
IN THE
United States Court of Appeals
FOR THE FOURTH CIRCUIT

No. 79-1345

**VIRGINIA ACADEMY OF CLINICAL
PSYCHOLOGISTS, et al.,**

Appellants,

v.

BLUE SHIELD OF VIRGINIA, et al.,

Appellees.

**On Appeal from the United States District Court for the
Eastern District of Virginia**

**BRIEF OF AMERICAN
PSYCHOLOGICAL ASSOCIATION AS
AMICUS CURIAE**

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This amicus brief is conditionally filed, pursuant to Rule
29, Fed. R. App. P., and is accompanied by a Motion for
Leave to File.

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 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 in the broadest and most liberal manner."

The APA has 49,000 members—1,092 in Virginia—and includes the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. One of the APA's central functions is to establish ethical standards for the guidance of psychologists. The principles in APA's code of ethics have been incorporated into the laws of many states, thus governing the professional conduct of psychologists licensed in those states.

Since 1948 the APA has accredited doctoral programs in professional psychology. Accreditation policies and procedures have undergone almost continual re-examination in keeping with the changing and expanding nature of professional psychology, and the last major revision was completed earlier this year. APA has also been instrumental in developing testing standards for the validation and administration of psychological tests.

A substantial and growing number of APA's member psychologists are health care providers licensed to provide mental health care to individual clients. APA has undertaken several recent projects intended to assist the public and other interested institutions to identify qualified practitioners. For example, the National Register of Health Service Providers in Psychology, a project initiated by, but operated apart from, APA, publishes a directory identifying psychologists licensed and qualified to independently deliver health care services. And, in order to provide consumers and third-party payors with a formal but readily accessible avenue of redress should a question arise regarding services or fees, APA has actively participated

in the establishment of peer review programs on a nationwide basis.

APA has long been active in the effort to improve mental health care delivery in the United States, and this most significant issue lies at the heart of this case. Mental and emotional disorders afflict more Americans than any other category of disabling condition, and the 1978 Report of the President's Commission on Mental Health indicates that at least 15 percent of the population—approximately 33 million people—require some form of professional mental health treatment. However, the Commission found that the mental health field is plagued by a shortage of personnel trained to deliver these much needed services.¹

The interest of amicus in the outcome of this case is clear: the decision of the district court, if allowed to stand, will constitute a serious obstacle to the effective delivery of mental health services by diminishing the ability of its member psychologists in Virginia to provide mental health services on an independent basis and by limiting the range of services and treatment methods available to Virginia consumers.

SUPPLEMENTAL STATEMENT OF THE CASE²

At issue in this appeal is the unlawful refusal of Blue Shield of Virginia ("BSV") and Blue Shield of Southwestern Virginia ("BSSV") to provide direct payments to clinical psychologists for outpatient psychological services rendered to Blue Shield subscribers unless those services are ordered, supervised, and billed by a physician.

¹ 1 PRESIDENT'S COMMISSION ON MENTAL HEALTH, REPORT TO THE PRESIDENT 2-10 (1978).

² The Supplemental Statement is not a complete statement but rather a summary of facts germane to the arguments propounded by amicus.

Appellants, the Virginia Academy of Clinical Psychologists ("VACP") and Dr. Robert J. Resnick, a practicing clinical psychologist, contended at trial that this policy, developed by BSV and BSSV in conjunction with the Neuropsychiatric Society of Virginia ("NSV"), constitutes a combination in restraint of trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976). The United States District Court for the Eastern District of Virginia disagreed and denied appellants' claim for injunctive relief, holding, as an alternative basis for the judgment, that there was no restraint of trade within the meaning of Section 1 because clinical psychologists do not compete with psychiatrists. Memorandum Opinion at 12-14.³ It is this erroneous ruling that amicus will address in this brief.

A. Statement of the Facts

Amicus adopts the statement of facts set forth by appellants Resnick and VACP in their brief to this Court. However, for the convenience of the Court, and in order to provide a factual context for the argument that follows, major factual points are summarized below.⁴

VACP is an association composed primarily of clinical psychologists licensed to practice under Virginia law.⁵ Clinical psychologists provide such services as psychotherapy, psychological evaluation, and testing for the purpose of diagnosing and treating mental health problems.⁶ Dr. Res-

³ The district court's opinion has been unofficially reported at 1979-1 TRADE REG. REP. (CCH) ¶ 62,635 (E.D. Va. 1979).

⁴ Because the record in this case has been transmitted under seal, the exhibits admitted into evidence at trial were not available to amicus for preparation of this brief. Although amicus recognizes a formal motion for appropriate relief could have been filed with this Court, such a course of action was effectively impossible because of time constraints. The transcript of testimony at trial was available to amicus.

⁵ See Va. Code Ann. §§ 54-274, 54-309.1, 54-939 (1978).

⁶ Virginia law defines a clinical psychologist as "a psychologist

nick, a licensed clinical psychologist who practices in Virginia, is immediate past president of VACP.

BSV and BSSV (collectively the "Blue Shield defendants") are nonstock corporations that operate various plans for furnishing prepaid health care services to Virginia consumers. Covering virtually the whole state, the Blue Shield defendants are the dominant operators of prepaid health care plans in Virginia,⁷ and they are dominated and controlled by physicians. For example, until recently the BSV bylaws specified that one-third of its fifteen-member board of directors be physicians designated by the Medical Society of Virginia, which is composed of physicians practicing in the state.⁸ Moreover, BSV has described itself as "sponsored by the Medical Society of Virginia" and "the doctors' plan for doctors." See Va. Code Ann. § 38.1-811 (Cumm. Supp. 1979) (permitting nonstock corporation to serve as agent for physicians in operating prepaid health plan).

NSV is a nonprofit, nonstock corporation whose members are psychiatrists who practice in Virginia. Although licensed by the state as physicians, psychiatrists are not required to have any special state certification in order to practice psychiatry.⁹ NSV has, consistent with its objec-

chological evaluation and psychotherapy to individual clients for the purpose of ameliorating or attenuating problems of behavioral and/or emotional maladjustment." Va. Code Ann. § 54-936(c) (1978).

⁷ For example, BSV has as subscribers approximately 40 percent of the health care consumers within its area of the state. No commercial insurance carrier has a market share that approaches that of BSV.

⁸ While state law requires the majority of the Blue Shield board to be "providers of health care services," Va. Code Ann. § 38.1-817 (Cumm. Supp. 1979), there is no requirement that these members be physicians. However, the Blue Shield defendants have never had "provider" members other than physicians.

⁹ See Va. Code Ann. §§ 54-273(3), 54-309 (1978).

tive of promoting the economic interests of psychiatrists, sought to expand Blue Shield coverage and benefits for services rendered by psychiatrists, and has opposed direct reimbursement for psychologists.

Prior to early 1972, the Blue Shield defendants reimbursed subscribers for services rendered them by clinical psychologists. However, in light of the increasing concern of NSV and the Medical Society of Virginia about "encroachment" of non-physician health care providers, and in collaboration with NSV, Blue Shield altered its reimbursement policy and refused to pay for the services of clinical psychologists unless those services were billed by a physician.

In 1973, the Virginia General Assembly enacted a statute prohibiting Blue Shield from refusing to pay for services provided by clinical psychologists if Blue Shield paid for those services rendered by physicians. The statute provides:

No plan for furnishing prepaid medical and surgical, and similar or related services, or any of such services, shall fail or refuse, either directly or indirectly, to allow or to pay for services, or any part thereof, rendered by any doctor of podiatry, doctor of chiropractic, or optometrist, optician, psychologist, or clinical social worker duly licensed to practice in Virginia, to the holder of any contract or subscription contract issued under or pursuant to such plan if the services rendered (i) are services provided for by such contract or subscription contract and, in the case of services by a clinical social worker, have been specifically contracted for by the holder of any such contract or subscription contract, which coverage must be made available to the holder of such contract, and (ii) are services which the doctor of podiatry, doctor of chiropractic or optometrist, optician and psychologist is licensed to render in Virginia.

Va. Code Ann. § 38.1-824 (Cumm. Supp. 1979). Despite this statute, commonly known as a "freedom of choice"

law because it affords consumers the opportunity to choose among qualified health care providers (in this case between psychologists and psychiatrists), the Blue Shield defendants have continued their practice of refusing to make direct payments to psychologists.¹⁰ Moreover, NSV, which aided in formulating this discriminatory policy, has consistently reaffirmed its support of the Blue Shield position.

B. Relevant Background

Psychology is the scientific study of behavior and experience and the application of that knowledge to human problems. Since the last century, psychology and psychologists have figured prominently in research and teaching concerning mental, emotional and behavioral processes. These contributions are particularly important today, when, in the words of the President's Commission on Mental Health, "mental illness . . . probably constitutes our primary public health issue."¹¹

The practice of psychology has been defined as the rendering of services involving the application of principles, methods, and procedures of understanding, predicting, and influencing behavior. The application of such principles and methods includes diagnosis, prevention, treatment, and amelioration of psychological problems and emotional disorders of individuals and groups.¹²

¹⁰ The constitutionality of the "freedom of choice" law, a question irrelevant to the instant case, is at issue in state proceedings initiated by the Virginia State Corporation Commission and in which BSV is a respondent. BSSV is not a party to the state legal action, and although it has modified some of its contracts to allow direct payments to psychologists, it has continued the nonpayment policy in others and has reiterated its opposition to such payments.

¹¹ 2 PRESIDENT'S COMMISSION ON MENTAL HEALTH, TASK PANEL REPORT ON THE NATURE AND SCOPE OF THE PROBLEMS 11 (1978).

¹² See Cal. Bus. & Prof. Code Ann. § 2903 (Supp. 1979); Va. Code Ann. § 54-936(d) (1978).

By 1977, all fifty states and the District of Columbia had enacted laws regulating the practice of psychology. Most states establish the doctoral degree in a field of study primarily psychological in nature, two years of supervised experience, and a successful written and oral examination as the minimum requirements for licensure or certification.¹³ Psychologists, by virtue of their training and experience, are recognized as fully qualified to diagnose and treat mental disorders.

Indeed, no other mental health profession requires of its practitioners as high a degree of education and training specifically in mental and emotional processes as does the profession of psychology. Generally, a doctoral level program in clinical psychology requires four to five years of rigorous and extensive didactic and field placement experience, with approximately three years devoted to coursework, one year to a fulltime supervised internship at a clinic, hospital or other training center, and one year to dissertation research. The basic training model for doctoral programs in clinical psychology is the scientist-professional model, *i.e.*, the teaching of the basic science and methods of psychology combined with the theory and techniques of clinical intervention.¹⁴ By way of contrast, psychiatrists are not required to have additional training or certification other than the M.D. degree.

As in other professions, licensure/certification is generic, that is, a license or certificate does not pinpoint the psychologist's practice to any one specialty area (*e.g.*, clinical, counseling, industrial-organizational, or school psycholo-

¹³ *E.g.*, Cal. Bus. & Prof. Code Ann. § 2914 (Supp. 1979); Md. Code Ann. art. 43, § 629 (Supp. 1978); Regulations of Virginia Board of Behavioral Science for Virginia Board of Psychology, § II, POR 2.2 (1979).

¹⁴ *See generally* American Psychological Association, *Criteria for Accreditation of Doctoral Training Programs and Internships* (January 1979).

gy). To further ensure a high quality of professional practice, the states have adopted ethical codes identical or quite similar to the APA's *Ethical Standards of Psychologists*.¹⁶ The *Ethical Standards* deal with a variety of professional and scientific issues such as confidentiality, utilization of assessment techniques, consumer welfare, and professional relationships. The ethical code also mandates that psychologists practice only within their areas of expertise and specifically states that the psychologist is to seek expert assistance—such as medical consultation—when necessary.

Psychologists have long been leaders in the field of psychotherapy, which can be defined informally as "an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes, and behavior which have proven troublesome to [the patient]."¹⁶ The efficacy of psychotherapy as a general category of treatment has been repeatedly confirmed,¹⁷ and, in terms of specific application, studies have marked the beneficial effects of psychological treatment on a wide range of problems, including sexual disorders, learning difficulties, schizophrenia, and alcoholism.¹⁸

In addition, psychologists are actively involved in treating the emotional complaints of many health conditions

¹⁶ See, e.g. Md. Code Ann. art. 43, § 627 (1971); Regulations of Virginia Board of Psychology § V, POR 5.1 (1979).

¹⁶ GARFIELD & BERGIN, *HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE: AN EMPIRICAL ANALYSIS* 3 (2d ed. 1978).

¹⁷ E.g., MELTZOFF & KORNREICH, *RESEARCH IN PSYCHOTHERAPY* (1970); Bergin & Lambert, *The Evaluation of Therapeutic Outcomes*, in GARFIELD & BERGIN, *supra* at 139; Smith & Glass, *Meta-Analysis of Psychotherapy Outcome Studies*, 32 *AMERICAN PSYCHOLOGIST* 752 (1977); Kellner, *The Evidence in Favor of Psychotherapy*, 46 *BRITISH JOURNAL OF MEDICAL PSYCHOLOGY* 341 (1967).

¹⁸ See generally GARFIELD & BERGIN, *supra*.

previously seen as solely "physical" or "medical" in nature. For example, behavior therapists apply psychological principles and have been notably successful in the assessment and treatment of many conditions, including problems related to tension (heart disease, ulcers), addiction (alcohol, drugs), and chronic pain.¹⁹

Although the interdependence between mental and physical health has been recognized even in traditional medicine for some time,²⁰ the disappearance of arbitrary distinctions between the two has been highlighted in recent years. Mental health is increasingly viewed as a necessary component of overall human health, and health care planners are acknowledging the role that psychology can play in improving the physical and mental well-being of individuals afflicted with many diseases and disabilities. Psychologists are continuing to pioneer in the development of procedures effective in resolving specific health problems,²¹ and the increased availability of psychological services will lead to improved health care.

An estimated 54 percent of the mentally disordered receive mental health services primarily from the general

¹⁹ E.g., Olbrisch, *Psychotherapeutic Intervention in Physical Health: Effectiveness and Economic Efficiency*, 32 AMERICAN PSYCHOLOGIST 761 (1977); Kellner, *Psychotherapy in Psychosomatic Disorders*, 32 ARCH. GEN. PSYCHIATRY 1021 (1975); Emrick, *A Review of Psychologically Oriented Treatment of Alcoholism*, 36 JOURNAL OF STUDIES ON ALCOHOL 88 (1975).

²⁰ See generally Kaufman, *Psychiatric Findings in Admission to a Medical Service in a General Hospital*, 26 JOURNAL OF THE MOUNT SINAI HOSPITAL 160 (1959); Kellner, *Psychiatric Ill Health Following Physical Illness*, 112 BRITISH JOURNAL OF PSYCHIATRY 71 (1966); Nigro, *A Psychiatrist's Experiences in General Practice in a Hospital Emergency Room*, 214 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1657 (1970).

²¹ See, e.g., Fordyce, *An Operant Conditioning Method for Managing Chronic Pain*, 53 POSTGRADUATE MEDICINE 123 (1973); *Biofeedback in Action*, World Medical News (March 9, 1973), at 47.

health care system rather than from practitioners specifically trained for these services.²² As HEW Secretary Joseph Califano said in a recent speech:

Medical education has not fully come to grips with the issue of emotional and mental problems. By one recent estimate, 60 to 70 percent of mental and emotional illness, including alcohol-related problems, is treated in the medical system rather than in the mental health system. This represents an important burden for thousands of physicians in the health care system: a burden for which too few are properly trained.²³

It has been repeatedly demonstrated that psychological intervention can lower the cost of medical services and can ease the load on our overburdened medical facilities. Studies have consistently shown that emotionally distressed individuals are unnecessarily heavy users of general health services, and that significant declines in the use of those services occurred when these patients received psychological services.²⁴ In addition, a survey of insurance claims of patients who utilized psychological services has shown that the total costs of health care services to the insurer

²² TASK PANEL REPORT ON THE NATURE AND SCOPE OF THE PROBLEMS, *supra* at 51.

²³ The Blue Sheet: Drug Research Reports S-5 (November 1, 1978).

²⁴ E.g., NATIONAL INSTITUTE OF MENTAL HEALTH, IMPACT OF ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH TREATMENT ON MEDICAL CARE UTILIZATION—A REVIEW OF THE LITERATURE (February 1979); Rosen & Wiens, *Changes in Medical Problems and Use of Medical Services Following Psychological Intervention*, 34 AMERICAN PSYCHOLOGIST 240 (1979); Cummings & Follette, *Brief Psychotherapy and Medical Utilization: An Eight-Year Follow-up*, in DORKEN, THE PROFESSIONAL PSYCHOLOGIST TODAY: NEW DEVELOPMENTS IN LAW, HEALTH, INSURANCE AND HEALTH PRACTICE (1976); Goldberg et al., *Effect of a Short-term Outpatient Psychiatric Therapy Benefit on The Utilization of Medical Services in a Prepaid Group Practice Medical Program*, 8 MEDICAL CARE 419 (1970).

were substantially lowered,²⁵ and similar benefits to employers have been documented.²⁶

As the utility of psychologists as health care professionals has been established, over the past decade psychologists have earned public and legal recognition as autonomous and equal providers of health care services, i.e., without mandatory referral or supervision by a physician. Most relevant federal statutes require direct recognition of clinical psychologists as independent health care providers.²⁷ Two notable examples are the Federal Employees Health Benefits Program,²⁸ which covers approximately 10 million federal workers and their beneficiaries, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),²⁹ which covers both inpatient and outpatient

²⁵ Jameson, et al., *The Effects of Outpatient Psychiatric Utilization on the Costs of Providing Third-Party Coverage*, Research Services 118, Blue Cross of Western Pennsylvania (1976).

²⁶ E.g., Alander & Campbell, *An Evaluative Study of an Alcohol and Drug Recovery Program: A Case Study of the Oldsmobile Experience*, 14 HUMAN RESOURCE MANAGEMENT 14 (1975); Goldbeck, *Corporate Mental Health Benefits*, Boston University Health Policy Conference on Industry Sponsored Health Programs (1977). In the latter study, employers cited lowered employee absenteeism, improved productivity, reduced hospitalization, and fewer instances of severe mental illness requiring sick leave as reasons for including mental health coverage in their health care benefits.

²⁷ E.g., Federal Employees Compensation Act, 5 U.S.C. § 8101(2) (1976); Vocational Rehabilitation Act, 29 U.S.C. § 723(a) (1976); Health Maintenance Organization Act, 42 U.S.C. § 300e-1 (1976); 42 C.F.R. §§ 110.101, 110.104 (1978); Disaster Relief Act, 42 U.S.C. § 5183 (1976); 42 C.F.R. § 38.2(e) (1978); Veterans Health Care Expansion Act, 38 U.S.C. § 613(b) (1976); Comprehensive Employment and Training Act, 29 U.S.C. §§ 801 et seq. (1976); 29 C.F.R. § 94.4(bb) (1978).

²⁸ 5 U.S.C. § 8902(k) (1976).

²⁹ 10 U.S.C. §§ 1071 et seq. (1976), 32 C.F.R. § 199(c) (3) (iii) (a) (1978).

services for approximately 7 million dependents of military personnel, retired military personnel, and other beneficiaries. In addition, the President's Commission on Mental Health has recommended independent status for clinical psychologists under Medicare and under any future national health insurance program."

Twenty-nine states representing 80 percent of the population—including Virginia—have passed legislation assuring the insured consumer the choice between psychiatric and psychological services under policies providing mental health coverage.¹¹ The Health Insurance Association of America, which represents more than 300 insurance companies that write approximately 80 percent of all health insurance contracts issued by United States companies, formally supports the introduction of such "freedom of choice" legislation in the remaining states and has endorsed a model statute.

Other state statutes recognize the expertise of psychologists in a variety of settings,¹² and a majority of the states provide that the communications between a psy-

¹⁰ REPORT TO THE PRESIDENT, *supra* at 29-30.

¹¹ *E.g.*, Ark. Stat. Ann. § 66-3212.6 (1966); Md. Code Ann. art. 48A, § 490A (1979); Miss. Code Ann. § 83-41-211 (1972); N.Y. Ins. Law §§ 164(7-d), 221(5)(e), 250(1) (Supp. 1978); Va. Code Ann. §§ 38.1-824, 38.1-347.1 (Cumm. Supp. 1979); Tenn. Code Ann. § 56-1145 (1968).

¹² *E.g.*, Colo. Rev. Stat. Ann. § 10-8-116 (1973) (group hospitalization or medical benefits policies must provide coverage for psychological services); Del. Code Ann., tit. 16, §§ 902, 903 (1974 & Supp. 1978) (report by psychologist of child abuse); N.Y. Mental Hygiene Law § 41.11 (1978) (psychologist to serve on community services board); Ohio Rev. Code Ann. § 2947.06 (1975) (court appointment of psychologist to make reports on criminal defendants); Md. Code Ann. art. 31B, §§ 1 *et seq.* (Supp. 1978) (rehabilitation program for convicts); Va. Code Ann. § 37.1-65.1 (Cumm. Supp. 1979) (civil commitment).

chologist and his or her patient are privileged." In addition, numerous federal and state courts have held that clinical psychologists are competent to testify as expert witnesses in the field of mental disorders.³⁴

Recognition of psychologists as independent health care providers, in the marketplace³⁵ as well as in legislatures, has met with strenuous opposition from physicians in general and psychiatrists in particular. Psychiatrists view their "territory" as being "assailed from every side" by psychologists and consider the economic implications to be grave indeed.³⁶ This is hardly surprising, since, as a Senate committee has concluded, "there is little if any benefit derived from the practice of [physician] supervision

³⁴ *E.g.*, Ky. Rev. Stat. Ann. § 319.111 (1977); Tenn. Code Ann. § 63-1117 (1976); Va. Code Ann. § 8.01-399 (1977). *See also* Rule 501, Fed. R. Evid.

³⁵ *E.g.*, *United States v. Riggleman*, 411 F.2d 1190 (4th Cir. 1969); *United States v. Brawner*, 471 F.2d 969 (D.C. Cir. 1972) (en banc); *United States v. Portis*, 542 F.2d 414 (7th Cir. 1976); *Hogan v. State*, 496 S.W. 2d 594 (Tex. Crim.), *cert. denied*, 414 U.S. 862 (1973); *Rollins v. Commonwealth*, 207 Va. 575, 151 S.E. 2d 622 (1966), *cert. denied*, 386 U.S. 1026 (1967); *Roberts v. State*, 41 Wis. 2d 537, 164 N.W. 2d 525 (1969). *See also* Rule 702, Fed. R. Evid.

³⁶ Several major commercial insurance carriers, such as Aetna, Travelers, Prudential, and Occidental, routinely reimburse for psychological services. And, earlier this year, Blue Shield of California accorded psychologists "participating provider" status under its prepaid plan. The United Rubber, Cork, Linoleum and Plastic Workers of America recently negotiated an industry-wide health plan contract covering services rendered by psychologists, and many local unions in other areas have obtained similar benefits. Many employees recognize the advantages of providing mental health coverage, and many offer a choice of providers. *See* note 26, *supra*. For example, the company health plan of Delta Airlines, covering 26,000 employees, reimburses for psychological services.

³⁷ *Province of Psychiatry Questioned, Said to Need Defining*, *Clinical Psychiatry News* (November 1977), at 1.

of [mental health] service other than the earning of money by doctors of medicine. . . ."³⁷

The oft-stated policy of the American Psychiatric Association is to do everything possible to keep psychologists and other professionals in a subordinate role under the direction of physician-psychiatrists despite their authority to practice independently under state and federal law.³⁸ In addition to these official pronouncements, various leaders in the field of psychiatry have candidly stressed the need to "declar[e] war on anyone trying to move in on their territory" and to "push for treatment supremacy over allied health professionals practicing in the mental health field."³⁹

One example of this effort is the attempted "remedicalization" of psychiatry, i.e., an attempt to define all treatment of mental health problems as "medical."⁴⁰ 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

³⁷ S. REP. NO. 92-861, 92d Cong., 2d Sess. 5 (1972). See also S. REP. NO. 93-961, 93d Cong., 2d Sess. (1974).

³⁸ E.g., *Position Statement on Hospital Privileges for Psychologists*, 128 AMERICAN JOURNAL OF PSYCHIATRY 1456 (1971); *Position Statement on Psychiatrists' Relationships with Non-Medical Mental Health Professionals*, 130 AMERICAN JOURNAL OF PSYCHIATRY 386 (1973); *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, 130 AMERICAN JOURNAL OF PSYCHIATRY 1058 (1973); *Position Statement on Administration of Psychiatric Facilities*, 133 AMERICAN JOURNAL OF PSYCHIATRY 604 (1976).

³⁹ *Psychiatry Faces Survival Battle, Threats to Profession Seen*, American Medical News (May 26, 1978), at 1 (summarizing remarks of president of American Psychiatric Association).

⁴⁰ For example, the fourth edition of *A Psychiatric Glossary* (American Psychiatric Association 1974) introduced a new term, "medical psychotherapy." Advertising material emphasized that this "new definition will be helpful to psychiatrists in relation to the third-party payment problem."

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.⁴¹

This policy of "control" by the medical profession has long been the policy of Blue Shield in Virginia as well. Indeed, Blue Shield grew out of "medical service bureaus" organized by county medical societies to combat plans developed by employers to deliver medical care to their employees on a contract basis. The more direct ancestors of the present Blue Shield plans were established in the 1940s, offering prepaid coverage through medical societies and other physician-controlled organizations.⁴² And, as early as 1947, the medical profession's control over Blue Shield plans was being criticized, particularly because of the impact of that control on physician's fees.⁴³

Today Blue Shield plans comprise by far the Nation's largest source of private third-party payments for medical services. During 1977, Blue Shield plans underwrote or administered medical care coverage for approximately 85.3 million Americans, or about 39.5 percent of the nation's total population.⁴⁴ Physician dominance of Blue Shield has continued, as medical societies and other physician orga-

⁴¹ *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).

For a specific example involving psychologists, see FTC BUREAU OF COMPETITION, MEDICAL PARTICIPATION IN CONTROL OF BLUE SHIELD AND CERTAIN OTHER OPEN-PANEL MEDICAL PREPAYMENT PLANS 159-61 (1979).

⁴² FTC BUREAU OF COMPETITION, *supra* at 54-60.

⁴³ REED, BLUE CROSS AND MEDICAL SERVICE PLANS 236 (1947). For more recent criticism, see KENNEDY, IN CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE 210 (1972).

⁴⁴ FTC BUREAU OF COMPETITION, *supra* at 80.

nizations "participate extensively in the control of most Blue Shield plans."⁴⁶

Blue Shield's exclusionary practices regarding services provided by non-physician practitioners is well-documented. Initially, the plans excluded dentists, nurses, pharmacists and doctors of osteopathy on the theory that these "auxiliary professional groups" might "dominate the situation."⁴⁶ Many Blue Shield plans continue to act on the premise that physician organizations should control all aspects of health care, including the services of non-physicians.⁴⁷

Although many Blue Shield plans extended coverage for mental health services in the 1960s, some—particularly in areas with high concentrations of psychiatrists—refused to recognize and reimburse clinical psychologists as independent providers, even though psychologists were licensed to practice independently in most states.⁴⁸ This, of course, has been the experience in Virginia. And, on the national level, Blue Shield refused to afford psychologists independent status in its program for Federal employees until Congress mandated coverage for psychologists' services in 1974.⁴⁹

SUMMARY OF ARGUMENT

By collectively refusing to reimburse clinical psychologists for outpatient psychological services rendered to Blue Shield subscribers unless their services are ordered by, supervised by, and billed through a physician, the

⁴⁶ *Id.* at 87.

⁴⁶ *Id.* at 159.

⁴⁷ *Id.*

⁴⁸ *Id.* at 163.

⁴⁹ 5 U.S.C. § 8902(k) (1976). See S. REP. No. 93-961, 93d Cong., 2d Sess. (1974) ("no justification" for requiring supervision of psychologists by physicians).

defendants have engaged in a group boycott against such psychologists—a *per se* violation of Section 1 of the Sherman Act. Moreover, since defendants' collective refusal diminishes price competition between psychiatrists and psychologists, it is illegal on its face on this ground as well.

It is also clear that the defendants' actions are illegal under a "rule of reason" analysis. The district court's conclusion that no restraint of trade had been proven because psychologists and psychiatrists do not compete is clearly erroneous as well as invalid as a matter of law. Both professional groups are independent providers of psychotherapy, the most common form of outpatient treatment for mental illness, and both groups serve a generally similar patient population. Indeed, the overlapping services provided by the two professions has so often been recognized in state and federal law⁴⁰ that this Court could take judicial notice of the fact that psychologists and psychiatrists compete in the delivery of mental health care services.

As a result of the restrictive Blue Shield reimbursement policy, effective competition for psychiatrists from licensed non-physician health care providers—particularly psychologists—has indeed been delayed and obstructed in Virginia. Although the authority of psychologists to practice independently has been recognized by state and federal law, the Blue Shield policy effectively keeps psychologists in Virginia in a "subordinate" or "physician-support" role and assures continued physician control over health care services and prices. The district court's decision, if allowed to stand, has seriously adverse implications for the effective delivery of mental health care services, not only in Virginia but in the nation as a whole.

⁴⁰ *E.g.*, 5 U.S.C. § 8902(k) (1976); 5 U.S.C. § 8101(2) (1976); Md. Code Ann. art 48A, § 490A (1979); Va. Code Ann. §§ 38.1-824, 38.1-347.1 (Cumm. Supp. 1979).

ARGUMENT

I. DEFENDANTS' ACTIVITIES CONSTITUTE A PER SE VIOLATION OF THE SHERMAN ACT

A. *Defendants Have Carried Out An Illegal Group Boycott Against Plaintiffs*

Defendants' concerted efforts to deny psychologists direct payment for their services constitutes a group boycott which is a *per se* violation of the Sherman Act.⁵¹ Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976), declares unlawful every "contract, combination . . . or conspiracy in restraint of trade or commerce among the several States. . . ." A combination or conspiracy which is the subject of Section 1 is formed where the participants have a common objective which, if carried out, will restrain trade and there is some course of conduct undertaken by the participants to accomplish that objective. *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951); *Interstate Circuit, Inc. v. United States*, 306 U.S. 208 (1939). No express agreement is necessary for a conspiracy finding. It is enough that concerted action is contemplated or that there is a "common design and understanding" and that defendants seek to conform to the arrangement or understanding. *United States v. General Motors Corp.*, 384 U.S. 127 (1966); *United States v. Singer Mfg. Co.*, 374 U.S. 174 (1963).⁵²

⁵¹ The district court did not even consider the applicability of the *per se* rule to defendants' conduct. The failure of the court to apply the *per se* rule, which is the proper legal standard in this case, constitutes reversible error. See *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1976); *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959).

Moreover, where competitors establish and control an organization, the anticompetitive effects of the organization's actions must be attributed to the competitors. *United States v. Sealy, Inc.*, 388 U.S. 350 (1967); *United States v. Topco Associates, Inc.*, *supra*.

There are a variety of activities which, when undertaken as a result of an arrangement or understanding among persons or groups of persons, constitute a violation of Section 1 of the Sherman Act. Most conspicuous are those activities which "because of their pernicious effect on competition and lack of any redeeming virtue" are deemed to be illegal *per se*. *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 5 (1958). Such is the case with a group boycott. A group boycott is illegal *per se* because it represents a "naked restraint of trade with no purpose except stifling of competition." *White Motor Co. v. United States*, 372 U.S. 253, 263 (1963).

A boycott is an agreement by a group of persons not to deal with another group of persons, and the law forbids this type of activity because it interferes with the free flow of competition. *Radiant Burners, Inc. v. Peoples Gas Light & Coke Co.*, 364 U.S. 656 (1961); *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959); *Associated Press v. United States*, 326 U.S. 1 (1945). Thus, boycotts are unlawful without regard to the motive or purpose of the persons, and even if instituted for laudable ends, are still unlawful. See *Fashion Originators' Guild v. FTC*, 312 U.S. 457 (1941). Moreover, even peaceful actions "designed to persuade persons from dealing with others" fall within the Sherman Act's proscription. *Ballard v. Blue Shield of Southern West Virginia, Inc.*, 543 F.2d 1075, 1078 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977).

The activities of the defendants here constitute a group boycott. By concerted action resulting in a refusal to pay the fees of clinical psychologists for out-patient psychological services rendered to subscribers of Blue Shield unless their services are ordered by, supervised by, and billed through a physician, the defendants have engaged in a group boycott against psychologists which restrains trade in violation of Section 1 of the Sherman Act. The effect is clearly horizontal, since the psychiatrists, in conjunction

with physician-dominated Blue Shield, are seeking to eliminate their major competitors—clinical psychologists—from the mental health market.”

Blue Shield has as subscribers approximately 40 percent of the consumers of health services in Virginia. Defendants’ boycott has effectively foreclosed psychologists from this substantial market. Without “access” to the Blue Shield plans, psychologists are denied one of the most important means by which they can effectively compete for business in the mental health care services market.

The exclusionary and anticompetitive effects of Blue Shield plans with restrictive reimbursement policies was recently stressed in a study conducted by the Bureau of Competition of the Federal Trade Commission. After a three-year investigation of Blue Shield plans across the country, the Bureau concluded:

The decision as to which providers are eligible to receive reimbursement has a significant impact on competition in the health care services market. To the extent that providers’ services are not covered by the Blue Shield contracts, those providers may be virtually eliminated as competitors in the portion of the market represented by Blue Shield subscribers. If the plan in question has a substantial market share, such providers may in fact be seriously hampered in competing in the market as a whole. Naked restraints having these exclusionary and market-division effects would clearly be *per se* illegal.”

“ Although the boycott at issue here has both vertical and horizontal characteristics, its impact is plainly horizontal. “[A] restraint becomes primarily horizontal in nature [when] one customer is seeking to suppress its competition by utilizing the power of a common supplier.” *Cernuto, Inc. v. United Cabinet Corp.*, 595 F.2d 164, 168 (3d Cir. 1979). *Accord, Klor’s, Inc. v. Broadway-Hale Stores, Inc.*, *supra* (agreement between department store and various suppliers placed competing retailer at severe disadvantage).

“ FTC BUREAU OF COMPETITION, *supra* at 210-11.

Although the court below erroneously thought it a crucial defense, it matters not that defendants' boycott has not *totally* excluded plaintiffs from access to the market (*i.e.*, plaintiffs do not dispute that they are paid *if* their services are ordered by, supervised by, and billed through a physician). Collective action that deprives competitors of "a valuable business service which they [need] in order to compete *effectively*" is sufficient to constitute a *per se* violation of Section 1. *Silver v. New York Stock Exchange*, 373 U.S. 341, 347 (1963)(emphasis supplied); *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, *supra* at 210 (boycott deprived plaintiff of goods needed to compete effectively)."

The *Silver* case is particularly instructive. There, the New York Stock Exchange denied two over-the-counter broker-dealers access to direct-wire telephone connections, and the brokers brought suit on the ground that the Exchange and its members had engaged in a group boycott in violation of Section 1. The Supreme Court agreed, noting that the brokers had been deprived of a "valuable business service which they needed in order to compete effectively" and had been stripped of "important business advantages." 373 U.S. at 347-48.

Although the boycott in *Silver* did not totally exclude the plaintiff from the over-the-counter securities market, it "hampered substantially" plaintiff's business activities, causing a loss of a "significant volume" of business in violation of Section 1. *Id.* at 348. Similarly, defendants' activities in the instant case have substantially interfered with the ability of psychologists to compete effectively for

" See also *Radiant Burners, Inc. v. Peoples Gas Light & Coke Co.*, *supra*; *Associated Press v. United States*, *supra*; *Fashion Originators' Guild v. FTC*, *supra*.

business in the mental health services market. The restriction of mental health reimbursements to those situations where there has been physician ordered and supervised care naturally results in physicians (e.g., psychiatrists) gaining a more dominant portion of the mental health care business to the exclusion and economic detriment of psychologists.

Just as complete exclusion from the market is not a prerequisite to a Section 1 violation, the conditional nature of the boycott here does not render it any less illegal. Although psychologists may obtain payment from Blue Shield if their services are ordered, supervised and billed through physicians, the effects of the restrictions are still substantial—and still illegal. The Supreme Court has emphasized on numerous occasions that the exacting of conditions as a requirement of doing business is as illegal as refusing to do business at all. *Paramount Famous Lasky Corp. v. United States*, 282 U.S. 30, 41-43 (1930) (insistence upon adherence to standard form contract is illegal); *United States v. First National Pictures, Inc.*, 282 U.S. 44, 53-55 (1930) (refusal to do business except on particular credit terms is illegal). See *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 552 (1978); *Proctor v. State Farm Mut. Auto. Ins. Co.*, 561 F.2d 262, 276 (D.C. Cir. 1977), *vacated on other grounds*, ___ U.S. ___, 99 S. Ct. 1417 (1979).⁴⁶ And, this is so even though the group boycott “may only have been partially successful” or “may have been designed only to reduce, not completely eliminate, [competition].” *Proctor*, *supra* at 276.

⁴⁶ Writing for the majority in *Proctor*, Judge McGowan stated that “[w]e cannot agree with the District Court’s opinion . . . that a total refusal to deal is necessary to prove a group boycott in violation of the Sherman Act.” 561 F.2d at 276, n. 23.

Incredibly, the district court in the instant case relied on *Proctor* in concluding, erroneously, that a conditional boycott stands in a different light than the unconditional variety. Memorandum Opinion at 17-18.

The motives underlying defendants' boycott are readily apparent. By placing roadblocks in the path of psychologists' equal access to the mental health care market, defendants have enabled psychiatrists to maintain and enhance their dominant competitive position in the Virginia mental health care market.¹⁷

B. Defendants' Activities Also Constitute Illegal Price Tampering

Through the group boycott, the defendants have also established a mechanism for restraining price competition in the market—by eliminating (or substantially handicapping) their competitors, physicians have set the stage for price stabilization and/or manipulation. This effect upon the price structure is, of course, "inherent in the success of the [boycott] in this case" and a "goal unlawful *per se* when sought to be effected by combination or conspiracy." *United States v. General Motors Corp.*, *supra* at 147.

The Supreme Court has recently reconfirmed the long-standing principle that "[p]rice is the 'central nervous system of the economy,' and an agreement that 'interfere[s] with the setting of price by free market forces' is *illegal on its face*." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978) (emphasis supplied), quoting *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n. 59 (1940), and *United States v. Container Corp.*, 393 U.S. 333, 337 (1969).

¹⁷ We note that illegal boycott activities like those occurring here often result, as a natural consequence, in the establishment of a monopoly. At least one federal court has already made this point, stating that where the existence of an illegal boycott which violates Section 1 is demonstrated, "a Section 2 violation is just a short step away, for most, if not all, unreasonable restraints have as their purpose the acquisition of at least a greater share of commerce than would otherwise be obtained in a free economy." *United States v. New Orleans Insurance Exchange*, 148 F. Supp. 915, 920 (E.D. La.), *aff'd per curiam*, 355 U.S. 22 (1957).

Defendants' combination is not a classic price-fixing agreement; that is, defendants have not, to amicus' knowledge, conspired to set fees for psychiatric services at an exact level. But as the Third Circuit has recently explained, "such a traditional conspiracy is not a *sine qua non* of a *per se* violation of the [Sherman] Act under the price-fixing rubric." *Cernuto, Inc. v. United Cabinet Corp.*, 595 F.2d 164, 169 (3d Cir. 1979). If the purpose and effect of the party's conduct "is to restrain movement and the free play of market forces, it is then illegal *per se*." *Id.*"

The *Cernuto* case highlights the adverse—and illegal—effects that activities such as those engaged in by defendants here have on price competition. There, the plaintiff distributor alleged that at the urging of a competing distributor, a manufacturer had terminated plaintiff's discount dealership. The Third Circuit, reversing the district court's grant of summary judgment for the defendants, recognized that it was not confronted with the classic boycott/price-fixing case but nevertheless held that the conduct in question might well be shown at trial to constitute a *per se* violation of the Sherman Act. The Court said:

By prevailing upon . . . [defendant] to terminate their contract with . . . [plaintiff], [defendant] effectively eliminated the threatened competition and was able to maintain prices at its own preferred levels. It is just this type of conduct that the antitrust laws were designed to reach.

Id. at 169.

The underlying rationale of *Cernuto* is immediately applicable to the instant case. The activities of Blue Shield and the psychiatrists here, just as those of the defendants in *Cernuto*, resulted in the elimination of competition and the maintenance of fees at a level established by psychia-

"See *United States v. General Motors Corp.*, *supra* at 147 ("the *per se* rule applies even when the effect upon prices is indirect").

trists. It is understandable that defendants are concerned that increased competition from psychologists might well force down the fees charged for mental health care services. The courts, however, have made clear that such interference with the free play of market forces is illegal *per se*.

II. DEFENDANTS' ACTIONS ARE ALSO UNLAWFUL UNDER THE RULE OF REASON

If allegedly anticompetitive conduct is not deemed to be illegal *per se*, it may still be unlawful under the "rule of reason."¹⁰ This rule, founded on the policy favoring free competition, enables courts to judge whether activity which apparently restrains trade is unreasonably anticompetitive.

The inquiry mandated by the rule is "whether the challenged agreement is one that promotes competition or one that suppresses competition." *National Society of Professional Engineers v. United States*, *supra* at 691. *Accord*, *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977); *Board of Trade of Chicago v. United States*, 246 U.S. 231, 238 (1918). The purpose of the analysis is "to form a judgment about the competitive significance of the restraint," 435 U.S. at 692. In order to make such a determination, the "relevant market" must be identified and its competitive dimensions established. *American Motor Inns, Inc. v. Holiday Inns, Inc.*, 521 F.2d 1230, 1247 (3d Cir. 1975); *Twin City Sportservice, Inc. v. Charles O. Finley & Co.*, 512 F.2d 1264, 1274-75 (9th Cir. 1975).

¹⁰ Although the preceding section demonstrates that the arrangement at issue in this case is illegal *per se*, we believe it would also be illegal under "rule of reason" analysis. The district court in this case, however, apparently held that the activity here did not violate the rule of reason.

The method for analyzing the relevant market in a Section 1 case is the same as in cases under the Clayton Act or other provisions of the Sherman Act. *Coniglio v. Highwood Services, Inc.*, 495 F.2d 1286, 1292 (2d Cir.), cert. denied, 419 U.S. 1022 (1974); *Twin City Sportservice, supra* at 1275.⁶⁰ Although the inquiry calls for consideration of both the geographic market and the product market, only the latter is actually at issue here since the geographic market—the State of Virginia—is not in dispute.

In identifying the product market, the courts have consistently held that the appropriate focus is the "area of effective competition," *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 328 (1961), and that "complete interindustry competitive overlap need not be shown." *United States v. Continental Can Co.*, 378 U.S. 441, 457 (1964). Put another way, it is not "a proper interpretation of the Sherman Act to require that products be fungible to be considered in the relevant market." *United States v. E.I. duPont de Nemours & Co.*, 351 U.S. 377, 394 (1956). See also *Liggett & Myers, Inc. v. FTC*, 567 F.2d 1273 (4th Cir. 1977).

Overlaying these principles are the oft-cited guidelines set forth by the late Chief Justice Warren in *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962):

The outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it.

These standards apply to services as well as to products. *United States v. Grinnell Corp.*, 384 U.S. 563 (1966);

⁶⁰ See also *United States v. Grinnell Corp.*, 384 U.S. 563, 573 (1966). Although the inquiries into the scope of the competition under the various provisions are not precisely the same, the basic guidelines do not vary. *Columbia Metal Culvert Co. v. Kaiser Aluminum & Chemical Corp.*, 579 F.2d 20, 26-27 & n.11 (3d Cir.), cert. denied, ____ U.S. ____, 99 S.Ct. 214 (1978).

Times-Picayune Publishing Co. v. United States, 345 U.S. 594 (1953).

A. The District Court Applied Incorrect Legal Standards in Defining the Relevant Market in This Case

If a district court misapplies the appropriate legal standard in determining the relevant market, or if the court fails to utilize the proper standard, reversal is compelled as a matter of law. *United States v. E. I. duPont de Nemours & Co.*, *supra* at 381; *SmithKline Corp. v. Eli Lilly & Co.*, 575 F.2d 1056, 1062 (3d Cir. 1978); *Cass Student Advertising, Inc. v. National Educational Advertising Service, Inc.*, 516 F.2d 1092, 1093 (7th Cir.), *cert. denied*, 423 U.S. 986 (1975). In the instant case, the district court simply ignored the controlling principles of law in concluding that there is no competition between psychologists and psychiatrists, and since this finding was derived from the application of an improper legal standard to the facts, it cannot stand. *United States v. Singer Mfg. Co.*, *supra* at 194 n.9; *Owen v. Commercial Union Fire Ins. Co.*, 211 F.2d 488, 489 (4th Cir. 1954).

In its opinion here, the district court wrote:

It is true that both psychologists and psychiatrists professionally render psychotherapy to patients. But in the treatment of nervous and mental disorders, psychiatrists are capable of providing a full range of psychiatric treatment, not just psychotherapy. In addition, as medical doctors psychiatrists may render medical treatment and diagnosis.

* * *

It thus appears that the clinical psychologist is not competitive with the psychiatrist in regard to treatment of nervous and mental disorders unless the clinical psychologist is working under the supervision of a doctor.

* * *

It is only within these conditions [i.e., referral, supervision, and billing by a physician] that [psychologists] can render services competitive with psychiatrists.

Memorandum Opinion, at 12-14. As a result, the district court held that there had been no "restraint of trade" caused by defendants' actions. *Id.* at 15.

As these passages make clear, the district court's primary error was its refusal to recognize the cardinal principle that "complete competitive overlap" need *not* be shown to establish an antitrust violation. *United States v. Continental Can Co.*, *supra*; *United States v. E.I. duPont de Nemours & Co.*, *supra*. Intertwined with this fundamental mistake was the court's failure to "delineate markets which conform to areas of effective competition and to the realities of competitive practice." *L.G. Balfour Co. v. FTC*, 442 F.2d 1, 11 (7th Cir. 1971).

Ironically, the district court correctly recognized that "both psychologists and psychiatrists professionally render psychotherapy to patients." Memorandum Opinion, at 12. However, the court failed to treat this "psychotherapy market" as an "effective area of competition," concluding instead that there is no competition because psychiatrists "are capable of providing a full range of psychiatric treatments, not just psychotherapy" and "may render medical treatment and diagnosis." *Id.* It is thus apparent that the court considered "complete competitive overlap" a necessity, despite the Supreme Court's instructions to the contrary.

Moreover, the district court failed to consider the role of submarkets in determining a relevant market for products or services. "[W]ithin [a] broad market, well-defined submarkets may exist which, in themselves, constitute product markets for antitrust purposes. . . ." *Brown Shoe Co., Inc. v. United States*, *supra* at 325. See also *United States v. Grinnell Corp.*, *supra* at 572; *United States v. E.I. duPont de Nemours & Co.*, *supra* at 393-95; *Case-*

Swayne Co. v. Sunkist Growers, Inc., 369 F.2d 449, 456-57 (9th Cir. 1966), *rev'd on other grounds*, 389 U.S. 384 (1967).

Although psychologists do not provide certain types of medical treatment⁴¹ and generally cannot admit patients to physician-controlled hospitals, there is no doubt—and the district court so found—that psychologists and psychiatrists *both* furnish psychotherapy. The mere fact that there exists a broad range of other possible mental health treatment “is not dispositive of whether [the entire range] forms a relevant product market for antitrust purposes.” *Beatrice Foods Co. v. FTC*, 540 F.2d 303, 308 (7th Cir. 1976). Thus, just as the district court erred in requiring a “complete competitive overlap,” it erred in treating all mental health services as the relevant market without considering psychotherapy as a submarket.⁴²

Psychotherapy is the most common form of outpatient treatment for mental disorders, and the fact that there are alternative methods of treatment available neither demands that the relevant market be defined in terms of those who can offer all types of treatment nor precludes a determination that psychotherapy is a submarket. The salient point, however, is that the district court completely disregarded the legal standards for determining the relevant market and the degree of competition therein;⁴³ in-

⁴¹ Psychiatrists can prescribe certain treatments, such as chemotherapy or electro-convulsive shock therapy, that cannot be prescribed by psychologists.

⁴² In *Beatrice Foods*, for example, the court held that the relevant market was paint brushes and rollers, despite the fact that aerosols and other spray paints were available. Similarly, in *Avnet, Inc. v. FTC*, 511 F.2d 70 (7th Cir.), *cert. denied*, 423 U.S. 833 (1975), the court held that the relevant market was new auto electrical units, not a market comprised of both new and rebuilt units.

⁴³ If the district court's analysis were applied in analogous cases, few—if any—antitrust suits could be brought against com-

deed, the court cited no authority whatsoever in support of its conclusion that psychologists and psychiatrists do not compete. This is not surprising, since the relevant authority makes plain that the court's approach is fundamentally flawed. Accordingly, the judgment must be reversed in light of this failure to apply the proper legal test.

B. Notwithstanding the District Court's Legal Errors, Its Finding That Psychologists and Psychiatrists Do Not Compete is Clearly Erroneous

Generally speaking, determination of the relevant market is a question of fact that is to be reviewed under the "clearly erroneous" standard of Rule 52(a), Fed. R. Civ. P. *International Boxing Club v. United States*, 358 U.S. 242, 251 (1959); *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 709 (7th Cir. 1977), cert. denied, ____ U.S.

panies making several different but related products or offering a wide range of services. Cf. *U.S. Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) (U.S. Steel obviously produces items other than the prefabricated homes at issue here); *H&B Equipment Co. v. International Harvester Co.*, 577 F.2d 239 (5th Cir. 1978) (defendant manufactures everything from farm implements to passenger vehicles, in addition to the excavation equipment involved in this case); *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530 (5th Cir. 1978) (OB-GYN specialists clearly do more than perform abortions); *Foster v. Maryland State Sav. & Loan Ass'n*, 590 F.2d 928 (D.C. Cir. 1978), cert. denied, ____ U.S. ____, 99 S.Ct. 842 (1979) (lawyers offer a wide range of services, including real estate settlement services; moreover, in some states, non-lawyers can perform some settlement services, such as title searches); *United States v. Black & Decker Mfg. Co.*, 430 F. Supp. 729 (D. Md. 1976) (defendant produces numerous electric power tools, such as saws, drills, and sanders, as well as stationary wood and metal working equipment and portable air tools, but this case involved only chain saws); *Murphy Tugboat Co. v. Shipowners & Merchants Towboat Co.*, 467 F. Supp. 841 (N.D. Cal. 1979) (defendant offered tug service to both large and small vessels; plaintiff claimed exclusion from the large-vessel market).

_____, 99 S.Ct. 87 (1978); *SmithKline Corp. v. Eli Lilly & Co.*, *supra* at 1062. The district court's conclusion that psychologists do not compete with psychiatrists is clearly erroneous, wholly apart from the incorrect legal standard that the court utilized.

As the Third Circuit has recently noted, "defining a relevant product market is a process of describing those groups of producers which, because of the similarity of their products, have the ability—actual or potential—to take significant amounts of business away from each other." *SmithKline Corp. v. Eli Lilly & Co.*, *supra* at 1063. There is no doubt that Virginia psychologists do in fact provide psychotherapy services in competition which psychiatrists,⁴ and the district court's determination that psychologists do not compete with psychiatrists completely ignores this reality.

At the outset, it should be made clear that (1) amicus recognizes that psychiatrists can provide services such as drug therapy and electroconvulsive shock therapy that psychologists cannot; and (2) amicus does not contend that psychologists should be permitted to engage in such activities. These matters are not at issue here. Rather, the question is whether psychologists and psychiatrists—both duly qualified and licensed to practice psychotherapy—are in competition with one another as providers of mental health care. The answer is plainly "yes".

Even the district court admitted that "both psychologists and psychiatrists professionally render psychotherapy to patients." Memorandum Opinion at 12. However, the court's ultimate conclusion that the two professional groups do not compete strays far afield from that key point. The central flaw in the court's factual "analysis" is obvious: it is completely circular to reason that there is no competition because physician referral and supervision is

⁴ See, e.g., Tr. 400-01 (testimony of Dr. Green).

required when that requirement is imposed by the Blue Shield policy at issue in the case.

The Federal Trade Commission's Bureau of Competition has recently put the matter of competition among these mental health professionals in the proper perspective. After pointing out that independent health care providers such as psychologists provide services that "overlap substantially with the normal scope of physicians' medical services," the Bureau said:

To the extent that non-physician practitioners can independently provide services that otherwise would be provided only by physicians, they represent economic substitutes for physicians—that is, actually or potentially, they compete with certain physicians. In contrast, to the extent that non-physician practitioners are required by law or by the reimbursement policies of third party payers to work under the supervision or control of physicians, they do not function as competitors of physicians. Rather, they become "economic complements" to physicians—mechanisms for increasing the productivity and ultimately the earnings of physicians."

In the instant case, psychologists are recognized as independent practitioners under the Virginia licensing and freedom of choice laws, and it is the Blue Shield reimbursement policy that forces them into the role of "economic complements" of physicians. To conclude, as did the district court, that there is thus no competition is to beg the question of whether psychologists could be more effective competitors but for the challenged reimbursement practice.

A brief examination of the realities of mental health treatment makes plain that psychologists do in fact compete with psychiatrists, particularly with regard to psychotherapy. Since psychiatrists are trained in medicine and psychologists in the behavioral sciences, they often

" FTC BUREAU OF COMPETITION, *supra* at 49.

approach mental disorders from different conceptual bases,⁶⁶ but the most common procedure of either group is psychotherapy.⁶⁷ Psychiatrists "use many of the same psychological techniques of intervention" in the treatment of their patients as do psychologists.⁶⁸ The key difference is that even when psychiatrists assume the causes of mental disorders are basically psychological and that the appropriate treatments are psychotherapeutic, they nevertheless "postulate a model of personnel utilization" that places a physician at the head of treatment efforts,⁶⁹ as Blue Shield has done in Virginia.

Available data indicate that there is also a large degree of overlap in the characteristics of patients seen by psychiatrists and by psychologists. For example, a 1970 study of more than 12,000 patients found that the patients of psychiatrists in private practice were no more "severe" in terms of mental problems than those of private practice psychologists.⁷⁰ That psychologists and psychiatrists are serving a generally similar patient population makes plain that there is competition between the two professional groups. See *United States v. E.I. duPont de Nemours & Co.*, *supra* at 392-93 (attitudes of consumers must be considered in determining relevant market).

⁶⁶ The medical-psychiatric model assumes that mental disorder is an illness like any other illness, while the psychological-behavioral model assumes that the pathology of mental disorders lies in psychological and behavioral reaction patterns. See 2 PRESIDENT'S COMMISSION ON MENTAL HEALTH, TASK PANEL REPORT ON MENTAL HEALTH PERSONNEL 448-49 (1978).

⁶⁷ Dorken, *CHAMPUS Ten-State Claim Experience for Mental Disorder: Fiscal Year 1975*, 32 AMERICAN PSYCHOLOGIST 697, 699-702 (1977).

⁶⁸ TASK PANEL REPORT ON MENTAL HEALTH PERSONNEL, *supra* at 434. See also *id.* at 449.

⁶⁹ *Id.* at 448-49.

⁷⁰ Webb, *Differences in Patient Populations of Private Practice Psychologists and Private Practice Psychiatrists*, Southeastern Psychological Association Convention (April 1970). See also Dorken, *CHAMPUS Ten-State Claim Experience for Mental Disorder: Fiscal Year 1975*, *supra*.

Moreover, it cannot be seriously disputed that psychotherapy, whether offered by a psychologist or a psychiatrist, is a viable alternative to and an effective substitute for other modes of treatment. For example, studies involving schizophrenics have found that it is both more clinically effective and cost-effective to provide psychotherapy to such patients than to provide just medication.¹¹ Indeed, at a time when it is charged that tranquilizers and amphetamines are among the top five chemical substances abused in the United States, non-drug therapy for mental health problems is becoming increasingly important.¹²

The district court's conclusion as to competition between psychologists and psychiatrists is also clouded by a number of misconceptions about mental health care. For example, the district court placed great reliance on the fact that psychiatrists can offer a broader range of mental health services than psychologists. Although that is undoubtedly true, it is legally irrelevant—as previously noted—and factually misleading as well, since many medical procedures are rapidly falling into disuse. Leucotomy, lobotomy, and other brain surgeries for treatment of mental disorders are now widely restricted under state laws except in highly select circumstances. Moreover, with the excep-

¹¹ E.g., Karon & VandenBos, *The Consequences of Psychotherapy for Schizophrenic Patients*, 9 *PSYCHOTHERAPY: THEORY, RESEARCH AND PRACTICE* 111 (1972); Karon & VandenBos, *Treatment Costs of Psychotherapy versus Medication for Schizophrenics*, 6 *PROFESSIONAL PSYCHOLOGY* 293 (1975). See also PAUL & LENTZ, *PSYCHOLOGICAL TREATMENT OF CHRONIC MENTAL PATIENTS: MILIEU VERSUS SOCIAL-LEARNING PROBLEMS* (1977).

¹² More than 97 million prescriptions are written annually for tranquilizers alone. TASK PANEL REPORT ON THE NATURE AND SCOPE OF THE PROBLEMS, *supra* at 32. Moreover, there has been a gross over-diagnosis and consequent over-institutionalization of elderly persons who suffer from treatable and often reversible disorders. 3 PRESIDENT'S COMMISSION ON MENTAL HEALTH, TASK PANEL REPORT ON MENTAL HEALTH OF THE ELDERLY 1131 (1978). Drug intoxication is one of the largest single causes of false senility.

tion of its use in some cases of endogenous depression, electroconvulsive shock therapy has also been largely discarded, placed under heavy restraints by state law, or restricted by higher malpractice insurance costs.⁷³

Similarly, the district court's emphasis on the fact that psychologists routinely refer patients to physicians for physical examinations is misplaced, as is the court's focus on the fact that psychiatrists are trained in medicine. In terms of the comparative practices and competencies of psychologists and psychiatrists, a distinction must be drawn between what is theoretically possible and what actually occurs. Psychiatrists theoretically should be more sensitive to and more likely to detect physical health problems and physical problems causing mental symptoms than psychologists. There is little to suggest this is true, and in reality the reverse may be the case.

A recent survey of practicing psychiatrists found that *none* of the respondents routinely performed physical examinations on new outpatients, while 16 percent routinely sought such examinations on a referral basis. Significantly, more than half of the respondents reported that they no longer felt competent to perform physical examinations.⁷⁴ Another survey indicates that 22 percent of psychologists "often" or "very often" make referrals to non-psychiatrist physicians, thus suggesting that psychologists are indeed responsive to symptoms of a non-psycho-

⁷³ For a discussion of the legal restrictions, see Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW U.L. REV. 461 (1977).

⁷⁴ Patterson, *Psychiatrists and Physical Examinations: A Survey*, 135 AMERICAN JOURNAL OF PSYCHIATRY 967 (1978). The author warned that the "resulting 'disuse atrophy' of [physical examination] skills may serve to diminish the personal and public identity of the psychiatrist as a physician." *Id.* at 968.

logical nature and that they make referrals to have those symptoms evaluated.⁷⁵

There is no doubt that referrals by psychologists to other qualified health specialists are appropriate, and the APA has specifically so stated in its *Ethical Standards of Psychologists*.⁷⁶ For example, a psychologist may send a patient to a physician for medication, in which case the two specialists would work together to monitor the patient's progress. Such a relationship between professionals is reasonable and desirable; however, to suggest that supervisory responsibility for all mental health care should be entrusted to physicians simply because they can prescribe drugs and offer other forms of treatment is simply specious. The argument rings particularly hollow in the case of psychotherapy, since psychologists are better trained in this area than are psychiatrists, and since psychologists serve in significant numbers on the faculties of the nation's 115 medical schools,⁷⁷ teaching psychotherapy to prospective physicians.

In sum, the district court plainly erred in concluding that psychologists and psychiatrists are not competitors as providers of mental health services. Indeed, given the professional literature, the recent study by the President's

⁷⁵ Dorken & Webb, *Licensed Psychologists in Health Care: A Survey of Their Practices*, Annual Conventions of the Southeastern Psychological Association (March 1978) and American Psychological Association (August 1978).

⁷⁶ Principle 7(a) of the Standards, which have been adopted by several states, provides that psychologists are to "make full use of all the professional . . . resources that best serve the interests of consumers" and "secur[e] for their clients the best possible professional service."

⁷⁷ The number of psychologists in such teaching positions increased rapidly from a total of 255 in 1952 to 2,336 in 1976. Matarazzo, et al., *Psychologists' Membership on the Medical Staffs of University Teaching Hospitals*, 31 AMERICAN PSYCHOLOGIST 23, 24 (1978).

Commission on Mental Health, and the "freedom of choice" legislation on both the state and federal level, this Court can take judicial notice of the fact that such competition exists. In any event, there is no doubt that the district court's finding is clearly erroneous within the meaning of Rule 52(a), Fed. R. Civ. P., since a review of the facts leaves one with "the definite and firm conviction that a mistake has been committed." *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948).

CONCLUSION

Amicus American Psychological Association respectfully submits that for the foregoing reasons, this Court should reverse the decision of the district court.

Respectfully submitted,

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