For many years the learned professions enjoyed immunity from antitrust regulation. The basis for this immunity was that physicians were not thought to be engaged in the kind of commercial activity for which the Sherman Act and the Federal Trade Commission (FTC) Act were intended. In 1975, the US Supreme Court ended that immunity by declaring that the scope of antitrust law included the business activities of the professions. It gave no indication of exactly how antitrust regulation was to be applied to medicine. Since then numerous legal actions have been taken against physicians or physician groups to curb what government has perceived to be “anticompetitive” activities. These actions have been resisted by organized medicine in the courts and in the Congress, but to no avail.

Although the federal government now believes that at least some aspects of medical practice belong under antitrust surveillance, the laws enforced by the FTC do not prohibit medical associations from adopting ethical codes designed to protect the public—so long as such codes are not “anticompetitive.” Thus, with respect to commercial conflicts of interest and ethical rules that simply requires physicians to disclose equity interests in health care facilities to which they refer their patients would probably not raise antitrust problems. L. Barry Costilo, a lawyer with the FTC, stated in 1985, “If an ethics rule prohibited physicians from having any ownership interest in a facility to which they referred patients, antitrust questions would be raised, since the rule would probably be overly broad as a means of preventing deceptive behavior or other abuses.” This possibility may be worrying organized medicine’s lawyers enough to cool whatever enthusiasm may have existed about taking stronger stands on the conflict of interest issue. The American Medical Association (AMA) has already had frustrating, expensive legal encounters with the FTC and clearly does not seek another antitrust confrontation at this time.

The underlying questions raised by the application of antitrust law to
medicine cries out for public discussion and clarification. Does our society want to draw a line between the medical profession and the growing investor-owned health care industry, and if so, where? Should government encourage the profession to set its own ethical standards, even when the latter limit the freedom of physicians to make business arrangements in the medical marketplace? In the final analysis, where does the public interest lie—in strengthening the profession's fiduciary commitments to patients or in encouraging entrepreneurialism and commercial competition among physicians? It is clear that we cannot have it both ways. The kind of freewheeling business competition envisioned by antitrust law is simply not compatible with the ethical obligations of doctors to their patients. To quote Clark C. Havighurst, Professor of Law at Duke University, a leading authority on antitrust applications in health care, "Antitrust law does not, as a general rule, tolerate competitor collaboration simply because it serves worthy purposes, professional or otherwise. Instead the legal inquiry . . . focuses on whether a particular collaboration is compatible with the maintenance of competition in the market as a whole." According to Havighurst, federal policy today "starts from the proposition that the health care sector is a competitive industry to be guided, for better or worse, by market forces unless Congress declares otherwise. . . ."

Uncomfortable and costly though the process may be, organized medicine may have no choice but to pursue this issue in the courts and in state and federal legislative chambers. For if the free-market theoreticians and the antitrust enforcers have their way, the ethical foundations of our profession will be undermined, and the practice of medicine will come to be treated purely and simply as commerce. To avoid this, courts and legislatures will have to distinguish carefully between the collective activities of physicians that are appropriately subject to antitrust law and those that are not. In the former category, I suggest, belong such "anticompetitive" economic actions as boycotting, price fixing, unreasonable prohibitions on the dissemination of truthful information about the availability of medical services, and collusion to restrain the development of new types of practice organizations or the practice opportunities of competing but qualified physicians. Most of the FTC actions described by Mr. Costilo have been concerned with problems of this kind. In the off-limits category, however, should be all the self-regulating activities that defend the ethical integrity of the profession and the quality of its services, regardless of the effect on entrepreneurial activity. There are fundamental differences between medical care and the usual kinds of commerce, and the public interest requires that these differences be preserved, no matter what the consequences for "competition."

But even if we were to accept for the moment Havighurst's description of health care as a competitive industry, "to be guided, for better or worse, by market forces," and even if we were to apply the yardstick suggested by Costilo, I find it hard to understand how an ethical ban on investments in facilities to which physicians refer their own patients could be regarded as a threat to competition. If anything, such an ethical rule would be procompetitive, for it would ensure that physicians' decisions to use facilities and