Professional Power and Judicial Review: The Health Professions

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It has become almost trite today to speak of a health care "crisis." For several years commentators of varying disciplines, persuasions, and degrees of sophistication have been alerting the health professions and the public to various critical problems associated with the organization and delivery of health care in America.\(^1\) Crisis or not, these problems undeniably have serious national ramifications and are not readily solved. Increasingly, commentators are recognizing that the solutions lie not in remodeling isolated aspects of health care or in lubricating the system's gears, but in substantially restructuring the entire health care system.\(^2\)

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2. See, e.g., COMMITTEE FOR ECONOMIC DEVELOPMENT, BUILDING A NATIONAL HEALTH-CARE SYSTEM (1973). For a framework for a systems analysis of health care, see U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, TOWARDS A SYSTEMATIC ANALYSIS OF HEALTH CARE IN THE UNITED STATES (1972). Restructuring does not imply complete disavowal of the present system. As one commentator has noted:

[I]t is the height of fancy to believe that we can prescribe entirely
The role of the health professions themselves and their interlocking national, state, and local professional associations is a focal point of the ongoing debate. Through a variety of direct and indirect standard-setting mechanisms, these associations exert great influence in their professions. The health professional associations have controlled, almost exclusively, entry to the professions, definition of professional functions, and award of professional recognition and benefits, such as specialty certification or hospital privileges. They have, moreover, set the standards for measuring the capacity and performance of all the health care system's participants—the dentists, optometrists, and physicians, the nurses, the pharmacists, the allied health professionals, the professional schools and health education programs, and the hospitals, laboratories, and clinics.

Standard-setting in health care, being the province of the health professions, has been relatively isolated from public scrutiny and the demands of the "public interest." As the health care delivery system grows in size and complexity, it increasingly affects societal interests and becomes, therefore, a subject of public policy. The recent wave of public concern about health care has precipitated a trend toward public scrutiny of professional standards. This trend has created a tension in the system which is prompting a redefinition of the role of professionalism within the health care system, as well as a rethinking of governmental and public roles in the system's operation.

Courts and legislatures, the ultimate propounders of public policy, can play a crucial role in this redefinition and rethinking. As policy makers and interest groups have sought firmer handholds on the professionally dominated standard-setting processes, the demands on courts and legislatures to scrutinize the system have escalated. Re-

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**Mechanic, Problems in the Future Organization of Medical Practice, 35 LAW & CONTEMP. PROS. 233, 251 (1970).**

3. As used in this article, "public interest" means the community of societal interests held by the general public which may merge with, but tends to transcend, the professional, economic, and personal interests of health professionals, professional associations, or other private individuals or groups in society. See J. MILLER, ORGANIZATIONAL STRUCTURE OF NONGOVERNMENTAL POSTSECONDARY ACCREDITATION: RELATIONSHIP TO USES OF ACCREDITATION 7, 109, 120-21 (Nat'l Comm'n on Accrediting 1973).

4. "Public policy is the cornerstone—the foundation—of all Constitutions, statutes, and judicial decisions; and its latitude and longitude, its height and its depth, greater than any or all of them." Pittsburgh, C.C. & St. L. Ry. v. Kinney, 95 Ohio St. 64, 69, 115 N.E. 505, 507 (1916). As the legislator and the judge formulate public policy, "the choice of methods, the appraisement of values, must in the end be guided by like consideration for the one as for the other. Each is indeed legislating within the limits of his competence." B. CARDOZO, THE NATURE OF THE JUDICIAL PROCESS 114 (1921). As used in this article, "public policy" is assumed to be policy formulated in pursuit of the public interest. See note 3 supra.
sponding to these demands, courts and legislatures are beginning to reshape the relationship of the law to the health care system. This article examines the reshaping process and suggests directions for future development in one crucial area of concern: The role of the judiciary in reviewing exercises of power by health professional associations, particularly with respect to their standard-setting functions.

Professional Power and the Standard-Setting Role of the Health Professions

A great variety of professional associations participate in the process of setting standards for the health care system. Most powerful among them is the American Medical Association, about which it has been said:

No other voluntary association commands such power within its area of interest as does the AMA. It holds a position of authority over the individual doctor, wields a determining voice in medical education, controls the conditions of practice, and occupies a unique position of influence in shaping government health policies.\(^5\)

Many other professional associations increasingly share standard-setting responsibility with the AMA and the state and local medical societies affiliated with the AMA. Medical specialty boards and associations, such as the American Society of Clinical Pathologists, greatly influence the medical specialties.\(^6\) In their respective domains, the American Dental Association, the American Optometric Association, the American Osteopathic Association, and the American Podiatry Association assume roles similar to the AMA for other groups of primary care providers. Professions not providing primary care are represented by comparable groups, such as the American Dietetic Association, the American Pharmaceutical Association, the American Psychological Association, and the American Public Health Association. In nursing, both the American Nurses' Association and the National League for Nursing exert an important influence. In each of the numerous, rapidly expanding allied health professions and paraprofessions, such as physical therapy, some professional associations such as the American Physical Therapy Association, seek control over the occupation.\(^7\)


7. See M. Pennell, J. Profttt & T. Hatch, Accreditation and Certification in Relation to Allied Health Manpower 1-2, 5-6 (1971). See Selden,
Associations also represent health care institutions. Notably, the American Hospital Association and the Association of American Medical Colleges increasingly have become involved in standard-setting as medical schools and hospitals, particularly teaching hospitals, have become central to the modern health care system. These institutional associations often cooperate to establish yet another layer of standard-setting organizations, such as the Liaison Committee on Medical Education and the Joint Commission on Accreditation of Hospitals.

Certain health professional associations operating on the state and substate level also perform standard-setting functions. Within individual hospitals, organized medical staffs, each a small scale professional association, engage in standard-setting. Professional Standards Review Organizations (PSRO's), required by the 1972 amendments to the Social Security Act, are assuming standard-setting and review responsibility over the professional activities of both practitioners and hospitals.

Despite the number and diversity of the health professional associations, their standard-setting is often interrelated. For instance, membership selection is crucial to a health professional not merely because of the adverse implications concerning fitness that inhere in exclusion or expulsion, but because membership may be a condition of obtaining other forms of professional status. National, state, or local society membership, for example, may be a condition of eligibility for hospital staff privileges, membership in another association.

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11. See Maricopa Medical Soc'y v. Blende, 104 Ariz. 12, 448 P.2d 68 (1968). Staff privileges are themselves a type of membership status operating as a standard-setting mechanism. As with other membership mechanisms, the grant of privileges may be a prerequisite to other professional status. Under the PSRO legislation, for example, only doctors "having active hospital staff
tion,12 permission to hold oneself out as a specialist,13 or certification or registration in a medical or allied health specialty.14

Certification and registration of individual professionals are other standard-setting devices.15 Board certification or eligibility may be a prerequisite for hospital privileges16 and, in some allied health professions, may be required for membership in the professional association.17 Some accrediting agencies use certification and registration to evaluate the personnel and staffing arrangements of educational or health service agencies applying for accreditation.18 The federal government may require certification or registration for job eligibility and mobility,19 or for appointment to selected staff positions in hospitals and laboratories participating in Medicare.20 States sometimes require certification or registration either as the sole or an alternate means for licensure.21

Yet another standard-setting device, accreditation, focuses upon programs and institutions rather than upon individuals.22 Hospital accreditation, among other things, provides a basis for the certification of hospitals as Medicare providers.23 For a practitioner, graduation from an accredited program of study is often a prerequisite for certification or registration,24 membership in a professional association,25 and licensure itself.26

Licensure, the last major standard-setting device, differs from the other devices because it is government sponsored.27 Despite public

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13. Id. at 815-16.
15. "Certification" is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by the agency or association. "Registration" is the process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency. These definitions, as well as those in notes 22 and 27 infra, are taken from SASHEP, COMMISSION REPORT (Nat'l Comm'n on Accrediting 1972).
16. Rayack, supra note 5, at 211-13; Comment, supra note 5, at 952-53.
17. Pennell, Proffitt & Hatch, supra note 7, at 7.
18. Id. at 1-3.
20. See, e.g., 20 C.F.R. §§ 405.1038(b), .1040(a), (c) (1), .1311(b), .1314(b) (1976).
22. "Accreditation" is the process by which an agency or association evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. In the health care system, accreditation of professional schools, health education programs, intern and residency programs, hospitals, and laboratories is conducted primarily by nongovernmental organizations.
24. See Grimm, supra note 14, at I-4 to I-7 and app. table 4.
25. See Pennell, Proffitt & Hatch, supra note 7.
sponsorship, however, licensure is still controlled, at least indirectly, by the private professional associations. State licensing boards are usually composed of members of the pertinent professions and often are chosen from nominee lists submitted by the state professional society. Membership in the state society may be a prerequisite for membership on the state licensing board. State boards generally rely upon the accreditation standards of the national professional associations in determining eligibility of graduates to take the licensure exam and in otherwise measuring the educational qualifications of licensure applicants.

Clearly, these interlocking standard-setting devices greatly influence the operation of the health care system. Through these devices, professional associations control access to the system at every critical point, enabling the associations to govern quality and quantity and to particularize the functions of health manpower. Similarly, the professional associations employ standard-setting devices to control the education and training of members and prospective members of the health professions. Since quality of care, manpower shortages, and educational reform are primary subjects of concern in the current health care debate, increased public scrutiny of the standard-setting power of health professional associations is appropriate.

Courts can be expected to participate in this increased scrutiny. Each time a health care professional runs afoul of the standard-setting process, the potential for litigation exists. The physician whose local medical society membership is revoked, the allied health professional who is rejected for certification, the professional school or hospital whose accreditation is denied are all potential plaintiffs.


29. In Gibson v. Berryhill, 411 U.S. 564 (1973), the Alabama Board of Optometry charged the plaintiffs, licensed optometrists, with unethical practices for working as salaried employees rather than as independent practitioners. In seeking to enjoin the Board’s delicensing proceedings against them, the plaintiffs noted that “only members of the Alabama Optometric Association could be members of the Board, and... the Association excluded from membership optometrists such as the plaintiffs who were employed by other persons or entities. The result was that 92 of the 192 practicing optometrists in Alabama were denied participation in the governance of their own profession.” Id. at 571. The Court held that the Board, as constituted, could not constitutionally adjudicate the charges lodged against plaintiffs. Id. at 579.

30. Grimm, supra note 14, at 1-12 to 1-15. This practice was upheld by the courts as long ago as 1922 in Jones v. State Bd. of Medical Registration, 111 Kan. 813, 208 P. 639 (1922). But see Duson v. Poage, 318 S.W.2d 89 (Tex. Civ. App. 1958) (government agency may not prospectively bind itself to all changes in association’s standards).

Conversely, litigation may arise when a professional succeeds in the standard-setting process, but other professionals disagree with the professional association's decision, such as when a hospital staff member contests the staff's refusal to withdraw another member's privileges. Consumers of health services are also potential plaintiffs in litigation concerning standards. A patient, for example, may contest a professional association policy that allegedly restrains professional practice.

**Considerations Influencing Judicial Review of Professional Association Activity**

American courts, following their British predecessors, historically have been reluctant to review affairs of private associations. Sometimes courts have refused to hear cases by invoking the exhaustion of remedies doctrine; at other times, they have simply held judicial review to be inappropriate. In recent years this reluctance has decreased, particularly with regard to professional associations, although courts have varied in their willingness to intervene in the affairs of private associations. When and why a particular court will hear an association dispute is often difficult to determine because courts have often inadequately articulated the reasons influencing them to take jurisdiction. A need exists for clarifying the reasons and underlying policy considerations that should govern judicial intrusion into areas dominated by professional power.

When asked to review an action of a private association, the courts should consider that action in the context of the association's particular functions in society. The courts must distinguish between

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32. See, e.g., Gashgai v. Maine Medical Ass'n, 350 A.2d 571, 575-77 (Me. 1976), in which the court considered but rejected the defendant's exhaustion argument. Under the exhaustion doctrine, an aggrieved party must exhaust all internal remedies which the association makes available to him, assuming resort to such remedies would not be futile and could provide proper redress, before seeking review in the courts. See generally Developments in the Law—Judicial Control of Actions of Private Associations, 76 HARV. L. REV. 983, 1069-80 (1963). Although the exhaustion doctrine has generally been applied only to association members, its use arguably should depend upon the issues raised in the dispute rather than the membership status of the complainant. Comment, Exhaustion of Remedies in Private, Voluntary Associations, 65 YALE L.J. 369, 386-87 (1956).


34. Particularly in the professions, each association ... plays a ... role in our society, and the legal content of the relationships involved is molded in part by the nature of that role, by the appropriateness of particular actions and policies to that role, and by the reasonable expectations of the public and the individuals affected. Such factors are neither abstractly determined nor static in nature but are derived from examination of the life and dynamics of the organization itself and from its own definition of its role expressed through its rules and customs.

Tobriner & Grodin, The Individual and the Public Service Enterprise in the New Industrial State, 55 CALIF. L. REV. 1247, 1262-63 (1967). See also Falcone v. Middlesex County Medical Soc'y, 62 N.J. Super. 184, 162 A.2d 324 (1960), aff'd, 34 N.J. 582, 170 A.2d 791 (1961), in which the court advocated "distinguishing between the various types of organizations and the effect on pub-
professional associations and other organizations, such as social clubs, religious societies, and fraternal associations, which have entirely different relationships to society.\(^{35}\) In addition, the courts must differentiate among professional associations according to each association's purposes, expectations, and impact on society.\(^{36}\) Principles taking such differentiations into account must be devised to guide judicial review of professional associations.\(^{37}\) These principles should embrace four considerations: The association's need for autonomy, the expertise of the association, the public interest in the functions of the association and the profession it represents, and the potential harm that the association's actions can inflict on a member or prospective member of the association or the public. The greater the association's expertise and need for autonomy, the less likely should judicial intervention be. The greater the public interest in an association's activities and the harm the association can cause, the more likely should judicial intervention be.

**Autonomy**

Private associations' desire and need for autonomy are probably the chief reason for the judiciary's traditional reluctance to review association activities. Autonomy was to be protected because:

> The health of society will usually be promoted if the groups within it which serve the industrial, mental, and spiritual needs lic policy of a specific act of a specific organization.” Id. at 195-96, 162 A.2d at 330.

\(^{35}\) One court made this distinction as follows:

> When courts originally declined to scrutinize admission practices of membership associations they were dealing with social clubs, religious organizations and fraternal associations. Here the policies against judicial intervention were strong and there were no countervailing policies. When courts were later called upon to deal with trade and professional associations exercising virtually monopolistic control, different factors were involved. The intimate personal relationships which pervaded the social, religious and fraternal organizations were hardly in evidence and the individual's opportunity of earning a livelihood and serving society in his chosen trade or profession appeared as the controlling policy consideration.


\(^{36}\) Such a functional approach, emphasizing the relationships among the organization, the individuals with whom it deals, and the society in which it operates, is by no means new to the common law. The common law has often focused upon function and status concepts, as in the law of master-servant, bailor-bailee, or parent-child. Although contract concepts often replaced status concepts as the common law developed, contract principles cannot sufficiently protect individuals in modern organized society, who must confront private power concentrations with which they cannot effectively bargain.

Toibriner & Grodin, *supra* note 34, at 1251-56. Thus “the common law responds in part to the challenges of organized society by reformulating common law principles to impose duties and obligations on the basis of status or relationship . . .” Id. at 1248-49. For a discussion of professionalism's evolution from status concepts to contract concepts and back to status, see J. Lieberman, *Tyranny of the Experts* ch. 3 (1970).

\(^{37}\) See Edel, Commentary: Shared Commitment and the Legal Principle,
of citizens are genuinely alive. Like individuals, they will usually
do most for the community if they are free to determine their
own lives for the present and the future . . . . Legal supervision
must often be withheld for fear that it may do more harm than
good.\textsuperscript{38}

This belief in the need for autonomy for professional associations is
an outgrowth of the theory of pluralism, which maintains that social
value inheres in the existence of many and diverse private associa-
tions operating within society. Such a pattern of social and political
organization presumably stimulates voluntarism and dynamism within
society and diffuses power by enabling private centers of influence
to operate independently of the state. The result is an open and
estatic society which promotes individual freedom by providing a
receptive social and political structure.\textsuperscript{39} Such a pluralistic society,
in turn, presupposes a system of private associations representing
various interest groups within limited spheres of operation, whose
competing interests are balanced and adjusted by the state.

Professional associations are private power centers and interest
groups for the professions they represent. The role of these associa-
tions, therefore, conforms with the pluralistic concept of society and
supports the association's claim to the autonomy of pluralism. Pro-
fessional associations, unlike other types of private associations, can
also assert economic laissez-faire as a second foundation for autonomy.
Comprehensive professional autonomy "constitutes the kind of entre-
preneurial position that nineteenth-century Western Liberal notions
of 'freedom' readily embrace."\textsuperscript{40}

The professions have historically attempted to expand their auton-
omy, often with government as an ally. Complete professional auton-
omy has come to mean that the profession determines its own
standards for the education and training of members and prospective
members; is recognized through a system of governmental licensure,
control over which the government delegates largely to the profession
itself; shapes the legislation which affects it; and is free from lay
evaluation and control.\textsuperscript{41} Of all professions, the health professions,
particularly dentistry and medicine, have probably most closely
approached complete autonomy. Not only are the dental and medical
professions protected by a comprehensive system of licensure granting
them effective professional monopolies in their respective areas of

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\textsuperscript{38} Chafee, The Internal Affairs of Associations Not for Profit, 43 Harv. L.
Rev. 993, 1027 (1930).

\textsuperscript{39} See Chapman, Voluntary Associations and the Political Theory of Pluralism, in Voluntary Associations, supra note 37, at 87-93.

\textsuperscript{40} E. Freidson, Profession of Medicine: A Study of the Sociology of Applied Knowledge 44 (1970). For a discussion of the ill effects of laissez-faire
in the medical profession, see R. Stevens, American Medicine and the Public Interest (1971).

operation, but they also have developed comprehensive systems of accreditation, certification, and registration that, in conjunction with licensure, assure them control over standards for education and training. In the legislature arena, the dental and medical professions have been strong pressure groups, and since the basis of dentistry and medicine is a core of esoteric scientific knowledge familiar only to each profession’s members, lay evaluation has been almost nonexistent.

Autonomy in the health professions is a highly organized group autonomy which seeks to protect the autonomy of individual members by using interlocking professional associations to represent the professions in their relations with government and the public. Although this autonomy has served to shield health professional associations from public scrutiny in the past, limitations on the societal value of organized autonomy are increasingly apparent. Some limitations are inherent in the concept of autonomy; by its own terms, autonomy loses value whenever its exercise distorts the division of private and public power envisioned in a pluralistic society. Other limitations on the value of autonomy are evident in countervailing societal interests to be discussed below, such as the public interest in health care and the avoidance of individual and social harm.

Insofar as it is supportive of pluralism, autonomy is intended to promote the privateness and voluntariness of group action and to enable groups to form associations as buffers against centralized governmental power in particular areas of interest. The law that has developed concerning such associations is called the law of voluntary, private associations. Yet, most professional associations today, particularly in the dental and medical professions, are no longer truly voluntary or truly private. Because of the interdependence of professional associations and the government’s reliance on their standard-setting and self-regulation, membership and good standing in one or more associations may be a matter of necessity rather than of voluntary choice. The government’s reliance on professional associations and delegation of power to them, moreover, blurs the line between public and private activity. Goals that once may have been accomplished through independence from government may now be accomplished through cooperation with government; activities once private may now be “quasi-public.” Especially in the professions, private associ-

44. See Hurst, Commentary: Constitutional Ideals and Private Associations, in Voluntary Associations, supra note 37, at 64.
ation may connote not privateness, but a "hidden hierarchy" of interlocking public and private concerns.45

When the voluntarism and privateness of professional associations decline, the societal value of their autonomy must be reevaluated.46 Neither courts nor the rest of society can ignore these changed circumstances when determining the extent to which professional autonomy should limit the judiciary's role in solving professional power disputes.

**Expertise**

The health professions' assertion of autonomy is premised, in part, upon their possession of an expertise which they allege transcends the competence and perhaps even the comprehension of nonprofessionals. To nurture and apply this expertise for society's benefit, the professions contend that they must be free from intervention by government and private interests not possessing the requisite expertise. In short, to operate expertly, the professions must operate autonomously. Undoubtedly there is merit in this argument. Through professional schools and research programs, the health professions perpetuate and develop a body of knowledge vital to society. If this knowledge is to be used in society's best interests, professional standards must guide its application. In the health care area, where professional action is so dependent upon esoteric scientific knowledge and can so vitally affect individuals, a high level of expertise is required in standard-setting. Only those trained and experienced in the health professions themselves have this necessary special competence.

The courts have respected the professional expertise of health professions and the high degree of public esteem accorded them. "[T]he court must guard against unduly interfering with [a health professional association's] autonomy by substituting judicial judgment for that of the . . . association in an area where the competence of the court does not equal that of the [association]."47 When reviewing professional affairs, however, the courts should not end their inquiry with the determination that the association possesses a special competence. The degree of judicial deference accorded professional expertise should depend upon two other considerations: Whether the association was applying its expertise in taking the challenged action, and whether the association's expertise is competent to satisfactorily resolve the matter in dispute.

Decisions of professional associations can be based on considerations other than expertise, although the claim of expertise may be used to

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mask other considerations influencing decisionmaking. Receptivity to considerations other than expertise is inherent in the character of professional associations, which typically represent not only broad public interest, but the narrower interests of their own members. Since these two sets of concerns do not always coincide, a potential conflict of interests arises. Thus, when considerations other than expertise influence professional action, the association may be acting more as a professional "union" for its members than as a protector of societal interests. Only when the professional association in fact relies upon its expertise is it genuinely pursuing its standard-setting function and likely to be operating in the public interest.

The courts must differentiate situations where expertise predominates from those where it does not and defer to professional judgment only where expertise is predominant. A few courts have made this distinction. In Falcone v. Middlesex County Medical Society, a local medical society denied membership to a licensed physician because he had graduated from a school of osteopathy which, though providing a full medical curriculum, was not recognized by the AMA. Determining that the society's action was "arbitrary and unreasonable," the court remarked:

When the County Society engages in action which is designed to advance medical science or elevate professional standards, it should and will be sympathetically supported. When, however, as here, its action has no relation to the advancement of medical science or the elevation of professional standards but runs strongly

49. The example most often discussed is probably the doctor shortage: the profession's economic interests in limiting the number of physicians and in circumscibing permissible forms of doctor-patient relationships allegedly conflicts with society's interest in an adequate medical manpower pool. See, e.g., Rayack, supra note 5, at 72-73, 81-88; Kessel, The A.M.A. and the Supply of Physicians, 35 Law & Contemp. Pob. 267 (1970). For a recent case presenting a similar conflict situation, see Gibson v. Berryhill, 411 U.S. 564 (1973); see note 29 supra and accompanying text.
50. On the one hand, the maintenance of professionally established quality standards is generally accepted as a socially desirable function of professional organizations; this is particularly true of medical care, where the quality of services provided may mean the difference between life and death. On the other hand, the professional organization is inevitably concerned with protecting and advancing the economic interests of its members. Since it is inherently difficult to translate "quality" into objectively quantifiable terms, there arises the possibility of an internal contradiction in the dual role of the professional organization as protector of society's welfare through the regulation of quality and as defender of the economic interests of the members of the organization.
counter to the public policy of our State and the true interests of justice, it should and will be stricken down.\textsuperscript{52}

Similarly, in \textit{Greisman v. Newcomb Hospital}, a hospital denied staff membership to a licensed physician who had graduated from the same osteopathic school as Dr. Falcone, invoking a bylaw requiring staff members to be graduates of schools approved by the AMA and to be members of the local medical society.\textsuperscript{53} In overturning the hospital’s decision, the court noted that the denial of membership was not because of any lack of individual merit, but for a reason “unrelated to sound hospital standards . . . .”\textsuperscript{54}

The conclusions of the courts in \textit{Falcone} and \textit{Greisman} presuppose judicial awareness of the appropriate boundaries of expertise. To determine whether a professional association is applying its expertise in undertaking a certain course of action, the courts must define that profession’s expertise and mark its limits carefully.\textsuperscript{55} Although courts have seldom raised such questions, they may be expected to do so increasingly as social scientists advance the state of the art.\textsuperscript{56}

To confine expertise to areas where it should predominate over lay opinion, the courts must distinguish true expertise from the “social and political power of the expert.”\textsuperscript{57} In terms of a particular profession’s work, this requires a separation of the technical content of the work from its “nontechnical zones,” such as working conditions, resources, and relationships with colleagues.\textsuperscript{58} The technical content of the work requires the direct application of expertise; the nontechnical zones require expertise only indirectly or not at all.

For the health professions, the technical content of work centers on

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\item \textsuperscript{52} \textit{Id.} at 598, 170 A.2d at 800. To support its proposition that the society had not relied on its expertise, the court noted:

\textit{[T]he record establishes that Dr. Falcone received a full medical course along with the degree of D.O. at the Philadelphia School, received the degree of M.D. from the College of Medicine at the University of Milan (an A.M.A. accredited medical school), received an unrestricted license to practice medicine and surgery from the New Jersey Board of Medical Examiners after passing the prescribed examination, completed internships at the Detroit Osteopathic Hospital and St. Peter’s General Hospital (the latter being approved by the A.M.A.), consistently practiced surgery and obstetrics but not osteopathy, is regarded by his medical colleagues as a qualified physician and surgeon, and has not engaged in any conduct which would raise any question as to his ethics and competency as a member of the medical profession.}

\textit{Id.} at 584-87, 170 A.2d at 792-94.

\item \textsuperscript{53} 50 N.J. 389, 192 A.2d 817 (1963).

\item \textsuperscript{54} \textit{Id.} at 404, 192 A.2d at 825. The considerations on which the court relied were similar to those given in \textit{Falcone}. \textit{See notes} 51, 52 supra.

\item \textsuperscript{55} For an analytical social science approach to defining and limiting expertise in the health professions, see \textit{Freidson}, \textit{supra} note 40, at 335-82.

\item \textsuperscript{56} Limiting professional expertise is important, for excessive deference to expertise is potentially inconsistent with the democratic ideal of individual freedom. As society’s reliance upon the expert increases, the layperson’s ability to control the details of his everyday life decreases. Actions premised on the application of professional expertise may be insulated from judicial and legislative processes and from the critical eye of public debate; lay persons may be precluded from participation in decisionmaking even when the decisions are allegedly made for their own benefit. \textit{Id.} at 335-38. \textit{See generally Lieberman, supra} note 37.

\item \textsuperscript{57} \textit{Freidson}, \textit{supra} note 40, at 336.

\item \textsuperscript{58} \textit{Id.} at 45-46.
\end{itemize}
diagnosis and treatment, which rely, in turn, on the scientific foundation of medicine. The nontechnical zones, on the other hand, concern institutions of medicine rather than medical science. While the physician, for example, can claim expertise in the science of medicine, he cannot claim expertise in the "liberal arts, humanities, and social sciences of medicine" or "in matters concerning the organization, distribution, and economics of medical care." Although an expert in diagnosis and treatment, the physician is not necessarily an expert in the economic, political, and social problems of medicine's institutions. Such distinctions in individual professional expertise suggest the appropriate limits of the expertise possessed by a health professional association. The association applies its true expertise only when its decision or action concerns the development or content of the scientific knowledge of medicine and is based upon that body of knowledge.

Even when the association is applying its expertise in setting standards, a court might find that a particular action cannot be determined solely by the association's expertise. The expertise of professions other than health care professions or the moderating influence of lay opinion may be needed in resolving complex issues concerning standards. The expertise of the social sciences, for example, is needed in the solution of many health care problems. Where the problem is one of organization or delivery of health services, expertise in business management and engineering may be as important as medical expertise. As the Carnegie Report on higher education and health noted, there is now an "extension of medical concerns beyond science


60. Knowles, supra note 59, at 28 (emphasis omitted).

61. Mechanic, supra note 59 at 707.

62. A recent Maine case illustrates the distinctions discussed in this section. In Maine Medical Center v. Houle, Civ. No. 74-45 (Me. Super. Ct. 1974), the plaintiff hospital sought a court order prohibiting the withdrawal of artificial life-support services from a severely deformed newborn infant. At the parents' request, the attending physician had agreed to such withdrawal because in his opinion the child's deformities, including the near certainty of permanent brain damage, made the infant's life not worth preserving. The court intervened to protect the child and observed that "the doctor's qualitative evaluation of the value of the life to be preserved is not legally within the scope of his expertise." But see Fitzgerald v. Porter Memorial Hosp., 523 F.2d 716 (7th Cir. 1975), cert. denied, 425 U.S. 916 (1976), upholding a hospital rule that prohibited fathers from the delivery room, over a dissent criticizing the majority for "bow[ing] to the expertise of the medical profession without the benefit of an evidentiary hearing." 523 F.2d at 722 (Sprecher, J., dissenting).

63. See notes 57-61 supra and accompanying text. See also CARNEGIE COMM'N ON HIGHER EDUCATION, supra note 31, at 3-4, 45-46.

64. The point has been well made with specific reference to hospitals. "[I]t is conceivable that business and engineering could eventually take over and provide the two ingredients that are so often alleged to be missing: an incentive to managerial efficiency, and a systems approach to the organization
into economics, sociology, engineering, and many other fields." Similarly, lay opinion may be an important partner of medical expertise in certain situations. The early twentieth century revolution in medical education was accomplished not by the medical profession alone, but by the profession's acting in concert with the lay assistance of Abraham Flexner and the Carnegie Foundation. In hospitals, broad policy has traditionally been set by neither the expert medical staff nor the expert hospital administrator, but by the lay board of trustees. As society becomes more complex, greater lay involvement in professional affairs is needed. As technological advances increase the number of specialties and professions, the likelihood that a problem can be solved by a single specialty diminishes. A need is emerging for the expertise "of the generalist who can weave together into a workable whole the separate expertness of the specialists."

The issue of expertise can be analyzed in a wide range of professional standard-setting activities. The accreditation of health education programs is one prominent example. Accrediting policies regarding class size and admissions may depend as much on considerations of professional self-interest as on professional expertise. Standards concerning management of the professional school or its relation to the delivery system may involve business, economics, or engineering as much as medical expertise. Some curriculum standards may require education technology or learning psychology more than medical expertise, or may reflect lay value judgments on teaching technique rather than scientific judgments based upon medical knowledge. Other standards, such as rank and tenure standards, may involve the formulation of general social policies for which the expertise of the generalist is as competent as that of the professional.

Public Interest and Concern

Professional associations affect public interests more than traditional private associations, such as fraternities and clubs. Traditional private associations often operate in islands of privacy isolated from the rest of society and its concerns. Professional associations, by contrast, operate in areas of vital public interest. Accordingly, the public is affected to a much greater degree by activities of professional associations and has a much greater interest in their operation.

Because of the public concern with professional associations, courts should scrutinize their activities more closely than those of other private associations. An increase in judicial scrutiny commensurate...
with the public interest has roots deep in the common law. The "public callings" doctrine imposed special obligations, independent of tort or contractual obligations, upon enterprises holding themselves out as serving the community and thus "affected with a public interest." The *Falcone* decision gives currency to this common law notion in the health context. In describing the defendant county medical society, the court emphasized that the society was "not a private voluntary membership association with which the public has little or no concern. It is an association with which the public is highly concerned and which engages in activities vitally affecting the health and welfare of the people." The characterization in *Falcone* can apply to almost every professional association in the health field; each exerts extensive influence in a health care system that has been accorded a "high priority ... in both public and private values throughout the history of this country."

It is their standard-setting function that thrusts health professional associations most deeply into the public arena. By setting standards for professional conduct, the associations influence societal decisions about health care. Public reliance upon these professional standards reinforces the social impact of association action and generates public concern with association activities. The associations' standard-setting activities cannot, therefore, be considered solely "internal affairs," since a vital public interest in association activities transcends the particular interests of the association. As guardians of the public interest, courts should be more concerned with the activities of professional associations than with those of associations exerting less impact upon society. The greater the public interest in an association's activities, the greater should be the likelihood of judicial scrutiny of those activities.

**Harm**

An association's potential for harming individuals or the public increases as its influence on society increases. Courts are sensitive to

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71. See note 36 *supra*. For an overview of this early common law and its modern import, see Tobriner and Grodin, *supra* note 34, at 1249-54.


75. See notes 3, 4 *supra*; notes 115-17 *infra*.
questions of harm, for most law suits are premised upon injury to personal or proprietary rights. The likelihood of judicial scrutiny of association affairs should increase, therefore, in proportion to the seriousness of the harm caused by association action.

The harm resulting from the action of private associations most often arises where membership is at issue. The cases fall into two categories: expulsion—the termination of an existing membership—and exclusion—the denial of an application for membership. Although the courts traditionally have been more hesitant to intervene in cases of exclusions than in those of expulsions, the distinction is now made less frequently in professional association cases. Both individuals and society are affected as much by professional exclusions as by expulsions, especially in the health professions. "[T]n either case the critical question would seem to be the extent of harm suffered by the person excluded or expelled."

A health professional association's potential for inflicting serious harm is not limited to membership decisions; it inheres in all the association's standard-setting activities. An individual denied certification or a school denied professional accreditation, for example, is denied a valuable status whose absence can cause significant harm. Such denials can be as harmful as exclusion or expulsion from membership, and they should be similarly treated by the courts.

In scrutinizing actions of health professional associations, the courts should look to the character of the status or privilege that the association has denied or terminated. The greater the importance of the status or privilege, the greater is the injury to the deprived party. And the greater the harm, the more likely it is that "courts...[will scrutinize] the standards and procedures employed by the association notwithstanding their recognition of the fact that professional societies possess a specialized competence in evaluating the qualifications of an individual to engage in professional activities." Some courts have stated that professional status must be a "virtual prerequisite to...practice," an "economic necessity," or a "necessity for successful

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76. See, e.g., Higgins v. American Soc'y of Clinical Pathologists, 51 N.J. 191, 199-202, 238 A.2d 665, 669-71 (1968). The rationale for the distinction has been that a member gains certain membership rights, particularly the rights embodied in his "contract" with the association, which he is entitled to protect. See notes 95-97 infra and accompanying text. The nonmember has none of those rights.


operation” before the courts will review its denial or termination. Too literally construed, however, such phrases are overly restrictive characterizations of the harm required for judicial review. Important interests other than pure job protection may be at stake. These other interests include professional standing in the community and among peers, access to professional services and benefits such as liability insurance and continuing education programs, and the opportunity to participate actively in the governance of the profession. Substantial deprivation of such advantages should be sufficient to trigger judicial review.

The courts should also consider the larger social harm that may result from some professional association actions. If a physician is denied membership in a local medical society and is thus deprived of access to the society’s education programs, not only is he harmed, but his patients and, ultimately, society may be harmed. Similarly, if a medical school is denied accreditation and experiences the multiple disadvantages accompanying unaccredited status, not only is the school harmed, but its students and faculty, and perhaps society may be harmed as well. Such social harm, in many instances, may be a more important consideration than the individual party’s injury. The presence of social harm not only requires the court to consider matters other than narrow and technical inquiries of “economic necessity”; it lessens the justification for an association’s claim of autonomy. Because autonomy is premised upon the societal value of private associations, it follows that when the association is harming society, there is less reason to respect its autonomy as to the matter causing harm.

84. If the association is applying its special expertise to protect the public from professional incompetence, its decision may benefit rather than harm society. Thus, the court’s consideration of societal harm must be intertwined with its consideration of expertise. See text accompanying notes 47–70 supra.
85. See text accompanying notes 38–46 supra.
When harm to society is the focus, moreover, the court considers social goals rather than merely the association's goals, a task for which the judiciary is presumably more competent than the association.

The Monopoly Power Theory

The weight courts should give each of the preceding four considerations—autonomy, expertise, public interest, and harm—will vary according to the kind of association and the nature of the association's action. When the association represents a health profession and the action affects professional standards, public interest and harm are likely to outweigh professional autonomy and expertise so as to justify judicial scrutiny of the contested association action. Such a balancing of interests is sometimes expressed under the rubric of "monopoly power." Although the monopoly power theory does not explicitly recognize and balance each of these four considerations, the theory is premised on policy concerns similar to those underlying the four considerations.

To possess monopoly power, an association must control access to some important professional status or privilege so that individual practitioners or professional schools or programs must turn to the association to obtain the benefits accompanying the status or privilege. The association's resulting "stranglehold" enables it to influence significantly members or prospective members of the profession seeking the status or privilege controlled by the association. Additionally, because the association operates in an area of vital public concern, its actions have a significant impact upon society. This power to affect both the profession and the general public is in the nature of monopoly power because the association alone can bestow the particular status or privilege. The more the public relies upon the association, the greater its monopoly power; the greater its monopoly power, the greater is the association's capacity to harm the profession's actual and prospective members, as well as the general public.

The reservoir of monopoly power held by professional associations has been enlarged by the current trend toward greater concentrations of private power and increased reliance by government and the public upon such concentrations of power. This is particularly true in the health professions. Government has given various health professions legal monopolies over the performance of their work. In organizing to protect this legal monopoly, professional associations have them-

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86. See, e.g., Marjorie Webster Jr. College, Inc. v. Middle States Ass'n of Colleges & Secondary Schools, Inc., 302 F. Supp. 459, 469 (D.D.C. 1969), rev'd, 432 F.2d 650 (D.C. Cir.), cert. denied, 400 U.S. 965 (1970); notes 90-94 infra. A similar but more generalized type of balancing process could also justify legislative intervention into areas dominated by professional monopoly power. See note 4 supra; notes 225-26 infra and accompanying text. Courts have their own role to play in the absence of or as a supplement to legislative action. See Chafee, supra note 38, at 1021-23.

87. See supra note 45; Hurst, supra note 44, at 63-64.
selves, in some ways, become virtual monopolies.\textsuperscript{89} Courts have taken increasing notice of this trend since the \textit{Falcone} decision in 1961. In analyzing the powers of a local medical society, the \textit{Falcone} court spoke of “professional associations exercising virtually monopolistic control” and determined that:

\begin{quote}
[T]he County Medical Society . . . is an association with which the public is highly concerned . . . . Through its interrelationships, the County Medical Society possesses, in fact, a virtual monopoly over the use of local hospital facilities. As a result it has power, by excluding Dr. Falcone from membership, to preclude him from successfully continuing in his practice of obstetrics and surgery and to restrict patients who wish to engage him as an obstetrician or surgeon in their freedom of choice of physicians. Public policy strongly dictates that this power should not be unbridled . . . .\textsuperscript{90}
\end{quote}

Courts subsequently have applied the monopoly power theory to other local medical societies,\textsuperscript{91} local and national specialty societies,\textsuperscript{92} hospital staffs,\textsuperscript{93} and with some qualifications, accrediting associations.\textsuperscript{94}

\textbf{Theories of Liability in Professional Association Disputes}

If, after balancing considerations such as those suggested above, a court decides that judicial scrutiny of a particular association’s action is warranted, the plaintiff must base his cause of action against the association on some theory of liability. Associations have been held liable for their actions on five different theories: Contract; tort; public trust; antitrust; and state action. There is no consensus among the courts on which theory is the most suitable for handling professional power problems.

Under the contract theory, a private association is a conglomerate of contractual relationships. The association’s rules form the basis of the contract, and each association member contracts with the association and with every other member to abide by the rules. When

\begin{footnotesize}
\begin{enumerate}
\item See \textit{Fimison}, \textit{supra} note 40, at 27-33 (American Medical Association).
\item 34 N.J. at 596-97, 170 A.2d at 799.
\item Blende v. Maricopa County Medical Soc’y, 96 Ariz. 240, 393 P.2d 926 (1964).
\end{enumerate}
\end{footnotesize}
the association or a member violates a rule, a breach of contract results. In Berberian v. Lancaster Osteopathic Hospital Association, for example, the court held that the defendant hospital breached the contract embodied in its medical staff bylaws by revoking the plaintiff staff member’s privileges without providing the hearing required in the bylaws.

The contract theory provides narrow grounds for judicial involvement in associational affairs. Since privity of contract is required, the theory extends only to disputes between the association and a member, leaving untouched disputes between the association and applicants for membership or other individuals adversely affected by association action. Even when the dispute is between the association and a member, the contract theory affords relief only when an association rule applies to the dispute and the association has violated the rule. The contract theory, moreover, is the most rigid of the theories applicable to private associations. Recovery depends upon legal technicalities concerning the nature of intra-associational relationships, and the association’s societal functions or influence are not considered. The theory has been aptly described as “a legal fiction which prevents the courts from considering attentively the genuine reasons for and against relief.”

Several theories of tort liability have potential applicability in association disputes, depending on the factual circumstances and the jurisdiction in which the suit arises. These tort theories are generally applicable in both suits against association members individually and suits against the association itself. When the dispute is between the association and a member, the tort alleged may simply be wrongful interference with the membership relationship. In Higgins v. American Society of Clinical Pathologists, the court ordered the plaintiff recertified as a pathologist and reinstated in the association’s registry, asserting that “the real reason for judicial relief . . . is the protection of the member’s valuable personal relationship to the association and the status conferred by that relationship . . . . ‘The wrong is a tort, not a breach of contract . . . .’”

Other theories of tort liability can be invoked by applicants for membership and third parties, as well as by association members. The developing theory of tortious interference with prospective advantage is perhaps most adaptable to problems of professional power.

95. Chafee, supra note 38, at 1001-07. See, e.g., North Dakota v. North Central Ass’n, 99 F.2d 697, 700 (7th Cir. 1938); Medical Soc’y v. Walker, 245 Ala. 135, 16 So. 2d 321 (1944); Geshai v. Maine Medical Ass’n, 350 A.2d 571 (Me. 1976).
98. 51 N.J. 191, 238 A.2d 665 (1968).
99. Id. at 200, 238 A.2d at 699-70, quoting Chafee, supra note 38, at 1007.
100. See Estes, Expanding Horizons in the Law of Torts—Tortious Interference, 23 Drake L. Rev. 341 (1974). The elements of this tort are: (1) the present or probable future existence of a contract, business relations or business expectancy beneficial to the injured person; (2) knowledge of the contract, relations or expectancy on the part of the
This theory covers a broad range of situations where the association or certain of its members intentionally interfere with important professional relations or business expectancies. In Cowan v. Gibson,\textsuperscript{101} for example, the court ruled the complaint sufficient to state a cause of action in tort when the plaintiff physician, who had been denied staff privileges, alleged that the defendant hospital staff members and trustees had conspired to interfere with his occupational pursuits and his contractual relations with patients.\textsuperscript{102} The tort of "concerted refusal to deal" is applicable if the plaintiff alleges that the association misused competitive devices to interrupt plaintiff's professional pursuits.\textsuperscript{103} When professional reputation has been harmed, as usually occurs when an association withdraws or refuses certification, accreditation or other symbols of professional status, the tort of defamation may apply.\textsuperscript{104} The theory of prima facie tort may be useful in novel situations. Under this theory, an association would be liable for any intentional infliction of injury unless the action was justified in light of the competing private and public interests concerned.\textsuperscript{105}

The third theory of liability recognized by courts, a public trust or fiduciary theory, is premised upon a functional analysis of a professional association's relationship to society and is closely associated with the monopoly power concept.\textsuperscript{106} The origins of the theory can be traced to the "public callings" decisions of early common law and, more recently, to decisions on membership policies of labor unions.\textsuperscript{107} The Falcone decisions\textsuperscript{108} in 1960 and 1961 mark the

\textsuperscript{101} Id. at 343.
\textsuperscript{102} 392 S.W.2d 307 (Mo. 1965).
\textsuperscript{103} Id. at 310; see, e.g., Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. 2d 806, 376 P.2d 568, 26 Cal. Rptr. 640 (1962); Raymond v. Cregar, 38 N.J. 472, 185 A.2d 856 (1962).
\textsuperscript{104} See Developments in the Law—Competitive Torts, 77 Harv. L. Rev. 888, 929-32 (1964).
\textsuperscript{105} See text accompanying notes 86-94 supra.
\textsuperscript{108} Falcone v. Middlesex County Medical Soc'y, 84 N.J. 562, 170 A.2d 791 (1961).
theory's first direct application to a health professional association:

Public policy strongly dictates that this power [i.e., the monopoly power of a local medical society] ... should be viewed judicially as a fiduciary power to be exercised in reasonable and lawful manner for the advancement of the interests of the medical profession and the public generally . . . .

The public trust or fiduciary theory correctly recognizes the professional associations' powerful role in modern society and imposes upon the associations a commensurate duty to act as fiduciaries of the public. It is the most difficult theory of liability to apply and to contain in specific cases because "public interest" and "public policy" are abstractions neither readily grasped nor defined. Used without a keen sense of judicial restraint, these abstractions can lead to judicial infringement on legislative prerogatives; courts have often stated that "primarily it is for the lawmakers to determine the public policy of the State." The public trust theory is both the most straightforward theory that courts have utilized in private association cases and the one most adaptable to the special problems posed by professional associations. It encompasses considerations of autonomy, expertise, public interest, and harm. Although the theory must be developed to balance more explicitly these four considerations and to define more clearly the relevant sources of public policy, it is nevertheless compatible with historical concepts of the judicial function. The common law "is made up of adjustments or compromises of conflicting individual interests in which we turn to some social interest, frequently under the name of public policy, to determine the limits of a reasonable adjustment." Judicial equity powers have also traditionally focused upon protection of the public interest; the more deeply public interests are involved in a controversy, the more broadly and flexibly courts have exercised their equity powers. Thus, both common

(1961), aff'g 62 N.J. Super. 184, 162 A.2d 324 (1960); see text accompanying notes 51-52 supra.

110. Id. at 597, 170 A.2d at 799; see Marjorie Webster Jr. College, Inc. v. Middle States Ass'n of Colleges & Secondary Schools, Inc., 302 F. Supp. 459, 470 (D.D.C. 1969), rev'd, 432 F.2d 650 (D.C. Cir.), cert. denied, 400 U.S. 965 (1970) (concerning private accrediting associations, "[I]n view of the great reliance placed on accreditation by the public and the government, these associations must assume responsibility not only to their membership but also to society"); Greisman v. Newcomb Hosp., 40 N.J. 389, 397-402, 192 A.2d 817, 821-24 (1963) (concerning private hospitals, "powers are deeply imbedded in public aspects, and are rightly viewed, for policy reasons . . . as fiduciary [responsibility]. . . .")

111. See notes 3-4 supra for definitions. For an extended analytical framework for public policy and public interest analysis, see 3 R. POUND, JURISPRUDENCE §§92-93 (1959).


114. See text accompanying notes 180-94 infra.

115. R. POUND, supra note 111, § 93, at 270; see note 187 infra.

law and equity conceptions of the judicial function parallel the judicial role that the public trust theory requires of reviewing courts.\footnote{117}

Other theories of liability against professional associations can be based on the Sherman Antitrust Act\footnote{118} or state antitrust statutes and constitutional provisions.\footnote{119} Since such theories of liability usually are derived from statutes authorizing judicial involvement, they pose less danger of impinging on legislative functions than does the public trust theory. Antitrust statutes, moreover, afford a greater range of remedies than those available under other theories of liability. Under the Sherman Act, for example, injunctive relief and treble damages are available to private litigants, and injunctive relief, actual damages, criminal fines, and imprisonment may be sought by the United States.\footnote{120} Antitrust theories also have a broader economic focus than the other theories of recovery and, consequently, may offer more appropriate solutions to disputes concerning patterns of entry into a profession,\footnote{121} competitive relationships between professions,\footnote{122} sized that equity powers should be exercised without undue deference to the legislative branch and should yield only in response to a clear legislative command.\footnote{Id. 117.}


\footnote{118. 15 U.S.C. §§ 1-7 (1970), as amended, (Supp. V, 1975). Under section 1 of the Sherman Act, every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . . . Id. § 1. Section 3 contains a comparable provision for restraints occurring within the District of Columbia or federal territories. Id. § 3; see American Medical Ass'n v. United States, 317 U.S. 519 (1943). A finding that the alleged trade restraint affects interstate commerce is a predicate to application of section 1 but not section 3. Doctors, Inc. v. Blue Cross, 490 F.2d 48 (3d Cir. 1973).}

\footnote{119. See, e.g., Group Health Cooperative v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951). Many state antitrust statutes contain restraint of trade language similar to that in the Sherman Act. For a compilation of state antitrust provisions, see 4 CCH TRADE REG. REP. ¶¶ 30,000-35,501 (1974).}

\footnote{120. 15 U.S.C. §§ 1, 3-4, 15, 15a, 26 (1970), as amended, (Supp. V, 1975).}

\footnote{121. See generally Wallace, supra note 104 at 89-110.}

\footnote{122. See United States v. College of Am. Pathologists, 1969 Trade Cas. ¶ 72,625 (N.D. Ill. 1969); American Soc'y for Medical Technology v. American Soc'y of Clinical Pathologists, Civ. No. 69-C-1028 (N.D. Ill. 1971) (complaint}
or restrictions on the organizational forms of health services delivery.\textsuperscript{123}

The application of antitrust theories to health professional associations has been limited by occasional judicial recognition of what is called the "learned professions" or "professional" exemption from antitrust laws. Courts have created this exemption by limiting the Sherman Act prohibition of combinations in restraint of "trade or commerce" to business and commercial activities, thus excluding the activities of professions and professional associations.\textsuperscript{124} Similar distinctions have been made under state antitrust laws.\textsuperscript{125} \textit{American Medical Association v. United States},\textsuperscript{126} the leading health profession decision in this area, is inconclusive concerning the existence of a professional exemption. Although the Supreme Court enjoined the AMA from inhibiting the operation of the Group Health Association, a nonprofit prepaid medical services plan, the Court avoided deciding whether the practice of medicine was within the Sherman Act. The Court found instead that Group Health itself was engaged in the "business or trade" of securing "services and facilities" for its members.\textsuperscript{127}

In a recent decision concerning the legal profession, however, the Supreme Court disavowed the existence of any absolute professional exemption from antitrust liability. In holding that defendants' minimum fee schedule system constituted price-fixing, the Court in \textit{Goldfarb v. Virginia State Bar}\textsuperscript{128} stated that the "nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public service aspect of professional practice controlling in determining whether § 1 includes professions."\textsuperscript{129} The Court was careful, however, to limit the scope of its holding:

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 inter-

\textsuperscript{123} See generally Miller, \textit{Structure of Accreditation of Health Educational Programs}, in \textit{SASHEP}, supra note 7, at B-24 to B-26.


\textsuperscript{127} See generally Miller, \textit{Structure of Accreditation of Health Educational Programs}, in \textit{SASHEP}, supra note 7, at B-24 to B-26.


\textsuperscript{129} The court of appeals had faced the question directly and refused to recognize the existence of a professional exemption. See \textit{American Medical Ass'n v. United States}, 130 F.2d 233, 236-38 (D.C. Cir. 1942).

\textsuperscript{130} 421 U.S. 773 (1975).

\textsuperscript{131} Id. at 787. For recent government actions that may test application of this principle to this health professions, see United States v. American Pharmaceutical Ass'n, complaint filed, No. G75-558-CA5 (W.D. Mich. Nov. 24, 1975); \textit{In re American Medical Ass'n}, complaint filed, F.T.C. Docket No. 9064 (Dec. 22, 1975); Proposed Trade Reg. § 447, \textit{Disclosure Regulations Concerning Retail Prices for Prescription Drugs}, 40 Fed. Reg. 24031 (1975), all concerning professional association prohibitions against advertising.

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changeable 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.130

The different treatment of professions could manifest itself in a qualified professional exemption applicable where the business aspect of a profession is not involved.131 If such an exemption is recognized, it should only be where a profession engages in self-regulation in a manner affording procedural safeguards to those upon whom the regulatory burden falls.132 Even without such a qualified exemption, the health professions could be "treated differently" under the rule of reason133 used in judging restraints of trade. The flexibility of the rule of reason would permit consideration of the public service and other unique aspects of the professions.134

The last theory of liability is the constitutional or state action theory. The federal constitutional requirements of due process and equal protection135 apply directly to governmental entities and instrumentalities in the health field. Except for state licensing boards136 and medical staffs in government hospitals,137 however, most health professional activity is private action, which is not normally subject to the constitutional restraints limiting exercises of governmental

130. 421 U.S. at 787 n.17.
131. See id. at 792-93. The District of Columbia Circuit adopted essentially this position in Marjorie Webster Jr. College, Inc. v. Middle States Ass'n of Colleges & Secondary Schools, Inc., 432 F.2d 650, 654 (D.C. Cir.), cert. denied, 400 U.S. 965 (1970), and refused to apply the Sherman Act to the "non-commercial aspects" of professional activity. The Ninth Circuit may have been suggesting a similar approach in refusing to recognize a professional exemption from the prohibition of price-fixing on the ground that pricing policy is "an area of 'entrepreneurial,' rather than professional activity . . . ." Northern Cal. Pharmaceutical Ass'n v. United States, 306 F.2d 379, 385 (9th Cir.), cert. denied, 371 U.S. 862 (1962); cf. Coons, Non-Commercial Purpose as a Sherman Act Defense, 56 Nw. U.L. Rev. 705 (1962).
135. U.S. Const. amend. XIV, § 1; U.S. Consv. amend. V. Due process and equal protection are and will likely remain the constitutional guarantees most often invoked against professional associations under state action theories.
136. E.g., Gibson v. Berryhill, 411 U.S. 564 (1973); see note 29 supra.

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power. For the Constitution to reach ostensibly private activity, courts must find the activity to be sufficiently public to constitute state action. The basis for this transformation is whether "to some significant extent the State in any of its manifestations has been found to have been involved" in the private activity, an inquiry which "frequently admits of no easy answer." Courts have used three theories to reach private activity under the state action doctrine. The delegated power theory applies when a private corporation, association, or other entity acts as an agent of government in exercising powers assigned to it by government. The public function theory applies when a private entity fulfills a governmental function with the implied consent of the government. The government contacts theory applies when a private entity obtains a significant amount of its power, prestige, or resources from the government. The following discussion briefly outlines the potential application of each theory to professional associations in the health professions.

Many states have delegated to the state associations of various health professions the power to nominate members of the licensing board for their particular profession. Several courts have declared that a state association performing this function acts as an agent of the state and that those associational actions relating to this function, including admission of new association members are subject to the constitutional guarantee of equal protection. Likewise, when membership in a local society is a prerequisite to membership in the state association, courts have held the local society's membership policies to the same constitutional standards as those of the state association.

In Marjorie Webster Junior College, Inc. v. Middle States Association of Colleges & Secondary Schools, Inc., the United States District Court of the District of Columbia applied the delegated power theory to the regional accrediting associations recognized by the United States Commissioner of Education under aid-to-education statutes as reliable authorities on the quality of training at particular institutions. The district court found that such associations "have operated as service agencies for the federal government in determining eligibility for

140. See Smith v. Allwright, 321 U.S. 649, 663-66 (1944); Powe v. Miles, 407 F.2d 73, 82-83 (2d Cir. 1966).
143. See notes 28-29 supra and accompanying text. Delegation ordinarily is accomplished by state statute or administrative regulation.
146. 302 F. Supp. at 478; see id. at 470, 477-78. The court of appeals did

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funding.” The same reasoning might apply to professional accrediting associations recognized by the Commissioner, including those in the health professions, and thus subject their accrediting activities to constitutional requirements. Additionally, the delegated power theory of state action might apply to Professional Standards Review Organizations, recently established by federal statute, and to some of the medical service plans created or regulated by state law.

The public function theory of state action, while somewhat overlapping the delegated power theory, focuses less on formal relationships with government and more on the performance of an activity traditionally reserved to government. Since standard setting for health care has traditionally been a prerogative of government under the police power, a professional association that sets health standards in lieu of the government and with the government’s acquiescence arguably fulfills a governmental function. This theory has been utilized as an alternative to the delegated power theory when a health professional association is intimately involved in the selection of a governmental board or commission. In Hawkins v. North Carolina Dental Society, the court held defendant’s activity to be state action by reasoning:

[H]ere the Dental Society appears to be functioning clearly as the agent of the State in the selection of the dental members of the state’s boards and commissions. Our conclusion is not dependent, however, upon a finding of fact to that effect. It is enough that North Carolina in some of its manifestations has involved itself in the Society’s activities and that the Society’s exercise of its powers of practical control or significant influence in the selection of state officials is a public function performed under the general aegis of the state.

The public function theory also may apply to professional accrediting not disagree with this reasoning and “assume[d], without deciding, that either the nature of [Middle States’] activities . . . or the federal recognition which they are awarded renders them state action subject to the limitations of the Fifth Amendment.” 432 F.2d at 658.


150. See notes 228-36 infra and accompanying text.

151. 355 F.2d 718 (4th Cir. 1966).

152. Id. at 722-23.
activities on which state and federal governments widely rely as an alternative to governmental standard setting. In most instances, however, the blurry distinction between governmental and private activity in the health field makes it difficult to determine what functions are sufficiently associated with government to constitute state action.

The third state action theory, the government contacts theory, has been the theory most discussed in recent litigation and probably has the greatest potential applicability to health professional associations. The activities of private hospitals, in particular, have been scrutinized under this theory, and certain activities, such as staff appointments, have been held subject to the constitutional requirements of due process and equal protection. A private hospital's most significant government contact is usually receipt of federal funds for hospital construction and modernization, which must be spent in accordance with state planning and use requirements. Some courts find the use of such funds alone sufficient to transform private hospital activity into state action; other courts require additional government contacts before finding state action. Recent decisions concerning medical staff determinations have refined the government contacts theory, considering not merely whether the government involved itself in the hospital's operation, but whether such involvement extended to the particular activity causing plaintiff's alleged


154. In Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974), the Court appears to limit public functions to those "traditionally exclusively reserved to the State," see id. at 352, or "traditionally the exclusive prerogative of the State." See id. at 353. In separate dissenting opinions, Justices Marshall and Douglas argue that the public function theory should be based on balancing considerations similar to those of autonomy and public concern discussed earlier in this article and should take into account the private entity's monopoly power. See id. at 362-63, 366.


Where government involvement is not so extensive as to permeate all hospital activity, this latter question will significantly limit the theory's future application to medical staff decisions, as well as other health professional association activities.

Despite their difficulties of application, the three state action theories will grow in importance as private concentrations of power become increasingly significant in American life and more aligned with government. "The conditions of modern institutional life tend strongly to break down the distinction between the law of the political state and the internal law of associations." Already, "for the stronger professional associations, [government] is a continuum, a matter of continual interaction and close integration between private and public governments." As these trends increase, courts will be more likely to consider private professional action sufficiently public to incur constitutional sanctions.

Scope of Judicial Review of Professional Association Activities

A court deciding to review the action of a professional association must delineate the scope of its review. It must determine both the depth of its inquiry into the rules, policies, and practices of a professional association and the standards it will use to measure the validity of the association's action.

The above discussion of autonomy, expertise, public interest, and harm provides some notion of how actively and by what methodology courts should review professional association action. In general, the greater the weight of public interest and harm in relation to autonomy and expertise, the more probing judicial review should be. The theories of liability also provide some assistance in determining the proper scope of review since each suggests certain review standards. These theories are sufficiently vague and difficult to apply to professional associations, however, that additional guidance may be desirable.


161. Fuller, Two Principles of Human Association, in VOLUNTARY ASSOCIATIONS, supra note 37, at 14; see notes 43-45 supra and accompanying text.

162. C. Gibb, supra note 45, at 156.
In considering scope of review, situations where the association action is alleged to be procedurally invalid must be distinguished from those where the alleged invalidity is substantive. Courts will scrutinize procedural defects in an association’s decisionmaking more carefully than the association’s substantive standards and policies. The difference is between the procedures followed and the criteria relied upon in making a decision. Courts are well versed in procedural problems, while professional associations have no such special competence; hence, a broad scope of review is likely. Concerning substantive problems, however, the association may be engaged in a standard-setting role inextricably implicating its professional expertise. If so, courts are likely to defer to the association’s special competence; hence, a narrower scope of review is employed.

A variety of judicial statements have been made with regard to the scope of review appropriate to professional association action. The statements are usually somewhat cryptic, and the grounds relied upon in adopting a particular scope of review are sometimes not enunciated. Little consensus has been reached on the appropriate test to apply in particular cases. It is possible, however, to detect three broad levels of judicial review employed by the courts.

At the first and shallowest level of judicial review, courts determine only whether the association has violated its own rules. This is the type of limited review traditionally accorded private associations. It comports with the contract theory, which holds that action contravening association rules is a breach of the association’s contract with its members for which judicial relief generally is available. This first level of review applies with equal force to substantive and procedural rules, provided the rules are clear enough to be understood by the court. When a rule is so vague that the court must interpret it before determining whether the rule was violated, courts may defer to the association’s interpretation, particularly if the rule is a substantive one. Review on the first level is thus relatively simple and straightforward, although limited. Though useful within its narrow confines, it is not adaptable to most of the problems regarding professional associations and is therefore of little utility in solving them.

163. See text accompanying notes 47-70 supra.
166. Sometimes, however, a court will utilize the first level of review only with the proviso that the association’s rules “must not contravene public law, nor any principle of public policy.” Medical Soc. v. Walker, 245 Ala. 135, 138, 16 So. 2d 321, 324 (1944) (citation omitted); accord, Bernstein v. Alameda-Contra Costa Medical Ass’n, 139 Cal. App. 2d 241, 246-47 n.5, 293 P.2d 362, 365 n.5 (1956). This is a step in the direction of the more complex level three review described in the text accompanying notes 180-94 infra.
The second level of review is somewhat of a catchall. It encompasses a variety of tests, most of which are described by shorthand phrases supported by little theoretical analysis. These second level tests share a common background and design: they are attempts to provide judicial review more flexible and probing than that afforded on the first level, while, at the same time, protecting the private associations' autonomy in all but clear cases of abuse of associational powers.

Perhaps the oldest and narrowest test utilized at the second level is that of "good faith." It is primarily a substantive test that permits limited judicial inquiry into the reasons for the action and invalidates actions not motivated by a legitimate association objective. A similar test was used in North Dakota v. North Central Association, the first major accreditation litigation. Holding for the defendant association, the court required that the association's decisions be free from "fraud, collusion, [or] arbitrariness." Other courts have said that they would invalidate association action that is "arbitrary" or "capricious" or "unreasonable," or that fails to "meet judicial standards of fairness and unreasonableness." These tests comprise a balance of both substantive and procedural considerations. Other shorthand tests employed at this level are primarily procedural, such as the old "natural justice" concept and the more modern "rudimentary due process" formulation.

Of all these catch phrases, "reasonableness" is most used and probably the best single descriptor of second level review of professional action. The reasonableness standard can be used in varying degrees with each of the five theories of liability discussed above.

167. See, e.g., Robinson v. Stevens, 249 F.2d 731 (9th Cir. 1957), cert. denied, 356 U.S. 939 (1958). See also Chaee, supra note 38, at 1020.
168. 23 F. Supp. 694 (E.D. Ill.), aff'd, 99 F.2d 697 (7th Cir. 1938).
169. 23 F. Supp. at 699.
172. E.g., Milkie v. Academy of Medicine, 13 Ohio App. 2d 44, 246 N.E.2d 598 (1969); see Chaee, supra note 38, at 1015-18.
174. The reasonableness of the association's interpretation of its rules can become an issue under the contract theory; the "reasonable person" standard is basic to the application of many tort theories; the public trust theory permits inquiry into the reasonableness of association action in light of the association's own policies and goals. But cf. notes 177-80 infra and accompanying text. Under antitrust theory, only unreasonable restraints of trade are illegal. The state action theories usually lead to application of due process or equal protection guarantees, the former involving the reasonableness of the procedures by
Although vague, the reasonableness standard is sufficiently flexible to facilitate judicial review of professional action by courts willing to examine reasonableness in that special context. At the second level of review, reasonableness is determined in relation to the policies and objectives of the association, not in relation to some external standard.

The third and deepest level of judicial review considers the health professions' role in society and the special problems created by their exertion of professional power. Level three review cuts to the heart of these problems: the vital relationship between professional power and the public interest. The validity of association action at this level depends on its consonance with the public interest and public policy. This standard of review can be used to some degree with any of the five theories of liability discussed above. It is particularly compatible with the public trust theory, which fortifies the judicial conception of a profession as a public service pursuit and holds the health professions to their self-proclaimed goal of protecting the public interest.

which association decisions are made, and the latter involving the reasonableness of any discriminatory impact of an association decision.

175. When used to measure the procedural validity of association action, reasonableness is tantamount to a rudimentary due process standard. Requiring that an association's procedures be reasonable is essentially requiring that they provide at least the minimal protections commonly associated with due process. In a procedural context, the rudimentary due process concept is more direct and familiar and is therefore preferable as a standard of review to the more general term "reasonableness."


177. For discussion of third level review under the contract theory, see note 166 supra and accompanying text. Some tort theories, particularly that of prima facie tort, necessitate balancing individual and public interests. See Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. 2d 806, 807 P.2d 568, 26 Cal. Rptr. 640 (1962). For discussion of the public trust theory, see text accompanying notes 106-17 supra. The antitrust theory is sensitive to the public interest insofar as it protects against a "special form of public injury . . . " Apex Hosiery Co. v. Leader, 310 U.S. 469, 493 (1940). The state action theories, as well as the due process and equal protection guarantees which they embrace, are constitutional manifestations of public policy to be implemented consistently with the public interest.


179. See Wiggins, Generic Problems in Graduate Medical Education, in The Medical Staff in the Modern Hospital 354 (C.W. Eisele ed. 1967):

There is a certain substance to the profession of medicine which calls upon the conscience of its members both collectively and individually to honor the common good of the public it serves. At the core of this substance and central to medicine's responsibility as a learned profession is the role of stewardship of a body of knowledge essential to the public welfare. Our value to society is measured ultimately by the extent to which we exercise our stewardship to the benefit of the society which has entrusted it to us.

For a comparable view of accrediting associations' public trust responsibilities, see Selden, Accreditation and the Public Interest (June, 1976) (an occasional paper of The Council on Postsecondary Accreditation). See also Pennell, Proffitt & Hatch, supra note 7, at 11:

There has been and should continue to be a valid plurality of interests connected with each of the health professions. However, the pretensions of each group or sub-group need to be tested against fact, reality, and the larger public interest.
Like second level review, the third level of review is based largely on a standard of reasonableness. Unlike level two, however, it measures reasonableness with reference to public policy rather than to the association's own policies. For a court using this external standard, the greatest difficulty is determining the public policy or public interest inherent in a particular exercise of professional power.\textsuperscript{180} The search is basically one for prevailing social and political values. The constitution and statutes of the jurisdiction constitute the major source of such values. Sometimes a constitutional or statutory provision will apply directly to a dispute, such as ones brought under the antitrust and state action theories and occasionally under the tort theories discussed above. In such instances, public policy is relatively clear. When pertinent constitutional and statutory provisions do not apply directly, a court may nevertheless extract from them an expression of public policy. In \textit{Falcone}, for example, the lower court found in the state medical licensure laws a public policy that had been contravened by the local medical society in excluding plaintiff from membership:

\textit{The State of New Jersey has determined that it is in the public interest that graduates of [a state-approved school] who successfully pass the State Board examination be admitted to the practice of medicine and surgery in this State. The State of New Jersey is the appropriate authority for the declaration of public policy in relation to this field, and the same may not lawfully be exercised by any independent agency.}\textsuperscript{181}

In addition to state constitutions and statutes, prior judicial decisions are important public policy sources.\textsuperscript{182} Executive pronouncements, the regulations and policies of administrative agencies, and other official action evidencing "long governmental practice" in the jurisdiction also may be bellwethers of public policy.\textsuperscript{183} When these

\textsuperscript{180} See notes 111–13 \textit{supra} and accompanying text. See generally Harris, \textit{Voluntary Association as a Rational Ideal}, in \textit{Voluntary Associations, supra} note 37, at 53–60.


\textsuperscript{182} Twin City Pipe Line Co. v. Harding Glass Co., 283 U.S. 353, 357 (1931); \textit{see note} 4 \textit{supra}; \textit{cf.} notes 112–15 \textit{supra} and accompanying text.

\textsuperscript{183} See Muschany v. United States, 324 U.S. 49, 66 (1945).
sources are exhausted, public policy may be found in the “general current” of legislation and judicial opinion.\textsuperscript{184} Other more amorphous sources mentioned by some courts include “modern experience and thought,”\textsuperscript{185} “history and experience,”\textsuperscript{186} and “obvious ethical or moral standards.”\textsuperscript{187}

A search of public policy sources, even at the statute level, is usually a complex undertaking. A court often will require the testimony of government officials or experts in health or other disciplines who are trained to identify the predominant needs and demands of society.\textsuperscript{188} The farther afield the search extends, the greater the deference to be accorded the professional association’s position, especially if the dispute involves an association’s substantive determination based on its true expertise. If the search for public policy fails, level three review also fails for lack of an external standard by which to gauge the validity of associational action. A reviewing court should revert then to level two. In the health care field, however such a result will become less likely as governmental interest and activity grow\textsuperscript{189} and as scholarly and professional attention to the public interest increases.\textsuperscript{190}

The search for public policy is easier for procedural issues than for substantive issues. In the procedural realm, the due process guarantees of state and federal constitutions may be persuasive guides to public policy. Under the state action doctrine, the federal constitution may apply directly to professional action and impose due process as a requirement of constitutional law, rather than as mere pronouncements of public policy.\textsuperscript{191} Under other theories of liability, courts may find constitutional due process a predominant source of public policy.

\textsuperscript{184} See Funk v. United States, 290 U.S. 371, 381-82 (1933).  
\textsuperscript{185} Id. at 381.  
\textsuperscript{187} Muschany v. United States, 324 U.S. 49, 66-67 (1945); see Rosenthal v. Harwood, 35 N.Y.2d 469, 323 N.E.2d 179, 363 N.Y.S. 939 (1974) (codes of professional ethics as a source of public policy). Although elusive, such sources are clearly among the wellsprings of judge-made law. As Justice Holmes noted long ago, legal considerations include “the felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed or unconscious.”

\textsuperscript{188} The litigation in Marjorie Webster Jr. College, Inc. v. Middle States Ass’n of Colleges & Secondary Schools, 302 F. Supp. 459 (D.D.C. 1969), rev’d, 432 F.2d 650 (D.C. Cir.), cert. denied, 400 U.S. 965 (1970), see notes 94, 131, 153 supra and accompanying text, is illustrative of a judicial search for public policy. The ten-week trial included voluminous testimony by government officials and experts in education, economics, sociology, and administration. Federal and state statutes and governmental practices were analyzed for their public policy content. The policies of other accrediting associations and a wide sampling of “modern thought and experience” were considered.

\textsuperscript{189} See notes 225-41 infra and accompanying text.  
\textsuperscript{190} See, e.g., R. Stevens, supra note 6; Hospitals, Doctors, and the Public Interest (J. Knowles ed. 1965); Cohen, Professional Licensure, Organizational Behavior, and the Public Interest, 51 Milbank, Mem. Fund Q. 73 (1973). See generally notes 1-3, 5, 7-9, 14, 21, 26, 27, 31, 40-42, 64 supra.

\textsuperscript{191} See text accompanying notes 155-66 supra.
and impose due process restrictions on professional associations by analogizing the "private governments" of the professions to public governments.192

In substantive disputes, no single public policy source is predominant, and the public interest will vary with the nature of association action and the social values involved. While the professional association's expert view on substantive public policy is important, the court should avoid merely accepting the association's view because the association's notion of the public interest will necessarily be affected by its own special interests.193 The court, moreover, should remember that "the public interest is more than the arithmetical sum of the private interests of the nation."194 The search at level three must be for a transcendent public interest superior to the private interest of any or all private groups in the social and political structure.

The depth of a particular court's review can seldom be categorized neatly into one of the above three levels, partly because insufficient attention has been accorded to review standards and partly because courts may simultaneously pursue more than one level of review. In Falcone, for instance, the court required the defendant medical society to act "in a reasonable and lawful manner for the advancement of the interest of the medical profession and the public generally."195 In Greisman v. Newcomb Hospital,196 the test was whether the hospital's action was "reasonab[le] and for the public good."197 The Marjorie Webster litigation198 is illustrative of an intermixture of review standards. The district court began its analysis under an antitrust theory by evaluating the reasonableness of the association's action in relation to the association's stated objectives.199 It next undertook an amalgam of public trust and state action analyses, using a standard of "arbitrary, discriminatory, and unreasonable" at one point and "arbitrary, unreasonable, and contrary to the public inter-

192. See generally text accompanying notes 5-31 supra. For a discussion of the analogy between public governments and professional associations see notes 43-46 supra and accompanying text.
193. See Harris, supra note 100, at 54-55. See also notes 48-50 supra and accompanying text.
196. 40 N.J. 389, 192 A.2d 817 (1963); see text accompanying notes 53-54 supra.
197. 40 N.J. at 402-03, 192 A.2d at 824.
199. 302 F. Supp. at 469.
The court of appeals restated the public trust standard as "reasonable, applied with an even hand, and not in conflict with the public policy of the jurisdiction," but used a reasonableness test relating to the association's objectives, rather than the public interest, because of its doubts concerning the strength of the association's monopoly power. The appellate court also relied on a similar reasonableness standard in its state action-due process analysis.

The best attempt thus far at organizing the various review standards into a workable pattern is probably the opinion in Blende v. Maricopa County Medical Society. In reviewing the medical society's rejection of the plaintiff physician's membership application, the court first considered whether the society had complied with its own procedural rules—a level one inquiry. Next, the court determined that the society had not acted in bad faith—a level two inquiry. Advancing to a combined level two and level three approach, the court observed that the society could reject the application "only on a showing of just cause established by the Society under proceedings embodying the elements of due process." Under this approach, due process is the test of procedural validity and "just cause" the test of substantive validity. "Just cause" embodies a standard of reasonableness which, in turn, requires consideration of the public interest:

When determining whether "just cause" has been shown, the court must consider whether the grounds for exclusion were (1) supported by substantial evidence and (2) reasonably related to legitimate professional purposes of the Society. The judicial process involved in determining such a standard of reasonableness is essentially one of balancing individual, group and public interests: the right of the individual to practice his profession without undue restriction; the right of the public to have unrestricted choice of physicians; and the justification for the Society's action. When examining the justification for the exclusion, the court should consider several factors: the social value of the goal of the Society's action; the appropriateness of the Society as a means for achieving the goal, and the reasonableness of this particular action of the Society in relation to the goal.

Utilizing this reasonableness-public interest standard, the court held that the plaintiff's complaint stated a cause of action and remanded the case for further proceedings consistent with its opinion.

Procedural Due Process

Procedural due process is a major component of the standards utilized at the second and third levels of judicial review and deserves exten-
sive treatment because of its special importance in the developing law of health professional associations. Procedural due process requirements inhibit arbitrariness and impose order and regularity on professional decisionmaking processes. They seek to assure both the integrity of the decisionmaking process and the substantive validity of the decisions, thus protecting affected parties and the public against abuses of professional power.207

Due process is a constitutional concept embodied in the fifth and fourteenth amendments to the United States Constitution. In professional association law, however, due process has been increasingly invoked as a nonconstitutional doctrine which limits professional power even when an association's action does not constitute state action.208 Although constitutional due process is theoretically more stringent than the nonconstitutional concept, the two concepts have substantially the same effect on professional power problems.209

To determine the requirements that procedural due process places on professional association decisionmaking, a distinction must be made between adjudicatory procedures and rulemaking procedures. Rulemaking procedures are used in formulating general standards and policies; adjudicatory procedures are used in applying those standards and policies to specific cases. Although adoption of comprehensive rulemaking procedures may improve the quality of the decisions made by a health professional association and may increase judicial and public confidence in its standards, courts have not imposed rulemaking procedures on professional associations. In the adjudicatory context, however, courts have increasingly applied procedural requirements to professional association decisions, such as a hospital medical staff's decision to exclude or expel a particular physician.

207. Due process is substantive as well as procedural, as is the law concerning the scope of review of the activities of professional associations. See text accompanying notes 163–94 supra. In the context of professional associations, substantive due process, as either a constitutional or nonconstitutional concept, subjects an association's substantive standards and policies to general reasonableness requirements like those used in level two and three review. See text accompanying notes 167–90, 206 supra. Courts resort to substantive due process less frequently, and with greater restraint, than procedural due process. See text accompanying notes 163–64 supra. They often do not refer to it by name even when applying its principles.

208. See notes 96, 172–78, 191–92, 205 supra and accompanying text. Procedural requirements are most likely to be imposed under the contract or public trust theories, see text accompanying notes 95–97, 106–17 supra, although there is also precedent under federal antitrust law. See note 132 supra and accompanying text. Procedural requirements are occasionally imposed on professional associations by statute. See Needleman v. Dade County Medical Ass'n, 205 So. 2d 17 (Fla. 1967).

209. See Duby v. American College of Surgeons, 468 F.2d 364, 368 (7th Cir. 1972). For the purposes of this discussion the requirements of constitutional and nonconstitutional due process will be considered as being the same. All cited cases are based on the nonconstitutional approach unless otherwise noted.
The procedures to be imposed on association decisionmaking should depend on the gravity of the decision to be made and its potential impact on the affected party, the importance of a particular procedure in assuring the decision's substantive validity, and the burden that a particular procedure would place on the association's pursuit of its organizational objectives. The likelihood of judicial imposition increases as the gravity of the decision and the importance of the procedure increase, and decreases as the procedure's burden on the association increases. Since the health professional associations' monopoly power often heightens the gravity of their decisions, courts are likely to require substantial procedural protection in association decisionmaking.

The adjudicative hearing is the core of procedural due process. It provides the affected party an opportunity to present his case before adverse action is taken against him. In Pinsker v. Pacific Coast Society of Orthodontists, the California Supreme Court upheld a doctor's right to a hearing before being rejected for admission to a medical society. After canvassing the relevant professional association decisions, the court concluded that "[e]very one of the numerous common law precedents in the area establish that this element [the hearing] is indispensable to a fair procedure.

To assure a fair hearing, due process normally guarantees the affected party the right to appear personally and to present witnesses, written testimony and documents, and other evidence in his behalf. Often he must be accorded the opportunity to confront and refute the evidence against him. Due process does not ordinarily guarantee the right to counsel to perform these functions, however, unless the professional association is itself represented by counsel at the hearing. Imposition of such requirements need not transform associa-


211. See text accompanying notes 76-94 supra.


tion hearings into "formal proceedings with all the embellishments of a court trial... [or otherwise] fix a rigid procedure... Instead, the associations themselves retain the primary responsibility for devising... [procedures appropriate to the dispute]."217 As one court recently explained in distinguishing accreditation decisions from disciplinary decisions:

The nature of the hearing... may properly be adjusted to the nature of the issue to be decided.... Procedures appropriate to decide whether a specific act of plain misconduct was committed are not suited to an expert evaluation of education quality. Here, no trial-type hearing with confrontation [of adverse witnesses], cross-examination, and assistance of counsel would have been suited to the resolution of the issues to be decided. The question was not principally a matter of historical fact, but rather of the application of a standard of quality in a field of recognized expertise.218

The opportunity for a hearing would little benefit an affected party with no adequate opportunity to prepare for it. Due process requires, therefore, that the party be given advance notice of the "time, place, and subject of the inquiry, [and] adequate notice of exactly what conduct was under investigation."219 This notice must normally include a "written statement... adequate to apprise... [the party] of the specific charges against him"220 and provide a definite and understandable basis for organizing the defense. The affected party must also be provided notice of the hearing's format and allowed sufficient time for defense preparation.

Specification of the contested conduct is of full value to the affected party only if he has advance notice of the standards for evaluating the conduct. Although courts seldom address this matter, due process would normally require an association to have such standards and to apprise the affected party of which standard he allegedly has not met. Pre-existing standards are useful not only to the affected party, but to all potential parties who desire guidance in evaluating their own professional performance. Professional action that penalizes an association member or prospective member for noncompliance with a standard that is either nonexistent or not constructively known to

the party at the time of the alleged noncompliance is inconsistent with modern notions of due process.

To provide adequate notice, standards should be in writing and stated with sufficient definiteness to be intelligible. Extensive definition or technical detail is usually not required. A professional association is "entitled to make a conscious choice in favor of flexible standards to accommodate variation in purpose and character among its constituent institutions [or members], and to avoid forcing all into a rigid and uniform mold." The more deeply the association's professional expertise is implicated in the formulation and application of its standards, the more flexibility will due process ordinarily permit.

Due process requires that a decision made after a hearing be based on the record of the proceedings. The decision must be based upon the charges or deficiencies specified by the association, the association standards allegedly violated, and the factual evidence presented at the hearing. The decisionmakers must be impartial. Additionally, due process may sometimes require that the association justify its decision in a written statement to substantiate that the decision is based on the record.

Conclusion

The activities of health professional associations have received varied treatment in the courts. The judicial response to problems of professional power has been inadequately reasoned and often has failed to consider the broad social issues these problems raise. The courts must develop a more comprehensive methodology for reviewing professional association activity. They cannot ignore abuses of professional power in health care, and they must chart a careful course between competing public policy concerns. Courts must identify more clearly these public policy concerns and further define the theories of liability and scope of judicial review in individual cases. They must

221. Parsons College v. North Central Ass'n, 271 F. Supp. 65, 73 (N.D. Ill. 1967); see Sosa v. Val Verde Mem. Hosp., 437 F.2d 173, 176-77 (5th Cir. 1971) (constitutional theory in which the court stated: "[I]n the area of personal fitness for medical staff privileges, precise standards are difficult if not impossible to articulate. The subjectiveness of selection simply cannot be minutely codified.").
also expand the role of empirical data and expert testimony in resolving professional power disputes.

Solving problems of professional power is a task for legislatures as well as the judiciary. To date, however, legislatures have remained aloof from such problems.\textsuperscript{226} Only the antitrust theories of liability are based on statutory texts, and the application of these theories to the health professions has been accomplished by judicial craftsmanship rather than by express legislative command.\textsuperscript{226} Although many of the decisions discussed above demonstrate that courts play a role independent of legislatures in modernizing and developing legal responses to professional power problems,\textsuperscript{227} growing public awareness of the vital relationship between professional standard setting and the public interest may prompt legislatures to increase their scrutiny of professional associations.\textsuperscript{228} State legislatures have extensive authority under the police power to regulate the delivery of health care and to establish professional standards.\textsuperscript{229} Similarly, Congress can exert considerable regulatory influence under its spending and commerce powers.\textsuperscript{226} Although both state and federal legislative activity concerning health care is increasing,\textsuperscript{229} statutes regulating the standard-setting activities of professional associations are rare.\textsuperscript{232}

\textsuperscript{225} For analyses of influences within the legislative process that have inhibited legislative activism, see Gilb, supra note 45, at 196-223; Akers, The Professional Association and the Legal Regulation of Practice, 2 Law & Soc. Rev. 463, 465-70 (1968).

\textsuperscript{226} See notes 118-34 supra and accompanying text.

\textsuperscript{227} See notes 4, 115-17, 190-87, 195-205 supra and accompanying text; cf. notes 111-13 supra and accompanying text.

\textsuperscript{228} For a general approach to determining whether legislative intervention is appropriate, see notes 4, 86 supra and accompanying text.


\textsuperscript{231} An example of state legislative activity is the regulation of new categories of auxiliary health personnel, such as physician assistants. See U.S. Dept. of Health, Education, & Welfare, supra note 26, Appendix B (1971). The major federal example is the Professional Standards Review legislation. See note 10 supra and accompanying text. For a discussion of federal legislative activity, see R. Stevens, supra note 6, at 496-527 (1971).

\textsuperscript{232} But see N.Y. Pub. Health Law § 296-a (McKinney 1971) (prohibition
Future legislation could set standards under the hospital licensure laws for the extension and revocation of hospital privileges; impose minimal procedural requirements on professional associations under state corporation law for the extension and revocation of association membership; clarify or extend the application of federal and state antitrust laws to professional associations; and devise structural or procedural conditions to be met by a professional association before state or federal governments will rely on its decisions.

Health professional associations should note carefully the current judicial and prospective legislative trends. Even though these trends indicate increasing public scrutiny of professional power, they do not presage an end to professional autonomy or an undermining of professional expertise. Rather, they suggest that the deference accorded autonomy and expertise will be weighed against a broader backdrop of public interest considerations.

The health professional associations must accommodate this increased public concern and assure the courts, the legislatures, and the general public that professional power is not being abused. Suggested areas for associational reform include developing an empirical basis for the establishment and validation of professional standards; affording affected outside parties an opportunity to comment on proposed standards; strengthening due process safeguards in decisions to deny, revoke, or limit professional status or privileges; requiring formal representation of other professions and the public in standard-setting and enforcing processes; and rethinking and justifying on denial of hospital staff privileges due to participation in group practice).

\[\text{id. at § 2801-b (requirement that hospitals state reasons for any denial or limitation of staff privileges, and that reasons be related "to standards of patient care, patient welfare, the objectives of the institution, or the character or competency of the applicant");} \]

\[\text{N.Y. NOT-FOR-PROFIT Corp. LAW § 1406 (McKinney 1970) (right to appeal to state medical society from certain membership decisions of county medical societies); FlA. STAT. ANN. § 617.10 (1975) (right to hearing before expulsion from professional association).} \]

\[\text{See generally, Comment, Hospital Staff Privileges—the Need for Legislation, 17 STAN. L. REV. 900 (1965).} \]

\[\text{See N.Y. NOT-FOR-PROFIT Corp. LAW § 1406 (McKinney 1970); FlA. STAT. ANN. § 617.10 (1975).} \]

\[\text{See notes 118-34 supra and accompanying text.} \]

\[\text{See Criteria and Procedures for Recognition of Nationally Recognized Accrediting Agencies and Associations, 45 C.F.R. §§ 149.1-24 (1975) (criteria by which Commissioner of Education recognizes accrediting bodies under federal aid-to-education programs).} \]

\[\text{See generally Selden, Research in Accreditation of Health Educational Programs, in SASHEP, supra note 7, pt. I.} \]

\[\text{See notes 207-24 supra and accompanying text.} \]

\[\text{See generally J. Miller, supra note 3, at 186-94. If an association’s procedures provide affected parties with remedies, courts will usually require the parties to exhaust those procedures as a prerequisite for judicial review. See note 32 supra and accompanying text. Thus, procedural reform would not only remove a ground on which courts frequently have invalidated professional decisions, see notes 207-24 supra and accompanying text, but would greatly increase the association’s opportunity to handle disputes internally, insulated from judicial intervention.} \]

\[\text{See SASHEP, supra note 15, at 23, 27; Selden, Accreditation and the Public Interest (an occasional paper of The Council on Postsecondary Accreditation, June 1976); cf. Cohen, note 190 supra, at 81-83, 84-85 (public and interprofessional representation on state licensing boards).} \]
Such reforms are not panaceas. Reforms never are. But their implementation can regenerate public confidence in the health professions, better protect the public interest in health care, and decrease the likelihood of judicial involvement in the affairs of health professional associations.

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241. See notes 11-31 supra and accompanying text. See also Grimm, supra note 14, at I-1, I-22 to 24.