The Health Care Industry and Its Medical Care Providers: Relationship of Trust or Antitrust?

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I. INTRODUCTION

The United States health care system consists of relationships between consumers, as potential and actual patients, and the health care providers who treat them. These relationships are, in an important sense, unequal, because the parties involved openly rely on the information and knowledge provided by the opposite party – the patient who relates to the health care provider (hopefully) an accurate and relevant medical history, and in turn, the provider who diagnoses and treats the patient derived from (again, hopefully) extensive and essential education and clinical training. For this reason, consumers choose their health care providers on notions of immense trust that state and federal laws licensing those health care providers mandate qualified, competent and careful medical professionals. In recent years, as health care costs have continued to increase, many non-physician groups, those being health care providers who did not attend medical school, have engaged in exhaustive lobbying efforts to expand the scope of practice afforded to them by state laws. While the increase of health care professionals in the market may seem beneficial to consumers as a way to increase access to care or decrease the ever-rising costs of health care, it may still create precarious risks for patients and consumers of health care services when the scope of a non-physician’s practice exceeds his or her level of education or clinical training experience.

In response to increasing health care costs, falling reimbursements for physician services, and general impediments to access to medical care for consumers, non-physician providers, specifically advanced

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1. Examples of licensed non-physician practitioners include, but are not limited to, advanced practice nurses (such as nurse practitioners and nurse anesthetists), podiatrists, chiropractors, and physician assistants. The scope of this Article will be limited to focus on the advanced practice nursing profession as compared to physician services.
practice nurses and physicians’ assistants, are staffing retail-based health clinics around the country to provide convenient, speedy, and inexpensive medical care to patients. The recent advent of in-store health clinics at national retail superstores such as Walgreens, CVS/Caremark®, and Wal-Mart has provoked physicians and their respective professional medical societies to argue that these clinics are largely unregulated and put patients’ health at risk. While the clinics present many benefits for consumers, physicians are losing patients and income, and, whether or not prompted by these professional consequences, physicians and their advocates discourage the use of stop-and-shop medical treatment by claiming reduced quality of care.

This Article will demonstrate that in light of the chronic turf battle between physicians and non-physician practitioners, and the related lobbying for scope of practice expansion legislation, non-physician practitioners are finding new ways to effectively compete with physicians in the provision of medical care to patients that antitrust laws are not necessarily designed to remedy.

II. BACKGROUND

For decades, physicians have enjoyed a monopoly in the provision of patient care services. State regulations have bolstered that monopoly by restricting non-physicians’ opportunities to practice medicine. Because state legislatures have a great deal of latitude in the regulation of non-physician groups, it has proven difficult to develop nationwide, coordinated, and uniform policies regarding the provision of health care services by non-physician practitioners. In response to rising health care costs, geographic and economic barriers

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2. See infra Section III. B.
3. See Bruce Japsen, Doctors push law on clinics in stores; Patients are put at risk, they contend, CHI. TRIB., May 6, 2007, at B1; see also infra Section III.C.
7. Grumbach & Coffman, supra note 5, at 825.
8. Id.
to consumer access medical care, as well as increased demand for providers, many non-physicians have confronted the monopolistic delivery of health care. 9 Specifically, nurse practitioners have expanded the professional role of the registered nurse to "advanced practice," offering them professional autonomy to provide primary care to patients instead of secondary care to that of a physician. 10 This Section will provide an overview of the history of regulation of medical professionals in the United States and how antitrust concerns must be balanced with public policy to promote patient safety in the provision of health care.

A. Scope Of Practice: Who Is Licensed To "Practice Medicine"?

State Medical Practice Acts define what constitutes the "practice of medicine," and no one definition is exactly the same across the fifty states. 11 As a general matter, "scope of practice" is comprised of the activities that an individual health care practitioner is permitted to perform within a specific profession or specialty, as determined by factors such as education, training, and experience. 12 There is immense variation within and among states in the provisions of scopes of practice among physician groups. 13 Scope of practice regulations establish boundaries within and between medical care professions and attempt to distinguish practitioners of medicine from non-physician practitioners and other health care providers who are not licensed medical doctors. 14

The health care market regards physicians as medical doctors in a learned profession who are well schooled in the practice of medicine and have extensive, specialized education and clinical training. 15 The basic training of a physician includes four years of premedical education at a college or university, four years of medical school, and a resi-

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10. See id.
11. See Safriet, supra note 4, at 306.
12. Federation of State Medical Boards of the United States, supra note 4.
13. Safriet, supra note 4, at 313-14; see also Williamson v. Lee Optical of Okla., 348 U.S. 483, 488 (1955) (holding that while it was well within the police power of a State to regulate the examination of eyes even though the law limited the practice of opticians, the Supreme Court noted that it would not "strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought. . . . 'For protection against abuses by legislatures the people must resort to the polls, not to the courts.'") Williamson, 348 U.S. at 488 (quoting Munn v. Illinois, 94 U.S. 113, 134 (1877)).
dency consisting of three to seven years of postgraduate education and training.\textsuperscript{16} Physicians must pass an exam to become licensed to practice medicine in the state in which they seek to provide health care services.\textsuperscript{17}

In comparison, non-physicians generally have less rigorous clinical training and education requirements, and are restricted or even prohibited by state law in their use of the modifier "doctor" to describe their practice.\textsuperscript{18} Licensed non-physician health care providers do not "practice medicine" in the traditional sense, even though they administer services to patients that are viewed as "medical care."\textsuperscript{19} A typical graduate program for advanced practice nurses, including nurse practitioners, nurse anesthetists, and nurse midwives, ranges anywhere from two to three years.\textsuperscript{20} Nurse practitioners are registered nurses who complete graduate-level education and advanced clinical training and to practice, national board certification and state licensing are required. Even so, scope of practice issues are implicated in the context of advance practice nursing when marketed as a substitute to primary care, because the length of training and education programs is half than that of a physician, and entry into the workforce to treat patients is similarly less stringent.\textsuperscript{21} More specifically, and for purposes of this Article, nurse practitioner educational programs are typically geared towards a specific specialty, patient population, or geographical region.\textsuperscript{22} Consequently, specialty courses for advanced practice nursing vary across schools and programs, and no uniform requirement for didactic or clinical education for nurse practitioners exists.\textsuperscript{23} At bot-

\begin{itemize}
  \item \textsuperscript{16} Id.
  \item \textsuperscript{17} Id.
  \item \textsuperscript{18} \textit{Federation of State Medical Boards of the United States}, \textit{supra} note 4.
  \item \textsuperscript{19} \textit{Furrow}, \textit{supra} note 13, at 149.
  \item \textsuperscript{20} \textit{American Medical Association, AMA Scope of Practice Data Series: Nurse Practitioners} 25 (2009), available at http://www.aanp.org/AANPCMS2/publicpages/08-0424\_20SOP\_20Nurse\_20Revised\_2010-09.pdf. Nurse practitioners must have a graduate degree to enter the profession. While most programs award master's degrees or post-master's certificates, many programs are moving toward the nurse practitioner doctoral degree with the degree title of doctor of nursing practice. \textit{American Academy of Nurse Practitioners, Position Statement on Nurse Practitioner Curriculum} (1993), available at http://www.aanp.org/NR/rdonlyres/59523729-0179-466A-A7FB-BDEE68160E8E/0/NPCurriculum.pdf.
  \item \textsuperscript{22} \textit{American Medical Association}, \textit{supra} note 19, at 27.
  \item \textsuperscript{23} \textit{Id}. "Any program that is to receive federal funding, however, must follow the basic curriculum outlines provided in the most recent versions of the \textit{Criteria for Evaluation of Nurse Practitioner Programs} and [the National Organization of Nurse Practitioner Faculties']\textit{ Advanced Nursing Practice: Curriculum Guidelines and Program Standards.} \textit{Id}.
\end{itemize}
tom, this posits a significant patient safety issue when scope of practice laws do not align with professional capabilities, especially when nurse practitioners are substituted for primary care to patients instead of physicians.\textsuperscript{24}

In addition, state scope of practice laws often fill the void of broad federal regulation to promote inter- and intra-state commerce, which can foster competition,\textsuperscript{25} and courts are reluctant to second guess the laws enacted by state legislatures, especially on matters concerning medical care.\textsuperscript{26} For example, a given non-physician’s authority to administer health care services, which may or may not be based on educational or clinical requirements or even qualified abilities, can vary greatly depending on such factors as geographic location of practice (e.g., rural vs. urban areas), the type of patient being treated (e.g., elderly vs. pregnant women) and the actual nature of the practice setting (e.g., hospitals vs. retail “minute clinics”).\textsuperscript{27} Depending on the state, non-physician practitioners may be authorized to practice independently, required to collaborate, be supervised, or practice under a combination of these provisional instructions with licensed physicians.\textsuperscript{28} Many state statutes that mandate physician “supervision” or “collaboration” have failed to define the term, leaving physicians (supervisors) and non-physicians (supervisees) to work out the appropriate roles and scope of responsibility among themselves.\textsuperscript{29} Obviously, this agitates existing turf battles for professional autonomy among health care providers.

\textsuperscript{24}See, e.g., California Healthcare Foundation, Retail-based health clinics: Six State Approaches to Regulation and Licensing, at 3, available at http://www.chcf.org/~media/Files/PDF/R/RetailClinicsSixStateApproaches.pdf.

\textsuperscript{25}See generally Parker v. Brown, 317 U.S. 341, 352 (1943) (holding that nothing in the Sherman Act suggests that its purpose was to restrain state action from activities directed by its legislature). “Because of its local character also there may be wide scope for local regulation without substantially impairing the national interest in the regulation of commerce by a single authority and without materially obstructing the free flow of commerce, which were the principal objects sought to be secured by the Commerce Clause.” Id. at 363. See also James W. Hilliard & Marjorie E. Johnson, State Practice Acts of Licensed Health Professions: Scope of Practice, \textit{8 DePaul J. Health Care L.} 237 (2004).


\textsuperscript{28}See id.

B. The Medical Profession Is Not Exempt From Antitrust Regulation

Antitrust laws seek to protect competition and consumer welfare, not actual competitors.\textsuperscript{30} Federal antitrust laws are set forth in the provisions of the Sherman, Clayton, and Federal Trade Commission Acts.\textsuperscript{31} These statutes are based on the principles that free and unrestricted competition benefits society as a whole and that restrained or controlled competition results in the misallocation of economic resources.\textsuperscript{32} Antitrust laws are enforced by the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ").\textsuperscript{33} For purposes of this Article, the practice of medicine is regarded as a "trade" within the meaning of the Sherman Antitrust Act,\textsuperscript{34} Section 1 of which provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, . . . is declared to be illegal."\textsuperscript{35} Section 2 of the Act provides that monopolization, "or attempt[s] to monopolize, . . . any part of the trade or commerce" are deemed illegal.\textsuperscript{36} In sum, the Sherman Act endeavors to promote efficiency or consumer welfare by eliminating conduct that suppresses competition within a properly defined antitrust market.\textsuperscript{37}

Licensed professionals are not without means to influence the market and are subject to federal antitrust laws. Physicians and non-physicians engage in vigorous competition, both within and outside the legal scopes of their profession, in the quest for consumer recognition. In \textit{Goldfarb v. Virginia State Bar},\textsuperscript{38} the United States Supreme Court enunciated the principle that Congress did not intend any sweeping "learned profession" exclusion from the reach of the Sherman Antitrust Act.\textsuperscript{39} In its analysis, the Court conceded that states have a com-

\begin{thebibliography}{99}
\bibitem{Brooke} See generally \textit{Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.}, 509 U.S. 209, 224 (1993) ("It is axiomatic that the antitrust laws were passed for 'the protection of competition, not competitors.'") (quoting \textit{Brown Shoe Co. v. United States}, 370 U.S. 294, 320 (1962)).
\bibitem{DOJ1} Id.
\bibitem{Goldfarb} 421 U.S. 773 (1975).
\bibitem{Conceded} Id. at 787.
\end{thebibliography}
pelling interest in the practice of professions as part of their broad police power “to protect the public health, safety, and other valid interests,” and in some instances, the state legislature “may decide that ‘forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.’”

Goldfarb and its progeny resulted in other courts examining potential anticompetitive behavior within learned professions under the more lenient “Rule of Reason” judicial review standard, rather than the strict “Per Se” standard, because professional services, by their nature, may significantly differ from other business services based on ethical norms or considerations within the profession. Goldfarb implied that anticompetitive conduct is only immune from Sherman Act scrutiny when the state, through its sovereign police power, mandates the practice in question and actively supervises its process — commonly referred to as the state action immunity doctrine.

40. Id. at 792.
41. Id. (citing United States v. Or. State Med. Soc'y, 343 U.S. 326, 336 (1952)). See also Am. Med. Ass'n v. Fed. Trade Comm'n, 638 F.2d 443, 450 (2d Cir. 1980), aff'd, 455 U.S. 676 (1982) (holding that business aspects of the activities of the medical associations fell within the scope of the FTC because the record showed that the AMA “intended and expected” state and local medical associations to enforce limitations on advertising and solicitation of services of non-physicians, which effectively prohibited natural competition in the provision of medical services.).

42. The Rule of Reason is a standard of analysis employed by courts to determine whether certain commercial behavior is an unreasonable restraint of trade to warrant sanctions under antitrust laws. The doctrine originally surfaced in United States v. Addyston Pipe & Steel Co., 85 F. 271 (6th Cir. 1898), and was later affirmed by the Supreme Court in Standard Oil Co. v. United States, 221 U.S. 1 (1911). The standard creates a rebuttable presumption whereby the defendant must show legitimate business reasons for anticompetitive behavior. Under such an approach, the plaintiff must prove (a) a conspiracy among two or more entities, (b) an injury to competition caused by conspiracy, and (c) an intent among the entities to restrain competition. See generally Standard Oil, 221 U.S. at 48-49.

43. The Per Se approach is the most stringent standard by which a court examines anticompetitive behavior. Conduct that is so restrictive of trade and inherently unreasonable that it is considered effectively illegal, without any further deliberation, is a per se violation of the Sherman Antitrust Act. See, e.g., United States v. Andreas, 216 F.3d 645, 666 (7th Cir. 2000).


45. Goldfarb, 421 U.S. at 791. The state action immunity doctrine was created by the United States Supreme Court to exempt states from antitrust prosecution when certain activities are undertaken in specific economic areas where the state has decided to regulate, rather than allow the marketplace to discipline itself – essentially authorizing anticompetitive conduct. Actions of the state itself are not subject to the Sherman Act. See, e.g., Parker v. Brown, 317 U.S. 341, 350 (1943) (holding an anticompetitive marketing program which “derived its authority and its efficacy from the legislative command of the state” was not a Sherman Act violation). The antitrust immunity doctrine is invoked when a state enacts legislation that clearly articulates an intent to displace competition with regulations, where subsequent regulatory actions can be deemed immune from federal antitrust laws. The Supreme Court outlined a two-pronged test, known as the Midcal test, for determining whether the “state action immunity doctrine” will protect anticom-
state will seek to promote competition in all industries, the regulation
of the health care profession requires the balancing of competitive in-
terests with the protection of consumers of health care services. Thus, if
state laws or regulations require a certain practice with anticompetitive
effects, it will be exempt from antitrust scrutiny so long as it meets the state action immunity doctrine standard.

In a market with finite resources for health care providers, a fine
line exists between collaboration and competition. While the prac-
tice of medicine is a profession that benefits public welfare, it is also a
business that affects trade and interstate commerce. Likewise, Gold-
farb stands for the proposition that learned professions, including
medicine, are not exempt from antitrust law. "It is no disparagement
of the practice of law as a profession to acknowledge that it has a
business aspect, and Section 1 of the Sherman Act '[o]n its face . . .
shows a carefully studied attempt to bring within the Act every person
engaged in business whose activities might restrain or monopolize
commercial intercourse among the states.'" As the provision of
health care in the modern world continues to expand and adapt to
changes in science and technology, it is clear that the activities of med-
cal professionals play an integral role in commercial activities, and
any anticompetitive conduct promoted or encouraged by members of
the profession, aside from being condoned by state law, may result in
a strain on commerce and negatively affect consumer welfare.

competitive conduct of private parties directed to enforce a state regulatory program. The basic
judicial inquiry requires (1) anticompetitive actions (2) of private parties (3) taken pursuant to a
clearly articulated and affirmatively expressed policy by the state to supplant competition with
regulation, be (4) subject to active state supervision. However, the debate over the breadth of
the state action doctrine often comes down to how much weight should be given to each prong
and likewise, what constitutes "active state supervision." Midcal Aluminum, Inc., 445 U.S. at
105-106, 114.

46. Federation of State Medical Boards of the United States, supra note 4.

47. See generally Parker, 317 U.S. at 350 (holding an anticompetitive marketing program
which "derived its authority and its efficacy from the legislative command of the state" was not a
Sherman Act violation); Midcal Aluminum, Inc., 445 U.S. at 114. See also Clark C. Havighurst,
Contesting Anticompetitive Actions Taken in the Name of the State: State Action Immunity and

48. Benjamin G. Druss et al., Trends in Care by Nonphysician Clinicians in the United States,

49. Goldfarb, 421 U.S. at 788 (quoting United States v. Se. Underwriters Ass'n, 322 U.S. 533,
553 (1944)).
C. The Structure Of The Medical Care System Makes Antitrust Relief An Obstacle For Non-Physician Practitioners Excluded From The Product Market

For non-physician practitioners to succeed in their antitrust claims, they must prove that two or more entities agreed or conspired to restrain competition and that the conspiracy resulted in economic harm within the relevant product market. This can prove very difficult for non-physician practitioner plaintiffs, depending on how the geographic and product markets are defined. Certain activities trigger heightened antitrust scrutiny of health care providers, such as joint action between competitors, denial or limitation of professional privileges of certain practitioners at hospitals or other similar facilities, or involvement in an exclusive provider network or other integrated delivery system that poses a threat to consumer welfare by effectively limiting choice in care. Antitrust concerns can arise when non-physicians are denied access to hospitals, physicians refuse to include non-physician practitioners in their provision of medical care, and in situations where managed care organizations place certain contingencies on reimbursement for services, such as the requirement of physician supervision over non-physician practitioners in the provision of certain health services to patients. If powerful enough, these initiatives can essentially eliminate a certain class of providers from the market, but it is not always clear whether such actions are anticompetitive and in violation of antitrust laws, or actually meeting the objective of vigorous competition in the health care market.

Both physicians and non-physicians are exposed to the same antitrust liability and are entitled to the same defenses as other industries that are subject to antitrust laws. The medical staff structure has bolstered significant physician control over access to hospital privileges based on the overarching concern of assurance of quality patient care and commitment to professional values. The denial of staff privileges at a medical facility or other medical organization, by itself, is not an unreasonable restraint of trade under Section 1 of the Sherman Act. It is sometimes reasonable for hospitals to deny privileges

50. Greg Timmons & Nancy Ridenour, Restraint of Trade Implications for Nurse Practitioners: Denial of Hospital Admitting or Staff Privileges, 5 J. AM. ACAD. NURSE PRACT. 177 (1993).
51. Furrow, supra note 13, at 1124-25; see also supra text accompanying notes 26 and 27.
53. Furrow, supra note 13, at 850. Likewise, the structure of the health care environment and provision of medical care has led various courts to assert that federal antitrust laws have no role in lawsuits alleging conspiracy to deny hospital privileges or the requirement of physician supervision. See id.
to avoid potential liability for acts or omissions by non-physicians who do not possess the same levels of advanced medical training as medical doctors.\textsuperscript{55} In fact, exclusive dealing arrangements with certain physician providers are generally regarded as pro-competitive because they can help coordinate and maximize use of personnel and facilities to ensure that different types of providers are available to address patient needs.\textsuperscript{56} Because physicians are afforded the exclusive right to practice medicine based on their education and certifications, it necessarily follows that many hospitals or clinics would exclusively deal with physicians instead of non-physicians in providing care to their patients.\textsuperscript{57}

Even though some exclusive dealing arrangements can be used to exercise market power to effectively eliminate competitors and create barriers to entry, such agreements are unlawful only if their anticompetitive effects outweigh their pro-competitive benefits.\textsuperscript{58} Hospitals typically lack economic incentives or significant market power to exclude non-physicians from practicing in their facilities.\textsuperscript{59} Instead, economic incentives are based on employing the highest quality and quantity of qualified practitioners on hospital staffs with an understanding that the demand for hospital services will fall as the price of medical services rises.\textsuperscript{60} Even so, many non-physician practitioners file suit challenging exclusive dealing arrangements or alleging conspiracy to eliminate their services in favor of those offered by physicians, thereby obstructing access to patients and stunting their professional development.\textsuperscript{61} Many non-physicians are unsuccessful in

\textsuperscript{55.} Id.; see also Bhan v. NME Hosps., Inc., 929 F.2d 1404, 1412 (9th Cir. 1991) (holding, as a threshold matter, that hospitals must make choices about the types of qualifications a practitioner must have to apply for staff privileges in certain fields of practice, and those restrictions allow the hospitals to provide more efficient and higher quality health care, reduce malpractice exposure, and productively compete with other hospitals in the market).

\textsuperscript{56.} Robert E. Bloch & Donald M. Falk, \textit{Antitrust, Competition, and Health Care Reform}, \textit{Health Aff.}, Spring 1, 1994, at 216.

\textsuperscript{57.} FURROW, \textit{supra} note 13, at 1124-25.

\textsuperscript{58.} Bloch, \textit{supra} note 55, at 216.

\textsuperscript{59.} Andrew K. Dolan, \textit{Antitrust Law and Physician Dominance of Other Health Practitioners}, 4 \textit{J. Health Pol'y, Pol'y & L.} 675, 679 (1980).

\textsuperscript{60.} Id. \textit{See also} Timmons & Ridenour, \textit{supra} note 49, at 177-78.

\textsuperscript{61.} See, e.g., Abraham v. Intermountain Health Care, Inc., 461 F.3d 1249, 1263 (10th Cir. 2006) (holding that a managed care organization's refusal of membership to optometrists in favor of ophthalmologists was not economically motivated, and pro-competitive justifications existed for the preference); Va. Acad. of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 483 (4th Cir. 1980) (holding that while there was evidence of close contact between the state professional psychiatric society and insurer Blue Shield, where the society recommended and the insurer implemented a policy prohibiting reimbursement for services rendered by psychologists even though identical services billed through psychiatrists were reimbursed, it did not rise to the level of a Sherman Act violation). \textit{See also} FURROW, \textit{supra} note 13, at 1124-25.
challenging such arrangements because of proffered defenses of increased efficiencies, where the expansion of consumer choice in medical providers promotes quality of care and consumer welfare, and in effect, does not implicate the need for federal antitrust regulation in the health care market.62

D. That's MY Job! Professional Turf Wars Resulting From Diminished Monopoly Power Of Physicians And Expanded Scope Of Practice Of Non-Physicians

The fact that physicians have a monopoly on the provision of health care is not due to anticompetitive behavior, but is instead a result of state legislative actions to protect citizens from potentially “harmful” health services rendered by under-qualified practitioners.63 In almost every state, physicians are given exclusive rights in “the practice of medicine” as a result of their extensive education, training, and clinical experience.64 Meanwhile, non-physician practitioners are limited in the amount of health care they can provide to patients based on state legislative boundaries.65 Consumers lack key information about the quality and price of medical services, because they lack the expertise to evaluate the qualifications of their health care providers and because standards of care are actually dictated by the medical profession itself.66 In addition, consumers are often uninformed as to the full range of alternative sources of health care or how the prospective outcomes of these alternatives would allow them to make informed decisions regarding whether to choose a licensed physician or a non-physician practitioner for their respective medical needs.67 For the most part, consumers blindly rely on the lawmakers within their

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62. See Havighurst, supra note 46 and accompanying text. Many of these cases have been aptly named the “junk food of antitrust healthcare litigation,” see, e.g. Furrow, supra note 13, at 1124-25 (citing Boczar v. Manatee Hosps. & Health Care Sys., 993 F.2d 1514 (11th Cir. 1993) for proposition of “a rare example” of a successful antitrust challenge to a staff privileges determination based on factors such as the hospital’s pretextual explanations defending its actions and the professional shortcomings of other physicians with staff privileges).

63. See Safriet, supra note 4, at 306.

64. Id.

65. See supra Section II.A.

66. See, e.g., Congressional testimony of Paul B. Ginsburg, Ph.D., President of Center for Studying Health System Change, before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, hearing on “What’s the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs” (March 15, 2006), Center for Health System change, available at http://www.hschange.com/CONTENT/823/

states to dictate the appropriate boundaries for scopes of practice for physicians and non-physicians.68

The overlap in the range of medical care provided by physicians and non-physicians is fostered by the systemic organization of health care.69 Medical professions are highly regulated by state and federal agencies, which in turn influence the reimbursement policies determined by managed care organizations and insurance companies.70 Many routine tasks traditionally performed by physicians are now within the scope of non-physician practice, and the range of technical complexity of these tasks is expanding. The stakes are highest for those providers with the greatest overlap in training or specialty, where they compete for the same prospective patients, such as between general practitioner physicians and nurse practitioners.71 In fact, results of a nationwide survey illustrate that consumers are confused or uncertain about the qualifications and educational backgrounds of health care providers, specifically the variance between medical doctors and limited license health care practitioners.72

As the lines between the practice of medicine and complementary health care services become more blurred in the delivery of modern...
health care, state laws and regulations attempt to keep up with the ever-changing practices within the medical profession.\textsuperscript{73} While physicians maintain that only they can engage in the practice of medicine, many non-physician groups are lobbying to expand their respective scopes of practice in the provision of what may be considered "medical" services.\textsuperscript{74} However, the non-physician response to the monopolistic regime of the physician-dominated provision of health care – advocating expansion of authority and autonomy – raises serious concerns about patient safety, especially in the absence of uniform national standards of scopes of practice.\textsuperscript{75} Because each non-physician group has its own curriculum, services, and approaches to care within its respective regulatory framework, state legislatures, which are not necessarily familiar with the required education and training of individual health care provider classes, usually adopt and codify the specific practice acts of non-physician groups without taking into account the need for a fluid, uniform standard to ultimately protect consumers.\textsuperscript{76}

Both state legislatures and courts must balance competing objectives of professional autonomy, the safety and welfare of citizens, and above all, the overarching goals of halting the ever-increasing health care costs and the paucity of practitioners available to consumers. While state agencies and local medical associations presumptively enforce these practice requirements, it is not the type of state action the Sherman Act was meant to proscribe as anticompetitive.\textsuperscript{77} Despite

\textsuperscript{73} See generally, Hilliard, \textit{ supra} note 24, at 237.

\textsuperscript{74} See Safriet, \textit{ supra} note 4, at 301. In fact, a primary argument for expanding scopes of practice rights for non-physicians and rates of reimbursement for services rendered is that non-physicians serve a "complementary role" and will provide care for populations that lack access to physicians, such as those living in rural areas or poor patients without insurance. Druss, \textit{ supra} note 47, at 136. For example, in 1977, the Rural Health Clinics Act provided the first direct Medicare and Medicaid reimbursement for nurse practitioners, physician assistants, and certified nurse midwives, limited to areas where there was a shortage of physicians and non-physicians worked in free-standing rural clinics directed by physicians. See Cooper, \textit{ supra} note 67, at 57. However, payments are now allowed in all geographic areas, and no longer restricted to just rural areas, as permitted under state licensing laws. See \textit{Dept. of Health & Human Services, Office of Inspector General, Medicare Coverage of Non-Physician Practitioner Services}, June 2001 at 4, available at http://oig.hhs.gov/oei/reports/oei-02-00-00290.pdf.

\textsuperscript{75} Catherine Dower, \textit{Promising Scope of Practice Models for Health Professions}, The Center for Health Professions, University of California, San Francisco, at 1 (2007).

\textsuperscript{76} Richard A. Cooper, \textit{Roles of Nonphysician Clinicians as Autonomous Providers of Patient Care}, 280 J. AM. MED. ASS'N 795 (1998).

\textsuperscript{77} See Havighurst, \textit{ supra} note 46 and accompanying text. \textit{See also} Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc. 445 U.S. 97, 105-106 (1980); New England Motor Rate Bureau, Inc. v. FTC, 908 F.2d 1064, 1074 (1st Cir. 1990) (holding that the state action immunity doctrine is based on the Supreme Court's determination that congressional intent with regard to federal antitrust laws was not meant to preempt state programs and policies).
the fact that state legislatures delineate the scope of medical care in which a non-physician practitioner may engage, largely based on education and training, these laws do not express a preference for physicians over non-physicians, nor do they advocate for the exclusion of non-physicians from facilities in favor of physicians only. Even though some courts hint that legislative advocacy within states is the preferred remedy for turf wars within certain professions, medical providers are far from achieving perfect harmony because of competing considerations of professional autonomy and patient welfare in the health care market.

III. IMPLICATIONS OF ANTITRUST REGULATION IN HEALTHCARE – IF YOU CAN’T JOIN ‘EM, BEAT ‘EM . . . RIGHT?

This Section will analyze how the general composition of the health care industry has influenced the regulation of its professionals, inflaming existing tensions among physicians and non-physicians, with regard to independent practice and patient care, which the antitrust laws were not specifically designed to remedy. The regulation of the provision of health care must consider patient safety and welfare in addition to the promotion of professional autonomy in the health care field. The introduction of retail-based health clinics to the market has created a facility for non-physicians to practice without having to jump through hoops for hospital privileges or kowtow to supervisory or collaborative physician demands. In effect, this has increased choice for consumers while addressing costs of, and access to, medical care concerns. Fundamentally, retail-based health clinics are fostering effective competition among medical care providers, and physicians are now on the other side of the battle with non-physicians, who are often promoted as a substitute to primary care practitioners. Retail-based health clinics differ from urgent care clinics, commonly known

78. See, e.g., Wilk v. Am. Med Ass'n, 719 F.2d 207, 229 (7th Cir. 1983). In addition, many of the joint efforts by physicians and state medical societies to promote public health and safety in the provision of health care services by employing tools of legislative advocacy are immune from the scope of the Sherman Act under the Noerr-Pennington doctrine. The doctrine earned its name from two cases considered by the Supreme Court in which the Court limited the enforcement of federal antitrust laws against certain private acts meant to urge government legislative action in an effort to protect fundamental First Amendment rights under the United States Constitution. See E. R.R. Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961); United Mine Workers of Am. v. Pennington, 381 U.S. 657 (1965). See also Mo. v. Nat'l Org. for Women, 620 F.2d 1301 (8th Cir. 1980). For example, the AMA and other professional organizations have formed the Scope of Practice Partnership (SOPP) as an advocacy group to influence the regulation of non-physician health care providers, which is exempt from antitrust scrutiny under the doctrine permitting advocacy.

79. Dolan, supra note 58, at 678. See also infra Section III.B.
as "doc-in-the-box" services primarily staffed by physicians, and are giving doctors a run for their money — literally. These clinics raise important issues regarding the future of providing primary health care to patients, and the long term effects of the clinics' introduction to the medical market, both good and bad, remain to be seen.

A. The Health Care System As A Competitive Product Market

In general, competitive markets have certain common characteristics. On the supply side, providers compete with one another for customers on the basis of price, quality, and sometimes quantity of services. On the demand side, consumers weigh quality and cost when choosing to purchase a provider's product or service. The composition of markets for medical care are different from other markets because of the influential role of federal and state governments in terms of regulation of scope of practice, licensing and credentials, and even financial subsidies, in the form of Medicare, Medicaid, and tax expenditures, allow some consumers greater access to medical care than they would otherwise have. However, the de facto medical monopoly dominated by physicians, in combination with the restrictive licensing laws and regulations that limit the scope of services offered by non-physician practitioners, has arguably created higher prices for consumers while limiting meaningful choice in providers.

The introduction to the market of retail-based health clinics arguably promotes competition among physician groups by increasing price and quality competition in the market for basic health care services. These health clinics are a "demand-side solution" to increased health costs because they allow "consumers (patients) to discipline providers who compete against one another on the basis of quality and price . . . ." As for the supply-side, however, while there is a shortage of

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80. See generally Bohmer, supra note 3, at 765.
82. Id.
83. FURROW, supra note 13, at 567-69.
86. Id. (citing Uwe Reinhardt, Economists in Health Care: Saviors, or Elephants in a Porcelain Shop, 79 AM. ECON. REV. 337, 339 (1989)).
physicians in the United States, most retail-based health clinics are based in urban areas where there are plenty of primary care physicians to choose from and thus do not solve the chronic paucity problem of providers.\textsuperscript{87} In fact, according to a recent study, approximately thirty million people live in a federally designated shortage area where there is an inadequate supply of health care providers.\textsuperscript{88}

Increased costs of health care and issues regarding access to care spurred the introduction of retail-based health clinics through state legislation by addressing regulatory barriers.\textsuperscript{89} Furthermore, most, but not all, retail-based health clinics employ nurse practitioners rather than physicians and, depending on state law, may or may not require physician supervision.\textsuperscript{90} According to the American College of Nurse Practitioners, twenty-three states allow nurse practitioners to treat patients without a physician present while twenty-eight states require documented physician involvement, either in the form of supervision, collaboration, or consultation.\textsuperscript{91} Also, in some states, non-physicians are directly employed by the drugstore company giving rise to concern that such providers of health care might place the interests of their employer above those of the patient.\textsuperscript{92} Even though the impetus for retail-based health clinics was based on efforts to offer greater consumer choice at lower costs for the provision of health care, the varied laws across state lines and the lack of a uniform national stan-

\textsuperscript{87} Jennifer F. Wilson, \textit{Primary Care Delivery Changes As Nonphysician Clinicians Gain Independence}, 149 \textit{ANNALS INTERNAL MED.} 597, 598 (2008) ("Because they are for-profit, they are not necessarily an answer to improving health care access in rural areas, shortage areas, or any other areas of the most need.") (quoting Scott A. Shipman, MD, MPH, assistant professor of pediatrics and family and community medicine at Dartmouth Medical School and researcher at the Dartmouth Institute for Health Policy and Clinical Practice).


\textsuperscript{90} \textit{Id.} The purpose behind requiring active state supervision is not to monitor potential anticompetitive activity, but rather to keep private action aligned with select state policy, such as protection of its citizens. In the context of the medical profession, states regulate the practice of medicine by defining permitted scopes of practice within its borders, likely a reflection of its chosen state policy; see also supra text accompanying note 46.


B. The Rise Of Retail-Based Health Clinics – The Nurse Practitioner Will See You NOW!

As previously asserted, the training and skills of almost all non-physician groups have changed dramatically in recent years in response to health care demands, increased costs of care, developments in preventative and curative treatments, and health-promotion strategies. Most important, however, the non-physician desire for professional autonomy appears to be the driving force behind these changes. Intuitively, the nature of the provision of medical care is that a facility is needed to provide adequate treatment to patients. Thus, when non-physicians are denied privileges or access to hospitals or similar medical facilities, for whatever pro-competitive proffered justification, many of these non-physicians, specifically nurse practitioners, make lemonade out of lemons by instead seeking professional employment with or access to retail-based health clinics to treat patients.

In fact, the introduction and operation of over one thousand retail-based health clinics around the United States combine quick and convenient medical treatment to consumers with the retail approach of selling at fixed prices to the consumer patient, regardless of insurance coverage. These clinics are overseen by an assortment of state agencies without any uniform system of regulation. The concept for retail medical clinics was developed in 2000 by QuickMedx (now known as MinuteClinic), and several thousand more are expected to open in the near future. Currently, most clinics are located in states that grant prescriptive privileges to nurse practitioners and require limited, if any, physician involvement. However, the growing number and increasing popularity of retail-based health clinics creates pressure to

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93. Id.
94. Safriet, supra note 4, at 305.
96. Dolan, supra note 58, at 678.
97. See infra Section II.C for a discussion of denial of hospital privileges.
102. Id.
increase the number of nurse practitioners that a physician may supervise, which arguably raises heightened concerns about patient safety, especially once medications have been prescribed.\textsuperscript{103}

Perceptibly, these health clinics are consumer-driven models based out of retail stores, rather than patient-driven health care (like a hospital), and the potential long-term effect of the retail-based health clinics on health insurance plan insured behavior and the clinics’ impact on the health care delivery system is a serious issue for some, specifically primary care physicians.\textsuperscript{104} In addition, retail-based health clinics seem to be responsive to consumer needs and demands in not only medical care, but also in everyday life. Premised on assigning patients control of their own health care budgets through devices such as health savings accounts, retail-based health clinics illustrate that consumers make choices based on cost rather than on qualifications or experience.\textsuperscript{105} As a result, entrepreneurs jumped at the opportunity to expand on a profitable business model and found a way to provide less expensive primary care in a convenient setting, for the on-the-go person who does not have the time or patience to wait in a doctor’s office or emergency room.\textsuperscript{106} These retail-based health clinics, the free-standing, walk-in medical providers often located in drug stores like Walgreens, CVS/Caremark®, and Wal-Mart, advertise quick service, low fees, treatment to both the insured and uninsured, with little or no waiting time.\textsuperscript{107} Whether treated by a nurse practitioner or physician assistant, customers (patients) are provided with acute care for routine problems ranging from the common cold to routine checkups and vaccinations.\textsuperscript{108} For anywhere from $30 to $60, a patient can be in-and-out with diagnosis and treatment for an ear infection, sore throat, allergies, or other common ailments.\textsuperscript{109} Overall, it seems that retail-based health clinics are responding to consumer needs, promoting competition in the provision of health care, and providing non-

\textsuperscript{103} Phyllis Coleman & Ronald A. Shellow, Extending Physician’s Standard of Care to Non-Physician Prescribers: The Rx for Protecting Patients, 35 Idaho L. Rev. 37, 57-58 (1998) (arguing that prescribing medications requires “sufficient knowledge to respond” to potential side effects, or when used in combination with other medications that may not be known to the non-physician).

\textsuperscript{104} See Bohmer, supra note 3.

\textsuperscript{105} John Goodman, Networks Financial Institute Policy Brief, Indiana State University, Consumer Directed Health Care 6 (2006).

\textsuperscript{106} See Bohmer, supra note 3.

\textsuperscript{107} See Jeffrey Kluger, Drive-Thru Medical: Retail-based health clinics’ Good Marks, Time, Sept. 1, 2009.

\textsuperscript{108} Id.

\textsuperscript{109} Families USA, Retail Medical Clinics: Okay in a Pinch, but No Substitute for Real Health Coverage 1 (2007). See also Annie Hsu, Legal Issues Concerning Retail-based health clinics, 20 Health Law. 13 (2008).
physician clinicians with greater professional autonomy – so what's not to like? According to primary care physician groups, who are competing for patients with these clinics' services, the answer is "plenty."

C. Retail-Based Health Clinics And Antitrust – NOT What The Doctor Ordered

The retail-based health clinics themselves are regulated by the states, and each state, much like the laws governing scope of practice of non-physician groups, has a great deal of latitude, not to mention variation, in the regulation of such clinics. The application of the antitrust laws becomes controversial when competition in the provision of health care must be balanced with quality of care. Competition among medical care providers for consumers is usually directed toward the non-price aspects of medical care, such as education and licensure, and consumers are legally or effectively prohibited from making many medical decisions based on inherent market constraints. But antitrust laws protect competition, not competitors. Health care practices that seem to impinge on the actual “practice of medicine” based on state laws and regulations, or create inconveniences for physicians that drive down their incomes, such as being substituted by non-physician services, usually do not constitute an antitrust violation unless it is shown that such practices also impair consumers’ welfare. Countless health care professionals have been denied adjudicative relief under antitrust laws after filing suit because their hospital privileges had been denied, suspended, or revoked in light of pro-competitive justifications offered by hospitals relating to quality of care or economic efficiencies.

The general effect of retail-based health clinics is that they have taken away patients from the waiting rooms of primary care physicians. Some physicians have criticized the clinics being run by nurse practitioners as “cream skimming” and a threat to their professional

110. FAMILIES USA, supra note 106, at 2.
111. FURROW, supra note 13, at 150.
112. See Brooke Group Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209, 224 (1993) ("It is axiomatic that the antitrust laws were passed for ‘the protection of competition, not competitors.’") (quoting Brown Shoe Co. v. United States, 370 U.S. 294, 320 (1962)).
114. FURROW, supra note 13, at 1124-25; see also Oksanen v. Page Mem’l Hosp., 945 F.2d 696, 711 (4th Cir. 1991) (stating “the antitrust laws were not intended to inhibit hospitals from promoting quality patient care through peer review nor were the laws intended as a vehicle for converting business tort claims into antitrust causes of action.”).
115. See generally Bohmer, supra note 3, at 765.
revenue, especially those that rely on simple appointments, such as the common cold or routine vaccinations, to subsidize the cost of more complex, time-consuming appointments.116 Still, other physicians are less critical and regard retail-based health clinics as a way to improve access to care for patients, reduce patient wait times, and allow the physicians to spend more quality time with existing patients.117

Opponents to the recent advent of these clinics remain dubious about the quality of care provided at retail-based health clinics and concerned about their potential to undermine the primary care relationship between patient and physician.118 “It seems clear that retail [health] clinics could become a disruptive innovation in health care, capable of fundamentally challenging long-established models of care, and changing consumer expectations of the cost, quality, and delivery of care.”119 In addition, critics argue that retail medical clinics impede continuity of care, which can affect diagnoses of underlying conditions and the provision of preventative care.120 This is especially troublesome for physicians because the clinics are modeled for one-time care rather than ongoing treatment, and some are not required to make referrals to traditional health care providers or hospitals.121 This particular "business" model precludes clinics from offering comprehensive care in the form of physical exams, diagnostic tests, or follow-up care, and in the absence of a central health record, largely leaves the patient (consumer) ultimately responsible for giving any health care provider a clear picture of his or her medical history.122 However, regardless of commentary by critics or proponents, retail-based health clinics appear to fill a need for convenient, easy access to medical care and, for now, are here to stay.

IV. THE FUTURE OF THE HEALTH CARE PROVIDER MARKET—ATTENTION LAWMAKERS, VACCINATIONS IN AISLE FIVE!

Whether it is due to the convenience, price transparency, or reduced waiting times for medical treatment, many retail-based health clinics have gained widespread acceptance in the marketplace.123

116. See id. at 767.
117. Id.
118. Id.
119. Id.
120. CONNECTICUT HEALTH POLICY PROJECT, RETAIL MEDICAL CLINICS: WHAT ARE THEY AND WHAT DO THEY MEAN FOR CONNECTICUT? (April 2008).
121. Id.
122. See FAMILIES USA, supra note 106, at 2.
123. CALIFORNIA HEALTHCARE FOUNDATION, supra note 86.
However, state and federal laws have struggled to keep up, and in addition to considering the needs of medical professionals and competitive business concerns, legislatures must keep consumer welfare on the forefront when issuing laws and policy. For example, some states have established restrictions on in-store clinics while others have banned them altogether. This, however, can raise antitrust concerns because the retail medical clinics are the primary focus of regulation, not necessarily all health care facilities, which could put them at a competitive disadvantage when forced to comply with stringent regulatory standards. For example, in 2008, the FTC admonished the Illinois state legislature for a bill regulating retail-based health clinics by prohibiting the sale of alcohol or tobacco products in stores that house retail-based health clinics. As a result, the bill ultimately failed, largely because of stated anticompetitive concerns that threatened greater economic repercussions for Illinois consumers. Even so, there is no federal regulation of retail-based health clinics, and compounded by wide-ranging state scope of practice laws, this could prove a dangerous combination for patients in the long run.

State legislatures have considered a variety of issues with regard to these clinics, including, but certainly not limited to, scope of practice issues for advanced practice nurses who staff the clinics, physician oversight and ownership requirements, limiting types of services offered, and heightened compliance with public health and sanitation standards in an effort to protect the health of customers (patients or not). In addition, states must decide on what they are actually regulating—a business entity or a health care institution. For example, Rhode Island has prohibited CVS/Caremark® from opening clinics in the state, and Florida requires retail-based health clinics to post signs stating whether a physician is on-site and to disclose the credentials of the clinic staff to patients, while California has mandated that retail-based health clinics be physician-owned. While some states seem to enact legislation based on the overarching goal of patient safety, in

125. See FAMILIES USA, supra note 106.
126. Id.
128. See generally AMERICAN MEDICAL ASSOCIATION, supra note 19.
129. See Kaiser Daily Health Policy Report, supra note 121.
130. For example, see 20 CSR 2200-4.200 (Mo. 2008). Missouri requires store-based health clinics to have a physician immediately available for consultation at all times. A nurse practi-
contrast, states such as Texas and Wyoming have lessened restrictions on the list of treatments nurse practitioners are able to administer to patients as an ostensible effort to protect competitive business.\footnote{131}{Health Strategies and Solutions, Retail-based health clinics: Flash in the Pan or Wave of the Future? (September 2007), available at http://www.hss-inc.com/documents/e-news0907.pdf.}

As such, regulations relating to scope of services provided by non-physicians and potential physician oversight create an ongoing battle for the state legislatures in determining the future of retail health clinic operations across the nation.\footnote{132}{See, e.g., California Healthcare Foundation, Health Care in the Express Lane: The Emergence of Retail-based health clinics, at 12 (July 2006). See also, National Conference of State Legislatures, Retail Store Health Clinics: State Legislation and Laws, available at http://www.ncsl.org/IssuesResearch/Health/Retailstorehealthclinicsstateroles2009/tabid/13959/Default.aspx (last updated November 2009).} However, legislation that calls for greater regulation of retail-based health clinics is subject to intense antitrust scrutiny when viewed as a restriction on commercial activity, not as an effort to regulate the professional practice of medical care. What is more, physicians who notice a decrease in the volume of their patient visits because of the popularity of retail-based health clinics, or nurse practitioners who feel hindered by scope of practice regulations in their respective states, will have little recourse under federal antitrust laws since the laws seek to protect competition, not disadvantaged competitors.\footnote{133}{See Brown Shoe Co. v. United States, 370 U.S. 294, 344 (1962).} If clinics continue to expand across the nation, as they have in recent years, they will likely attract more regulatory attention, which may enhance scope of practice expansion efforts by nurse practitioners or other non-physician groups, creating significant market repercussions that current laws, antitrust or otherwise, are not necessarily structured to remedy.

\section*{V. Conclusion}

Even though the promotion of consumer choice is a fundamental principle of the free market system, the fact that many consumers lack the information critical to make informed decisions is the driving force behind state legislation regulating non-traditional health care providers. All the same, consumers are lured by the convenience and affordability of retail-based health clinics. However, lower one-time costs for patients can lead to increased risks and higher costs over time if these clinics are not properly and uniformly regulated. Because retail-based health clinics are premised on in-and-out provision of medical care, there is no real system for consistent care or follow-
up treatment. Thus, if a patient has a serious condition that is mis-diagnosed or requires referral to a physician, the convenience and affordability of treatment from a retail clinic is eventually quashed by the costs and renewed efforts by physicians to subsequently treat the patient.

Altogether, the lack of consumer information, and essentially empty promises of convenience and low-cost health care, is the very reason states must regulate retail-based health clinics. The variation among state laws regarding non-physician practitioner scopes of practice and the operation of these retail-based health clinics inflame the existing professional tensions within the health care industry. In sum, either the federal government should regulate providers of health care in accordance with antitrust laws, or states should be given wider latitude to define the limits of the provision of health care, anticompetitive or not, with the ultimate goal to protect consumer patients' health and welfare.