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THE SPECIALTY BOARDS AND ANTITRUST: A LEGAL PERSPECTIVE

*John J. Smith, M.D.**

Health care in the United States is a vast, sophisticated undertaking, which touches the lives of all Americans. At the heart of the medical system is the American physician, arguably the best-trained health professional in the world. Today, most American physicians are specialists, concentrating on a particular type of medicine. These specialists affect the character, quality, and costs of medical care.

Despite the influence of specialty medicine, its practice is essentially unregulated by government. Instead, a comprehensive private system has emerged to train and credential specialists. This system is largely based on the standards created by the twenty-four specialty boards recognized by the American Board of Medical Specialties. These private organizations assess a physician's skill through an evaluation and examination process, which uses criteria established by the boards themselves. Successful candidates are considered "board certified" specialists, a status with important implications.

Certification is a voluntary process and is not legally required to practice medicine in any jurisdiction. Likewise, neither the boards nor any other national medical organization encourages health care institutions to limit specialty practice to certified physicians alone. These realities notwithstanding, the private standards of the boards have a profound effect on physicians' practice opportunities, an effect that raises a variety of antitrust issues.

I. THE SPECIALTY BOARD SYSTEM

Specialty training and board certification are more important than ever in the practice of medicine. More than ninety percent of United States

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medical school graduates complete a formal period of specialized postgraduate training in the form of a "residency,"[1] and ninety-one percent of recent graduates are either board-certified or seeking board certification.[2] This broad acceptance has enabled certification to have a significant impact on hospital privileges, peer and patient recognition, economic compensation, and the standard of care.

A. *The Basics of Certification*

As defined by the American Board of Medical Specialties (ABMS), a specialty board is a separately incorporated, financially independent body that determines its requirements and policies for certification, selects the members of its governing body in accordance with the procedures stipulated in its bylaws, accepts its candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who submit and pass its evaluations.[3] Today, there are 24 ABMS-recognized boards.[4] These boards have generally established a three-step process for obtaining certification: (1) graduation from a Liaison Committee on Medical Education (LCME) accredited medical school or its equivalent; (2) completion of an Accreditation Council for Graduate Medical Education (ACGME) accredited residency; and (3) passage of a certification examination. Even after certifi-

1. Medical education undertaken after completion of medical school is often referred to as "postgraduate" medical education. It typically involves a residency, a period of three or more years, during which a new physician learns a specialty under the supervision of experienced physicians.

2. *History of Accreditation of Medical Education Programs*, 250 JAMA 1502, 1506 (1983) [hereinafter *History of Accreditation*].

3. ABMS is composed of the 24 specialty boards, the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the Council of Medical Specialty Societies, the Federation of State Medical Boards, and additional public representation. Recognition of a board by the ABMS requires approval by the Liaison Committee for Specialty Boards (LCSB), a committee composed of the ABMS and the American Medical Association (AMA) Council on Medical Education. AMERICAN BD. OF MEDICAL SPECIALTIES RESEARCH & EDUCATION FOUNDATION, 1992 ANNUAL REPORT AND REFERENCE HANDBOOK 43, 94 (1992) [hereinafter ABMS HANDBOOK]. Essentially, ABMS recognition amounts to acceptance of a board by mainstream organized medicine.

4. Specialty boards exist for Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family Practice, Internal Medicine, Medical Genetics, Neurological Surgery, Nuclear Medicine, Obstetrics and Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventative Medicine, Psychiatry and Neurology, Radiology, Surgery, Thoracic Surgery, and Urology. *Id.*

cation is achieved, the boards are likely to continue to affect a physician's practice, since most boards now require periodic recertification.

1. *LCME Accredited Medical School*

Candidates for certification must complete undergraduate medical education at an LCME-accredited medical school or its equivalent.[5] The LCME includes representatives of the AMA, the Association of American Medical Colleges (AAMC), the Committee for Accreditation of Canadian Medical Schools, the federal government, and medical students.[6] There is no explicit specialty board involvement at this level of medical education.

2. *ACGME Accredited Residency*

A second requirement for board certification is postgraduate training in an ACGME-accredited residency.[7] As described in the AMA's Directory of Graduate Medical Education, the primary purpose of accreditation is to provide a professional judgment as to the quality of an educational program, thus assuring the potential candidate that the program meets the standard set by professionals in that specialty.[8] While ACGME accreditation is a key requirement for certification, it has great importance in medicine generally, as the AMA and other professional organizations implicitly recommend residency training before a physician undertakes independent practice.[9]

The ACGME is composed of the AMA, AAMC, ABMS, the American Hospital Association (AHA), and the Council of Medical Specialty Societies (CMSS, an organization composed of the various medical specialty societies), as well as nonvoting representatives of the public and federal government.[10] ACGME accreditation requirements and deci-

5. Graduates from a medical school accredited by the American Osteopathic Association will also qualify.

6. *History of Accreditation*, *supra* note 2, at 1504.

7. Some intimately familiar with the certification and accreditation process feel that specialty programs can be accredited without concurrent existence of certification programs, especially in small subspecialties in which a full certification mechanism is probably unwarranted. *See, e.g.*, John A. Benson, Jr., *Certification and Recertification: One Approach to Professional Accountability*, 114 ANN. INTERN. MED. 238, 241 (1991).

8. AMERICAN MEDICAL ASS'N, GRADUATE MEDICAL EDUCATION DIRECTORY 1993-1994 9 (1993) [hereinafter AMA DIRECTORY].

9. Revision of the General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education, *in* AMERICAN MEDICAL ASS'N, DIRECTORY OF GRADUATE MEDICAL EDUCATION PROGRAMS 1992-93, 16 (1992).

10. AMA DIRECTORY, *supra* note 8, at 1.

sions in individual specialties are made in conjunction with the appropriate Residency Review Committee (RRC), a specialty-specific committee including representatives of the AMA, the concerned specialty board, and relevant specialty societies.[11]

The specialty boards influence ACGME decisions at several levels. They are represented on the ACGME by the ABMS, and are important members of their respective RRCs. Another powerful influence is the certification standards themselves: as board certification is generally the ultimate goal for physicians-in-training, accreditation standards for their training programs almost always come to reflect certification standards.

3. *Certification By A Specialty Board*

Following graduation from an LCME-accredited medical school or its equivalent, and successful completion of an ACGME-accredited residency, a physician seeking certification must satisfy the clinical proficiency and examination requirements of the certifying board for his or her specialty. Due to their subjective nature, clinical competence evaluations are rarely invoked to deny certification.[12] Consequently, the final requirements for board certification are generally met by successful performance on written examinations, and in some cases, on oral examinations as well.

4. *Recertification*

Originally, certification was a one-time process: once certified, a physician was certified for life. Faced with criticism that this system did little to encourage physicians to keep current with medical knowledge, the ABMS passed a statement endorsing the principle of recertification in 1973.[13] By 1992, most specialty boards had adopted mandatory recertifi-

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11. *See* Joseph N. Ewing, Jr., *Standards Affecting Training Programs*, *in* LEGAL ASPECTS OF CERTIFICATION AND ACCREDITATION, 87, 89 (Donald G. Langsley ed., 1983). There are actually two types of ACGME accreditation requirements: general and special. General requirements are applicable to all residency programs, while special requirements are specialty-specific. Decisions regarding special requirements are made by the ACGME, acting on the proposal of the appropriate RRC. *See* AMA DIRECTORY, *supra* note 8, at 9. Accreditation decisions on individual programs may be made either by the ACGME itself or delegated by the ACGME to an RRC. *Id.* at 1.

12. A recent study noted that only 2.5% of certification candidates in Internal Medicine did not receive satisfactory clinical ratings from their residency programs, while approximately 27% of first-time applicants failed the written examination. John M. Eisenberg, *Evaluating Internists' Clinical Competence*, 4 J. GEN. INTERN. MED. 139, 140 (1989).

13. AMERICAN BD. OF MEDICAL SPECIALTIES RESEARCH & EDUC. FOUND., 1993 ANNUAL REPORT & REFERENCE HANDBOOK 69 (1993).

cation requirements.[14] This system largely functions by issuing "time limited" certificates (i.e., certificates that expire after a period of several years), and by making new certificates contingent on passing a recertification examination.

B. *Implications of Certification*

The specialty board system amounts to a voluntary, private system of specialty regulation which uniformly applies various standards to physician-applicants. It is largely controlled by the AMA, ABMS, and the specialty boards themselves, with essentially no direct government oversight. The system's overwhelming acceptance by the medical profession has caused it to become widely pervasive and influential in American medical practice, with implications for virtually all U.S. physicians.

1. *The Position of the Boards*

Specialty boards tend to minimize certification's impact on medical practitioners and the practice of medicine. The American Board of Internal Medicine (ABIM) views certification as recognition of a number of years of specialty training and the demonstration of medical knowledge and clinical judgment, the latter established by an examination administered by the Board.[15] Individual boards and the ABMS stress that the boards do not grant licenses to practice medicine, nor have they been delegated to do so by any state legislature.[16] They also emphasize that certification is not necessary to practice a specialty or subspecialty.[17]

A respected authority on certification, John A. Benson, Jr., M.D., has noted that board certification has practical implications that the specialty boards cannot control.[18] These practical implications include salary benefits, lower malpractice insurance rates, admission to hospital staffs, election to membership in professional societies, and credibility in expert testimony.[19] Dr. Benson feels that specialty boards cannot ignore these very real implications of certification in considering the potential effects

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14. Donald G. Langsley, *Medical Competence and Performance Assessment*, 266 JAMA 977, 978 (1991).

15. Goussis v. Kimball, 813 F. Supp. 352, 355 (E.D. Pa. 1993) (citing to affidavit of John J. Norcini, Jr., M.D., Vice President for Evaluation and Research of the ABIM) [hereinafter *Norcini Affidavit*].

16. *Id.* (rejecting plaintiff's claim that denial of ABIM certification in endocrinology and metabolism subspecialties involved state action).

17. *Id.*

18. Benson, *supra* note 7, at 239.

19. *Id.*

of their certificates.[20]

2. Practical Implications of Board Certification

As Dr. Benson has noted, there are numerous real-world benefits of board certification. These benefits, the result of broad professional acceptance of the system, explain why nearly all U.S. physicians voluntarily subject themselves to specialty training and the board certification process. These same implications indicate the real power that certification and the specialty boards have assumed in the health care system.

Perhaps the most fundamental and important benefit of board certification is hospital staff privileges. Such privileges allow a physician to admit patients and practice medicine in an institution. These privileges are important for all physicians, but they are crucial to specialists whose practice absolutely requires the facilities of a hospital, such as surgeons or anesthesiologists. Accordingly, hospital privileges have very real economic implications to the individual physician.

Hospitals will often limit categories of work to board-certified specialists, effectively shutting out noncertified physicians.[21] The AHA has encouraged hospitals to use certification as an important factor in the decision to grant privileges.[22] The federal government, through the Health Care Financing Administration (HCFA), also recognizes certification as an important element in granting staff privileges. However, HCFA specifically prohibits using certification as the sole criteria for granting privileges.[23]

The ABMS, in its statement on "Delineation of Staff Privileges," does recognize that board certification may be used as "only" one of several factors in determining staff privileges.[24] It emphasizes, however, that there is no specific requirement that a physician be board-certified in a specialty or subspecialty in order to practice that skill in a hospital.[25] In closing, the ABMS statement stresses that staff privileges are an institutional responsibility and are distinctly separate from the certification

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20. *Id.*

21. STEVEN JONAS, MEDICAL MYSTERY: THE TRAINING OF DOCTORS IN THE UNITED STATES 231 (1978).

22. *See* ROSEMARY STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 253 (1971).

23. Gerald E. Thomson, *The Future Effects of Failure to Be Certified*, *in* AMERICAN BD. OF INTERNAL MEDICINE, SUMMER CONFERENCE REPORT 1989 44 (1989).

24. ABMS HANDBOOK, *supra* note 3, at 52-53.

25. *Id.*

process.[26]

Peer recognition is another benefit of board certification.[27] Besides being obvious grounds for recognition by fellow board-certified physicians, board certification is often a prerequisite for membership in prestigious professional societies.[28] Membership in these societies may be all but necessary to advance professionally and academically in certain specialties.[29]

Patients may also look to board certification in seeking a physician. Today's patients, especially the more educated and affluent, will often bypass generalists to deal directly with a specialist.[30] In such an environment, a physician who is not board-certified may be subject to a competitive disadvantage vis-a-vis his or her certified peers.[31]

Board-certified physicians are widely believed to enjoy higher salaries than their noncertified peers. As early as the 1930s, specialists were recognized as having consistently higher incomes than general practitioners.[32] Some commentators believe that board-certified specialists earn more only because they work more hours than nonboard-certified peers.[33] Others, however, note a significant income advantage to board certification without such qualifications.[34]

Finally, board certification has an impact on medical malpractice, in establishing both the standards for expert testimony and the standard of practice for the physician accused of malpractice. Some feel that board-certified practitioners are held to a higher standard of care, a standard which crosses over the arbitrary line of the old "locality" rule.[35] Others see certification having an impact upon the entire malpractice proceed-

26. *Id.*

27. Benson, *supra* note 7, at 239.

28. *Id.*

29. *See* Treister v. American Academy of Orthopaedic Surgeons, 396 N.E.2d 1225 (Ill. App. Ct. 1979).

30. STEVENS, *supra* note 22, at 196.

31. Note that here the effect of board certification may not be as strong as recognition in the peer context, as there are numerous non-ABMS boards that may be willing to certify a physician not certified by an ABMS board. In addition, a physician may be able to hold him or herself out to the public as a specialist, regardless of certification status. In any event, even relatively sophisticated health care consumers may be unaware of the difference between a non-ABMS board certified physician and one certified by an ABMS board.

32. STEVENS, *supra* note 22, at 176.

33. Benson, *supra* note 7, at 241.

34. Thomson, *supra* note 23, at 45.

35. *See, e.g.*, Buck v. St. Clair, 702 P.2d 781, 785 (Idaho 1985) (holding that the local standard of care for "nationally board-certified specialists" is the same as the national standard of care).

ing, affecting the thinking and decisions of both judges and juries.[36]

II. Basic Antitrust Doctrine

The United States has a longstanding national policy against economic arrangements that restrain interstate trade. The extensive, nationwide scheme of private regulation that is the specialty board system carries with it the potential to restrain such trade, and thus invoke liability under the Sherman Antitrust Act and related legislation.

A. Statutory Basis

The national policy against arrangements in restraint of interstate trade is largely found in the Sherman Act. Section 1 of the Sherman Act provides: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."[37] As interpreted by the courts, a Section 1 claim requires three elements: (1) a contract, combination, or conspiracy; (2) restraint of trade; and (3) an effect on interstate commerce.[38]

Section 2 of the Sherman Act provides a mandate against persons who monopolize or attempt to monopolize.[39] Courts interpreting this provision have recognized two factors necessary for a successful action: (1) the possession of monopoly power in the relevant market; and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.[40]

The Sherman Act also requires that the activity under scrutiny affect interstate commerce. Today, this "effects test" is very lenient, satisfied even in instances where the activity has a predominantly local effect.[41]

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36. Thomson, *supra* note 23, at 45.

37. 15 U.S.C. § 1 (1988 & Supp. III 1992).

38. Weiss v. York Hosp., 745 F.2d 786, 812 (3d Cir. 1984) (citations omitted).

39. 15 U.S.C. § 2 (1988 & Supp. III 1992).

40. *Weiss*, 745 F.2d at 825 (citing United States v. Grinnell Corp., 384 U.S. 563, 570-71 (1966)).

41. *See, e.g.*, Marrese v. Interqual, Inc., 748 F.2d 373, 383 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985) (finding the effects test satisfied in an antitrust challenge to a hospital's peer review system). The plaintiff physician alleged that he treated out-of-state patients, purchased medicine, equipment, and medical supplies from out-of-state purveyors, derived revenues from Medicare, Medicaid, and out-of-state private insurance companies, and paid management and accounting fees to out-of-state consultants. *Id.*

B. Judicial Interpretation

Federal courts have exclusive jurisdiction over Sherman Act and related federal antitrust actions, while the United States Supreme Court is the ultimate interpreter of the underlying statutes.[42] The Court has recognized that the language of the Sherman Act cannot be read literally, as such an interpretation would reach virtually every contract and agreement in the economy. Accordingly, the Sherman Act is seen as granting antitrust jurisdiction to the federal courts, with broad yet fluid coverage.

The initial antitrust analysis employed by the Court came to be known as the "rule of reason." As articulated in *Chicago Board of Trade v. United States*, the test 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. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts.[43]

Thus, a court applying this test is free to consider the facts and circumstances of the restraint at issue.

Subsequently, the Court developed a more stringent test to evaluate restraints recognized as having predominantly anticompetitive effects. As explained in *Northern Pacific Railway v. United States*, the "per se" rule covers: ". . . certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use."[44] Practices that are generally subject to this analysis include horizontal and vertical price fixing agreements, horizontal territorial restrictions, tying arrangements, and certain group boycotts.[45]

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42. *See, e.g.*, Marrese v. American Academy of Orthopaedic Surgeons, 470 U.S. 373 (1985).

43. Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).

44. Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

45. United States v. Brown Univ., 805 F. Supp. 288, 299 (E.D. Pa. 1992), *rev'd on other grounds*, 5 F.3d 658, 678 (3d Cir. 1993). Vertical arrangements are those between businesses and their suppliers and/or distributors; horizontal arrangements involve businesses competing in the same type of economic activity, e.g., manufacturing, distributing, or retail

Thus, once a plaintiff presents a threshold case of an activity that is illegal per se, there is generally no inquiry into the facts when determining antitrust liability.[46]

The stark contrast between the rule of reason and the per se rule may be less pronounced than the respective analyses indicate. Justice Powell once commented that characterization of an activity is the only real difference between the two tests; as such, per se analysis is really not a question of labels as much as applying labels to conduct.[47] In addition, there are a variety of immunities and related doctrines that complicate the application of these basic tests in certain situations, particularly activities of the learned professions.[48]

C. *Enforcement*

Enforcement of federal antitrust laws comes from several sources. The federal government may bring actions either through the Department of Justice or the Federal Trade Commission. However, the overwhelming majority of antitrust actions are private, brought either by private citizens or by the states in their "parens patriae" capacity on behalf of their respective citizens.[49] The states also enforce their own antitrust laws, which

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sales. Tying arrangements involve situations in which the sale of one product or service is "tied" to the purchase of another product or service. Lastly, the type of group boycott subject to per se analysis is a matter of debate. For example, Circuit Judge Posner feels that such activity cannot be considered per se illegal unless the boycotts are used to enforce agreements that are themselves illegal per se. Marrese v. American Academy of Orthopaedic Surgeons, 692 F.2d 1083, 1093 (7th Cir. 1983), *rev'd on other grounds*, 470 U.S. 373 (1985).

46. Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284, 297-98 (1985).

47. Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 362 (1982) (Powell, J., dissenting).

48. The learned professions doctrine generally affords rule of reason analysis to professional activities that involve public service or ethical norms. *See infra* note 85 and accompanying text. The doctrine does not fashion a broad antitrust exemption for the professions under the rule of reason. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975); National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 696 (1978). In addition, there is true antitrust immunity for state action under the *Parker* doctrine, and for legislative advocacy under the *Noerr-Pennington* doctrine. There is no state involvement in the specialty board system at present. The topic of legislative advocacy and the boards is beyond the scope of this analysis.

49. During the 1980s, there were 10 private suits for every suit brought by the federal government. E. THOMAS SULLIVAN & HERBERT HOVENKAMP, ANTITRUST LAW, POLICY AND PROCEDURE 77 (2d ed. 1989).

are assuming a growing importance in antitrust litigation.[50]

III. Antitrust Principles Applied to the Specialty Boards

A. A Historical Perspective

Concern about antitrust liability for the activities of specialty boards is almost as old as the boards themselves. Much of the early anxiety focused on a 1943 decision, *American Medical Ass'n v. United States*, involving an attempt by the AMA and the Medical Society of the District of Columbia to undermine a government prepaid health plan.[51] The Court had little problem finding antitrust liability in the scheme, in which hospitals participating in the plan were threatened with loss of AMA approval for their postgraduate physician training programs, and participating physicians were threatened with loss of membership in both the AMA and District of Columbia Medical Society.[52] The holding left no doubt that organized medicine was subject to antitrust laws, and that antitrust liability applied to attempts by organized medicine to limit the practice of physicians and influence hospital policies.

At the time of *American Medical Ass'n*, many hospitals and specialty boards were advocating certification as an essential requirement for granting hospital privileges. In the wake of *American Medical Ass'n*, those organizations began to rethink their position.[53] In 1947, the AMA's Council on Medical Education disclaimed any responsibility for encouraging board certification as an important credential for hospital staff appointments.[54] Subsequently, the Advisory Board for Medical Specialties (predecessor of the ABMS), the American Board of Surgery, and several other boards adopted the position that they were not concerned with hospital privileges for board-certified physicians.[55]

The specialty board policy disclaiming any particular use of their certificates continues to this day. For example, the ABMS's general statement on the purpose of certification reads:

> The intent of the certification process, as defined by the Mem-

50. An analysis of state antitrust laws and their implications is beyond the scope of this discussion.

51. American Medical Ass'n v. United States, 317 U.S. 519 (1943). It is important to note such a plan was quite revolutionary at the time, and was viewed as an economic threat by organized medicine.

52. *Id.*

53. Stevens, *supra* note 22, at 307.

54. *Id.*

55. *Id.* at 308.

> ber Boards of the American Board of Medical Specialties, is to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality patient care in that specialty.[56]

This position is reinforced by the ABMS's Statement on the Delineation of Staff Privileges. The ABMS's statement recognizes that certification may be considered as "only one of several valid and important criteria" in granting staff privileges, but it emphasizes that it does not specifically require a physician to be board-certified to obtain hospital privileges in a specialty or subspecialty.[57]

B. The Argument for Antitrust Liability

Despite the position of the ABMS and the specialty boards, there is no question that board certification does have some effect on commerce. This effect may be characterized as a restraint of trade under a number of theories.

1. The Necessity of Economic Significance

Any antitrust theory invoked against the specialty boards must be based on the contention that certification carries with it considerable economic significance. Without such economic impact, denial of certification could not be characterized as restraining trade.

There is no question that the boards have an economic effect on physicians' practice through third party use of certification standards. However, it is not clear that setting these standards — since meeting the standards is not a legal requirement to practice medicine[58] — affects commerce to the degree that would invoke antitrust liability.[59] In addi-

56. ABMS HANDBOOK, *supra* note 3, at 51.

57. *Id.* at 52-53.

58. The overwhelming majority of U.S. jurisdictions do not legally require board certification to practice medicine. In a notable exception, New York State, beginning in 1993, requires emergency room physicians to be board certified or board eligible in emergency medicine, family medicine, internal medicine, or surgery in order to practice. This requirement has led to an antitrust challenge to the certification requirements of the American Board of Emergency Medicine. *See* Daniel v. American Bd. of Emergency Medicine, 802 F. Supp. 912 (W.D.N.Y. 1992). The case is described *infra* note 78.

59. This lack of board impact on commerce is implied in Flegel v. Christian Hosp. Northeast-Northwest, 804 F. Supp. 1165 (E.D. Mo. 1992), *reh'g denied*, 4 F.3d 682 (8th Cir. 1993) (involving a requirement of ABMS certification or board-eligible status for hospital privileges). *See infra* notes 112-116 and accompanying text. The *Flegel* court upheld the

tion, the absence of direct or indirect board activity to enforce any particular application of certification standards makes it very difficult to demonstrate that board conduct has any direct commercial effect at all, let alone an impact which could be considered a restraint of trade.[60]

2. *Group Boycott or Refusal to Deal*

Under current antitrust doctrine, board certification is most easily characterized as a group boycott or refusal to deal, as the boards simply grant or deny a physician the privilege of certification.[61] A basic group boycott/refusal to deal claim could involve allegations of a conspiracy between a certifying board and a hospital that requires board certification for staff privileges, a conspiracy which limits the practice of non-certified physicians and consequently restrains trade.[62]

The structure of the boards themselves may contain elements of a group boycott/refusal to deal theory. As organizations comprised of physician specialists — potential competitors who set standards for themselves and other physician-competitors in the various specialty fields — the boards could be characterized as conspiracies among competitors in restraint of trade. The Supreme Court, in *American Society of Mechanical Engineers v. Hydrolevel Corp.*[63] and in *Allied Tube & Conduit Corp.*

use of the ABMS certificates as prerequisites for staff privileges, but failed even to address the standard-setting activities of the boards in its discussion of the merits. Where certification is legally required for the practice of a medical specialty, as in *Daniel*, the impact of certification requirements on commerce becomes much more concrete, and may actually rise to the level necessary to prevail in an antitrust action. *See infra* note 78.

60. Note how this argument parallels the argument made in Schachar v. American Academy of Ophthalmology, Inc., 870 F.2d 397 (7th Cir. 1989), in which the court looked to the nature of ophthalmological services, with literally thousands of "competitors," and the lack of any enforcement mechanism for a position taken by the academy. The court then went on to hold that there can be no restraint of trade without a restraint. *See infra* notes 93-95 and accompanying text.

61. Note that under a group boycott theory, the right or privilege at issue does not have to constitute an "essential facility." *See infra* notes 68-72 and accompanying text (discussing the essential facilities doctrine).

62. Lending additional weight to such an argument is the general nature of the license held by all physicians who can legally render medical care: as such a license technically grants its holder the unrestricted right to practice medicine, any certification mechanism that denies this right may be seen as an illegal restraint of trade.

63. 456 U.S. 556 (1982) (involving a nonprofit organization that promulgated widely-adopted advisory codes). The society was found to be liable under the antitrust laws because its members, who were also officers in a firm which competed with the plaintiff firm, used their position within the society to economically disadvantage the plaintiff firm. *Id.* at 565-66. The Court held that principals, in this case the society, are liable when their agents (members) act with apparent authority. The Court defined such authority as "the power to

v. Indian Head, Inc.,[64] has explicitly recognized that such organizational structures carry with them the risk of anticompetitive effects.[65]

Any group boycott/refusal to deal claim based on a pure conspiracy or a conspiracy among competitors theory faces a significant obstacle in the establishment of an underlying conspiracy: a party alleging that conspiracy must produce evidence to exclude the possibility that "conspirators" acted independently. The party alleging a conspiracy must exclude this possibility in order to prove a conscious commitment to a common scheme designed to achieve an unlawful objective.[66] In the context of board certification, a party must produce actual evidence that the boards conspired either with other entities or with their own members acting as individuals to prove the required conspiracy; a mere possibility of such a conspiracy is not sufficient.[67]

The boards may also be implicated under another type of group boycott theory, the "essential facilities" doctrine.[68] The doctrine is applicable to situations in which an organization denies an economically vital

affect the legal relations of another person by transactions with third persons, professedly as agent for the other, arising from and in accordance with the other's manifestations to such third persons." *Id.* at 566 n.5 (citing RESTATEMENT (SECOND) OF AGENCY § 8 (1957)). Justice Powell, dissenting, noted a real danger in the *Hydrolevel* ruling: the possibility of extending antitrust liability to standard setting organizations, even though the actions of the agent were never ratified or authorized, and even though the organization derived no benefit whatsoever from the fraudulent actions of the agent. *Id.* at 579 (Powell, J., dissenting).

64. 486 U.S. 492 (1988). In *Allied Tube*, the Court noted the potential for serious anitcompetitive harm where a standard-setting organization is composed of competitors with both horizontal and vertical business relationships. *Id.* at 500 (citing 7 PHILLIP E. AREEDA, ANTITRUST LAW 373 (1986)).

65. This rationale is seen in Daniel v. American Bd. of Emergency Medicine, 802 F. Supp. 912 (W.D.N.Y. 1992), in which a physician challenged a board's refusal to admit him to the certification examination in Emergency Medicine. In refusing to dismiss the complaint, the district court observed that the board resembled a professional association, as the board itself was composed of physicians who had taken and passed the certification examination in emergency medicine. *Id.* at 924 (citations omitted).

66. Wilk v. American Medical Ass'n, 895 F.2d 352, 375 (7th Cir.), *cert. denied*, 498 U.S. 982 (1990) (citing Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 574, 597-98 (1986); Monsanto v. Spray-Rite Servs., 465 U.S. 752, 764 (1984)).

67. It is doubtful that a board member, acting in his or her official capacity, could be viewed as conspiring with his or her own board in undertaking an official board action.

68. The essential facilities doctrine originated in Court decisions that actually involved refusals to deal. *See, e.g.*, United States v. Terminal R.R. Ass'n, 224 U.S. 383 (1912), Associated Press v. United States, 326 U.S. 1 (1945). The concept of an essential facility is similar to that of monopolization. Violations occur when a competitor is denied access to another party's facility that the competitor requires in order to do business. For a more complete discussion of the doctrine, see SULLIVAN & HOVENKAMP, *supra* note 49, at 590-92.

"good" to a third party.[69] Its relevance to board certification is implicitly confirmed in the latest chapter of *Marrese v. American Academy of Orthopedic Surgeons.*[70] The Seventh Circuit referred to certification in parallel with licensure as a key requirement to practice medicine: as a medical license is an absolute requirement to practice medicine, this treatment indicates that the court believed certification to be similarly important.[71] Despite the *Marrese* court's reasoning, it would be very difficult to demonstrate that certification is an "essential facility," as certification is not an absolute requirement to practice specialty medicine.[72]

3. *The Specialty Boards as a Monopoly*

It may be possible to characterize the boards as either a monopoly or an attempt to monopolize under Section 2 of the Sherman Act. It is important to note that Section 2 does not render an organization illegal merely because it constitutes a monopoly. Rather, a monopoly and some anticompetitive conduct is necessary for a violation.[73]

According to an often-discussed Section 2 theory, certification acts as a restriction to protect certified physicians from the legitimate competition of noncertified physicians.[74] An ancillary argument under this theory is that the boards are designed to protect the existing "turf" of organized medicine, by preventing the formation of new specialties and subspecialties.[75]

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69. *See, e.g.*, Silver v. New York Stock Exch., 373 U.S. 341 (1963) (finding antitrust liability where the Exchange denied a nonmember private wire connections to member brokers). The Court characterized the Exchange's actions as amounting to a per se illegal group boycott, but in the face of specific federal legislation regulating the exchange, refused to apply a per se rule. *Id.* at 347.

70. Nos. 91-1366 and 91-1508, 1992 U.S. App. LEXIS 25530 (7th Cir. 1992) (unpublished order).

71. *Id.* at *16.

72. *See* Goussis v. Kimball, 813 F. Supp. 352, 355 (E.D. Pa. 1993) (specifically finding that certification is not necessary to practice medicine in the context of an international medical graduate's challenge to the ABIM's subspecialty certification system). The only absolute requirement to practice any type of medicine in the U.S. is a valid state medical license.

73. *See supra* notes 39-40 and accompanying text.

74. Joel I. Klein, *The Antitrust Laws and Medical Specialty Certification*, *in* LEGAL ASPECTS OF CERTIFICATION AND ACCREDITATION 17, 20 (Donald G. Langsley ed., 1983). A variation of this theory is "attempted monopolization," which is another Section 2 violation. *See Daniel*, 802 F. Supp. at 927 (allowing an attempted monopolization allegation to survive a motion to dismiss in legal action against the American Board of Emergency Medicine).

75. Klein, *supra* note 74, at 20.

A successful Section 2 claim requires demonstration of market power, which may be difficult to establish, given the questionable impact of board activities on commerce.[76] Even if such market power is found, Section 2 demands anticompetitive conduct, in the form of either willful acquisition or maintenance of market power, a difficult burden when a board has taken no action to preserve its preeminent position.[77]

C. Judicial Application of Antitrust Doctrine to Issues in Board Certification

There are a number of theories under which the specialty boards could be subject to liability under current antitrust doctrine. While antitrust suits are commonly filed against health care institutions and professional societies, federal antitrust actions with the specialty boards as named parties are rare.[78] Potential board liability is thus largely analyzed by analogy to cases where private parties establish standards in the name of quality or safety. These standards may have the ancillary effect of restraining competition.

1. Direct Application of "Private" Standards To Third Parties

This line of cases involves private parties who formulate and then apply standards to third parties, a fact pattern very similar to that found in the specialty boards' private system of regulation.

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76. *See supra* notes 58-60 and accompanying text (describing the boards' effect on commerce).

77. *See supra* notes 39-40 and accompanying text.

78. There is only one reported federal antitrust action involving a specialty board. Daniel v. American Bd. of Emergency Medicine, 802 F. Supp. 912 (W.D.N.Y. 1992) (involving an antitrust challenge to the board's actions in discontinuing the so-called "practice track"). The practice track allowed practicing emergency physicians, who met specified conditions, to sit for the certification examination in Emergency Medicine without the need to complete a residency in Emergency Medicine. Plaintiff Daniel, who had completed a residency in General Surgery, failed to satisfy the conditions before the "practice track" was discontinued in 1988; after the Board refused to admit him to the exam, he filed suit, requesting an injunction to gain admission to the certification examination. The case was complicated by New York state law, which required the plaintiff to be board certified in order to practice emergency room medicine. *See supra* note 58.

Daniel is only a district court ruling upholding a magistrate's order refusing to dismiss the complaint. The lack of a holding on the substantive issues involved, the absence of an appellate court ruling, and the presence of the New York law requiring certification for Emergency Medicine practice all lessen the precedential value of the case. Nonetheless, it demonstrates that federal courts will entertain antitrust actions against the specialty boards.

a. Medical Organizations and Admission Standards

Courts have generally supported the right of medical organizations to limit admission to their membership as they see fit. An example is *Marrese v. American Academy of Orthopedic Surgeons*, in which the Seventh Circuit found no restraint of trade where an orthopedic surgeon was denied membership in an organization that allowed members to associate with or refer patients to nonmembers.[79] The court added that even if the denial of membership "stigmatized" the physician who was denied admission, such stigmatism did not affect competition in a way that would invoke the antitrust laws.[80]

There is no Supreme Court decision addressing the right of a medical organization to set standards and limit membership. However, in *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.*, the Court upheld the right of a buying cooperative to exclude a potential competitor from its organization.[81] This freedom to exclude exists unless an organization possesses market power or exclusive access to an element necessary for effective competition; if either condition is present, however, there is the possibility that exclusion will have an anticompetitive effect.[82]

Marrese appears to follow the line of "necessary element" analysis the Court alluded to in *Northwest Wholesale Stationers*.[83] Specifically, the *Marrese* court implied that certification may actually be an "essential element" of competition such that its denial may have an anticompetitive effect.[84] Thus, denial of board certification may not be evaluated under the same lenient analysis as denial of membership in a medical specialty society.

79. *Marrese*, 1992 U.S. App. LEXIS 25530.

80. *Id.* at *18-19.

81. Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284 (1985). This case marked the beginning of a relaxation of antitrust law as applied to group boycotts, generally subjecting such activities to the rule of reason.

82. *Id.* at 296.

83. Note also the analogy to the essential facilities doctrine *supra* notes 68-72 and accompanying text.

84. *Marrese*, 1992 U.S. App. LEXIS 25530, at *16 (noting that denial of membership in a professional organization did not constitute a restraint of trade and that membership was not necessary for either licensure or to take board examinations). Discussing a key requirement for board certification in parallel with medical licensure, an absolute requirement for the practice of medicine, indicates that the *Marrese* court considered certification to be of great importance in the practice of medicine.

b. Setting "Industry Wide" Standards

Courts generally afford deferential treatment to standards set by professional organizations, particularly when an organization can demonstrate legitimate safety or ethical considerations underlying those standards. As stated in *National Society of Professional Engineers*, ethical norms that promote and regulate competition within a profession are subject to a rule of reason analysis.[85] Justice Blackmun, concurring in *National Society of Professional Engineers*, clearly felt that this rule of reason treatment should be extended to ethical rules with more than "de minimis" anticompetitive effects. He specifically noted "[a] medical association's prescription of standards of minimum competence for licensing or certification . . ." as one such case.[86]

The Court reinforced this rule of reason analysis in *Allied Tube*, in which competitors adopted industry-wide standards by consensus.[87] Specifically, the opinion recognized the potential for pro-competitive benefits of safety standards based on objective, expert judgement, if the private organizations setting such standards employ procedures that prevent the process from being abused.[88] Medical specialty boards may be characterized as such organizations, entitled to rule of reason analysis when their standards are the product of reasonable and fairly applied decision-making mechanisms.

The Court addressed private standard setting in the provision of health care in *Federal Trade Commission v. Indiana Federation of Dentists*.[89] There, rule of reason analysis was invoked where a dental society refused to provide x-rays to third party payers, with the Court noting its reluctance to condemn rules adopted by professional organizations as illegal per se.[90] Taken together with *National Society of Professional Engineers*

85. National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679 (1978) (addressing the "learned professions" doctrine). According to this doctrine, the professions are afforded special treatment under antitrust laws, following the Supreme Court's sound rejection of an unqualified antitrust exception for the professions. *Goldfarb*, 421 U.S. at 788-98 n.17. The Court used the opportunity provided by *National Soc'y of Professional Engineers* to further refine the doctrine, holding that the professions were entitled to rule of reason treatment in situations involving ethical norms which promote and regulate competition 435 U.S. at 696.

86. 435 U.S. at 700 (Blackmun, J., concurring).

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

88. *Id.* at 500.

89. 476 U.S. 447 (1986).

90. *Id.* at 458. Though the Court nominally applied rule of reason analysis in ruling against the Federation, it did not consider the market effects of the challenged restraint. As the rule of reason normally includes such analysis, the test applied in *Indiana Fed'n of*

and *Allied Tube*, this decision strongly suggests that private, standard-setting organizations such as the boards are entitled to rule of reason analysis.

Lower courts generally afford similar if not greater deference to private, standard-setting organizations. *Marjorie Webster Junior College v. Middle States Ass'n of Colleges & Secondary Schools, Inc.*, dealt with a proprietary junior college's antitrust challenge to a voluntary, nonprofit accreditation association's policy of refusing to extend accreditation to for-profit institutions.[91] In declining to find antitrust liability, the U.S. Court of Appeals for the District of Columbia Circuit held that antitrust laws are not applicable to restrictions that are not commercial, that only incidentally restrain trade, and that are not intended to have an effect on the commercial aspects of a profession.[92]

This same lower court deference has been applied to certain standards established by private medical groups. *Schachar v. American Academy of Ophthalmology* examined an Academy statement endorsing a National Eye Institute report classifying "radial keratotomy" as an experimental procedure; a group of ophthalmologists who performed the operation claimed that this statement decreased demand for their services and therefore restrained trade.[93] The *Schachar* court held that where thousands of providers are present in a market such as ophthalmology,

Dentists is often considered something less than the rule of reason. A partial explanation for this treatment may lie in the practice's prior history. Originally, the Indiana Dental Association formulated the policy of refusing to provide third-party payers with x-rays, but the association was subsequently subject to an FTC consent decree, which ordered it to cease and desist the practice on antitrust grounds. The Indiana Federation of Dentists, a much smaller splinter group of the Indiana Dental Association, was founded as an organization opposed to the consent decree and committed to continuing the policy of denying x-rays to third parties. Thus, there was little question that the actions of the Federation constituted antitrust violations as outlined in the consent decree. The situation was complicated by the quality of care argument presented by the federation, a contention which probably weighed in favor of some type of rule of reason analysis, despite the almost certain illegality of the practice itself.

91. Marjorie Webster Junior College v. Middle States Ass'n of Colleges & Secondary Schools, Inc., 432 F.2d 650 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970).

92. *Id.* at 654. The court's deference to the "learned professions" may have anticipated the rule of reason approach of the later *Goldfarb* decision.

93. Schachar v. American Academy of Ophthalmology, 870 F.2d 397 (7th Cir. 1989). Radial keratotomy corrects the optical defect that produces nearsightedness. The procedure involves making a number of small incisions in the eye itself. The Academy's endorsement of the institute's position can almost certainly be characterized as a safety standard, given radial keratotomy's similarity to an unsuccessful procedure attempted in the 1950s.

there must be an enforcement mechanism to effect a restraint of trade.[94] This decision potentially affords specialty boards great latitude in setting standards under antitrust law, as long as no formal or informal mechanisms to "enforce" the standards are employed.[95]

The Seventh Circuit also applied a rule of reason analysis to a medical association's ethical standards. In *Wilk v. American Medical Ass'n*, a group of chiropractors alleged that the AMA and other physicians' and hospital groups had been engaged in an illegal restraint of trade directed against the chiropractic profession.[96] Key to this alleged antitrust violation were the AMA Principles of Medical Ethics, which provided that "[a] physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate with anyone who violates this principle."[97] Chiropractors had been determined to be "unscientific practitioners" by the AMA, thus excluding their interaction with AMA members.[98]

Despite this blatant restriction and evidence which tended to support the contention that economic and not scientific considerations actually formed the basis for the AMA's position, the court applied the rule of reason. According to the court, a canon of medical ethics, not unfrivolously purporting to address the importance of the scientific method, gives rise to questions of sufficient delicacy and novelty as to escape per se treatment.[99] Though the court went on to hold that the AMA's conduct did in fact violate antitrust laws, it noted that a legitimate concern for patient care would have served as a justifiable excuse for the Association's activities.[100] Specifically, the court stated that four factors should be considered in determining if such an excuse exists: (1) whether the association genuinely entertained a concern for what they perceive as the scientific method in the care of each person with whom they have entered into a doctor-patient relationship; (2) whether this concern is objectively reasonable; (3) whether this concern had been the dominant motivating

94. *Id.* at 399. In addition, the court held that the "towering reputation" of an organization does not prevent it from speaking out on a subject of concern. *Id.*

95. Note that this "no enforcement" requirement closely parallels the current "hands off" policy of the boards with regard to the ultimate use(s) of their certificates. Thus, under the rationale of *Schachar*, it would be difficult to successfully attack the current specialty board scheme on antitrust grounds.

96. Wilk v. American Medical Ass'n, 895 F.2d 352 (7th Cir. 1990).

97. *Id.* at 355 n.1 (quoting AMA Principles of Medical Ethics, Former Principle 3).

98. *Id.* at 355.

99. *Id.* at 359.

100. *Id.* at 362.

factor in the decision to promulgate an ethical standard and the conduct intended to implement it; and (4) whether this concern for the scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition.[101]

Wilk and *Schachar*, in conjunction with related Supreme Court precedent, indicate that private medical organizations which set legitimate, unenforced medical practice standards would most likely receive the deferential rule of reason analysis in the face of an antitrust challenge. This rationale is clearly applicable to the boards as private entities promulgating non-binding professional standards.

c. *Hospital Privileges*

The process by which hospital privileges are extended, denied or terminated involves decisions by private and public actors, ostensibly based on patient safety and quality of care considerations.[102] Staff privilege decisions are therefore a direct application of "institutional" standards to an individual physician, which may seriously affect that physician's ability to practice medicine. When the denial or termination of privileges results in a legal challenge, antitrust allegations are usually included as part of an "arsenal" of federal and state claims against the involved institution.

Courts addressing such antitrust challenges are overwhelmingly deferential to hospital staffing decisions where legitimate medical reasons form the basis for denial or termination of privileges.[103] This deference has been extended to the use of peer review in privilege decisions.[104] Many courts have also held that a medical staff is entitled to exclude a physician on grounds of unprofessional conduct as well as professional incompetence.[105]

Court treatment of staff privilege decisions again illustrates the judicial

101. *Id.* (quoting Wilk v. American Medical Ass'n, 719 F.2d 207, 227 (7th Cir. 1983)).

102. Whether these decisions are made by private or public actors depends on the nature of the institution itself and the employment status of those taking part in the decision-making process. Note also that economics can play a role in privilege decisions.

103. *See* Johnson v. Nyack Hosp., 964 F.2d 116, 121 (2d Cir. 1992); Marrese v. American Academy of Orthopaedic Surgeons, Nos. 91-1366 and 91-1508, 1992 U.S. App. LEXIS 25530, at *10 (7th Cir. Oct. 1, 1992); Brown v. Our Lady of Lourdes Medical Ctr., 767 F. Supp. 618, 628 (D.N.J. 1991), *aff'd without opinion*, 961 F.2d 207 (3d Cir. 1992).

104. *Marrese*, 1992 U.S. App. LEXIS 25530, at *9. Note that the Health Care Quality Improvement Act of 1986 has granted limited antitrust "immunity" to peer review. *See* 42 U.S.C. §§ 11111-11115 (1988). Some, however, feel that the qualifications to this "immunity" are such that its protections lack practical effect. *See generally* Charity Scott, *Medical Peer Review, Antitrust, and the Effect of Statutory Reform*, 50 MD. L. REV. 316 (1991).

105. *See Brown*, 767 F. Supp. at 628.

deference afforded to ostensibly medical decisions, even where the economic effects of these decisions may be profound. This deference is especially notable because privilege committees are often composed of physicians who are potential competitors of those challenging the privilege decision. Given the medical nature of specialty board decisions, their economic effect, and the presence of physician-competitors on the boards, a strong analogy can be drawn between the antitrust issues confronting the boards and hospital privilege decisions: demonstrated judicial deference in the context of privilege decisions indicates a tendency towards such deference with the boards.

2. *Application of Specialty Board Standards by Third Parties*

While the private standards established by the specialty boards have not been the subject of a direct antitrust challenge, these standards and those of similar professional organizations have been used as a basis for decisions by third parties. Challenges based on these third-party decisions give insight into prospective judicial treatment of the standards themselves, and provide perhaps the best evidence of the judicial deference likely to be applied to direct antitrust challenges of the boards.

The Supreme Court has never ruled on an antitrust challenge to the application of specialty board standards by third parties, though several notable lower federal court decisions have addressed similar questions. In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, the Fourth Circuit found that a joint refusal by Blue Shield of Virginia and another plan to reimburse its insureds directly for the services of psychologists violated the Sherman Act.[106] The position of Blue Shield was at least partially due to the recommendation of a physicians' specialty society, the Neuropsychiatric Society of Virginia.[107] Despite its role in establishing what was found to be an illegal restraint of trade, the court held that the society could advocate its position without antitrust liability, so long as no coercion was employed to further that position.[108] Lawyers familiar with board certification have cited this decision as support that specialty boards may advocate the use of their certificates for various purposes without incurring antitrust liability.[109]

The Third Circuit addressed an indirect application of board standards

106. Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 484-85 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).
107. *Id.* at 483.
108. *Id.*
109. Klein, *supra* note 74, at 25.

in *Weiss v. York Hospital*, where an osteopathic physician challenged his denial of hospital privileges. The system at issue generally afforded osteopaths the lowest level of privileges, while allopathic physicians were given higher levels based on skills established through board certification.[110] The court held that per se treatment is normally applied to such a group boycott, but noted that the rule of reason was appropriate where the qualifications of health care professionals are at issue in privilege decisions.[111] Though the court did not find that such qualifications were at issue in the facts before it, the decision indicates that the use of specialty board standards, and perhaps the content of the standards themselves, may be subject to rule of reason analysis where medical qualifications are being evaluated.

Perhaps the most important antitrust case in which specialty board standards were an issue is *Flegel v. Christian Hospital Northeast-Northwest*.[112] *Flegel*, like *Weiss*, addressed a challenge by osteopathic physicians to hospital privilege decisions employing board standards. Importantly, Christian Hospital did not merely assign a level of hospital privileges linked to board certification; it required certification by an ABMS-recognized board, or eligibility for such certification, to qualify for privileges.[113] Several reasons were offered by the institution to justify this position: (1) to enhance the reputation of the hospital; (2) to respond to community concerns about the hospital's quality; and (3) to satisfy the requirements of hospital accrediting organizations.[114]

The *Flegel* court, applying rule of reason analysis to the hospital's privilege policy, found no violation of antitrust laws.[115] Importantly, the court noted that the conduct of the institution did not fall into a category likely to have predominantly anticompetitive effects, nor was the economic impact of the practice immediately obvious.[116] As the standards of board certification were the de facto requirement for privileges at Christian

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110. Weiss v. York Hospital, 745 F.2d 786, 791-96 (3d Cir. 1984).

111. *Id.* at 820.

112. 804 F. Supp. 1165 (E.D. Mo. 1992), *aff'd*, 4 F.3d 682 (8th Cir. 1993).

113. *Id.* at 1169.

114. *Id.*

115. *Id.* at 1172. Interestingly, the district court also found no constitutional equal protection violation as a result of this policy. The Eighth Circuit did not reach this issue.

116. *Id.* at 1173. The appellate court declined to make such a general holding, focusing instead on the facts before it and concluding there was insufficient evidence of actual detrimental effects on competition. Flegel v. Christian Hosp. Northeast-Northwest, 4 F.3d 682, 688-89 (8th Cir. 1993).

Hospital, the decision may be seen as explicit judicial approval of the board's substantive standards.

IV. Conclusion: The Boards and Antitrust

There are no major cases addressing substantive federal antitrust issues in the context of board certification, thus making definitive analysis impossible. Decisions addressing organizations and issues similar to those found in board certification do, however, give respectable insight into possible treatment of the specialty boards.

Emerging from this case law are several trends. Initially, courts appear to favor the application of the rule of reason to legitimate professional standards promulgated by private organizations. The availability of this treatment, and the deference afforded by the courts in actually applying it, appear to depend heavily on one and perhaps two factors. The key consideration is whether the record suggests that the standard at issue was promulgated primarily for economic reasons. If such a motive is present, courts will either apply a per se rule, or quickly find liability while ostensibly applying the rule of reason.[117] Another qualification may exist where the privilege or benefit denied by application of private standards effectively prevents an individual from engaging in an economic activity, i.e., the privilege or benefit is of paramount commercial significance.[118] Should neither condition exist, there is strong evidence of significant judicial deference under the rule of reason to medical or academic standard decisions.[119]

The specialty boards as they presently exist promulgate certification standards based on the medical knowledge deemed necessary to practice

117. Federal Trade Comm'n v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986) ostensibly involved application of the rule of reason, although the Court wasted relatively little time in finding antitrust liability where the federation's motives in denying third-party payers x-rays appeared to have more to do with economics than with quality of care. *See supra* notes 89-90 and accompanying text; *see, e.g.*, Weiss v. York Hosp., 745 F.2d at 820, where the court explained why the rule of reason should be applied to hospital privilege decisions involving the qualifications of health professionals, and then upheld the application of a per se rule where osteopaths were denied hospital privileges. *See supra* notes 110-111 and accompanying text.

118. For examples of this "essential element" analysis, *see Northwest Wholesale Stationers, Inc.*, 472 U.S. at 296; *Marrese*, 1992 U.S. App. LEXIS 25530, at *16.

119. *See Flegel*, 804 F. Supp. at 1173 (upholding use of ABMS certificates as a prerequisite to hospital staff privileges); *Marjorie Webster Junior College*, 432 F.2d at 654 (involving a policy of an academic accrediting organization to deny accreditation to proprietary institutions). In both instances, the practice at issue had significant economic effects on the parties denied the benefit or privilege, yet no antitrust liability was found.

high-quality specialty medicine; economics plays no explicit role in this decision-making process. In addition, certification is not essential to practice medicine, nor is there any concerted effort on the part of the boards or organized medicine to enforce a particular use(s) of certification standards. These realities make the commercial significance of board certification activities tenuous at best. Given the lack of both an underlying economic motive and commercial impact, it is highly likely that any antitrust challenge to the specialty boards would be evaluated under a deferential rule of reason analysis, an analysis which does not pose a serious threat of liability.