

CONNECTING THE DOTS: QUALITY, ANTITRUST, AND MEDICINE

Theodosia Stavroulaki^{1*}

Antitrust applies to healthcare. Questioning the wisdom of this universal truth, medical professionals actively insisted and still insist on professional discretion, self-regulations and other practices that violate the antitrust laws. What do medical professionals aim to achieve by resisting the application of antitrust into their profession? What do antitrust enforcers aim to achieve by applying antitrust law to the medical profession? The answer is simple. Among others, both antitrust enforcers and medical professionals aim to ensure quality. Interestingly, albeit their goal is identical, their approach is different. Why? This essay explores this enigma by analyzing some seminal healthcare antitrust cases. It concludes that the U.S. antitrust enforcers by remaining faithful to the narrative that, the more the available choices, the better the quality, miss a crucial point: that the quality of medical treatment also depends on non-economic values such as the notions of safety and trust, essential features of the therapeutic enterprise. This essay proposes that the antitrust enforcers should extend the notion of healthcare quality when they apply antitrust law in the healthcare sector so that this

¹ * 2018-2019 Michigan Grotius Research Scholar, Michigan Law School, 2017-2018 Fulbright Scholar and Hauser Global Postdoctoral Fellow at NYU School of Law, Theodosia.Stavroulaki@eui.eu. I am indebted to Professor Giorgio Monti, Professor Daniel Sokol, Professor Farasat Bokhari, Professor Nicholas Bagley as well as the participants in the 2017 Michigan Junior Scholars Conference for their invaluable insight, criticism and ideas. I would also like to thank the American Bar Association, Section of Antitrust law and the Fulbright Commission that funded my research in the U.S. in 2015 and 2017-2018 respectively. I am also indebted to the numerous prominent U.S. antitrust scholars and practitioners that I have met in the U.S. as an International Scholar in Residence at the American Bar Association in 2015 for their useful insights on my research. A special thanks to Professor Eleanor Fox, Professor Harry First, Professor Scott Hemphill, Professor Douglas Ross for being an immense source of inspiration for my research in the U.S.. I am also indebted to the editors for their excellent editing. The views expressed in this paper are solely those of the author.

notion encompasses the multiple facets of healthcare quality and the ethical values the doctor - patient relationship crucially depends on. Adopting an alternative, less myopic, approach would allow the antitrust enforcers to create an analytical framework under which the multiple dimensions of healthcare quality could be balanced against harm to competition. More importantly, it would ensure that antitrust enforcers and medical associations do not continuously struggle to impose their own views on what the prevailing facets of healthcare quality should be. In Donabedian's language, an alternative approach would ensure that all functions of the health system commit to the quality goals that the system as a whole pursues.

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INTRODUCTION

Courts and law makers once believed that healthcare markets should escape antitrust scrutiny.² The Supreme Court

² David A. Hyman et al., *Improving Health Care: A Dose of Competition*, A REPORT BY THE FED. TRADE COMM'N AND THE DEP'T OF JUSTICE 1, 33 (July 2004), <https://www.ftc.gov/sites/default/files/documents/reports/improving-health->

applied the antitrust rules to the activities of the American Medical Association (AMA).³ Nonetheless, the Court had not specifically decided whether physicians' activity constituted 'trade' on the basis of the Sherman Act leaving the question of whether, and the extent to which, traditional antitrust rules applied fully to physicians' practice unexamined.⁴ In general, it was widely believed and accepted that the 'learned professions' exception applied to the antitrust principles.⁵

Nonetheless, following the Supreme Court's landmark decision *Goldfarb v. Virginia State Bar*,⁶ the strong belief that the 'learned professions' were not engaged in a commercial activity and hence were not subject to Section 1 of the Sherman Act was rejected.⁷ The *Goldfarb* opinion made clear that learned professions are not immune from the antitrust rules. The opinion, though, did not clarify whether special treatment of the 'learned professions' under the antitrust laws was totally precluded. In its legendary footnote 17, the Court stated:

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 to 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. We intimate no view on any other situation than the one with which we are confronted today.⁸

Goldfarb, "marked a crucial watershed in American health policy".⁹ Before the Court ruled, two underlying ideas

care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

³ *Id.*

⁴ *Id.* at n.161.

⁵ *Id.*

⁶ *Goldfarb v. Va. State Bar*, 421 U.S. 773, 793 (1975).

⁷ BARRY R. FURROW ET AL., *HEALTH LAW* 587 (West Academic Publishing, 7th ed. 2013).

⁸ *Goldfarb*, 421 U.S. at 788-89.

⁹ Clark C. Havighurst, *Healthcare as a (Big) Business: The Antitrust Response*, 26 DUKE UNIV. J. HEALTH POL'Y & L. 939, 942 (2001).

dominated healthcare delivery. First, markets fail in healthcare and therefore ordinary market competition is either inappropriate or unachievable in this sector.¹⁰ Second, the medical profession is a self-regulating profession appropriately invested with substantial market power in the healthcare sector.¹¹ After the Court spoke, however, medical associations were no longer free to regulate either themselves or others in ways that restrained 'trade' in the language of the Sherman Act.¹² Instead, in the post-*Goldfarb* era, physicians were actively prohibited from establishing any form of alliance or cooperation that run afoul the antitrust principles. In line with this new approach, one year after *Goldfarb*, in *Arizona v. Maricopa County Medical Society*,¹³ the Supreme Court underlined that healthcare industry does not deserve special treatment and therefore is fully subject to the antitrust principles.¹⁴

The application of antitrust law upon healthcare has encountered strong resistance from medical professionals. In fact, a number of cases in the post-*Goldfarb* era reveal that medical professionals actively insisted on professional discretion, freedom from lay interference, self-regulating activities, and other practices that inevitably breach the antitrust principles.¹⁵ Essentially, their fear is that antitrust rules and enforcement, being tailored to apply to commodities, may disregard the special facets and characteristics of the therapeutic enterprise, mainly the healthcare quality concern and the medical profession's self-regulatory duties.¹⁶

Antitrust scholarship provides several reasons why the application of the antitrust rules in the healthcare marketplace have not prevented physicians' from engaging in anticompetitive activity. These are mainly under enforcement and lack of certainty as to the legal rules governing all forms of physicians' alliances and collaborations.¹⁷ Exploring this puzzle again, this essay asks: What do medical professionals aim to achieve by resisting the application of antitrust into their profession? What

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Arizona v. Maricopa Cty Medical Soc'y*, 457 U.S. 332, 357 (1982).

¹⁴ Hyman et al., *supra* note 2, at 34.

¹⁵ See FURROW ET AL., *supra* note 7, at 586.

¹⁶ Clark C. Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?* 58 MILBANK MEM'L FUND QUARTERLY 89, 92 (1980).

¹⁷ Thomas L. Greaney, *Thirty Years of Solitude: Antitrust Law and Physician Cartels*, 7 Hous. J. Health L. & Pol'y 189, 195. (2007).

do antitrust enforcers aim to achieve by insisting that antitrust law should apply to the medical profession? The answer is simple. Among others, both antitrust enforcers and medical professionals aim to ensure quality of care. Interestingly, albeit their goal is identical, their approach is different? Why?

Primarily, for two reasons. First, medical professionals and antitrust enforcers do not see quality through the same lens. While antitrust enforcers remain faithful to the dogma that quality will be the result of the economic process, medical professionals mainly believe that the medical process and not the competitive rivalry will lead to quality improvements.¹⁸ From an antitrust perspective, quality is considered to be the outcome of the competitive process in which consumers enjoy choices and producers have incentives to enhance the quality of the products and services they offer in order to increase their sales and therefore their profits.¹⁹ From medical professionals' perspective, "quality is effectively binary[;]" either excellent care is offered to a specific individual or it isn't.²⁰ Additionally, while medical professionals consider that health outcomes are improved through the attributes of professionalism, such as altruism, respect, and the notion of trust in the doctor-patient relationship, antitrust authorities mainly believe that vigorous competition and not professionalism ensure health improvements. This difference in opinion inevitably leads to disagreement on how quality of care is improved, with both antitrust enforcers and medical professionals supporting their positions in the name of quality.²¹

Accommodating plausible professional concerns in a competitive market ranks among the most difficult tasks for antitrust.²² Surely, some quality claims can easily be condemned and judged by antitrust as they amount to nothing more than naked restraints to competition. As Robert Pitofsky famously noted, quality-of-care justifications "have been advanced to support, among other things, broad restraints on almost any form of price competition, policies that inhibited the development of managed care organizations, and concerted refusals to deal with providers or organizations that represented a competitive threat

¹⁸ Peter J. Hammer & William M. Sage, *Antitrust, Healthcare Quality and the Courts*, 102 COLUM. L. REV. 545, 556 (2002).

¹⁹ Thomas E. Kauper, *The Role Of Quality Healthcare Consideration In Antitrust*, LAW AND CONTEMP. PROBS., 273, 293 (1998).

²⁰ Hyman et al., *supra* note 2, at 11.

²¹ See Hammer & Sage, *supra* note 18, at 557.

²² See FURROW ET AL., *supra* note 7, at 587.

to physicians.”²³ Other claims are obviously more difficult to examine and assess. These include claims, that due to the healthcare markets’ economic facets, consumers cannot easily assess the quality level of the services they receive and, therefore, are vulnerable to exploitation by insensitive providers. Arguably, such claims often necessitate closer examination by antitrust authorities.²⁴ To a certain extent these claims serve a clear purpose: they prevent medical professionals from taking advantage of their patients’ vulnerability, ignorance, and lack of expertise.²⁵ Since opportunistic behavior by physicians harms patients’ trust in their physicians and generates anxieties harmful to the medical enterprise, there is good reason to consider whether a principled basis in competition law for deeming such claims compatible with a competitive regime is necessary.²⁶ Is this an easy task? Obviously, the answer is a strong no. Nonetheless, this is not sufficient to justify antitrust enforcers’ unexamined and unconditional rejection of medical associations’ healthcare quality claims.

This essay is structured as follows: First, to set the stage, Part I identifies the heart of the conflict. It explains the main reasons why medical markets are considered special, and explores how medical professionals assess and define quality. Part II, raises the questions that are at the heart of this article. It asks: what are the main concerns and justifications medical associations and physicians raise with an eye to protect quality? How do the antitrust enforcers respond to these claims? Under what techniques do they value them? Do they manage to reach the appropriate balance between the protection of competition and the multiple dimensions of healthcare quality? In unravelling Ariadne’s thread, this article analyzes a few seminal antitrust cases where healthcare quality claims were actually addressed and examined. A short conclusion follows.

DIVING INTO THE HEART OF THE DEBATE: *PROFESSIONALISM V. ANTITRUST*

The healthcare policy debate is dominated by different ways of thinking about medical treatment—about different

²³ Hyman et al., *supra* note 2, at 28.

²⁴ See Havighurst, *supra* note 9, at 946.

²⁵ *Id.* at 947.

²⁶ *Id.*

paradigms.²⁷ Advocates of the traditional professional paradigm insist that market forces do not function well in medical care, and therefore medical care should be insulated from market forces, at least in certain cases.²⁸ Medical treatment involves technical decisions that patients are unable to make.²⁹ Medical professionals with specialized knowledge and scientific expertise should be entrusted with medical care decision making because of the asymmetry information problem—providers can judge the quality of the services they offer, consumers cannot.³⁰

Physicians and medical associations animated by this belief often consider themselves the guardians of healthcare quality. Inspired by their commitment to professionalism, they feel entitled to intervene in the healthcare markets they operate to correct the asymmetric distribution of information between patients and doctors, and secure quality. These interventions usually take the form of ethical norms restricting the forms of advertising that can actually take place in a market pervaded by information asymmetries,³¹ standards and certification arrangements, price setting for physicians' fees, and occupational licensing and other forms of self-regulation. Inevitably, these practices and norms often catch the attention of antitrust law which generally assumes that consumers are better off if competitor's independence is preserved.

To fully understand and assess medical associations' claims that self-regulation may in fact correct the asymmetry of information pervading medical markets and ensure quality, one should first consider what a free healthcare market would actually look like. Proponents of occupational licensing warn that a free market may fail to efficiently allocate professional services to consumers due to the extremely low quality of services provided without licensing.³² The asymmetric distribution of information between professionals and consumers as to the quality of the services they receive would inevitably cause the

²⁷ James F. Blumstein, *The Application of the Antitrust Doctrine to the Healthcare Industry: The Interweaving of Empirical and Normative Issues*, 31 INDIANA L. REV. 1, 91 (1998).

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs*, 98 MICH. L. REV. 849, 871 (2000).

³² Aaron Edlin & Rebecca Haw, *Cartels By Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV., 1093, 1115 (2014).

'lemons problem':³³ if consumers cannot identify and assess quality, they may choose to pay only for average quality.³⁴ If consumers are unable to recognize superior quality they are unwilling to pay a premium; therefore, providers may be unwilling to undertake the higher costs the provision of above-average quality services may entail.³⁵ Ultimately, the quality of professional services will be substantially reduced. This would result in "deadweight loss"³⁶ in the form of all market transactions that did not take place "between high quality providers and high-quality demanding consumers."³⁷ Occupational licensing reduces this risk by ensuring that only qualified individuals that conform to minimum levels of quality can offer their services to consumers.³⁸ In antitrust parlance, licensing establishes an entry barrier against incompetent and unqualified practitioners.

Medical markets are also pervaded by negative externalities. An individual may choose to purchase low quality services for a low price rather than no service at all, only because she does not fully internalize the costs of poor service.³⁹ Licensing or other means of self-regulation enhance public safety by imposing minimum quality standards on professional providers.⁴⁰

If the story ended here it would be incomplete. Licensing is costly and can therefore lead to an increase in service prices.⁴¹ Some consumers may be deterred from buying professional services, namely the services that they would be able to buy in a world without licensing.⁴² Some would-be practitioners would be harmed too; these are the non-qualified individuals that would be willing to compete with the qualified ones by offering cheaper

³³ *Id.*; see also George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON., 488, 489 (1970).

³⁴ Marina Lao, *Comment: The Rule of Reason and Horizontal Restraints Involving Professionals*, 68 ANTITRUST L. J. 499, 513 (2000).

³⁵ *Id.*

³⁶ In general "Deadweight loss is the loss of consumer and producer surplus when output declines from the competitive to the monopoly level; it is the most common measure of the social cost of monopoly." Richard A. Posner, William M. Landes, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937, 954 (1980).

³⁷ See Edlin & Haw, *supra* note 32, at 1116.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Edlin & Haw, *supra* note 32, at 1116 (citing MORRIS M. KLEINER, *Licensing OCCUPATIONS: ENSURING QUALITY OR RESTRICTING COMPETITION* 65-96 (2006)).

⁴² See Edlin & Haw, *supra* note. 32, at 1114-15.

services.⁴³ In sum, self-regulation and professional licensing limit the deadweight loss linked with the lemons problem and negative externalities but at the same time also result in deadweight loss by restraining competition.⁴⁴

The remedy, though, should not be worse than the disease. Therefore, if competition authorities have to decide whether a specific form of self-regulation or professional licensure is pro- or anti- competitive, they should be required to weigh harm to competition against quality improvements. Do the U.S. antitrust enforcers perform this task? And, if yes, how? By examining medical associations' quality claims and justifications in a number of seminal healthcare antitrust cases, the following section is dedicated to answering these questions.

FROM GOLDFARB TO TELADOC: HOW DO THE U.S. ANTITRUST ENFORCERS AND THE COURTS TAKE INTO ACCOUNT HEALTHCARE QUALITY?

A. Protecting Healthcare Quality by Excluding Antitrust: Quality as Professionalism

State Boards active in the field of healthcare often invoke that their anticompetitive actions aimed at protecting public safety and health are immune from antitrust law on the basis of the state action doctrine. The latter articulates that “antitrust laws do not apply to anticompetitive restraints imposed by the States as an act of government”.⁴⁵ The Supreme Court introduced this doctrine in *Parker*⁴⁶, after acknowledging that “nothing in the language of the Sherman Act or in its history suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature”.⁴⁷ The Court underlined that a state cannot “give immunity to those who violate the Sherman Act by authorizing them to violate it or by declaring that their action is lawful”.⁴⁸ The Court identified three situations in which defendants may claim that they should not be subject to antitrust

⁴³ *Id.* at 1115.

⁴⁴ *Id.* at 1116.

⁴⁵ *The N.C. State Bd. of Dental Exam'rs v. FTC*, 717 F.3d 359, 366 (4th Cir. 2013).

⁴⁶ *Parker v. Brown*, 317 U.S. 341 (1943).

⁴⁷ *The N.C. State Bd. of Dental Exam'rs*, 717 F.3d at 366.

⁴⁸ *Id.*

rules as the state action doctrine applies.⁴⁹ First, if “a state’s own actions ‘ipso facto are exempt’ from the antitrust laws”.⁵⁰ Second, when private entities “act on the basis of a clearly articulated and affirmatively expressed as state policy and their behavior is actively supervised by the State itself”.⁵¹ Third, “when municipalities or other sub state governmental entities act pursuant to state policy to displace competition with regulation or monopoly public service”.⁵²

In general, U.S. courts have taken the view that “given the fundamental national values of free enterprise and economic competition that are embodied in the federal antitrust laws, state action immunity is disfavored, much as are repeals by implication”.⁵³ Thus, they recognize “state action immunity” only in cases where it is clear that the anticompetitive behavior under scrutiny is undertaken on the basis of regulatory regime that “is the State’s own”.⁵⁴ When examining the state action doctrine in healthcare cases, the FTC and the U.S. courts do not seem willing to abstain from the *Parker* doctrine as the courts in *North Carolina State Board of Dental Examiners*, *South Carolina State Board of Dentistry*, and *Teladoc* cases clearly demonstrate.

In the *South Carolina State Board of Dentistry*, the FTC examined whether the State Board of Dentistry in South Carolina breached the antitrust principles by introducing a regulation that contravened legislation aiming to facilitate access to dental care for poor children in South Carolina.⁵⁵ In the early 1990s, only a limited percentage of Medicaid-eligible children received preventive dental care.⁵⁶ To address this problem, the South Carolina legislature amended the applicable framework to allow dental hygienists to offer preventive dental care to students.⁵⁷ The amended legislation, however, foresaw that students should be examined by a dentist before the hygienist offers them dental care. Therefore, access to preventive dental care in schools

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.* at 367.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *South Carolina State Board of Dentistry*, Docket No. 9311, 1 (Fed. Trade Comm’n Sept. 11, 2007) (opinion and order), <https://www.ftc.gov/sites/default/files/documents/cases/2004/07/040728commissionopinion.pdf>.

⁵⁶ *Id.*

⁵⁷ *Id.*

remained limited.⁵⁸ In 2000, the state legislature again amended its regulatory framework to facilitate the provision of preventive dental care in schools.⁵⁹ Shortly after these amendments took place, the Board introduced a new regulation that reinforced the pre-examination condition.⁶⁰ Consequently, even a lower percentage of poor children in South Carolina received preventive dental care. In 2003, the South Carolina legislature amended the law again in order to clarify that the pre-examination condition did not apply in cases where hygienists offered their services in public health settings.⁶¹ In response to this amendment, the Board reclaimed its initial position that all students should be examined by dentist before a hygienist offers them services.⁶²

As expected, the FTC initiated antitrust proceedings against the Board.⁶³ In defending the challenged policy, the Board asserted that considering its status as a state agency, its actions are those of the State and were therefore covered by the state action doctrine.⁶⁴ It further asserted that “it acted pursuant to a ‘clearly articulated’ state policy to displace competition.”⁶⁵

The FTC rejected this antitrust defense. In unfolding its legal thinking, the FTC explained that “where the actor is . . . a political subdivision of a state or a private party ostensibly acting pursuant to state authorization, the Court has applied a more rigorous analysis to determine whether the entity is excluded from the federal antitrust laws.” In such cases, the FTC stated, “the party is not *ipso facto* entitled to state action protection; rather, the party must demonstrate that it acted pursuant to a clearly articulated and affirmatively expressed state policy to displace competition in favor of regulation and that the state actively supervised the actions.”⁶⁶ Such non-governmental entities lack the political accountability to shape competition policy.⁶⁷ Refusing to treat them as equivalent to the state was therefore in line with the state action test.⁶⁸ The FTC further stressed that “[c]ourts have consistently declined to afford *ipso facto* state

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.* at 2.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.* at 14.

⁶⁶ *Id.* at 15.

⁶⁷ *Id.* at 18.

⁶⁸ *Id.*

action status to state licensing or regulatory boards that are composed at least in part of members of the regulated industry”.⁶⁹ In this light, the challenged regulation was “in direct conflict with the South Carolina statute and inconsistent with the policy ideals behind the state action doctrine: that federalism permits the state as sovereign to displace the national policy of open competition with regulation, only if such anticompetitive intent is clearly shown”.⁷⁰ The FTC concluded, therefore, that the conditions of the state action test were not met.⁷¹

In *North Carolina State Board of Dental Examiners*, the case centered around the strategy of the Board to bar non-dentists from offering teeth whitening services in North Carolina.⁷² In the early 1990s, only dentists provided teeth whitening services in North Carolina; in 2003, however, non-licensed individuals started providing these services at mall kiosks, spas, and retail stores.⁷³ The non-dentists’ services differed from dentists’ teeth whitening services in certain facets such as the immediacy of the results, the ease of use, and price.⁷⁴ On the other hand, the in-office teeth whitening services offered by qualified dentists were faster, more effective, and did not necessitate repeated sessions.⁷⁵

Shortly thereafter, dentists expressed their concerns regarding the quality of the services to the Board.⁷⁶ The Board initiated formal proceedings, relying on North Carolina’s Dental Practice Act (the Act) to prevent non-dentists from providing these services. The Act stated that “it is unlawful for an individual to practice dentistry in North Carolina without a license from the Board”.⁷⁷ Although the Board did not have any power to prevent non-licensed providers from violating the Dental Practice Act,⁷⁸ they sent numerous cease-and-desist letters

⁶⁹ *Id.* at 18.

⁷⁰ *Id.* at 27.

⁷¹ *Id.* at 27-29.

⁷² North Carolina Board of Dental Examiners, Docket No 9343, 1 (Fed. Trade Comm’n June 4, 2013) (Opinion by Commissioner Rosch), <https://www.ftc.gov/sites/default/files/documents/cases/2011/12/111207ncdentalopinion.pdf>.

⁷³ *Id.*

⁷⁴ *The N.C. State Bd. of Dental Exam’rs*, 717 F.3d at 364.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ North Carolina Board of Dental Examiners, Docket No 9343, 1, 3 (Fed. Trade Comm’n Dec. 7, 2011) (Opinion by Commissioner Rosch), <https://www.ftc.gov/sites/default/files/documents/cases/2011/12/111207ncdentalopinion.pdf>.

to non-dentists providing teeth-whitening services.⁷⁹ The Board also sent letters to mall operators to prevent them from leasing kiosk spaces to non-qualified teeth whiteners.⁸⁰ Undoubtedly, the Board's expelling strategy was successful.⁸¹ Non-licensed individuals started refraining from offering teeth whitening services in North Carolina and producers of teeth whitening products used by non-dentists soon exited the market in the state.⁸²

Unsurprisingly, the FTC initiated antitrust proceedings against the Board. Alleging that the Board's actions prevented non-dentists from offering teeth whitening services in North Carolina and therefore deprived consumers of lower prices and choice, the FTC found the challenged conduct anticompetitive.⁸³

In defending its strategy, the Board alleged that it was covered by the state action doctrine.⁸⁴ To be exempted from the antitrust rules, the Board claimed, its conduct should only meet the first condition of the state action test, "that the challenged restraint must be one clearly articulated and affirmatively expressed as state policy."⁸⁵ The Board further claimed that even if it was subject to the second condition of the state action doctrine, that its activity must be actively supervised by the State, North Carolina's "structural legal oversight of the Board" was sufficient to satisfy that condition.⁸⁶

The FTC claimed that the Board failed to prove the active supervision requirement, and rejected the Board's defense.⁸⁷ The U.S. antitrust enforcers clarified that the Court always applied antitrust law to public-private hybrid entities, such as regulatory bodies consisting of market participants.⁸⁸ If these entities were not subject to the active supervision requirement, the FTC claimed, they may act according to their own interests rather than

⁷⁹ *Id.* at 1.

⁸⁰ *Id.* at 5.

⁸¹ *The N.C. State Bd. of Dental Exam'rs*, 717 F.3d at 365

⁸² *Id.*

⁸³ North Carolina Board of Dental Examiners, Docket No 9343, supra note at 78 at 6.

⁸⁴ North Carolina Board of Dental Examiners, Docket No 9343, 1, 8 (Fed. Trade Comm'n Feb. 8, 2011) (Opinion by Commissioner Kovacic), https://www.ftc.gov/sites/default/files/documents/cases/2011/02/110208commo_pinion.pdf.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.* at 8-11.

⁸⁸ *Id.* at 9.

the governmental interests of the State.⁸⁹ Requiring active supervision by the state itself in cases where the state agency financially benefits from the anticompetitive restraint is in line with the policies underlying the state action doctrine.⁹⁰ The North Carolina Board was controlled by licensed dentists in North Carolina, thus market participants motivated by their self-interest that were elected directly by their colleagues.⁹¹ Consequently, the FTC alleged that the defendant could escape from the antitrust mandate only in case its conduct was actively supervised by the state.⁹²

Before the Fourth Circuit the defendant again raised the state action defense. The Court did not divert from the FTC's legal analysis.⁹³ The Supreme Court affirmed the lower's court decision. It also outlined the conditions under which the active supervision condition is generally met.⁹⁴ First, the Court clarified that the supervisor must review the substance of the anticompetitive decision and not only the procedure under which the decision was adopted.⁹⁵ Second, the Court clarified that the supervisor must not be an active market participant.⁹⁶ Concluding that the defendant failed to satisfy the necessary conditions of the state action test, the Court rejected this antitrust defense.⁹⁷

The state action defense was also raised by the Texas Medical Board, a state agency "statutorily empowered to regulate the practice of medicine in Texas".⁹⁸ The latter concerned the antitrust proceedings brought by Teladoc, a telemedicine company, against the Board over a rule⁹⁹ that prohibited "prescription of any dangerous drug or controlled substance without first establishing a defined physician-patient relationship". This mainly included a physical examination that should be performed "by either face-to-face visit or in-person evaluation' elsewhere defined as requiring the provider and

⁸⁹ *Id.*

⁹⁰ *Id.* at 10.

⁹¹ *Id.* at 13.

⁹² *Id.*

⁹³ *The N.C. State Bd. of Dental Exam'rs*, 717 F.3d at 370-76.

⁹⁴ *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, 135 S. Ct. 1101 (2015).

⁹⁵ *Id.* at 1107.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Teladoc et al. v. Texas Medical Board*, 112 F.Supp.3d 529, 533 (W.D.Tex. 2015) (quoting 22 Tex. Admin. Code § 161.1 (2016)).

⁹⁹ 22 Tex. Admin. Code § 190.8 (2019).

patient to be in the same physical location or medical site.”¹⁰⁰ Essentially, the plaintiffs alleged that the rule in question restricted competition by limiting price competition, restricting access and by restricting the overall supply of medical services.¹⁰¹

The Texas Medical Board argued that the challenged rule is not subject to the antitrust rules because the state action doctrine applied.¹⁰² The Board claimed that it was actively supervised by the state as its decisions were subject to “judicial review by the courts of Texas and the State Office of Administrative Hearings as well as review by the Texas Legislature”.¹⁰³ Noting, though, that the judicial review on which the Board relied was rather limited, the court alleged that the Supreme Court’s state action test was not met¹⁰⁴

B. Quality as a Public Safety Claim

The Supreme Court initially dealt with quality claims related to the learned professions in 1978, when the U.S. initiated antitrust proceedings against the National Society of Professional Engineers. The plaintiff claimed that the National Society of Professional Engineers’ Code of Ethics prevented “its members from submitting competitive bids for engineering services[,]”¹⁰⁵ and therefore violated Section 1 of the Sherman Act.¹⁰⁶ Relying on footnote 17 of the *Goldfarb* decision, the defendant claimed that its ethical norms served clearly a public safety purpose: they minimized the risk “that competition would produce inferior engineering work endangering the public safety”.¹⁰⁷ The District Court rejected this justification without delving into the question of whether competition had actually harmed public safety or welfare.¹⁰⁸ To the Court, this inquiry was not necessary.¹⁰⁹ The District Court easily dismissed the defendant’s public safety

¹⁰⁰ *Teladoc*, 112 F.Supp.3d at 534.

¹⁰¹ *Id.* at 537.

¹⁰² *Teladoc, Inc. v. Tex. Med. Bd.*, No. 1-15-CV-343 RP, 2015 U.S. Dist. LEXIS 166754, at *17 (W.D. Tex. Dec. 14, 2015).

¹⁰³ *Id.* at 21-22.

¹⁰⁴ *Id.* at 22-23.

¹⁰⁵ *Nat’l Soc’y of Prof’l Engineers v. United States*, 435 U.S. 679 (1978).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *United States v. Nat’l Soc. of Prof’l Engineers*, 404 F. Supp. 457, 460 (D.D.C. 1975), *aff’d in part, modified in part*, 555 F.2d 978 (D.C. Cir. 1977), *aff’d*, 435 U.S. 679 (1978), and *opinion withdrawn and superseded*, No. 2412-72, 1978 WL 1395 (D.D.C. Aug. 3, 1978).

¹⁰⁹ *Id.*

claim, taking the view that “the ban clearly imped[ed] the ordinary give and take of the market place and operat[ed] on its face [as] tampering with the price structure of engineering fee”.¹¹⁰

The lower court’s view was affirmed both by the Court of Appeals and the Supreme Court.¹¹¹ In rejecting the defendant’s antitrust defense, the Supreme Court grasped the opportunity to clarify to what extent under U.S. antitrust law safety concerns can be assessed under the rule of reason.¹¹² The Court stated that an antitrust legal analysis can be conducted under two complementary categories.¹¹³ The first includes agreements, that due to their nature and necessary effects, are so obviously anticompetitive that they can be found illegal without extensive examination of the industry¹¹⁴; these “are per se illegal”.¹¹⁵ The second category includes agreements whose effect on competition can be evaluated only if the facts peculiar to the business and the reasons why the restraint under scrutiny was imposed are assessed.¹¹⁶ In both cases, the Court held, the purpose of the analysis is to assess the impact of the restraint on competition and “not to decide whether a policy favoring competition is in the public interest”.¹¹⁷

The Court stated that “ethical norms may serve to regulate and promote competition in professional services, and thus fall within the rule of reason”.¹¹⁸ It underlined that in this particular case, the defendant’s quality claim was “a far cry from such a position”.¹¹⁹ The Court acknowledged that competition may in fact cause some providers to sell a defective product.¹²⁰ In this light, the Court stated “competitive bidding for engineering projects may be inherently imprecise and incapable of taking into account all the variables that are involved in the actual performance of the project”.¹²¹ Therefore,

a purchaser might conclude that his interest in quality—
which may embrace the safety of the end product—

¹¹⁰ *Id.*

¹¹¹ *Nat’l Soc’y of Prof’l Engineers*, 435 U.S. at 699.

¹¹² *Id.* at 687.

¹¹³ *Id.* at 692.

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 696.

¹¹⁹ *Id.*

¹²⁰ *Id.* at 694.

¹²¹ *Id.*

outweighs the advantages of achieving cost savings by pitting one competitor against another. Or an individual vendor might independently refrain from price negotiation until he has satisfied himself that he fully understands the scope of his customers' needs.¹²²

The Court admitted that such decisions may make sense.¹²³ Such justifications, however, "cannot satisfy the rule of reason".¹²⁴

The Court noted an alternative approach would amount "to nothing less than a frontal assault on the basic policy of the Sherman Act".¹²⁵ It underlined that the Sherman Act reflects the notion that competition will lead not only to lower prices but also to higher quality goods and services.¹²⁶ In rejecting the defendant's defense, the Court contended that "the statutory policy precludes inquiry into the question of whether competition is good or bad".¹²⁷ Therefore, any claim that is based on the rationale that competition is too intense cannot be analyzed under the rule of reason.¹²⁸ Adopting a different approach, the Court explained, would undoubtedly create the "sea of doubt".¹²⁹

The Supreme Court dealt with analogous quality concerns and claims in the seminal case, *FTC v. Indiana Federation of Dentists*.¹³⁰ The Supreme Court examined the question of whether the FTC correctly assessed that "a conspiracy among dentists to refuse to submit x-rays to dental insurers for use in benefits determinations" constituted an antitrust violation.¹³¹ Since the 1970s, dental health insurers, in response to the demands of their policyholders, initiated efforts to suppress the cost of dental treatment by "limiting payment of benefits to the cost of the least expensive yet adequate treatment suitable to the needs of individual patients".¹³² In applying such cost-containment measures, known as "alternative benefits" plans, insurers were required to evaluate the diagnosis and recommendation of the treating dentist, either in advance or

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.* at 695.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.* at 696.

¹³⁰ *Fed. Trade Comm'n v. Ind. Fed'n of Dentists*, 476 U.S. 447 (1986).

¹³¹ *Id.* at 448-49.

¹³² *Id.* at 449.

following the dental treatment.¹³³ In carrying out such evaluation, insurers often asked dentists to submit, “along with insurance claim forms requesting payment of benefits, any dental x-rays that had been used by the dentist in examining the patient”.¹³⁴ Typically, claim forms and accompanying x-rays were reviewed by lay claims examiners who were entitled either to approve payment of claims or to refer claims to dental consultants for further review.¹³⁵ The dental consultants may recommend that the insurer approve a claim, deny it, or pay only for a less expensive course of treatment.¹³⁶

Such review of diagnostic and treatment decisions had been viewed by some dentists as a threat to their autonomy and economic welfare.¹³⁷ In this context, the Indiana Dental Association, a professional association consisting of almost 85% of dentists in the State of Indiana, initiated an aggressive effort to prevent insurers from implementing alternative benefit plans “by enlisting member dentists to pledge not to submit x-rays in conjunction with claim forms”.¹³⁸ The Association’s efforts were undoubtedly successful; numerous dentists signed the pledge, and insurers operating in Indiana could not easily obtain compliance with their requests for x-rays.¹³⁹ Insurers were forced either to adopt more costly methods of making alternative benefits determinations or to completely abandon such efforts.¹⁴⁰

The FTC initiated antitrust proceedings against the Association.¹⁴¹ In its complaint, the FTC alleged that the Association’s strategy amounted to a conspiracy that unlawfully restrained trade on the basis of Section 1 of the Sherman Act.¹⁴² “Absent such a restraint[,]” the FTC alleged, “competition among dentists for patients would have tended to lead dentists to compete with respect to their policies in dealing with patients’ insurers”.¹⁴³ Hence, the FTC claimed that the Association’s policy had the actual effect of “eliminating such competition among dentists and preventing insurers from obtaining access to x-rays

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.* at 449-50.

¹³⁹ *Id.* at 450.

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at 451.

¹⁴² *Id.* at 451-52.

¹⁴³ *Id.* at 452.

in the desired manner”.¹⁴⁴ The FTC held that these findings of anticompetitive effect “were sufficient to establish that the restraint was unreasonable, even absent proof that the Association’s policy had resulted in higher costs to the insurers and patients than would have occurred had the x-rays been provided”.¹⁴⁵

The defendant raised a public safety defense that, not surprisingly, did not alter FTC’s initial assessment. More specifically, the FTC rejected the Association’s argument that its ethical policy of withholding x-rays “was reasonable because the provision of x-rays might lead the insurers to make inaccurate determinations of the proper level of care, and thus injure the health of the insured patients”.¹⁴⁶ They found no evidence that use of x-rays by insurers would lead to inferior dental treatment.¹⁴⁷

The Seventh Circuit fundamentally diverted from the FTC’s findings. Accepting the defendant’s characterization of its rule against submission of x-rays as merely an ethical and moral policy designed to enhance the welfare of dental patients, it concluded that the FTC’s findings were erroneous.¹⁴⁸ Applying a rule of reason analysis, the court held that by deterring dentists from joining together to promote standards of quality that are in line with the American Dental Association’s Code of Professional Conduct and the Indiana Dental Code, the FTC, “with absolutely no expertise” in the field of dentistry, “unwisely regulates the dental profession and all of its specialties”, and “to the detriment of consumers”.¹⁴⁹ Underlining that “the group of dental health care insurers should not be permitted to forsake standards of quality and proper dental care in an attempt to decrease their dental costs”, especially in this case where there were no actual proof that the review of dental x-rays had actually decreased the costs of care, the Seventh Circuit vacated the FTC’s ruling.¹⁵⁰

Before the Supreme Court, the defendant once again raised a public safety defense.¹⁵¹ In line with the FTC’s legal analysis, the Supreme Court found that the defendant’s argument

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Ind. Fed’n of Dentists v. Fed. Trade Comm’n*, 745 F.2d 1124, 1136 (7th Cir. 1984).

¹⁴⁹ *Id.* at 1144.

¹⁵⁰ *Id.*

¹⁵¹ *Ind. Fed’n of Dentists*, 476 U.S. at 462.

was “flawed both legally and factually”.¹⁵² Citing *National Society of Professional Engineers*, the Court held that claiming that an unrestrained market in which consumers are provided with information will lead them to make dangerous or unsafe choices amounts to “nothing less than a frontal assault on the basic policy of the Sherman Act”.¹⁵³ The Court insisted that there was no reason to believe that the provision of information in the dental services market will harm consumers more than in other markets.¹⁵⁴ The Supreme Court emphasized that the insurers that determine the level of care to pay for are not the ones that receive the dental services.¹⁵⁵ The Court, however, did not assess whether this market failure might affect the quality of dental care. Adopting the view that “insurers are themselves in competition for the patronage of the patients”, the Court easily concluded that insurers have the incentives to consider patients’ welfare.¹⁵⁶ In making this assessment and without providing any essential justification, the Court concluded that while insurers always behave as their patients’ perfect agents, medical professionals behave always as their patients’ imperfect ones.

Similar patient safety concerns were also raised by the Dental Board in *North Carolina*, where the Board claimed that its strategy against non-dentists aimed to protect public health and patients’ welfare.¹⁵⁷ In brief, the Board held that if non-dentists were permitted to offer teeth whitening services, the quality of these services would be reduced.¹⁵⁸ The FTC condemned defendant’s quality justification as non-cognizable.¹⁵⁹ “Cognizable is a justification”, the FTC explained, “that stems from measures that increase output or improve product quality, service or innovation”.¹⁶⁰ Alleging, however, that the Courts have repeatedly rejected the notion that welfare and public safety concerns constitute “cognizable justifications” the FTC dismissed the defendant’s quality concerns.¹⁶¹

¹⁵² *Id.*

¹⁵³ *Id.* at 463.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ North Carolina Board of Dental Examiners, Docket No 9343, 1, 24 (Fed. Trade Comm’n June 4, 2013) (Opinion by Commissioner Rosch), <https://www.ftc.gov/sites/default/files/documents/cases/2011/12/111207ncdentelopinion.pdf>.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* at 24-25.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

In defending its policy, the Board also alleged that “a valid defense to a Sherman Act claim exists where a state agency promotes public health and enforces state’s law even if the conditions of the state action doctrine are not met”.¹⁶² Adopting, once again, the view that “a public safety defense is extraneous to an analysis of competitive effects”, the FTC rejected the Board’s public safety concerns.¹⁶³ Before reaching this conclusion though, the FTC did not omit to examine the Board’s claim in substance. To substantiate its health safety claim, the Board submitted four anecdotal reports of harm.¹⁶⁴ The FTC held that “four anecdotal reports of harm over a multi-year period based on products considered safe by the FDA cannot be considered “adequate evidence of a potential health or safety risk””.¹⁶⁵ The FTC also noted that “although several board members had identified a number of theoretical risks from non-dentist teeth whitening, none was able to cite any clinical or empirical evidence validating any of these concerns.”¹⁶⁶ In light of this assessment, the FTC found, again, the Board’s claim unsubstantiated.

The Fourth Circuit fully aligned with the FTC’s legal reasoning. Interestingly, Circuit Judge Barbara Milano Keenan, who concurred in the majority’s opinion, wrote separately “to emphasize the narrow scope of the Appellate Court’s holding that the Board is a private actor for the purposes of the state action doctrine.”¹⁶⁷ Judge Keenan made clear her belief that the Board was mainly incentivized by a desire to limit the provision of teeth whitening services by non-dentists “under unsanitary conditions.”¹⁶⁸ She also stressed that (a) the Board “was aware that several consumers had suffered from adverse side effects, including bleeding or chemically burned gums”, following treatment by unqualified individuals;¹⁶⁹ (b) several mall kiosks where such teeth-whitening services took place did not even have access to running water;¹⁷⁰ (c) the Board had received several reports that non-dentists offered teeth whitening services “without using gloves or masks, thereby increasing the risk of

¹⁶² *Id.* at 25-26.

¹⁶³ *Id.* at 26.

¹⁶⁴ *Id.* at 27.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *North Carolina State Bd. of Dental Exam’rs*, 717 F.3d at 376.

¹⁶⁸ *Id.* at 377.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

adverse side effects.”¹⁷¹ In this light, Judge Keenan admitted that the record was in line with the Board’s core quality claim that “there is a safety risk inherent in allowing certain individuals who are not licensed dentists” to offer teeth whitening services.¹⁷² She emphasized, however, that only North Carolina “is entitled to make the legislative judgment” that the benefits of deterring non-dentists from performing dental services surpass the harm to competition, and not a private consortium.¹⁷³

The Massachusetts Board of Registration in Optometry,¹⁷⁴ the sole licensing authority for optometrists in Massachusetts¹⁷⁵ was also involved in an analogous antitrust dispute. The Board enjoyed considerable power because Massachusetts law authorized the Board to take disciplinary action against any licensee engaged in unprofessional conduct, fraud, deceit, or misrepresentation in practice or in advertising.¹⁷⁶ Following antitrust investigation, the FTC found that the Board restrained competition among optometrists in Massachusetts by conspiring with its members or others to unreasonably restrict truthful advertising by optometrists.¹⁷⁷ Among other things, the Board prohibited optometrists from (a) advertising discounts from their usual prices and fees, (b) permitting optical establishments and other commercial practices to truthfully advertise the optometrists’ names or professional abilities, and (c) making use of truthful advertising that contained testimonials or that is “sensational” or “flamboyant”.¹⁷⁸ Essentially, the Board prohibited all the above irrespective of the truth or falsity of the advertisements.¹⁷⁹ The Board also prevented retail optical stores from informing the public of their lawful affiliation with an optometrist and of the availability of the optometrist’s services.¹⁸⁰ In challenging the Board’s policy, the FTC found that the alleged advertising restrictions had harmed consumers considerably. In fact, because of these restrictions, consumers had been deprived of the benefits of vigorous price and service competition among

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. 549 (1988).

¹⁷⁵ *Id.* at 550.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 551.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 551-52.

¹⁸⁰ *Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. at 577 (citing Administrative Law Judge James P. Timothy).

optometrists' and truthful information about optometrists' services, prices and fees.¹⁸¹

At trial, the Board did not offer a procompetitive justification for its restraints on discount advertising.¹⁸² Essentially, the Board attempted to justify its ban on affiliation advertising by supporting the view that its purpose was "to reduce the risk of harm to the public from unrestrained competition in optometry".¹⁸³ More specifically, the Board argued that affiliation may actually incentivize optometrists to offer lower quality care either because "a lay person may interfere with the optometrists' independent professional judgment, or because 'the commercial motivation' of the optometrist may *lessen* professional standards".¹⁸⁴ In that sense, the advertising restriction aimed to prevent consumers from falsely believing that they are getting a good offer at a large chain store when in reality they only received a lower price for lower quality of eye care.¹⁸⁵

In evaluating these claims, the Administrative Law Judge (ALJ) referred to Dr. Kwoka's study that examined the relationship between advertisement restrictions and quality.¹⁸⁶ Relying on the findings of this study, the ALJ noted that "restrictions on advertising in the market for optometrist goods and services raise prices and total cost to consumers without affecting quality."¹⁸⁷ The ALJ further observed that (a) advertising has the effect of decreasing the cost of offering optometric goods and services, (b) advertising optometrists offer *less thorough* eye examinations than by the non-advertising ones, and (c) in markets where advertising is permitted, 55% of the optometrists do not advertise and a higher percentage of all optometrists provide higher quality examinations than in markets where advertising is banned.¹⁸⁸ In examining the Board's pro-competition claims under the rule of reason, the ALJ alleged that there was no proof that the banned advertising had deceived the public and that deception "cannot justify a total ban on truthful advertising".¹⁸⁹ Therefore, the Board's alleged pro-competitive

¹⁸¹ *Id.* at 551.

¹⁸² *Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. at 587 (citing Administrative Law Judge James P. Timothy).

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 548-49.

¹⁸⁶ *Id.* at 561.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.* at 561-62.

¹⁸⁹ *Id.* at 588.

claims were rejected in their entirety.¹⁹⁰

On appeal, the FTC fully approved these findings. However, it did so after addressing the issue of the appropriate standard for evaluating similar restraints. The Commission proposed that such restraints should be examined under the so-called “structured rule of reason.”¹⁹¹ According to this method of analysis, the first question to be asked about any competitive restraint is whether it is inherently suspect.¹⁹² If not, traditional rule of reason applies¹⁹³, but if so, a second question must be examined and answered: is there a plausible efficiency justification for the restraint? If not, the restriction can easily be found unlawful, but if a plausible efficiency justification exists, then a third inquiry is needed: whether the proposed justification is valid. If it is proved to be valid, a full rule of reason legal test should apply.¹⁹⁴ If it is not valid then the restriction is easily condemned under the rule of reason.¹⁹⁵ This structured legal test aimed to serve as the basis for the assessment of competition restraints in an era in which the possibility of procompetitive restraints was not totally precluded.¹⁹⁶ Applying its proposed legal test and noting, once again, that defendant’s justifications are not cognizable as they are premised on the belief that competition itself is inappropriate in optometry, the FTC found all the restraints imposed by the Massachusetts Board anticompetitive.¹⁹⁷

¹⁹⁰ *Id.*

¹⁹¹ John E. Kwoka, Jr., *The Federal Trade Commission and the Professions: A Quarter Century of Accomplishment and Some New Challenges*, 72 ANTITRUST L.J. 997, 1006 (2005).

¹⁹² *Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. at 604.

¹⁹³ *See* Chicago Board of Trade v. United States, 246 U.S. 231, 238 (1918). The rule of reason analysis legal test was introduced by the Supreme Court in the Chicago Board of Trade case where Justice Brandeis famously quoted: “the true test of legality is whether the restraint is such as merely regulates, and perhaps thereby promotes, competition, or whether it is such as may suppress or even destroy competition. To determine this question, the court must ordinarily consider the facts peculiar to the business, its condition before and after the restraint was imposed, the nature of the restraint, and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts, not because a good intention will save an otherwise objectionable regulation or the reverse, but because knowledge of intent may help the court to interpret facts and predict consequences.”

¹⁹⁴ *Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. at 604.

¹⁹⁵ *Id.*

¹⁹⁶ *See* Kwoka, *supra* note 191, at 1007.

¹⁹⁷ *Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. at 609-10.

In attempting to defend the challenged regulation against telemedicine, the Texas Medical Board, in *Teladoc*, also raised a public safety defense. The Board mainly asserted that its revised rule¹⁹⁸ was necessary for the protection of healthcare quality.¹⁹⁹ In substantiating its claim the Board cited affidavit testimonies presented by medical professionals explaining the limitations and weaknesses of a telephone-only diagnosis²⁰⁰ The Board claimed these testimonies demonstrated that “there is material risk of harm from treatment without any physical examination”.²⁰¹ The Board also questioned Teladoc’s argument that telemedicine improves access to patients who cannot easily reach other healthcare providers. The Board insisted that the group of consumers attracted to Teladoc – “a more affluent and, likely, a more technologically savvy group - might have fewer access needs than people living in area’s characterized by shortage of primary care or socio-economic disadvantage.”²⁰² In this light it added that “further research is needed to understand whether Teladoc might be improving access for patients with lower income and those in rural areas and if not, can it be positioned to do so in the future.”²⁰³

The Court was not convinced. Taking the view that Teladoc submitted evidence that put into question the Board’s claim that its regulation aimed to secure quality and insisting that the Supreme Court has ruled that public safety concerns cannot justify the adoption by a professional association of an anti-competitive strategy, the District Court fully dismissed the Board’s quality claims.²⁰⁴

The Board appealed the Court’s decision to a higher court. Nonetheless, the Board dropped the appeal due to the influx of amicus curie briefs that were filed with the court, most of which supported Teladoc’s position. This includes a significant brief jointly submitted by the FTC and the Department of Justice (the Agencies).²⁰⁵ In this brief, the Agencies asked the Court to

¹⁹⁸ 22 Tex. Admin. Code § 190.8 (2019) (“prohibited prescription of any dangerous drug or controlled substance without first establishing a defined physician – patient relationship.”).

¹⁹⁹ *Teladoc*, 112 F.Supp.3d at 534.

²⁰⁰ *Id.* at 538.

²⁰¹ Brief of American Medical Association and Texas Medical Association as Amici Curiae Supporting Defendant-Appellants at 20, *Teladoc, Inc. v. Texas Med. Bd.*, 112 F. Supp. 3d 529 (W.D. Tex. 2015) (No. 16-50017).

²⁰² *Teladoc*, 112 F.Supp.3d at 539

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ Brief of United States of America and Federal Trade Commission as

ignore the Board's appeal of Teladoc's case by insisting that the court doesn't have the authority to review the decision and the rule itself should be thrown out.²⁰⁶

Interestingly, in support of Board's appeal, the AMA and the Texas Medical Association (the Associations) jointly filed a brief.²⁰⁷ In the brief they explained why public safety may be harmed if the future of telemedicine was left to market forces. The Associations acknowledged that telemedicine substantially benefits patients, mainly by improving access to healthcare services.²⁰⁸ They clarified that telemedicine "is inappropriate for certain medical conditions and it carries risks".²⁰⁹ They claimed "[w]ithout the ability to conduct in person physical examinations, treating physicians risk misdiagnosing or mistreating patients especially through over prescription of antibiotics and other medications".²¹⁰ In proving their safety claims, the defendants relied on research showing that in cases where medical professionals cannot conduct physical examination, they may either use a conservative approach or propose the use of antibiotics in cases where the benefit of antibiotics therapy is actually unclear.²¹¹ They emphasized that in identifying both benefits and risks, medical associations and State medical boards across the U.S., cooperate in order to determine how the use of telemedicine may "best serve patients and the public".²¹² Since research demonstrates that allowing the prescription of dangerous drugs without requiring in person examination by any medical professional may harm the quality of care, some regulation aiming to protect public health may in fact be necessary, doctors said.²¹³ Such regulation, they held, is precisely what the Texas Medical Board undertook with the rules that *Teladoc* challenged.²¹⁴ As the Board dropped the appeal,

Amici Curiae Supporting Plaintiffs-Appellees, *Teladoc, Inc. v. Texas Med. Bd.*, 112 F. Supp. 3d 529 (W.D. Tex. 2015) (No. 16-50017).

²⁰⁶ *Id.* at 35.

²⁰⁷ Brief of American Medical Association and Texas Medical Association as Amici Curiae, *supra* note 201.

²⁰⁸ *Id.* at 5.

²⁰⁹ *Id.*

²¹⁰ *Id.* at 16.

²¹¹ *Id.* at 22.

²¹² *Id.* at 16-23. The AMA and the Texas Medical Association claimed that several state medical boards have adopted restrictions on the ability to prescribe medications without prior physical examination by the prescribing physician or a patient site presenter.

²¹³ *Id.* at 27.

²¹⁴ *Id.*

unfortunately, their arguments remained unexamined.

C. Protecting Quality by Correcting the Market Imperfections

Another way by which medical associations have attempted to justify antitrust violations is by spelling out that: as doctors they know what is best for their patients' welfare. They have better information regarding what quality of care means and how it is achieved. Therefore, it is in their sphere of responsibility to fix poorly functioning markets and protect people's health. The FTC and the U.S. courts have thoroughly examined this quality argument in two seminal cases: *Wilk*²¹⁵ and *California Dental Association*.²¹⁶

In *Wilk*, the legal issue centered around chiropractors' complaints that the AMA conspired to eliminate the chiropractic profession by refusing to cooperate with chiropractors.²¹⁷ Defendants achieved their goal, plaintiffs argued, by relying on former Principle 3 of the AMA's Principles of Medical Ethics, which deterred physicians "from associating professionally with unscientific practitioners".²¹⁸ The plaintiffs asserted that the AMA used Principle 3 to eliminate the chiropractic profession by characterizing them as "unscientific practitioners".²¹⁹

The court rejected the plaintiffs' argument that the defendants' strategy was a per se violation of Section 1, holding that "a canon of medical ethics purporting, surely not frivolously, to address the importance of scientific method gives rise to questions of sufficient delicacy and novelty at least to escape per se treatment."²²⁰ Through a rule of reason analysis the District Court took the view that the AMA by applying former Principle 3, had unreasonably restrained trade in violation of §1 of the Sherman Act.²²¹ The court found that the AMA's main goal was "to prevent medical physicians from referring patients to chiropractors and from accepting referrals of patients from chiropractors, so as to prevent chiropractors from obtaining access to hospital diagnostic services and membership on hospital medical staffs."²²² The court also found that the AMA aimed "to

²¹⁵ *Wilk v. American Medical Association*, 895 F.2d 352 (7th Cir. 1990).

²¹⁶ *In re California Dental Ass'n*, 121 F.T.C. 190 (1996).

²¹⁷ *Wilk*, 895 F.2d at 355.

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.* at 359.

²²¹ *Id.* at 355.

²²² *Id.* at 356.

prevent medical physicians from teaching at chiropractic colleges or engaging in any joint research.”²²³ In sum, AMA’s strategy aimed to “prevent any cooperation between the two groups in the delivery of health care services.”²²⁴

At trial, the AMA attempted to defend its strategy on the basis of the so-called “patient care defense.”²²⁵ This defense required the AMA to prove that

- (a) It genuinely entertained a concern for what doctors perceived as scientific method in the care of each person with whom they had entered into a doctor-patient relationship;
- (b) this concern was objectively reasonable;
- (c) this concern had been the dominant motivating factor in defendant’s promulgation of Principle 3 and in the conduct intended to implement it;
- (d) this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition.²²⁶

Considering that the AMA failed to meet the defense’s second and fourth conditions, the district court easily dismissed this antitrust defense.²²⁷

Although the court questioned “the AMA’s genuineness regarding its concern for scientific method in patient care”, it finally reached the conclusion that the AMA had established the first factor.²²⁸ In shaping its conclusion, the court considered that while the AMA “was attacking chiropractic as unscientific, it simultaneously was attacking other unscientific methods of disease treatment (e.g., the Krebiozen treatment of cancer), and the existence of medical standards or guidelines against unscientific practice was relatively common.”²²⁹

The court, however, took the view that the AMA had not met the required burden of proof as to the second element of the defense, “whether its concern for scientific method in patient care was objectively reasonable.”²³⁰ To carry out this assessment, the court took into account substantial evidence demonstrating that chiropractors can treat more effectively than physicians certain

²²³ *Id.*

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ *Id.* at 362.

²²⁷ *Id.*

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

medical issues, such as back injuries.²³¹ It also noted that the AMA's members did not seem to examine pro-chiropractic arguments with open mind.²³² With these elements in mind, the court held that: there was no objectively reasonable concern that would support a boycott of the entire chiropractic profession."²³³

It also held that the AMA had carried its burden of proof in establishing the third element of the defense, "that its concern about scientific method was the dominant motivating factor" in the challenged conduct.²³⁴ The court found that the AMA had not met its burden of proving that "its concern for scientific method in patient care could not have been satisfied adequately in a manner less restrictive of competition."²³⁵ Since the AMA had submitted no evidence of other policies less restrictive of competition, such as public education, the Court found that the AMA had not satisfied the defense's final condition.²³⁶

The case reached the Seventh Circuit. The Court identified "the central question in this case was whether the AMA's boycott constituted an unreasonable restraint of trade under §1 of the Sherman Act".²³⁷ A restraint is unreasonable "if it falls within the category of restraints held to be *per se* unreasonable, or if it violates what is known as "the rule of reason."²³⁸ Acknowledging that "the Supreme Court historically has been slow to condemn rules adopted by professional associations as unreasonable *per se*", the court examined AMA's challenged boycott under the rule of reason.²³⁹

In brief, the AMA claimed that it should be exempted from antitrust liability under the rule of reason as Principle 3 had pro-competitive effects.²⁴⁰ The AMA essentially alleged that healthcare markets are characterized by information asymmetries and therefore patients may be easily deceived by "unscrupulous health care providers". To avoid this risk, consumers may avoid necessary treatments.²⁴¹ In that sense, the AMA's practice did nothing more than protect consumers from unscientific forms of

²³¹ *Id.*

²³² *Id.*

²³³ *Id.*

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ *Id.*

²³⁷ *Id.* at 358.

²³⁸ *Id.*

²³⁹ *Id.* at 359.

²⁴⁰ *Id.* at 361.

²⁴¹ *Id.*

treatment.²⁴² The Seventh Circuit remained skeptical. Expressing its belief that the AMA was not wholeheartedly driven by its altruistic and scientific concerns, it rejected the defendant's quality justifications.²⁴³ In line with the lower court's view, it found AMA's boycott anti-competitive.²⁴⁴

California Dental Association v. FTC involved an association of dentists with membership of a large percentage of all dentists in California.²⁴⁵ The antitrust issue in this case concerned California Dental Association's (CDA) code of ethics, including Section 10 of CDA's professional code which prohibited advertising or solicitation "false or misleading in any material respect."²⁴⁶ CDA's Judicial Council, whose role was to enforce CDA's Code, had issued multiple advisory opinions and guidance elaborating upon the scope of this standard.²⁴⁷ These opinions, which formed the basis of the FTC's challenge, argued that a statement or claim could be considered false or misleading where:

(a) it contained a misrepresentation of fact; (b) it made only a partial disclosure of relevant facts (c) it was likely to create false or unjustified expectations of favorable results and/or costs (d) it related to fees for specific types of services without fully and specifically disclosing all variables and (e) it contained other representations or implications that in reasonable probability would cause an ordinarily prudent person to be deceived.²⁴⁸

Concerning price advertising, CDA allowed advertising discounts only with extensive disclosures.²⁴⁹ CDA's Code of Ethics and all relevant guidelines required that "all price advertising be exact and that discount advertising list the regular fee for each discounted service, the percentage of the discount, the length of time that the discount will be available, verifiable fees, and the specific groups who are eligible for the discount."²⁵⁰ When applying and enforcing these conditions, CDA often "cited

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.* at 361-64.

²⁴⁵ *Cal. Dental Ass'n v. F.T.C.*, 128 F.3d 720 (9th Cir. 1997), *judgment vacated*, 526 U.S. 756 (1999).

²⁴⁶ *Id.* at 722.

²⁴⁷ *Id.*

²⁴⁸ *Id.* at 723.

²⁴⁹ *Matter of California Dental Ass'n*, 121 F.T.C. at 300.

²⁵⁰ *Id.* at 294.

members for using phrases such as low, reasonable or inexpensive fees, and for failing to include the regular fees for each service covered by across-the-board senior citizen discounts, or coupon discounts for new customers”.²⁵¹

Additionally, adopting the opinion that non-price claims “are not susceptible to measurement or verification” and therefore “likely to be false or misleading” in practice CDA prohibited all quality claims.²⁵² For example, CDA recommended “denial of membership to one dentist because her advertising included the phrase quality dentistry which CDA thought was not susceptible of verification”.²⁵³ Furthermore, although written regulations had not been adopted, CDA did not allow “claims of superiority and the issuance of guarantees.”²⁵⁴ CDA had considered an advertisement including the phrase “we can provide the uncompromised standards of excellence you demand’ to be “an impermissible representation of superiority.”²⁵⁵

When examining the anti-competitive effects of CDA’s policies and norms, the FTC rejected the Massachusetts Board analysis, finding instead that the restrictions on discount advertising were illegal per se.²⁵⁶ The FTC took the view that CDA’s restrictions on advertising “low” or “reasonable” fees, and its extensive disclosure requirements for discount advertising, “effectively preclude its members from making low fee or across-the-board discount claims regardless of their truthfulness.”²⁵⁷ Noting that the professional context of this restriction cannot alter the analysis, as well as that in cases involving agreements not “premised on public service or ethical norms, the Supreme Court has repeatedly applied the per se rule,”²⁵⁸ the FTC stressed that a ban that significantly restricts price competition is illegal per se.²⁵⁹ Applying an abbreviated analysis, the FTC also condemned the non-price advertising restrictions. With regard to these restraints, the FTC stated, “we cannot say with equal confidence that, as a facial matter, CDA’s concerns are unrelated to the public service aspect of its profession, or that the practice

²⁵¹ *Id.*

²⁵² *Id.* at 230.

²⁵³ *Id.*

²⁵⁴ *Id.* at 309.

²⁵⁵ *Id.*

²⁵⁶ Timothy. J. Muris, Cal. Dental Ass’n v. Federal Trade Comm’n: *The Revenge of Footnote 17*, 8 SUP. CT. ECON. REV., 265, 271 (2000).

²⁵⁷ *Matter of California Dental Ass’n*, 121 F.T.C. at 300.

²⁵⁸ *Id.* at 306.

²⁵⁹ *Id.* at 300.

facially appears to be one that would always or almost always tend to restrict competition and decrease output.”²⁶⁰ Considering, however, that CDA had not provided a “convincing argument, let alone evidence, that consumers of dental services had been, or were likely to be, harmed by the broad categories of advertising that it restricted”, the FTC concluded that the non-price restrictions were clearly anticompetitive.²⁶¹

Taking the view that this case concerned a set of ethical norms introduced by a professional organization that aimed to prevent false and misleading advertising and that “CDA’s policies do not, on their face, ban truthful, non-deceptive ads,” the Ninth Circuit rejected the use of per se analysis with regards to price advertising restrictions.²⁶² The court refused to accept CDA’s procompetitive justifications that its policy encouraged disclosure and prevented false and misleading advertising.²⁶³ Since the record “provided no evidence that CDA’s policy has in fact led to increased disclosure and transparency of dental pricing[,]” such claim, the court noted, carried little weight.²⁶⁴ As to the non-price advertising restrictions, the court dismissed CDA’s concerns that “claims about quality are inherently unverifiable and therefore misleading.”²⁶⁵ Although this danger exists, it cannot justify preventing all quality claims and irrespective of whether they are false or misleading.²⁶⁶ In light of these concerns, the Ninth Circuit fully aligned with the FTC’s view that the non-price advertising restriction was nothing more than “a naked restraint on output” and therefore no further assessment under a rule of reason legal analysis was necessary.²⁶⁷

Surprisingly, the Supreme Court vacated and remanded the judgment to the Ninth Circuit for a fuller inquiry into whether CDA’s activities violated antitrust laws.²⁶⁸ The Court made clear that a quick look analysis should be limited only to cases where “an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and

²⁶⁰ *Id.* at 308.

²⁶¹ *Id.* at 319.

²⁶² *Cal. Dental Ass’n*, 128 F.3d at 727.

²⁶³ *Id.* at 728.

²⁶⁴ *Id.*

²⁶⁵ *Id.*

²⁶⁶ *Id.*

²⁶⁷ *Id.*

²⁶⁸ *Cal. Dental Ass’n. v. F.T.C.*, 526 U.S. 756 (1999), *vacating* 128 F.3d at 727 (9th Cir. 1997).

markets”.²⁶⁹ Considering the special facets of the professional services market, the Supreme Court found that CDA’s practice was not one of these cases.²⁷⁰ To the Court, CDA’s restrictions aimed to eliminate false or deceptive advertising “in a market characterized by striking disparities between the information available to the professional and the patient”.²⁷¹ Examining defendant’s restrictions from this perspective, the Court concluded that CDA’s restrictions might, instead, be pro-competitive.²⁷² Citing Akerlof’s famous work ‘The market for lemons, Quality Uncertainty and the Market Mechanism’, the Court stated that

in the market for professional services, in which advertising is relatively rare and the comparability of service packages not easily established, the difficulty for customers or potential competitors to get and verify information about the price and availability of services can magnify the dangers to competition associated with misleading advertising.²⁷³

The Court acknowledged that “the quality of professional services tends to resist either calibration or monitoring by individual patients or clients”.²⁷⁴ This related to the expertise required to evaluate these services and the challenge in determining the extent to which “an outcome is attributable to the quality of services (like a poor job of tooth-filling) or to something else.”²⁷⁵ When examining the market’s special characteristics, the Court further recognized that “patients’ attachments to particular professionals, the rationality of which is difficult to assess, complicate the picture even more.”²⁷⁶

The Court analyzed CDA’s price advertising restrictions, and found that they do not necessarily limit price competition. On the contrary, the Court held they may even enhance competition “by reducing the occurrence of unverifiable and misleading across the board discount advertising.”²⁷⁷ Even if across the board

²⁶⁹ *Id.* at 757.

²⁷⁰ *Id.*

²⁷¹ *Id.* at 771.

²⁷² *Id.*

²⁷³ *Id.* (citing George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q.J. Econ. 488 (1970)).

²⁷⁴ *Id.* at 722.

²⁷⁵ *Id.*

²⁷⁶ *Id.*

²⁷⁷ *Id.* at 773.

discount advertisements are more effective “in drawing customers in the short run, the recurrence of some measure of intentional or accidental misstatement, due to the breadth of their claims, might leak out over time to make potential clients skeptical of any such across the board advertising, so undercutting the method’s effectiveness.”²⁷⁸ The Court explained that across the board discount advertisements might continue to attract business indefinitely but only because they mislead customers.²⁷⁹ In this light, their effect may be anti-competitive instead of pro-competitive.²⁸⁰ The Court stated that CDA’s rules reflected the prediction “that any costs to competition associated with the elimination of across the board advertising will be out weighted by gains to consumer information that is exact, accurate and more easily verifiable (at least by regulators).”²⁸¹ Although this view may not necessarily be correct from an economics perspective, “neither a Court nor the Commission may initially dismiss it as presumptively wrong.”²⁸²

As to the CDA’s non-price advertising restrictions, the Court again abstained from adopting the lower court’s competition analysis. The Court took the view that the Ninth Circuit erred in dismissing the countervailing claim “that restricting difficult to verify claims about quality or patient comfort would have a precompetitive effect by preventing misleading or false claims that distort the market”.²⁸³ It underlined that “CDA’s restrictions should be assessed differently: as nothing more than a procompetitive ban on puffery.”²⁸⁴ Following the Supreme Court’s judgment the FTC announced its decision not to seek further review in the Supreme Court for this case and dismissed the complaint.²⁸⁵

UNRAVELLING ARIADNE’S THREAD: HOW DO THE U.S. ANTITRUST ENFORCERS AND THE COURTS BALANCE CONFLICTS BETWEEN

²⁷⁸ *Id.* at 774.

²⁷⁹ *Id.*

²⁸⁰ *Id.*

²⁸¹ *Id.* at 757.

²⁸² *Id.*

²⁸³ *Id.* at 778.

²⁸⁴ *Id.*

²⁸⁵ Press Release, FTC Dismisses Complaint Against California Dental Ass’n, Fed. Trade Comm’n (Feb. 15, 2001), available at: <https://www.ftc.gov/news-events/press-releases/2001/02/ftc-dismisses-complaint-against-california-dental-association>.

DIFFERENT QUALITY PERSPECTIVES?

A. Identifying the Core of the FTC's and the U.S. Courts' Approach

The descriptive analysis of the above seminal cases demonstrates that the U.S. courts and the FTC do examine healthcare quality arguments in the context of their competition assessment. To the FTC and the courts, quality of care matters. However, it matters to the same extent it matters in other industries, such as airline or automotive. Both the U.S. courts and the FTC are straightforward with this point. With the exception of the *California Dental Association* case, the central message they constantly transmit when they deal with antitrust violations in healthcare markets is that healthcare is not special.

I argue that there are two main implications of this approach. First, both the FTC and the U.S. courts constantly take the view that, as in other markets, quality will be the result of the competitive process. Quality of care is ensured only to the extent choice, vigorous competition and information are ensured. Second, when the U.S. antitrust enforcers and the courts are required to examine whether *a restriction to competition* and not the maximization of the available choices is necessary for the protection of healthcare quality, the answer is primarily no. Convinced of the democratic and economics merits of the competitive model, they seem unwilling to consider any claim implying that market forces may not necessarily function properly in this sector.²⁸⁶ Consequently, when the FTC and the U.S. courts are forced to accommodate conflicting views between antitrust and medicine on what the main attributes of healthcare quality are, the bottom line is that *antitrust knows better*. An alternative approach was adopted by the Seventh Circuit in *Indiana Federation of Dentists*, where the Court held that by “preventing dentists from joining together to promote standards of quality dental care that comport with the Indiana Dental Code, the FTC with no expertise in the field of dentistry unwisely regulated the dental profession.”²⁸⁷ By retelling however the story that vigorous competition and not collaboration between medical professionals improves quality, the Supreme Court chose to divert from the Appellate Court’s approach.

This assessment does not imply that the FTC and the U.S.

²⁸⁶ Havighurst, *supra* note 16, at 94.

²⁸⁷ *Ind. Fed'n of Dentists*, 745 F.2d at 1144.

courts completely disregard medical associations' quality claims. On the opposite, they do examine them. Nonetheless, they allow these claims to enter into the equation only to the extent they reflect the notion that healthcare markets are pervaded by market imperfections that may diminish healthcare quality. Indeed, the antitrust enforcers do not seem to preclude the possibility that improving the workings of a market characterized by market failures might make a restraint less naked.²⁸⁸ This conclusion can be easily reached taking into account the Courts' legal analysis in two seminal antitrust cases: *Wilk* and *California Dental Association* (CDA).

In the *CDA* case, Judge Souter, in delivering the opinion of the Court, explained how the healthcare market's special facets may affect antitrust analysis when price and non-price advertising restrictions are analyzed and assessed. Among other things, Judge Souter identified (a) consumers' challenges in verifying price information and assessing the quality of the services they receive; (b) the asymmetric distribution of information between professionals and patients; (c) the patients' attachment to particular professionals, the rationality of which is far from easy to analyze and assess.²⁸⁹ As Judge Souter noted, all these characteristics complicate the picture of the professional services market and require antitrust enforcers to examine on the basis of the rule of reason whether certain restrictions to competition, such as advertising restrictions, are in fact procompetitive, instead of anticompetitive.²⁹⁰

The Court's analysis in *California Dental Association* is illuminating. To begin with, the Court's analysis leaves no doubt that antitrust enforcers should not shut their ears to medical associations' claims that healthcare markets are special. *California Dental Association* has also been characterized as a setback for what was considered "the quick look antitrust movement".²⁹¹ Indeed, the Supreme Court specifically claimed that "the Court of Appeals erred when it held as a matter of law that quick look analysis was appropriate."²⁹² Nonetheless, although the Court declared that the medical markets' special characteristics necessitate a more vigorous legal analysis, it

²⁸⁸ Thomas L. Greaney, *A Perfect Storm on the Sea of Doubt: Physicians, Professionalism and Antitrust*, 14 LOY. CONS. L. REV. 481, 484 (2002).

²⁸⁹ *Cal. Dental Ass'n*, 526 U.S. at 772-73.

²⁹⁰ *Id.* at 757.

²⁹¹ Stephen Calkins, *California Dental Association: Not a Quick Look but Not the Full Monty*, 67 ANTITRUST L. J. 495, 496 (2000).

²⁹² *Id.* at 532.

missed the opportunity to clarify: (a) under what conditions the healthcare markets' economic and non-economic facets should be examined under the rule of reason analysis, and (b) how antitrust enforcers should strike the appropriate balance between restrictions to competition and quality improvements. Not elaborating on these issues, though, the Supreme Court inevitably opened the door to market failure defenses much wider than it initially aimed.

Arguably, information asymmetry will be present – albeit in different degrees – in most cases centered around health professionals' activities.²⁹³ Unfortunately, trial courts will obtain no guidance from *California Dental Association* as to what extent such information deficits may justify a rule of reason analysis or when quick look is “meet for the case”.²⁹⁴ Future litigants and courts, not knowing just how much proof a reviewing court may require to decide that trade under the Sherman Act was restrained, may opt for broader, more extensive discovery and analysis than may in fact be necessary, increasing the cost and therefore the difficulty of successfully challenging professional associations' anti-competitive self-regulatory activities.²⁹⁵

Surely, this is not the only weakness in the Supreme Court's analysis regarding the information deficits characterizing healthcare markets. The Court's analysis concerning the extent to which the challenged advertising restrictions may cure this information asymmetry has also caught the attention of the antitrust scholarship. As noted, the Supreme Court held that informational deficits may impair the functioning of the healthcare market and may therefore justify professional interventions, without explaining why and how advertising restrictions may actually cure such deficits. Since advertising seeks to correct market failure by increasing the amount of information available to consumers, this, indeed, is “a critical lapse”.²⁹⁶ Relying also on the Akerlof's article to argue that “dishonest dealings tend to drive honest dealings out of the market[,]” the Court overreacted as to the extent to which information deficits in the healthcare marketplace may diminish quality.²⁹⁷ As economists argue, the lemons problem claim completely disregards the governmental institutions aiming to

²⁹³ See Greaney, *supra* note 288, at 487.

²⁹⁴ *Id.*

²⁹⁵ See Havighurst, *supra* note 9, at 950.

²⁹⁶ See Greaney, *supra* note 288, at 488.

²⁹⁷ *Id.* at 493.

protect consumers.²⁹⁸ Indeed, occupational licensing or government regulation that limits deceptive or misleading advertising can effectively protect consumers from exploitative advertising strategies.²⁹⁹

While the Supreme Court in *California Dental Association* explored why healthcare markets might differ from others, in *Wilk*, the Seventh Circuit focused more on crafting a process under the rule of reason for assessing quality claims associated with healthcare market's special facets. Was this attempt successful? Considering that there are several reasons to question the wisdom of the Seventh Circuit's "patient care defense[,]the answer is not an easy one.³⁰⁰

As analyzed, at issue in this case were the AMA's ethical norms that essentially deterred physicians from establishing any form of cooperation with chiropractors. Such restrictions, the AMA claimed, contributed to the protection of healthcare quality and the advancement of scientific knowledge.³⁰¹ The Seventh Circuit responded to this argument with the patient care defense. Under this legal test, the defendant was required to prove that its strategy was essentially animated by "objectively reasonable" concern for issues related to the "scientific method" underlying medical treatment; More importantly, the test further required the defendant to prove that less restrictive alternatives for protecting quality were not available.³⁰² This test, which subsequently was never applied by the FTC or the courts, proved to be demanding.³⁰³ By reformulating the rule of reason, and, by requiring defendants to prove both objective and subjective elements, this test invited an open-ended inquiry into scientific concerns and beliefs that arguably increased the level of challenge both for judges and juries.³⁰⁴ How could the defendants prove that their concerns about chiropractic profession are based on scientific findings considering that scientists, in general, and doctors, in particular, constantly disagree on whether a specific treatment is scientific? For instance, while some doctors consider homeopathy a pseudoscience - a belief that is incorrectly presented as scientific—others believe that this alternative form of treatment has a positive effect on health outcomes. In addition,

²⁹⁸ See Muris, *supra* note 256, at 20.

²⁹⁹ See Greaney, *supra* note 288, at 493.

³⁰⁰ *Id.* at 489.

³⁰¹ *Id.*

³⁰² *Id.* at 488.

³⁰³ *Id.*

³⁰⁴ *Id.* at 489.

how can judges and antitrust enforcers assess whether the defendants' primary incentive in excluding competitors is the protection of healthcare quality and not their self-interest? And if reality clearly demonstrates that defendants' exclusionary strategies are animated both by their commitment to maintain high standards of professionalism and their self-interest, how should antitrust enforcers balance such conflicting goals and motives? Which incentive should weigh more in their antitrust analysis?

One would also wonder why the Court chose to introduce a test that required defendants to prove subjective elements, namely their dominant motives and beliefs. This is especially striking because in antitrust cases, market characteristics and effects, not intentions, shape the legal analysis and outcomes. As noted in *Wilk*, the AMA emphasized that healthcare is burdened with information asymmetries that may harm patients' trust in their doctors and that their policy did nothing more than curing this market failure. The Court, by formulating its standard in terms of purpose, noted it is the physicians' intentions and motives that became crucial³⁰⁵ and not market structures and effects.

More importantly, while the Courts seem to embrace the possibility of integrating quality concerns into their analysis in the context of a "market failure defense," they essentially exclude any possibility of integrating quality concerns into their assessment in the context of a "public safety defense." The FTC and the U.S. courts continuously claim that "[t]he Sherman Act reflects a legislative judgment that, ultimately, competition will produce not only lower prices but also better goods and services."³⁰⁶ Hence, adopting an alternative approach, one that would accept that less choice and competition may be necessary for the protection of health care quality, would amount "to nothing less than a frontal assault on the basic policy of the Sherman Act."³⁰⁷ The U.S. antitrust enforcers and the courts tell the same story even when public safety claims are raised by medical associations arguing that their challenged strategies are in line with their ethical and moral policy to protect the public from actions that create risks to public safety and health. Unless their initiatives to protect quality meet the narrow conditions of the state action doctrine, the courts confidently claim that their

³⁰⁵ See Kauper, *supra* note 19, at 323.

³⁰⁶ *Nat'l Soc'y of Prof'l Engineers*, 435 U.S. at 695.

³⁰⁷ *Id.* at 680.

patient safety concerns are not induced by their ethical responsibilities to protect public safety but by mere opportunism.

Let us recall *North Carolina State Board of Dental Examiners* where Judge Keenan clarified that “the record supported the Board’s argument that there was a safety risk inherent in allowing certain individuals, who are not licensed dentists, particularly mall kiosk employees, to perform teeth whitening services.”³⁰⁸ Judge Keenan did not miss the opportunity to admit that she was convinced that the Board’s expelling strategy against non-dentists was mainly animated by its commitment to “eliminate an unsafe medical practice.”³⁰⁹ This essential finding, though, did not alter the court’s antitrust narrative. To the antitrust enforcers and the courts, “the statutory policy precludes inquiry into the question of whether competition is good or bad[,]” and any evaluation as to the risks to healthcare quality the available market choices in reality create is just unnecessary.³¹⁰

B. What are the Main Pros and Cons of the FTC’s and the U.S. Courts’ Approach?

The above analysis revealed that the U.S. antitrust enforcers and the courts primarily take into account quality by ensuring that competition and choice in the healthcare services market is not restricted. The beauty of this legal analysis lies in its simplicity. Indeed, it offers a simple solution to a complex problem: to ensure quality one must maximize the available choices. It also revealed that while the U.S. antitrust enforcers and the courts seem less unwilling to evaluate quality claims in the context of a market failure defense, they seem clearly less willing to assess quality concerns in the context of a public safety defense. To them, such justifications are neither cognizable, nor plausible. Why do the U.S. antitrust enforcers and the courts draw such a strict line between these two types of quality justifications? Why do they completely disregard public safety claims? And more importantly, would the outcome of their analysis necessarily change in case they chose to widen the range of the quality justifications they actually consider and accept? The answer should be negative.

In *Wilk*, the defendants attempted to convince the court that the market imperfections burdening healthcare markets

³⁰⁸ *N.C. State Bd. of Dental Exam’rs*, 717 F.3d at 376-77.

³⁰⁹ *Id.* at 377.

³¹⁰ *Nat’l Soc’y of Prof’l. Engineers*, 435 U.S. at 695.

justify their expelling strategy against chiropractors. In *Massachusetts Board*, the optometrists argued that their anti-competitive behavior was primarily fueled by their motivation to protect consumers from inferior eye care. In *Teladoc*, the Texas Medical Board alleged that the telemedicine regulation aimed to protect patients from inadequate diagnosis and excessive use of antibiotics.

Although the rationale behind all these justifications seems to differ, in fact it does not. This is because in all these cases the alleged quality claims could be structured either as public safety or market failure defenses. In *Wilk*, for instance, the AMA could have argued that chiropractors' treatment may lead to inferior patient care. In *Massachusetts Board*, the Board, alternatively, could have argued that consumers in eye care services lack the adequate knowledge to evaluate the quality of the services they receive, and thus, the challenged regulation ensures that the imperfect market in which the Board's members operate becomes less imperfect. Accordingly, in *Teladoc*, the Texas Medical Board could have alleged that since a medical professional treating a patient on a telephone diagnosis only may be called upon to act with uncertain information, the quality of care may suffer. Therefore, their self-regulation by correcting this market failure does nothing more than ensure that the risk is reduced. Importantly, the antitrust enforcers and the courts would have rejected all the above quality justifications irrespective of the way they were structured, either as public safety or market failure defenses. This is because none of the alleged pro-competitive justifications would have convinced the U.S. courts that the challenged restraints to competition were the least restrictive ones.

Why then do the U.S. antitrust enforcers and the courts constantly reject public safety claims? First, because if they took patient safety justifications into account this might be translated as a sign of distrust in the power of markets to always deliver high quality healthcare services. It may also be seen by potential cartelists as a sign that in healthcare markets, antitrust enforcement is more lenient. More importantly, it may be seen by antitrust infringers in other markets as a sign that quality justifies restrictions to competition. Therefore, deterrence may be weakened. Furthermore, if public safety was considered a plausible and cognizable justification, both judges and agencies may be more tempted to shape their decisions in line with their political preferences and ideologies. If courts and the FTC integrated public safety claims in their analysis one additional

risk might emerge: medical associations may be more incentivized to raise safety claims that mask their self-interest. Additionally, accepting patient safety claims as plausible justifications might erode price competition and lead to price increases. In light of these risks, their narrow approach ensures accountability, transparency and enhances price competition.

What are the cons of this approach? Insisting that the competitive process will ultimately protect healthcare quality does not necessarily reflect market reality. Arguably, the claim that more choice necessarily brings better outcomes sounds more like a textbook myth rather than a sound economic principle. This is because this simple heuristic claim is based on the erroneous presumption that human beings do a remarkably good job in making choices or at least a better job than anyone else.³¹¹ Nonetheless, behavioral economics warn that the ways human being act do not always and necessarily reflect the predictions of rational choice theory.³¹²

Humans predictably make mistakes.³¹³ For instance, although medical research indicates that obesity is linked with an increased risk for heart disease and diabetes, frequently causing premature death, obesity rates in the United States approximate 20% and more than 60% of Americans are considered either obese or overweight.³¹⁴ Certainly, this example neither suggests nor indicates that humans repeatedly fail to make good choices. On the opposite, people choose well “in contexts in which they have experience, good information and prompt feedback, such as when choosing ice cream flavors.”³¹⁵ They do less well though in cases in which they lack either experience or good information.³¹⁶ Why?

People generally tend to make biased assessments of risks. They estimate frequencies or probabilities by asking “how readily examples come to mind.”³¹⁷ Inevitably, these biased assessments of risk adversely affect people’s decision-making process and their ability to construct rational choices. As Professors Thaler and Sunstein observe, “easily remembered events may inflate

³¹¹ See RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH AND HAPPINESS* 6 (2008).

³¹² Maurice E. Stucke, *Behavioral Economists at the Gate: Antitrust in the Twenty-First Century*, 38 *LOY. U. CHI. L. Rev.* 513, 527 (2007).

³¹³ See THALER & SUNSTEIN, *supra* note 311, at 7.

³¹⁴ *Id.*

³¹⁵ *Id.* at 9.

³¹⁶ *Id.*

³¹⁷ *Id.* at 25.

people's probability judgements; and if not such events come to mind, their judgements of likelihoods might be distorted downwards.³¹⁸ Humans are also unrealistically optimistic when they exercise choice.³¹⁹ As they often underestimate the possibility of being harmed, they may even decide not to take the necessary preventive measures.³²⁰ People also suffer from loss aversion which is a form of cognitive nudge.³²¹ This may deter humans from making changes even when such changes align with their interests.³²²

Additionally, although generally people appreciate choice, "the tendency to search long and hard reduces enjoyment from the end result."³²³ This is because not all people have the ability to adequately assess any type of information. Some people even fail to assess fairly simple information.³²⁴ In one study, participants were presented with decision tasks that mainly involved locating information in tables and graphs.³²⁵ Surprisingly, the youngest participants', aged 18-35, errors averaged 8% while the oldest ones', aged 85-94, averaged 40% errors.³²⁶

These challenges are magnified especially when people have to predict how their choices will affect their lives.³²⁷ This is because of the ambiguity aversion people exhibit, a notion implying that people prefer to make choices in contexts where they can more easily predict the outcome rather than in contexts in which the end results are much more ambiguous.³²⁸ Thus, when humans cannot easily translate the choices they make into the experiences they may have, they may benefit less from numerous choices or from choosing not to choose for themselves.³²⁹ In these situations, increasing the amount of information available to consumers can overwhelm cognitive abilities and inevitably lead to choices that do not serve

³¹⁸ *Id.* at 26.

³¹⁹ *Id.* at 32.

³²⁰ *Id.* at 33.

³²¹ *Id.* at 34.

³²² *Id.*

³²³ Ariel Ezrachi & Maurice Stucke, *The Curious Case of Competition and Quality*, 3 J. OF ANTITRUST ENFORCEMENT 227, 247 (2015).

³²⁴ Ellen Peters, William Klein, Annette Kaufman, Louise Meilleur, & Anna Dixon, *More is not always better: Public Policy Can Lead to Unintended Consequences*, 7 SOC. ISSUES AND POL'Y REV. 114, 117 (2013).

³²⁵ *Id.*

³²⁶ *Id.* at 117-18.

³²⁷ THALER & SUNSTEIN, *supra* note 311, at 76.

³²⁸ Peters, Klein, Kaufman, Meilleur, & Dixon, *supra* note 324, at 118.

³²⁹ THALER & SUNSTEIN, *supra* note 311, at 76.

consumers' interests.³³⁰

Surely, one could argue that choosing a doctor, hospital, or treatment is a complicated task since the amount of information a patient should actually evaluate in order to make the choice that best serves her interests is usually high. For example, choosing the appropriate medical treatment involves assessing the probabilities of benefit or harm from alternative forms of treatment or no treatment at all. And, as noted, experimental evidence reveals that individuals face difficulties in making good and rational decisions when they are required to weigh probabilities. Therefore, to the extent product or service characteristics increase in complexity, consumers in general (and patients in particular) may be unwilling to invest extensive time and energy into assessing all the available choices, comparing various levels of prices and quality, and choosing the product or service that better meets their needs.³³¹

Research in behavioral economics further indicates that individuals also lack the ability to construct the right choices when they are particularly influenced by fears of regret from a decision.³³² This is because consumers may often overestimate the probability of an adverse outcome simply because they are afraid that they might regret this decision.³³³ Therefore, patients that are empowered to make autonomous decisions may anticipate greater risk from treatment options compared to those whose doctors chose for them.³³⁴ Indeed, when consumers make more autonomous decisions, they tend to opt for more conservative treatment options.³³⁵

Patients' choices regarding medical treatment may not necessarily improve their welfare for one additional reason: because they are often socially constructed.³³⁶ This means that when patients face complex health decisions, they often prefer relying on their intuition and emotions as well as trusted

³³⁰ Peters, Klein, Kaufman, Meilleur, & Dixon, *supra* note 324, at 117.

³³¹ Ezrachi & Stucke, *supra* note 323, at 247.

³³² Thomas. L. Greaney, *Economic Regulation of Physicians: A Behavioral Economics Perspective* 53 ST. LOUIS U. L.J. 1189, 1196 (2008).

³³³ *Id.*

³³⁴ Peters, Klein, Kaufman, Meilleur, & Dixon, *supra* note 324, at 133.

³³⁵ *Id.*

³³⁶ Marianna Fotaki, *What Market Based Patient Choice Can't Do for the NHS: The theory and evidence of how choice works in healthcare* 1, 13, Centre for Health and the Public Interest, (2014), <https://chpi.org.uk/papers/analyses/market-based-patient-choice-cant-nhs-theory-evidence-choice-works-health-care/>.

networks, rather than on objective, reliable information.³³⁷ When such biases, norms, and heuristics are at stake, there are two important implications for antitrust enforcers and policy makers: individuals will tend to make judgment errors, and act in ways that do not necessarily reflect the presumptions of expected utility theory.³³⁸

Moreover, arguing that vigorous competition will necessarily improve quality completely disregards medicine's perceptive on how patients' lives are actually improved. As medical professionals spell out, quality of medical treatment also depends on non-economic values such as the notions of acceptability and trust, essential features of the patient-doctor relationship and the therapeutic enterprise. Indeed, the notion of trust is crucial in the case of medical treatment, where the stakes are as dear as life itself.³³⁹ Patients that trust their physicians are more likely to seek care in a timely manner, share sensitive information and conform to their physicians' advice.³⁴⁰ All of these are extremely important determinants in health outcomes.

How would the U.S. antitrust enforcers and courts reply to this critique? Considering how they apply the state action doctrine, a plausible answer might be that to the extent regulation exists that exempts a specific activity from the application of antitrust, and this activity is actively supervised by the state, the appropriate balance is actually reached between the pursuit of healthcare quality and vigorous antitrust. If such regulation exists and if the conditions of the state action doctrine apply, this answer is convincing. If, however, such a regulation does not exist and if state Boards give good reasons why specific practices create serious risks to healthcare quality and threaten public safety, this answer is inadequate. Faithful to the belief that markets always ensure quality and that public health and safety justifications are extraneous to antitrust analysis, the U.S. courts and the FTC would reject such justifications even if reality showed that patients' safety is at risk and therefore medical professionals' intervention seems necessary.

Arguably, this approach suffers from important

³³⁷ *Id.*

³³⁸ Greaney, *supra* note 332, at 1196.

³³⁹ Jordan J. Cohen, *Professionalism in medical education, an American perspective: from evidence to accountability*, 40 MEDICAL EDUCATION 607, 608 (2006).

³⁴⁰ Michael D. Brennan & Verna Monson, *Professionalism: Good for Patients and Health Care Organizations*, 89(5) MAYO CLIN. PROC. 644, 645 (2014).

drawbacks. Essentially, it disregards the fact that unregulated medical markets are pervaded by negative externalities. In this light, an individual might decide to receive a low-quality treatment rather than no service at all because she does not fully internalize the cost of poor service. When, however, poorly-informed consumers receive poor care, the effects fall beyond those who receive medical treatment. As physicians stressed in *Teladoc*, “[r]epercussions of poor care are felt from emergency rooms and inner-city clinics to schools and the workplace – not to mention on government agencies that may themselves have to pay for the bad outcomes.”³⁴¹ The FTC and the U.S. courts by limiting their analysis to the impact of a specific competition restriction on the variety of choices consumers in fact enjoy, they forget to consider the costs to the overall society these choices actually create. Consequently, they end up disregarding that a restriction to competition may avoid more deadweight loss than it actually creates.

Moreover, an antitrust policy that relies on the notion that more choice necessarily improves healthcare outcomes without examining the risks to healthcare quality these choices may in reality create, runs the risk of applying in a way that contributes to the health disparities between the rich and the poor. Absent effective regulation protecting healthcare quality, while the poor or the uninsured would end up buying the low cost, low-quality or even unsafe services offered by low skilled unqualified providers, the rich would buy the more expensive and higher quality services offered by high skilled qualified providers. Surely, the application of antitrust law in the healthcare sector should not aim to reduce the health inequalities between different social groups. Nonetheless, this does not imply that its application in healthcare markets should also widen them.

Potential risks to healthcare quality may also disincentive consumers from enjoying a specific good or service. This risk is not an imaginary one, as *North Carolina State Board of Dental Examiners* clearly demonstrates. In this case, Judge Keenan illustrated in her separate statement, that the Board was aware that several consumers had received teeth whitening services that did not even respect the minimum standards of hygiene. Inevitably, some consumers were harmed. Because consumers cannot easily assess medical professional’s qualifications or

³⁴¹ Brief of American Medical Association and Texas Medical Association as Amici Curiae Supporting Defendant-Appellants at 29, *Teladoc, Inc. v. Texas Med. Bd.*, 112 F. Supp. 3d 529 (W.D. Tex. 2015) (No. 16-50017).

medical treatment' adequacy and effectiveness, they might not be able to fully understand and identify the reason why they suffered a specific harm. Therefore, they might decide to stop receiving teeth whitening services both from dentists and non-dentists. Ultimately, non-licensed or incompetent professionals would harm the reputation of licensed and high qualified professionals. Arguably, this is another form of negative externality the FTC's and the U.S. courts' analysis clearly ignores.

Additionally, the courts' and the FTC's approach with regards to health safety claims may lead to contradictions and considerable confusion taking into account the Supreme Court's antitrust analysis in *North Carolina State Board of Dental Examiners*. As discussed, in this case the Board alleged that permitting non-dentists to perform teeth whitening creates risks to healthcare quality. The FTC rejected this quality concern on the basis that such a justification is not a cognizable one, which means one that stems from measures that increase output, improve product quality or innovation. Nonetheless, this strict view may lead to contradictory outcomes for the following reason: one important aspect of product's or service's quality is safety. In this regard, a competition restraint that may enhance a product's or service's safety would also improve its quality. However, since public safety justifications are not considered cognizable, they would be rejected by the FTC and the U.S. courts, as extraneous to an antitrust analysis.

Moreover, an antitrust analysis that clearly disregards medical professionals' views on what health care quality is and how it is achieved disregards that medicine "is not only a business but also a calling."³⁴² Doctors' motivation to protect quality does not always and necessarily stem from their self-interest, but also by their commitment to altruism, excellence, and public service ethos. By considering, however, only economic incentives and by disregarding the benefit to the public which occurs from the promotion of scientific medicine and the protection of professionalism, the FTC and the U.S. courts end up adopting an analysis that is one-dimensional.³⁴³

³⁴² Leonard H. Calabrese, *Sir William Osler Then and Now: Thought for the Osteopathic Profession*, 105 J. AM. OSTEOPATH ASS'N 245, 248 (2005), <https://jaoa.org/article.aspx?articleid=2093135> (quote by Sir William Osler, who was a Canadian physician and one of the four founding professors of Johns Hopkins Hospital).

³⁴³ See Allen R. Dyer, *Ethics, advertising and the definition of a profession*, 11 J. MED. ETHICS 72, 73 (1978).

From health policy perspective though, improvements to healthcare quality cannot be achieved if not all functions of a health system commit to the quality goals the health system as a whole pursues. As Avedis Donabedian, the father of research in healthcare quality, insists, “the commitment to quality should pervade an institution at all its levels and in all its aspects.”³⁴⁴ Arguably, medical professionals and antitrust enforcers are responsible for protecting quality in different ways. While antitrust enforcers aim to promote quality by protecting competition, healthcare providers promote quality by ensuring that the services they provide meet the highest possible standard of care.³⁴⁵ Nonetheless, to them, this goal is better achieved through professionalism and less through vigorous competition. Since, however, doctors’ commitment to protect quality is highly linked with their commitment to professionalism, a health care system as well as an antitrust policy that aims to protect quality as a whole should not disregard this essential dimension of the notion. An antitrust policy that sees doctors mainly as knaves, “individuals that are predominantly motivated by self-interest[,]” and not as knights,³⁴⁶ “professionals that are predominantly public-spirited[,]” might seriously undermine medical professionals’ commitment to professionalism and therefore their commitment to protect healthcare quality.

What are the alternatives? The U.S. antitrust enforcers and the courts should extend the notion of quality when they apply antitrust law in healthcare. In fact, they should adopt a definition that echoes the perspectives of both medicine and antitrust law; a definition that in fact takes into account that the notion of healthcare quality is a multidimensional concept that encompasses the goals of safety, acceptability, effectiveness and trust in the doctor-patient relationship. This definition would be in line with the definition that has been adopted by key players in the field of healthcare such as the Organization for Economic Cooperation and Development, the World Health Organization, the Institute of Medicine, and Avedis Donabedian.³⁴⁷

³⁴⁴ AVEDIS DONABEDIAN, AN INTRODUCTION TO QUALITY ASSURANCE XXX (2003).

³⁴⁵ WORLD HEALTH ORGANIZATION, QUALITY OF CARE: A PROCESS FOR MAKING STRATEGIC CHOICES IN HEALTH SYSTEMS, 10 (2006).

³⁴⁶ For the definition of these notions, see JULIAN LE GRAND, MOTIVATION, AGENCY AND PUBLIC POLICY: OF KNIGHTS AND KNAVES, PAWNS AND QUEENS 2 (2003).

³⁴⁷ See DONABEDIAN *supra* note 344, at 4 (Donabedian, for example, conceives quality as a multidimensional concept whose main attributes are

Would the adoption of this wider definition of healthcare quality transform the application of antitrust law in healthcare? Surely, the answer is positive. Adopting a wider notion of healthcare quality would allow the FTC and the courts to create an analytical framework under which conflicting goals between antitrust and medicine could in fact be balanced. This is because if the U.S. antitrust enforcers adopted a more holistic approach when they examine how a specific restriction to competition may impact healthcare quality, they would be able to balance different components of quality against harm to competition. They would be able, for example, to balance safety and effectiveness versus choice and competition, acceptability and trust versus choice and competition. As Professor Allensworth has observed, “the U.S. courts have avoided developing a framework for when competition may suppress rivalry for the sake of a more functional market.”³⁴⁸ Since the U.S. antitrust enforcers and the courts have chosen to define quality as choice, any balancing exercise between harm to competition and the multiple facets of healthcare quality has become simply unnecessary. Widening, however, the values and the dimensions of quality that shape their legal analysis and outcomes, would incentivize them to provide more accurate guidance on whether and how improvements to quality may outweigh harms to competition.

Undoubtedly, if the U.S. antitrust enforcers and the Courts balanced potential harm to competition against the protection of quality, the costs of antitrust enforcement may be increased. Nonetheless, if antitrust authorities adopted the proposed solution, an important goal would be achieved: they would apply an antitrust analysis that does not ignore healthcare markets’ limits, imperfections, and special facets. They would also apply an antitrust analysis that is in line with behavioral economics research indicating that human beings in general and patients in particular do not necessarily and always make the decisions that serve their interests. In other words, they would apply an analysis that reflects more healthcare markets realities and less textbook myths. They would also apply antitrust law in the healthcare sector in a way that does not disregard the perspective of medicine on what healthcare quality is and how it is achieved. Indeed, adopting this holistic approach would allow

effectiveness, efficacy, efficiency, acceptability (or else the notion of trust in the doctor-patient relationship), optimality, equity, legitimacy).

³⁴⁸ Rebecca Haw Allensworth, *The Commensurability Myth in Antitrust*, 69 VAND. L. REV. 1, 55 (2016).

different institutions pursuing different goals to respect each other's views and perspectives on what healthcare quality is and how it is achieved.

CONCLUSION

This article has identified how the FTC and the U.S. courts define and assess healthcare quality and how they respond to medical associations' claims that a certain restriction of competition is necessary for the protection of healthcare quality. In concluding, this article does not aim to claim that the U.S. antitrust enforcers and the courts should evaluate healthcare quality defenses and justifications in a more lenient way. Undoubtedly, a more lenient approach may incentivize medical associations to raise quality concerns that may disguise self-interest. More importantly, it may substantially suppress price competition and prohibit citizens from enjoying healthcare services that are essential for their well-being and flourishing. It has argued, though, that the U.S. antitrust enforcers and the courts should adopt a definition of quality that reflects the notion that healthcare quality is a multidimensional concept consisting of the notions of effectiveness, safety, trust and acceptability. Adopting this wider definition would incentivize the antitrust enforcers to create an analytical framework under which they would be able to balance harm to competition against the multiple facets of healthcare quality. Adopting a wider more holistic approach to healthcare quality would also allow the U.S. antitrust enforcers and the courts to adopt an analysis that reflects healthcare markets' limits and special facets. Expanding their approach would also ensure that antitrust enforcers and medical associations do not constantly struggle to impose their own views on what the prevailing facets of healthcare quality should be. In *Donabedian's* language, an alternative approach would ensure that all functions of the health system commit to the quality goals the system *as a whole* pursues.