The Doctors' Trust: Self-Regulation and the Law

by Clark C. Havighurst

Prologue: For a decade or more, Clark Havighurst has been a philosophical thorn in the side of organized medicine, preaching a view of the health sphere that rejects decision making by professional self-regulation in favor of a system based on marketplace principles. Havighurst also opposes command-and-control government regulation, a position that puts him at odds with the commercial health insurance industry, which in recent years has been promoting state rate setting. A professor of law at Duke University and a member of the National Academy of Sciences' Institute of Medicine, Havighurst initially became involved in health policy issues in the late 1960s when he served as editor of the journal Law and Contemporary Problems. As a leading advocate of a medical care system that is based on decentralized, market-based solutions, Havighurst envisions a health industry where individual consumers, armed with solid information, have a chance to decide for themselves what standards of medical practice best suit their preferences and pocketbooks. A major tool in Havighurst's philosophical arsenal is the nation's antitrust laws. Havighurst was an early proponent of Federal Trade Commission involvement in health care through the application of its antitrust enforcement powers. But his view of government's proper place is as rule-setter and referee of private sector action, not as the dictator of events. Thus, he regards as a highly constructive step in a long policy drama, the Reagan administration's policy to focus its cost-containment policies on public programs, forcing the private sector as a consequence to more effectively exercise its own economic leverage in efforts to moderate the medical cost spiral. Havighurst is the iconoclast among the marketplace advocates, pursuing his view of the truth relentlessly, without fear, favor, or compromise.
It is now possible to see that the Supreme Court’s decision in the 1975 Goldfarb case, which involved a state bar association, created more problems for physicians than it did for lawyers. Whereas the legal profession adapted itself rather easily to the Court’s ruling that the so-called learned-professions are subject to the Sherman Antitrust Act, the medical profession has found that antitrust law challenges not only many of its customary practices but also its fundamental conception of itself as the guardian of the quality of medical care. The American Medical Association (AMA), reacting to this perceived threat to professional traditions, recently spearheaded a legislative campaign to obtain an exemption for the state-regulated professions from the jurisdiction of the Federal Trade Commission (FTC), the agency that, following Goldfarb, assumed the lead role in bringing antitrust principles to bear on the health care industry. Although the AMA proclaimed physicians’ willingness to abide by basic antitrust rules as enforced by the courts, it clearly hoped for a congressional rebuke to the FTC that would signify that competitor collaboration in the professions deserves special treatment. Despite the setback received by the AMA’s lobbying effort in the last days of the 97th Congress, the conflict between the traditions of the medical profession and the rules of free enterprise remains on the public agenda.

Physicians have long enjoyed considerable insulation from market forces and have collectively exercised a great deal of authority over the making of social policy with respect to how and how much of society’s resources are employed in treating the sick. The recent history of the health care industry is largely a story of the erosion of doctors’ accustomed powers, not only as a result of antitrust actions, but also through the operation of market forces (which Goldfarb helped to unleash) and new governmental policies (which Goldfarb helped to make feasible). Consideration of the conflict between emerging public policy and the sovereignty of the medical profession will demonstrate that professional self-regulation, developed by the medical profession to a high art, is facing serious challenges. This overview may also contribute to the needed assessment of what the public stands to gain or lose as the medical profession’s dominance erodes and as market forces displace professional self-regulation as the chief mechanism of social control in the delivery of health care.

A Sovereign Profession

In his recent book, The Social Transformation of American Medicine, sociologist Paul Starr has documented the rise of the medical profession to a position of “cultural authority, economic power, and political influ-

Work on this paper was supported by Grant No. HS04089 from the National Center for Health Services Research, U.S. Department of Health and Human Services.
ence” that seems to have reached its apex, coincidentally or not, at about the time of the Goldfarb decision. Starr argues that it was not inevitable that physicians would achieve the status and autonomy that they came to enjoy. Although the scientific aura surrounding medicine and the special dependency of patients on their physicians gave the medical profession significant advantages in their reach for power, hard and skillful work by dedicated professionals was necessary to raise the profession from a lowly to an exalted state.

The medical profession achieved effective control of its legal, economic, and institutional environment by espousing an ideology of medical care that knit the profession into a cohesive unit and kept decision making on crucial issues largely in professional hands. Proceeding under the banner of science and patient welfare, the profession was frequently able to designate those who effectively controlled such vital matters as state licensing policies, the nature and extent of medical training, the nature of medical specialization, the internal organization of hospitals, the politics and practices of prepaid medical service plans, and the appropriateness of payment for particular services under third-party financing programs. Where it could not nominate the actual decisionmakers, the profession frequently succeeded, often with government’s acquiescence or assistance, in restricting the decision-making scope of such potentially independent entities as medical schools, hospitals, nonphysician health professionals, private health insurers, and government itself. The effect of profession-dictated limits on the discretion of these parties was to deny consumers access to agents who might represent their interests better than did physicians.

The ideology used so successfully by the medical profession in shaping the industry to its liking was rooted in a system of professional ethics restricting the individual practitioner’s scope for independent action. The history of modern medical ethics essentially began with Thomas Percival, a conservative English physician whose authoritative ethical principles, written in 1794, served as the AMA’s model for its first ethical code in 1847. As a contemporary of Adam Smith, Percival faced the task of countering the free-trade liberalism of his time by distinguishing medicine from “trade” and establishing the concept of a learned, self-governing profession. His principles, many of which were nothing more than rules of professional etiquette, strengthened professional solidarity, minimized competition, and launched the profession on a path quite different from that envisioned somewhat earlier by one John Gregory, a professor of medicine in Adam Smith’s Edinburgh. Sociologist Jeffrey Berlant has written of Percival and Gregory: “Percival saw the forces binding the profession into a group- esprit de corps, a common academic training, and support of each other’s reputations as the source of the best in medicine . . . . Gregory challenged this central presumption and thereby also
the medical profession’s elitist autonomy as an independent institutional body. The domination of medical thought by men of the practicing profession, he explained, distorted the pursuit of medical knowledge and blocked the development and delivery of medical care. It is striking that the same fundamental issues that have been raised in medicine following the Goldfarb case were actively debated in the time of Adam Smith.

Though not technically inaccurate, the characterization of the medical profession in its prime as a monopoly or a cartel is probably too pejorative and unduly demeaning to the profession’s accomplishment in building a health care system that yielded a high standard of technical quality, sustained rapid scientific progress, lengthened life expectancy, and provided a great deal of free care for patients unable to pay. It is nevertheless the case that this complex system was subject, at critical points, to a degree of central control that warrants description in monopolistic terms. It is ironic that the public health movement came to criticize the health care delivery system for being a “cottage industry” and a “nonsystem,” for, although the profession-dominated system did not choose to serve the objectives espoused by its public-health critics, it was a system nevertheless - and an impressive one at that.

Despite its achievements, the health care system, as operated under the medical profession’s domination, had one fatal flaw - its inability to control its huge appetite for consuming societal resources. Its claims on GNP rose from 4.6 percent in 1950 to 7.7 percent in 1973 to 10.5 percent today. In the last decade of slow economic growth, this toll, together with recognition of the high median income of physicians relative to other professionals, has played an important part in ending the public’s willingness to let medicine’s otherwise benign monopoly alone. For the moment, proposals to regulate the health care industry are being held in abeyance while more market-oriented policies, aimed at breaking down monopoly power and decentralizing decision making, are being tried.

### Antitrust And Medicine

Prior to the Goldfarb case, the medical profession enjoyed an unwritten but seemingly substantial antitrust exemption that enabled it to act in ways that would be risky today. In part, this immunity was traceable to language in the Supreme Court’s 1952 opinion in United States v. Oregon State Medical Society, observing the ethical considerations involved in the doctor-patient relationship and opining that “forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.” The context of this statement suggested that, had the proof called for it, the Court would have excused a physician boycott of a type that would normally have been a “per se” violation of the Sherman Act - that is, a practice regarded as so dangerous to competition that it is treated
as unlawful even without proof of any specific harm.

Despite the broad deference to professionalism indicated by the quoted dictum, the medical profession’s de facto antitrust immunity probably owed more to constitutional limitations on the reach of federal law into local markets for professional services. Certainly, deference to medical ethics had not been apparent in the 1943 case of *AMA v. United States*, which resulted in criminal convictions of two professional associations for sponsoring boycotts aimed at enforcing ethical strictures against an early health maintenance organization (HMO). Only the location of that offense in the District of Columbia prevented the case from serving as a precedent for further federal enforcement actions. In addition to clarifying that professionals are engaged in trade, the *Goldfarb* case heralded a significant relaxation of the tests for finding the requisite impact on interstate commerce.

Subsequent cases have further reduced the number of ways in which powerful physician groups can hope to escape antitrust liability. In *National Society of Professional Engineers v. United States*, the Court indicated that professionals, far from having their anticompetitive conduct evaluated under a relaxed legal standard, can only be excused, like other defendants, if their collective actions do not harm competition. In emphasizing that the effect on competition is controlling, the Court conceded only that competition in the professions may differ in form from other competition and that “ethical norms may serve to regulate and promote this competition” and thus be lawful. As a further demonstration that a worthy purpose is no defense for restraining competition, a four-justice majority in *Arizona v. Maricopa County Medical Society* found a dominant professional organization guilty of a per se price-fixing violation in setting a maximum limit on fees. Although the law is not finally settled, the Supreme Court has gone quite far toward establishing that professionals are trusted no more than other competitors to restrain trade without injuring the public.

### Control Of The Financing System

The unusual features of competition in health care have less to do with its professional character than with the prominent role played by third parties in paying for services. Private and public insurance programs that reimburse patients or providers for incurred costs dilute the incentive of consumers to shop for less expensive care and the incentive of patients and physicians to consider benefit/cost ratios in buying or ordering services. Competition under such circumstances tends to raise costs without any assurance that consumers and taxpayers really want their resources spent as they are in fact being spent. Once widespread third-party payment was coupled with the inexhaustible capacity of the modern, high-technology health care system to find new ways to spend money, the system
quickly gobbled up whole percentage points of GNP. Although undeniable good has come from this investment, there is some basis for suspecting that, at the margin, much health care spending is not justified by the benefits-obtainable.

This resource-allocation problem calls attention to defects in the way consumers are currently protected against the unpredictable costs of health care. In particular, third-party payers have been quite complacent about the increased costs that their coverage induces and reluctant to take aggressive action to encourage efficient behavior-by physicians. When Congress itself adopted such a passive stance toward physicians in the Medicare and Medicaid programs, it was simply reflecting deferential practices that were already well established in the private sector. Yet logic suggests that competition should have induced private third-party payers to assume more control over the uses made of their funds. One explanation for the failure of these middlemen to represent consumers better and to transmit their cost concerns to practitioners appears to be that the medical profession has frequently employed its collective power to stay the competitive market’s invisible hand. The profession’s attempts to discipline or control the private financing system, keeping payers in a passive role, have been a primary target for antitrust enforcement.

Organized medicine at first collectively resisted medical care insurance of all kinds on the ethical ground that no one should intervene in the doctor-patient relationship. As the public increasingly demanded financial protection, however, the profession began to offer its own coverage by sponsoring Blue Shield plans. To prevent the growth of lay-controlled middlemen, physicians were ethically enjoined against engaging in “contract practice,” and health care plans were warned, under threat of boycott, against interfering with patients’ “free choice of physician.” Although the egregious tactics used by organized medicine in the early days to stamp out objectionable financing plans became less common after the AMA case in 1943, more subtle techniques also proved effective. For example, the record in the Oregon State Medical Society case revealed how the society’s adoption of a Blue Shield plan, together with a partial boycott of alternative plans, forced the latter to cease their cost-control efforts and to assume the passive stance that physicians preferred. From time to time, other innovations in health care financing, including the formation of HMOs, have triggered other boycotts of varying explicitness and completeness.

Professional domination of the financing system took other forms as well. The FTC has threatened to challenge direct control of Blue Shield or other medical care prepayment plans by dominant medical organizations, alleging that such control insulates physicians from price competition and precludes innovation. Some of the potential targets for antitrust attack under this FTC theory are widely viewed as valuable professional re-
forms that advance the cause of cost containment. Although the FTC’s challenge to such reforms can be justified legally under the rule that worthy purposes do not excuse harm to the competitive process, its policy justification is somewhat harder to find. The argument has been made, however, that allowing the organized profession to assume responsibility for health care costs perpetuates its power and forecloses independent competitive initiatives.\textsuperscript{12} Under this analysis, the bird in the hand of immediate cost containment is valued less than the potential benefits of competition. Although this hard-line stance can be viewed as making the best the enemy of the good, profession-sponsored reforms have often been responses to actual competitive threats already in being or appearing distinctly on the horizon. If it is true that the medical profession seldom reforms itself except to shore up a market position that is in danger of crumbling, then a legal rule barring dominant professional organizations from operating their own prepayment plans might facilitate more desirable change than it would prevent.

Professional boycotts against independent innovations in health care financing represent the darkest side of the medical profession’s self-regulatory activities, and antitrust law has now made them largely a thing of the past. More controversial has been the use of antitrust law in the Maricopa County Medical Society case, for example, to prevent dominant professional organizations from attempting to correct the system’s economic faults. The conclusion that such organizations are affirmatively barred from acting to solve the cost problem is a striking demonstration that traditional conceptions of the medical profession and its role are no longer valid. Even when the leaders of such reform movements act selflessly and in the best traditions of the profession, they may still find themselves in violation of the Sherman Act because they are working from an obsolete monopolistic premise. The law seems now to require that solutions to cost problems be sought through competition exclusively.

Noncommercial Purpose

Professional activities that impact less directly on the economics of health care may be less vulnerable to antitrust action because of a distinction that is widely supposed to exist between actions aimed at affecting the business aspects of medicine and actions intended to maintain the quality of care. To some extent, distinctions of this kind are indeed embodied in the rigorous (per se) antitrust rules governing competitor agreements related to price and in the tendency to treat less dangerous activities under the “rule of reason”-which requires proof of actual harm to competition. Nevertheless, distinctions based on noncommercial purpose cannot be said to be well established in the law, which insists on competition, for better or for worse, in virtually all matters. As a result of this legal
uncertainty, Congress, in seeking to resolve the AMA-FTC conflict in 1982, briefly entertained proposals to confine the FTC to regulating the commercial aspects of professional practice. Although the AMA, in opposing these attempts to compromise the conflict, argued that such distinctions are spurious, similar approaches to defining professional prerogatives have appeared in later proposals.\(^\text{13}\)

Existing law suggests another reason why quality-related self-regulation is unlikely to suffer the same legal fate as the profession’s attempts to control the commercial aspects of medicine. Such self-regulation employs techniques that, in themselves, do not or should not raise serious antitrust concerns. As described below, much self-regulation in the health care industry involves the accreditation of institutions and the certification of personnel, activities that are in themselves valuable in generating information useful to consumers and others in making purchasing, employment, and other marketplace decisions. Such collective action by competitors is therefore presumptively more helpful than harmful to competition. The presumptive lawfulness of such activities suggests that there may be no need to accord them special statutory protection, which might, after all, immunize abuse of self-regulatory powers as well as their procompetitive exercise.

---

**Physicians And Hospitals**

In comparison with the medical profession’s efforts to shape the health care financing system, self-regulatory actions with respect to hospitals are more formalized and less obviously dedicated to protecting physicians’ economic interests. At the level of the individual institution, hospital medical staffs have assumed major responsibility for maintaining the quality of care. Because these physician organizations act within and are accountable to the larger hospital enterprise, a medical staff cannot be viewed as a naked conspiracy in restraint of trade. Thus, a refusal to admit a competing physician to the staff should be permissible if the hospital itself exercises the final authority, consulting its own interests rather than joining in a conspiracy with its physicians.\(^\text{14}\)

As an administrative arm of the hospital, a medical staff is not, strictly speaking, a self-regulatory instrument of the medical profession as a whole. Collective actions of the profession have, however, had a substantial influence on the internal organization of hospitals. It was not inevitable that hospitals would come to be organized with a self-governing staff of independent practitioners who use the facility, without charge, as a workshop in which to treat their paying patients. Efficiency considerations might have pointed toward a quite different set of arrangements. Indeed, an M.D.-economist has recently observed how the almost total separation of a hospital’s revenue centers (physician departments) from its cost
centers (administrative departments) renders cost containment an almost impossible task. An important reason why physicians are almost universally independent contractors independently organized within the hospital and why physician decisionmakers are generally not accountable for costs in the hospital administrative structure is that physicians have preferred to have things so arranged. To this end, they have shaped the detailed accreditation standards of the Joint Commission on Accreditation of Hospitals. The JCAH, which is one of the most important self-regulatory bodies in the health care industry, was founded and is still dominated by physicians.

Although the JCAH is highly influential, it does not engage in regulation in the strict sense. Regulation, properly understood, involves compulsion through the imposition of binding sanctions, whereas accreditation is essentially voluntary, its significance and desirability being determined by numerous independent decisionmakers and not by the accreditors themselves. Any attempt to enforce an accreditation decision, such as by an agreement to boycott an unaccredited institution, would be an antitrust violation, but a collective denial of accreditation should be subject to only limited judicial scrutiny under common law or antitrust principles, and should be sustained if the action taken has some rational basis. Thus, even though one might question the wisdom and motives underlying some JCAH standards, its accrediting activities are presumptively lawful. Aside from antitrust attacks on JCAH standards affecting the opportunities of nonphysician practitioners, the JCAH has not faced any serious legal challenge to its substantial power. In general, it would appear that the available grounds for antitrust or other action against accreditation standards are quite limited.

Health Care Personnel

The medical profession has also used its self-regulatory powers to shape the personnel employed in the health care system. Accreditation of medical schools, though no longer used to restrict the supply of physicians, still serves to structure the educational process, thus promoting the uniformity of physicians entering practice from U.S. schools. Similarly, accreditation of specialty training programs operates, in conjunction with specialty boards for certifying individual specialists, to standardize specialists in each recognized field. The medical profession also participates in the design of training programs for nonphysician personnel and in providing credentials for the personnel trained. For the reasons indicated above, educational accreditation and the certification of qualified personnel are presumptively lawful professional activities.

The influence of the medical profession over the design and production of health manpower undoubtedly helps to maintain high quality
standards and to ensure an easy fit between the personnel available and the needs of the system, as defined by medical interests. It might be argued, however, that greater flexibility in educational approaches and greater diversity of output would serve the public better by giving different educational theories and different types of personnel a chance to show what they can do. Because ideology can affect educational, organizational, and therapeutic choices as well as the values that providers bring to their interactions with patients, it may be helpful to regard the health care marketplace as a marketplace of ideas. First amendment traditions, as well as the values underlying a free economy, suggest the possible dangers of allowing a single educational, professional, or other philosophy to dominate a given field. They also suggest, however, that the best answer to the dominance of a particular philosophy does not lie in litigation aimed at changing that philosophy. Instead, it seems wiser to maintain a climate in which alternative accrediting and personnel credentialing systems may develop to compete with dominant ones and in which the products of different educational traditions may fairly compete for consumer favor. Antitrust law could be helpful in ensuring that such a climate exists.

It is possible that the medical profession’s maintenance of its own systems for certifying medical specialists has acted to suppress the emergence of competing sources of information concerning physicians’ skills and attributes. The profession’s long effort to ban physician advertising amounting to solicitation of patients—recently discontinued as a result of FTC action—had the effect of concealing from consumers the existence of significant differences among practitioners. Professional provision of authoritative information concerning medical specialists could have the same effect if it effectively curbed the entrepreneurial urge of individual physicians to differentiate themselves from their competitors. Although the medical profession’s personnel credentialing activities are undoubtedly lawful in themselves, close antitrust scrutiny of the details and interrelationships of the various programs might reveal that competition in the production and dissemination of valuable information has been restrained.

**Professional Standards**

A particular coup of the medical profession has been its success in establishing and maintaining professional norms and standards as the chief determinants of spending for health care services. Third-party payers’ complaisance toward physicians has generally taken the form of a willingness to pay any claim that is not demonstrably unjustified under prevailing professional standards. Thus, professional fees are reimbursed if “usual and customary,” and costly treatment decisions are questioned only if the
prescriptions fall outside professional norms. Such acceptance of professional norms and standards as guides for spending embodies the rather large assumption that the medical profession knows best what value society should place on particular health services; a similar assumption also underlies the use, in the law of medical malpractice, of customary practice as the benchmark for assessing professional negligence. But, because professional norms and standards have emerged in a market with weak cost constraints, widespread reliance on them may be inefficient. Surprisingly few standard medical practices have ever been scientifically shown to be superior in all relevant respects to other possible methods.

Professional self-regulation has played a central role in developing professional standards and establishing their authority. By creating local physician committees to evaluate the reasonableness of fees and the quality and appropriateness of care in specific cases, the medical profession has effectively pre-empted decision-making responsibilities that the various payers might have assumed independently, choosing their own physician arbiters. It is likely, however, that, as the health care industry becomes more competitive, decision making on such crucial subjects will become more decentralized. Because HMOs appear to have some freedom within the constraint of malpractice law to establish their own practice patterns, they represent one way in which departures from dominant professional norms and standards have begun to occur. In view of the unreliability of customary practice as a guide to efficient behavior, HMOs and other organized health plans should be allowed some freedom to contract with their subscribers to provide a standard of care that departs from prevailing norms.

Professional peer review of the reasonableness of fees raises obvious antitrust issues. In a 1982 decision, the Supreme Court held that the McCarran-Ferguson Act’s antitrust exemption for the business of insurance does not extend to profession-sponsored bodies engaged in reviewing fees for insurers, and the Maricopa County Medical Society case prohibited the promulgation of maximum fees. On the other hand, the FTC has allowed local peer-review committees to review fee disputes between insurers and physicians on an ad hoc basis as long as insurers are free to adopt other approaches to solving their cost problems.

Peer review of the appropriateness of care (and thus its eligibility for reimbursement) is also open to antitrust challenge. A strict reading of the antitrust laws, along the lines of Maricopa County, would invalidate the promulgation by a dominant professional organization of practice standards that effectively limit the output of medical services. In this case, however, federal legislation specifically authorizes “peer review organizations” (PROs) and requires them not only to review Medicare and Medicaid claims but also to make their “facilities and resources” available to private payers. Nevertheless, this statute does not clearly authorize PROS
to accept delegation of insurers’ responsibility for generally defining the coverage of their health plans. For this reason, dominant professional organizations should probably be advised to confine themselves to providing administrative services and advice on request and to avoid assuming responsibility for economic decisions of the kind that antitrust law requires be made on a decentralized basis.

Conclusion

The federal appeals court in the 1943 AMA case said of the medical society defendants, “Appellants are not law enforcement agencies. . . and although persons who reason superficially concerning such matters may find justification for extra-legal action to secure what seems to them desirable ends, this is not the American way of life.” Antitrust law today appears to do no more than to embody this stricture against coercive extragovernmental action and to require powerful professional organizations to refrain from dictating, as government regulators might do, the pricing or clinical practices of physicians, the reimbursement and other policies of private financing plans, the nature of personnel and other system inputs, or the kinds of information that consumers may receive. In accordance with “the American way of life,” however, the medical profession remains free to express its authoritative views, however influential they may be, on quality-of-care and other matters. In particular, the accrediting of hospitals and training programs and the credentialing of health care personnel, if undertaken under the proper auspices, are not only unobjectionable practices but can be positive contributions to the quality of care and the efficient operation of the health care marketplace.

There is no question that more vigorous enforcement of the antitrust laws poses unfamiliar hazards to professional groups and requires a rethinking of the medical profession’s position in the larger scheme of things. But even though decision-making responsibilities are shifting away from the organized profession, the finest aspects of medicine’s traditions are not likely to be impaired. One should expect the medical profession, even faced with new necessities, to continue to stand for the highest professional standards and to assist the nation in resolving the difficult ethical dilemmas and practical trade-offs with which medical care inevitably abounds.
NOTES

5. 317 U.S. 519 (1943).
7. 102 S. Ct. 2466 (1982).
8. See, for example, AMA v. FTC, 638 F.2d 443 (2d Cir. 1980), affd mem. by equally divided court, 455 U.S. 676 (1982).
10. See, for example, “In the Matter of Michigan State Medical Society,” Trade Regulation Reporter (CCH) 21,991, Feb. 28, 1983 (FTC docket No. 9129, Feb. 17, 1983).
17. For example, State of Ohio ex rel Celebrezze v. JCAH, (S.D. Ohio), Civil action No. C-2-79-1158.
18. See note 8 above.
19. See note 16 above.
23. 42 U.S.C.A §1320(c)-1320(c)( 12) (West Supp., 1982).