

Antitrust Liability for Collective Speech: Medical Society Practice Standards

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While it would probably be excessive to say that the fox is guarding the chicken coop, it is undeniable that a great many critical judgments in [the medical] field are being made by persons with a direct economic stake in particular outcomes The vast majority of physicians and their organizations sincerely believe that they are acting in the public interest. Yet this is not enough. To be genuinely well served, the public must have assurance that those in control are responsive to consumer needs.

—Former F.T.C. Chairman Michael Pertschuk¹

INTRODUCTION

In the provision of professional services,² as in other commercial arrangements, the antitrust laws are intended to preserve competi-

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1. Statement prepared for presentation to the Subcommittee on Health and Scientific Research of the United States Senate, Oct. 10, 1977, *quoted in* American Medical Ass'n v. F.T.C., 638 F.2d 443, 455 (2d Cir. 1980) (Mansfield, J., dissenting), *aff'd by an equally divided Court per curiam*, 455 U.S. 676 (1982).

2. This Article focuses particularly on medical services. In part, that is because it responds to several recent decisions regarding standard-setting in medical societies. But it is also because medical standard-setting remains a largely private activity, in contrast to, for example, the same process in the legal profession, where standards of the American Bar Association are often adopted by state supreme courts. *See, e.g.,* MASS. SUP. JUD. CT. R. 3:07 (setting out "canons and rules [that] are based on but are not identical to the American Bar Association 'Code of Professional Responsibility and Canons of Judicial Ethics' (1970)"). State action in standard-setting is exempt from antitrust scrutiny to the extent that the government involvement meets certain established requirements. *See infra* text accompanying notes 241-46.

The proposals made here are also relevant to non-professional standard-setting. However, non-professional standards present less of an antitrust problem for several reasons. First, the members of industrial standard-setting organizations, unlike those of professional societies, are in many cases not competitors in the field to which their standards apply. Second, industrial organizations often do not possess, at least to the extent that professional societies do, specialized expertise that the general public lacks. Finally, perhaps because of their relative lack of specialized knowledge, industrial organizations are not deferred to by the public as readily as are professional societies. *See infra* text accompanying notes 33-43.

tion.³ Ideally, the laws protect the ability of consumers to receive the professional services they desire and the ability of individual professionals to provide those services. In promoting this goal, the laws can conflict with the activities of professional societies, which directly and indirectly restrict the services provided by their members. The societies' activities take a variety of forms, from establishing certification requirements⁴ to enacting codes of ethics⁵ and practice standards,⁶ but all are agreements⁷ imposing restraints of one form or another on professional services.⁸ Of course, not all of the restraints are anticompetitive.⁹ Some benefit not only the professionals themselves, but also the consumers of professional services as well. Establishing education and training requirements, for example, both ensures that professionals

3. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975) ("The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions." (citations omitted)).

4. The basic functions of most professional societies are the establishment and enforcement of membership credentials, which necessarily limit the activities of their members, both prior to and after joining the society. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 90-91 (1982) (noting that the formation of the American Medical Association had two basic purposes: to standardize the requirements for medical degrees and to adopt a code of professional ethics, "with its concern for excluding sectarian and untrained practitioners"); Clark C. Havighurst & Nancy M. P. King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective* (pts. 1 & 2), 9 AM. J. L. & MED. 131, 9 AM. J. L. & MED. 263 (1983).

5. See, e.g., American Medical Association, *Principles of Medical Ethics* (1980); Council on Ethical and Judicial Affairs, American Medical Association, *Current Opinions* (1989) ("intended as an adjunct to the revised Principles of Medical Ethics").

6. See, e.g., American Society of Anesthesiologists, *Basic Standards for Pre-anesthesia Care* (1987), *Standards for Basic Intra-Operative Monitoring* (1986) (amended 1992), *Standards for Postanesthesia Care* (1988) (amended 1992).

7. See 7 PHILLIP E. AREEDA, *ANTITRUST LAW* ¶ 1477 (1986) ("Although the issue is seldom discussed, trade associations are routinely treated as continuing conspiracies of their members, as are bodies promulgating rules or standards for the competitive conduct of their members, such as the National Society of Professional Engineers.").

8. Of course, professional societies today also serve an important educational role, independent of their other functions. But the very importance of that role pressures professionals to join and therefore to comply with the societies' requirements. See MANCUR OLSON, *THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS* 139-40 (1971 ed.) ("The many technical publications of the American Medical Association, and the state and local medical societies, also give the doctor a considerable incentive to affiliate with organized medicine.").

9. As expressed in the Supreme Court's often-quoted statement establishing the scope of the Sherman Act's § 1, "[t]he true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Board of Trade of City of Chicago v. United States*, 246 U.S. 231, 238 (1918).

possess a basic level of competency and communicates information regarding that competency to consumers.¹⁰

However, professional standards, especially in medicine, often go well beyond the basic requirements for professional competence to prescribe (or proscribe) particular methods of practice.¹¹ Because there are often differences of opinion regarding the appropriateness of particular services, especially when they are new,¹² the establishment of standards inevitably places some professional services outside the officially accepted area of practice. Furthermore, the standards are generally established by a professional society's mainstream members, who have a vested interest in continuing to practice by the profession's established methods. In such a situation, where a group's economic interests coincide with its regulatory power, skepticism regarding the exercise of that power is warranted.¹³ Indeed, at least one physician has suggested that a doctor's evaluation of a controversial procedure can depend on whether he profits from it.¹⁴ Even putting aside the problem of immediate economic incentives, it has been observed that there is a general conservatism and reluctance to accept innovation among professionals.¹⁵

10. For discussions of both pro and anticompetitive aspects of the certification process, see Havighurst & King, *supra* note 4.

11. See David M. Eddy, *Practice Policies—What Are They?*, 263 J. A.M.A. 877, 877 (1990) (They are “preformed recommendations issued for the purpose of influencing decisions about health interventions.”); see also Clark C. Havighurst, *Practice Guidelines for Medical Care: The Policy Rationale*, 34 St. Louis U. L.J. 777 (1990) (describing several recent initiatives, both private and public, that promote practice standards).

12. As an example, even a technique as widely accepted as magnetic resonance imaging (MRI) was initially the subject of dispute. See *Goodman v. Sullivan*, 891 F.2d 449, 450 (2d Cir. 1989) (affirming denial of Medicare coverage for MRI treatment on the ground that it was “not yet generally accepted in the medical profession”). See also James S. Goodwin & Jean M. Goodwin, *The Tomato Effect: Rejection of Highly Efficacious Therapies*, 251 J. A.M.A. 2387 (1984) (describing the medical establishment's rejection of various effective treatments that did not fit its then-current theories).

13. See *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 500 (1988) (“There is no doubt that the members of such [private standard-setting] associations often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm.”).

14. See Gina Kolata, *Amid Fears About a Fetal Test, Many Are Advising Against It*, N.Y. TIMES, July 15, 1992, at C13, col. 4 (quoting Dr. Benjamin Sachs, obstetrician-gynecologist-in-chief at Beth Israel Hospital and Harvard Medical School as stating that in the evaluation of chorionic villus sampling, a prenatal test, “there had been a very unfortunate ‘polarization, depending on whether people make money on the procedure’”).

15. See, e.g., Gina Kolata, *A Tradition of Caution: Confronting New Ideas, Doctors Often Hold On to the Old*, N.Y. TIMES, May 10, 1992, § 4, at 6, col. 1:

Doctors generally are “reactionary,” said Dr. Jeffrey Isner, a cardiologist at Tufts University School of Medicine. “As a group, they are relatively slow

Of course, given the special expertise possessed by professionals, it is not surprising that much information regarding the practice of the profession originates with the profession itself. But it is exactly the advantage in knowledge that professionals possess over the public that creates a danger of anticompetitive activity. Because consumers typically have not received professional training, they are unable to effectively evaluate the professionals' claims for their services.¹⁶ This would not present a problem if each professional operated independently, and was not subject to the influence of professional societies. In that case, competing professionals would step in to provide alternative descriptions of their services, and free competition would prevail. However, very little of the information received by consumers comes from individual professionals.

Instead, professional societies have taken on the role of providing a wide range of information and guidance, both to their members and the public at large. Medical societies, of course, claim that this role for professional groups is desirable and procompetitive.¹⁷ Legal commentators generally agree, asserting that the societies' production and communication of information benefit the market because they provide valuable professional expertise¹⁸ and because they help remedy the information advantage otherwise possessed by professionals.¹⁹ This might

to accept new ideas. There is a lot of criticism—'Oh, it will never work.' 'Oh, that's crazy.' A lot of negative responses.'

Much of it is a reflection on medical school, specifically which students are chosen and how they are trained, Dr. Isner said. "You spend a lot of time learning and memorizing how you're supposed to deal with things," he explained. "Now someone says, 'We're going to do it a different way.' That means all your investment is worthless."

See also Joe Sims, Maricopa: *Are the Professions Different?*, 52 ANTITRUST L.J. 177, 177 (1983) ("[Another] significant distinction between the professions and other occupations is that many in the former camp actively seek to discourage entrepreneurial efforts by their counterparts, going so far as to seek to label as unethical (and thus presumably bad) the use of normal business organization structure for the marketing of services.').

16. See *Shapiro v. Kentucky Bar Ass'n*, 486 U.S. 466, 490 (1988) (O'Connor, J., dissenting) ("[M]arket forces, and the ordinary legal prohibitions against force and fraud, are simply insufficient to protect the consumers of their necessary services from the peculiar power of the specialized knowledge that [physicians and lawyers] possess.').

17. See AMERICAN MEDICAL ASSOCIATION, *LEGAL IMPLICATIONS OF PRACTICE PARAMETERS* (1990).

18. See Clark C. Havighurst, *Applying Antitrust Law to Collaboration in the Production of Information: The Case of Medical Technology Assessment*, 51 LAW & CONTEMP. PROBS., Spring 1988, at 341, 350 ("The participation of professional organizations in technology debates . . . offers the public access to a valuable reservoir of knowledge and insight.').

19. See Thomas L. Greaney, *Quality of Care and Market Failure Defenses In*

be true if consumers were assured that the information were accurate, or if, in case it were inaccurate, equally accessible alternative sources of information were available.²⁰ But when a large, respected group gains a position of dominance from which its voice is virtually the only one heard, its statements, if incorrect, have a great potential for harm.²¹ This is especially true of a professional group, due to the difficulty that outsiders have in evaluating that information.

Therefore, a professional society should not be permitted to issue evaluations describing practices as appropriate or inappropriate without ensuring that its statements leave the ultimate choice with consumers.²² For example, if there is a possibility that consumers may be misled by its subjective evaluations, a society should confine its statements to objective and verifiable facts.²³ The Supreme Court's opinions are consistent with this view. Its opinions in both the antitrust and commercial speech areas have demanded objectivity from professionals and standard-setting organizations.²⁴ Moreover, a society should not be permitted to indirectly control consumer choices by determining which

Antitrust Health Care Litigation, 21 CONN. L. REV. 605, 664 (1989) ("Information supplied in this fashion—evaluating the scientific status of a procedure and the advisability of routinizing it by deeming it non-'experimental'—obviously counteracts information asymmetries in the health insurance market.").

20. See Havighurst & King, *supra* note 4 (pt. 1), at 154 n.72 ("Of course, where a self-certified group of professionals enjoys a substantial degree of monopoly power, there exists, by hypothesis, no close competitors who can be counted on to dispute its unwarranted claims of superiority. In such a case, the primary hope must be for competition to break out within the monopolistic group itself as individuals and subsets of providers within the group seek to differentiate themselves from their supposed peers.").

21. See Martin Rose & Robert F. Leibenluft, *Antitrust Implications of Medical Technology Assessment*, 314 N. ENG. J. MED. 1490, 1492 (1986) ("[S]ome concern about antitrust implications is warranted, even in the case of the expression of the opinion of a medical specialty society, if such expression is likely to have a substantial effect in the marketplace.").

22. See Havighurst, *supra* note 18, at 353 ("[A] professional organization pronouncing its opinions on medical technologies is quite likely to believe that its word should be received not merely as advice, but as gospel. If the effect of its pronouncements is to perpetuate a professional monopoly over crucial choices concerning medical care, there would be a problem that might concern an antitrust court.").

23. See *infra* section III.A. A society may also require its members to refrain from false or deceptive claims. See *infra* text accompanying notes 276-77.

24. See, e.g., *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 501 (1988) (stating that private standards should be "based on the merits of objective expert judgments and through procedures that prevent the standard-setting process from being biased by members with economic interests in stifling product competition."); *Peel v. Attorney Registration and Disciplinary Comm'n of Ill.*, 496 U.S. 91, 110 (1990) (holding that state licensing boards can require that professionals' advertisements be based on "objective and consistently applied standards."); see also *infra* sections II.C. & II.D.

medical services will be reimbursed by medical insurers.²⁵ The medical services market should be permitted to function free of the intervention of groups of practitioners.²⁶ As the Supreme Court said in a medical society case, the antitrust laws serve to prevent agreements that "may deter experimentation and new developments by individual entrepreneurs."²⁷

One would therefore expect the courts to provide a forum where consumers or professionals suffering from the anticompetitive effects of society standards could bring antitrust challenges to those standards. However, to a great extent, the lower courts have failed to let antitrust law meet that expectation. Until recently, courts often gave professional standards *ad hoc* antitrust exemptions that would never be given to agreements by other groups. The courts deferred to professional societies' judgments regarding, for example, the importance of the scientific method in patient care.²⁸ More recently, in response to the Supreme Court's explicit rejection of quality of care defenses,²⁹ courts have relied instead on what they characterize as the purely advisory, non-coercive nature of professional standards.³⁰ This Article presents

25. See *infra* section III.B.

26. See *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 462 (1986) ("The Federation is not entitled to pre-empt the working of the market by deciding for itself that its customers do not need that which they demand.").

27. *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 348 (1982).

28. See *Wilk v. American Medical Ass'n*, 719 F.2d 207, 227 (7th Cir. 1983) (approving a jury instruction to the effect that even if the plaintiffs showed that the defendants' actions restrained competition, rather than promoted it, the defendants would not be liable if they could show "(1) that they genuinely entertained a concern for what they perceive as scientific method in the care of each person with whom they have entered into a doctor-patient relationship; (2) that this concern is objectively reasonable; (3) that this concern has been the dominant motivating factor in defendants' promulgation of [the standard at issue] and in the conduct intended to implement it; and (4) that this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition."), *cert. denied*, 467 U.S. 1210 (1984). There is no support in the Sherman Act for this elevation of concern for the scientific method to a privileged status. The Act is concerned not with the "competition of ideas" engendered by the scientific method, but with the competition of the market, as even *Wilk* stated elsewhere in the opinion. See 719 F.2d at 225 (rejecting the district court's jury instructions because they were not "geared simply, clearly, and exclusively to the question whether the challenged conduct promoted or suppressed competition").

29. See, e.g., *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 25 n.41 (1984) ("[W]e reject the view of the District Court that the legality of an arrangement of this kind [tying] turns on whether it was adopted for the purpose of improving patient care."); *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 694 (1978) ("[A] purchaser might conclude that his interest in quality—which may embrace the safety of the end product—outweighs the advantages of achieving cost savings by pitting one competitor against another.").

30. See, e.g., *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d

two responses. First, coercion has never been a requirement for the application of the antitrust laws.³¹ Second, even advisory standards can have a significant anticompetitive impact, both on patients and on insurers.³²

The remainder of this Article is divided into four parts. Part I provides an overview of the nature of the professional standards of concern in the Article and discusses two recent cases challenging such standards. Part II describes the applicable legal precedent, particularly in the Supreme Court, regarding private standard-setting, and discusses more generally the anticompetitive effects of private medical standards. Part III offers proposals for determining antitrust liability for medical standards and discusses how societies can avoid such liability. Part IV concludes with a discussion of the role professional societies would play if the proposals of Part III were adopted.

I. MEDICAL PRACTICE STANDARDS

The specific standards of concern in this Article are those through which medical societies influence their members' methods of practice.³³ They include, for example, standards that regulate particular surgical techniques³⁴ or that mandate the selection of specific medical personnel to perform certain services.³⁵ It is in these aspects of professional practice that standard-setting presents particular problems, for two reasons. First, it is in these areas that professional judgment is most important, and, therefore, where restrictions on that judgment can be most harmful. Second, it is also in these areas that outside evaluation of the standards is most difficult, due to the special expertise of

397, 397-98 (7th Cir. 1989) ("There can be no restraint of trade without a restraint. . . . [The Academy] did not require its members to desist from performing the operation or associating with those who do."); see also John E. Lopatka, *Antitrust and Professional Rules: A Framework for Analysis*, 28 SAN DIEGO L. REV. 301, 309 (1991) ("Obligations' that are not enforced have little relevance to an analysis of the antitrust implications of professional rules." (footnote omitted)).

31. See *infra* section II.A.

32. See *infra* sections II.B & II.C.

33. See Eddy, *supra* note 11, at 878 ("Practice policies are extremely versatile. In addition to supporting individual decisions between practitioners and patients, practice policies can be used to specify who should perform a practice ([e.g.], accreditation), how it should be performed ([e.g.], performance criteria), where it should be performed ([e.g.], inpatient vs[.] outpatient), on whom it should be performed ([e.g.], patient indications), and whether it will be paid for ([e.g.], precertification criteria and coverage policies.'").

34. See *infra* section I.B.

35. See *infra* section I.A.

professionals.³⁶ In other areas, such as price, outsiders (e.g., consumers of professional services or the courts) are generally able to evaluate the reasonableness of professional regulations.³⁷

In some respects, the professional standards considered here are similar to standards for manufactured products.³⁸ In both cases, a private group issues its judgment as to the acceptability of particular products or services. However, the anticompetitive problems of professional standards are more fundamental than those of industrial standards.³⁹ For example, the uniform nature of manufactured products makes them fitter subjects of standards. Professional services are, or should be, the antithesis of such products. They should be tailored to the needs of the individual patient or client in a way that makes them unsuitable for standardization.⁴⁰

More important, though, are the differences in the entities that establish the two kinds of standards. Industrial standards are often established by organizations (e.g., Underwriters Laboratories or the American Society of Testing and Materials) whose primary purpose is standard-setting. Such organizations are, as the Supreme Court has observed, "composed of members with expertise but no economic

36. That does not mean, however, that courts should not review such standards. A court need not conduct a substantive review of the standard itself to determine that its effect is to deny individual professionals a meaningful opportunity to choose whether to conform to it.

37. Price-related standards have received more attention from the Supreme Court than have other practice standards. *See, e.g., Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978); *but see FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) (agreement not to provide x-rays for review by insurers).

38. Standards for industrial products are exemplified by those at issue in two recent Supreme Court cases. *See Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492 (1988); *American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982).

39. This is not to say that the anticompetitive dangers of industrial product standards are insignificant. *See, e.g., 7 PHILLIP E. AREEDA, ANTITRUST LAW* ¶ 1503a (1986) ("Product standardization might impair competition in several ways. . . . Such standardization might deprive some consumers of a desired product, eliminate quality competition, exclude rival producers, or facilitate oligopolistic pricing by easing rivals' ability to monitor each other's prices.").

40. *See Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 773 n.25 (1976) ("Physicians and lawyers, for example, do not dispense standardized products; they render professional *services* of almost infinite variety and nature" (emphasis in original)); *see also Shapero v. Kentucky Bar Ass'n*, 486 U.S. 466, 487 (1988) (O'Connor, J., dissenting) (noting the "defective analogy between professional services and standardized consumer products").

interest in suppressing competition."⁴¹ Professional standards, in contrast, are established by organizations whose members are providers of the services to which the standards apply. The temptation is great for a provider to promote standards favorable to his own services. It is this danger on which the Supreme Court has focused in its opinions regarding standard-setting associations:⁴² "There is no doubt that the members of such associations often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm."⁴³

The following sections discuss the realization of that potential as evidenced in two recent cases challenging medical society standards directed at two different groups: patients and third-party payers of medical bills.⁴⁴ It will be apparent that the facts in these cases are not well developed. That is in part because they arose on motions for summary judgment. However, as is argued in Parts II and III, it is also partly due to the courts' failure to recognize the nature of the potential anticompetitive harm in these cases. This has resulted in a focus, by both courts and litigants, on more peripheral issues. In any event, the point here is not to prove that the actions in these particular

41. *Allied Tube & Conduit Corp.*, 486 U.S. at 510 n.13. As an example, the Court cited *Sessions Tank Liners, Inc. v. Joor Mfg., Inc.*, 827 F.2d 458 (9th Cir. 1987), *vacated on other grounds*, 487 U.S. 1213 (1988). The trade association in *Sessions* allowed industry members to serve on committees considering new standards and to participate in hearings regarding them, but it permitted only public officials to vote on the standards. *Id.* at 460-61.

42. It is notable that in the cases that the Supreme Court has heard regarding industrial standards, the organizations involved were trade associations more akin to professional societies than to pure standard-setting organizations. See *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492 (1988); *American Soc'y of Mechanical Eng'rs v. Hydrolevel Corp.*, 456 U.S. 556 (1982); *Radiant Burners, Inc. v. Peoples Gas Light & Coke Co.*, 364 U.S. 656 (1961) (*per curiam*).

43. *Allied Tube & Conduit Corp.*, 486 U.S. at 500 (footnote and citation omitted); see also *American Soc'y of Mechanical Eng'rs*, 456 U.S. at 571 ("Furthermore, a standard-setting organization like ASME can be rife with opportunities for anticompetitive activity. Many of ASME's officials are associated with members of the industries regulated by ASME's codes. Although, undoubtedly, most serve ASME without concern for the interests of their corporate employers, some may well view their positions with ASME, at least in part, as an opportunity to benefit their employers.").

44. Although the text speaks of standards' effects on patients and third-party payers, it is likely that, to the extent those effects are anticompetitive, they would be challenged not by those groups themselves, but by physicians affected indirectly through decreased demand for their services. See *infra* sections III.A and III.B. It is one of the main points of this Article that much of the doctrinal confusion in this area is caused by a failure to distinguish between direct effects on providers, which reduce supply, and indirect, but still anticompetitive, effects on them, which are produced by a reduction in demand by consumers.

cases were anticompetitive. The point is to examine the true nature of the harm to competition in these cases and to show the economic incentives that medical societies have in enacting their standards.

A. *The Effects of Standards on Patients*

*Koefoot v. American College of Surgeons*⁴⁵ was a dispute between the American College of Surgeons (ACS) and Dr. Robert Koefoot, formerly a fellow of the ACS, regarding the ACS's rule forbidding "itinerant surgery."⁴⁶ The ACS defined "itinerant surgery" as surgery "under circumstances in which the responsibility for diagnosis or care of the patient is delegated to another who is not fully qualified to undertake it."⁴⁷ Because the ACS's position was that a physician was not qualified to provide post-operative care unless he was as qualified as the operating surgeon, the rule effectively reserved all post-operative care to surgeons.⁴⁸

Dr. Koefoot practiced in rural Nebraska and performed some "typically less complex and more routine" surgery at hospitals outside the city where his practice was based.⁴⁹ Post-operative care for those procedures was provided by general practitioners at the hospitals. Dr. Koefoot admitted that this practice constituted "itinerant surgery" as defined by the ACS, but he refused to stop it, and he was first suspended and then expelled from the ACS. The ACS's position was that "[i]f Dr. Koefoot chooses not to drive 20 miles to [the local hospitals] to see his patients, if Dr. Koefoot disagrees with the College policy, or

45. 610 F. Supp. 1298 (N.D. Ill. 1985).

46. *See generally id.* at 1300-03.

47. *Id.* at 1300.

48. *Id.* at 1300, 1303. According to the plaintiffs' allegations, the rule "inhibited the ability of rural community hospitals to compete with hospitals in major metropolitan areas, of surgeons in Dr. Koefoot's position to compete with local surgeons, and of general practitioners to compete with surgeons in the provision of post-operative care." *Id.* at 1303.

49. The court provided the following description of medical practice in Nebraska:

Plaintiffs provide medical care in the State of Nebraska, largely a rural state consisting of 92 counties, comprising approximately 70,000 square miles. In 1980, there were approximately 2,300 doctors in Nebraska, of whom 181 were general surgeons, such as Dr. Koefoot. Over 70% of the state's population resides in 21 of the 92 counties, located in and around the major cities of Omaha and Lincoln. Those 21 counties had 89% of the physician population, leaving only 247 physicians to serve the remaining 71 counties with their 457,000 residents. The state has 116 hospitals. The area outside that known as the "Fish Hook" has only 247 physicians to serve over 63,000 square miles and 450,000 people, a ratio of 1,850 people per doctor. Thus, the practice of rural medicine in Nebraska is vital to the health of its general populace.

Id. at 1301.

if Dr. Koefoot chooses to spend his time on pursuits other than surgery, that is his perfect right. But he may not call himself a Fellow of the American College of Surgeons."⁵⁰

Dr. Koefoot alleged that he suffered a variety of injuries as a result of this dispute. He said that his surgery practice declined⁵¹ and that he suffered a variety of professional injuries.⁵² It is important to note, however, that it was apparently only the latter injuries that stemmed from his expulsion from the ACS. For example, Dr. Koefoot said that the expulsion made it difficult for him to hire an associate, reduced the frequency with which he was employed as an expert witness, and injured his relationships with other doctors.⁵³ All of these injuries related to Dr. Koefoot's dealings with his fellow professionals, not his dealings with patients. He did not allege that his surgical practice was harmed by the expulsion.

Instead, Dr. Koefoot attributed the decline in his practice to "the publicity resulting from the disciplinary charges of unethical surgery relating to the delegation of post-operative care of patients under [his] supervision to family practitioners," and said that patients had declined to have surgery in their local hospitals "because of the accusations of unethical surgery."⁵⁴ These claims can be interpreted in two ways. The patients might have declined to receive surgery from Dr. Koefoot because of charges that he practiced in an unethical fashion, or they might have declined to receive itinerant surgery from anyone, including Dr. Koefoot, because of the allegations that the practice itself was unethical. In either case, the injuries to Dr. Koefoot's practice were caused by the influence the ACS's rule had on the decisions of his potential patients, not by his expulsion.⁵⁵ There is no mention in the

50. *Id.* at 1303.

51. *Id.* at 1307-09.

52. *Id.* at 1307-08.

53. *Id.* at 1308.

54. *Id.* at 1308-09.

55. It does not appear from the case that the ACS publicized its expulsion of Dr. Koefoot. In any event, he could have suffered the same damage from negative publicity regarding his practice methods even if he had never been a member. An informative contrast is provided by *Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479 (D.C. Cir. 1984), which reversed a grant of summary judgment in favor of the defendant medical society. The society standard in *Kreuzer*, similar to that in *Koefoot*, required the society's "active" members to confine their practices solely to periodontology. However, the focus of the *Kreuzer* court was on the society's policy, when contacted by potential patients, to provide referrals only to active members, as defined by the standard. The court observed that the standard harmed consumers in two ways: (1) they would never be referred to periodontists who refused to conform to the society's rule, thus limiting the number of periodontists available to them, and, therefore, increasing the market price;

case that patients were even aware of his expulsion from, or his prior membership in, the ACS.

Thus, merely by calling Dr. Koefoot's method of practice "unethical," his competitors in the ACS were able to damage his business. And they had an obvious economic interest in doing so. Any rule that justified a surgeon's refusal to allow another, perhaps lower-paid physician to perform post-operative care preserved the income from that service for the surgeon. The director of the ACS had even admitted that one of the purposes of the rule was to protect surgeons in local practices: "We had been thinking in terms of the practice of itinerant surgery freezing out young men who might wish to come into a community to practice."⁵⁶ The ACS claimed that the rule was necessary to assure "the highest quality post-operative care,"⁵⁷ but it apparently presented no evidence for that claim. Dr. Koefoot asserted that he had an "extremely low rate of post-operative complications."⁵⁸

Under these circumstances, it is reasonable to question the ACS's condemnation of itinerant surgery. Consider the following comment from the District of Columbia Circuit considering a similar society rule:

[W]e can set the following standard for application of a rule of reason analysis to questioned conduct of professional associations justified under a patient care motive. When the economic self-interest of the boycotting group and its proffered justifications merge the rule of reason will seldom be satisfied.⁵⁹

This well-describes the danger presented when a group of competitors has the power to issue influential standards regarding its own practices and those of competing groups. In *Koefoot*, where the ACS apparently was unable to provide any evidence that patient care benefitted from its rule against itinerant surgery, or any reason for labelling the practice "unethical," it seems likely that the rule was based more on the ACS's competitive goals than on any desire to convey information. This is not to say that medical societies always, or even often, use their statements to influence competition without regard to truth. The point

and (2) they could not receive additional non-periodontal care from society members, denying them the benefits of one-stop dental service. *Id.* at 1493-94. Thus the harm in *Kreuzer* was caused by the effects of the society's rule on the choices of periodontists, not by the effect of the rule on patient demand, which is the focus of this Article.

56. *Koefoot*, 610 F. Supp. at 1305 (quoting the director of the ACS).

57. *Id.* at 1303.

58. *Id.*

59. See *Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1494 (D.C. Cir. 1984). This case is described in note 55 *supra*.

is simply that society statements do have competitive effects and that, in cases like *Koefoot*, those effects can be produced in the absence of any objective support for the statements. The next section describes another avenue for society action affecting competition.

B. *The Effects of Standards on Third-Party Payers*

*Schachar v. American Academy of Ophthalmology, Inc.*⁶⁰ involved a new ophthalmological procedure known as radial keratotomy.⁶¹ The incidents that gave rise to the case began in 1976.⁶² In that year, Dr. Leo Bores visited the Soviet Union and performed several radial keratomies; he returned the following year to examine his patients. He performed the first radial keratotomy in the United States in 1978, and in 1979 he formed, with seven other eye surgeons, the National Radial Keratotomy Study Group (NRKSG). The NRKSG developed a protocol for use in performing the procedure and created a detailed informed consent form to be reviewed by patients undergoing the procedure.⁶³

In March, 1980, Dr. George Waring joined the NRKSG. Later that month, Dr. Waring convened a meeting of a different group of fourteen eye surgeons to discuss radial keratotomy and the possibility of getting a government grant to study the procedure. Dr. Waring then contacted Dr. Ronald Geller of the National Advisory Eye Council (NAEC), an

60. 1988-1 Trade Cases (CCH) ¶ 67,986 (N.D. Ill.). Some of the factual history related in the text comes from *Vest v. Waring*, 565 F. Supp. 674 (N.D. Ga. 1983), another case involving many of the same parties and issues. Although some of the facts presented here might therefore not have been before the court in *Schachar*, they are given to provide a more complete story, and because they do not change the analysis of the issues involved.

61. Radial keratotomy is a surgical procedure for the correction of nearsightedness. Nearsightedness occurs where the cornea focuses visual images in front of the retina rather than exactly on it, which results in an out-of-focus retinal image. Radial keratotomy corrects this problem by making shallow incisions radially on the surface of the cornea, which causes it to flatten slightly. The flatter cornea focuses images farther back in the eye, so vision is improved.

The procedure has had mixed results. See Jane E. Brody, *Study Cites Risks in an Operation for Myopia*, N.Y. TIMES, Feb. 23, 1990, at A20, col. 1 (noting that some patients receive undercorrection or overcorrection, and that ophthalmologists disagree regarding the effectiveness of the procedure). See also George O. Waring III *et al.*, *Results of the Prospective Evaluation of Radial Keratotomy (PERK) Study 4 Years After Surgery for Myopia*, 263 J. A.M.A. 1083 (1990); Perry S. Binder, *Radial Keratotomy in the 1990s and the PERK Study*, 263 J. A.M.A. 1127 (1990).

62. See generally *Schachar*, 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,050-51; *Vest*, 565 F. Supp. at 676-83.

63. *Vest*, 565 F. Supp. at 677.

advisory committee⁶⁴ for the National Eye Institute (NEI), which provides federal funding for vision research. Dr. Geller indicated that the NEI was interested in funding research in radial keratotomy, and Dr. Waring's group met again in May to make plans for submitting a proposal for a study called the Prospective Evaluation of Radial Keratotomy (PERK).

Shortly after that May meeting the NAEC issued a statement that "[t]he Council considers radial keratotomy to be an experimental procedure because it has not been subjected to adequate scientific evaluation in animals and humans."⁶⁵ The issuing of the NAEC statement was followed by similar statements⁶⁶ from ophthalmological and medical associations in several states,⁶⁷ orchestrated, the plaintiffs alleged, by

64. Federal advisory committees are governed by the Federal Advisory Committee Act, 5 U.S.C. App. 2. Such committees, though nominally public agencies, may themselves put private interests over those of the public. See Sidney A. Shapiro, *Public Accountability of Advisory Committees*, 1 RISK ISSUES IN HEALTH & SAFETY 189 (1990).

65. *Vest*, 565 F. Supp. at 678 n.6.

66. In this Article, the terms "standard" and "statement" are used, for the most part, interchangeably. Because the "statements" discussed are official communications of the societies involved, any technical differences that might exist between the two terms are not relevant here.

67. *Vest*, 565 F. Supp. at 679-80 n.8 (Georgia), 680 n.9 (New Mexico), 680-81 n.10 (Florida), 681 n.11 (Arizona). Following is the Arizona statement:

RESOLVED, that,

1. The Arizona Ophthalmological Society (AOS), a group of physicians primarily concerned with eye care, expresses their concern about potential widespread [*sic*] adoption of an operation intended to correct nearsightedness, a common condition that can be easily and safely corrected by the use of eyeglasses or contact lenses.

2. The operation called Radial Keratotomy has received widespread publicity during the last two years. It involves cutting the cornea with a series of deep incisions that extend from the sclera toward, but not into, the center of the cornea. The incisions are intended to be deep enough so that internal eye pressure causes the edge of the cornea to bulge slightly, thereby flattening the central portion of the cornea which improves focusing. The incisions result in permanent scars.

3. The AOS considers Radial Keratotomy to be an "experimental" procedure because it has not been subjected to adequate scientific evaluation in animals and humans.

4. The AOS endorses the conclusions of the National Keratotomy Workshop of March 15, 1980; and the National Advisory Eye Council (NAEC) Resolution approved May 29, 1980, concerning Radial Keratotomy.

5. The AOS urges restraint on the part of both Arizona Ophthalmologists and patients regarding the procedure until results of research known as the Prospective Evaluation of Radial Keratotomy (PERK) study of the National Eye Institute (NEI) are obtained and fully evaluated.

6. The AOS urges that its view on the subject of Radial Keratotomy as

the American Academy of Ophthalmology.⁶⁸ All of them, purportedly following the NAEC, declared radial keratotomy to be “experimental.”⁶⁹ In addition, despite the fact that some of the statements were issued *before* any PERK grants were awarded, they condemned in various terms the performance of radial keratotomy outside the confines of the PERK study. For example, the Georgia motion said that “[e]ach member of the [Georgia Ophthalmological] Society in good standing will agree to refrain from participating in such surgery outside the framework of [the PERK] study, for a period of one year, or until results indicate the technique is safe and effective.”⁷⁰ The original Florida statement was nearly identical to the Georgia one, but it was later withdrawn, and a somewhat less restrictive statement substituted. The new statement, tellingly, included the NRKSG study among the approved programs.⁷¹

The plaintiffs alleged that the statements issued by the societies decreased demand for radial keratotomies. It was not clear in this case, however, whether the decrease was caused by reduced demand from the patients themselves or by less willingness on the part of their insurers to pay for the procedure.⁷² There was no specific evidence reported in the cases regarding whether patients were discouraged from seeking the services.⁷³ It is clear, though, that the *intent* of the societies’ statements was to discourage patients from seeking the procedure, at

expressed in this resolution be announced to the general public, other health care professionals, institutions, including institutional review committees, and third party insurers and payers in Arizona; therefore be it

RESOLVED,

That the Arizona Medical Association endorses and supports the resolution of the Arizona Ophthalmological Society concerning the procedure known as Radial Keratotomy until the safety and efficacy of the procedure have been carefully demonstrated in controlled studies.

Id. at 681 n.11.

68. *Schachar*, 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,050-51.

69. *Vest*, 565 F. Supp. at 679-80 n.8, 680 n.9, 680-81 n.10, 681 n.11.

70. *Id.* at 680 n.8.

71. *Id.* at 680-81 n.10.

72. Indeed, in *Vest* the plaintiffs included potential patients who wanted to receive radial keratotomies, but were hindered in doing so by the societies’ statements. *Id.* at 682.

73. However, the notice issued in *Vest* when a settlement agreement was reached in the case notes that one of the conditions of settlement was that Dr. Waring would issue a statement that radial keratotomy was no longer “experimental” and that “[p]laintiffs also anticipate that the statement will encourage public employers to accept applicants who have had the procedure performed on them.” *Vest v. Waring*, No. C82-325A, Revised Notice to Class Members, at 2 (N.D. Ga. Mar. 25, 1985). Apparently, then, some of those employers had been unwilling to hire patients who had received radial keratotomies, due at least in part to the societies’ statements regarding the procedure.

least outside of the PERK study.⁷⁴ The statements explicitly said that they were intended to "be announced to the general public."⁷⁵ Moreover, the statements' use of dramatic, if not inflammatory, language⁷⁶ could only have been directed at the public.

But most of the reduced patient demand for radial keratotomies in *Schachar* was apparently caused by decisions by third-party payers not to reimburse for the procedure.⁷⁷ After the NAEC and the state medical societies issued their statements, several insurance companies made such decisions.⁷⁸ The plaintiffs alleged that the American Academy of Ophthalmology was instrumental in causing insurance companies to take that action.⁷⁹ It accomplished this, the plaintiffs claimed, through its membership in the Council of Medical Specialty Societies (CMSS), which is associated with the Health Insurance Association of America (HIAA). The HIAA is an organization of insurance companies which together account for approximately eighty-five percent of health insurance in the United States.⁸⁰ When the academy classified radial keratotomy as experimental, the CMSS transmitted that information to the HIAA through a newsletter under a heading entitled "Procedures Which Should Not Be Reimbursed Routinely by Third Party Payers Without Written Justification."⁸¹ Insurers apparently followed this instruction.⁸²

74. The goal of the PERK group was not to eliminate radial keratotomy altogether, but only to confine its practice to their study. They were not, therefore, intending to convey the message that radial keratotomy was *unsafe*, but only that its safety and effectiveness were unproven and, further, were only appropriately tested in their study. Even this, however, was questionable. There was no evidence that the PERK group provided better care or more useful research than the NRKSG (Dr. Bores's group). As mentioned above, the NRKSG had developed and implemented its own research protocol. See *supra* text accompanying note 63.

75. *E.g.*, *Vest*, 565 F. Supp. at 681 n.11.

76. This sort of evaluation is necessarily subjective, but to express "concern" about an "experimental" procedure that involves "deep incisions" into the cornea, resulting in "permanent scars," though perhaps not technically inaccurate, seems calculated more to alarm than to inform. This is especially so in light of the absence, discussed in the text, of efforts to place the statements in any objective context. For the full text of the statement including these descriptions, see note 67 *supra*.

77. This result is not unique to the medical field. In the industrial area, a product's failure to meet a standard can also result in third-party insurers' unwillingness to provide insurance where the product is used. See *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 495-96 (1988).

78. *Vest*, 565 F. Supp. at 681-82.

79. *Schachar*, 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,051.

80. *Id.*

81. *Id.*

82. In addition, the case reports that some hospitals do not allow "experimental"

The adoption by insurers of medical society decisions on these matters is not surprising. Both private⁸³ and public⁸⁴ insurers rely heavily on medical society assessments of services. The societies are generally consulted in determining whether a given service should be covered by the patient's policy, which most often excludes procedures that are "experimental."⁸⁵ As described above,⁸⁶ the state medical societies ap-

procedures to be performed in their operating rooms, so that after the statements were issued surgeons were no longer permitted to perform radial keratotomy in those hospitals' operating rooms. *Vest*, 565 F. Supp. at 682. This made the purchase of personal surgical equipment necessary for those surgeons who wished to continue performing the surgery. *Id.* Hospitals are not, of course, third-party payers, but the effects of their actions were in some ways analogous to the payers' actions. The increased costs incurred by the affected physicians would have resulted in higher costs to their patients, as did third-party payers' decisions not to reimburse for the procedure. The higher costs would have reduced the affected physicians' output of radial keratotomies, benefiting their competitors. See Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 YALE L.J. 209 (1986); Steven C. Salop & David T. Scheffman, *Raising Rivals' Costs*, 73 AM. ECON. REV. (Papers & Proceedings) 267 (1983). Moreover, the hospitals apparently directly accepted the societies' evaluations of the procedure in much the same way as did third-party payers, as discussed in this section and section III.B *infra*.

83. See INSTITUTE OF MEDICINE, *ASSESSING MEDICAL TECHNOLOGIES* 2 (1985) ("Blue Cross and Blue Shield Association and other major insurers increasingly seek assistance from medical associations such as the American College of Physicians, the American College of Radiology, and the American College of Surgeons in formulating coverage policies.").

84. See Health Care Financing Administration, *Medicare Programs; Criteria and Procedures for Making Medical Services Coverage Decisions That Relate to Health Care Technology*, 54 Fed. Reg. 4302, 4311 (1989) (Medicare coverage decisions by private contractors "are usually made in consultation with the contractor's own medical staff and local medical specialty groups.").

85. A typical coverage provision excludes "[a]ny treatment or procedure, medical or surgical, or any facilities, drugs, drug usage, equipment, or supplies which are Experimental or Investigative." *Thomas v. Gulf Health Plan, Inc.*, 688 F. Supp. 590, 593 n.2 (S.D. Ala. 1988) (quoting coverage exclusion). Medicare coverage has similar limitations, derived from the Social Security Act's requirement that a covered procedure be "reasonable and necessary." See 42 U.S.C. § 1395y(a)(1)(A). The Department of Health and Human Services's Health Care Financing Administration has interpreted this requirement to mean that a procedure must be (1) safe and effective, (2) not experimental or investigational, and (3) appropriate. Health Care Financing Administration, *Medicare Programs; Criteria and Procedures for Making Medical Services Coverage Decisions That Relate to Health Care Technology*, 54 Fed. Reg. 4302, 4307 (1989). Under this test, a procedure's experimental status would presumably be sufficient in itself to preclude its coverage, but an experimental procedure is also unlikely to satisfy the other two criteria, given their close interdependence. See INSTITUTE OF MEDICINE, *ASSESSING MEDICAL TECHNOLOGIES* 5 (1985) ("Safety and effectiveness are addressed only indirectly in some evaluations; payers generally rely on a determination of a technology's diffusion, i.e., whether it is standard practice rather than experimental or investigative, as an indicant of a physician's judgment of its

plied this label to radial keratotomy, which caused insurers to refuse to reimburse for it. There is reason to think that professional societies should not be permitted to exercise such power.

A basic problem is that there is no objective definition of "experimental." The Health Care Financing Administration has proposed regulatory guidelines for evaluating a treatment's experimental status, but to the extent that they are not circular,⁸⁷ they rely on general acceptance by the medical community.⁸⁸ Therefore, the evaluation is an imprecise process, and determination of which procedures are experimental has been extremely inconsistent, even in the presumably impartial forum of the court system.⁸⁹ Even more significantly, the use of acceptance by the medical community as the evaluation criterion has inherent problems when it is a subgroup of that same community that is making the evaluation and that subgroup has an economic interest in the outcome.

The evaluation of radial keratotomy in *Schachar*, made by the medical societies and allegedly influenced by the PERK group, was a self-interested one.⁹⁰ Recall that the effect of the societies' efforts was

safety and effectiveness."); Health Care Financing Administration, Medicare Programs; Criteria and Procedures for Making Medical Services Coverage Decisions That Relate to Health Care Technology, 54 Fed. Reg. 4302, 4308 (1989) ("Among the many relevant considerations [in evaluating appropriateness], safety and effectiveness are the key factors for our review.").

86. See *supra* text accompanying notes 65-69 & 77-82.

87. See Health Care Financing Administration, Medicare Programs; Criteria and Procedures for Making Medical Services Coverage Decisions That Relate to Health Care Technology, 54 Fed. Reg. 4302, 4316 (1989) ("'Experimental' means a technology that should be confined to a research setting under which human or animal subjects are assigned, in accordance with predetermined rules.").

88. See *id.* at 4307-08 ("Has the service been generally accepted by the medical community, and has it emerged from the research stage?").

89. See Richard S. Saver, Note, *Reimbursing New Technologies: Why Are the Courts Judging Experimental Medicine?*, 44 STAN. L. REV. 1095, 1098-1104 (1992).

90. The court outlined the plaintiffs' description of the process as follows: The Academy commissioned its Eye Banks Committee to determine the status of radial keratotomy, although the committee members were unqualified to do so, and it declared the procedure experimental. In March of 1980 at the Academy's direction various co-conspirators held a meeting at the Atlanta airport and also concluded that radial keratotomy should be designated experimental. Defendants then began a national campaign to pressure state and local medical societies, governmental agencies and hospital staffs to declare a moratorium on radial keratotomy until self-appointed academicians could study the procedure and decide whether it should be approved.

Schachar, 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,050-51.

There is some indication that the evaluations of radial keratotomy were not based solely on scientific considerations. The NAEC first declared radial keratotomy experimental

not to halt the practice of radial keratotomy, but to reserve the practice of it, even in research, to the PERK group's academic studies.⁹¹ This was true despite the absence of any showing of a significant difference between the PERK study and Dr. Bores's (non-academic) NRKSG work. As described above,⁹² Dr. Bores's NRKSG was not performing radial keratotomies indiscriminately, but had itself established a research protocol for the procedure. There was no showing, or even any allegation, that the NRKSG was performing radial keratotomies irresponsibly. The main difference between its work and that of the PERK study was apparently that the NRKSG's patients paid for the procedure, while patients in the PERK study did not. Although the ophthalmologists in the NRKSG therefore stood to gain from performance of the procedure, and thus had an economic interest at stake, so did the PERK ophthalmologists.⁹³ Dr. Waring and the other ophthalmologists in the study were compensated for their work as part of the grant.⁹⁴ Moreover, even if they had not been paid, the receiving of a grant has significant implications for career advancement for an academic researcher. There-

in August, 1979. *Vest v. Waring*, 565 F. Supp. 674, 677 n.3 (N.D. Ga. 1983). At that time the NAEC stated that "[n]o clinical research employing refractive keratoplasty [*i.e.*, radial keratotomy] should be supported by the National Eye Institute (NEI) until the results of animal research can be evaluated." See 18 *Investigative Ophthalmology and Visual Science* 882 (1979). However, on May 28, 1980, shortly after the meeting between Dr. Waring's study group and Dr. Ronald Geller of the NAEC, the Council changed its opinion and "urged the [National Eye Institute] to 'take whatever measures are necessary to encourage research in radial keratotomy . . . in scientifically designed clinical trials conducted by qualified investigators.'" See *Vest*, 565 F. Supp. at 678. The turnaround just as the PERK group was lobbying the NAEC for a research grant seems more than coincidental.

It is also notable that Dr. Waring himself eventually decided that he could approve radial keratotomy as part of a settlement agreement in *Vest*. The settlement notice included the following statements:

[O]ne of the Defendants, Dr. George O. Waring, has agreed to issue a statement which will be released when the proposed settlement becomes final. The statement is intended to set forth certain current and historical facts about the radial keratotomy procedure, and states, *inter alia*[,] that enough information is now available to establish that radial keratotomy is not an experimental procedure.

Vest v. Waring, No. C82-325A, Revised Notice to Class Members, at 2 (N.D. Ga. Mar. 25, 1985).

91. See *supra* text accompanying notes 70-71.

92. See *supra* text accompanying note 63.

93. The third-party payers also have economic interests in the evaluations. Because insurance companies usually receive payment *per capita*, they have every reason *not* to cover a service if they can justify non-payment. Therefore, any effort by a society to persuade an insurer to eliminate reimbursement is likely to be readily accepted.

94. They probably continued to receive their paychecks from academic institutions, of course. But research grants typically include compensation for the researchers, paid to institutions for their benefit.

fore, it was in the PERK group members' economic interests to establish that radial keratotomy was experimental before widespread practice of the procedure provided data regarding its efficacy; otherwise, there would have been no need for their study. Furthermore, establishing the societies' rules that no radial keratotomies should be performed outside their study assured the PERK group of patients who might otherwise have preferred to receive the procedure without the additional burden of the experimental procedure.⁹⁵

Thus, as in *Koefoot*, the defendants in *Schachar* were able to use the influence of their medical societies to injure the practices of their competitors. Again, as with *Koefoot*, it should be emphasized that this is not to say that the medical society evaluations were necessarily wrong. And even if they were, it is not to say that any members of either of the radial keratotomy study groups intentionally made false statements regarding the procedure. The point is only that the economic interests of the participants and the potential for effects on competition argue for a critical analysis of the society statements. The next two Parts of this Article provide a framework for that analysis.

II. CURRENT LEGAL STANDARDS

The facts in *Koefoot* and *Schachar* appear to make *prima facie* cases of combinations to restrain trade. Both trial judges thought so and denied the defendants' motions for summary judgment.⁹⁶ Nevertheless, in both cases the juries found for the defendants.⁹⁷ Although this may truly indicate that the societies' actions were, on balance, procompetitive, the economic incentives and anticompetitive potential discussed in Part I suggest that other possibilities should be considered. One is that the juries might have deferred to the professionals' justifications for their actions more readily than they would have for other groups. This possibility seems plausible when one considers that juries have returned plaintiffs' verdicts against non-professional trade associations in somewhat similar cases.⁹⁸ However, another possibility is that the medical societies received deference not from the juries but from the courts. *Koefoot* and *Schachar* may have had jury instructions

95. See Havighurst, *supra* note 18, at 370 (discussing denial of consumer choice in conduct of clinical trials).

96. *Schachar*, 1988-1 Trade Cases (CCH) ¶ 67,986; *Vest*, 565 F. Supp. 674.

97. See *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397, 398 (7th Cir. 1989) (noting jury verdict for defendants); *Koefoot v. American College of Surgeons*, 692 F. Supp. 843, 845 (N.D. Ill. 1988) (same).

98. See, e.g., *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 497-98 (1988) (noting jury verdict for plaintiff); *American Soc'y of Mechanical Eng'rs v. Hydrolevel Corp.*, 456 U.S. 556, 565 (1982) (same).

similar to those in *Wilk v. American Medical Association*,⁹⁹ another society standard case that produced a jury verdict for defendants. Those instructions could not “be defended successfully as an adequate approximation of a rule of reason test geared simply, clearly, and exclusively to the question whether the challenged conduct promoted or suppressed competition.”¹⁰⁰

Support for this explanation can be found in the opinion of the Seventh Circuit affirming the verdict in *Schachar*. This opinion, by Judge Easterbrook, sounded two notes often heard in professional society cases:

[The Academy] did not require its members to desist from performing [radial keratotomies] or associating with those who do. It did not expel or discipline or even scowl at members who performed radial keratotomies.¹⁰¹

An organization’s towering reputation does not reduce its freedom to speak out. Speech informed, hence affected, demand for radial keratotomy, but the plaintiffs had no entitlement to consumers’ favor. The Academy’s declaration affected only the demand side of the market, and then only by appealing to consumers’ (and third-party payors’) better judgment. If such statements should be false or misleading or incomplete or just plain mistaken, the remedy is not antitrust litigation but more speech—the marketplace of ideas.¹⁰²

If the trial courts gave jury instructions in line with these statements, it is not surprising that the juries decided for the defendants. As Judge Easterbrook points out, the Academy in *Schachar* did not force its members or others to cease providing radial keratotomies. Instead, it and the ACS in *Koefoot* were able to influence patients and third-party payers to cease buying the services they disapproved. Contrary to Judge Easterbrook’s view, however, that should not remove the societies’ actions from the reach of the antitrust laws.¹⁰³

99. 719 F.2d 207, 211 (7th Cir. 1983) (noting jury verdict for defendants), *cert. denied*, 467 U.S. 1210 (1984). *Wilk* was subsequently retried (on a more limited set of issues) without a jury, and the trial judge found for the plaintiff. See *Wilk v. American Medical Ass’n*, 671 F. Supp. 1465 (N.D. Ill. 1987), *aff’d*, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 476 U.S. 927 (1990).

100. *Id.* at 225. In contrast, the Supreme Court in *Allied Tube* specifically noted that “[t]he jury, instructed under the rule of reason that respondent carried the burden of showing that the anticompetitive effects of petitioners’ actions outweighed any pro-competitive benefits of standard setting, found petitioner liable.” 486 U.S. at 497-98.

101. *Schachar*, 870 F.2d at 398.

102. *Id.* at 399-400.

103. Even commentators who are generally sympathetic to society standard-setting

A. Anticompetitive Effects on Demand

As a preliminary matter, it is clear that some medical standards, such as the one in *Koefoot*, do have a coercive effect. Although Dr. Koefoot did not give up his practice of what the ACS called "itinerant surgery," he was thereby forced to give up his ACS membership.¹⁰⁴ It would be a cramped definition of coercion that excluded a rule with effects like these from its reach. "Coercion" is present not only when the society member has no choice at all, but also when the society exercises some degree of undue influence.¹⁰⁵

In any event, the view that coercion is necessary to establish an antitrust violation is simply wrong. In *Schachar*, Judge Easterbrook cited several trade association cases in which standards were found anticompetitive, and he said that in those cases the standard was enforced.¹⁰⁶ However, his characterization of those cases was at best disingenuous. Several of the cases cited involved only standard-setting, not enforcement, or explicitly said that coercion was not necessary to find a violation.¹⁰⁷

have expressed skepticism about Judge Easterbrook's comments. See Greaney, *supra* note 19, at 663 ("The Seventh Circuit's dismissive analysis of [Schachar's] antitrust claim is questionable")

104. See *Koefoot v. American College of Surgeons*, 610 F. Supp. 1298, 1303 (N.D. Ill. 1985) (The ACS stated that "[i]f Dr. Koefoot chooses not to drive 20 miles to [plaintiff hospitals] to see his patients, if Dr. Koefoot disagrees with the College's policy, or if Dr. Koefoot chooses to spend his time on pursuits other than surgery, that is his perfect right. But he may not call himself a Fellow of the American College of Surgeons.'). See *supra* section I.A.

105. A standard that operated much like the one in *Koefoot* was at issue in *Wilk v. American Medical Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984), *decision on remand*, 671 F. Supp. 1465 (N.D. Ill. 1987), *aff'd*, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 496 U.S. 927 (1990). The AMA's standard prohibited its members from practicing in association with chiropractors. 719 F.2d at 213-14. Although, as in *Koefoot*, an AMA member physician need only have left the society to practice as she liked, the *Wilk* court had no difficulty finding a coercive effect. On remand, it enjoined the AMA from "restricting, regulating or impeding, or aiding and abetting others from restricting, regulating or impeding, the freedom of any AMA member or any institution or hospital to make an individual decision as to whether or not [to] professionally associate with chiropractors." 671 F. Supp. at 1507.

106. *Schachar*, 870 F.2d at 399 (citing *National Soc'y of Professional Eng'rs, Inc. v. United States*, 435 U.S. 679 (1978); *Wilk v. American Medical Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984); *Moore v. Boating Indus. Ass'ns*, 819 F.2d 693 (7th Cir. 1987); *Hydrolevel Corp. v. American Soc'y of Mechanical Eng'rs*, 635 F.2d 118, 124-27 (2d Cir. 1980), *aff'd on other grounds*, 456 U.S. 556 (1982); *Indian Head, Inc. v. Allied Tube & Conduit Corp.*, 817 F.2d 938, 946-47 (2d Cir. 1987), *aff'd on other grounds*, 486 U.S. 492, 499 n.3 (1988)).

107. See, e.g., *American Soc'y of Mechanical Eng'rs v. Hydrolevel Corp.*, 456 U.S. 556, 559 (1982) ("These codes, while only advisory, have a powerful influence"); *Wilk v. American Medical Ass'n*, 719 F.2d 207, 230 (7th Cir. 1983) ("[E]ven without

Moreover, the Supreme Court has repeatedly found antitrust violations by professional societies in the absence of coercive enforcement, so it is clear that antitrust liability does not require that there be any formal enforcement mechanism.¹⁰⁸ It is true that the Court has also said that “[c]oncerted efforts to *enforce* (rather than just agree upon) private product standards face more rigorous antitrust scrutiny.”¹⁰⁹ But this merely indicates that the mechanism by which standards act is relevant; it does not suggest that the Court would exempt from scrutiny standards that lack formal enforcement. Thus, neither the antitrust laws nor the Supreme Court’s interpretation of those laws imposes a requirement that a restraint of trade be formally coercive. It is the practical effects of a standard that matter.¹¹⁰

Actually, this seems to be acknowledged in *Schachar*. After Judge Easterbrook’s rhetorical flourish regarding coercion, he evaluated whether the Academy’s action produced anticompetitive effects. As evidence of

coercive enforcement, a court may find that members of an association promulgating guidelines sanctioning conduct in violation of § 1 participated in an agreement to engage in an illegal refusal to deal.”), *cert. denied*, 467 U.S. 1210 (1984); *see also* United States v. National Soc’y of Professional Eng’rs, Inc., 389 F. Supp. 1193, 1200 (D.D.C. 1974) (stating that the society “actively pursue[d] a course of policing adherence” to its ban on competitive bidding, but referring only to “educational campaigns and personal admonitions to members and clients”), *aff’d in part, modified in part on other grounds*, 555 F.2d 978 (D.C. Cir. 1977), *aff’d*, 435 U.S. 679 (1978). In addition, Judge Easterbrook described the enforcement mechanism in *Allied Tube* as an agreement “not to manufacture, distribute, or purchase certain types of products.” *Schachar*, 870 F.2d at 399 (quoting *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 500 (1988)). But no evidence was offered in *Allied Tube* of any efforts to enforce such an agreement. A competitor was free to manufacture any product it chose; it would just be unable to sell it due to the established standard labelling it unacceptable. The situation is thus exactly analogous to that in *Schachar*, where the resolutions of the medical societies required members to “refrain from participating in [radial keratotomies] outside the framework of [the PERK study].” *Vest v. Waring*, 565 F. Supp. 674, 680 n.9 (N.D. Ga. 1983) (quoting resolution of the New Mexico Ophthalmological Society).

108. For example, the defendant bar association in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), set fee standards that it argued were voluntary, so that there was no real price-fixing. *Id.* at 781. But the Court responded that the standards presented not only the threat of professional discipline but “the desire of attorneys to comply with announced professional norms.” *Id.* (citation omitted). Thus, the Court seemed to say that any norm issued by a professional society would be a restraint that could create antitrust liability, merely because the society’s members tended to follow it.

109. *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 501 n.6 (1988) (citations omitted, emphasis in original).

110. *See Eastman Kodak Co. v. Image Technical Servs., Inc.*, 112 S. Ct. 2072, 2082 (1992) (“Legal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust law. This Court has preferred to resolve antitrust claims on a case-by-case basis, focusing on the ‘particular facts disclosed by the record.’” (citations omitted)).

a lack of such effects, he pointed out that radial keratotomies continued to be performed. But this point is hardly conclusive. The Sherman Act proscribes not just total elimination of trade, but all unreasonable restraint of trade.¹¹¹ In fact, the court went on to discuss the number of radial keratotomies that were performed, indicating that it acknowledged the number's relevance. It should, therefore, have considered the extent, if any, of the reduction in the number of radial keratotomies performed.¹¹² Reduced output is what antitrust law is all about.

B. *Medical Society Power in the Market for Information*

The misplaced emphasis on coercion is a result of a misconception regarding the nature of medical societies' market power. Coercion of society members is a product of the power of societies to grant or deny membership. If a society, as in *Koefoot*, denied membership to those who did not conform to its standards, it might be able to force its members to conform. It is true that some society power is of this kind and derives from the importance to individual professionals of society membership. Membership provides a source of referrals,¹¹³ and it may be useful for marketing one's services. It may even be necessary to qualify for staff privileges in a hospital.¹¹⁴ But it is not this sort of power in the professional employment market that is reflected in *Schachar* and to a large extent in *Koefoot*.

In those cases, competitive effects were produced by society influence over third parties, i.e., patients and insurers, rather than society members. That influence was produced by the evaluations communicated in the societies' statements: in *Koefoot*, labelling itinerant surgery "unethical,"¹¹⁵ and in *Schachar*, labelling radial keratotomy "experimental" and saying it should not be performed outside a particular research study.¹¹⁶

111. See *supra* note 9.

112. That was the approach taken by the Supreme Court in *Goldfarb*, where it pointed out that every lawyer that the petitioners had contacted had adhered to the fee schedule, which it said "reveal[ed] a situation quite different from what would occur under a purely advisory fee schedule." *Goldfarb*, 421 U.S. at 781. Thus, the Court expressed its willingness to rely on the effects of a society's standards as evidence of their coercive power. It made this approach more explicit in *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986), where it noted the FTC's finding that the federation's restrictions were adhered to by its members and said that those effects were "legally sufficient to support a finding that the challenged restraint was unreasonable." *Id.* at 461.

113. *Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1484 (D.C. Cir. 1984).

114. *Koefoot v. American College of Surgeons*, 610 F. Supp. 1298, 1301 (N.D. Ill. 1985).

115. See *supra* section I.A.

116. See *supra* section I.B.

In a very real sense, therefore, the societies' influence was caused by their power in a market for medical information.¹¹⁷ Although neither consumers nor (usually) third-party payers actually purchase medical information directly, both actively seek it out. Professional societies willingly respond by supplying this information. Indeed, professional societies are major suppliers in the medical information market.¹¹⁸ For better or worse, their prominent positions in their fields, and the respect and esteem in which they are held, give them power in that market.¹¹⁹ Moreover, it is difficult for new entrants to attain comparable positions in order to provide alternative views regarding medical services.¹²⁰

As was made clear in *Koefoot* and *Schachar*, the medical information market has strong effects on the medical services market. The exact mechanism of these effects can be described in any of several ways,¹²¹

117. The same observation has been made in the context of medical credentials and accreditation: "The key to the analysis—and the shortest and surest path to sensible legal results—is recognition that a market for commercially valuable information and opinion exists and can be kept competitive by applying traditional antitrust principles to those participating in it." Havighurst & King, *supra* note 4 (pt. 2), at 334. See also Howard Beales, Richard Craswell, & Steven C. Salop, *The Efficient Regulation of Consumer Information*, 24 J. L. & ECON. 491, 505 (1981) ("When scale economies in information generation and dissemination lead to natural monopoly problems, information intermediaries can achieve a high level of market power, though it may not be exercised in practice.").

118. See Havighurst, *supra* note 18, at 350 ("Much of the privately generated information concerning medical technology emanates from professionals and professional organizations.").

119. See, e.g., *Schachar v. American Academy of Ophthalmology, Inc.*, 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,052 (N.D. Ill.) ("The views of [a large and highly respected professional] organization specializing in a field about which the general public is generally uninformed, especially where the views are publically disseminated to potential patients and third party payers, acquire significantly more weight and thus have a more coercive effect than would the views of individuals.").

120. See Havighurst, *supra* note 18, at 350 ("Because of the difficulties of marketing public goods . . . , private technology assessment is more likely to be undertaken by large organizations that can themselves internalize enough of the benefit to justify the cost.").

121. For example, one can look at the effect of standards from the perspective of purchasers of medical services. For such a group, standards greatly affect information costs. See *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 112 S. Ct. 2072, 2085-87 (1992) (discussing effects of information costs generally). The relative availability of information regarding different medical services, and the nature of that information, will be largely a function of the standards and statements that have been issued regarding those services. Therefore, because information about medical services is difficult and costly to obtain, when a standard is available it is likely to be the only information a consumer will use. See *id.* at 2086 ("[E]ven if consumers were capable of acquiring and processing the complex body of information, they may choose not to do so. Acquiring the information is expensive.").

Imposing liability on competitors who worsen this problem has been considered. In *Town Sound and Custom Tops, Inc. v. Chrysler Motors Corp.*, 959 F.2d 468 (3d Cir.

but the important point is that information (or misinformation) conveyed

1992), *cert. denied*, 113 S. Ct. 196 (1992), the plaintiff argued that Chrysler's policy of requiring consumers to purchase radios with its cars allowed it to include part of the price of the radios in the base price of the car, thus misleading consumers regarding the price that they were paying for the radios. The court agreed that "[a]ctions creating or exacerbating problems of imperfect information could be seen as 'restraining trade' or 'substantially lessening competition' even though not leading to monopoly or oligopoly." *Id.* at 492 n.34. The court also noted that some comments in the Supreme Court's opinion in *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984), might justify such a view. 959 F.2d at 490-92. But it declined to consider that option itself, "absent a much clearer mandate from the Court." *Id.* at 492. *Kodak* may be that mandate. In any event, Chrysler's actions in *Town Sound* were not specifically directed at conveying information. In professional standard-setting, where informing others is the goal of the actions at issue, more searching scrutiny is appropriate.

Alternatively, one can look at the costs of the suppliers who compete with standard-setters. Although in principle it is possible for competing suppliers to correct misleading information conveyed by a standard, so as to recover the demand of consumers, it may be prohibitively expensive to do so. *See Kodak*, 112 S. Ct. at 2086 n.21 ("Even in a market with many sellers, any one competitor may not have sufficient incentive to inform consumers because the increased patronage attributable to the corrected consumer beliefs will be shared among other competitors." (citation omitted)). And even if a supplier did expend the resources to compete against a misleading standard, doing so would raise his costs, and, therefore, disadvantage him in competition. This occurred in *Interstate Circuit, Inc. v. United States*, 306 U.S. 208 (1939). The defendant in *Interstate Circuit*, a monopoly operator of first-run movie theaters, prevailed upon a distributor to require second-run theaters to charge a minimum price. *Id.* at 215-18. As Professors Krattenmaker and Salop point out, the effect of this action was to raise the costs of the second-run theaters: "The price that theaters paid for exhibition rights did not necessarily rise but, presumably, their costs of attracting patrons did." Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 YALE L.J. 209, 239 n.97 (1986). The necessity of competing with a deceptive standard imposes similar additional costs on competitors of the standard-setters. Professors Krattenmaker and Salop note that under these circumstances the theory that monopoly power in one market (*i.e.*, medical information) can be "leveraged" into another (*i.e.*, medical services) is plausible. *Id.* at 248-49.

Interestingly, both of these mechanisms were discussed in a recent article on professional rules, yet the author of that article had little concern regarding the demand-related effects described here. *See* John E. Lopatka, *Antitrust and Professional Rules: A Framework for Analysis*, 28 SAN DIEGO L. REV. 301 (1991). Professor Lopatka describes, in a discussion emphasizing economic theory, how restrictions in the supply of information can both increase consumer search costs, *id.* at 317-23, and raise the costs of providers, *id.* at 323-32. He further notes the parallels between these two phenomena and observes, as does this Article, that "[t]he best way to view the matter may be to recognize a demand for information." *Id.* at 329. Nevertheless, when he discusses what he calls the "theoretical possibility" of a group of professionals collusively manipulating demand by establishing rules that mislead consumers, he states only that "determining that such a rule is likely to reduce welfare would be difficult." *Id.* at 333-35.

Professor Lopatka does not apply his observations on cost-raising to the manipulation of demand by professionals because he focuses only on markets defined by professional

in society standards, and the interpretation of that information by its recipients, influences the purchase of medical services. The influence is effective independent of any influence or coercion that societies impose on their members. This has two important implications. First, the cases that look at the percentage of physicians belonging to a society¹²² or at the importance to a physician of belonging to a society¹²³ are missing the point. Those factors affect only the society's power in the market for medical society membership, not necessarily its power in the medical services market.¹²⁴ Second, and conversely, a society's power to affect

services as a whole, rather than on particular product markets. For example, although Professor Lopatka notes that his model of increased consumer costs "depends on a change in demand, not a change in the costs of the supplies," *id.* at 321, he examines this phenomenon only in the context of the suppression of price information, an action that affects the entire professional services market. *See id.* at 318-21. Similarly, in describing the efforts of dentists who do not use dental hygienists to raise their rivals' costs by banning those rivals' use of hygienists, he notes only that "[t]he industry supply curve rotates up and to the left." *Id.* at 324. The industry focus of Professor Lopatka is confirmed by his statement dismissing the importance of professional rules affecting information: "The information restrained by such a rule might have no effect on the demand for professional services, but merely cause a shift in the pattern of supply among professionals." *Id.* at 334. But it is exactly control over the shifting of supply patterns (that is, the allocation of productive capacity) that the antitrust laws seek to prevent. *See, e.g.,* 1 PHILLIP AREEDA & DONALD F. TURNER, ANTITRUST LAW ¶ 103 (1978) ("The economic objective of a pro-competitive policy is to maximize consumer economic welfare through efficiency in the use and allocation of scarce resources . . ."). A focus on an entire industry is only appropriate when the cross-elasticity of demand among the various services in that industry is high. *See generally* 2 PHILLIP AREEDA & DONALD F. TURNER, ANTITRUST LAW ¶ 525 (1978). That is, it is only appropriate when consumers perceive the services in the industry as close substitutes. *Id.* This may be the case in Professor Lopatka's examples. For instance, consumers are probably largely indifferent between dental-services-without-dental-hygienists and dental-services-with-dental-hygienists. However, in many other cases, consumers are not indifferent between professional services. In the ophthalmological area, for example, consumers do not treat even contact lenses and eyeglasses as completely interchangeable, and it is not likely that a surgical procedure like radial keratotomy would be perceived as a close substitute for either. Therefore, radial keratotomy probably constitutes a market in itself, and the effects of manipulation of demand should be assessed in that market, not in the market for ophthalmological (or, even more broadly, medical) services in general. The same anticompetitive potential that Professor Lopatka describes for entire industries also applies to individual product markets.

122. *See, e.g., Schachar*, 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,050 (noting that over ninety percent of all ophthalmologists in the United States belong to the American Academy of Ophthalmologists).

123. *See supra* text accompanying notes 113-14.

124. Of course, the importance of society membership and power in the information market will often both be present when a society is prominent and well respected. But power in the information market does not derive from the importance of membership; instead, both are a result of the prominence of the society.

the consumption of medical services may be much greater, due to the esteem in which it is held or the effectiveness of publication of its statements, than its size or market share of physicians would predict.¹²⁵

The Supreme Court has recognized exactly this sort of market power in two trade association cases. In *American Society of Mechanical Engineers v. Hydrolevel Corp.*,¹²⁶ for example, it said that the society's "agents exercise economic power because they act with the force of the Society's reputation behind them."¹²⁷ That power derived not from influence over the members of the society, but because the Society's "codes and standards influence the policies of numerous States and cities, and, as has been said about 'so-called voluntary standards' generally, [the Society's] interpretation of its guidelines 'may result in economic prosperity or economic failure for a number businesses of all sizes throughout the country,' as well as entire segments of an industry."¹²⁸ Similarly, in *Allied Tube & Conduit Corp. v. Indian Head, Inc.*,¹²⁹ the Court said that it was deciding the case "on the theory 'that the stigma of not obtaining [Code] approval of its products and [the defendant's] 'marketing' of that stigma caused independent marketplace harm'" to the plaintiff.¹³⁰ The "independent marketplace harm" produced by the absence of Code approval was a result of the standard's impact on third parties, not its effect on society members.¹³¹

125. *Cf. Mozart Co. v. Mercedes-Benz of North America, Inc.*, 833 F.2d 1342, 1346-47 (9th Cir. 1987) (pointing out that although the uniqueness of Mercedes automobiles may provide market power in the consumer market, it does not necessarily do so in the dealer market for automobile franchises), *cert. denied*, 488 U.S. 870 (1988).

126. 456 U.S. 556 (1982).

127. *Id.* at 574.

128. *Id.* at 570 (quoting H.R. Rep. No. 1981, 90th Cong., 2d Sess. 75 (1968)).

129. 486 U.S. 492 (1988).

130. 486 U.S. at 498 n.2 (quoting *Indian Head, Inc. v. Allied Tube & Conduit Corp.*, 817 F.2d 938, 941 n.3 (2d Cir. 1987), with interpolations by Supreme Court); *see also Koefoot v. American College of Surgeons*, 610 F. Supp. 1298, 1308 (N.D. Ill. 1985) ("[T]his Court simply cannot accept the defendants' contention that any injury to Dr. Koefoot's reputation is irrelevant to his antitrust claim. To the extent that the number of patients referred to a surgeon depends on his reputation, that reputation is critically important and directly affects his income. Because Dr. Koefoot is a direct competitor of surgeons who are Fellows of the American College of Surgeons, injury to his reputation and income is precisely the sort of anti-competitive injury that the antitrust laws were designed to prevent.').

131. It should be pointed out that at another point the *Allied Tube* Court said that the effects of the code were not solely a result of the "power of persuasion." It noted that "[t]he Association's members, after all, include consumers, distributors, and manufacturers of electrical conduit, and any agreement to exclude [a particular product] from the Code is in part an implicit agreement not to trade in [the product]." 486 U.S. at 507. The presence of consumers in a trade association, when the association takes a

C. *Competitive Effects in the Medical Information Market*

Accepting that medical societies influence the operation of the medical services market by issuing evaluations of products and services to third parties, how does that information affect competition? Third-party payers, as discussed below,¹³² present a special case because they often respond not to the information in a standard but merely to the fact of its issuance. For consumers, it is the specific statements of the society that affect their decisions. Therefore, as the Supreme Court has said in addressing this issue, it is important that "private economic decisions . . . be intelligent and well informed."¹³³ The focus should be on whether the information provided enables patients to make better, *i.e.*, better informed, choices of services.¹³⁴ In other words, do the medical societies provide accurate information, or do they merely (mis)lead patients to purchase the services the societies prefer?¹³⁵

There are two ways to attempt to ensure that information flows cleanly and accurately: information can be tested for substantive content, or the generation of information can be governed by rules that ensure the integrity of the information-generating process. The Supreme Court in *Allied Tube* relied on both tests in stating its view that if private

position disapproving a product, lends the association's action the character of a group boycott. See Havighurst & King, *supra* note 4 (pt. 1), at 173-74. Because professionals societies do not have patients as members, they do not share this problem.

132. See *infra* section III.B.

133. *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 765 (1976).

134. See Havighurst, *supra* note 18, at 350 ("[T]he issue that antitrust courts must resolve is whether professional sponsorship of technology assessment perpetuates professional dominance, thus impeding rather than promoting the movement toward a competitive market in which choices are made, with good information, by consumers and independent agents acting on their behalf.').

135. The staff of the Federal Trade Commission has described a variety of ways in which standards can be deceptive or misleading. See BUREAU OF CONSUMER PROTECTION, FEDERAL TRADE COMMISSION, STANDARDS AND CERTIFICATION: FINAL STAFF REPORT 188-209, 288-95 (1983). As described in notes 152 and 218 *infra*, the F.T.C. proposed regulations in this area, but its authority to issue such regulations was withdrawn by Congress with the comment that deceptive standards were already prohibited by the antitrust laws.

At least one court of appeals has appeared to accept this theory of competitive impact, at least in principle. In *Clamp-All Corp. v. Cast Iron Soil Pipe Inst.*, 851 F.2d 478 (1st Cir. 1988), *cert. denied*, 488 U.S. 1007 (1989), the plaintiff alleged that the form of a trade association's standard might have misled users regarding the significance of the association's approval. The court affirmed a finding of no antitrust liability because there was "no testimony that any of [the consumers] was fooled." *Id.* at 487-88. It did not, however, reject the argument that such deception could be anticompetitive. See *id.* For a similar view in a somewhat different context, see the discussion of *Town Sound and Custom Tops, Inc. v. Chrysler Motors Corp.*, 959 F.2d 468 (3d Cir. 1992), *cert. denied*, 113 S. Ct. 196 (1992), in note 121 *supra*.

standards are derived “based on the merits of objective expert judgments and through procedures that prevent the standard-setting process from being biased by members with economic interests in stifling product competition, those private standards can have significant procompetitive advantages.”¹³⁶ However, despite this statement’s reference to both substantive and procedural tests, the rest of the case focused solely on the procedural protections.

Allied Tube involved the National Fire Protection Association (NFPA), which sets and publishes standards routinely adopted as law in many jurisdictions.¹³⁷ A change was proposed to a standard established by the NFPA, and the standard’s supporters (most of whom were manufacturers of products that conformed to it) packed the association’s annual meeting with new members recruited specifically to vote against the proposed change, which would have approved a new and competing product.¹³⁸ The change was voted down.¹³⁹ The Court said that even though the packing of the meeting did not actually violate the association’s rules, and even though most of the damage to plaintiffs was done by government adoption of the NFPA’s standards, the association was responsible for seeing that its power was not used in such a fashion:

[T]he hope of procompetitive benefits depends upon the existence of safeguards sufficient to prevent the standard-setting process from being biased by members with economic interests in restraining competition. An association cannot validate the anti-competitive activities of its members simply by adopting rules that fail to provide such safeguards.¹⁴⁰

It is not clear, however, that there could ever be procedural safeguards sufficient to protect the standard-setting process from economic self-interest. The problem is especially acute in a case like *Wilk v. American Medical Association*,¹⁴¹ where the American Medical Association sought to “eliminate” the practice of chiropractic, in part through enactment of an “ethical principle” that prohibited its members from practicing in association with chiropractors.¹⁴² In that case, where the disapproved

136. *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 501 (1988) (citation omitted).

137. *Id.* at 495-96.

138. *Id.* at 496-97.

139. *Id.* at 497.

140. *Id.* at 509 (footnote omitted).

141. 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984), *decision on remand*, 671 F. Supp. 1465 (N.D. Ill. 1987), *aff'd* 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 496 U.S. 927 (1990).

142. Until 1980, Principle 3 of the American Medical Association (AMA) Principles

practitioners (*i.e.*, the chiropractors) were not members of the society issuing the standard, it was arguably in every society member's self-interest to pass a restrictive standard. Even when society members disagree about a standard, presumably the best that can be done is to determine whether it is preferred by a majority of society members. Enactment of such a standard would still not meet antitrust requirements, for two reasons.

First, any new practice technique adopted by professionals is introduced first by a minority of professionals. There is no reason to suppose that these innovative professionals are less able than others to determine whether the new technique is safe. To the contrary, their experience with the new technique places them in the best position to evaluate it.¹⁴³ Furthermore, it is possible, if not likely, that those professionals not yet practiced in the new technique will be suspicious of it.¹⁴⁴ Therefore, given the uncertainty in evaluating any medical technique, a majority (or even super-majority) vote is likely to reject most new techniques, regardless of merit.

Second, and more important, the antitrust laws do not operate by majority vote of producers, but by the market decisions of consumers. One could certainly adopt the position that, given safety concerns, new procedures should be adopted only when a majority of professionals approve them, but that is not the position adopted by the Sherman Act. The Supreme Court has never said that the choice in these matters should not remain with consumers. It is especially unlikely that the Court would allow a group of producers to decide on the proper form of services to provide to consumers. In *National Society of Professional Engineers v. United States*,¹⁴⁵ the Court said that, even in the absence of a professional society's quality standards, quality goods could still be produced because "a purchaser might conclude that his interest in quality—which may embrace the safety of the end product—outweighs

of Medical Ethics provided: "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily professionally associate with anyone who violates this principle." 719 F.2d at 231. The AMA at the time considered chiropractic unscientific, and its official interpretation of Principle 3 described it as such, so Principle 3 discouraged physicians from associating with chiropractors. *Id.*

143. This is not to say that such groups will not have their own bias, probably in favor of the new technique, or that they are the only ones who should be able to evaluate it. The point is just that, given their experience with the technique, their views are likely to be well informed and should not be permitted to be overwhelmed by the majority's less informed perceptions. To the extent that the innovators made deceptive statements regarding the technique, though, they would be liable on the same terms as the larger group (assuming that they too had market power). *See infra* section III.A.

144. *See supra* note 15.

145. 435 U.S. 679 (1978).

the advantages of achieving cost savings by pitting one competitor against another."¹⁴⁶ The choice, therefore, should remain with consumers. When the profession restricts the consumer's options by imposing norms for the behavior of its members, it "imposes the Society's views of the costs and benefits of competition on the entire marketplace."¹⁴⁷ Similarly, the Court in *FTC v. Indiana Federation of Dentists*¹⁴⁸ said that "[a] refusal to compete with respect to the package of services offered to customers, no less than a refusal to compete with respect to the price term of an agreement, impairs the ability of the market to advance social welfare."¹⁴⁹ The Court again emphasized its concern that consumers have free choice: "The Federation is not entitled to pre-empt the working of the market by deciding for itself that its customers do not need that which they demand."¹⁵⁰

These statements suggest that *Allied Tube's* emphasis on procedural protections was due more to the actions of the defendant to "subvert the consensus standard making process"¹⁵¹ than to any unwillingness of the Court to impose substantive requirements.¹⁵² Procompetitive standards

146. *Id.* at 694.

147. *Id.* at 695.

148. 476 U.S. 447 (1986).

149. *Id.* at 459.

150. *Id.* at 462. The Court was actually somewhat equivocal on this question in *Indiana Federation of Dentists*. When the federation attempted to use patient care as its justification for declining to provide x-rays to insurers, the Court rejected the justification because it was unsupported by any evidence that consumers had in fact been harmed. It did not rule out a patient-care defense entirely, though, resting its decision on the facts of the case "even if concern for the quality of patient care could under some circumstances serve as a justification for a restraint of the sort imposed." *Id.* at 464. But the Court has since categorically rejected a quality-of-care argument in another case involving the medical profession (though not a professional society). In *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984), the plaintiff anesthesiologist claimed that a hospital's contract with a single anesthesiology group was an illegal tie-in. The Court rejected the claim, but said in a footnote that if there had been evidence of an illegal tying arrangement, the reasons for its creation would have been irrelevant. The Court "reject[ed] the view of the District Court that the legality of an arrangement of this kind turns on whether it was adopted for the purpose of improving patient care." *Id.* at 25 n.41.

151. *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 498 (1988).

152. As described in note 218 *infra*, the staff of the Federal Trade Commission in 1978 proposed substantive rules to prevent deception of consumers by standards, but Congress withdrew the F.T.C.'s rule-making authority in this area. Following Congress's action, the F.T.C. staff issued a final rule proposal that mandated only procedural processes for complaint handling by standards organizations. See BUREAU OF CONSUMER PROTECTION, FEDERAL TRADE COMMISSION, STANDARDS AND CERTIFICATION: FINAL STAFF REPORT 339-44 (1983). In the end, even that rule was not issued, because the Commission decided to use case-by-case enforcement in situations of anticompetitive standard-setting. See 50 Fed. Reg. 44,971 (1985). The Commission noted that it made that decision in part because the

should therefore be required to meet a substantive test like the one expressed in that case, where the Court said that standards should be based on "objective expert judgments."¹⁵³ Only then will the standards promote, rather than hinder, the workings of the market. This test, however, immediately raises the question of a conflict between the antitrust laws and the First Amendment. Are professional societies not free, as Judge Easterbrook says,¹⁵⁴ to speak out regarding their services regardless of whether their statements are false or misleading? The answer, as the following section shows, is no.

D. *The Antitrust Laws and Speech*

The Sherman Act is, of course, subject to the limitations of the Constitution. Part of that limitation is the First Amendment's protection of freedom of speech, which must be considered in enforcing the antitrust law. But a group cannot merely point to the First Amendment to immunize speech that restrains trade:

[I]t has never been deemed an abridgment of freedom speech or press to make a course of conduct illegal merely because the conduct was in part initiated, evidenced, or carried out by means of language, either spoken, written, or printed. . . . Such an expansive interpretation of the constitutional guaranties of speech and press would make it practically impossible ever to enforce laws against agreements in restraint of trade as well as many other agreements and conspiracies deemed injurious to society.¹⁵⁵

The interrelationship of the antitrust laws and the First Amendment has been explored almost exclusively in the context of "political" speech. The two areas of law have been reconciled in the development of the *Noerr-Pennington* doctrine,¹⁵⁶ which provides immunity from the antitrust laws for speech addressed to the government. Such speech, and other activities seeking government action, are protected even if the activities

anticompetitive dangers presented by standards had decreased as a result of changes in standards organizations' procedures following a Supreme Court decision that imposed liability on a standard-setting society for the anticompetitive activities of its members. *Id.* The decision to which the Commission referred was presumably *American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982), which is discussed in note 190 *infra*.

153. *Allied Tube*, 486 U.S. at 501.

154. *See supra* text accompanying note 102.

155. *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 514 (1972) (quoting *Giboney v. Empire Storage Co.*, 336 U.S. 490, 502 (1949)).

156. The application of the *Noerr-Pennington* doctrine to society standards is discussed in more detail in section IV.C *infra*.

are motivated by an anticompetitive purpose. But even this First Amendment protection is limited, and the nature of the limitation sheds light on the permissible boundaries for standard-setting.

Noerr-Pennington immunity has been held by the Supreme Court not to extend to misrepresentations or fraud, at least in forums less political than the legislature, such as the courts and administrative agencies.¹⁵⁷ Significantly, the Court in *Allied Tube* focused on this exception in denying *Noerr-Pennington* immunity in that case.¹⁵⁸ The Court reaffirmed the exception to immunity for deceptive speech before courts and administrative agencies, and even suggested, contrary to previous cases, that it might extend to some legislative bodies.¹⁵⁹ The Court then made clear that deceptive speech is also unprotected in the private context. It observed that because private standard-setting involves collaboration among business competitors, "the standards of conduct in this context are, at least in some respects, more rigorous than the standards of conduct prevailing in the partisan political arena or in the adversarial process of adjudication."¹⁶⁰

Thus, *Allied Tube* shows little tolerance for deception in the standard-setting process. The Court's focus, however, was on proceedings before the standard-setting body, not on the standards as they were addressed to the public.¹⁶¹ Therefore, *Allied Tube* does not necessarily show that the Court's concern for substantive accuracy extends to speech directed outside the organization.¹⁶² As it happens, a demand for accuracy from

157. *California Motor Transport Co.*, 404 U.S. at 510-13.

158. The defendants there argued that, because their standards were enacted into law by many local governments, their standard-setting efforts were "quasi-legislative." The Court disagreed: "That rounding up supporters is an acceptable and constitutionally protected method of influencing elections does not mean that rounding up economically interested persons to set private standards must also be protected." *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 504 (1988).

159. *Id.* at 500 (citing *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 512-13 (1972)); *id.* at 504 (suggesting that "misrepresentations made under oath at a legislative committee hearing" would not be protected).

160. *Id.* at 507.

161. See *supra* text accompanying notes 138-41.

162. At least one case suggests that the Court's standards for speech to the public would be at least as strict as those for speech within the organization. In *Noerr* itself, where a group of railroads were seeking legislative action to disadvantage the trucking industry, the railroads also engaged in a campaign to persuade the public to support its legislative efforts. *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 142-44 (1961). The Court specifically noted though, that to the extent the truckers suffered injury as a result of the publicity campaign, the injury was only incidental to the railroads' efforts seeking legislative action. *Id.* at 143. It said that "[t]here [were] no specific findings that the railroads attempted directly to persuade anyone not to deal with the truckers." *Id.* at 142. Therefore, in a case like *Schachar*, where the societies

groups of professionals is supported by another line of Supreme Court cases that requires such accuracy from individual professionals.

Individual professionals often make advertising claims for their services not unlike the claims of professional societies. In the cases described below, such advertising claims were challenged by professional societies as violations of their codes of ethics. Because many of these professional organizations, such as bar associations, are state agencies, their restrictions on members' speech are subject to the First Amendment. That is, professional societies' rules regarding members' speech are subject to much the same limitations as is antitrust regulation of the societies' speech. Therefore, the Court's treatment of these cases should provide insight into its views on collective professional speech as well.

In applying the First Amendment to professional advertising, the Court has moved from an initially broad protection of speech to an emphasis on accuracy that recognizes the element of trade regulation in these cases.¹⁶³ The evolution began in *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*,¹⁶⁴ where the Supreme Court held that the First Amendment protected the advertisement of drug prices by pharmacists. In this case, there was no question of the advertisements' accuracy, so the Court saw no reason to restrict them. It said, for example, that the state-imposed restrictions rested on the assumption that there were benefits from keeping the public in ignorance.¹⁶⁵ However, the Court recognized that commercial speech must be judged by its commercial impact. It said that "proper allocation of resources in a free enterprise system" depends on the flow of information about the operation of that system.¹⁶⁶ Accordingly, the Court said that if the state had chosen only to restrict "false or misleading" speech, the First Amendment would not have been an obstacle.¹⁶⁷ The majority did not

specifically sought to influence the public not to receive radial keratometries outside their own studies the Court would likely interpret the societies' First Amendment protections narrowly.

163. Consider, for example, *Ohralik v. Ohio State Bar Ass'n*, 436 U.S. 447 (1978), where the Court rejected an attorney's argument that his in-person solicitation of potential clients was protected by the First Amendment. The conduct is barely acknowledged to have a speech component at all—the Court says that it is "only marginally affected with First Amendment concerns" and compares it to direct selling techniques regulated by the Federal Trade Commission. *Id.* at 459, 464-65. See also C. Lee Peeler & Michelle K. Rusk, *Commercial Speech and the FTC's Consumer Protection Program*, 59 ANTITRUST L. J. 985 (1991) (describing compatibility between the Supreme Court's protection of commercial speech and the FTC's prohibition of deceptive advertising).

164. 425 U.S. 748 (1976).

165. *Id.* at 769-70.

166. *Id.* at 765.

167. *Id.* at 771-72. The Court said that, given both the verifiability provided by

elaborate on this conclusion, but Justice Stewart, concurring, drew an analogy to the speech of employers in labor relations, which must "be carefully phrased on the basis of objective fact" and must avoid conscious overstatement.¹⁶⁸ He emphasized that when the speaker has "specific and unique knowledge of the relevant facts," she has a special obligation to avoid false or misleading speech.¹⁶⁹

This concern regarding specialized knowledge came to the fore in *Bates v. State Bar of Arizona*,¹⁷⁰ which followed *Virginia Board of Pharmacy* in upholding advertising of routine legal services.¹⁷¹ In doing so, *Bates* made some observations that are particularly relevant to professional standard-setting. Most importantly, it expressed concerns regarding claims of quality, and made clear that it would examine them closely.¹⁷² It said, for example, that "because the public lacks sophistication concerning legal services, misstatements that might be overlooked or deemed unimportant in other advertising may be found quite inappropriate in legal advertising."¹⁷³ Two dissenting opinions would have gone further and rejected *any* First Amendment protection for the advertising, on the grounds that legal services are too individualized to be susceptible to non-misleading advertisement of prices.¹⁷⁴

The implications of these statements in *Bates* are as yet unclear, because the Court has not yet addressed a case in which claims of quality have been made.¹⁷⁵ The closest it has come are two additional cases involving lawyer advertising, *In re R.M.J.*¹⁷⁶ and *Peel v. Attorney*

the familiarity of the speaker with his product and the strong commercial motivation for it, it may be "less necessary to tolerate inaccurate statements for fear of silencing the speaker." *Id.* at 772 n.24.

168. *Id.* at 778-79 (Stewart, J., concurring) (quoting *NLRB v. Gissel Packing Co., Inc.*, 395 U.S. 575, 618 (1969)).

169. *Id.* at 779 (Stewart, J., concurring).

170. 433 U.S. 350 (1977).

171. The Court said that the conclusion in *Bates* "might be said to flow *a fortiori*" from that in *Virginia Board of Pharmacy*. *Id.* at 365.

172. *Id.* at 366 ("[W]e need not address the peculiar problems associated with advertising claims relating to the *quality* of legal services. Such claims probably are not susceptible of precise measurement or verification and, under some circumstances, might well be deceptive or misleading to the public, or even false.").

173. *Id.* at 383 (footnote omitted); see also *Virginia Board of Pharmacy*, 425 U.S. at 773 n.25.

174. 433 U.S. at 386-87 (Burger, C.J., dissenting), 389-96 (Powell, J., dissenting).

175. That is, the Court has not considered a case in which quality claims were the center of the dispute. It has, of course, considered cases in which quality was used as a justification for other society actions. See, e.g., *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 464 (1986); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 25 n.41 (1984); *National Soc'y of Professional Eng'rs*, 435 U.S. 679, 694 (1978).

176. 455 U.S. 191 (1982).

Registration and Disciplinary Commission of Illinois.¹⁷⁷ In *In re R.M.J.*, a lawyer had advertised that he was "Admitted to Practice Before THE UNITED STATES SUPREME COURT."¹⁷⁸ The Court said that the statement "could be misleading to the general public unfamiliar with the requirements of admission to the Bar of this Court."¹⁷⁹ However, in the absence of findings in the record regarding whether the information was misleading, the Court allowed the advertising.¹⁸⁰

In *Peel*, the Court had the opportunity to consider a similar issue on a more fully developed record. The petitioner had stated on his letterhead, truthfully, that he was a civil trial specialist certified by the National Board of Trial Advocacy ("NBTA"), a private group. The Illinois attorney disciplinary commission found the advertisement to be a violation of the state's code of professional responsibility, which prohibited an attorney from advertising himself as "certified" or as a "specialist." The Illinois Supreme Court adopted the commission's conclusion. The plurality opinion from the United States Supreme Court rejected the state court's decision, focusing on the allegedly misleading nature of the advertisement. The Court concluded that it was not actually misleading because there was no showing that the advertisement produced the impression among the public that the certification was by the state, or that the public was unable to distinguish "between statements of opinion or quality and statements of objective facts that may support an inference of quality."¹⁸¹ It acknowledged that the advertisement might be potentially misleading, but said that, even assuming that some might be misled, the blanket ban on such advertising was broader than reasonably necessary to prevent that danger.¹⁸² In drawing these conclusions, however, the Court observed that the NBTA's "standards . . . are objective and demanding."¹⁸³ Furthermore, a narrower constraint might have been permissible. For example, the state could have required that certification be based on "objective and consistently applied standards" or that the advertisement include a disclaimer.¹⁸⁴

The plurality's emphasis on the need for objectivity in the advertised standards highlights the evolution in commercial speech doctrine. The concern regarding misleading speech has become a dominant issue in the cases since its passing mention in *Virginia Board of Pharmacy*. In

177. 496 U.S. 91 (1990).

178. 455 U.S. at 197.

179. *Id.* at 205.

180. *Id.* at 205-08.

181. *Peel*, 496 U.S. at 101.

182. *Id.* at 106-10.

183. *Id.* at 95.

184. *Id.* at 109-10.

that case, the concern was overridden by the Court's belief that the market depends on the flow of information about products. In *Peel*, the focus has shifted to a concern with market failure due to deceptive or misleading information. This brings the commercial speech test very close to the antitrust test for association standards, which, as described above,¹⁸⁵ requires that standards be derived "based on the merits of objective expert judgments."¹⁸⁶ Thus, *Peel* gives no reason to believe that a requirement of accuracy runs afoul of the First Amendment. This is all the more true because *Peel* did not involve a true claim of quality. In contrast, the medical standards at issue in, for example, *Schachar*, purport to assess the quality or safety of a particular medical service. The opportunity for deception with such a claim is, as the Court has stated, much greater. Hence the Court would probably allow *more* regulation of quality claims.

It is true that regulation of professional advertisements that may be misleading—the commercial speech problem—is significantly different from imposing antitrust liability, including possible treble damages, for misleading standards.¹⁸⁷ However, professional disciplinary proceedings can also impose severe penalties, and the problem of evaluating the statements in the two cases is similar. Professor Havighurst argues that professional speech should not be subject to antitrust limitation because it is difficult for courts to evaluate its accuracy.¹⁸⁸ But there are several

185. See *supra* section II.C.

186. *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 501 (1988) (citation omitted).

187. On the other hand, deceptive standard-setting may present greater dangers than deceptive advertising. This is true because, as described in the text accompanying notes 41-43 *supra*, professional standards, unlike most industrial standards, are generally set by groups with economic interests in the standards. If consumers are unaware of this fact, and interpret professionals standards as if they were set by disinterested groups, they may give the standards more credence than they would advertising. On the same problem in the related area of medical credentials, see Havighurst & King, *supra* note 4 (pt. 1), at 153 ("Consumers can readily perceive advertising's self-serving character and may consequently greet it with a healthy skepticism. They may be significantly less skeptical toward personnel credentialing as a result of its apparently objective and authoritative character, the professional auspices under which credentials are granted, and the typical absence of competing claims.")

188. His argument emphasizes both theoretical and practical considerations: Antitrust courts are poorly equipped to evaluate the quality and honesty of opinions and information generated by professional organizations. By hypothesis, the issues are highly technical and controversial. Litigation closely examining the merits of these issues, the circumstances and effects of various pronouncements, the motives of the parties, the honesty of the opinions expressed, and the accuracy and completeness of the facts reported would always be protracted and costly. Yet it would usually be inconclusive on the central questions.

Havighurst, *supra* note 18, at 362.

reasons for rejecting this argument. First, it is not clear that making these judgments is significantly more difficult than other antitrust decisions.¹⁸⁹ Moreover, the antitrust laws operate by deterrence as well as judicial enforcement, so they may have benefits beyond the courtroom that outweigh the occasional difficulties encountered in litigation. More importantly, the accuracy of the speech need not be determined in some absolute sense. It is, after all, only the speech's effects on the market that are important, so it is only those effects that must be evaluated. This can be done by investigating the effects the speech has on the choices of the decision-makers at whom it is directed. The standard would be a potential violation only if the speech leads consumers to make different choices based on a standard's subjective evaluations than they would have made with the available objective facts.

III. PROPOSALS

As part II described, a deceptive or misleading medical standard is anticompetitive to the extent that it makes patients forgo services that they would have purchased with accurate information (or at least in the absence of the misleading information). The market does not gain from purchasing decisions made incorrectly. I propose, therefore, that professional societies be liable for economic injury suffered by their enactment of misleading standards. Although this may seem like a radical proposal, it actually would result in liability in only a limited range of cases. To establish a violation, a consumer or physician would be required to satisfy the usual antitrust burdens of proof by showing that the society possessed market power, that its standard was on balance anticompetitive (*i.e.*, misleading), and that he actually suffered injury as a result of the society's standard. Not many society standards are so firmly expressed and so publicly known that they will affect the demand for a particular service, and presumably few of those are deceptive. Those that are, however, are exactly the standards that are appropriate subjects of concern.

189. For example, a typical rule of reason case under section 1 requires the assessment of market power and the weighing of procompetitive and anticompetitive effects, both tasks which are difficult and often inconclusive. That does not lead, however, to Professor Havighurst's conclusion that the conduct challenged in such cases should be *per se* legal. *See id.* at 362-63 n.82.

The dissent in *Allied Tube* made an analogous argument, objecting to the majority's failure to define "workable boundaries" to the *Noerr* doctrine's distinction between political and commercial speech. 486 U.S. at 513 (White, J., dissenting). The Court acknowledged the dissent's criticism of "the uncertainty of such a particularized inquiry," but said that blanket immunity was inappropriate and evaluation must rest on "the context and nature of the activity." *Id.* at 507-08 n.10, 509.

Standards can also influence the choices of consumers through their effects on insurers. As Part I described, an insurer's unwillingness to reimburse for a procedure is likely to discourage patients from seeking it. Although such reimbursement decisions are generally the insurer's to make as it chooses, they too can be improperly influenced by medical societies. Therefore, I also propose that the societies be liable for anticompetitive harm that is effected in form through insurers but in fact by the societies.

Both of these topics—the skewing by medical societies of decisions by patients and third-party payers—are discussed below. A third section discusses a topic mentioned briefly earlier. If a medical society is sufficiently concerned about encouraging or discouraging a particular practice, it can seek to have its position on that practice enacted into law. Its efforts to do so will generally receive antitrust immunity under the *Noerr-Pennington* doctrine. This then provides a legitimate, political avenue for societies to impose the restrictions on patient choice that I propose they should be forbidden to impose privately.

A. *Speech Directed at Patients*

Under the antitrust rule of reason, a violation of Section 1 of the Sherman Act occurs when a group with market power agrees on conduct that is, on balance, anticompetitive. Because the actions of a medical society are by their nature the subjects of agreement,¹⁹⁰ proof that a

190. See *supra* note 7. Of course, an action taken by a society is actually effected only by a subset of its members. The society is still liable for its actions, however. This issue was considered by the Supreme Court in *American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982) (*ASME*), where it decided that normal agency principles should apply.

In *ASME*, the anticompetitive activity was initiated by an executive of one of the plaintiff Hydrolevel's competitors, McDonnell & Miller, Inc. (M&M). The executive was vice-chairman of the ASME subcommittee responsible for standards governing two of the companies' competing products. He and the chairman of the subcommittee drafted an inquiry to the full committee questioning the safety of Hydrolevel's product. The inquiry was sent to the ASME over the signature of M&M's president. Following standard procedures, the ASME referred it back to the subcommittee, where the chairman "predictably" returned an unfavorable response. The chairman made the response "unofficial" to avoid having to take it before the entire subcommittee, but it was signed by an employee of the ASME and issued on ASME stationery. *Id.* at 560-64.

That the activity was anticompetitive was not at issue. The question on appeal was the extent of the society's liability for its members' actions. The Court's strict approach to trade associations is indicated by its willingness to find the society liable regardless of whether it was an intended beneficiary of the anticompetitive practices: "The anticompetitive practices of ASME's agents are repugnant to the antitrust laws even if the agents act without any intent to aid ASME, and ASME should be encouraged to eliminate the

medical standard violates the antitrust laws requires proof (1) that the society enacting and promoting it possesses market power, (2) that the standard's effects are anticompetitive, and (3) that the plaintiff suffered injury. These tests are neither particularly difficult to apply to society speech nor as likely as societies claim to chill desirable information-generating activity.

1. *Market Power*.—As described above,¹⁹¹ the market in which professional societies operate is not the same one in which their members sell their services. Medical societies, with regard to standards, operate in the market for medical information. Therefore, one could evaluate societies' market power by directly evaluating the effects of their actions in that information market. For example, one could estimate market power from market share by evaluating whether a society that issued a statement regarding a particular service provided a large fraction of the information available regarding the subject of that standard. The problem with this approach, though, is that a society could provide *all* of the information regarding a service, and it could even be believed,¹⁹² but it still might not affect the demand for the service. For example, the price of a service could be so low, and its dangers, even as presented by a society discouraging it, so minimal, that consumers would choose to purchase it anyway. The information market, though it has the potential to affect the medical services market, does not necessarily do so.

Therefore, a society's market power should be examined in the market where the effects of its statements are ultimately felt, the market for medical services.¹⁹³ In this market, there must be proof a society standard affected demand for a service. This approach, the proof of market power by market effects, was the one adopted by the Supreme Court in the

anticompetitive practices of all its agents acting with apparent authority" *Id.* at 574. The parallel to professional societies is clear: regardless of whether the society itself benefits, or the benefits accrue only to some of its members, the society can be held liable for its anticompetitive acts.

191. *See supra* section II.B.

192. That a society provides a large proportion of the information regarding a service does not, by itself, establish that it has market power, only that it has market share. But if the society's statements are accepted, so that it actually influences opinions regarding the service, it has market power (in the market for information regarding that service). It must be remembered, though, that it is not anticompetitive effect in the information market that is of concern. A distortion of consumers' views regarding medical services is only significant (in the view of antitrust law) if it affects purchasing decisions for those services. Therefore, it is only if power in the information market is "leveraged" into the service market that there is anticompetitive harm. *See supra* note 121 and accompanying text.

193. Of course, a society presumably only issues and publicizes a standard because it believes that it has the power to affect demand for its services. *See supra* sections I.B & II.B.

only professional society case in which it examined market power,¹⁹⁴ *FTC v. Indiana Federation of Dentists*.¹⁹⁵ That case challenged the federation's rule prohibiting members from providing patients' x-rays to insurers for evaluation of the services that the members provided. The federation claimed that it lacked market power to enforce its rule. However, the Court noted the FTC's finding that the federation's restrictions were adhered to by its members, and it said those effects were "legally sufficient to support a finding that the challenged restraint was unreasonable."¹⁹⁶ Since a finding of market power is generally a question of fact, the Court did not decide the question, but the discussion indicated that the Court believed the federation had such power.¹⁹⁷

In a professional standard case the effects at issue are the reduction (or increase) in demand for a particular service as a result of the standard. Therefore, the plaintiff has the burden of showing that the standard had sufficient market power to influence potential consumers' decisions regarding the services. There are at least two ways of making this showing. Following *Indiana Federation of Dentists*, the plaintiff could show that the issuance of the standard was followed by a reduction in demand for the service. The plaintiffs in *Schachar* alleged such a reduction, and the Seventh Circuit apparently acknowledged that it occurred, stating that "[s]peech informed, hence affected, demand for radial keratotomy."¹⁹⁸ Under those circumstances, market power would be established, though it would remain to be shown that the power had an anticompetitive effect.

Another means of showing market power would be to offer the testimony of specific patients who were themselves influenced not to purchase the services in question. This was the approach taken, though not explicitly, by the plaintiff in *Koefoot*, who provided an affidavit stating that potential patients had declined to use him as a surgeon because of the allegations of unethical surgery.¹⁹⁹ Proving market power

194. The issue of market power has not appeared in most professional society cases heard by the Supreme Court because those cases have generally involved price restrictions. In price cases, the Court has focused on the agreement among the members, and has generally found a *per se* violation without making a specific finding of market power. See, e.g., *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 348 (1982).

195. 476 U.S. 447 (1986).

196. *Id.* at 461.

197. *Id.* at 460 ("The Commission found that . . . Federation dentists constituted heavy majorities of the practicing dentists and that as a result of the efforts of the Federation, insurers in those areas were, over a period of years, actually unable to obtain compliance with their requests for submission of x rays").

198. *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397, 399-400 (7th Cir. 1989).

199. See *supra* text accompanying notes 54-55. Dr. Koefoot's affidavit reported the

in this manner is analogous to the approach in tying cases, where actual influence over purchasing decisions can show market power.²⁰⁰ Although the testimony of a "handful" of patients is not sufficient,²⁰¹ the plaintiff need not show that every buyer was affected. In *Fortner Enterprises, Inc. v. United States Steel Corp.*,²⁰² the Supreme Court said that in the tying context "sufficient economic power" is present "whenever the seller can exert some power over some of the buyers in the market, even if his power is not complete over them and over all other buyers in the market."²⁰³ It must be remembered, though, that the power over buyers must actually come from the seller. If particular buyers, for their own reasons, find the seller's product uniquely attractive, and therefore feel compelled to purchase it, that does not show market power. For that reason, liability in *Fortner* was rejected by the Court. Despite testimony from buyers that they were coerced, there was nothing that indicated that the defendant had any special advantage that allowed it to force customers to accept its products.²⁰⁴ The Court contrasted the deficiency in proof in *Fortner* with the situation in *Northern Pacific*

statements made to him by patients, so the statements were hearsay. However, such statements are admissible under the state-of-mind exception to the hearsay rule. Fed. R. Evid. 803(3); see *Hydrolevel Corp. v. American Soc'y of Mechanical Eng'rs, Inc.*, 635 F.2d 118, 128 ("Statements of a customer as to his reasons for not dealing with a supplier are admissible for this limited purpose . . .") (quoting *Herman Schwabe, Inc. v. United Shoe Machinery Corp.*, 297 F.2d 906, 914 (2d Cir. 1962), cert. denied, 369 U.S. 865 (1962) (citations and footnote omitted)), aff'd, 456 U.S. 556, cert. denied, 456 U.S. 989 (1982); see also JACK B. WEINSTEIN & MARGARET A. BERGER, WEINSTEIN'S EVIDENCE ¶ 803(3)[03] (1992) ("The declarant's state of mind may be an issue in a wide variety of contexts. Statements may be admitted, for example, to show . . . a customer's reason for refusing to deal with a supplier . . ." (footnote omitted)). In any event, Dr. Koefoot's affidavit was submitted only in opposing summary judgment; he could presumably have offered the patients' testimony directly at trial.

200. See, e.g., *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 112 S. Ct. 2072, 2080 (1992) ("Market power is the power 'to force a purchaser to do something that he would not do in a competitive market.'") (quoting *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 14 (1984)); see also HERBERT HOVENKAMP, ECONOMICS AND FEDERAL ANTITRUST LAW § 8.10 (1985) ("[M]arket power is a necessary condition for inefficient coercion . . .").

201. See, e.g., *Grappone, Inc. v. Subaru of New England, Inc.*, 858 F.2d 792, 794-97 (1st Cir. 1988).

202. 394 U.S. 495 (1965).

203. *Id.* at 502-03.

204. The defendant agreed to provide credit to the plaintiff for the purchase and development of land, but only if the plaintiff would agree to purchase prefabricated homes from the defendant. Although the credit terms offered by the defendant were apparently not available elsewhere, the Court said that in the absence of evidence that the defendant had any cost advantage in providing the credit, mere "uniqueness" of the credit arrangements would not provide economic power over buyers. See *United States Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610, 617-22 (1977).

Railway Co. v. United States,²⁰⁵ where it said not only that “[t]he very existence of [the] host of tying arrangements [was] itself compelling evidence of the defendant’s great power,” but that the defendant “possessed substantial economic power by virtue of its extensive landholdings.”²⁰⁶ The point of this distinction is that it is not sufficient to show the simple fact of conformity to the seller’s wishes; there must also be some reason to think that the conformity was caused by the power of the defendant. In this respect, the case of professional societies is more akin to *Northern Pacific* than to *Fortner*, because the societies’ large numbers of members and general prestige lend them the ability to influence patients.²⁰⁷

2. *Anticompetitive Effect*.—Proof of market power demonstrates that the defendant has the potential to impose anticompetitive effects, but a violation occurs only when that potential is realized. As described above,²⁰⁸ a society standard is anticompetitive when it is misleading or deceptive. Because it is market effects that are important, the test for deception is not a metaphysical search for truth, but only a test of effect on consumers’ decision-making. The Supreme Court, in its commercial speech decisions, has indicated that empirical evidence of deception can be used to make this determination.²⁰⁹ Such evidence could, for example, be produced by a consumer survey of the kind used in trademark cases. The two kinds of cases are in this respect quite similar, since both involve the alteration of consumer choices by deceptive market

205. 356 U.S. 1 (1958).

206. *Id.* at 7-8. The United States government had granted to the defendant approximately forty million acres of land along the defendant’s railroad tracks. Some of the land contained valuable timber or mineral rights. Over the years the defendant sold or leased many of the holdings. Some of the sales and lease agreements required use of the defendant’s services to ship products produced on the land, as long as its rates were no worse than those of competitors. *Id.* at 3. No doubt it was not just the extent of the defendant’s holdings that concerned the Court, but also the fact that its means of acquisition could not be duplicated by competitors.

207. The district court in *Schachar* addressed specifically this point:

However, in a case such as this where the statements are made by a large and highly respected professional organization, factors other than the mere persuasive power of its arguments render its statements influential. The views of such an organization specializing in a field about which the general public is generally uninformed, especially where the views are publically disseminated to potential patients and third party payers, acquire significantly more weight and thus have a more coercive effect than would the views of individuals.

Schachar v. American Academy of Ophthalmology, Inc., 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,052 (N.D. Ill.).

208. See *supra* section II.C.

209. See *Peel v. Attorney Registration and Disciplinary Comm’n of Illinois*, 496 U.S. 91, 108 (1990) (plurality opinion).

information.²¹⁰ Surveys to determine whether consumers have in fact been deceived have long been admissible in this context,²¹¹ and similar surveys could be conducted to determine whether statements by medical societies mislead consumers or potential consumers of medical services. For example, a society pronouncement regarding the safety of a procedure could be tested to determine whether it conveyed accurate information about the procedure's dangers. If the pronouncement under- or overstated the dangers, either in frequency or in character, it would be anticompetitive.²¹² Or, more to the point, a survey could be conducted to determine whether a society statement has the same effect on a consumer's likelihood of purchasing a service as does the objective information available at the same time.²¹³

One possible concern is that the evaluation of professional services, unlike that of trademarks, can change over time. A procedure once thought unsafe may later appear to be safe, and *vice versa*. It might therefore seem that to subject a society to liability for standards later found to be misleading is overly restrictive. However, the Court has noted that in the commercial arena, unlike the political one, the danger of overbroad restrictions is not a significant concern.²¹⁴ It is therefore

210. See Havighurst & King, *supra* note 4 (pt. 1), at 136-37 (comparing medical credentials to trademarks).

211. See, e.g., Zippo Mfg. Co. v. Rogers Imports, Inc., 216 F. Supp. 670, 680-86 (S.D.N.Y. 1963); see also Handbook of Recommended Procedures for the Trial of Protracted Cases, 25 F.R.D. 351, 426-29 (1960).

212. For example, in *Koefoot*, the defendant, the American College of Surgeons (ACS), promulgated its view that the practice of "itinerant surgery" was "unethical," and said that it should be avoided in order to provide the highest quality of patient care. See *supra* section I.A. Potential patients hearing the ACS's statements presumably formed opinions regarding the safety of the practice. Although it might be difficult to quantify those opinions, the patients could be surveyed to determine whether they understood itinerant surgery to be unsafe, either in general or as practiced by Dr. Koefoot. If so, and if the ACS could point to no objective facts to back up its statements, those statements would have had anticompetitive effect. (Recall that even if the statements were anticompetitive, there would be no antitrust violation unless the ACS had sufficient market power to affect Dr. Koefoot's business. See *supra* text accompanying notes 191-207.).

213. This test focuses more directly on the anticompetitive harm that a deceptive standard may cause. It also allows the test to include deception due to factors other than the substantive evaluation in the standard. For example, in *Clamp-All Corp. v. Cast Iron Soil Pipe Inst.*, 851 F.2d 478 (1st Cir. 1988), *cert. denied*, 488 U.S. 1007 (1989), discussed in note 135 *supra*, the plaintiff's allegation was that a trade association's standard might have misled consumers into thinking that the association was a "disinterested certifying organization." *Id.* at 487. Deception of this type is as capable of causing anticompetitive harm as is deception regarding particular services. The test in either case is whether the standard distorts consumer choice.

214. See *Bates v. State Bar of Arizona*, 433 U.S. 350, 380 (1977) ("[T]he justification for the application of overbreadth analysis applies weakly, if at all, in the ordinary commercial context.").

not too great a demand on societies that they ensure that they do not mislead consumers. This is especially so because a society can avoid the problem entirely by confining its pronouncements to objective facts. For example, instead of issuing a statement that a medical procedure is unsafe, it could simply report the results of a study without providing a conclusive interpretation of those results.²¹⁵ Interpretation of the results is then left to the individual patient and her physician.

3. *Damages*.—Finally, a plaintiff must prove she was damaged. This requires that she show a loss in demand for her services as a result of the society action. The proof is likely to be closely related to the plaintiff's proof of market power. Both require establishment of the same sort of connection between the defendant's actions and those of patients. Indeed, if the proof of market power were made through the testimony of coerced individuals, the evidence would also establish damages if the testifying individuals were potential patients of the plaintiff. However, if market power were proved by demonstration of an overall reduction in demand, the plaintiff would also be required to show that she would have been selected as the provider of the forgone services. This would require, for example, that the plaintiff show that she had the skills and facilities available to provide the service.

Meeting these burdens of proof to establish an antitrust violation for issuing a deceptive standard is sufficiently difficult to discourage frivolous claims. To appreciate this, consider that the tests provide two "safe harbors" through which professionals can avoid all liability. First, a single physician can say whatever she likes, as can a group of physicians without market power.²¹⁶ It is only market power that raises what would

215. To some extent, this is the practice currently used in many instances. Medical journals often publish an article reporting the quantitative results of a research study, with the implications of those results examined in an accompanying editorial. This approach was used, in fact, in reporting the results of the PERK study of radial keratotomy. See George O. Waring III *et al.*, *Results of the Prospective Evaluation of Radial Keratotomy (PERK) Study 4 Years After Surgery for Myopia*, 263 J. A.M.A. 1083 (1990); Perry S. Binder, *Radial Keratotomy in the 1990s and the PERK Study*, 263 J. A.M.A. 1127 (1990).

216. See *Wilk v. American Medical Ass'n*, 719 F.2d 207, 226-27 (7th Cir. 1983) ("Clearly, an individual medical doctor is free to act on this belief [that chiropractic is undesirable] by declining to associate with a particular chiropractor in the care of a particular patient. It seems reasonable that two or three medical doctors, sharing this view and working as a team in the care of a particular patient would be free to agree, and to act on the agreement, to decline to associate with a particular chiropractor in the care of that patient. The Sherman Act problem in the present case arises from the express embodiment of this viewpoint in a formal set of ethical principles promulgated by a large association of medical doctors, and by the alleged efforts of that association and kindred associations to give effect to the exclusionary attitude in the setting of hospitals staffed by medical doctors.").

There would no doubt be disputes regarding the status of particular statements. For

otherwise be a breach of professional ethics or false advertising to a subject of antitrust concern.²¹⁷ Second, even a society with market power can freely issue statements of objective fact. That means, for example, that it can publicize the results of research studies. It need only ensure that it does not put a "spin" on the facts that misleads patients.²¹⁸ It

example, is a statement by the president of a medical society, in which she refers to her position in the society, a statement by the individual or by the society? Is a statement by an individual that he has contacted most of the members of a medical society and that most of them agreed that a particular procedure is unsafe a statement of the society? These are fact-specific questions that cannot be answered here. Presumably they would be resolved by determining whether the statements were made with the apparent authority of the society. This test was established by the Supreme Court in *American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982). See *supra* note 187.

217. Cf. *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397, 400 (7th Cir. 1989) ("The Sherman Act is not a code of medical ethics or methodology . . .").

218. The staff of the Federal Trade Commission addressed precisely this problem in a rule-making proceeding in 1978. The proposed rule included the following requirement:

A standard shall contain the following:

- (a) a statement of its intended scope and use, including products and product attributes intended to be covered by the standard;
- (b) a disclosure of any products or product attributes not covered by the standard that users of the standard would reasonably presume were covered;
- (c) a disclosure of any serious risks or limitations associated with use of products that conform to the standard, when such risks or limitations would not be apparent to reasonable buyers; and
- (d) a statement as to how persons voted on the standard if a list of persons who participated in the development proceeding is printed with the standard.

BUREAU OF CONSUMER PROTECTION, FEDERAL TRADE COMMISSION, STANDARDS AND CERTIFICATION: PROPOSED RULE AND STAFF REPORT (1978). The staff stated that the purpose of these provisions was "to guard against deception and misreliance . . . which might occur in their absence and thereby to ensure informed use of standards." *Id.* (footnotes omitted).

The rule was never enacted. In 1980, Congress passed the Federal Trade Commission Improvements Act of 1980, one section of which removed the F.T.C.'s authority to establish rules regarding unfair or deceptive acts or practices in the development of standards. See Pub. L. No. 96-252, § 7, 94 Stat. 374, 376 (1980). Interestingly, the committee report for this statute expressed the view that an F.T.C. rule was unnecessary because a deceptive standard would constitute a violation of the Sherman Act: "Given that the rule is largely directed toward antitrust problems and the existence of adequate remedies under the antitrust laws, the Committee believes that there is insufficient justification for a rulemaking in this area." S. REP. No. 500, 96th Cong., 2d Sess. 19, reprinted in 1980 U.S.C.C.A.N. 1102, 1120. The specific antitrust doctrine to which Congress referred was the prohibition of group boycotts. *Id.* However, so long as a standards organization does not include consumers among its members, its standard-setting activities will not constitute a boycott. See *supra* note 131. Therefore, a challenge to a standard based on its deceptive or misleading effects must proceed on a different theory, such as the one described in this paper. It is important to note, however, that Congress, in precluding the F.T.C.'s rule-making, did not intend to discourage any such challenges

is that sort of subjective and deceptive assessment that this proposal seeks to prevent by requiring that a society with market power use it wisely.²¹⁹

B. *Speech Directed at Third-Party Payers*

The competitive effects of society standards on third-party payers are both similar to and different from their effects on individual patients. The fundamental concern is still influence over patient choices, but the mechanism by which those choices are influenced is entirely different. In this case, patients' choices are influenced not by the standard itself but by the insurer's response to it. If the insurer declines to reimburse for a procedure, the cost to the patient rises from zero (or a small insurance copayment) to the full price of the service. The likely result is that the patient will be discouraged from receiving the procedure. Of course, in general, an insurer is free to decide whether to reimburse for a given service, and can make its decision on whatever basis it chooses. A danger arises, though, when the insurer's power to make that reimbursement decision is controlled by a group of competing suppliers, such as a medical society. If a society provides the insurer with information that distorts its decisions, or if the insurer more directly defers to the society in its reimbursement decisions, the result can be anticompetitive.

1. *Market Power*.—A medical insurer's decisions affect competition in the market in which patients choose their medical services. The Supreme Court considered this issue in *Blue Shield of Virginia v. McCready*,²²⁰ where the plaintiff's insurer had adopted a policy of reimbursing for psychotherapy only if it was performed by a psychiatrist rather than a psychologist. The plaintiff challenged the policy, which she alleged was the result of a conspiracy between the insurer, Blue Shield, and psychiatrists. Blue Shield argued that, because its policy's most direct effect was on the terms of its contract with the plaintiff's employer, the relevant market was that in which employers chose group health plans, not the

to specific deceptive standards; it specifically stated that its action did "not preclude the Commission from engaging in case-by-case activities in this area." S. REP. NO. 500, 96th Cong., 2d Sess. 19, reprinted in 1980 U.S.C.C.A.N. 1102, 1120.

219. The suggestion of Professor Havighurst that a society's acquisition of respect and esteem—power in the information market—should not subject it to scrutiny is, needless to say, contrary to this view. See Havighurst, *supra* note 18, at 362 ("To subject a professional body to close judicial review solely on the basis of the influence it wields might be seen as penalizing its success in establishing its credibility and earning the confidence of independent decisionmakers.'). Antitrust law is premised on obligations imposed by the possession of market power.

220. 457 U.S. 465 (1982).

one in which patients chose psychotherapy services.²²¹ The Court disagreed, noting that the challenged act was the denial of reimbursement, which affected the individual, not her health plan.²²² The relevant market was therefore that in which the effects of the denial of reimbursement were felt, the market for medical services. As the Court observed, "the goal of the competitors was to halt encroachment by psychologists into a market that physicians and psychiatrists sought to preserve for themselves."²²³

Given, then, that insurers can affect the market for medical services, how is it that medical societies influence insurers? As described above,²²⁴ insurers often rely on evaluations by medical societies in making their reimbursement decisions. One possibility, therefore, would be that discussed in the last section: the society could issue standards or statements that mislead or deceive the insurer. However, the danger of deception does not exist for insurers nearly to the extent that it does for consumers. Insurers often have physicians on their staffs, or, if they do not, they can afford to have doctors serve in an advisory role. Furthermore, insurers, unlike patients, encounter the same procedure numerous times, so they have more reason to incur the information costs of evaluating the procedure themselves. Therefore, even if a society issues a standard that misleads consumers, it is unlikely to mislead insurers.

The situation is different, however, if the insurer does not take an active role in making its reimbursement decisions. It is possible for the insurer just to defer to the conclusions reached by a medical society. This was the situation alleged by the plaintiffs in *Schachar*, and the district court accepted the possibility:

Defendants' evidence that some third party payers made their decisions on whether radial keratotomy would be covered independent of defendants' statements merely highlights the presence of disputed facts. By this evidence defendants have shown that while some third party payers may not have relied upon defendants' statements, others may have relied in whole or in part upon defendants' statements.²²⁵

When an insurer relies "in whole" on a medical society's statement, the decisions it reaches are not its own, but the society's.²²⁶ One might

221. *Id.* at 479-81.

222. *Id.* at 480.

223. *Id.* at 478-79.

224. *See supra* text accompanying notes 83-85.

225. *Schachar v. American Academy of Ophthalmology, Inc.*, 1988-1 Trade Cases (CCH) ¶ 67,986, at 58,051-52 n.4 (N.D. Ill.).

226. A similar phenomenon was considered in a different context by the court in

therefore hold the society responsible for the anticompetitive effects of decisions made in that manner. That would be unfair, however. Although society members typically agree on statements issued by the society,²²⁷ they do not necessarily seek to have those statements acted upon by a third-party payer. The insurer may adopt the society's views for any of a variety of reasons of its own. It may, for example, seek any available excuse not to reimburse so as to minimize its costs, it may believe that it is appropriate to defer to the expertise of medical professionals, or it may just prefer the administrative convenience and reduced cost of relying on the work of others.

A medical society should be liable for the effects of the adoption of its statements by insurers only if it sought that adoption. That was the case in *Schachar*, where the medical societies sought to have their decisions put into effect by insurers.²²⁸ The societies there did not merely say that radial keratotomy was as yet unproven. Instead, they issued formal statements that the procedure was "experimental," choosing to apply the specific label on which insurers and hospitals based their decisions.²²⁹ They issued their statements with the explicit direction that they be announced to "third party insurers and payers."²³⁰ Finally, through the auspices of the Council of Medical Specialty Societies, they represented radial keratotomy to health insurers as a procedure that should not be routinely reimbursed.²³¹ All of these actions show an active attempt to persuade insurers to adopt the societies' decisions. To the extent that the attempt was successful, the societies exercised the insurers' power in the medical services market.

The question that remains is that of determining the degree of market power that medical societies can obtain by this means. *Blue Shield* did not specifically address the market power issue, because its focus was on the nature of the potential competitive injury caused by the insurer's

George R. Whitten, Jr., Inc. v. Paddock Pool Builders, Inc., 508 F.2d 547 (1st Cir. 1974), *cert. denied*, 421 U.S. 1004 (1975). The plaintiff there alleged that the defendant had restrained trade by influencing a state agency's specification regarding swimming-pool recirculation systems. The court disagreed, stating that "the specifications were the product of the judgment, not unduly influenced by [the defendant], of the pool consultant." *Id.* at 556. The court appeared to be sympathetic to the view that control over the decision-making process could have been a Section 1 violation, *see id.* at 555-61, but because "[the defendant] was not the operative cause of decision," there was no violation, *id.* at 559.

227. Even if not all of a society's members agree on a statement, the society is still liable for its effects. *See supra* note 190.

228. *See supra* section I.B.

229. *See supra* text accompanying notes 72-86.

230. *See supra* note 67.

231. *See supra* text accompanying notes 79-82.

reimbursement decisions. Nevertheless, the Court's reference in that case to the insurer's "concerted refusal to reimburse under a [health insurance] plan"²³² suggests that the Court viewed the market as one consisting specifically of Blue Shield subscribers, the only group for which Blue Shield had the power to make reimbursement decisions. Normally the relevant market for antitrust purposes is not as narrow as the customers of a single provider. However, the Court has recently accepted the possibility of such a market in cases in which customers are "locked-in" to one provider.²³³ The situation of insureds who are contractually bound to their insurer is a quintessential example of lock-in, as the Court observed in *Blue Shield*.²³⁴ Given a market defined in this way, *i.e.*, as the subscribers of a single insurer, a medical society that could influence the insurer's decisions would unquestionably have market power, because it would control the reimbursement policy for virtually all that insurer's subscribers.

Even in a broader market, though, a medical society could still acquire significant market power. Consider, for example, the broadest plausible market, which would be the entire market for the medical service at issue. A medical society would control that share of that market defined by the percentage of customers covered by insurers whose decisions it influences. Since in many areas there are large insurers (*e.g.*, Blue Shield or popular HMOs) with appreciable market shares, to attain a large market share a medical society would need to persuade only a few of those insurers. Market share in these circumstances would provide market power, due to the entry barriers created by the established relationships between current medical societies and insurers.²³⁵ Therefore, a society could acquire a large degree of market power through its influence over insurers.

2. *Anticompetitive Effect.*—To illustrate the inherent anticompetitive potential that exists when medical societies have the power to make reimbursement decisions, consider a scenario based on the facts of *Blue Shield*. Assume that an insurer has decided that it will defer to the judgment of the American Psychiatric Association (Association), as a

232. *Blue Shield*, 457 U.S. at 480.

233. See *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 112 S. Ct. 2072, 2087 (1992).

234. See *Blue Shield*, 457 U.S. at 480 n.17 ("Although her employer's decision to purchase the Blue Shield plan for her benefit was in some sense a factor that contributed independently to [plaintiff's] injury, her coverage under the Blue Shield plan may, at this stage of the litigation, properly be accepted as a given . . .").

235. Recall the relationship discussed above between the Council of Medical Specialty Societies and the Health Insurance Association of America. See *supra* text accompanying notes 77-82.

prominent and respected medical society, in deciding whether to reimburse for psychotherapy services. Assume further that its intention to do so is known to the Association. The Association then decides, in good faith or otherwise, that psychotherapy services are only properly performed by psychiatrists, not psychologists, and the insurer, accordingly, declines to reimburse for psychotherapy provided by psychologists. Under these circumstances, it is the Association that has exercised the decision-making power of the insurer. Moreover, it has exercised that power in the market for psychotherapy services, a market in which its members directly compete.²³⁶

The anticompetitive effects in these circumstances are very great. If an insurer will not pay for a service, the patient must, and the price of services to the patient therefore rises from zero (or near zero) to the full price of the service.²³⁷ Thus, from the point of view of the patient, who makes the purchasing decisions in the market at issue, a denial of reimbursement is in effect a fixing of price.²³⁸ Again, this is not a problem as long as the insurer makes the decision (*i.e.*, sets the price) itself, for it individually is free to make any pricing arrangements it chooses. If, however, it is the medical society that is actually making the reimbursement decision, it engages in a horizontal price-fixing agree-

236. A medical society might argue in this situation that, because its services (in providing information) are used only by the insurer, not its insureds, it is the insurance company market that is relevant. This is analogous to the defendant's unsuccessful argument in *Blue Shield* that the relevant market in that case was for group health plans, and it fails for the same reason: the intended and actual effect of the society's action is the denial of reimbursement to the individual insured patients. See *supra* text accompanying notes 220-23.

237. See *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 483 (1982) ("Those [Blue Shield] subscribers were compelled to choose between visiting a psychologist and forfeiting reimbursement, or receiving reimbursement by forgoing treatment by the practitioner of their choice. . . . [Plaintiff] did not yield to Blue Shield's coercive pressure, and bore Blue Shield's sanction in the form of an increase in the net cost of her psychologist's services.").

238. The most plausible alternative way to look at the arrangement is as a refusal by insurers to deal with practitioners offering the non-reimbursed service. However, this analysis is not as accurate, because there is no unwillingness to deal with those practitioners; there is just a refusal to pay for a particular service. In any event, a refusal to deal, like a fixing of price, would be an act by the medical society, not the insurer. Therefore, it would be a concerted refusal to deal, or group boycott, which under these circumstances would be treated as severely as price-fixing. See *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.*, 472 U.S. 284, 294 (1985) (noting the Court's *per se* treatment of cases involving joint efforts "to disadvantage competitors by 'either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle'" (quoting LAWRENCE ANTHONY SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* 261-62 (1977))).

ment as a group of professionals competing in the market at issue.²³⁹ The society should be liable for the effects of that agreement.²⁴⁰

Although imposing liability for a group's solicitation of action implemented by a third party may seem severe, it is supported by a Supreme Court decision from this past term. In *FTC v. Ticor Title Insurance Co.*,²⁴¹ the defendants were a group of title insurance companies that formed state-licensed rating bureaus to propose rates for their services to state insurance offices.²⁴² The rates were proposed as part of a so-called "negative option" system, under which rates became effective unless the states rejected them.²⁴³ The companies claimed that, because these programs were authorized by the states, the price-fixing was immune from the antitrust laws under the state-action doctrine, which exempts certain government acts from antitrust liability.²⁴⁴ The Court rejected

239. A possible objection to this analysis is that there is no agreement between the society and the insurer. But the absence of *that* agreement is irrelevant. The relevant agreement is among the members of the society, who agree regarding the service and then impose that agreement on their competitors via the intermediary of the insurer. See *Business Electronics Corp. v. Sharp Electronics Corp.*, 485 U.S. 717, 730 n.4 (1988) ("[A] facially vertical restraint imposed by a manufacturer only because it has been coerced by a 'horizontal carte[l]' agreement among his distributors is in reality a horizontal restraint." (interpreting ROBERT H. BORK, *THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF* 288 (1978))).

The insurer's absence from the agreement does exempt *it* from liability, however. This is true even if the insurer is in favor of the society's decision, and is willing to rely on it. So long as it acts independently and does not agree with the society, it is not liable. See *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 768 (1984) ("The correct standard is that there must be evidence that tends to exclude the possibility of independent action . . .").

240. In these circumstances, that would probably require something approaching a rule of reason inquiry. Although a *per se* rule still exists against blatant price-fixing, the Supreme Court has applied a test between the *per se* rule and the rule of reason when the challenged agreement is not so straightforward. See *National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85, 104 n.26 (1984) ("[T]here is often no bright line separating *per se* from Rule of Reason analysis."); *Broadcast Music, Inc. v. CBS*, 441 U.S. 1 (1979). In the present case, because a medical society's actions persuading an insurer to discontinue reimbursement could serve legitimate informational purposes as well as illegitimate competitive ones, application of the *per se* rule would be inappropriate.

241. 112 S. Ct. 2169 (1992).

242. *Id.* at 2174.

243. *Id.*

244. The state action doctrine as originally established in *Parker v. Brown*, 317 U.S. 341 (1943), broadly exempted all actions of the states from antitrust liability. The doctrine was based on the view that in enacting the antitrust laws Congress did not intend to restrain the states, and on more general notions of federalism. Since its establishment, the doctrine has been narrowed. It now requires that for state actions to be exempt they must be "clearly articulated and affirmatively expressed as state policy" and "actively supervised" by the state. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (quoting *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978) (plurality opinion)).

immunity, stating that the negative option schemes did not provide the "active supervision" by the states that is required by the doctrine.²⁴⁵ It described the reason for that requirement:

Its purpose is to determine whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties. Much as in causation inquiries, the analysis asks whether the State has played a substantial role in determining the specifics of the economic policy. The question is not how well state regulation works but whether the anticompetitive scheme is the State's own.²⁴⁶

The parallels with the medical standard-setting in a case like *Schachar*²⁴⁷ are clear. In both situations a private group agreed on a restriction for the market in which its members sold their services. In both, the group proposed that restriction for adoption by a third party with power in its members' market. In both, the third party adopted the restriction. In *Ticor*, there was no meaningful review of the restriction; in *Schachar*, none was shown. The Supreme Court determined that the defendants in *Ticor* were liable for the effects of their actions. In *Schachar*, where the society sought and received similar action, it should also be liable, especially because the action was effected by a private entity, not the state.

3. *Damages*.—Damages for an antitrust violation of this kind could be claimed either by patients or by practitioners. The injury to patients, as in *Blue Shield*, would be the cost of medical services for which they were not reimbursed because a society succeeded in having a decision not to reimburse enacted.²⁴⁸ The injury to practitioners would be the loss of business caused by the non-reimbursement decision.²⁴⁹ One could

245. *Ticor*, 112 S. Ct. at 2178-80.

246. *Id.* at 2177. See also *Patrick v. Burget*, 486 U.S. 94, 101 (1988) ("The active supervision prong of the *Midcal* test requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy. Absent such a program of supervision, there is no realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests.').

247. See *supra* section I.B.

248. See *supra* text accompanying notes 220-23.

249. As described above, the defendant in *Blue Shield* argued that the plaintiff in that case, a patient, did not have standing to bring the action. See *supra* text accompanying notes 220-23. The defendant argued instead that the proper plaintiffs were the competing practitioners (psychologists) who were harmed by its reimbursement decision. 457 U.S. at 478. The Supreme Court rejected the defendant's argument with regard to patients, but

also imagine a claim of damages by the insurer itself. In a situation like that in *Blue Shield*, if the insurer adopted the decision not to reimburse for psychologists' services as a result of the actions of the psychiatrists, the insurer might in the end pay more to reimburse psychotherapy services (if psychologists provide those services more cheaply). The insurer might then have a colorable claim against the psychiatrists. However, an insurer in this situation, claiming damages for what is, in form if not in fact, its own act, is perhaps in an unsympathetic position.²⁵⁰

Imposing liability on medical societies in the circumstances described in this section may seem less justifiable than imposing it for the deception of consumers. However, as in that context, the tests proposed here provide easily reached safe harbors for the societies. The easiest is for a society to refrain from soliciting particular reimbursement decisions from insurers. Although the evaluation of a society's actions in this respect will be a fact-specific inquiry, liability should normally be avoided if the society avoided overt solicitation of insurer action like that in *Schachar*. Alternatively, even if it solicits a particular decision, the society need only ensure that the insurer actually gives serious consideration to the decision and does not automatically enact it in response to the society's solicitation. Neither of these approaches is particularly burdensome, as long as the society truly does not seek to impose its decisions on the marketplace.

Notably, in this case, accuracy in the society's statements is not in itself a defense because liability is based not on any objective validity or invalidity of the society's reasons for its decision, but on the fact that the reimbursement decision is not the society's to make. Paraphrasing *Ticor*, "[t]he question is not how well [the insurer's] regulation works but whether the anticompetitive scheme is the [insurer's] own."²⁵¹ The rationale is no different from that which guides more typical antitrust cases: market participants are not permitted to agree on restraints on the market, no matter how objectively reasonable those restraints may appear to them.²⁵²

it did not disagree with the defendant's view regarding practitioners. Instead, it made clear that both patients *and* competitors could recover: "[T]he remedy cannot reasonably be restricted to those competitors whom the conspirators hoped to eliminate from the market." *Id.* at 479 (footnote omitted).

250. *Cf. Ticor*, 112 S. Ct. at 2178 (noting that thirty-six states filed a brief as *amici curiae* stating that broad state-action immunity for insurance companies operating under the supervision of state insurance commissioners was not in the states' interests).

251. 112 S. Ct. at 2177. *See supra* text accompanying note 246.

252. *See, e.g., United States v. Socony-Vacuum Oil Co., Inc.*, 310 U.S. 150, 221-22 (1940) ("Any combination which tampers with price structures is engaged in an unlawful activity. Even though the members of the price-fixing group were in no position to control

C. *Speech Directed at the Government*

The preceding sections argued that professional societies should not be permitted to control buying decisions in the markets in which the societies operate. However, at times the anticompetitive danger of such control may be outweighed by legitimate public health concerns. Unscrupulous medical practitioners sometimes promote treatments that are either worthless or actually harmful. When that occurs, medical professionals, and medical societies, have a legitimate role to play in discouraging the practice of such "quack" treatments. Typically, that role will take the form of disciplinary proceedings within the framework of private membership or state licensing procedures. For example, a medical society may enforce against its members the same prohibitions on professional deception that this paper advocates be applied to the societies themselves.²⁵³ Sometimes, however, as when the offending practitioner is not a member of the society, internal procedures are not effective. In that case, a society must resort to other attempts to discourage performance of the service it believes to be unsafe. It does, however, have an avenue to do so that does not implicate the dangers of anti-competitive collusion addressed in this Article.²⁵⁴

the market, to the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces. . . . Congress has not left with us the determination of whether or not particular price-fixing schemes are wise or unwise, healthy or destructive. . . . It has no more allowed genuine or fancied competitive abuse as a legal justification for such schemes than it has the good intentions of the members of the combination.'"); see also *supra* text accompanying notes 145-50.

253. See *infra* text accompanying notes 276-77.

254. One commentator has suggested that the public safety should be a defense to an antitrust challenge of a standard. See Michael Goldenberg, *Standards, Public Welfare Defenses, and the Antitrust Laws*, 42 BUS. LAW. 629 (1987). He states that "[a] standard having potential anticompetitive effects should be upheld only when the standards organization can demonstrate that the standard is reasonably necessary to protect the public." *Id.* at 650 (footnote omitted). Mr. Goldenberg's concern is with standards that effectively exclude products from the market, *id.* at 632-33, 650-51, so his focus is narrower than that of this Article, which includes standards and statements that discourage but do not actually exclude products. Nevertheless, the specific test that he describes is a more lenient one than that presented in this Article. To determine whether an exclusionary standard is "reasonably necessary" for public safety, Mr. Goldenberg proposes the application of eight criteria. *Id.* at 653-65. Four of these criteria define a more-or-less substantive test for safety-related standards, and it is those four that will be considered here. (As to the remaining factors, one, safety-relatedness, is basically a prerequisite for application of the test at all. See *id.* at 653-55. Another, anticompetitive intent, is discussed only briefly and is apparently included largely because it may cast light on the other factors. See *id.* at 660. There are also two procedural factors, one requiring that a standard be applied non-discriminatorily and the other demanding that the standard-setting organization's procedures be reasonable. See *id.* at 657-58, 662-65. These two criteria are subject to the

If a society believes that any of the services of its profession, or related professions, are undesirable because of safety or other reasons,

objections to procedural protections that were discussed above. *See supra* text accompanying notes 141-53.)

Two of the substantive criteria address the issue of information availability. One says that a standard should not be permitted to pre-empt consumer choice when consumers have, or should have, access to the relevant information for making that choice. 42 *BUS. LAW.* at 655-56. The other says that a standard should not be permitted to exclude a product if a less restrictive alternative to exclusion is available. The most plausible such alternative, and the one on which Mr. Goldenberg focuses, is the provision of relevant safety information to consumers. *Id.* at 656-57. Considering these two factors together makes clear that the only circumstance in which an exclusionary standard would be permissible is when an organization was justified in not merely informing consumers of any danger in the product in question. Mr. Goldenberg touches on this issue and notes that in some cases "consumers and public officials may be unable to obtain all information about a product and even the attempt to obtain such information may be costly," so that a product ban may be the more efficient approach. *Id.* at 649; *see also id.* at 633-35. He does not, however, discuss how to determine when that is the case, so these criteria of his test provide little real guidance.

The other two substantive criteria more directly address the reasonableness of standards. One requires that an exclusionary standard be based on objective evidence, and Mr. Goldenberg states that "the evidence at a minimum needs to be substantial enough to have convinced most consumers not to use the product, had they been aware of the evidence." *Id.* at 658. Somewhat similar is the last factor, in which Mr. Goldenberg proposes to use "knowledgeable and reputable purchasers or other industry members" as proxies for "reasonable consumers" in their purchasing decisions, because "a standard should not be considered reasonable if consumers, with knowledge, would decide to purchase the excluded product." *Id.* at 661. If these consumer proxies would use the product, he says, exclusion of it is likely to be unreasonable, *id.* at 661-62; though he does not say so, presumably acquiescence by a consumer group in an exclusionary standard would be evidence that the standard is reasonable. These tests bear a surface similarity to the test described in this Article, which proposes treating a standard or statement issued by a group with market power as anticompetitive if it is deceptive, as evaluated by a survey of consumer perceptions. *See supra* text accompanying notes 208-15. However, the two tests are actually very different. This Article proposes making a determination of whether a statement conveys accurate information for consumers to use in making purchasing decisions; it does not propose removing the decision from consumers. Mr. Goldenberg, in contrast, proposes excluding a product if most consumers, or perhaps a consumer representative, given the relevant information, would opt not to purchase it. In other words, Mr. Goldenberg would allow the removal of a product from the market by a majority of consumers, or by a consumer group. But the antitrust laws do not permit the market to be pre-empted by a majority vote of consumers, any more than they allow such an action by a majority of producers. The market works through the choices of all consumers, not just a majority of them. Recall that the Supreme Court has said that "a purchaser might conclude that his interest in quality—which may embrace the safety of the end product—outweighs the advantages of achieving cost savings by pitting one competitor against another." *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 694 (1978). It is implicit in that statement that a purchaser instead might, and should be permitted to, choose cost savings over the safety of the product. *See supra*

so that they should not be available, it can attempt to persuade the state to impose the restrictions it desires.²⁵⁵ Activities petitioning the government, even if for an anticompetitive purpose, are protected from antitrust liability by the *Noerr-Pennington* doctrine. The foundations of the doctrine were laid in *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*,²⁵⁶ where the Supreme Court held that the Sherman Act does not prohibit an association's attempt to persuade the legislative or executive branches²⁵⁷ to take actions restraining trade.²⁵⁸ Even if a group's motive in petitioning the government is to provide advantage to itself and disadvantage to its competitors, legitimate petitioning activity does not violate the Sherman Act.²⁵⁹ The *Noerr-Pennington* doctrine thus provides a broad immunity from antitrust liability for actions to influence public officials.

As described above,²⁶⁰ there are some limitations on permissible speech under the *Noerr-Pennington* doctrine. To a large extent, these restrict only the use of misrepresentation or fraud in less political forums

text accompanying notes 145-50. A group of market participants must not interfere with that choice. Such a group can properly seek to exclude a product only through the public avenues provided by the state-action and *Noerr-Pennington* doctrines. See *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 501 (1988) (“We may presume, absent a showing to the contrary, that [a government] acts in the public interest. A private party, on the other hand, may be presumed to be acting primarily on his or its own behalf.”) (quoting *Hallie v. Eau Claire*, 471 U.S. 34, 45 (1985) (interpolation in *Allied Tube*)).

255. It is possible that some insurers' actions, and even perhaps some professional societies' actions, might be immune from antitrust liability if directed by regulations of a federal agency, such as HCFA's coverage guidelines. See generally 1 PHILLIP E. AREEDA & DONALD F. TURNER, *ANTITRUST LAW* ¶¶ 222-27 (1978). However, liability would still attach for effects on privately insured patients.

256. 365 U.S. 127 (1961).

257. *Noerr's* basic holding was later extended to administrative and adjudicative settings, albeit perhaps with more restrictions, in *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972).

258. The Court supported its holding on two grounds. First, it said that since the government has the power to restrain trade, the people should be able to make known their wishes regarding such restraints. *Noerr*, 365 U.S. at 137. Second, it said that to hold otherwise would raise constitutional questions of the right to petition, and that the Court “cannot . . . lightly impute to Congress an intent to invade [that right].” *Id.* at 137-38.

259. *Id.* at 138-39. The Court has since held, though, that legitimate petitioning activity may be relevant for proof of the anticompetitive intent of other activities. *United Mine Workers of Am. v. Pennington*, 381 U.S. 657 (1965). Evidence relating to government petitioning may be admitted “if it tends reasonably to show the purpose and character of the particular transactions under scrutiny.” *Id.* at 670-71 n.3 (quoting *FTC v. Cement Institute*, 333 U.S. 683, 705 (1948)) (citations omitted). Admission of such evidence is subject only to the usual limitation that it be probative and not unduly prejudicial. *Id.*

260. See *supra* text accompanying notes 157-60.

than the legislature, such as the courts and administrative agencies.²⁶¹ Although the Supreme Court in *Allied Tube* suggested that this limitation might extend to legislative committees,²⁶² it has imposed no general accuracy requirement in the legislative arena. The reason for its reluctance is its view that Congress in the Sherman Act did not intend to regulate political activities.²⁶³ Nevertheless, it is clear that where a private petitioner possesses the information advantages of a professional society, advantages that may not be shared by any other party, speech intended by the society to persuade the government presents many of the same dangers as does (other) commercial speech.²⁶⁴

Therefore, several commentators have proposed that commercial speech standards be applied to *Noerr-Pennington* immunity, either by eliminating *Noerr-Pennington* immunity as an independent doctrine²⁶⁵ or

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

262. *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 504 (1988).

263. *Noerr*, 365 U.S. at 140-41; see also *California Motor Transport Co.*, 404 U.S. at 512-13.

264. The informational advantages of professional societies present problems even in the absence of any intent to deceive. See, e.g., ANTHONY DOWNS, *AN ECONOMIC THEORY OF DEMOCRACY* 255 (1957):

[T]he cost of acquiring information and communicating opinions to government determines the structure of political influence. Only those who can afford to bear this cost are in a position to be influential.

A striking example of this fact is the failure of consumers-at-large to exercise any cogent influence over government decisions affecting them. For instance, legislators are notorious for writing tariff laws which favor a few producers in each field at the expense of thousands of consumers. On the basis of votes alone, this practice is hardly compatible with our central hypothesis about government behavior. But once we introduce the cost of information, the explanation springs full-armed from our theory. Each producer can afford to bring great influence to bear upon that section of the tariff law affecting his product. Conversely, few consumers can bring any influence to bear upon any parts of the law, since each consumer's interests are spread over so many products.

The possibility of deception is, *a fortiori*, of greater concern.

265. See Ernest Gellhorn, *Another Perspective on Antitrust Immunity for Petitions to Government*, in *THE POLITICAL ECONOMY OF REGULATION: PRIVATE INTERESTS IN THE REGULATORY PROCESS* 89 (1984). Professor Gellhorn proposed what he called "a merger of the developing doctrine of commercial speech under the first amendment with the doctrine of immunity for petitions to government under the antitrust laws." *Id.* at 90 (footnote omitted). He referred to the similarities in function between the antitrust laws in preserving an open private market with vigorous product competition and the first amendment in maintaining an open political "market" with "competition in ideas and interests." *Id.* at 91. The approach that he proposed was basically to apply traditional first amendment tests of time, place, and manner to government regulations of speech for antitrust purposes, though he would have also allowed more strict commercial speech standards to be applied as they developed. *Id.*

by applying it only where the speech is not commercial.²⁶⁶ Both of these approaches, however, are undesirable because it is unwise to base antitrust immunity purely on the evolving commercial speech standard. It is not impossible that the Supreme Court could decide that commercial speech is not worthy of protection at all.²⁶⁷ Even if that were to happen, *Noerr-Pennington* speech, because it is directed at the government, would still have an undeniably political component that would remain worthy of protection. Commercial entities should continue to be able to petition for government action favorable to their competitive positions independent of any restrictions that may be imposed on their speech in the marketplace.

I suggest, however, that professional societies should be liable for intentional deception in their government petitioning. In *California Motor Transport Co. v. Trucking Unlimited*,²⁶⁸ the Supreme Court said that practices such as perjury or patent fraud could be an abuse of governmental processes sufficient to remove them from *Noerr-Pennington* immunity.²⁶⁹ The Court there limited this exception only to administration

266. See Natalie Abrams, Note, *The Sham Exception to the Noerr-Pennington Doctrine: A Commercial Speech Interpretation*, 49 BROOK. L. REV. 573 (1983). The author there suggested that "legislative petitioning be considered commercial speech if it (1) involves the business of the entity, and (2) if effective, would result in an economic benefit to the speaker." *Id.* at 596. She recognized, though, that this test could have encompassed some speech that would have typically been thought of as political, not commercial. *Id.* See also *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y.*, 447 U.S. 557, 563 n.5 (1980) ("[M]any, if not most, products may be tied to public concerns with the environment, energy, economic policy, or individual health and safety."). To meet this problem, she said that it could also be required that the speech be of the character that the Court said in *Virginia Board of Pharmacy* justified the lesser restriction on commercial speech: that is, first, that it be easily verifiable by the speaker and, second, that the speaker have a significant commercial motivation to make it so that he is less likely to be deterred by regulation. Note, *supra*, at 596. See also *supra* note 164 and accompanying text. But her proposed test was then no more than a restatement of the second of the requirements of the Court. After all, if the speaker is strongly motivated to make the speech for commercial reasons, it must concern his business and be to his economic benefit. This is not to deny that businessmen and businesswomen might sometimes make speech related to their businesses that is not to their benefit, but presumably the *Virginia Board of Pharmacy* Court's concern for strong commercial motivation would not be met in such a case. For similar views, see also James D. Hurwitz & Debra Simmons Neveu, *The Noerr Doctrine: Its Significance and Current Interpretation*, in *THE POLITICAL ECONOMY OF REGULATION: PRIVATE INTERESTS IN THE REGULATORY PROCESS* 33 (1984), and James D. Hurwitz, *Abuse of Governmental Processes, the First Amendment, and the Boundaries of Noerr*, 74 GEO. L.J. 65 (1985).

267. This possibility appears unlikely in light of the Court's most recent discussion of the issue. See *Cincinnati v. Discovery Network, Inc.*, 113 S. Ct. 1505 (1993).

268. 404 U.S. 508 (1972).

269. *Id.* at 512.

or judicial processes.²⁷⁰ However, at least for professionals, who possess specialized knowledge that makes their statements difficult, if not impossible, for others, such as legislators, to evaluate, the fraud exception to *Noerr-Pennington* immunity should be extended to the legislative arena. *Allied Tube* apparently supported this view in its *dicta* to the effect that misrepresentations to legislative committees would be impermissible.²⁷¹ This restriction on immunity should, however, be confined to active misrepresentations, as *Allied Tube* appears to contemplate. This would allow societies to petition the government with statements that were inaccurate at the time of the petitioning or were later found to be misleading, so long as the societies were unaware of the inaccuracies. Such a rule would provide sufficient protection to encourage professionals to seek government action based on legitimate concerns of safety.

IV. CONCLUSION

There is "no basis for believing that professionals act without regard for their own economic interests and, therefore, no basis for antitrust purposes of a broad distinction between 'professional' and 'business' conduct."²⁷² If members of a non-professional business group with market power joined together to make deceptive or misleading statements about competitors' products, and consumers were in fact dissuaded from purchasing those products, or if the group through a third party was able to raise the products' prices to consumers, the group would be subject to antitrust liability.²⁷³ There is no reason not to apply the same rule to professional groups, especially since the specialized knowledge that professionals possess makes it difficult for others to evaluate their statements.

The basic rationale animating the proposals in this paper is that a professional group should not be able to distort the workings of the market through its private decisions.²⁷⁴ Restraints enacted by a private society are "imposed by persons unaccountable to the public and without

270. *Id.*

271. *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 504 (1988).

272. Thomas E. Kauper, *Antitrust and the Professions: An Overview*, 52 ANTITRUST L.J. 163, 172 (1983); see also Philip C. Kissam, *Antitrust Law and Professional Behavior*, 62 TEX. L. REV. 1, 11 (1983) ("[S]everal 'Chicago school' economists studying the professions assume that professionals have the same profit-maximizing interests as people in other businesses and that professional self-regulation, like any regulatory legislation, is more likely to result from 'interest group' bargaining than from a principled consideration of the public interest." (footnote omitted)).

273. As described in notes 121, 213 & 226 *supra*, several cases have, at least in principle, accepted these damage theories in cases involving non-professional groups.

274. See *supra* text accompanying notes 145-50.

official authority, many of whom have personal financial interests in restraining competition."²⁷⁵ The other side of this rule is that a society should be permitted to seek state-imposed restraints. By requiring the organization to take that route, its proposed standards are made subject to the scrutiny (such as it is) that results from any attempt to obtain government action, and they are subject to question from other segments of society. Standards established through this process are more likely to benefit all of society, not just the profession.

The elimination of all but governmentally-adopted professional standards need not eliminate the traditional self-policing role of the professions. It would, however, shift its focus. Under this approach, a professional association's self-policing activities would be confined to the investigation of individual cases in which unprofessional activity is alleged. It could, for example, enforce prohibitions against deceptive practices by its members.²⁷⁶ This would allow it to discipline members who were misleading patients regarding the risks of procedures that the society believed were dangerous, and would therefore obviate much of the need for possibly deceptive speech by the society discouraging those procedures. Furthermore, this sort of disciplinary proceeding would require specific evidence of a violation of professional standards, as well as a process providing quasi-judicial procedural protections, so it would eliminate much of the anticompetitive danger created by purely internal society proceedings.²⁷⁷

As to the undesirability of an association supporting sanctions against its members, such a practice would seem to be an essential function of a self-policing profession. Indeed, it is just the professions' failure to

275. *Allied Tube & Conduit Corp.*, 486 U.S. at 502.

276. The right of medical societies to perform this function was upheld in *American Medical Ass'n v. F.T.C.*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court per curiam*, 455 U.S. 676 (1982). In that case, the American Medical Association (AMA) and two local medical societies challenged an FTC cease and desist order that prohibited them from effecting restraints on advertising, solicitation, and contracting by physicians. The order allowed the AMA to enforce prohibitions on false and deceptive advertising by its members, but the AMA contended that that exception afforded it insufficient protection in case it initiated enforcement proceedings against advertising that was later determined not to be deceptive. *Id.* at 452. In response, the court amended the order to allow the AMA to "enforc[e] reasonable ethical guidelines governing the conduct of its members with respect to representations, including unsubstantiated representations, that [the AMA] *reasonably believes* would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act." *Id.* (emphasis in original). This standard gives medical societies considerable freedom to control attempts by their members to promote unproven or dangerous procedures.

277. *Id.* at 450 (noting that the FTC's Order "require[d] AMA in any proceeding involving violations of its ethical standards to provide (A) reasonable notice, (B) a hearing, and (C) written findings and conclusions.").

perform this function, the tendency of professions to "protect their own," that has caused much of their loss of public trust and esteem. In addition, any argument by a profession that such a practice is undesirable for professional morale is too self-serving to be given much credence. On the contrary, it should greatly benefit professional morale to ensure that the standards of the profession are maintained by sanctioning those who do not meet them.

These changes to current rules would therefore result in a somewhat different role for professional societies. Instead of functioning as quasi-legislatures deciding how their professions should be practiced, as they often do now, they would serve more as information clearinghouses,²⁷⁸ and decisions regarding particular practices would be made by individual professionals.²⁷⁹ The result would be a much more open professional environment, with greater opportunity for procompetitive development of new techniques and, consequently, better long-range health for the professions.

278. Nothing in this Article prevents professional societies from communicating objectively supported information to the public or to insurers. *See supra* sections II.C & II.D.

279. *See* Clark C. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 346-47 n.184 (The author "would permit professional groups to emphasize positive professional values but would encourage courts to regard with suspicion collective actions to denigrate alternative approaches or to focus professional disapproval on a specific competitor or would-be innovator.").

