their members may be sufficient to establish jurisdiction. *See* FTC STAFF REPORT *supra* note 6, at 328-31. Certifiers and accreditors of individuals and institutions at a different level of the market might be somewhat harder to reach.

[186] Section 7 of the Federal Trade Commission Improvements Act of 1980, Pub. L. 96-252, 94 Stat. 374 (1980), limited the Commission's power to make consumer-protection rules under 15 U.S.C. § 57a(a)(1)(B) (1976 & Supp. V 1981), by prohibiting rules "with respect to the regulation of the development and utilization of the standards and certification activities." This change was designed to prevent issuance of a rule governing standard setting and certification that the FTC had proposed in 1978 (43 Fed. Reg. 57,269, Dec. 7, 1978). *See* FTC PROPOSED RULE AND STAFF REPORT, *supra* note 183.

[187] Proposed legislation limiting the FTC's jurisdiction over the professions was defeated in the Senate in 1982. 128 CONG. REC. S15069-80 (daily ed. Dec. 16, 1982); *Despite AMA Effort, Authority of FTC Remains Unclear,* AM. MED. NEWS, Jan. 7, 1983, at 1. This setback for the AMA-led campaign for an exemption was widely regarded as decisive, and subsequent proposals were much narrower in scope.

[188] Compromise legislation reported in 1983, H.R. 2790, 98th Cong., 1st Sess. (1983), would affect only the Commission's consumer-protection authority under 15 U.S.C. §§ 45 and 57(a) (1976 & Supp. V 1981) to police unfair or deceptive acts or practices, not its antitrust power to proscribe unfair methods of competition under 15 U.S.C. § 46(g) (1981). *See* H.R. REP. No. 156, 98th Cong., 1st Sess. 3 (1983).

[189] *In re* Ohio Christian College, 80 FTC 815 (1972). *See also, e.g., In re* Hearst Magazines, 32 FTC 1440 (1941); National Ass'n of Scuba Diving Schools, FTC Dkt. No. C-3094, TRADE REG. REP. (CCH) ¶ 21,921 (May 18, 1982) (consent order). In addition, numerous consent orders deal with misrepresentations of the accreditation of eduational programs. *E.g., In re* Angel Orestes Rigoli, 76 F.T.C. 587 (1969).

never officially attacked the standards actually maintained or the procedures followed by credentialing or similar bodies.[190] A recent staff report,[191] however, summarizes a substantial number of case studies of industrial standards, concluding that, in most cases, serious questions had been raised concerning the fairness of the procedures followed and the substantive validity of the actions taken. On the basis of this report, the staff—this time invoking the agency's antitrust powers[192]—proposed a new set of regulations to govern industrial standard setting.

Unlike the sweeping rules proposed in 1978, the FTC staff's new proposal on industrial standards would govern only the procedures employed by standard-setting bodies, requiring in particular that complaints about the validity of standards be received and handled expeditiously, with written reasons provided whenever the cause of the complaint was not rectified. The staff visualized that these requirements would induce significant changes in standard-setting practices and would improve the prospect that either the FTC or an injured competitor would be able to obtain antitrust relief in situations where the inadequacy of a standard became clear as a result of the increased disclosure. Thus, the staff's proposed regulations, though far from being adopted, indicate a possible line of attack on the problem. Although the Commission might not be technically correct in treating inadequate complaint procedures as an "unfair method of competition,"[193] the idea of specifying essential procedures through regulation, and thereby eliminating the uncertainty associated with case-

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[190] The Commission has issued several advisory opinions giving general guidelines to product standards and certification programs. *See, e.g.*, 16 C.F.R. §§ 15.96, 15.152, 15.457 (1983). It addressed the matter in greater detail in its 1978 PROPOSED RULE AND STAFF REPORT, *supra* note 183. The only case in which the Commission intervened to overturn a specific standard was *In re* Soc'y of the Plastics Indus., 84 F.T.C. 1253 (1974) (consent order), where it charged that a laboratory flammability test and standard were insufficiently related to flammability in actual use conditions and therefore unsafe. Although the Commission's primary focus was on the consumer product safety implications of the standard, the complaint also charged that the standard was misleading because consumers were likely to assume that the ratings related to safety in ordinary use.

[191] FTC STAFF REPORT, *supra* note 6.

[192] Because § 7 of the Federal Trade Commission Improvements Act of 1980 curtailed only the FTC's authority under § 18 to promulgate rules on standards, *see supra* note 186, the staff proceeded under § 6(g) of the FTC Act, which the legislative history indicated was not affected and which gives the Commission rulemaking authority over unfair methods of competition. *See* FTC STAFF REPORT, *supra* note 6, at 8, 302-06.

[193] The FTC staff relies on the *Silver* case for its conclusion that the Commission can by a trade regulation rule declare that failure to adhere to specified procedures constitutes an antitrust violation. FTC STAFF REPORT, *supra* note 6, at 262-70. Earlier discussion has suggested, however, that *Silver* does not support the conclusion that procedural defects in credentialing programs are illegal in themselves. *See supra* note 162 and accompanying text. On the other hand, the Commission's power to declare a practice an "unfair method of competition" even though it would not be a Sherman Act violation might be used to advantage here. *See, e.g.*, FTC v. Sperry and Hutchinson Co., 405 U.S. 233 (1972); FTC v. Brown Shoe Co., 384 U.S. 316 (1966); FTC v. Motion Picture Advertising Serv. Co., 344 U.S. 392 (1953).

by-case adjudication, is attractive. Obviously, any approach adopted by the FTC with respect to industrial standards would be a candidate for carryover into the analogous field of personnel credentialing.[194]

So far, the FTC has taken few actions with respect to credentialing and accrediting in the health care field. In 1977, the FTC staff opposed, with limited success, the U.S. Commissioner of Education's recognition of the Liaison Committee on Medical Education (LCME) as an accreditor of medical schools; the issue raised was the AMA's heavy involvement in the LCME and the possibility that this involvement enabled the medical profession to exercise undue influence over the number of physicians being trained.[195] The Commission also considered issuing a complaint in 1978 against the American Society of Plastic and Reconstructive Surgeons.[196] The staff believed that the Society knowingly made and encouraged deceptive representations concerning the significance of certification by the American Board of Plastic Surgery. Evidence suggested that, contrary to the representations made, board-certified otolaryngologists were as well qualified as plastic surgeons to perform certain facial plastic surgery. The decision not to pursue this case appeared to reflect a judgment that differences of opinion concerning certification's value should be resolved in the marketplace, not in an antitrust court or regulatory tribunal.

The FTC had considered challenging the plastic surgeons' misrepresentations not only as an antitrust offense but also as "deceptive acts or practices." Under such a consumer-protection theory, the Commission might police credentialing practices prospectively without employing antitrust theories that chill the credentialers' efforts to differentiate among competitors by exposing them to treble damage liability. Such oversight might be pressed too far, however. Indeed, the Commission's current reform-minded leadership, viewing the agency's past use of its consumer-protection powers in the analogous field of deceptive advertising as overly protective, has proposed narrower tests for deception. Under the new formulation, deceptive practices would be only those likely to cause actual harm to consumers who, despite acting reasonably in the circumstances, are misled to their detriment.[197] Although examination of credentialing

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[194] If the pending legislation described *supra* note 188 is enacted, the Commission will presumably rely solely upon its antitrust powers in the personnel credentialing area as well.

[195] *See* Letter from Daniel C. Schwartz, Acting Director, Bureau of Competition, FTC, to Edward Aguirre, U.S. Commissioner of Education, Nov. 11, 1976: Statement of Daniel C. Schwartz before the Advisory Committee on Accreditation and Institutional Eligibility, U.S. Office of Education, March 24, 1977.

[196] *See* Randall, *The FTC and the Plastic Surgeons,* 299 NEW ENG. J. MED. 1464 (1978).

[197] Statement of James C. Miller, III, Chairman, FTC, before the Committee on Commerce, Science and Transportation, United States Senate, March 18, 1982. *See also* FTC, Advertising Substantiation Program, 48 Fed. Reg. 10,471 (March 11, 1983) (request for comments on standards for judging whether advertisers have a reasonable basis for their objective claims).

programs according to this test would raise difficult technical issues such as courts have carefully avoided, the FTC's statutory responsibility for protecting consumers and its ability to garner the needed expertise provide a basis for its going further than the courts have gone in providing guarantees against deception. At the same time, its statutory mandate as narrowed by the proposed redefinition of "deceptive acts or practices" should ensure that the Commission would not overly interfere in the market for information. Despite these arguments supporting substantive scrutiny by the FTC of private credentialing activities, significant jurisdictional barriers, as well as serious legal and policy objections to governmental interference with the private production of information, would still have to be confronted.

Another way in which government might seek to enhance the net value of a private credentialing scheme would be to establish a program comparable to that maintained by the Department of Education for officially recognizing certain educational accrediting agencies.[198] Although the government might formally accredit or otherwise control the certifying bodies themselves, it might instead wish to concentrate, as the Department of Education has done, on accrediting accreditors. By thus focusing on a higher tier in the multi-layered certification-accreditation process, government would remove itself from direct intervention at the level where the most critical information is generated. Nevertheless, the questions remain the same: What level of scrutiny is appropriate? Should the goal be to police only clear deception or to ensure the objective validity of all claims made or implied? Are overlapping credentialing schemes to be encouraged or discouraged?[199] The arguments for limited governmental scrutiny are equally strong in the accreditation of both educational institutions and bodies otherwise engaged in certifying individual attributes and attainments.

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[198] *See supra* note 14. The Department of Commerce has a similar program for recognizing voluntary bodies engaged in setting industrial standards. *See* Final Issuance of OMB Circular No. A-119: Federal Participation in the Development and Use of Voluntary Standards, 45 Fed. Reg. 4,326 (1980); Federal Interaction with Voluntary Standards Bodies, Procedures, 15 C.F.R. 19 (1983).

[199] According to Finkin, *supra* note 14, at 400-02, 405, the Department of Education has, since 1969, followed a policy, subject to exceptions, of recognizing only one accreditor in each field. Officials, including former Commissioner Ernest Boyer, testified to the contrary in Sherman College of Straight Chiropractic v. United States Comm'r of Educ., 493 F. Supp. 976, 977, 980 (D.D.C. 1980) (discussed *infra* note 205), where the court referred to five instances of dual recognition as of 1979. In fact, only four fields—business education, medical assistant training, medical laboratory technician training, and physical therapy programs—had overlapping accreditors. *See* Office of Education, Nationally Recognized Accrediting Agencies and Associations, 44 Fed. Reg. 4,017 (Jan. 19, 1979). Because the regulations require nationwide acceptance of an accrediting body and its standards, 34 C.F.R. § 603.6 (1981), it may be difficult in practice for a small, philosophically distinct accreditor to gain the requisite acceptance, regardless of whether a policy against recognizing multiple accreditors in fact exists.

D. Reasons for Limiting Scrutiny of Credentialing Standards

Although the courts have not fully specified their rationale for limiting their scrutiny of certification and accreditation practices, their nonintervention reflects both a recognition of the procompetitive value of information of the kind being generated and deference to the credentialers' expertise. Considerations such as these do indeed justify limiting judicial and regulatory oversight to ensuring minimal procedural fairness and the existence of some rational connection between credentialing standards and the claims that are made or implied in the credentials granted. The conclusion that only limited scrutiny is warranted can be reached without departing at all from competitive values and is not rooted in any notion that the law's insistence on competition should be relaxed in markets for professional services or where consumers face serious information problems. On the contrary, encouragement of competition among numerous sources of information appears to be the more promising strategy for obtaining good economic performance in information-poor markets. The discussion here sets forth some fundamental reasons for not directly or closely regulating credentialing activities. In so doing, it expands upon the argument that, because credentialing inevitably expresses opinion, ideology, and self-interest rather than purely objective conclusions, it is best subjected to scrutiny, not in judicial or administrative proceedings, but in the free marketplace of ideas. The considerations introduced here complement the view suggested earlier that an unconstrained market for health services would provide substantial, though inevitably imperfect, protections against deceptive credentialing.

1. The Elements of Opinion and Belief in Standards

Perhaps the most obvious reason for relying on the market to generate its own corrective information rather than upon judicial or regulatory policing of dominant information sources is the immense practical difficulty of correcting by regulatory means any but obvious defects in credentialing systems. A court undertaking to ensure the objective validity of private credentialing would quickly find itself embroiled in complex issues that would seldom yield clear answers even after detailed examination. Such a court would discover that what seem to be purely technical issues are usually nothing of the sort.[200] Indeed, it is surprising how soon one leaves the field of established scientific truth in standards and enters areas in which judgment, opinion, and conventional wisdom—all easily influenced by self-interest—predominate. An enlightened court might thus suspect that the consensus of experts that is embodied in credentialing

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[200] *See* Part Two, Section V.A.

standards reflects old dogma and unexamined assumptions rather than demonstrated fact. Yet it might still hesitate to substitute its own views, or those of some other expert, for those of the credentialing body, on the ground that such alternatives are no more likely to be technically sound or free from subjective bias. As long as credentialing yields only information and opinion and is not accompanied by sanctions unlawful in themselves, the courts' natural and understandable tendency will probably be to employ a presumption of reasonableness that can be overcome only by a clear showing of abuse.

Credentialing standards would undoubtedly prove most complex in professional fields, but industrial standards also defy easy assessment in many cases. For example, even though the relatively simple plywood design standard in the *Structural Laminates* case was arguably unrelated to performance, a closer examination of the standard might have run into difficulties of the kind that the courts would like to, and should, avoid.[201] Although it is generally believed that, in product certification, design standards are more restrictive of innovation than are performance standards, the former are substantially easier to apply, and may often be good proxies for performance. Moreover, procedures permitting their timely revision could offset their restrictiveness. Finally, performance standards may sometimes be objectively untrustworthy. For example, there may be no reliable performance standards for personnel credentialing because, unlike products whose prototypes can be tested, individuals are impossible to compare with predetermined norms. Certification examinations (which may be the closest thing to performance standards) are probably less reliable indicators of competence than are education and training requirements (which are equivalent to design standards).[202]

Obviously, the process of certifying professional personnel would present numerous vexing problems to courts seeking to ensure its objective validity. Because no program offers its certification examination to all who offer to pay the fee, each represents a mix of design and performance standards, whose proper balance could be endlessly debated. Minimum educational and training requirements, though sometimes supplemented by recognition of the equivalency of practical experience, are always vulnerable to challenge on fairness and cost-benefit grounds. Similarly, a court could theoretically scrutinize each question on a certification examination for its validity as an indicator of clinical competence. Finally, a less-restrictive-alternative inquiry into credentialing standards would eventually open to question the numerous assumptions that underlie the choice of particular standards and methods. Because these assumptions could never

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[201] *See supra* text accompanying note 169.
[202] *See supra* note 31.

be anything but problematic, empirical validation of a credentialing scheme against all alternatives is both a practical and a theoretical impossibility. Ultimately, certification standards and the resulting certifications themselves can be regarded only as expressions of opinion.[203] How well-founded an opinion is is of course likely to be itself a matter of opinion.

Problematic issues of the kinds just noted can be raised with particular force with respect to educational accreditation, the results of which are regularly incorporated by reference into personnel certification. The standards for accrediting educational programs focus almost exclusively on such design characteristics as course length, curriculum, faculty-student ratios, and facilities. Because of the elusiveness of quality in education and the uncertain links between education and clinical performance, debate over the validity of particular standards could be interminable. In the last analysis, most issues would have to be judged matters of "educational philosophy"—the term used by Judge Bazelon in the *Marjorie Webster* case to justify the court's noninterference with an accrediting body's refusal to certify proprietary schools.

If personnel credentialing bodies were perceived to express only technical opinions and philosophical beliefs and preferences, they would present few problems. Certification would then perform the function of trademarks, drawing vertical distinctions based on the auspices under which certified individuals received their training and credentials rather than purely horizontal distinctions based on measurable quality.[204] Competition could then exist among those whose different labels signified their origins in different traditions, leaving consumers to express their preferences among those alternatives in the marketplace. Judge Bazelon's opinion in the *Marjorie Webster* case suggested the possibilities for such ideological competition among credentialing systems:

> The core of . . . [the accrediting body's] argument is not that proprietary institutions are unworthy of accreditation, but rather that they, like many trade and professional schools, should properly be measured by standards different from those used by appel-

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[203] This view of certification has been thoughtfully developed by Professor Kissam. *See* Kissam, *supra* note 153, at 11 ("Most credentialing standards are thus based upon professional opinion about what constitutes good quality medicine, rather than upon objective data about the impact of these standards on health outcomes"); Kissam, *Applying Antitrust Law to Medical Credentialing*, 7 AM. J.L. & MED. 1, 19 (1981); *see also* Dolan, *The Law and the Maverick Health Practitioner*, 26 ST. LOUIS U.L.J. 627 (1981).

[204] Indeed, some certifiers already employ collective trademarks and certification marks (*see supra* note 10) in credentialing. For example, the National Commission on Certification of Physician's Assistants permits successful examinees to use the designations "Physician Assistant—Certified" and "PA—C," both of which are registered certification marks. *See* NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN'S ASSISTANTS, ANNOUNCEMENT OF THE PHYSICIAN ASSISTANT NATIONAL CERTIFYING EXAMINATION 9, 13 (1983).

> lant, and which appellant is possessed of no special competence or experience in using . . . . Appellee . . . is free to join with other proprietary institutions in setting up an association for the accreditation of institutions of such character; and such an association, if recognized, could obtain for its members all the benefits of accreditation by appellant save, perhaps, prestige.[205]

The choice between nonprofit and for-profit providers of a service is peculiarly suited for determination in the marketplace,[206] and competing accrediting systems would seem to facilitate informed choices.

Unfortunately, most credentialing systems obscure the ideological dimensions of the issues they appear to address. If pressed, most credentialers, like the accrediting association in *Marjorie Webster,* would probably deny that the distinctions they draw are necessarily invidious.[207] But the implication that credentials signify higher quality cannot be dissipated so easily. Indeed, because consumers cannot be expected to heed disclaimers that only vertical, trademark-like distinctions are intended, all credentialing schemes are probably deceptive in some degree. Nevertheless, it would still be a hopeless enterprise to try to set things right by judicial or regulatory intervention. The best policy solution available is to recognize explicitly that we have entered a marketplace of ideas, to cultivate ideological competition, and to fight monopolies or conspiracies that threaten to suppress alternative versions of the truth.

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[205] 432 F.2d at 658. *See supra* notes 101-07 and accompanying text. Similar considerations influenced the decision in Sherman College of Straight Chiropractic v. United States Comm'r of Educ., 493 F. Supp. 976 (D.D.C. 1980), which rejected the plaintiff's challenge to the Commissioner's recognition, under the program discussed *supra* notes 14 and 199 and accompanying text, of a chiropractic accrediting body that had refused to accredit plaintiff for philosophic reasons. The court explained: "Plaintiffs themselves emphasize their distinct view of the chiropractic profession. The proper channel for their efforts is to establish their own chiropractic accrediting agency and secure federal recognition for it." *Id.* at 980. Although the practical feasibility of attaining recognition for a competing accreditor may be doubtful, *see supra* note 199, the court appeared to regard such philosophic competition as desirable. For another expression of judicial reluctance to resolve an "intellectual dispute," see Kreuzer v. American Academy of Periodontology, 558 F. Supp. 683, 686 (D.D.C. 1983) (quoted and discussed *supra* note 175).

[206] Professor Henry Hansmann, in reconceptualizing the foundations of the law of nonprofit corporations, has argued that adoption of the nonprofit form should be viewed simply as a firm's way of reassuring its patrons that their money is being used to provide services and is not being distributed as profits to investors. *See* Hansmann, *Reforming Nonprofit Corporation Law,* 129 U. PA. L. REV. 497 (1981); Hansmann, *The Role of Nonprofit Enterprise,* 89 YALE L.J. 835 (1980). So understood as a competitive strategy, nonprofit firms should rise or fall in competition with for-profits on the basis of their respective ability to attract patronage and capital.

[207] *See supra* note 30 and accompanying text; *see also infra* text accompanying notes 226-27.

2. The Danger of Perpetuating Credentialing Monopolies

Another argument against close judicial or regulatory control of competitor-sponsored credentialing is the special status that a supervised scheme might enjoy precisely because of the oversight to which it is subject. Close judicial scrutiny of competitor-sponsored credentialing programs, even if prompted in the first instance by concern about the credentialers' power, would confirm the inevitability of monopoly in credentialing by suggesting that there is one right way to think about the innumerable issues involved in a credentialing decision. In light of this concern, one can see the error in the frequent assumption or suggestion, such as Judge Bazelon's in the *Marjorie Webster* case, that the degree of judicial scrutiny should increase in proportion to the de facto impact of the credential conferred.[208]

A rule such as that suggested by Judge Bazelon, under which certifiers' judgments would be accepted without much question unless they were decisive, would reflect an assumption that the conduct of a credentialing monopoly can be effectively policed. As we have seen, however, courts and regulators are incapable of eliminating all ideological and subjective factors and all vestiges of conflict of interests in credentialing. At some point, apparently reasonable judgments would have to be accepted and the credentialing system given a clean bill of health. The resulting judicial imprimatur would confirm the myth of objectivity in credentialing and strengthen the authority of the dominant scheme. Thus, oversight designed to correct defects in private credentialing could easily have the perverse effect of enhancing the status of already dominant information sources and of reducing the likelihood that alternative information sources would materialize.

A policy much better than closely scrutinizing dominant credentialing schemes would be to presume that they enjoy their predominant positions by virtue of their ability to satisfy the information needs of the public and that alternative credentialing systems will arise spontaneously if failings are detected.[209] Although these presumptions may seem naive, they have a better warrant than the presumptuousness of courts or regulators that seek through oversight to convert a dominant competitor-sponsored credentialing body into a regulatory agency serving the objectively defined interests of consumers. Moreover, faith in market forces is not misplaced if the

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

[209] Comparable presumptions underlie the law's tolerance for large firms, which are increasingly presumed to have earned their success and allowed to compete without special handicaps. *E.g.*, Berkey Photo, Inc., v. Eastman Kodak Co., 603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980); California Computer Prod., Inc., v. IBM, 613 F.2d 727 (9th Cir. 1979); Telex Corp. v. IBM, 510 F.2d 894 (10th Cir. 1973), *cert. denied*, 423 U.S. 802 (1975). *See* R. BORK, *supra* note 128, at 194; Sullivan, *Monopolization: Corporate Strategy, the IBM Cases, and the Transformation of the Law*, 60 TEX. L. REV. 587 (1982).

dominance of a single scheme results from problems elsewhere in the market that could be overcome by interventions of other kinds. It seems wiser to address these other problems directly than to confirm the monopolistic situation by embarking on a regulatory course. Recent progress in making the health care marketplace more competitive and cost-conscious has greatly improved prospects for the success of this strategy and undercut the assumptions underlying the regulatory impulse. Although it will not be easy to dissipate the deep-seated myth that credentialing professional personnel is a purely technical undertaking appropriately left to dominant professional organizations, the task would be aided if courts would be as explicit as was Judge Bazelon in recognizing that competition among credentialing schemes, rather than judicial oversight, is the consumer's best protection.[210]

3. The Law and the Marketplace of Ideas

The irreducible elements of opinion and ideology in credentialing decisions suggest that we are looking not only at a complex economic marketplace whose integrity is safeguarded by antitrust principles but also at a marketplace of ideas such as the first amendment to the Constitution seeks to preserve against governmental interference. Basing his judgment on a recognition of the ideological dimensions of credentialing, Professor Philip Kissam has explicitly invoked first amendment principles to limit antitrust attacks on information-generating credentialing efforts.[211] Although his concern about protecting credentialing from close scrutiny is well-founded, Professor Kissam's wholesale importation of vague first amendment doctrines into these controversies seems unnecessary.

The common-law and antitrust cases already reviewed reveal no judicial tendency to chill the exercise of constitutionally protected rights. Moreover, a sensitive reading of antitrust law suggests that it shares the first amendment's libertarian roots and needs no help from the Constitution to accommodate free speech concerns. On the contrary, the task of preserving free competitive markets includes concern for the flow of information and opinion. Although introducing constitutional issues into antitrust cases appears to sacrifice clarity, Professor Kissam's basic message may be no different from that here: Antitrust and common-law doctrine must be rigorous in recognizing the value of free expression and in maintaining conditions that are conducive to ideological competition.

[210] However, an individual who is treated unfairly by credentialers lacks the same opportunity that discriminated-against groups possess to establish an alternative credentialing system. According to the *Marjorie Webster* court, this fact provides a justification for common-law courts to scrutinize the procedures (as opposed to substantive standards) followed in credentialing. 432 F.2d at 658.

[211] *See* Kissam, *supra* note 153, at 38, 44-48; Kissam, *supra* note 203, at 18-22; *see also* LEWIN REPORT, *supra* note 35, at III—93-94.

The first amendment does not preclude antitrust enforcement wherever speech is a factor in the alleged offense. Instead, its requirements give way before clear and present dangers such as a conspiracy to boycott or to restrain trade in other ways.[212] Early attempts to invoke the antitrust laws to control the dissemination of information that threatened to impair rather than facilitate competition were rather easily resolved without violence to either legal tradition;[213] indeed, it was not even necessary in those cases to argue—as was done later in nonantitrust cases—that the first amendment has only limited application in the commercial arena. The only evidence that Professor Kissam finds of conflict between the two traditions is in some commentators' proposals to treat educational accreditation as boycott activity.[214] Although the reminder that values inherent in the first amendment are implicated here is well taken, sound antitrust analysis does not threaten those values.

For a time, "commercial" speech was deemed to be entirely outside the scope of first amendment protection, permitting government to control and even prohibit certain kinds of economically self-interested speech.[215] Recent rulings by the Supreme Court that commercial speech is, after all, entitled to some constitutional protection[216] prompt Professor Kissam to worry that antitrust law must be curbed to make way for this new constitutional right. The commercial speech doctrine, however, has not deprived government of its power to police deceptive advertising.[217] More importantly, each opinion in which the Supreme Court has invalidated regulation of commercial speech has emphasized the consumer's need for truthful commercial information, thus reflecting concerns identical to those underlying the antitrust laws.[218] The Court has also stressed that commercial transactions frequently embody more than purely economic values and may serve to vindicate personal freedoms similar to those protected by the

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[212] *See* Havighurst, *supra* note 126, at 355-60.

[213] American Column & Lumber Co. v. United States, 257 U.S. 377 (1921); United States v. American Linseed Oil Co., 262 U.S. 371 (1923). The prohibitions against anticompetitive dissemination of data have stood the test of time. United States v. Container Corp., 393 U.S. 333 (1969).

[214] Kissam, *supra* note 153, at 39 n.189 and Kissam, *supra* note 203, at 3 n.6.

[215] *See, e.g.*, Breard v. Alexandria, 341 U.S. 622 (1951); Valentine v. Chrestensen, 316 U.S. 52 (1942).

[216] *E.g.*, Bates v. State Bar of Arizona, 433 U.S. 350 (1977); Virginia State Bd. of Pharmacy v. Virginia Citizens' Consumer Council, 425 U.S. 748 (1976). *See generally* Note, *Constitutional Protection of Commercial Speech*, 82 COLUM. L. REV. 720 (1982).

[217] *See In re* RMJ, 455 U.S. 191, 199-200 (1982); Friedman v. Rogers, 440 U.S. 1, 11 n.9 (1979); Bates v. State Bar of Arizona, 433 U.S. 350, 383; Virginia State Bd. of Pharmacy v. Virginia Citizens' Consumer Council, 425 U.S. 748, 771-72 and n.24 (1976).

[218] *E.g.*, Bates v. State Bar of Arizona, 433 U.S. at 364; Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, 425 U.S. at 763-65. The emphasis on the rights of listeners in these cases was a logical extension of the analysis in Red Lion Broadcasting Co. v. FCC, 395 U.S. 367 (1969), discussed *infra* text accompanying notes 220-22.

first amendment.[219] The first amendment values thus recognized are directly comparable to and perhaps indistinguishable from the consumer interests frequently at stake in economic and ideological competition in markets for professional services.

A particularly striking case illustrating the legitimacy of government intervention to ensure competition in the marketplace of ideas is *Red Lion Broadcasting Co. v. FCC,*[220] which featured a direct conflict between the first amendment rights of a broadcaster and the first amendment rights of the public to a free flow of information.[221] Coming down on the side of the public, the Supreme Court noted the broadcaster's virtual monopoly of the provision of information and opinion. At issue was the so-called Fairness Doctrine, under which the Federal Communications Commission (FCC) required broadcasters, if they raised a controversial issue, to present all sides of it. In upholding the FCC regulation, the Court stated, "It is the purpose of the First Amendment to preserve an uninhibited marketplace of ideas in which truth will ultimately prevail, rather than to countenance monopolization of that market, whether it be by the Government itself or a private licensee. . . . It is the right of the public to receive suitable access to . . . ideas . . . which is crucial . . . ."[222]

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[219] Bates v. State Bar of Arizona, 433 U.S. at 376-77 and n.32; Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc., 425 U.S. at 762-66; Bigelow v. Virginia, 421 U.S. 809, 822 (1975).

[220] 395 U.S. 367.

[221] The typical commercial speech case pits the rights of the speaker against those who would deny truthful information to consumers because of the choices that it might induce them to make. In such cases the interests of consumers—their right to receive that information and to make their own choices—are thus aligned with the rights of the speakers, and no issue of conflict between the Sherman Act and the first amendment can arise. Two other kinds of cases present spurious conflicts. In the data dissemination cases, *supra* note 213, the information was aimed primarily at producers, not consumers, and the consumer interest in maintaining competition prevailed over the producers' desire to share information that would facilitate collusion. (On intraprofessional exchanges of information, *see* Havighurst, *supra* note 126, at 345-62; Note, *Anticompetitive Data Dissemination in the Medical Profession: The Conflict Between the Sherman Act and the First Amendment,* 1980 DUKE L.J. 1142.) In the cases that are the focus of the present inquiry, the speakers are powerful professional organizations, and the information they generate in the form of credentials is meant to be used in making independent purchasing and hiring decisions. Thus, the speech itself would seem entitled to some constitutional protection if the antitrust laws were enforced to suppress it. But such information is essentially procompetitive and should not be suppressed as long as it contributes to the making of relevant distinctions. Without more, therefore, credentialing does not create a conflict between the interests of producers and consumers or between the first amendment and the antitrust laws. Of course, if a credentialing effort is obviously or intentionally deceptive or is part of a larger effort to suppress information, the consumer interest should prevail.

[222] 395 U.S. at 390. In a case contrasting sharply with the *Red Lion* decision, the Supreme Court invalidated a state law requiring newspapers, which enjoy a substantial natural monopoly over the dissemination of news and opinion about local politics, to carry at no cost replies by political candidates to their critical editorials. Miami Herald Publishing Co. v. Tornillo, 418 U.S. 241 (1974). One possible explanation for the seeming inconsistency be-

Because the *Red Lion* case seems to leave constitutional room for antitrust courts to impose a "fairness doctine" on monopolistic credentialing schemes, the limits imposed by the first amendment upon the substantive regulation of credentialing activities may actually be less strict than the limits that antitrust courts have imposed upon themselves. On the other hand, although the *Red Lion* decision did not foreclose regulatory solutions to the problem of monopoly in the production of information and opinion, it is clear that, under first amendment principles, the preferred solution would always be one that seeks not to regulate monopoly but to enhance competition in the marketplace of ideas. This Article embodies the same essential preference.

E. Conclusions on Unfair or Deceptive Credentialing

Even though this review of antitrust and common-law cases fails to yield a clear doctrinal explanation of precisely why the courts have limited their scrutiny of private credentialing standards, it does reveal that the antitrust laws apply no differently to professional activities than to industrial standard setting: Both are treated with a certain deference. It thus appears that the true basis for deference to competitors engaging in these kinds of collaboration lies not in special treatment of the learned professions but in the antitrust rule of reason itself.[223] Under traditional analysis, the activity of certifying especially qualified personnel for possible employment in the health care industry is a legitimate, procompetitive activity that, without more, should be applauded even though uncertified competitors are put at a competitive disadvantage. There is thus a clear basis for a presumption of legality that sharply limits the scrutiny given by common-law and antitrust courts to the standards employed by competitor-sponsored credentialing programs in arriving at and publishing their opinions on the qualifications of individuals. In addition to the antitrust laws' own implicit presumption that differences of opinion are best resolved in the marketplace, there are good pragmatic and even some quasi-constitutional reasons for not succumbing to the argument that a credentialing scheme's procompetitive value must be verified in each case by checking the basis for the representations made.

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tween the two cases is that newspapers enjoy a historically privileged status under the first amendment. *See* Bollinger, *Freedom of the Press and Public Access: Toward a Theory of Partial Regulation of the Mass Media,* 75 Mich. L. Rev. 1 (1976). This explanation of course provides no basis for giving credentialing bodies similar protection if their actions seem a disservice to consumers' information needs. Another possible distinction might be that the broadcaster's monopoly, unlike the newspaper's, was attributable to a government license. Under this theory, those credentialing and similar schemes that are maintained by licensed professionals or that enjoy special governmental recognition could be subjected to substantive regulation without offending the first amendment.

[223] *See supra* note 124.

None of the arguments for limiting scrutiny of credentialing standards would justify judicial tolerance for requirements that in some obvious way fail to advance the procompetitive purpose of helping consumers and others to discriminate among health care professionals on the basis of their professional qualifications. Because credential holders who control a credentialing scheme could easily succumb to the temptation to withhold credentials from competitors on wholly indefensible grounds, certification requirements and standards maintained by powerful professional groups should be subject to examination by antitrust or common-law courts to see if they have at least a rational connection to a purpose that can reasonably be deemed to be procompetitive. Likewise, a requirement of reasonable procedures (including expeditious handling of complaints) for correcting standards that unfairly disadvantage competitors would seem desirable. Most of the abuses allegedly found by the FTC staff in its numerous case studies of industrial standards could probably have been resolved satisfactorily under a rule of limited scrutiny.[224]

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[224] The case studies set forth in FTC STAFF REPORT, *supra* note 6, though not fully documented, offer an opportunity to test the rule of limited scrutiny proposed here. Many of the cited complaints questioning the substantive validity of standards concern products that, like the three-ply plywood in the *Structural Laminates* case, failed to meet design standards but nevertheless met the performance objectives that those design standards were intended to achieve. As argued earlier, *see supra* text accompanying notes 167-71, unreasonably prolonged adherence to design criteria in the face of evidence of equivalent or better performance bears no reasonable relationship to the standard setters' legitimate and procompetitive purposes. Thus, assuming that the FTC staff's frequently sketchy facts and judgments are sound and that other legal requirements are also satisfied (e.g., concerted action, *supra* text accompanying notes 122, 137-50, and injury to competition, *supra* text accompanying notes 131-33, 151-53), antitrust remedies should have been available in the following cases: testers for electrical grounding (FTC STAFF REPORT, *supra* note 6, at 70-73); plastic pipe in drain, waste, and vent systems (*id.* at 73-76); and toilet tank valves (*id.* at 77-82). Other episodes, only briefly summarized, that may be amenable to antitrust action using only limited scrutiny involved automatic plumbing vents, auto headlights, emergency aviation locators, flat electric cable, glass insulators, nonmetallic cable sheathing, plastic water pipes, pipe testing requirements, screw thread gauges, worker safety glasses, and underground heat distribution systems. *Id.* at 91-95 n.188. A related category of complaints that do not challenge the standards themselves but allege abuse by competitors of their strategic positions within the standards process might be challenged by analogy to the *Hydrolevel* case, discussed in *id.* at 82-86. *See also id.* at 92-93 (computer interface standards held up by computer manufacturers).

However, another group of cases that the FTC staff considered meritorious involved complaints that a dominant standard-setting body had refused to set any standards at all for new products which, though not directly competitive with certified products, were harder to sell without a seal of approval attesting to their safety or effectiveness. *E.g.*, ozone purification systems for swimming pools (*id.* at 95 n.188); steam cleaning equipment (*id.* at 181); gas stoves for recreational vehicles (*id.* at 185 n.324); hot tub heaters (*id.*). Presumably, a rule of limited scrutiny, while insisting on reasonable openness to competitive products, would not question a decision not to extend certification to unfamiliar fields. As the *Marjorie Webster* case suggested, a competitive certifying scheme could be established for some of these products. *See supra* text accompany notes 104, 205.

The FTC staff would also have afforded remedies in a number of instances where the substance of a standard seemed clearly to bear a rational relationship to a procompetitive

Thus, the remedy for unfair and deceptive credentialing need not lie entirely in the marketplace rather than in the courts. Although the market is the ultimate and best guarantor of quality in credentialing, there is no reason why obviously unfair credentialing practices should not be subject to

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purpose but some less restrictive alternative had been proposed by an excluded competitor. It appears that these standards would be upheld under a rule of limited scrutiny, which leaves room for such differences of opinion. These various disputes are reminiscent of numerous cost-benefit trade-offs in the health care field, where a range of defensible opinion exists regarding difficult value questions and technical uncertainties and where high industry-set standards, though encouraging demand for the industry's products, are not indefensible or irrational.

A particularly enlightening example of this class of cases involved standards of the Illuminating Engineers Society (IES) for minimum lighting levels. Experts, relying on studies of worker productivity under varying conditions, argued that the IES footcandle levels were too high. The IES cited other studies showing that productivity benefited from increased lighting. FTC STAFF REPORT, *supra* note 6, at 188-96. The FTC staff concluded that "the current IES levels reflect only one side of the issue about which there is a controversy and that side serves the financial interests of IES's members and supporters." *Id.* at 196. Although this dispute seems immune from resolution under a rational basis test, a related complaint about IES standards that might succeed, as an example of undue insistence on design criteria, was lodged by manufacturers of panels that polarize light, who argued that, by reducing glare, their product allowed equal visibility to be obtained at lower footcandle levels. *Id.* at 109-10, n.217.

Other examples of standards not contestable under a rational basis test include a standard excluding foreign ceramic wall tile that, being thinner than domestic tile, was subject to more breakage but had offsetting virtues (*id.* at 86-91); unless the balancing of conflicting values could be shown to be irrational or not in good faith, courts and regulators should not second-guess the standard setters' judgment even though their conflict of interests was clear. Similarly, a requirement that certain plumbing devices be accessible for service was alleged by the FTC staff to be unreasonable but did not seem irrational. *Id.* at 92. Finally, a furnace vent manufacturer argued that safety concerns could be overcome by requiring installation instructions, but the efficacy of that alternative appeared debatable. *Id.* at 97-104. Because the instruction alternative was in fact finally adopted, the latter case illustrates the risk that too much deference to the original standard, if coupled with too great a willingness to punish delays in approving changes (such as might be invited by our analysis of *Structural Laminates* and similar cases), could discourage standard setters from ever changing standards that they might eventually conclude were outdated; to solve this problem, ultimate adoption should not be treated as evidence that the original hesitancy was unjustified.

Finally, in those instances where the complaint is only that competitor-set standards are poorly conceived or do not adequately protect consumer interests, an antitrust remedy should not be available without some showing of intentional abuse. In these cases, however, unlike the previous category, a common-law tort action for unfair competition or an FTC action for deceptive practices might be allowable. Numerous examples cited by the FTC staff involved inadequate and therefore deceptive standards. *E.g., id.* at 109 n.217 (lock standard inadequate against forcible entry); *id.* at 198 (hard hat standard unsafe); *id.* at 204 (dangerous rear-discharge lawn mower approved); *id.* at 231 (dangerous chemicals in crayons certified as nontoxic); *id.* at 236 (treated wood certified for quality despite possible omission of a vital manufacturing step); *id.* at 108 n.217 (certifiers allowed inconspicuous disclaimers that undercut value of certification). Similarly, unless a conspiracy to restrict competition is shown, only nonantitrust remedies seem appropriate where testing is alleged to be inadequate or negligently done. *See, e.g., id.* at 175-81 (inappropriate test of furnace alleged); *id.* at 171-75 (reconditioned football helmets certified based on sampling nonuniform product), *id.* at 108 n. 217 (fire extinguishers certified despite clearly inadequate capacity); *id.* at 200 (safety shoes inadequately tested).

legal attack as a way of vindicating the larger public interest in the maintenance of free markets. Competitor collaboration on the scale involved in most credentialing is not such a desirable form of business conduct that it should be protected against all possible chilling effects of antitrust scrutiny.[225] Moreover, limited scrutiny of credentialing standards poses little danger to constructive programs. Indeed, the case law suggests that, if anything, the courts have been too slow to find procedures and standards, such as those in the *Structural Laminates* case, to be unreasonable. It should be possible for courts to identify and invalidate requirements wholly unrelated to individuals' accomplishments and skill without inquiring deeply into the basis for each requirement.

Under a rule of limited scrutiny, the hardest issues would undoubtedly arise where a certification requirement was defensible only on the basis of ideology—that is, on the basis of an asserted but essentially unsupported and implausible belief on the part of the certifiers that the particular requirement was related to quality. Such cases are likely to be more common in personnel credentialing and educational accreditation than in the setting and administration of industrial standards. On the authority of the *Marjorie Webster* decision, one might argue that courts should leave such issues of "philosophy" alone, letting the credential serve more as a kind of trademark, evidencing the auspices under which the holder was trained, and less as evidence of objectively measured quality. Although this argument has considerable force, it can be carried too far. Thus, Judge Bazelon was careful to rely upon it only where he thought an alternative credentialing scheme could be easily established. Moreover, where a particular philosophy dominates a field, an official body's disapproval may easily serve as a signal for other adherents of the dominant philosophy to boycott the disapproved provider.[226] Finally, consumers will find it hard to understand certification as a trademark that draws vertical rather than exclusively horizontal distinctions among practitioners.[227]

Each of these reservations about adopting a laissez-faire policy toward ideologically based credentialing standards—that is, those falling in the grey area between plausible indicia of quality and requirements obviously irrelevant to consumers' concerns—reflects a genuine, empirically based concern that is heightened by current defects in the market for health services. The difficulty of organizing alternative credentialing and accredit-

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[225] Credentialing by voluntary competitor groups is thus distinguishable from the business practices of dominant firms, which, if lawfully constituted, must not be exposed to unreasonable risks when they undertake to compete aggressively. *See supra* note 209.

[226] In *Marjorie Webster* it was clear that there was no boycott. *See* 432 F.2d at 656 & n.33 (evidencing independent decisions by accredited schools whether to accept plaintiff's graduates as transfer students).

[227] *See supra* note 30 and text accompanying note 207.

ing systems, the propensity of individual physicians to adopt the medical profession's official views, and the frequent overreliance by consumers and others on credentials all suggest that, in this limited class of cases, antitrust courts should scrutinize claims with some care. Thus, they should require more than a sincere belief by credentialers that a challenged standard is reasonably connected to legitimate credentialing objectives. If a standard seems questionable, it would not be inappropriate to take into account some collateral matters. In particular, the court might assess the good faith of the professional group as evidenced by its other activities, such as its cooperation with other groups engaged in activities dangerous to ideological diversity and free competition. Particularly in the area of complex professional services, the significance of a particular practice may be fully understandable only if the court or other decision maker appreciates the larger context in which it occurs. Part Two of this Article develops this larger context and should induce some judicial reluctance to accept professional activities at face value and heighten sensitivity to the dangers that such activities pose.

The legal rules suggested here for dealing with unfair and deceptive credentialing stop well short of solving the health care market's information-related problems. These problems can be better addressed by breaking down the existing ideological and informational monopoly than by seeking relief for disadvantaged competitors and misinformed consumers through regulation of established programs. Part Two of this Article demonstrates the nature of the current credentialing monopoly, highlighting the potential benefits of, and opportunities for, increasing the flow of information and opinion in the health care industry and expanding the range of options available to consumers. It also proposes some ways in which the antitrust laws can be used to break down the ideological and informational monopoly that is so much more important a problem in the health care industry than unfairness and deception in the operation of existing credentialing programs.

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