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A Perfect Storm on the Sea of Doubt: Physicians, Professionalism and Antitrust

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It is true that there are some cases in which the courts, mistaking, as we conceive, the proper limits of the relaxation of the rules for determining the unreasonableness of restraints of trade, have set sail on a sea of doubt, and have assumed power to say, in respect to contracts which have no other purpose and no other consideration on either side than the mutual restraint of the parties, how much restraint of competition is in the public interest, and how much is not. The manifest danger in the administration of justice according to so shifting, vague, and indeterminate a standard would seem to be a strong reason against adopting it.

Judge William H. Taft, *United States v. Addyston Pipe & Steel Co.*[1]

The object is to see whether the experience of the market has been so clear, or necessarily will be, that a confident conclusion about the principal tendency of a restriction will follow from a quick (or at least quicker) look, in place of a more sedulous one. . . .[T]here is generally no categorical line to be drawn between restraints that give rise to an intuitively obvious inference of anticompetitive effect and those that call for more detailed treatment. What is required, rather, is an enquiry meet for the case. . . ."

Justice Souter, *California Dental Ass'n v. FTC*[2]

I. Introduction

Judge Taft's eloquent warning about an unstructured antitrust jurisprudence has strong resonance today. Courts have steadily expanded the range of cases involving purported restraints of trade

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[1] 85 F. 271, 283-84 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899).

[2] 526 U.S. 756, 780-81 (1999).

under the rule of reason that require proof of the actual effects and have insisted on greater precision in the factual findings necessary to support plaintiffs' burden. While shortcuts, such as truncated or "quick look" inquiries, are theoretically possible in certain circumstances,[3] antitrust doctrine has not succeeded in simplifying or clarifying its inquiries. As Justice Souter's less eloquent framing reveals, the Supreme Court has recently muddied the water with a highly imprecise formulation of what is required in such investigations. For cases involving alleged restraints of trade by physicians, a number of other factors complicate the enterprise even further. Appreciation of the special character of professional services and the imperfect nature of the health care marketplace raise thorny issues for applying antitrust law to collective activities by physicians. Looking beyond legal doctrine, one finds political and social cross-currents that may dampen judicial enthusiasm to adhere to antitrust strictures. This essay describes these factors and explores several alternative paths to achieving a workable antitrust regime for professional restraints of trade.

II. Professional Restraints: From *Goldfarb* to *California Dental*

A. *Goldfarb*

Trade restraints by professionals have been a subject of close scrutiny from courts and antitrust enforcers for almost thirty years. Following the Supreme Court's landmark decision in *Goldfarb v. Virginia State Bar*,[4] the Federal Trade Commission ("FTC" or "Commission") and Department of Justice challenged a variety of ethical codes prohibiting advertising, contracting and affiliation with HMOs, and affiliation with alternative care providers. Federal enforcers also prosecuted dozens of private physician boycotts that sought to deter innovative financing plans, block competition from alternative care providers, or organize collective bidding.[5] Though

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[3] Willard K. Tom & Chul Pak, *Toward a Flexible Rule of Reason*, 68 ANTITRUST L.J. 391, 394-95 (2000); Timothy J. Muris, *The Federal Trade Commission and the Rule of Reason: In Defense of Massachusetts Board*, 66 ANTITRUST L.J. 773, 775-76 (1998); Frank H. Easterbrook, *The Limits of Antitrust*, 63 TEX. L. REV. 1, 16 (1984).

[4] 421 U.S. 773 (1975).

[5] *See, e.g., Am. Med. Ass'n*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2nd Cir. 1980), *aff'd by equally divided Court*, 452 U.S. 676 (1982); U.S. v.

defendants often justified their actions as attempts to ensure provision of high quality health care or to prevent "unprofessional" behaviors, the government was never pressed to prove its case under the exacting standards of the rule of reason.[6] Moreover, while disposing of the claim that professionals enjoyed an exemption from the antitrust laws by reason of their status as a "learned profession," the *Goldfarb* opinion nevertheless, in Footnote 17, suggested that judicial deference may sometimes be appropriate:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.[7]

Despite the apparent room it left for courts to consider benefits other than increased competition under the rule of reason, Footnote 17 has not played an important role in antitrust decisions. The Supreme Court itself has declined to apply the concept to professional restraints in a number of instances[8] and lower courts have rarely invoked it.[9] Unfortunately, in *California Dental Ass'n v. FTC*, the Supreme Court reopened the Pandora's Box of Footnote 17 with all its inherent ambiguities and with no metric to guide its

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N.D. Hosp. Ass'n, 640 F. Supp. 1028 (D.N.D. 1986); Mich. State Med. Soc'y, 101 F.T.C. 191 (1983). *See generally* B. FURROW ET AL., HEALTH LAW §14-10 (2000).

[6] The FTC and Department of Justice settled virtually all cases involving professional restraints of trade. Of the handful of private suits challenging ethical norms, only *Wilk,* discussed *infra* note 30, produced a substantial judicial opinion.

[7] *Goldfarb*, 421 U.S. at 788-89 n.17.

[8] *See, e.g.*, Nat'l Soc'y of Prof'l Eng'rs v. U.S, 435 U.S. 679 (1978); Am. Ass'n of Mech. Eng'rs Inc. v. Hydrolevel, 456 U.S. 556 (1982). In cases involving naked restraints of trade among professionals, the Court once specifically rejected the invocation of Footnote 17 to support rule of reason treatment, *Arizona v. Maricopa County Med. Society*, 457 U.S. 332 (1982), and twice did not mention it, *FTC v. Ind. Federation of Dentists*, 476 U.S. 447, 462 (1986); *FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990).

[9] The notable exception is *Wilk*, discussed *infra* note 30.

application.

A second aspect of antitrust analyses of collaborative activities by professionals is defendants' invocation of procompetitive benefits flowing from improved quality, enhanced information flows, or correction of market failures. The Supreme Court has dealt summarily with arguments that a "naked" restraint may escape sanction based on its propensity to improve quality. In *National Society of Professional Engineers*, it treated claims that anticompetitive professional rules were necessary to assure an appropriate level of safety as tantamount to a rejection of national competition policy.[10] At the same time, it has not foreclosed the possibility that improving the workings of an imperfect market might make a restraint "less naked" and that such propensities should be considered when undertaking the balancing mandated under the rule of reason.[11] In circumstances where benefits from collective professional actions were clear, such as those that make valuable information available to consumers, lower courts have repeatedly relied upon improvements in market performance to uphold such arrangements.[12] Not only are these interpretations well founded conceptually and consistent with the consensus core of antitrust doctrine, but as Clark Havighurst has noted, they serve the pragmatic purpose of answering critics who find excessive attempts to enforce competition policies that lessen, however slightly, the role of professional discretion.[13] This accommodation worked well and served antitrust's efficiency goals as long as the border between naked and ancillary restraints was observed by the courts.

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[10] 435 U.S. at 695-96; *see also Ind. Fed'n of Dentists*, 476 U.S. at 462.

[11] *See Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 696 ("[B]y their nature professional services may differ significantly from other business services and accordingly the nature of competition in such services may vary. Ethical norms may serve to regulate and promote this competition, and thus fall within the Rule of Reason."). *See generally* Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605 (1989) [hereinafter *Market Failure Defenses*].

[12] *See e.g.*, Koefoot v. Am. Coll. of Surgeons, 652 F. Supp. 882 (N.D. Ill. 1986); Marrese v. Am. Acad. of Orthopedic Surgeons, 977 F.2d 585 (7th Cir. 1992); Kreuzer v. Am. Acad. of Periodontology, 735 F.2d 1479 (D.C. Cir. 1984); Poindexter v. Am. Bd. of Surgery Inc., 911 F. Supp. 1510 (N.D. Ga. 1994).

[13] Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL., POL'Y & L. 939, 948 (2001) (defenses may "protect the law and its enforcers against the charge of being driven by a blind faith in competition and market forces. . . .").

B. *California Dental Association*: Doctrinal Uncertainty and Dubious Economics

California Dental Ass'n v. FTC involved the Commission's challenge to the rules of a private trade association restricting price and "nonprice" advertising by its members. Although on their face the challenged rules purported to control false and misleading advertising, the evidence showed they had been used to condemn many instances of truthful, non-deceptive advertising.[14] The Commission applied the *per se* rule to condemn the restrictions on price advertising (though it did rule in the alternative that the rule would also fail under an abbreviated analysis). Applying "quick look" scrutiny, it also struck down the nonprice restraints, finding that the association possessed market power and that the restraints had an anticompetitive effect.[15]

On appeal, the Ninth Circuit affirmed the Commission's decision, but declined to apply *per se* analysis to the price advertising rule.[16] Instead it opted for an "abbreviated rule of reason" analysis that did not engage in detailed analysis of the market or discuss arguments premised on economic literature suggesting that advertising restrictions may sometimes be procompetitive in the professional context.[17] The Supreme Court reversed and remanded to the Ninth Circuit, concluding that *per se* analysis was inappropriate and that a "more sedulous" inquiry was required.[18]

The controversy surrounding the Supreme Court's recent decision in *California Dental* stems less from the Court's holding that *per se* or the severely truncated standard was inappropriate to assess the economic effects of the specific professional restraints at issue, than its blurring of prior doctrine. The unfavorable commentary concerning the decision has criticized the majority opinion's failure to explicate the structure of analysis under the rule of reason; its casual examination of the economic justifications relied upon to

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[14] *See In re* Cal. Dental Ass'n, 121 F.T.C. 190, 252 (1996) (concluding that the Ass'n had challenged hundreds of representations that on their face were not false or deceptive). A dissenting Commissioner would have remanded the case for further findings. *Id.* at 333 (Azcuenaga, J., dissenting).

[15] *Id.* at 252.

[16] Cal. Dental Ass'n v. FTC, 128 F.3d 720, 727-28 (9th Cir. 1997), *rev'd*, 526 U.S. 756 (1999).

[17] *Cal. Dental Ass'n*, 128 F.3d at 727-28.

[18] 526 U.S. at 781.

reject truncated scrutiny; its failure to give deference to the FTC's findings; and its misapprehension of the appropriate measure of "output" in the context of restraints upon services.[19] These defects give rise to three central areas of concern for future antitrust inquiries involving professionals.

1. What Role for Professional and Quality of Care Justifications?

Emphasizing information failure in the market for dental services, the Court insisted that a more complete examination was required for restrictions whose stated purpose was to limit deceptive advertising.[20] Citing Footnote 17 of *Goldfarb*, the Court stated:

> [T]he [California Dental Association's] advertising restrictions might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition. The restrictions on both discount and nondiscount advertising are, at least on their face, designed to avoid false or deceptive advertising in a market characterized by striking disparities between the information available to the professional and the patient.[21]

Justice Souter went on to note a number of other special characteristics of the market for dental services, including the fact that information about prices and availability is "difficult to get and verify;"[22] the existence of "striking disparities between the information available to the professional and the patient;"[23] and that "the quality of professional services tends to resist either calibration

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[19] *See, e.g.*, Herbert Hovenkamp, *Competitor Collaboration After California Dental Association*, 2000 U. CHI. LEGAL F. 149; David Balto, *Some Observations on* California Dental Association v. FTC, 14 ANTITRUST, Fall 1999; Stephen Calkins, *California Dental Association: Not a Quick Look But Not the Full Monty*, 67 ANTITRUST L.J. 495 (2000); Marina Lao, *The Rule of Reason and Horizontal Restraints Involving Professionals*, 68 ANTITRUST L.J. 499 (2001); Thomas L. Greaney, *Antitrust and the Healthcare Industry: The View from the Three Branches*, 32 J. HEALTH L. 391, 392-97 (1999). For a more favorable assessment, see William J. Kolasky, California Dental Association v. FTC: *The New Antitrust Empiricism*, ANTITRUST, Fall 1999.

[20] *Cal. Dental Ass'n*, 526 U.S. at 780-81.

[21] *Id.* at 772.

[22] *Id.*

[23] *Id.* at 771.

or monitoring by individual patients or clients."[24] Further, the Court offered the confusing observation that "[p]atients' attachment to particular professionals, the rationality of which is difficult to assess, complicate the picture even further."[25]

The invocation of Footnote 17 and the Court's repeated references to market imperfections raises anew the question of whether special treatment will be afforded to professional activities. While there are several textual signals that the Court did not mean to upset entirely its prior treatments of learned professions or of quality-premised justifications, the majority opinion gives an unmistakable nod to claims that peculiarities of health care markets justify close consideration. Not only were special circumstances observed (and framed rather dogmatically), but the decision gave almost no deference to the FTC's specific findings about the market. Information deficits will be present (albeit in different degrees) in most cases involving health professionals. Unfortunately, trial courts will obtain no guidance from *California Dental* as to when those problems justify broad rule of reason treatment or when truncated review is "meet for the case."

Equally problematic is the fact that the *California Dental* majority opinion blends its treatment of professionalism and market imperfection considerations in a way that is certain to invite future litigants to insist on broad rule of reason inquiries whenever *either* is present. Close analysis of the Supreme Court's cases in this area would suggest that full-scale inquiries into suspect restraints are appropriate only when professional judgments seem well-suited and are reasonably necessary to ameliorate significant problems. In this connection, it is important to note that the *California Dental* opinion did not attempt to distinguish the market conditions at issue in *FTC v. Indiana Federation of Dentists*, in which the Court summarily struck down a restraint forbidding dentists from supplying to third party payors x-rays needed to review the appropriateness of claims.[26] This

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[24] *Id.* at 772.

[25] *Id.* The Court made no effort to explain why patient loyalty to physicians might be regarded as irrational. The comment betrays the majority's failure to appreciate the important role that trust plays in correcting market failures in medicine. *See* Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); Mark A. Hall, *Arrow on Trust*, 26 J. HEALTH POL., POL'Y & L. 1131 (2001).

[26] *Ind. Fed'n of Dentists*, 476 U.S. at 463 (rejecting as "flawed both legally and factually" justifications based on the claim that "consumers are given access to information they believe to be relevant to their choices will. . .make unwise and

suggests that it did not mean to upset entirely that decision's insistence that defendants adduce evidence of procompetitive effects and not rest on generalized assertions of imperfect market conditions. Moreover, a key difference between the two cases was that the restraint in *Indiana Federation of Dentists* interfered directly with the market mechanism (utilization review) that ameliorated significant market imperfections, including moral hazard, associated with third party insurance. To that extent, *Indiana Federation of Dentists* involved a more serious restraint than advertising restrictions, whose effect on the pricing mechanism is less direct.

At the same time, however, the *California Dental* majority did not delve deeply into the logic or the mechanisms by which information deficits would be cured by significant bans on the provision of price and nonprice information. Inasmuch as advertising at first blush seems aimed at correcting market failure by enhancing the stock of information available to buyers, this is a critical lapse. Without first requiring that defendants demonstrate more than what Justice Breyer referred to as "theoretical plausibility,"[27] defendants will have little difficulty in contending that market imperfections require full rule of reason treatment no matter how suspect their concerted activity and without regard to the existence of plainly less restrictive alternatives.

One notable, but flawed, attempt to craft a process under the rule of reason for addressing ethical and quality issues is found in *Wilk v. American Medical Ass'n.*[28] At issue were the AMA's ethical prohibitions against physician referrals and other forms of cooperation with chiropractors that it claimed advanced the profession's purposes of advancing scientific knowledge and improving quality of care. The Seventh Circuit responded with a "special" rule of reason (also termed a "patient care defense"). The decision announced a four-part test that afforded defendant the opportunity to demonstrate a dominant, "objectively reasonable" concern for issues going to the "scientific method" underlying the care given to patients; where those criteria were satisfied, the test further required defendant to demonstrate that less restrictive means of policing quality were not available.[29] This proved to be a demanding test. In assessing benefits under the rule of reason on

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even dangerous choices.").

[27] *Cal. Dental Ass'n*, 526 U.S. at 787.

[28] 719 F.2d 207 (7th Cir. 1983).

[29] *Id.* at 227.

remand, the trial court rejected as speculative the AMA's claim that procompetitive informational benefits flowed from the boycott (which the AMA characterized as "nonverbal communication" about differences in quality of care provided by chiropractors).[30] Essentially, the defendants argued that rules prohibiting cooperation signaled important facts and professional judgments about chiropractors, and thus improved medical doctors' competitiveness by allowing them to act on the basis of better information. In principle, certain collective actions by professional associations may improve competition by overcoming market imperfections in information about providers and the quality of care they supply. However, the court was entirely correct in rejecting this alleged benefit on the record before it. Given that the AMA's absolute boycott was designed to destroy chiropractic practice, a far more compelling showing of the nature and magnitude of these benefits and the absence of less restrictive alternatives should be required to overcome such restraints.

There are several reasons to question the wisdom of the Seventh Circuit's "patient care defense." For example, by blending subjective and objective standards, it invites an open-ended inquiry into scientific issues and motives that may confuse both judges and juries. Moreover, as discussed below, by failing to clearly delineate market failure as a justification for a departure from ordinary antitrust analysis, the approach invites considerations of "worthy objectives" and quality of service justifications that the Supreme Court has decisively rejected. Nevertheless, the approach is instructive in that it attempts to rigorously structure the rule of reason inquiry and appropriately puts those who assert defenses predicated on the peculiarities of health markets to the exacting tests of empirical proof and a less restrictive alternatives requirement.[31]

2. What is the Appropriate Measure of Output in Cases Involving Restraints of Trade by Professionals?

Apparently believing the only measure of output in the case to be dental services, the *California Dental* majority termed "puzzling" the Ninth Circuit's conclusion that the Association's advertising restrictions reduced output in the provision of information.[32] It went

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[30] Wilk v. Am. Med. Ass'n, 671 F. Supp. 1465 (N.D. Ill. 1987).

[31] *See infra* section IV.

[32] 526 U.S. at 776.

on to question whether any restriction on demand was cognizable:

> If quality advertising actually induces some patients to obtain more care than they would in its absence, then restricting such advertising would reduce the demand for dental services, not the supply; and it is of course the producers' supply that is normally relevant in determining whether a producer-imposed output limitation has the anticompetitive effect of artificially raising prices.[33]

The Court's implication that an informational service component (such as advertising) could not be regarded as a part of the output of the professional services rendered is incorrect. As an economic matter, the lessening of output in information can effectively injure consumers; moreover, it can do so without necessarily reducing output in the market for dental services. Properly viewed, dental consumers are purchasing a package of service and information about those services which make them more satisfied with the treatment, value, and care they receive.[34] The FTC had rehearsed this issue previously in a case involving a collective agreement by auto dealers to limit showroom hours.[35] The Sixth Circuit found the Commissioner's characterization of the restriction as a *per se* restraint as inappropriate, viewing the output of the dealers as car sales exclusively.[36] The Sixth Circuit's narrow interpretation of the market seems plainly at odds with the Supreme Court's treatment of a similar service aspect of competition in *Indiana Federation of Dentists*.[37]

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[33] *Cal. Dental Ass'n*, 526 U.S. at 776-77.

[34] Professor Hovenkamp analyzed the court's error as follows:

> The "output" of any firm is the combination of product-plus-other-services that the market produces. Thus the output of the car dealer is car transactions, its desirable showroom and hours of operation, and its advertising. An agreement among dealers not to have showrooms reduces costs and may or may not result in greater cars sales. But we attach significance to the fact that consumers value the showroom; otherwise a well-functioning competitive market would not have produced it.

Hovenkamp, *supra* note 19, at 174.

[35] *Detroit Auto Dealers*, 111 F.T.C. 417 (1989), *aff'd*, 955 F.2d 457 (6th Cir. 1992).

[36] Detroit Auto Dealers v. FTC, 955 F.2d 457 (6th Cir. 1992).

[37] *Ind. Fed'n of Dentists*, 476 U.S. at 453 ("A refusal to compete with respect

Equally problematic is the Court's broadly dismissive treatment of demand-side effects. Restraints operating on the demand side may have adverse competitive consequences under certain conditions.[38] Admittedly, it is necessary to distinguish efforts to spur demand that may be quality-improving or information generating as to a given product from tactics that artificially increase demand for one product at the expense of another. In *California Dental*, the essence of the demand-side claim was that the ban on advertising exacerbated market failure resulting from informational deficits. Some who might otherwise forego treatment might seek dental services in response to price or quality advertising.[39] The output restriction resulting from collusive agreements to dampen demand should be cognizable when it exploits or extends market failures. Unfortunately, on remand, the Ninth Circuit read the Supreme Court's admonition broadly and treated this claim as beyond the scope of antitrust law.[40]

3. How will Courts Evaluate Economic Evidence?

The courts' handling of the economic evidence in *California Dental* is a cause for concern. Both the Supreme Court and the Court of Appeals overreacted to some rather broad economic generalizations. Moreover, the Ninth Circuit's evaluation of the empirical evidence before it seemed to lose sight of the purpose and limitations of economic studies of particular markets.

For purposes of evaluating the economic effects of the advertising restraints, the record in the *California Dental* case was far from satisfactory. Because the trial staff elected to proceed on a *per se* theory, it did not call an expert economic witness and did not

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to the package of services offered to customers, no less than a refusal to compete with respect to the price term of an agreement, impairs the ability of the market to advance social welfare. . . .").

[38] *See* Mark R. Patterson, *Coercion, Deception, and Other Demand-Increasing Practices in Antitrust Law*, 66 ANTITRUST L. J. 1 (1997) (explaining that demand-increasing agreements like coercion and deception may adversely affect consumer welfare where the practice imposes costs on buyers of some other product).

[39] *See* Cox & S. Foster, *The Costs and Benefits of Occupational Regulation*, F.T.C. BUREAU OF ECONOMICS, Oct. 1990, at 35-36.

[40] *Cal. Dental Ass'n*, 224 F.3d at 952. The Ninth Circuit rejected the FTC's argument that in observing that supply effects are "normally relevant" to anticompetitive price increases, the Supreme Court had not ruled out consideration of demand-side effects. *See* Supplemental Brief of Federal Trade Commission in Cal. Dental Ass'n v. FTC at 30 n.9.

assemble a comprehensive account of the economic literature. Perhaps encouraged by the Supreme Court majority's statement that "[h]ad the Court of Appeals engaged in a painstaking discussion in a league with Justice Breyer's. . .and had it confronted the comparability of these restrictions to bars on clearly verifiable advertising, its reasoning might have sufficed to justify its conclusion," the FTC on remand argued that the record was sufficient to allow the court to evaluate the restraints under the rule of reason.[41] That said, both courts' handling of the evidence before them was problematic.

The Supreme Court relied heavily on several propositions found in theoretical economic literature. First, it noted that the "information asymmetries" that distort health care markets may impair the functioning of the market and may justify professional interventions that protect consumers. While this may be true in some circumstances, the Court neglected to note that the information problems are a double-edged sword when evaluating professional restraints. The same factors that impair consumers' capacity to evaluate care and calculate value also enhance professionals' ability to act opportunistically. Moreover, the Court gave no indication that it understood that market imperfection is a matter of degree. Inasmuch as all markets fall short of the neoclassical economist's ideal, it is surely necessary to limit the categories of market defects sufficient to trigger fuller analysis. For example, as a preliminary criterion, the Court might have insisted that the defendant's claim amounted to a claim of "market failure."[42] In this connection, it is appropriate to insist that professional interventions be justified as the least restrictive alternative to effectuating such improvements.[43]

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[41] It did argue that if the Ninth Circuit found the record did not support their conclusion that the restraints were anticompetitive under the rule of reason the case should be remanded to the Commission. *Cal. Dental Ass'n*, 224 F.3d at 958. The Ninth Circuit held however that the FTC had made a tactical decision not to introduce further empirical or expert economic evidence and was not entitled to "a second bite at the apple"; it therefore declined to remand the case to the Commission. *Id.* at 959.

[42] *See* Hovenkamp, *supra* note 19, at 176 (defining market failure as "situations where the unrestrained market is simply not doing an adequate job of providing the correct quality or price of the services in question."). *See also Market Failure Defenses*, *supra* note 11, at 633-41.

[43] *See Market Failure Defenses, supra* note 11, at 645-649 (proposing a structured market failure defense); Joseph Brodley, *The Economic Goals of Antitrust: Efficiency, Consumer Welfare, and Technological Progress*, 62 N.Y.U. L. REV. 1020, 1047-48 (1987) ("The existence of market failure indicates the need

Secondly, the Court was impressed with the argument that dental advertising may have the characteristics of a "lemons market." Though it was less than clear on the point, possibly the Court meant to rely on this contention as an indication that advertising threatened to harm consumers. Relying on a well-known article by George Akerlof, the Court observed that in some situations, dishonest dealings tend to drive honest dealings out of the market.[44] Yet the lemons market frame can not support blanket conclusions about professional advertising, nor should it, without more, be used to justify abandoning abbreviated analysis of suspect restraints. First, there is reason to doubt the extent of the phenomenon in dental advertising: many dental advertising claims are verifiable and subject to the testing common to experience goods.[45] As economists have pointed out, the risks of lemons markets are commonly dealt with by both private market forces and government interventions. Guarantees and warranties may counteract the effect of dishonest advertising, as indeed may counter-advertising and independent sources such as consumer newsletters.[46] Moreover, government regulation of deceptive advertising as well as legal interventions such as licensure place some limits on extreme behaviors.

The Ninth Circuit's treatment of the empirical evidence before it betrays a misapprehension of the evidentiary value of this evidence. Indeed, by declining to draw inferences from these studies, the court implicitly set an unwarranted standard for the proof of effect based on empirical economic evidence. Having first concluded that the nature of the association's restraints merited something approaching a full-blown rule of reason analysis,[47] the Ninth Circuit

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for regulation, but does not resolve whether the regulation should be public or private.")

[44] George Akerlof, *The Market for Lemons: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON 495 (1970). *See also* Hayne E. Leland, *Quacks, Lemons, and Licensing: A Theory of Minimum Quality Standards*, 87 J. POL. ECON 1328 (1979).

[45] Timothy J. Muris, California Dental Association v. Federal Trade Commission: *The Revenge of Footnote 17*, 8 SUP. CT. ECON. REV. 265, 289 (2000) (*California Dental* opinion "exaggerated the impact of adverse information").

[46] Benjamin Klein & Keith B. Leffler, *The Role of Market Forces in Assuring Contractual Performance*, 89 J. POL. ECON. 615 (1981); Muris, *supra* note 45, at 289.

[47] *Cal. Dental Ass'n*, 224 F.3d at 947 n.3 (court is "opt[ing] for a particularly searching rule-of-reason inquiry in light of the plausibility and strength of the procompetitive justifications" for the Associations advertising restraints).

undertook a review of the economic record before it. Although a number of studies indicated that price and nonprice advertising by professionals improved consumer welfare without harming consumers,[48] the Ninth Circuit was unjustifiably wary of drawing inferences from those studies as to the likely effects of advertising restraints by dentists. While the court observed that the authors of these studies cautioned against extrapolating from their conclusions without further research, the court's dismissive approach appears unwarranted. Given the number of studies finding that advertising restrictions tend to raise price and that professional advertising does not impair quality,[49] along with the Court's own pronouncements in the area of professional advertising,[50] the Ninth Circuit's treatment of the evidence seems inappropriate. In adopting a "particularly searching" rule of reason standard, the court appears to have adopted a heightened proof standard as well, one that sub silentio shifted to the government the burden of disproving the presence of significant market failure or that adopted a heightened evidentiary standard.

III. Politics and the Medical Profession

Another factor casting a shadow over antitrust enforcement involving professional restraints of trade is the unmistakable shift in attitude among judges and legislators regarding managed care. Dissatisfaction with bureaucratic delays, interference with patient choice of providers and other factors have encouraged a belief that managed care has become too powerful.[51] This "backlash" against managed care has resulted in extensive state regulation aimed at curbing perceived abuses. It has also spurred efforts to "level the playing field" between physicians and managed care organizations

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[48] *See* James A. Langenfeld & John R. Morris, *Analyzing Agreements Among Competitors: What Does the Future Hold?*, 36 ANTITRUST BULL. 651, 667 (1991) (reviewing literature and concluding empirical "studies of the price effects of advertising restrictions in professional occupations consistently have found that restrictions raise price").

[49] *Id.* An excellent review of the economic learning in this area is found in Muris, *supra* note 45, at 293.

[50] *E.g.*, Zauderer v. Office of Disciplinary Counsel, 471 U.S. 626, 646 (1985) ("[A]ssessment of the validity of legal advice and information contained in attorneys' advertising is not necessarily a matter of great complexity.").

[51] Clark C. Havighurst, *The Backlash Against Managed Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395 (2001); Alain C. Enthoven et al., *Consumer Choice and the Managed Care Backlash*, 27 AM. J.L. & MED. 1 (2001).

through legislation that would permit provider collaboration and bar application of antitrust law. For example, two states have adopted legislation designed to exempt physician collective bargaining from coverage of state and federal antitrust laws[52] and a federal bill that would permit such activities to come under labor exemption passed the House of Representatives in 2000.[53] While the merits of this debate are beyond the scope of this article,[54] it is worth noting that these attitudes have been reflected in court decisions and the attitude of government enforcers.

Courts are increasingly citing managed care's shortcomings, reflected by Judge Posner's acerbic epigram that "the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible."[55] One circuit court decision notably quoted the aforementioned passage in support of its questionable interpretation of patients' decisions to migrate to distant hospitals.[56] Moreover, federal enforcers have shifted resources and prosecutions away from scrutiny of provider markets, a move that can be explained at least in part by a growing disinclination to pursue cases involving professional judgments.[57]

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[52] TEX. INS. CODE ANN. § 29.06(a) (Vernon 2001); N.J. STAT. § 52:17B-196 (West 2002); *see* Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFFS. 185 (Mar./Apr. 2002) [hereinafter *Whither Antitrust*].

[53] 146 CONG. REC. H5652 (daily ed. June 29, 2000) (H.R. 1304 Quality Health Care Coalition Act passed the House).

[54] *See* Dionne Koller Fine, *Exploitation of the Elite: A Case for Physician Unionization*, 45 ST. LOUIS U. L.J. 207 (2001); William S. Brewbaker, III, *Physician Unions and the Future of Competition in the Health Care Sector*, 33 U. C. DAVIS. L. REV. 545 (2000); FURROW ET AL., HEALTH LAW, CASES, MATERIALS AND PROBLEMS 1073-75 (2001).

[55] Marshfield Clinic v. Blue Cross & Blue Shield United of Wis., 65 F.3d 1406, 1410 (7th Cir. 1995).

[56] FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1054 (8th Cir. 1999). *See generally Whither Antitrust*, *supra* note 52, at 186-88 (criticizing Tenet decision).

[57] The Department of Justice recently announced plans to shift enforcement responsibilities for health care matters to the FTC, an agency that has devoted the lion's share of its enforcement efforts in recent years to the pharmaceutical industry. *See Senator Derails Reform Effort at Last Minute*, WASH. POST, Jan. 18, 2002, at E1; *Whither Antitrust*, *supra* note 52, at 192-93.

IV. Future Directions

This brief article has sought to identify some of the missteps that have bred uncertainty and threaten to undermine sound economic analysis of the impact of physician collaboration. A principal shortcoming of the courts has been the abdication of their responsibility to craft presumptions and rules that will guide factfinders attempting to apply antitrust law against the confusing backdrop of market imperfections and legitimate professional goals. In the case of physician collaborations that restrain trade, care must be taken to separate bare-boned justifications premised on worthy objectives or enhancements to quality of care from those that accurately depict market-improving mechanisms. To do so, I have proposed elsewhere a "structured market failure defense" that requires proof that market failure actually impairs market performance, that professional self regulation is likely to improve consumer welfare, and that less restrictive means of obtaining such benefits are not available.[58] Much important scholarship, such as that of Peter Hammer, has begun to focus attention on dissecting the impact of trade restraints in the context of close analysis of the functioning of imperfect health care markets.[59] While neither the unpredictable political winds nor the shifting seas of Supreme Court jurisprudence give much room for optimism, these markers may help lower courts steer a course toward a more sensible jurisprudence in this area.

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[58] *Market Failure Defenses*, *supra* note 11, at 645-49.

[59] Peter J. Hammer, *Questioning Traditional Antitrust Presumptions: Price and Non-Price Competition in Hospital Markets*, 32 MICH. J. L. REF. 727 (1999); Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare and the Challenge of Intramarket Second-Best Tradeoffs*, 98 U. MICH. L. REV. 849 (2000). *See also* Cory S. Capps et al., *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers*, January 2001, *available at* http://www.kellogg.nwu.edu/faculty/satterthwaite/Research/2001%200131%20hospdemand_fallacy.pdf (last visited Apr. 27, 2002). James Langenfeld & W. Li, *Critical Loss Analysis in Evaluating Mergers*, 46 ANTITRUST BULL. (2001); Kenneth L. Danger & H.E. Frech, *Critical Thinking about 'Critical Loss' in Antitrust*, 46 ANTITRUST BULL. 331 (2001).