THE PHYSICIAN CARTEL—POTENTIAL HOSPITAL FEDERAL ANTITRUST LIABILITY IN CLASS-BASED DENIAL OF STAFF PRIVILEGES TO CLINICAL PSYCHOLOGISTS

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I. INTRODUCTION

A proliferation of federal antitrust litigation in the health care industry, focused on the issue of hospital staff privileges, has arisen in recent years. This litigation principally has involved physicians who have had their staff privileges denied, suspended, revoked, or terminated by a hospital. Recently, increasing numbers of lawsuits have stemmed from the exclusion of nonphysician health care providers. The Health Care Quality Improvement Act of 1986, which became effective in 1989, protects physician members of hospital review boards from liability under federal and state laws for good faith actions adversely affecting clinical privileges of physicians. However, the Health Care Quality Improvement Act specifically excludes immunity for decisions regarding nonphysician health care providers. Additionally, the removal of the prior Joint Commission on Accreditation of Hospitals ("JCAH") prohibition of nonphysician medical staff membership has eliminated an insulating device formerly used by hospitals to exclude allied health professionals. Challenges by nonphysician providers, therefore, retain viability as powerful weapons in the antitrust battle over staff privileges.

This Note examines the jurisdictional bases, proof requirements, and remedial aspects of a federal antitrust suit under the Sherman Act and Clayton Act. Specifically, this Note addresses how these components interface in litigation by clinical psychologists, one category of allied health providers that has been judicially recognized as a competitor of medically-

2. Id.
sion of entire groups of non-physicians. The parity achieved by psychology in federal legislation, in national government programs, and in private sector insurer reimbursement programs, invalidates application of the quality of care defense to these health care practitioners. The deferential judicial approach to individual denials is also not applicable to group denials.

The class-based exclusion of competing health service providers from the necessary hospital facility raises the inference of a predominantly anticompetitive effect present in a concerted refusal to deal. The denial of privileges to allied health provider groups limits consumer choice and has the anticompetitive effect of maintaining higher consumer prices, because physicians generally charge more than their nonphysician counterparts. A class of qualified psychologist-plaintiffs, who were denied staff privileges in a state with a practice law permitting hospital privileges and having proof of an effect on interstate commerce, should be able to succeed on a section one conspiratorial restraint of trade claim. A section two monopoly claim should be sustainable given a class-based denial of staff privileges to clinical psychologists who are otherwise state-authorized for independent practice, and evidence of the total exclusion or willfully maintained market power in the hospital in-patient mental health market. These violations are unreasonable per se and treble damages should be awarded to prevailing psychologist-plaintiffs with proven injury.

IX. CONCLUSION

Psychiatrists and psychologists have been adversaries in state and federal legislation and in the courts. They have battled over the right to insurance reimbursement, recognition as experts in court, the scope of state professional practice, and the opportunities for psychoanalytic training. The realities of the psychiatry/psychology economic rivalry must be legally acknowledged in the hospital privileges area as it has been in the outpatient insurance reimbursement area. The potential for predominately financially-motivated medical staff exclusions of clinical psychologists begs judicial recognition. When medical staff physicians conspire to exclude clinical psychologists because of their status as competitors, a horizontal group boycott that violates the Sherman Act is formed. This illegal “physician cartel” conduct should be subject to per se condemnation in antitrust litigation because the conduct harms competition and lacks procompetitive justification. It is antithetical to the purpose of the Sherman Act to allow hospital physicians to use patient protectionism or the quality of care as illusory facades to shield themselves against financial competition.

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3. Forensic Psychology

A rivalry between forensic psychologists and psychiatrists has been resolved with the passage of a 1988 bill that revised Rule 35 of the Federal Rules of Civil Procedure to allow psychologists to conduct court-ordered mental examinations and competence determinations. The Conference of Commissioners on Uniform State Laws has recommended model legislation, similar to the revised Rule 35, providing equality between psychology and psychiatry in state civil procedure codes. Prior to 1983 the Federal Rules of Criminal Procedure had limited expert testimony of a criminal defendant's mental condition or sanity to psychiatrists. In 1983 the rules were amended to allow the government to subject a criminal defendant to mental examinations by psychologists and to permit psychological testimony.

A 1987 executive order modified the Department of Defense Manual for Court-Martial and authorized appropriate amendments to provide uniform use of forensic military psychologists on the three Uniformed Services boards. These military boards determine the mental competence of personnel in the Uniformed Services in court martial proceedings. All of these psychology practice expansions at the federal government level are antithetical to the prevalence of physician opposition to granting psychology staff privileges and add credence to group boycott claims in the hospital staff decision process.

C. Horizontal Group Boycott

The intense physician resistance to full medical staff privileges for clinical psychologists as a group cannot be globally justified on the basis of quality of care. "Other procompetitive justifications a hospital might assert for qualitatively screening individuals do not necessarily apply to the exclu-

244. Bales, Psychologists Win Right to Perform Mental Exams, APA MONITOR, Dec. 1988, at 21; Fed. R. Civ. P. 35. Rule 35 was amended, effective Nov. 18, 1988, by the passage of the Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690. The amendment provides that when the mental condition of a person is in controversy, the court may order the party to submit to a mental examination by a psychologist. A psychologist is defined as one licensed or certified by a state or the District of Columbia. Fed. R. Civ. P. 35(a)-(c).


246. Fed. R. CRIM. P. 12.2(c) 1983 amendments advisory committee notes.


tion proposed in both the House and Senate provides for the autonomous hospital practice of psychology in the federal Medicare and Medicaid programs.\textsuperscript{237} Recently passed federal law provides for reimbursement for off-site psychological services to shut-ins and the handicapped, and for community and rural mental health centers covered by Medicare.\textsuperscript{238} This revision was passed over the opposition of the American Psychiatric Association.\textsuperscript{239}

2. Prescription Privileges

In exploring mental health service delivery to native Americans, the Senate Select Committee on Indian Affairs conducted hearings in which testimony indicated that Santa Fe Indian Hospital psychologists were given active medical staff status and limited prescription privileges.\textsuperscript{240} Psychologists trained in psychopharmacology are permitted to prescribe psychotropic medication to psychiatrically disturbed patients on the basis of medical staff standing orders.\textsuperscript{241} The Department of Defense is establishing a similar pilot program to authorize military psychologists to prescribe medication under specified conditions.\textsuperscript{242} The Hawaii Board of Psychology, in collaboration with the University of Hawaii School of Medicine, will establish a training program in psychopharmacology as part of its proposed state legislative agenda to attain prescription privileges for clinical psychologists.\textsuperscript{243}


\textsuperscript{238} Buie, Off-Site Services Approved in Medicare Amendment, APA Monitor, Dec. 1988, at 25. Rural, health clinic, out-patient services, which are covered by Medicare, now include services furnished by clinical psychologists. 42 U.S.C. § 1395x(aa)(B) (Supp. 1988). The Social Security Act's definition of inpatient diagnostic and therapeutic hospital services has been amended to specifically include those services provided by clinical psychologists. 42 U.S.C. § 1395x(b)(8) (Supp. 1988). The 1982 version of the act had included coverage only for inpatient psychiactric services. 42 U.S.C. § 1395x(c) (1982).

\textsuperscript{239} Buie, Psychology Confronts Efforts to Limit Practice, APA Monitor, Feb. 1989, at 21.

\textsuperscript{240} DeLeon, Prescription Privileges & S. 123, Register Report, Aug. 1988, at 9, 10.

\textsuperscript{241} Id.

\textsuperscript{242} Id. at 10.

National Institutes of Health to include a behavioral scientist on each of its fifteen national advisory councils.\textsuperscript{227} This requirement is expected to place psychology in parity with medical experts in the national health advisory agencies in determining research grant awards and in offering policy advice.\textsuperscript{228} The provision also establishes annual Congressional oversight of the behavioral science agenda.\textsuperscript{229}

The Federal Employee Health Benefit Act\textsuperscript{230} defines clinical psychologists as physicians per se within the scope of their state practice acts.\textsuperscript{231} The Federal Employees' Health Benefit Program, the largest single employer sponsored health benefit program in the United States with 3.9 million enrollees plus dependents, includes psychology in its “freedom of choice” provisions. The provisions allow enrollees to select psychologists for reimbursed mental health care.\textsuperscript{232}

The Social Security Disability Benefits Reform Act of 1984\textsuperscript{233} authorizes qualified psychologists to evaluate “medical impairments” for disability determination purposes.\textsuperscript{234} An approved revision to the Office of Management and Budget includes psychologists as medical practitioners permitted to make “medical documentation” for civil service disability retirement benefits.\textsuperscript{235}

Federal agencies, such as the Veterans Administration, the Indian Health Services, and the Department of Defense, currently possess legal authority for the unrestricted use of psychology in their facilities.\textsuperscript{236} Legislation


\textsuperscript{228} Landers, \textit{supra} note 213, at 1.

\textsuperscript{229} Id.; Pub. L. No. 100-607 at § 112, 102 Stat. at 3052 (amending 42 U.S.C. § 283 (Supp. 1988)).


\textsuperscript{232} 5 U.S.C. § 8902(k)(1) (Supp. 1988). The act provides for free selection and access to clinical psychologists without supervision or referral by another health practitioner, as well as direct payment or reimbursement to the clinical psychologist. Clinical psychologists must be licensed under state law to qualify.


\textsuperscript{234} DeLeon, \textit{supra} note 217, at 7. Both psychiatrists and psychologists are authorized to perform disability evaluations of mental impairment to complete the medical portion of a case review and any applicable residual functional capacity assessment. See 42 U.S.C. § 421(h) (Supp. 1988).

\textsuperscript{235} DeLeon, \textit{supra} note 217, at 7.

Rank,\textsuperscript{217} and in a related controversy in Florida.\textsuperscript{218} The Tennessee legislation, which effectively excluded psychology reimbursement for these mental disorders, was drafted by the state psychiatric association.\textsuperscript{219} This provision was subsequently deleted in an effort to gain lobbying support for the mandatory mental health benefit bill from the Tennessee Psychological Association.\textsuperscript{220} According to the American Psychological Association’s Practice Directorate, “If you look at California, Florida and now Tennessee, you can see that psychiatry is now casting about for a rubric by which they can lay claim to a new psychiatric monopoly.”\textsuperscript{221}

The Florida controversy also focuses on defining the scope of psychology practice.\textsuperscript{222} Draft legislation defining psychology practice was prepared by the Florida Board of Psychology Examiners at the request of the state legislature.\textsuperscript{223} Fashioned after the American Psychological Association’s model licensing law, the draft included the right to “diagnose and treat” mental, nervous, or emotional disorders, illness, or disability.\textsuperscript{224} The Florida Psychiatric Society, the South Florida Psychiatric Society, and the Florida Medical Association filed a formal complaint, alleging that the definition included diagnosis and treatment functions for which only medically-trained personnel were qualified.\textsuperscript{225} Competition between the two disciplines is not confined to the state level as seen in Florida and Tennessee, but may be seen at the national level as well.

B. Federal Legislative Parity

Significant federal government enactments provide parity between psychology and medically-trained practitioners in the areas of research, insurance reimbursement, forensic psychology, and the scope of professional practice. These changes will undoubtedly have the resultant effect of heightening competition in areas not regulated or controlled by the government.

1. Federal Programs

The Health Omnibus Programs Extension Act of 1983\textsuperscript{226} requires the

\textsuperscript{218} See infra notes 207-211.
\textsuperscript{219} Buie, Psychology Confronts Efforts to Limit Practice, APA MONITOR, Feb. 1989, at 1, 21.
\textsuperscript{220} Id.
\textsuperscript{221} Id. at 21.
\textsuperscript{222} Buie, Right to Diagnose is Challenged in Fla., APA MONITOR, Dec. 1988, at 23.
\textsuperscript{223} Id.
\textsuperscript{224} Id.
\textsuperscript{225} Id.
A. Competition Between Psychiatry and Psychology

In addition to competition in the area of hospital staff privileges, other professional practice issues evidence the parity and competition between psychiatry and psychology. For example, in the context of outpatient care, clinical psychologists have been found to compete, for antitrust purposes, with medically-trained practitioners. 209 Courts have recognized clinical psychologists as independent economic entities not subject to physician supervision in third-party insurer reimbursement for outpatient services. 210 A recent study indicates that registered clinical psychologists are now reimbursed by 78% of the national employer mental health plans, a figure which is only 20% lower than the 98% psychiatrist reimbursement. 211

Psychoanalytic practice is another area of rivalry where alleged anticompetitive conduct of physicians is being litigated. 212 Psychologists have attempted to expand psychoanalytic training and practice opportunities for nonphysicians by removing former barriers that excluded non-M.D.s. 213 Under a settlement agreement between psychologists and the American Psychoanalytic Association and the International Psychoanalytic Association, the American Psychoanalytic Association’s affiliates will admit 28% nonmedical applicants and 10% nonmedical researchers. 214

Competition between psychiatry and psychology is often evident in controversies over the scope of health practice as defined in state legislation. A recent Tennessee state bill, which mandated mental health benefits for citizens, specifically prohibited psychologist reimbursement for diagnosis and treatment of “medical mental disorders” with an organic etiology. 215 The proposed revision to the insurance code would allow only psychiatrists to be reimbursed for treatment of these disorders. 216

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210. Id.
216. Id.
in the state/local government category.\textsuperscript{201} The overall use rate of 39% remained near the 1984 survey level.\textsuperscript{202} Combining the results of these two studies, it is apparent that while clinical psychologists have a dominant presence in psychiatric hospital treatment, they are generally underrepresented in committee membership and in the voting processes of hospitals in general.

C. Proposed Policy Revisions

The American Hospital Association proposed a revised policy and statement on privileges for nonphysician providers.\textsuperscript{203} This revision was made to comply with the new JCAH standards and the many amended state professional and hospital licensure laws that have broadened the scope of practice for certain nonphysician practitioners.\textsuperscript{204} The proposal does not require hospitals to grant either medical staff membership or clinical privileges to any specific practitioner groups, but leaves that decision to hospital governing bodies.\textsuperscript{205} No differentiation is made based on specific nonphysician providers, nor is a distinction made between independent and dependent practitioners.\textsuperscript{206}

Reportedly, the American Medical Association ("AMA") has also encouraged granting clinical or medical staff privileges to nonphysician providers, conditioned on the determinations being made by each individual hospital.\textsuperscript{207} These AHA and AMA positions are in juxtaposition with the consistent organized opposition at the national, state, and county affiliate levels as to the diagnosis, treatment, and hospital admission of the mentally disordered by clinical psychologists as a class.\textsuperscript{208}

VIII. Class-Based Denials to Clinical Psychologists as Group Boycotts

The class-based denial of hospital staff privileges to clinical psychologists has been alleged to qualify as a horizontal group boycott, "a physician cartel," in those states that permit parity or prohibit discrimination between psychiatrists and clinical psychologists in hospital access. From the national medical organization down to the local hospital medical staff, these physician-controlled strata allegedly are motivated by anticompetitive economic self-interest in perpetuating the cartel's refusal to deal with clinical psychol-
doctors on their medical staffs. Larger hospitals and teaching hospitals were more likely to grant medical staff membership or clinical privileges to clinical psychologists. Nonphysician practitioners tend to be represented more in larger market areas where specialization is cost-effective due to the larger patient volume.

Medical staff membership was permitted by the bylaws of 44.1% of the hospitals surveyed. Only 6.9% of these hospitals permitted medical staff voting privileges, and 14.7% allowed medical staff committee membership in their bylaws. Bylaws permitted clinical psychologists co-admission privileges under the direction of a physician in 21.9% of the surveyed hospitals and only 2.2% allowed patient admission under the sole authority of the clinical psychologist.

In contrast, clinical psychologists are given the privilege to use the hospital facilities within the scope of licensure under the bylaws of 52.4% of the hospitals surveyed. This survey indicates the limited role clinical psychologists could potentially enjoy under current bylaws. Full voting membership status is possible under bylaws in only 6.9% of the hospitals, and unsupervised admission privileges are allowable in only 2.2% of the hospitals, despite the inclusion of psychologists on nearly 40% of the hospital medical staffs surveyed. As a result of committee membership and voting status being severely restricted, the control over staff privileges for clinical psychologists is effectively maintained in the hands of the dominant physician group.

B. The 1985 AHA Survey

A 1985 survey, also conducted by the American Hospital Association, showed a wide disparity in the offering of clinical psychology services, depending on the hospital’s classification. Federal psychiatric and general hospitals used these services in 100% of the responding hospitals. Other psychiatric hospitals had high use percentages as well: nongovernment voluntary hospitals had 90% use, investor-owned hospitals had 90% use, and state/local government hospitals had 99% use. Short-term general hospitals had an 18% use rate in the investor-owned category and a 19% use rate

190. Morrissey & Brooks, supra note 175, at 59.
191. Id.
192. Id.
193. Id.
194. Id.
195. Id.
196. Id.
197. Id.
198. C. Stromberg, supra note 24, § 6.01, at 319.
199. Id.
200. Id.
Furthermore, the court held that psychologists, as well as psychiatrists, are authorized by law to diagnose and treat psychological and emotional disorders in hospitals without discriminatory restrictions. In fact, the court recognized parity between psychology and medicine when viewing the state legislation at issue as designed to place the two professions on an equal level as possible within the scope of their respective licensures. The court concluded that physicians and psychologists “stand on an equal footing: neither is subject to constraints from which the other is free.”

D. New York

The New York legislature has recently advanced a bill intended to grant hospital staff privileges to psychologists. Sponsored by the bipartisan chairs of the legislatures’ mental health committees, the bill provides for full admitting and discharge privileges, as well as medical staff voting membership. Passage has been opposed by the New York State Psychiatric Association. A self-critical psychiatric press report on the joint legislative hearing characterized psychiatry’s opposition as “petty efforts to defend their turf.”

VII. Medical Staff Composition and Bylaws Relevant to Clinical Psychologists

In addition to the requisite state laws permitting hospital staff privileges, the psychologist-applicant must also be eligible under the bylaws of the hospital to which he or she applies.

A. The 1984 AHA Survey

A 1984 study conducted by the Hospital Research and Educational Trust of the American Hospital Association (“AHA”) found that 39.9% of surveyed hospitals grant membership or privileges to clinical psychologists. The average hospital had 1.9 clinical psychologists and 161 medical

182. Id.
183. Id.
184. Id.
187. Id.
188. Id.
189. Morrissey & Brooks, The Expanding Medical Staff: Nonphysician Practitioners, HOSPITALS, Aug. 1, 1985, at 58, 59; see also Richards, Nonphysician Practitioners Make Slow Headway on Staff Privileges, HOSPITALS, Dec. 16, 1984, at 82.
quired to submit to psychiatric care.\textsuperscript{169}

The California Hospital Association, the California Medical Association, and the California Psychiatric Association filed an amicus curiae brief that charged psychologists lack the comprehensive training and clinical competence to diagnose and treat hospitalized mentally ill patients.\textsuperscript{170} The question of whether California clinical psychologists may render services in health facilities, independent of physician supervision, was recently resolved by the California Supreme Court.\textsuperscript{171}

In a decision issued on June 25, 1990, the California Supreme Court reversed the judgment of the California Court of Appeal and upheld the ruling of the trial court.\textsuperscript{172} The supreme court concluded that a hospital which admits clinical psychologists to its staff may permit such psychologists to take primary responsibility for the admission, diagnosis, treatment, and discharge of patients.\textsuperscript{173} The court rejected the court of appeal’s distinction between psychology and medicine.\textsuperscript{174} The correct distinction, according to the court, turned on the nature of the treatment each of the professions could provide, not the origin of the condition treated.\textsuperscript{175} The court, noting that psychologists and psychiatrists treat mental conditions of both organic and nonorganic origin, concluded that the authority of the psychologist could not hinge upon a requirement that the patient’s condition derive from a nonorganic cause.\textsuperscript{176}

The court of appeal and the appellant distinguished between inpatient and outpatient care.\textsuperscript{177} The supreme court rejected that distinction.\textsuperscript{178} The supreme court also rejected the court of appeal’s interpretation of the hospital regulations as requiring psychologists to seek medical supervision or prior approval as a condition of hospital practice.\textsuperscript{179} According to the supreme court, the hospital practice law prohibited a rule that authorized members of one profession to have supervisory authority over the other.\textsuperscript{180} With respect to functions for which both physicians and psychologists were licensed and qualified, the court held that regulations could not establish a hierarchy under which physicians outranked psychologists.\textsuperscript{181}

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{169} Id.
\item \textsuperscript{170} Buie, \textit{Brief Slams Clinicians’ Training}, APA Monitor, Mar. 1989, at 15.
\item \textsuperscript{171} California Ass’n of Psychology Providers v. Rank, \textit{Id.}, 793 P.2d 2, 270 Cal. Rptr. 796 (1990) (en banc).
\item \textsuperscript{172} Id.
\item \textsuperscript{173} Id.
\item \textsuperscript{174} Id.
\item \textsuperscript{175} Id.
\item \textsuperscript{176} Id.
\item \textsuperscript{177} Id.
\item \textsuperscript{178} Id.
\item \textsuperscript{179} Id.
\item \textsuperscript{180} Id.
\item \textsuperscript{181} Id.
\end{enumerate}
\end{footnotesize}
C. California

California allows health facilities to appoint clinical psychologists to hold membership and serve on committees of the medical staff and to carry professional responsibilities consistent with the scope of their competency and licensure.\(^{160}\) Further, the California statute specifically prohibits discrimination between physicians and clinical psychologists in regard to services that both groups are authorized by law to perform.\(^{169}\) Another provision requires health facilities that provide staff privileges to clinical psychologists to include clinical psychologist members in their staff privilege review groups if possible.\(^{161}\)

The proper scope of the California statute has recently been tested in the state courts. In *California Association of Psychology Providers v. Rank*,\(^{162}\) the district court held that sections of the California Administrative Code of the Department of Health Services, which required a psychiatrist to be responsible for the diagnosis and treatment of all patients, were invalid.\(^{163}\) The district court found that the regulations unlawfully discriminated against clinical psychologists in violation of state law.\(^{164}\) The state court of appeals, sitting en banc, reversed, holding that clinical psychologists have the right to diagnose and treat patients without physician interference only after the need for medical treatment of a patient’s mental disorder had been eliminated by a physician.\(^{165}\) The California Supreme Court, sitting en banc, granted the clinical psychologists’ petition for review in August 1988.\(^{166}\)

The petitioners’ brief, supported by the American Psychological Association, contended that the California legislature intended to expand hospital patients’ access to psychological services, and that psychiatrists are economically motivated in their insistence on hospitalization controls.\(^{167}\) The psychologist-petitioners labeled the necessity of exhausting all organic origins and medical treatments as “impractical, impossibly costly, and harmful to patients.”\(^{168}\) The psychologists further contended that patients of clinical psychologists are denied continuity of treatment once hospitalized and re-

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160. *Id.*

161. *Id.*


163. *Id.* at ___, 247 Cal. Rptr. at 643.

164. *Id.*

165. *Id.* at ___, 247 Cal. Rptr. at 646.


168. *Id.*
cally authorize staff privileges for qualified psychologists.150 Georgia allows hospitals to appoint “health service provider psychologists” who shall be eligible to hold membership on medical staffs and possess clinical privileges consistent with the scope of their licensure.183

A state statute may delegate the decision entirely to a health care review committee. For example, the Minnesota statute authorizes review organizations to be established by hospitals to determine whether a professional shall be granted staff privileges in a medical institution.184 A “professional” is defined as a person licensed or registered to practice a healing art, which includes psychologists.185

B. District of Columbia

In the District of Columbia “qualified psychologists” are granted admitting privileges if they are licensed and have had either one year of formal training in a hospital or two years of supervised clinical experience in an organized health care setting.186 At least one year of the training requirement must be completed at the postdoctoral level.187 Admitting privileges extend to voluntary, nonprotesting, emergency, and court-ordered hospitalizations of mentally ill patients.188 The admitting psychologist must designate a psychiatrist or physician responsible for a medical evaluation and medical management of the patient during hospitalization.189 The psychologist is responsible for all other evaluation and management of the patient during hospitalization.190

151. GA. CODE ANN. § 88-3802 (1986). States often have a bi-level licensure scheme for psychologists. A distinction is made between licensed/certified psychologists and health service provider psychologists who are authorized to maintain independent practice and are required to meet more demanding educational and clinical training standards. The National Register of Health Service Providers of Psychology lists practitioners who meet the qualifications of the designation of “health service providers of psychology.” The requirements include state licensure at the independent practice level, a doctoral degree from an accredited institution and two years of supervised experience, one of which must be in an organized health service training program and one which must be post-doctoral. COUNCIL FOR THE NAT’L REGISTER OF HEALTH SERVICE PROVIDERS IN PSYCHOLOGY, NATIONAL REGISTER OF HEALTH SERVICE PROVIDERS IN PSYCHOLOGY XV (1987).
152. MINN. STAT. ANN. §§ 145.61, 148.91 (West Supp. 1989).
153. Id.
154. D.C. CODE ANN. §§ 21-501, 21-501.1 (1989). These qualifications are essentially identical to those required in Georgia to be designated a “health service provider;” and by the National Register of Health Service Providers. See supra note 151. Similarly, these are the requirements for the “health service provider” designation in Iowa. See IOWA ADMIN. CODE r. 645-240 (1986).
157. Id.
158. Id.
bring within its coverage both the specific health care provider who is being scrutinized and the members of the review committee. For example, California law specifies the individual professional disciplines covered,\textsuperscript{149} the type of review records and communications protected,\textsuperscript{141} and the groups protected by its immunity provisions.\textsuperscript{143} Similar protection is provided under federal legislation for peer review activity that meets certain requirements.

2. *Federal Law Immunity*

The enactment of the Health Care Quality Improvement Act of 1986\textsuperscript{148} provides immunity from liability and damages otherwise recoverable under federal and state antitrust laws for participants in physician peer review actions that adversely affect staff privileges.\textsuperscript{144} The statute requires compliance with procedural safeguards and good faith action in furtherance of quality health care.\textsuperscript{146} Under the statute, prevailing defendants are awarded reasonable attorneys’ fees and costs in defense of a suit if the suit was frivolous, unreasonable, without foundation, or was brought in bad faith.\textsuperscript{146} The Health Care Quality Improvement Act specifically excludes staff privilege decisions involving nonphysician, allied health care providers.\textsuperscript{147} Thus, this defense is unavailable in decisions by physicians that adversely affect privileges of clinical psychologists. Naturally, this defense only arises in a state that allows clinical psychologists to be granted hospital privileges in the first place.

VI. *STATE LEGISLATION ON CLINICAL PSYCHOLOGY STAFF PRIVILEGES*

A. *Statutory Authority in General*

State statutes must be consulted in determining whether granting staff privileges to specific nonphysician groups is mandated, permitted, or prohibited. In some states clinical psychologists have no cause of action against a hospital or the hospital’s medical staff members under the Sherman Act and the Clayton Act. For example, Ohio specifically prescribes granting admitting privileges to any groups other than physicians and dentists.\textsuperscript{148} Similarly, North Carolina limits granting hospital privileges to licensed physicians, dentists, and podiatrists.\textsuperscript{149} In other jurisdictions, however, statutes specifi-

\textsuperscript{140} CAL. EVID. CODE § 1157 (West 1988).
\textsuperscript{141} CAL. CIV. CODE § 43.8 (West 1988).
\textsuperscript{142} CAL. CIV. CODE § 43.7 (West 1988).
\textsuperscript{143} 42 U.S.C. §§ 11101-11152 (Supp. 1988).
\textsuperscript{144} 42 U.S.C. § 11111(a) (Supp. 1988).
\textsuperscript{146} 42 U.S.C. § 11113 (Supp. 1988).
\textsuperscript{147} 42 U.S.C. § 11115(c) (Supp. 1988).
\textsuperscript{148} OHIO REV. CODE ANN. § 3727.06 (Anderson 1988).
\textsuperscript{149} N.C. GEN. STAT. § 131E-85 (1988).
in group denials. Other courts look behind the defense for "the genuineness of the defendants' justification, the reasonableness of the standards themselves, and the manner of their enforcement." Finding an antitrust violation by physicians against clinical psychologists, the Fourth Circuit Court of Appeals refused to "condone anticompetitive conduct upon an incantation of 'good medical practice.'" One commentator noted that the rationale for the quality of care defense is weakened when used to justify group exclusion of nonphysicians because physicians are not experts in judging the skill, training, and experience of allied health practitioners. This commentator further noted that physician evaluation of nonphysicians is subject to physician bias stemming from pride, ego, and sense of superiority. The quality of care defense is more appropriately used when physicians make decisions regarding their peers. For this reason, physicians are often given protection by state and federal laws providing immunity for peer review activity directed at the improvement of health care.

B. Immunity from Liability

1. State Action Immunity

The doctrine of state action immunity protects conduct that would otherwise be violative of the Sherman Act when it is performed by a state or under state mandate. This defense has been used successfully by government-owned hospitals. However, the Supreme Court held that physicians in a state-recommended peer review of hospital staff privileges were not immune from antitrust liability because the state agencies and courts in that case lacked the power of review. According to the Court, immunity would be available to private parties only when there was active supervision by the state to assure compliance with state regulatory policy and to correct abuses. The state legislation must

133. See Note, supra note 20, at 1228.
134. Id.
138. Id. at 1660.
139. Id. at 1663.
absence of substantial procompetitive justifications\textsuperscript{126} even under a rule of reason analysis. An alternative device that historically has been used to reduce judicial scrutiny to the rule of reason level is the imposition of antitrust exemptions to certain professional groups’ decisions.

IV. LEARNED PROFESSIONS EXEMPTION

The learned professions exemption purportedly excused professionals engaged in community service from standard antitrust review.\textsuperscript{121} Since the Supreme Court decision in \textit{Goldfarb v. Virginia State Bar},\textsuperscript{122} the exemption generally has been abandoned in suits involving the purely commercial aspects of professional practice.\textsuperscript{123} The Court in \textit{Arizona v. Maricopa County Medical Society}\textsuperscript{124} refused to apply the exemption to physicians in a price-fixing scheme that was found to be per se violative of the Sherman Act.\textsuperscript{125} The remnants of the exemption surface when defendants attempt to justify otherwise per se violative conduct by raising a “public service” or “ethical norm rationale.”\textsuperscript{126} Courts may use the more lenient rule of reason and allow the defendants to justify otherwise per se conduct by evidence of the conduct’s procompetitive effects, a justification usually not available to nonprofessional conduct.\textsuperscript{127} Another justification that is sometimes successfully used in defending antitrust hospital suits is reliance on legitimate patient care motives to justify what otherwise would be antitrust conduct.

V. HOSPITAL DEFENSES

A. Quality of Care

A hospital unquestionably has the right to exercise control over the identity and the number of doctors to whom it grants staff privileges.\textsuperscript{128} In the health care market, where quality of care is a major competitive variable, exclusion of less qualified practitioners may serve a procompetitive function.\textsuperscript{129} Therefore, hospitals may legitimately use quality of care maintenance as a defense to charges of anticompetitive decision making. In dealing with this defense, courts greatly differ in the amount of discretion they afford the medical staff decision. Some courts are extremely deferential, even

\begin{enumerate}
\item[120.] Kissam, \textit{supra} note 43, at 651, 654.
\item[123.] Kissam, \textit{supra} note 43, at 615-16.
\item[124.] Arizona \textit{v. Maricopa County Medical Soc'y}, 457 U.S. 332 (1982).
\item[125.] \textit{Id.} at 351.
\item[126.] Weiss \textit{v. York Hosp.}, 745 F.2d 788, 820-21 (3d Cir. 1984).
\item[127.] \textit{Id.} at 820-21 n.60.
\item[129.] \textit{See Note, supra} note 20, at 1233.
\end{enumerate}
dards on medical staff privileges, state laws that mandate peer review, and the implementation of the Health Care Quality Improvement Act of 1986 provide sufficient self-regulation policy and due process safeguards to bring most physicians' privilege decisions under the rule of reason analysis. Because decisions regarding nonphysicians fall outside the sphere of self-regulation, however, the justification for a rule of reason approach is lacking in cases involving class-based denial of staff privileges to clinical psychologists. Giving physicians the benefit of self-regulators' lessened judicial scrutiny under the rule of reason would be illogical when their decision making moves outside the sphere of self-regulation. Physician regulation of another independent health care discipline, which results in a horizontal group boycott, is more appropriately and logically analyzed under the per se rule.

2. Applying the Per Se Rule

If a restraint on trade has a "pernicious effect on competition and lack[s] . . . any redeeming virtue," the restraint is per se unreasonable. Application of the per se rule eliminates the need for an evaluation of competitive effect and condemns certain conduct even if procompetitive justifications are offered. The per se rule is premised on a conclusive presumption that this particular form of restraint is unreasonable. Price fixing, division of markets, group boycotts, and tying arrangements have been held to be per se antitrust violations by the Supreme Court.

Class-based denial of hospital staff privileges has been characterized as a group boycott that is subject to the per se rule. A group boycott occurs when independent economic actors join to deny or inhibit potential competitors' access to the market. Possession of market power or exclusive access to a necessary facility raises an inference of predominately anticompetitive effect. The court in Weiss found that the defendant hospital's exclusion of D.O.'s was properly characterized as a group boycott, equal to a concerted refusal to deal, which was appropriate for per se condemnation. This form of horizontal group boycott by physicians has been labeled "physician cartel" behavior. This behavior is unlikely to survive antitrust scrutiny in the

109. See supra notes 14-21.
110. See infra notes 140-42.
114. Id. at 344.
117. See Note, supra note 18, at 600.
118. Id. at 601.
aspect of market power. In the Weiss group boycott case, the Third Circuit Court of Appeals affirmed the jury finding that a market share in excess of eighty percent was sufficient to find market power for section two purposes.98 Market power is not established if the defendant hospital does not maintain a dominant position in the relevant geographic market.99

F. Rules for Determining Violations

1. Rule of Reason Analysis

The determination of whether a violation of the Sherman Act has occurred is most often achieved by the application of the “rule of reason” analysis.100 The rule of reason analysis focuses on the challenged restraint’s impact on competition.101 Under this analysis the plaintiff must show that an adverse impact on competition is unreasonable under the circumstances.102 Application of the rule of reason analysis requires balancing the procompetitive effects and the anticompetitive effects of the alleged illegal conduct.103 If the anticompetitive effects outweigh the procompetitive, the Sherman Act is violated.104

In limited situations, conduct that amounts to a group boycott or horizontal price-fixing arrangement (which ordinarily constitutes a per se violation) is analyzed under the rule of reason.105 This type of exception to per se condemnation is recognized when an industry is self-regulated by mandate, such as a stock exchange or collegiate athletics association.106

Hospital staff privilege cases can be analogized to a form of industry regulation appropriate for rule of reason balancing.107 In this context, the rule of reason is used when three criteria are present: (1) a mandate for self-regulation; (2) action consistent with the policy justifying self-regulation; and (3) application of procedural safeguards.108 The presence of JCAH stan-

100. Enders, supra note 1, at 358-59.
103. See Note, supra note 20, at 1220.
104. Id.
105. Enders, supra note 1, at 358-59.
Clinical Psychologists v. Blue Shield found that Blue Shield was not a separate entity, but rather was a “combination of physicians, operating under the direction and control of their physician members.” The court found that this combination established a sufficient basis for the conspiratorial requirement under section 1 of the Sherman Act.

E. Geographic and Product Markets

A violation under section two of the Sherman Act requires a finding that the defendant monopolized the relevant market. Both the product market and geographic market must be examined to determine if the defendant controls market power. Monopoly power is characterized as “the ability to change the competitive variables of a product to the disadvantage of consumers without causing effective competitors to enter the relevant market.” The product market is composed of products or services that are reasonable substitutes for one another. In the hospital staff decision analysis, the product market can be defined as inpatient health care services or the product market can be defined in more precise terms by the specific types of inpatient services provided, such as pediatric surgery, anesthesia services, maternity care, or emergency room referrals.

The geographic market is determined by an analysis of the specific facts of each case. The presence of other hospitals in the area, the percentage of patients served by the defendant hospital, and other opportunities for the plaintiff to practice in the area are factors in determining the geographic

85. Id. at 479.
86. Id. at 481.
tribute to the finding that the interstate commerce requirement is satisfied. Conversely, courts often find that the presence of only one factor is an insufficient nexus.\textsuperscript{74}

D. Proving Conspiracy

A violation under section one of the Sherman Act requires proof of a "contract, combination . . . or conspiracy" that results in the antitrust effect on interstate commerce.\textsuperscript{76} Unilateral conduct, although not necessarily defeating to a section two violation,\textsuperscript{78} lacks the requisite agreement between two or more separate entities needed under section one.\textsuperscript{77} The action of a hospital corporation, through its employees, officers, or agents, is insufficient by itself to meet the conspiratorial requirement.\textsuperscript{78} Generally, courts hold that a hospital cannot, as a matter of law, conspire with itself.\textsuperscript{79} Nor can a hospital conspire with its medical staff when the hospital acts as a single entity in making staff privilege decisions on behalf of the hospital.\textsuperscript{80} A single entity, which is made up of competing independent entities, however, is sufficient to satisfy the joint action requirement.\textsuperscript{81}

In the context of a hospital staff decision, each staff member's economic interest is separate and independent, and the medical staff cannot be considered a single economic entity in an antitrust suit.\textsuperscript{82} Therefore, a conspiracy may be shown when the individual financial incentives and self-interest of the medical staff members act in concert to exclude competitors.\textsuperscript{83} Specific to clinical psychologists as a group, the court in \textit{Virginia Academy of}

\textsuperscript{74} See, e.g., Sarin v. Samaritan Health Center, 813 F.2d 755, 758 (6th Cir. 1987) (denial of privileges when physician performed less than one operation per week and had privileges at several other hospitals in the metropolitan area had no more than a "\textit{de minimus} effect on interstate commerce"); Seglin v. Eban, 769 F.2d 1274, 1280 (7th Cir. 1985) (temporary suspension of hospital privileges not sufficient to state an antitrust claim).


\textsuperscript{81} Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 356-57 (1982); \textit{see also} National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 692-93 (1978) (professional group's canons of ethics, which prohibited the submission of competitive bids for engineering services, was a restraint of trade on its face).

\textsuperscript{82} Weiss v. York Hosp., 745 F.2d at 815.

\textsuperscript{83} \textit{Id.}
the defendant’s general business activities. The Sixth Circuit Court of Appeals also rejected the general business test, and instead required a showing that the defendant’s allegedly unlawful activities affected interstate commerce. The Seventh, Eighth, and Tenth Circuit Courts of Appeal similarly focus on the specific allegations of antitrust violation to judge the jurisdictional prerequisite. Commentators suggest that the test employed by these courts will reduce the volume of nonmeritorious antitrust litigation and will uphold the principles of federalism.

C. Proving Effect on Interstate Commerce

Generally, facts that substantiate an effect on interstate commerce deal with sources of revenue, hospital purchases, and patient services. Courts frequently find a sufficient effect on interstate commerce when the defendant hospital purchases medical supplies, equipment, and drugs from out-of-state suppliers. Commonly, jurisdictional requirements are satisfied by out-of-state revenue sources such as Medicare, Medicaid, private third-party insurance companies, and payments from out-of-state patients. Often the fact that the hospital serves patients from an area encompassing two or three states will suffice for the required effect on interstate trade. In one case involving a teaching hospital, the court considered recruitment and travel of college students and college physicians and the receipt of federal subsidies as a sufficient nexus with interstate commerce. Usually several factors con-

65. See, e.g., Doe v. St. Joseph’s Hosp., 788 F.2d 411, 417 (7th Cir. 1986); Seglin v. Essau, 769 F.2d 1274, 1278 (7th Cir. 1985).
66. See, e.g., Hayden v. Bracy, 744 F.2d 1338, 1343 (8th Cir. 1984).
67. See, e.g., Mishler v. St. Anthony’s Hosp. Sys., 694 F.2d 1225, 1227 (10th Cir. 1983); Crane v. Intermountain Health Care, 637 F.2d 715, 724 (10th Cir. 1980).
68. Endera, supra note 1, at 399.
71. See supra note 70.
72. See supra note 70.
73. Tarleton v. Meharry Medical College, 717 F.2d 1523, 1531-32 (6th Cir. 1983) (also
Likewise, the Eleventh Circuit Court of Appeals has taken the position that jurisdictional requirements are satisfied by examining the effect of the defendant’s general business activities on interstate commerce.66 The Third Circuit Court of Appeals affirmed a district court opinion that held that the effect on interstate commerce could be satisfied without making a particularized showing of the effect being caused by the defendant’s alleged unlawful conduct.67 The Third Circuit Court of Appeals also addressed the issue directly by reversing a different district court that attempted to “tie the jurisdictional inquiry to the substantive offense by requiring that the same conduct be the basis for both showings.”68 The court viewed the defendant’s general conduct and opined that “there is no reason why an enterprise engaged in nationwide anticompetitive conduct should not be subject to suit by a local victim simply because the defendant’s conduct, as regards that particular plaintiff, does not affect interstate commerce.”69

The interpretation of McLain taken by these circuits has been criticized as casual dicta taken out of context, and because the interpretation allows virtually any defendant’s activity to affect interstate commerce, however local in nature.60 Another commentator who is critical of the general business test’s lower threshold contends that the test “virtually eliminates a meaningful interstate commerce limitation on the jurisdictional reach of the Sherman Act,” and therefore the commentator favors the test’s abandonment and replacement with the more stringent infected activities test.61 A contrasting interpretation, which endorses extending federal antitrust law to relatively local conduct, argues that this extension serves to prevent local protectionism, which is inherently harmful to interstate trade.62

2. Infected Activities Test

The majority of the circuit courts of appeal employ the infected activities test interpretation of McLain in staff privilege cases. The Second Circuit Court of Appeals held that the Sherman Act required a showing of an effect on interstate commerce resulting from the unlawful conduct, not from


59. Cardio-Medical Assocs. v. Crozer-Chester Medical Center, 721 F.2d at 75.


61. Enders, supra note 1, at 339.

straint on interstate commerce may be satisfied by a burden on the freedom of trade alone.\textsuperscript{48}

Regardless of whether a plaintiff attempts to show a direct effect under the “in interstate commerce test” or an indirect effect under the “not insubstantial effect” test, a dispute often arises concerning what activity of the defendant should be examined for its effect on interstate commerce. The court may focus only on the defendant’s alleged antitrust activity or look more globally at the defendant’s general business activity.\textsuperscript{49}

The determination varies by court due to a split in federal circuit authority regarding the scope of the defendant’s business activities that must impact on interstate commerce to satisfy the antitrust jurisdictional prerequisites.\textsuperscript{50} This split in authority has been generated by the circuits’ differing interpretations of the Supreme Court’s decision in \textit{McLain v. Real Estate Board of New Orleans, Inc.}\textsuperscript{51} After commenting in \textit{McLain} that the jurisdictional requirements were met in relation to the defendant’s overall business activity, the Court stated that the “petitioners need not make the more particularized showing of an effect on interstate commerce” caused by the specifically alleged conspiratorial conduct.\textsuperscript{52} Depending on the circuit’s interpretation of this \textit{McLain} quote, each circuit has adopted one of two tests: the “general business activities test,” or the “infected activities test.”\textsuperscript{53} A brief examination of each test shows that it is far easier for a plaintiff to prove that the defendant’s general business activities have an effect on interstate commerce, rather than prove that the specific activity complained of is infected with anticompetitive animus affecting interstate commerce.

1. \textbf{General Business Test}

The Ninth Circuit Court of Appeals has held that it is “not necessary for the alleged antitrust violations complained of to have affected interstate commerce as long as defendants’ business activities, independent of the violations, affected interstate commerce . . . .”\textsuperscript{54} A federal district court in the Ninth Circuit found support for adopting the general business test in a passage from \textit{McLain}, which stated: “If establishing jurisdiction required a showing that the unlawful conduct itself had an effect on interstate commerce, jurisdiction would be defeated by a demonstration that the alleged restraint failed to have its intended anticompetitive effect.”\textsuperscript{55}

\textsuperscript{48} Id. at 746.
\textsuperscript{49} See infra notes 54-69.
\textsuperscript{50} See Enders, supra note 1, at 335-39; Kissam, supra note 43, at 632.
\textsuperscript{52} Id. at 242-43.
\textsuperscript{53} Enders, supra note 1, at 335-39; Kissam, supra note 43, at 632-37.
\textsuperscript{54} Western Waste Serv. Sys. v. Universal Waste Control, 616 F.2d 1094, 1097 (9th Cir. 1980) (quoting McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232 (1980)).
four. The court found an antitrust violation for the group exclusion of doctors of osteopathy ("D.O.'s") from hospital staff privileges. The court allowed section sixteen injunctive remedies for class action members, regardless of whether they had individually applied and been denied privileges. The court reasoned that a threatened injury existed by the very existence of the discriminatory policy toward D.O. applicants. Treble damage claims, however, were subject to the prerequisite of actual harm. Actual harm was shown in Weiss by an applicant's denial of privileges, which was characterized by the trial court as "a serious adverse professional event which [was] likely to besmirch the [applicant's] professional reputation . . . ." Class-based denials additionally implicate damages sustainable from the loss of access to the "immense power of the referral network among physicians," which provides a source of patients and a pool of consultants to assist with complex medical problems.

B. **Effect on Interstate Commerce**

An antitrust claimant must allege as a jurisdictional prerequisite that the challenged conduct either is directly involved in interstate commerce (the "in interstate commerce test") or, although local in nature, the conduct has a "not insubstantial effect" on interstate commerce (the "effect on commerce test"). It is decisively important that the plaintiff allege the critical relationship between the alleged unlawful conduct and interstate commerce in the pleadings to survive a dismissal or summary judgment at the pretrial stage. The activity does not have to be "purposely directed" toward producing an effect on interstate commerce to be covered. Anticompetitive activity must result in substantially different transactions in terms of the number or volume of transactions, or the parties to transactions. The re-

38. Id. at 806-07. The members constituted a Rule 23(b)(2) class. F.R. CIV. P. 23(b)(2).
39. Id. at 807.
40. Id. at 807, 831.
41. Id. at 807 (quoting Weiss v. York Hosp., 548 F. Supp. 1048, 1052 (M.D. Pa. 1982)).
42. See Note, supra note 20, at 1230.
45. Id.
47. Id. at 745.
admission signature. Some state laws, however, mandate relative parity between psychologists and physicians with regard to patient admissions and hospital inpatient mental health services.

III. SHERMAN ANTITRUST ACT

A. Applicable Provisions

Section one of the Sherman Act requires that a plaintiff prove three elements to sustain a restraint of trade violation: (1) a contract, combination, or conspiracy; (2) restraint of trade; and (3) an effect on interstate commerce. To sustain a judgment for monopolizing under section two of the Act, a plaintiff must show that: (1) the defendant possesses monopoly power in the relevant market; and (2) that this power has been willfully acquired or maintained, as distinguished from growth or development resulting from a superior product, business acumen, or historic accident. Both sections one and two of the Sherman Act create criminal offenses and penalties for government-initiated actions. Therefore, a plaintiff in a private antitrust suit for civil liability must also plead under the parallel provisions of the Clayton Act.

Section four of the Clayton Act provides federal court jurisdiction in any district in which the defendant or the defendant's agents reside and does not provide an amount in controversy requirement. If an antitrust violation is proven and the plaintiffs can show actual injury and a causal relationship between the defendant's unlawful conduct and the plaintiff's economic injury, the plaintiff shall recover treble damages, the cost of the suit, and reasonable attorney's fees.

Section sixteen of the Clayton Act provides injunctive relief for threatened loss or damages caused by an antitrust violation without requiring proof of actual injury to the plaintiff. To obtain a section sixteen remedy, the plaintiff "need only demonstrate a significant threat of injury from an impending violation of the antitrust laws or from a contemporary violation likely to continue or recur . . . ." The equitable approach of section sixteen provides a lower threshold for the standing requirement and is applied more expansively by the courts than the more restrictive section

26. Id.
31. Id.
bylaws, rules, and regulations made by the medical staff. The medical staff reviews the applicant’s credentials and the conduct of current hospital practitioners and then makes recommendations to the hospital’s governing body on renewal, revocation, acceptance, suspension, or denial of privileges. The hospital’s governing board has the ultimate approval over these decisions. In practice, however, “the members of the medical staff are the main actors in the hospital staff decisions.”

B. JCAH Standards

Prior to 1985 the JCAH required the medical staffs of accredited hospitals to be composed solely of physicians and dentists. In 1985 the JCAH relaxed the standard, partially in response to four antitrust suits pending against the JCAH exposing it to potential liability of approximately $300 million. The new standard allows accredited hospitals to admit to their staffs any practitioner who is licensed to provide independent health care without physician supervision. The Attorney General of Ohio brought one antitrust suit against the JCAH on behalf of the state’s psychologists, alleging an antitrust violation based upon the categorical denial of staff privileges. The Attorney General argued that categorical denial foreclosed consumer choice and stabilized noncompetitive price levels in the mental health care market.

The new JCAH standard permits, but does not require, the extension of staff privileges to those nonphysicians who are permitted by hospital bylaws and authorized under state licensure laws to provide independent patient care services. The JCAH manual further allows clinical privileges to be delineated and limited regarding the ability to admit patients, treat hospitalized patients, and direct the course of treatment. Psychologists are commonly granted admitting privileges conditioned upon a physician’s co-

15. Id.
16. Id.
17. Id.
18. Note, Class-Based Denials of Hospital Staff Privileges and the Learned Professions Exemption, 64 Wash. U.L.Q. 597, 598 n.6 (1986).
21. Id. at 1224 n.36.
22. Id. at 1227-28.
23. Id. Although instrumental in the JCAH revision, this lawsuit was rendered moot by the subsequent passage of legislation in Ohio that mandated exclusive physician control of all hospital admissions and patient supervision. See Ohio Rev. Code Ann. § 3727.06 (Anderson 1988).
25. Id.
trained psychiatrists in the mental health product market. This Note documents evidence of this competition between psychiatry and psychology in insurance reimbursement, psychoanalytic practice, and state licensure issues. Recent federal legislative changes, which promote parity between the two disciplines in federal health care programs and facilities and in the judicial system, are reviewed. These legislative changes undoubtedly will increase significantly the potential for anticompetitive financial incentive in the hospital turf battle. The author of this Note submits that the class-based denial of hospital staff privileges to clinical psychologists may be properly viewed as unlawful "physician cartel" behavior, which is vulnerable to per se condemnation.

II. HOSPITAL STAFF DECISIONS

A. JCAH Procedural Process

The JCAH is a nonprofit corporation, which accredits over eighty percent of the acute care hospitals in the United States and assures the quality of participating hospitals. Although participation in a JCAH survey is voluntary, accreditation has significant import because accreditation is required for reimbursement under most federal government health plans and for private third-party insurance coverage. The JCAH member organizations, including the American Medical Association, the American Hospital Association, the American College of Surgeons, the American College of Physicians, and the American Dental Association, clearly are dominated by physicians.

Standards set by the JCAH establish procedures for organizing the medical staff of accredited hospitals and for conducting the decision-making process regarding staff privileges. Self-regulation is accomplished through

8. Psychiatry is a branch of medicine that specializes in the diagnosis, treatment, and prevention of mental illness. TABER'S CYCLOPEDIA MEDICAL DICTIONARY 158 (13th ed. 1977). The American Psychological Association's model licensing law defines the practice of psychology to include the diagnosis and treatment of mental, nervous, or emotional disorders, illness, or disability. AMERICAN PSYCHOLOGICAL ASSOCIATION, MODEL ACT FOR STATE LICENSURE OF PSYCHOLOGISTS (1987).


12. B. Furrow, supra note 10, at 345; see also R. Miller, Problems in Hospital Law 41-42 (5th ed. 1986).
