MER
DUROS
ND
IEFS

No. 86-1145

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

TIMOTHY A. PATRICK, M.D.,
Petitioner,

v.

WILLIAM M. BURGET, M.D., *et al.*,
doing business as ASTORIA CLINIC,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

BRIEF FOR *AMICUS CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF PETITIONER

DONALD N. BERSOFF
(Counsel of Record)
DAVID W. OGDEN
DONALD B. VERRILLI, JR.
ENNIS FRIEDMAN & BERSOFF
1200 17th Street, N.W., Suite 400
Washington, D.C. 20036
Telephone: (202) 775-8100
Attorneys for Amicus Curiae
American Psychological Association

November 25, 1987

TABLE OF CONTENTS

Page

INTEREST OF *AMICUS CURIAE* 1

INTRODUCTION AND SUMMARY OF ARGUMENT 3

ARGUMENT

I. "STATE ACTION" IMMUNITY IS INAPPLICABLE IN THE CIRCUMSTANCES OF THIS CASE BECAUSE THE CHALLENGED PEER REVIEW DECISION DENYING PETITIONER HOSPITAL PRIVILEGES WAS NEITHER IN FURTHERANCE OF A CLEARLY ARTICULATED STATE POLICY NOR CLOSELY SUPERVISED BY THE STATE, AND ITS IMPOSITION WOULD NEEDLESSLY THWART THE FREE MARKET GOALS OF THE SHERMAN ACT 6

A. The Hospital Peer Review Decision Challenged In This Case Was Not Made In Furtherance Of A Clearly Articulated State Policy 7

B. The State Of Oregon Does Not Actively Supervise Hospital Peer Review 16

II. RESOLUTION OF THE ANTITRUST ISSUES IN THIS CASE SHOULD BE INFORMED BY AN UNDERSTANDING OF THE POTENTIAL PROHEALTH AND PROCOMPETITIVE BENEFITS OF PEER REVIEW, BUT SHOULD ALSO ACKNOWLEDGE THE PARTICULAR ANTICOMPETITIVE RISKS OF UNSCRUTINIZED INTERPROFESSIONAL PEER REVIEW 20

A. The Nature of Hospital Peer Review Requires Care In Defining The Scope Of State Action Immunity To Ensure That Prohealth And Procompetitive Activity Is Protected While Conduct Intended Solely To Limit Competition Is Not 20

TABLE OF CONTENTS—Continued

	Page
B. These Principles Are Also Relevant To Deciding Broader Questions Of The Appropriate Antitrust Analysis For Hospital Peer Review Practices	25
CONCLUSION	26

TABLE OF AUTHORITIES

Cases:	Page
Blue Shield v. McCready, 457 U.S. 465 (1982)	3
California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97 (1980)	6, 7, 17, 20
Cantor v. Detroit Edison Co., 428 U.S. 579 (1976)	9, 10, 16
City of Lafayette v. Louisiana Power and Light Co., 435 U.S. 389 (1978)	6, 8
Community Communications Co. v. Boulder, 455 U.S. 40 (1982)	10
Corey v. Look, 641 F.2d 32 (1st Cir. 1981)	9
Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975)	9, 10, 15, 16
Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979)	10
Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398 (1975)	19
Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts, 471 U.S. 724 (1985)	3
National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378 (1981)	10
National Society of Professional Engineers v. United States, 435 U.S. 679 (1978)	25
Parker v. Brown, 317 U.S. 341 (1943)	3, 6, 12, 17
Ratino v. Medical Service of the District of Columbia, 718 F.2d 1260 (4th Cir. 1983)	9
Shaw v. Hosp. Auth., 614 F.2d 946 (5th Cir. 1980)	23
Silver v. New York Stock Exchange, 373 U.S. 341 (1963)	10, 11, 13, 16
Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48 (1985)	4, 6, 7, 9, 10, 17
Straube v. Emanuel Lutheran Charity Board, 278 Or. 375, 600 P.2d 381 (1979)	19
324 Liquor Corp. v. Duffy, —— U.S. ——, 93 L.Ed.2d 667 (1987)	6, 17
Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985)	16, 17

TABLE OF AUTHORITIES—Continued

	Page
United States v. National Association of Securities Dealers, 422 U.S. 694 (1975)	10
United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963)	10
Virginia Academy of Clin. Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980)	2, 23
Weiss v. New York Hospital, 745 F.2d 786 (3d Cir. 1984)	23
Wilk v. American Medical Association, 719 F.2d 207 (7th Cir. 1983)	25
Statutes:	
Sherman Act, 15 U.S.C. §§ 1 and 2	*passim*
Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101, *et seq.*	14, 22
Ark. Stat. Ann. § 66-3212.6 (1980)	24
Md. Code Ann. art. 48A, § 490A (Supp. 1981)	24
Miss. Code Ann. § 83-41-211 (Supp. 1981)	24
N.Y. Ins. Law §§ 164.7-d, 221.5(e), 250.1 (Supp. 1981)	24
Or. Rev. Stat. § 41.675(4)	5, 8, 12
§ 441.030	18
§ 441.055(3)	*passim*
§ 441.150	18
§ 441.155	18
§ 441.820	18, 19
§ 646.725	12
§ 743.123	24
Tenn. Code Ann. § 56-7-108	24
Va. Code Ann. §§ 38.1-824, 38.1-347.1 (Supp. 1979)	24
Miscellaneous:	
132 Cong. Rec. H11590 (daily ed. October 17, 1986)	14
Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 Harv. L. Rev. 435, 453 (1981)	15

TABLE OF AUTHORITIES—Continued

	Page
P. Areeda & D. Turner, *Antitrust Law* ¶ 213b (1978)	18
Bersoff, *Hospital Privileges and the Antitrust Laws*, 38 American Psychologist 1238 (1983)	23
Cohen, *Research on Mental Health Quality Assurance, in* Handbook of Quality Assurance in Mental Health 65 (G. STRICKER & A. RODRIGUEZ eds. forthcoming)	21
Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Houston L. Rev. 707 (1981)	23
Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071	22, 25
Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 Case Western Res. L. Rev. 1117 (1986)	21, 22
Lahman, *Licensure Requirements for Psychologists: USA and Canada* (1978)	24
Position Statement on Hospital Privileges for Psychologists, 128 American Journal of Psychiatry 1456 (1971)	23
Position Statement on Administration of Psychiatric Facilities, 133 American Journal of Psychiatry 604 (1976)	23
Sechrest & Hoffman, *The Philosophical Underpinnings of Peer Review*, 8 Professional Psychology 14 (1982)	21
Sechrest & Rosenblatt, *Evaluating Peer Review, in* Handbook of Quality Assurance in Mental Health 81 (G. Stricker & A. Rodriguez eds. forthcoming)	21, 22
Tension Rising Between Psychology, Psychiatry, Clinical Psychiatry News, November 1977	23
Young, *A Brief History of Quality Assurance and Peer Review*, 8 Professional Psychology 9 (1982)	21

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-1145

TIMOTHY A. PATRICK, M.D.,
Petitioner,

v.

WILLIAM M. BURGET, M.D., *et al.*,
doing business as ASTORIA CLINIC,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

BRIEF FOR *AMICUS CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF PETITIONER

INTEREST OF *AMICUS CURIAE*

The American Psychological Association ("APA"), a nonprofit scientific and professional organization founded in 1892, is the major association of psychologists in the United States. The APA has more than 70,000 members, including the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. The purpose of the APA, as set forth in its bylaws, is to "advance psychology as a science and

profession, and as a means of promoting human welfare by the encouragement of psychology in all branches and in the broadest and most liberal manner." A substantial and growing number of the APA's member psychologists are health-care providers licensed to provide mental health services to individual clients.

The APA believes it has a unique perspective on the issue of the proper application of the antitrust laws to hospital peer review decisions, which will be of value in resolving the present case. The APA is actively involved in the provision of quality assurance for the profession of psychology, including such programs as accreditation of doctoral programs in professional psychology, promulgation of ethical standards and guidelines for the delivery of psychological services, and establishment of peer review on a nationwide basis to provide consumers and third-party payors with a formal but readily accessible avenue of redress should a question arise regarding the reasonableness or necessity for mental health services. Aware of peer review's potential for enhancing public health and welfare, the APA has an interest in assuring that the antitrust laws do not needlessly chill these valuable quality assurance programs for health care.

But APA members who are health-care providers have an interest in ensuring that peer review is not abused for anticompetitive purposes. These anticompetitive risks are particularly acute with respect to hospital credentialing and peer review procedures governing access to hospital privileges. Physicians have historically opposed recognition of psychologists as independent health care providers and may have viewed the economic competition offered by psychologists as threatening. Yet courts reviewing physicians' exclusionary policies as applied to psychologists have typically found them to be unrelated to achievement of genuine health care objectives, and harmful to the public's interest in receiving the best care at reasonable rates. *See, e.g., Virginia Academy of Clin.*

Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). Because hospital peer review committees are typically controlled by physicians, psychologists face the risk of systematic denial of hospital privileges as a result of parochial, anticompetitive, or misguided motivations, rather than a genuine and empirically valid interest in assuring quality health care. Hospital privileges constitute an important—even essential—competitive advantage for many practitioners. Accordingly, the APA has an interest in ensuring that hospital peer review remains subject to appropriate antitrust scrutiny to avert the special risks posed by peer review conducted in the interdisciplinary and interprofessional context.

APA has appeared as *amicus curiae* before this Court in cases raising issues of health antitrust law and federalism. *E.g., Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts*, 471 U.S. 724 (1985); *Blue Shield v. McCready*, 457 U.S. 465 (1982).

The parties have consented in the filing of this brief *amicus curiae* pursuant to Rule 33 of the rules of this Court. Their letters of consent will be filed with the Clerk of this Court.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case presents the issue whether a bad faith, anticompetitive revocation of a physician's hospital privileges by the peer review committee of an Oregon hospital is exempt from federal antitrust liability by virtue of "state action" immunity, as set forth in *Parker v. Brown*, 317 U.S. 341 (1943), and its progeny. The case therefore requires this Court to reconcile the Sherman Act's goal of ensuring vigorous, unfettered economic competition with a federalism goal of preserving state power to supplant economic competition in limited areas to achieve particular objectives.

The court of appeals in this case failed to strike the proper balance between these interests, and thereby created the risk—not addressed by any party—that unchecked physician control of the hospital peer review process will lead to a systematic exclusion of competition from other licensed health care professionals, such as psychologists. *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986). The court held that the hospital peer review decision challenged in this case was clearly authorized under Oregon law and was actively supervised by the State. *See Southern Motor Carriers Rate Conference v. United States*, 471 U.S. 48, 57 (1985) (stating test). The court found that section 441.055(3), Or. Rev. Stat., supplied a clearly articulated state policy to supplant competition in the provision of health care services in hospitals. The court also found that the State actively supervised this policy through general oversight by the State Health Division, a requirement that peer review decisions denying privileges be reported to the Board of Medical Examiners ("BOME"), and judicial review. 800 F.2d at 1506.

This decision seriously misconstrues the nature and scope of "state action" antitrust immunity. The peer review challenged in the present case was found by the jury to be a bad faith effort to exclude competition, not a good faith decision based on the need to improve medical care. *See* Transcript 2922 (jury instruction). *Amicus* will demonstrate that immunizing this naked restraint was not necessary to further any clearly articulated policy of the State of Oregon. In requiring hospital peer review, the State articulated a policy to displace competition for the limited purposes of "reducing morbidity and mortality and for the improvement of patient care." Or. Rev. Stat. § 441.055(3). The State had no intention to permit or promote use of the peer review process for the sole purpose of excluding competitors. Moreover, the court of appeals overlooked a crucial fact that arguably disposes of the state action issue. *The*

State of Oregon itself explicitly permits civil actions, including state antitrust actions, for conduct by hospital peer review committees that is not undertaken "in good faith" to promote health objectives. Or. Rev. Stat. § 41.675(4). No purpose of federalism is served by immunizing from federal antitrust scrutiny particular anticompetitive conduct for which the State itself imposes state antitrust liability. (Point I.A.) Nor are hospital peer review decisions "actively supervised" within the meaning of this Court's decisions. Neither the State Health Division, nor the BOME, nor the state courts have any authority to conduct a "pointed reexamination" of particular peer review decisions to ensure that the decisionmaking power has been exercised in conformity with the purposes for which it was granted. (Point I.B.)

Amicus will also demonstrate that the court of appeals' undiscriminating grant of "state action" immunity for hospital peer review decisions threatens serious anticompetitive consequences that contravene the Sherman Act and the clear policies of most States. Although properly conducted and supervised peer review can enhance both the quality of health services and competition in the market for provision of those services, the hospital peer review process does present systemic anticompetitive risks where physicians control peer review committees and use that control to exclude competition from other health care professionals, such as psychologists. Overbroad grants of state action immunity for peer review will exempt this anticompetitive conduct from the antitrust laws, and thereby thwart both federal and state policies permitting and encouraging the provision of health care and mental health care by licensed professionals other than physicians. Neither the parties to this action nor the court of appeals have focused on the risk that arises in the interprofessional context, because the facts here do not directly raise it. But in resolving the state action issue before it, this Court should be aware of these serious, unintended anticompetitive consequences

of the sweeping immunity provided by the court of appeals in this case. (Point II.)

ARGUMENT

I. "STATE ACTION" IMMUNITY IS INAPPLICABLE IN THE CIRCUMSTANCES OF THIS CASE BECAUSE THE CHALLENGED PEER REVIEW DECISION DENYING PETITIONER HOSPITAL PRIVILEGES WAS NEITHER IN FURTHERANCE OF A CLEARLY ARTICULATED STATE POLICY NOR CLOSELY SUPERVISED BY THE STATE, AND ITS IMPOSITION WOULD NEEDLESSLY THWART THE FREE MARKET GOALS OF THE SHERMAN ACT.

In *Parker v. Brown*, based on an assumption that Congress did not intend the antitrust laws to nullify state power to displace unfettered competition for valid public health and welfare purposes, this Court held that the Sherman Act did not prohibit States from imposing restraints on competition. 317 U.S. at 351. *See Southern Motor Carriers Rate Conference v. United States*, 471 U.S. at 55-56.

In developing the *Parker* doctrine, this Court has also made clear that antitrust immunity for "state action" may shield the anticompetitive conduct of private parties, but only if the party claiming the immunity can demonstrate that the challenged conduct meets this Court's two-part test. *First*, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy." *Id.* at 57 (internal quotation and citation omitted). *Second*, "the state must supervise actively any private anticompetitive conduct." *Id. Accord 324 Liquor Corp. v. Duffy*, —— U.S. ——, ——, 93 L.Ed.2d 667, 677 (1987); *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980). *See generally City of Lafayette v. Louisiana Power and Light Co.*, 435 U.S. 389, 400 (1978) (party seeking immunity bears burden of persuasion). Within the limited

confines defined by the two-part test, state action immunity reconciles the federalism interest in preserving state power to regulate in ways that may displace some competition and the Sherman Act's goal of preserving vigorous free markets. *Southern Motor Carriers*, 471 U.S. at 61.

Amicus will show that the conduct of the hospital peer review board challenged in the present case deserves no exemption from the federal antitrust laws because it meets neither of the requirements for state action immunity. The court of appeals' erroneous finding of "state action" therefore thwarted the important procompetitive goals of the Sherman Act without measurably advancing the public health policies of the State of Oregon.

A. The Hospital Peer Review Decision Challenged In This Case Was Not Made In Furtherance Of A Clearly Articulated State Policy.

The first part of this Court's test for "state action" immunity—whether the state policy allegedly justifying a restraint is "clearly articulated and affirmatively expressed," *Southern Motor Carriers*, 471 U.S. at 57; *Midcal Aluminum, Inc.*, 445 U.S. at 105—demands a careful analysis of the scope of any state policy claimed as a justification for displacement of private economic competition. This careful scrutiny is imperative to striking the appropriate balance between the Sherman Act and the state's interest in displacing competition for particular policy reasons. It serves no purpose of federalism to immunize private anticompetitive conduct from the federal antitrust laws when the State has expressed no interest in promoting the conduct, especially when, as here, the State imposes liability for the conduct.

The court of appeals in the present case failed to undertake a careful analysis of the scope of the state policy at issue. The court correctly recognized that Oregon required peer review *only* "for the purposes of reducing

morbidity and mortality and for the improvement of patient care," Or. Rev. Stat. § 441.055(3)(d), and sought *only* to "replace pure competition with *some* regulation," 800 F.2d at 1506 (emphasis added). Furthermore, the State itself permits persons situated like petitioner to sue members of peer review committees for actions taken in bad faith, and not for medical reasons. Or. Rev. Stat. § 41.675(4). Yet the court of appeals concluded that "federal antitrust laws are simply displaced" by Oregon's peer review policy, *id.* at 1507, irrespective of whether the peer review process was abused for an anticompetitive end having nothing whatsoever to do with the State's policy of "reducing morbidity and mortality" or "the improvement of patient care," and whether or not it was made "in good faith." As a result of this undiscriminating approach, the court of appeals immunized a peer review committee's decision to revoke hospital privileges, despite a jury finding that the committee acted in bad faith to restrict economic competition.[1] In so doing, the court of appeals carved out a state action immunity far broader than is permitted under the decisions of this Court, and imposed a senseless restriction on the scope of federal antitrust law far broader than was necessary to vindicate Oregon's state policy requiring peer review.

Although a party "need not point to a specific, detailed legislative authorization" to establish a clearly articulated state policy, *City of Lafayette v. Louisiana Power and Light Co.*, 435 U.S. at 415 (opinion of Brennan, J.), this Court has consistently required a clear showing that the State intends to displace competition *in the way that the challenged restraint does.* Restraints unrelated to,

[1] The jury was instructed that it could not find for petitioner on the Sherman Act section 2 claim if it found that respondents were "motivated by concerns over the provision of health care to the community" (Transcript 2922). The jury found for petitioner on that claim. The court of appeals found ample evidence to support the jury finding of bad faith. 800 F.2d at 1507.

or significantly in excess of, those necessary to effectuate a state policy are not shielded from antitrust scrutiny. In such cases there is no reason to thwart the federal interests in vigorous enforcement of the antitrust laws. *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).[2]

In *Goldfarb*, this Court declined to immunize the efforts of state and county bar associations to set a mandatory minimum fee schedule for lawyers in Virginia. The Virginia Supreme Court, acting as sovereign, had adopted ethical codes directing attorneys determining appropriate fees to consider any schedules of minimum fees adopted by a bar association. This Court held that the existence of a state policy favoring *advisory* fee schedules was not sufficiently broad to justify the bar associations' efforts to establish essentially *mandatory* minimum fee schedules. In fact, as the Court found, the Virginia Supreme Court had expressed only a limited anticompetitive policy and directed attorneys not "to be controlled" by fee schedules. 421 U.S. at 789-790. Because the mandatory fee schedule significantly exceeded the limited goals of the state supreme court, the grant of immunity for that conduct would not further any articulated state policy. Under those circumstances, the Court held, there was no warrant for thwarting the procompetitive ends of the Sherman Act.[3]

[2] *See also Ratino v. Medical Service of the District of Columbia*, 718 F.2d 1260, 1268 n.22 (4th Cir. 1983); *Corey v. Look*, 641 F.2d 32, 37 (1st Cir. 1981) (requiring showing that "challenged restraint is necessary to the successful operation of the legislative scheme that the state sovereign has established").

[3] This Court's recent decision in *Southern Motor Carriers* understood the holding in *Goldfarb* in this way. Respondents had argued that *Goldfarb* stood for the proposition that state action immunity was appropriate only when the state compelled anticompetitive private conduct. Rejecting this argument, the Court in *Southern Motor Carriers* explained that state action immunity in *Goldfarb* was inappropriate because the state had no clearly articulated policy

Similarly, in *Cantor* this Court held that a utility whose rates for electricity were subject to state regulation could not claim immunity for other anticompetitive conduct unrelated to the provision of electricity—in particular, the provision of free light bulbs to customers. As in *Goldfarb*, the Court in *Cantor* carefully evaluated the scope of articulated state policies allegedly supporting a claim of immunity to ensure that the important procompetitive goals of the Sherman Act were not sacrificed unnecessarily.[4]

This Court has employed a similar approach to reconcile the Sherman Act with competing *federal* policy goals that require some displacement of competition. In recognition of "the indispensible role of antitrust policy in the maintenance of a free economy," *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 348 (1963), this Court has repeatedly held that implied antitrust immunities are disfavored. *Id.* at 350-351; *see also, e.g., National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 388-389 (1981); *United States v. National Association of Securities Dealers*, 422 U.S. 694, 719-720 (1975); *United States v. Philadelphia Nat'l Bank*, 374 U.S. at 350-351. Even in the rare instances when such immunities are recognized, they are strictly construed to prevent unnecessary restriction of Sherman Act enforcement. *E.g., Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979); *Silver v. New York Stock Exchange*, 373 U.S. 341, 357-358 (1963).

Unlike the court of appeals in the present case, which "simply displaced" the antitrust laws, 800 F.2d at 1507,

---

to displace competition in the way the defendants had, *i.e.*, with a mandatory fee schedule. 471 U.S. at 60-61.

[4] *Cf. Community Communications Co. v. Boulder*, 455 U.S. 40 (1982) (State's general "home rule" authorization to city did not constitute clearly articulated state policy to permit city to displace competition in cable television market).

this Court in *Silver v. New York Stock Exchange*, for example, held that "the proper approach . . . is an analysis which reconciles the operation of both statutory schemes with one another *rather than holding one completely ousted.*" 373 U.S. at 357 (emphasis added). At issue in *Silver* was the extent to which the Sherman Act's prohibition of anticompetitive boycotts applied to conduct of a securities exchange authorized under the Securities Exchange Act of 1934 to engage in self-regulation that included disciplining securities dealers. Given the important national policies served by the Sherman Act, the Court held that "the guiding principle to reconciliation of the two statutory schemes" was that antitrust immunity be granted only "to the minimum extent necessary" to achieve the competing policy goals of the securities laws. *Id.; see also id.* at 361. Applying these principles, the Court refused to immunize a boycott of a securities dealer by the stock exchange. Because the exchange had not afforded the dealer notice or opportunity to challenge the decision to boycott, the Court concluded, antitrust immunity would further "[n]o policy reflected in the Securities Exchange Act." *Id.* at 361.

The principles of *Goldfarb*, *Cantor*, and *Silver* should govern the present case. Oregon has articulated a policy that displaces competition in the medical field to only a limited extent and for only certain purposes. The statutory provision that allegedly supplies the clearly articulated and affirmatively expressed policy of the State authorizing peer review committees to deny hospital privileges for anticompetitive reasons is Or. Rev. Stat. § 441.055(3)(d). That provision requires hospitals, as a condition of obtaining and maintaining a license from the State Health Division, to "[i]nsure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the professional practices of the facility *for the purposes of reducing morbidity and mortality and for the improvement of patient care.*" *Id.* (emphasis added).

The statute merely permits a committee of physicians to make decisions about a fellow health care professional's ability to provide medically competent treatment. Peer review *does* displace free-market forces to a limited extent; the committee, rather than the market, determines the "quality" of a practitioner's skills, and if the committee finds the skill level to be inadequate then the practitioner is excluded from the market entirely. But this statutory provision is not intended to ensure the reviewing physicians the economic benefits of monopoly power by permitting them to restrict competition for economic reasons. *Compare Parker v. Brown*, 317 U.S. at 346 (state policy "to restrict competition among [raisin] growers and maintain prices in the distribution of their commodities"). Oregon thus has not articulated a state policy to supplant competition for hospital privileges in its entirety, but only to the extent necessary to advance the State's articulated policy goal of reducing morbidity and mortality and improving patient care.

Critically, Oregon itself has evinced no interest in absolutely immunizing privilege decisions of hospital peer review committees, irrespective of the reasons for their decisions. Oregon grants members of such committees only *limited* immunity. Or. Rev. Stat. § 41.675(4). Section 41.675(4) provides that "[a] person serving on or communicating information" to a hospital peer review committee "shall not be subject to an action for civil damages for affirmative actions taken or statements made *in good faith*." *Id.* (emphasis added). When a peer review committee denies or revokes privileges to restrict competition, and not to ensure competent health care, committee members are subject to a range of possible civil liability, *including liability under Oregon's state antitrust laws. See* Or. Rev. Stat. § 646.725 (prohibiting restraints of trade, language identical to Sherman Act).

In this case, the jury found that the peer review process was abused for the purpose of excluding a competitor from access to an essential facility by denying hospital privileges. This anticompetitive conduct can in no sense be said to further the substantive interests the State of Oregon seeks to advance in its hospital peer review statute. Far from granting immunity "to the minimum extent necessary" to permit achievement of the articulated state policy, *Silver*, 373 U.S. at 357, the court of appeals immunized anticompetitive conduct unrelated to, and significantly in excess of, the type of conduct that the State seeks to encourage. Indeed, under Oregon's own antitrust laws, the State actually makes actionable the very conduct the court of appeals would immunize from federal law in the name of federalism.

Because Oregon has articulated no substantive interest in immunizing peer review decisions taken for the purpose of restricting competition, granting "state action" immunity to such anticompetitive conduct could be thought necessary, and therefore compelled by the federalism purpose underlying state action immunity, only for "prophylactic" reasons. If the threat of antitrust liability for bad faith conduct would chill or distort the performance of hospital peer review and thereby thwart the articulated state interest, then blanket immunity might arguably be necessary to achieving the goals of the state policy. Such an argument has no force in the present case, however, because the State of Oregon itself permits the imposition of tort liability and, most importantly, the imposition of *state antitrust liability* for anticompetitive actions of peer review committees undertaken for the purpose of restricting or eliminating competition, and not for purposes of promoting health care. Oregon itself has decided that blanket immunity is *not* necessary to advancement of the state policy objectives articulated in section 441.055(3)(d). No federalism purpose is served by granting antitrust immunity to conduct, like that at issue in this case, that is specifically actionable under state antitrust law.

Although not dispositive, the conduct of the federal government in reconciling federal policy to promote peer review with the antitrust laws is persuasive authority for the position urged here. The Health Care Quality Improvement Act of 1986 immunizes peer review decisions from antitrust liability, but only if the decisions are made in good faith after reasonable investigation and in fair proceedings, and not for exclusionary reasons. 42 U.S.C. §§ 11101 *et seq.* *See also* 132 Cong. Rec. H11590 (daily ed. October 17, 1986) (statement of Rep. Waxman) ("Bad faith peer review activities permitted by the Patrick case could never obtain immunity under H.R. 5540"). Congress concluded that a limited threat of antitrust liability for bad faith anticompetitive conduct would not so seriously chill peer review and thereby jeopardize its pro-health (and procompetitive) benefits as to justify accepting the dangers to competition entailed by absolute immunity. The State of Oregon has made a judgment similar to that of Congress with respect to state liability for abuse of the peer review process. There is thus neither a substantive nor a prophylactic need to grant absolute immunity for hospital peer review in order to advance the state policy expressed in Or. Rev. Stat. § 441.055(3)(d). Indeed, to grant immunity when neither the state nor federal legislatures thought it necessary, and when both apparently considered it undesirable, would utterly pervert the concept of federalism.[5]

[5] Because antitrust liability will be imposed only for bad faith peer review decisions based on intent to exclude a competitor, and not on health-related criteria, there can be no claim in this case that a refusal to recognize state action immunity will result in overly intrusive federal judicial supervision of state decisionmaking or in inappropriate "second-guessing" of state decisionmakers. Under the standard urged here, federal courts would not impose antitrust liability for "mere error" in the execution of a clearly articulated state policy. Only if a defendant is shown to have been motivated by bad faith anticompetitive purposes unrelated to, or significantly in excess of, the scope of the state policy, will the antitrust laws even be implicated. Thus, there is no serious risk

If there is no federalism reason in this case for immunizing anticompetitive peer review decisions made for the purpose of eliminating competition, then the mere fact that application of the Sherman Act may result in burdening the federal courts with supervision of the peer review process is not a sufficient justification for absolute immunity. Although the court of appeals suggested that this supervisory role under the Sherman Act is inappropriate, 800 F.2d at 1507 (citing Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 Harv. L. Rev. 435, 453 (1981)), *amicus* suggests that there is no warrant in the text or legislative history of the Act for forbidding such review as was performed by the district court in this case.

State action immunity is rooted solely in the doctrine of federalism and the need to respect state sovereignty. Unless immunity is necessary to effectuate federalism, then the judiciary has no reason to redact Congress' " 'carefully studied attempt to bring within the Act every person engaged in business whose activities might restrain or monopolize commercial intercourse.' " *Goldfarb v. Virginia State Bar*, 421 U.S. at 787-788 (quoting *United States v. Southeastern Underwriters Assn.*, 322 U.S. 533, 553 (1944)). Congress or the States remain free to preclude all antitrust scrutiny of peer review decisions if they should find absolute immunity necessary to achieve sound policy goals. But neither Congress nor the State of Oregon has, however, made the choice to immunize bad faith, anticompetitive abuse of the peer review process to limit competition or eliminate competitors. The district court's test, like both federal and state law, permits antitrust plaintiffs to succeed only if they can persuade the

to federalism values in permitting such review. In any event, because Oregon would permit a *state* jury in a *state* antitrust, or tort, case to engage in this inquiry, there can be no federalism bar to the same level of "second guessing"—if it be second guessing—by a federal jury in a federal antitrust case.

trier of fact that the conduct of a peer review committee was indeed based on a motive to exclude competition.

Goldfarb, Cantor, and Silver compel a grant of immunity commensurate with the limited nature of Oregon's policy to displace competition. The State has expressed no interest in shielding hospital staff members from competition by other qualified practitioners. Nor has the State expressed the judgment that restricting immunity to cases of good faith decisionmaking would systematically chill or disrupt the proper exercise of hospital peer review. Under these circumstances, it can hardly be said that the grant of absolute "state action" immunity by the Court of Appeals was necessary to achieve the state policy articulated in section 441.055(3)(d). Accordingly, "state action" immunity from the antitrust laws should appropriately extend in this case—as the district court extended it—only to peer review decisions made in good faith on the basis of medical competency. The claim of blanket, absolute antitrust immunity for hospital peer review decisions in Oregon must be rejected.

B. The State Of Oregon Does Not Actively Supervise Hospital Peer Review.

Even if respondents' anticompetitive abuse of the peer review process could be justified as furthering a clearly articulated policy of the State of Oregon—and *amicus* has demonstrated that it cannot—"state action" immunity would still be improper in this case because the State does not "actively supervise" hospital peer review decisions.

This Court has recognized that "[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State." *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 47 (1985). Thus, the requirement of active state supervision of private anticompetitive conduct is also essential to striking the appropriate balance between the federalism interest in permitting state regulation and the Sherman Act goal of preventing anticompetitive economic conduct. In case after case, this Court has made clear that, at a minimum, "active supervision" means searching state scrutiny of the particular decisions of the private parties acting under cloak of state authority, to ensure that the delegated power is being exercised consistently with the purposes for which it was granted. *Town of Hallie v. City of Eau Claire*, 471 U.S. at 46; *Southern Motor Carriers*, 471 U.S. at 51 (state agencies "have and exercise ultimate authority and control over all intrastate rates" initially set by private parties); *Parker v. Brown*, 317 U.S. at 352 (state "adopts" privately set rate structure and "enforces it with penal sanctions").

California Liquor Dealers v. Midcal Aluminum, 445 U.S. 97 (1980) ("*Midcal*"), sets forth the type of state participation in authorized anticompetitive conduct that constitutes "active supervision" sufficient to confer immunity. *Midcal* involved a California statute authorizing resale price maintenance for wine. Although finding a clearly articulated state purpose to permit private parties to set resale prices, this Court declined to find active supervision because

> "[t]he State neither establishes prices nor reviews the reasonableness of the price schedules; nor does it regulate the terms of fair trade contracts. The State does not monitor market conditions or engage in any pointed reexamination of the program."

445 U.S. at 105-106 (internal quotation omitted). As this Court recently made clear in reaffirming the *Midcal* analysis in another case involving liquor resale price maintenance, *324 Liquor Corp. v. Duffy*, "state action" immunity requires that an agency of state government supervise the *particular instances* of anticompetitive conduct by private parties acting pursuant to state author-

ity. —— U.S. at ——, 93 L.Ed.2d at 677-678. *See also* P. Areeda & D. Turner, *Antitrust Law* ¶ 213b, at 73 (1978) ("The key question here is whether the operative decisions about the challenged conduct are made by public authorities or by private parties themselves. When the latter is the case, there is insufficient public control to confer antitrust immunity.").

In the present case, the court of appeals found active supervision in a combination of three forms of alleged oversight by the State: (i) supervision of the establishment of hospital peer review procedures by Oregon's Health Division, Or. Rev. Stat. §§ 441.030, 441.055(3); (ii) required reporting to the BOME of decisions restricting or terminating privileges, Or. Rev. Stat. § 441.820(1); and (iii) judicial review. 800 F.2d at 1506. Close scrutiny reveals that *none* of these means of alleged oversight—either alone or in combination with the others—rises to the level of "active supervision" within the meaning of this Court's decisions.

Health Division Scrutiny. In no sense do sections 441.030 and 441.055(3) empower the Health Division to supervise the particular decisions of hospital peer review committees. Section 441.055(3) requires hospital governing boards to establish peer review committees, and to ensure that the procedures of the committees conform to applicable law. Review by the hospital board—*a private entity*—cannot substitute for active supervision by the State of Oregon. Section 441.030 authorizes the Health Division to deny, suspend, or revoke a hospital's license for failure to comply with various statutory and regulatory standards for hospitals. Although other statutory provisions authorize general supervision of hospital procedures, *e.g.*, Or. Rev. Stat. §§ 441.030(2), 441.150, 441.155, none of these provisions even implicitly invests the Health Division with official authority to review and overturn individual peer review decisions. On their face, these provisions do not authorize any form of administrative review of hospital peer review. Nor is there any evidence that the Health Division has ever overturned, or even reviewed, the decision of a hospital peer review committee. Operational authority thus rests with the peer review committee and not with the Health Division.

BOME Scrutiny. That hospitals must report adverse peer review decisions to the BOME pursuant to Or. Rev. Stat. § 441.820 is irrelevant to the issue whether Oregon actively supervises peer review decisions. Neither the statutory nor the regulatory provisions setting forth the BOME's authority to regulate the practice of medicine even remotely suggest that the BOME possesses the authority to reverse, or even to review, hospital decisions denying or revoking privileges. Rather, the only plausible inference to be drawn from section 441.820 is that reporting is required in order to inform the BOME about instances of substandard medical practice so that the BOME can decide whether any official action, such as license revocation or suspension, is warranted. The BOME exercises no operational authority over peer review decisions.

Judicial Review. No court has ever held that decisions of hospital peer review committees in Oregon are subject to judicial review of any kind, much less the active supervision needed to confer state action immunity. The courts of Oregon have considered the issue of reviewability twice. In each instance, the court declined to resolve the question whether and to what extent hospital peer review decisions may be reviewed in the courts. *Straube v. Emanuel Lutheran Charity Board*, 287 Or. 375, 600 P.2d 381 (1979) (in banc); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398 (1975). Although *Huffaker* reserved the question whether any review of the substance of a peer review decision could be had in state court, *Straube*, the more recent case, suggested that a claimant would be at most entitled to challenge the fairness of peer review *procedures*. 600 P.2d at 384. Neither case

even hinted at the possibility of anything more than deferential ("arbitrary and capricious" or "substantial evidence") review. This uncertain and nonsubstantive review of peer review decisions falls far short of the type of active supervision necessary for state action immunity.

Under Oregon law, no organ of state authority ratifies, or even reviews, the peer review decision to ensure conformity with the state policy to promote sound medical practice. There is simply no "pointed reexamination" of peer review decisions. *Midcal*, 445 U.S. at 106. In short, the State of Oregon does not actively supervise individual peer review decisions in a manner sufficient to confer state action immunity upon the members of peer review committees.[6] Accordingly, the decision of the court of appeals should be reversed for this reason as well.

II. RESOLUTION OF THE ANTITRUST ISSUES IN THIS CASE SHOULD BE INFORMED BY AN UNDERSTANDING OF THE POTENTIAL PROHEALTH AND PROCOMPETITIVE BENEFITS OF PEER REVIEW, BUT SHOULD ALSO ACKNOWLEDGE THE PARTICULAR ANTICOMPETITIVE RISKS OF UNSCRUTINIZED INTERPROFESSIONAL PEER REVIEW.

A. The Nature of Hospital Peer Review Requires Care In Defining The Scope Of State Action Immunity To Ensure That Prohealth And Procompetitive Activity Is Protected While Conduct Intended Solely To Limit Competition Is Not.

In challenging the decision of the Court of Appeals to provide state action immunity for bad faith hospital peer review decisions in Oregon, *amicus* does not mean to suggest that hospital peer review is inevitably anticompetitive in purpose and effect. To the contrary, in the judgment of *amicus*, properly conducted and supervised peer review can enhance both the quality of health services and competition in the market for provision of those services.

[6] Indeed, it may be that the Oregon legislature was content to rely upon the judicial review provided by state and federal antitrust law to ensure that peer review served the purposes for which it is designed. The "good faith" immunity provided by statute was plainly intended to preserve liability for "bad faith" conduct.

The term "peer review" refers to a broad range of related practices in the health care area. In general, the term denotes reliance on a group of professionals to fix standards for the quality, appropriateness, and reasonable cost of health care services. The practice had its genesis in cost-containment pressures from third-party payors such as insurance companies, Young, *A Brief History of Quality Assurance and Peer Review*, 8 Professional Psychology 9, 10 (1982), and this remains an important purpose of peer review. Peer review such as that at issue in the present case, however, is directed primarily at assuring the quality of health care. *See* Sechrest & Hoffman, *The Philosophical Underpinnings of Peer Review*, 8 Professional Psychology 14, 17 (1982) (describing potential of peer review to be "a centripetal force that would unite professionals in a genuinely collegial effort to promote responsible professional practice of the highest order"). This means of quality assurance has long been used by hospitals to ensure that staff physicians meet adequate standards of care. *See generally* Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 Case Western Res. L. Rev. 1117 (1986).

The use of peer review as a means of quality assurance for mental health professionals is also widespread. Because of the relative newness of this development, the efficacy of peer review as a means to enhance the quality of mental health care has not yet been thoroughly affirmed by empirical methods. *See* Cohen, *Research on Mental Health Quality Assurance*, *in* Handbook of Quality Assurance in Mental Health 65 (G. Stricker & A. Rodriguez eds. forthcoming); Sechrest & Rosenblatt,

Evaluating Peer Review, *in* Handbook of Quality Assurance in Mental Health 81. But policymakers—including the United States Congress—endorse peer review as a means to advance quality in the provision of mental health care. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* (providing immunity for good faith peer review decisions).

In most situations, peer review for quality assurance purposes will not raise serious risks of anticompetitive conduct, and will in fact promote competition. Because hospitals generally will be in competition with other hospitals, peer review to enhance the quality of medical care will improve the competitive position of a hospital by enhancing the services it offers. *See* Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1093 (*"Doctors and Hospitals"*). Competition on this level can also indirectly overcome the problem of general consumer ignorance about the relative quality of health care providers: "Because a hospital can obtain professional assistance in making technical decisions and must satisfy patients in a competitive environment, it can be viewed as a sophisticated and accountable agent of the ignorant consumer in making personnel decisions." *Id.* at 1104. *See also*, Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 Case Western Res. L. Rev. at 1128.

In one situation, however, the hospital peer review process does present systemic risks of excluding competitors and limiting competition for reasons unrelated to the improvement of health care. The interprofessional or interdisciplinary nature of health care gives rise to special antitrust concerns. "A hospital's policy on the admission of patients under the care of nonphysicians might easily reflect the staff physicians' fear of competition over both price and therapeutic ideology." Havighurst, *Doctors and Hospitals*, at 1113. Hospital peer review committees are typically in the control of physicians.

Physicians are frequently antagonistic to independent practice by psychologists and other health care providers who have degrees other than medical degrees, *see Virginia Academy of Clin. Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), and the pervasive practice has been to prevent these professions from obtaining hospital privileges, even when limited to activities within the scope of their professional licenses. *See, e.g., Position Statement on Hospital Privileges for Psychologists*, 128 Am. J. Psychiatry 1456 (1971) (setting forth official position of American Psychiatric Association); *Position Statement on Administration of Psychiatric Facilities*, 133 Am. J. Psychiatry 604 (1976) (same). Although this conduct will sometimes be rationalized on specious health-related grounds,[7] often such arguments are pretexts, dressing up naked, unjustified efforts to restrict competition from alternative providers of mental health services or other health services. Courts have recognized this problem in numerous contexts.[8]

---

[7] Typically such arguments will take the form of an attempt to define all treatment of mental health problems and other health problems as "medical" treatments. An official of the American Psychiatric Association has described the effects of the process as follows:

> "Medical care becomes equated with health care, This brings psychiatry back into the mainstream of the medical establishment, because the equation of medical care with health care is the basis on which organized medicine claims the right to exert control over the total health care industry."

Tension Rising Between Psychology, Psychiatry, Clinical Psychiatry News, November 1977 at 1 (summarizing remarks of director of membership services and studies division of American Psychiatric Association).

[8] *See, e.g., Weiss v. New York Hospital*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985); *Shaw v. Hosp. Auth.*, 614 F.2d 946 (5th Cir. 1980), *cert. denied*, 449 U.S. 955 (1980).

Commentators have also perceived the potential for abuse. *See* Bersoff, *Hospital Privileges and the Antitrust Laws*, 38 Am. Psych. 1238, 1239 (1983); Dolan & Ralston, *Hospital Admitting Privileges and The Sherman Act*, 18 Houston L.R. 707, 728-729 (1981).

But these risks have not been addressed by the court of appeals or the parties in the present case. Given the prohealth and procompetitive potential of peer review, and the systemic risk of exclusionary practices in the interprofessional context, *amicus* suggests that it is crucial to exercise care in defining the scope of state action immunity. If a State has clearly articulated a policy that endorses purely exclusionary conduct by health care practitioners controlling peer review processes, then principles of federalism require this Court to respect the choice by recognizing an exemption from the antitrust laws. *Amicus* believes this situation will be rare or nonexistent. All States—as well as the federal government—recognize the scientific and therapeutic validity of mental health care provided by psychologists.[9] Most states, including Oregon, explicitly provide, through "freedom of choice" statutes, for direct recognition of psychologists for reimbursement purposes. Or. Rev. Stat. § 743.123.[10] Because *amicus* is confident of the ability of psychology to be accepted in the legislatures, *amicus* believes that a properly limited state action immunity poses little risk of exempting from antitrust scrutiny the systematic efforts by physicians to exclude psychologists and other health professions from hospital privileges. If, however, state enactments authorizing peer review for purposes of improving health care are broadly understood as immunizing exclusions for the sole purpose of limiting competition—such as the exclusion at issue in this case—then there exists a significant risk of systematic exclusion of

[9] All fifty states and the District of Columbia have certification or licensure laws authorizing psychologists to provide mental health care independently of medical supervision. Lahman, *Licensure Requirements for Psychologists: USA and Canada* (1978).

[10] *E.g.*, Ark. Stat. Ann. § 66-3212.6 (1980); Md. Code Ann. art. 48A, § 490A (Supp. 1981); Miss. Code Ann. § 83-41-211 (Supp. 1981); N.Y. Ins. Law §§ 164.7-d, 221.5(e), 250.1 (Supp. 1981); Tenn. Code Ann. 56-7-108; Va. Code Ann. §§ 38.1-824, 38.1-347.1 (Supp. 1979).

psychologists and other health professionals, in contravention of not only the free-market goals of the Sherman Act but also the explicit state and federal policies recognizing the validity of these professions.

B. These Principles Are Also Relevant To Deciding Broader Questions Of The Appropriate Antitrust Analysis For Hospital Peer Review Practices.

Should this Court find it necessary in the present case to reach the broader question of what standards of antitrust liability are appropriate for evaluating the hospital peer review process, *amicus* believes that the principles discussed in the foregoing section are highly relevant.

Some courts have provided a qualified immunity from antitrust liability for concerted activity by health care professionals where it is shown that an arguably anticompetitive decision was made for the purpose of promoting patient care. *E.g., Wilk v. American Med. Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984), *on remand* —— F.Supp. —— (No. 76C3777, N.D. Ill., Aug. 27, 1987). Although *amicus* believes this position has much to recommend it, immunity of this kind is difficult to square with this Court's decision in *National Soc. of Professional Engineers v. United States*, 435 U.S. 679 (1978). In that case, the Court made clear that an anticompetitive restraint on bidding imposed by a professional organization was not immunized from antitrust scrutiny on the ground that the restraint was imposed for purposes of promoting public safety. 435 U.S. at 694-696. Nonetheless, *National Soc. of Professional Engineers* made clear that reasonable restraints on trade may survive antitrust scrutiny if they are ancillary to a legitimate purpose. *Id.* at 696 n.22. As applied to hospital peer review, individual peer review decisions will often be ancillary to pro-competitive purposes. *See* Havighurst, *Doctors and Hospitals*, 1984 Duke L.J. at 1093. Where, however, peer review decisions involve the denial by one profession of access to essential health care facilities for

members of other health care professions, then *amicus* suggests that a far more exacting antitrust scrutiny should be applied.

CONCLUSION

For the foregoing reasons, *amicus* submits that the judgment of the court of appeals should be reversed.

Respectfully submitted,

DONALD N. BERSOFF
(Counsel of Record)
DAVID W. OGDEN
DONALD B. VERRILLI, JR.
ENNIS FRIEDMAN & BERSOFF
1200 17th Street, N.W., Suite 400
Washington, D.C. 20036
Telephone: (202) 775-8100
Attorneys for Amicus Curiae
American Psychological Association

November 25, 1987